A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF SUBSTANCE ABUSE PEER RECOVERY COACHES CAREER MOTIVATION AND PROFESSIONAL EXPERIENCES

by

Aaron Spence Hymes

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Approved by:

_____
Dr. John R. Culbreth

_____
Dr. Henry Harris

_____
Dr. Daniel Gutierrez

_____
Dr. Jae Hoon Lim

_____
Dr. Sean McCloud

ABSTRACT

AARON SPENCE HYMES. A phenomenological study of substance abuse peer recovery coaches career motivation and professional experiences. (Under the direction of DR. JOHN R. CULBRETH)

This dissertation examined the experiences leading to working as a Substance Abuse Peer Recovery Coach and experiences while working as a Substance Abuse Peer Recovery Coach. This study utilized a phenomenological approach to analyze Peer Recovery Coach interviews conducted face-to-face or via telephone. The primary researcher and independent coder compared extracted statements and placed them into categories, clusters of themes, and themes during data analysis. The essence of the participants' experiences was presented through narration. The results of this study indicated (a) a desire to give back and instill hope, (b) encouragement from someone within the recovery community, (c) an improved career outlook, and (d) job stability and the inclusion of benefits were factors in leading to working as a Peer Recovery Coach. Experiences while working as a Peer Recovery Coach included both professional and personal accounts. Professional experiences included: (a) serving as an agent bridging the gap, (b) adjusting to the Peer Recovery Coach role, (c) duality of role and identity, (d) the workplace environment, and (e) pursuing a professional career. Personal experiences included: (a) personal growth and contribution to recovery, (b) validation of change, and (c) belief in belonging.

DEDICATION

This dissertation is dedicated to all those who have supported and lifted me up through the challenges and good times of my life. Thank you to my amazing wife Rachel, who never wavered in believing in and supporting my dreams even when I did. Thank you to my wonderful parents, Mike and Cecelia, who remained steadfast in supporting my drive, even when it deviated from the path. Thank you to my in-laws, Luther and Diane, for providing me with love and the generosity of a home away from home. This dissertation is dedicated to my son Elliott. Don't let yourself be the barrier to achieving even your wildest dreams in this life. Be a light in this world and shine it on all you come into contact with. Lastly, I thank God for remaining by my side during my life's journeys.

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Lastly, I would like to thank the participants of this study. Without their openness and bravery to share their stories this study would not have been possible.

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LIST OF ABBREVIATIONS

Abbreviation	**Meaning**
AA	Alcoholics Anonymous
BRSS TACS	Bringing Recovery Supports to Scale Technical Assistance Center
CSB	Community Service Board
DBHDS	Department of Behavioral Health and Developmental Services
HPR	Health Planning Region
NA	Narcotics Anonymous
NAADAC	National Association for Alcoholism and Drug Abuse Counselors
NIDA	National Institute on Drug Abuse
NSDUH	National Survey on Drug Abuse and Health
P-BRSS	Peer-Based Recovery Support Services
PPR	Planning Partnership Region
RM	Recovery Management
RCSP	Recovery Community Service Program
SAARA	Substance Abuse and Addiction Recovery Alliance
SAMSHA	Substance Abuse and Mental Health Services Administration
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

The vastness of substance abuse continues to warrant our attention. The constant abuse of illicit substances despite availability of treatment services signaled the need to transform a fractured substance abuse treatment system. These concerns have driven the efforts of legislators and policymakers to take measures in an attempt to lower substance abuse rates and promote recovery-oriented services and the concept of community-based recovery (SAMSHA, 2009; 2011; 2012; White, 2010). The creation of these new initiatives placed renewed focus on the inclusion of peer-based services and specifically the creation of Peer Recovery Coach positions. These new positions, along with the recovery advocacy movement, are resulting in a reshaping of the substance abuse treatment system.

Peer Recovery Coaches often serve alongside professional service providers through varying settings. Previous studies have sought to describe the variation in roles and services provided by professional providers, Peer Recovery Coaches, and Twelve-step recovery sponsors (SAMSHA, 2009; 2012; White; 2006; 2012a; 2012b; 2014). Although there has been a need to delineate these roles, little focus has been placed on the lived experiences of those serving as Peer Recovery Coaches. Farkas, Ashcraft, and Anthony (as cited in SAMSHA, 2012) noted programs making good use of peer support services promote a culture embracing recovery-orientation, collaboration between staff members, and seeks to be a learning community. It is in this framework that we have an

obligation to hear the voices of Peer Recovery Coaches speak of their lived experiences working as a Peer Recovery Coach.

Current Trends in Substance Abuse

Current trends in substance abuse treatment suggest substance abuse largely affects society at an economic level. The United Nations Office on Drugs and Crime [UNODC] (2012) estimated it would cost between $200-$250 billion US dollars to cover substance abuse related treatment costs worldwide although the actual amount spent on treatment is much lower. The Substance Abuse and Mental Health Services Administration (2013) noted in the 2013 National Survey on Drug Use and Health (NSDUH) (Substance Abuse and Mental Health Services Administration [SAMSHA], 2013), a total of 22.7 million persons aged 12 and older were in need of treatment from a drug or alcohol use problem in 2013. The NSDUH (SAMSHA, 2013) further indicated that of these 22.7 million in need, a total of 2.5 million received treatment in a specialized facility. Additionally, the UNODC (UNODC, 2012) reported less than one in five persons who needed treatment actually received treatment. SAMSHA noted in the *Behavioral Health Barometer, Virginia 2013* (2013), 2.4% of persons aged 12 or older in the state of Virginia were substance dependent or abused illicit substances. SAMSHA indicates of the persons 12 and older reporting substance dependence or illicit drug abuse, approximately 18.8% received treatment in the year 2012. Despite the prevalence of substance abuse treatment services, the structure of care appears to fall short of meeting the level of those in need. (SAMSHA, 2013)

Substance abuse treatment services experienced a shift in structure as a result of changes in policy and funding. The creation of the Mental Health Parity and Addiction

Equity Act (2008) and more recently the Patient Protection and Affordable Care Act (2010) serve as the catalysts of change to an integrative community based approach. As a result of healthcare reform, funding in the form of block grants were redesigned to integrate recovery, wellness, and peer roles into substance abuse treatment services (SAMSHA, 2011; 2012). This change in focus and funding has been the driving force in substance abuse systems deviating from treatment through an acute care model to a more community-based and recovery-oriented approach (White, 2006; 2010). SAMSHA asserts behavioral health systems are striving to develop into a recovery-oriented approach, able to expand recovery opportunities for people experiencing substance abuse. The Recovery to Practice (RTP) initiative was introduced by SAMSHA in 2009 in an effort to urge awareness, acceptance, and adoption of recovery-based practices in substance abuse treatment services (SAMSHA, 2011). Transitioning into a community-based and recovery-oriented treatment approach led to a greater demand for peer recovery support services (SAMSHA, 2012). Specifically, SAMSHA estimated an increase in Peer Recovery Coaches being integrated into the recovery workforce. Additionally, White (2010) contends the recovery advocacy movement has resulted in an extensive menu of recovery support services being integrated into the changing infrastructure of substance abuse treatment.

Traditionally, there have been two distinct roles to support progress in substance abuse recovery: professional addiction service providers, and sponsors, who are typically found in Twelve-step recovery groups. However, these two roles fail to meet the changing direction of substance abuse treatment services into a recovery-oriented system of care. White (2010) notes Peer Recovery Coaches stand to fill the gap between

professional service providers and Twelve-step sponsors. Peer Recovery Coaches have lived experience with substance abuse recovery, serving in paid or volunteer roles across multiple domains of substance abuse treatment services (White, 2006). Peer Recovery Coaches provide recovery-oriented services in the form of outreach to those in need of recovery, as a linking agent to professional services and recovery communities (e.g. 12-step recovery groups, faith-based recovery groups), and as a system of support and recovery education pre-treatment, in-treatment, and post-stabilization (White, 2010; 2012). The overarching goals of Peer Recovery Coaches are to promote recovery, remove barriers to recovery, connect those seeking recovery from substance abuse with recovery support services, and to promote hope, optimism, and healthier lifestyles (Beckett, 2012). SAMSHA (Kaplan, 2008) recognized recovery in the community as needed and remains committed to meeting this need through the development of Recovery Support Services, particularly Peer Recovery Coach services.

Addiction counseling is rooted in the lived experiences of recovery (White, 2008). Traditionally, substance abuse counseling consisted of counselors who experienced the recovery process rather than having formal education in counseling or addiction treatment (Aiken & LoSciuto, 1985; Culbreth & Borders, 1999; Culbreth, 2008; LoSciuto, Aiken, Aussets, & Brown, 1984; West & Hamm, 2012). The creation of comprehensive community mental health centers by the National Institute on Mental Health resulted in recovering people being hired as counselors to work alongside more traditional treatment providers (White, 2000b). White (2012) postulated by the 1990's a shift in thought centered on the disconnection between the multibillion-dollar industry of addictions treatment and the recovery community.

White (2006) noted Peer Recovery Coaches emerged out of this need to reconnect substance abuse treatment to the process of substance abuse recovery. The prevailing belief of professional providers and the recovery community is the need for a bridge between the substance abuse treatment industry and the continual process of recovery (White, 2012a). Peer Recovery Coaches developed to become this bridge. Peer Recovery Coaches help bridge the gap between professional knowledge and services engagement and experiential knowledge of the recovery process through helping build client-driven recovery plans to promote recovery within their community (Kaplan, 2008; White, 2000c).

The role of the Peer Recovery Coach falls between that of professional treatment service providers and Twelve-step sponsors (White, 2006) making a clearly defined role difficult to achieve. PRCs serve in a non-clinical capacity within substance abuse treatment services (SAMSHA, 2012; White, 2011). The focus of PRCs is to maintain a recovery-focused perspective in working with clients. The experiential knowledge possessed as a result of lived experience positions Peer Recovery Coaches to work with the client through managing the stages of recovery as opposed to mere symptom reduction.

The role of PRCs is to focus on helping the client heal and improve their recovery outcome through support in improving health and wellness. In addition, they are also responsible for increasing the client's sense of self-efficacy, empowering the client, and becoming more engaged in their own communities (SAMSHA, 2012). This is accomplished through a strength-based approach and long-term interaction with the client (Mead & MacNeil, 2006; SAMSHA 2012; White, 2006). PRC services come in the form

of four types of support to the client. SAMSHA (2009) identifies these four types of support services as falling under the categories of emotional, informational, instrumental, and affiliational. These categories will be described in more depth in Chapter 2.

There still remains difficulty in understanding how the PRC roles differ from that of traditional substance abuse treatment professionals. Beckett (2012) and White (2006) note key differences in the roles include PRCs operating within a wide variety of environments and within multiple frameworks of recovery (Beckett, 2012), PRC roles diminish the power-differential in the relationship with clients (SAMSHA, 2012), and the length of the service relationship is much longer in duration compared to traditional substance abuse treatment professionals (White, 2006; 2011). Moreover, SAMSHA (2012) and White (2012) who asserted Peer Recovery Coaches do not make assessments, or dispense expert opinions. Peer Recovery Coaches, typically, have less formal education in counseling than do professional service providers, and as such are not involved in conducting assessment, diagnosis, and treatment planning (White, 2006). In earnest, Peer Recovery Coaches appear to have evolved directly from the paraprofessional movement.

Movement toward integrating paraprofessionals into the counseling field took place as far back as the 1960's (White, 2006). The supporting idea being paraprofessionals can be trained to fill counseling roles and provide valuable services in treating alcoholism. A large number of recovering people began providing services as counselors, aides, psychiatric technicians and house managers from the mid 1960's to the mid 1970's. Moreover, an evolution of paraprofessionals as the 1970's brought about advocacy for changes in federal legislation for addictions treatment led to credentialing

standards (White, 2012). Credentialing standards forced many paraprofessionals out of the addictions treatment field. The current movement and growth of Peer Recovery Coaches marks a return of people in recovery to the substance abuse treatment arena (White, 2014).

Peer Recovery Coaches continue to develop into an integral part of the current substance abuse treatment model. As previously noted, from the shift toward recovery–oriented services emerged the development of non-clinical recovery support services, specifically peer-based recovery support services (P-BRSS) (White, 2009). Further, White (2009) declared P-BRSS has developed into an affordable model of care accessible by those in need of treatment. P-BRSS supports the person's transition into stable long-term recovery through an increased duration of service contact with the client. As a result of P-BRSS, PRCs are working in paid and volunteer roles within community organizations, private practices, with child welfare and criminal justice initiatives, as well as substance abuse treatment organizations. Moreover, some managed care companies are currently reimbursing Peer Recovery Coach services and he foresees it becoming a reimbursable service under the new healthcare reform process (White, 2009; 2011).

A large amount of research has focused on the importance of defining the differences in functions of Peer Recovery Coaches in comparison to addiction counselors and Twelve-step sponsors (SAMSHA, 2009; 2012; White; 2006; 2012a; 2012b; 2014). Yet, a gap remains in describing why peer providers seek peer recovery coach positions. SAMSHA (2012) identified a need for research into the program structures, styles of supervision, and supports that help Peer Recovery Coaches experience job success and role satisfaction. SAMSHA further maintains Peer Recovery Coach training programs

need to be evaluated for their results and impact on client outcomes and the behavioral health field. As of 2012, no national consensus defining standards for recovery coach training programs exists and funding to train recovery coaches remains sparse in the field of addictions (SAMSHA, 2012).

Laudet and White (2010) declared the perspectives and experiences of substance users remain neglected in services research. Additionally, they claimed a lack of information focused on whether and how priorities and service needs change as recovery unfolds. Likewise, the experiences and perspectives of those working as PRCs are unheard, resulting in a lack of information about priorities and service structure needs as they work to maintain their own recovery, while helping others transition to recovery. According to Laudet and Humphreys (2013). Peer Recovery Coaching has not been systematically evaluated to date. Thus, a firm research base must be established to augment the availability and adoption of recovery support services. Perpetuating this gap in research prohibits policy makers, providers, and researchers from receiving funding of Recovery Oriented Systems of Care data needed to inform future decisions.
SAMSHA (2012) clearly stated the need for ongoing research and evaluation of peer support/recovery coaching in an effort to learn about their experiences. Furthermore, Davison et al. (2010) identified a paucity of research on the relationship between P-BRSS and the clinical care system, the role and career trajectory of P-BRSS providers, and ethical considerations inherent to P-BRSS services.

In the context of Counseling and Counselor Education, this study may serve to enhance the understanding of the shift in addictions treatment to a ROSC and the roles of Peer Recovery Coaches within this system. Specifically, The Council for Accreditation of

Counseling and Related Educational Programs (CACREP, 2009) noted program objectives under foundation of Professional Identity should "reflect current knowledge and projected needs concerning counseling practice in a multicultural and pluralistic society" (p. 8). *S*pecific to Clinical Mental Health Counseling standards, CACREP states under Foundations, section A, Knowledge number three:

> Understands the history, philosophy, and trends in clinical mental health counseling, as well as understands the roles and functions of clinical mental health counselors in various practice settings and the importance of relationships between counselors and other professionals, including interdisciplinary treatment teams (CACREP, 2009, p. 29).

Austin, Ramakrishnan and Hopper (2014) stated, "investigating peer support is important in its own right, as well as for what it reveals about the mental health system" (p.884). In keeping with the person-centered continuum of care elements of the model, the usefulness of research includes qualitative information tapping into the clients' experiences (Laudet & White, 2010). Moreover, qualitative inquiry describing the lived experiences of those working in Peer Recovery Coach roles are fundamental to fostering effective P-BRSS delivery and maintaining their personal recovery Laudet et al. (2009) contend:

> Qualitative methods that use an open-ended format and record participants' verbatim answers are useful because it taps into an individual's experiences through their own words. In doing so, it helps to identify topics and processes not previously identified or addressed (Laudet et al., 2009, p.183).

The growth of Peer Recovery Coach services calls for research to develop an increased understanding about the lived experiences of those providing these services. SAMSHA (2012) noted future direction ands recommendations to support states in promoting Peer Recovery Coaches. Among these recommendations was the development of "how to" manuals for implementing Peer Recovery Coaching services through involving peers in all aspects of development to ensure their perspectives are included. Through the narratives of those providing Peer Recovery Coach services, conclusions and recommendations are likely in such areas as increased understanding and support the Peer Recovery Coaches, improved training efforts, and improvement in treatment outcomes for clients. This study seeks to fill this gap by giving voice to those providing Peer Recovery Coaching services to clients.

Statement of Purpose

The purpose of this phenomenological study was to describe the experiences of substance abuse peer recovery coaches related to their career motivation and professional experiences. This study will explore what led participants into becoming substance abuse recovery coaches, what participants identify as the major challenges working as a substance abuse recovery coach, how participants view the relationship between his or her experience as a substance abuse peer recovery coach and his or her life trajectory, and what led participants formerly working as substance abuse peer recovery coaches to leave the recovery coaching position.

Phenomenological Question

Phenomenological research is used to give a rich description of a group of individuals lived experiences and their commonalities in experiencing a phenomenon

(Creswell, 2013). The overarching question that will direct this qualitative research study is "What are the lived experiences of substance abuse peer recovery coaches?" According to Glesne (2011), interpretivism allows for interpreting the social world through the perspective of those experiencing that social world. The focus being on the social world of the participant is in good fit with the focus of the study aimed toward increased understanding of the factors associated with working as a Peer Recovery Coach.

Significance of the Study

This study is significant due to the gap in literature regarding the experiences of Peer Recovery Coaches. Existing literature tends to focus on the need for clarity between Peer Recovery Coaches, Twelve-step recovery sponsors, and addictions counselors (White, 2006) and the differences between paraprofessionals and counselors (LoSciuto, Aiken, Aussets, & Brown, 1984). Moreover, one study also focused on the impact of substance abuse counselor's personal experiences in recovery and client perceptions (Culbreth, 2000). However, a paucity of research has been focused on Peer Recovery Coaches lived experience working in the role of providing services and the impact on his or her life. This study may also add to the understanding of the experiences of Peer Recovery Coaches by adding their personal voices to their lived experiences working within this role. Finally, this study will highlight the environmental factors that Peer Recovery Coaches identify as the most supportive; this will allow for addiction treatment programs to intentionally create these factors to help further develop supportive environments for Peer Support Services.

Definitions

A number of definitions are necessary for this study. The following definitions are provided to ensure uniformity and understanding of these terms throughout the study.

Coaching is a one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery (SAMSHA, 2009).

*Recover*y is process of change through which individuals improve their heath and wellness, live a self-directed life, and strive to reach their full potential (SAMSHA, 2012).

Paraprofessional is an individual not qualified or licensed to serve in a certain profession who handles tasks in support of qualified or licensed professionals within that profession.

Peer-Based Recovery Support Services are Peer-based recovery support is the process of giving and receiving nonprofessional, non-clinical assistance to achieve long-term recovery from severe alcohol/other drug-related problems (White, 2009).

Recovery Coach is a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovering community, and serves as a personal guide and mentor in the management of personal and family recovery (White, 2006).

*Recovery Managemen*t is a collaborative model between service consumers and traditional and non-traditional service providers aimed at stabilizing and then actively managing the ebb and flow of one or more chronic disorders (White, 2002).

Sponsor is an addicted person who has made some progress in the recovery

program and shares that experience on a continuous, individual basis with another addicted person who is attempting to attain or maintain sobriety through a twelve-step recovery program (Alcoholics Anonymous, 2001).

Delimitations

For the purpose of this study, the following delimitations were established:

1. Participants will be limited to substance abuse peer recovery coaches.
2. Participants will indicate that they are currently in recovery from an addiction.
3. Participants will be currently employed, previously employed by, or volunteer at, a Community Service Board in the state of Virginia.
4. Study participation will be limited to people who agree to be interviewed and recorded.

Limitations

Limitations of the study include participants' ability to voluntarily participate or to decline participation. Individuals choosing not to participate may have responded differently from those who choose to participate. This research project focused on Peer Recovery Coaches at Community Service Boards in the state of Virginia as defined by the Virginia Association of Community Services Boards [VACSB] (VACSB, 2012). As such, differences may exist between participants of this study and other individuals who provide peer support services in different geographical regions. Also, differences existed between participants and other Peer Recovery Coaches due to length of time in recovery, level of training received, certifications received, size of caseload, and professional climate at the CSB. The small sample size of this study may limited the primary researcher's ability to obtain a culturally diverse sample of participants.

Summary

This chapter provided background information pertinent to the proposed study; the statement of the problem, the purpose and significance of the study, the research questions, the need for the study, study delimitations and limitations, and operational definitions. Chapter two will provide a review of relevant literature directly related to the purpose of the study. In order to better understand the recovery-coaching concept, a clearer understanding of the inclusion of peer based recovery support services is needed. A discussion of peer based recovery support services, including, fit in the treatment arena, the transition of the behavioral health treatment system to a recovery-oriented system of care, role perception of Peer Recovery Coaches within the addictions treatment system, and the professional roles and responsibilities of Peer Recovery Coaches. Next, the coaching concept, its application across industries, and fit within peer based recovery support services will be discussed. Paraprofessionals in counseling services will be discussed as a historical framework of integrating peer based recovery support services and the development of Peer Recovery Coaches. Lastly, Peer Recovery Coaches will be discussed to establish a clearer understanding of the development of Peer Recovery Coaches and establish a base of understanding the study participants and establish need for the study. Chapter three will detail the research methodology of the proposed study, including the research design, description of participants, data collection and analysis, and strategies to ensure quality in the research.

CHAPTER 2: REVIEW OF LITERATURE

Introduction

The purpose of this chapter is to review the relevant literature pertaining to Peer Recovery Coaching. A number of areas significant to the formation and administration of Peer Recovery Coaching services are provided. Paraprofessionals in counseling services will be discussed as a historical framework of integrating peer services and the development of recovery focused programs. A review of the development of the coaching concept will be discussed to better understand the functions of Peer Recovery Coaches. In order to better conceptualize the recovery-coaching concept, a clearer understanding of the inclusion of peer based recovery support services is needed. This discussion of peer based recovery support services will include fit in the treatment arena, the transition of behavioral health treatment model to incorporate recovery-oriented systems of care, role perception of Peer Recovery Coaches, the professional roles and responsibilities of Peer Recovery Coaches, and a detailed description of Peer Recovery Coaches will be discussed as a framework to better understand the participants of this study.

Paraprofessionals in Counseling

The 1960's brought forth a movement toward integrating paraprofessionals into the counseling field. The paraprofessional movement hinged on the idea that paraprofessionals can be trained to provide valuable counseling roles in treating alcoholism. A large number of recovering people were providing services as counselors,

aides, psychiatric technicians and house managers from the mid 1960's to the mid 1970's (White, 2012) According to Brown (1974), the introduction of paraprofessionals brought new ways of thinking and changes in the mental health system. Additionally, a 1970 study of mental health program directors finding 54 percent of the directors preferred paraprofessionals to professionals because they provided services in innovative ways (Brown, 1974). However, roles for recovering people working in addiction treatment were ill defined (White, 2000a;White, 2000b).

Paraprofessionals in substance abuse treatment came about in support of the belief that those having personally experienced substance abuse recovery would have a greater understanding of the problems and challenges faced by those in active addiction (LoSciuto et al., 1984). According to Hecksher (2007), former substance users employed as counselors often lacked formal training or education in counseling and treatment, thus being labeled as paraprofessional staff. Hecksher further noted paraprofessional staff often had less formal demands for supervision, education, and job security when compared to professionals. The importance of continued training as a necessary component for paraprofessional effectiveness emerged and cannot be understated. According to Brown (1974) the amount and kind of training received by paraprofessionals was an urgent question requiring an answer if professionals and paraprofessionals were to coexist. A number of research articles (Faust & Zlotnick, 1995; Hattie, et al., 1984; Hoffman, 1976) support Brown's notion of training being an important component of paraprofessional effectiveness. In addition to training, the length of treatment contact is an important variable in the paraprofessional effectiveness debate. Research has suggested paraprofessionals to be more effective in long-term treatment

episodes and professionals more effective in short-term treatment episodes (Berman & Norton, 1985; Faust & Zlotnick, 1995; Hattie, et al., 1984)

Although a large amount of literature exists comparing the effectiveness of paraprofessionals to professionals, Brown (1974) indicated that much of the research has been objective rather than subjective. Conflicting results on the effectiveness of paraprofessionals when compared to professional counselors have been reported in numerous studies (Berman & Norton, 1985; Durlak, 1979; Hattie et al., 1984; LoSciuto et al., 1984; Nietzel & Fisher, 1981). Durlak (1979) reviewed forty-two studies comparing the effectiveness of professional and paraprofessional helpers. The result of these forty-two studies suggested paraprofessionals are significantly better or equal to professionals in clinical outcomes achieved. Furthermore, Durlak posited education, training, and experience were not necessary components for becoming an effective helper.

Previous research suggests paraprofessionals are not only effective in providing helping services, but are more effective than professional counselors in some cases. Effectiveness was related to duration of therapy, the number of sessions, and the total hours of sessions. However, increased reports of paraprofessional effectiveness were noted when rated by the helper rather than the client (Durlak, 1979; Hattie et al., 1984). Additionally, Hattie et al. disagreed with Durlak's view of training effectiveness as they supported training and the length of experience as sources leading to increased effectiveness for paraprofessionals when compared to professionals.

In contrast, Nietzel and Fisher (1981) contended Durlak's (1979) study misrepresented those termed paraprofessional, including medical students, speech pathologists, and nurses as paraprofessionals. Nietzel and Fisher suggested that only 5 of

the studies used by Durlak were able to provide evidence comparing the effectiveness of paraprofessional and professional therapists. Moreover, defining a paraprofessional as someone not enrolled in or having completed a recognized graduate program in a health specialty was viewed as contradictory toward Durlak's assertion of paraprofessionals being equal to or better than professionals. Furthermore, these discrepancies in the work of Durlak related to data analysis and validity, resulting in no convincing support for Durlak's claims (Nietzel & Fisher, 1981). Clearly, the debate over the effectiveness of paraprofessionals compared to professionals has produced conflicting results and continues to endure today.

The transformation of the addiction counselor role also marked the development of standards of certification and licensing for addictions counselors, along with increased educational requirements (White, 2008). The integration of treatment for alcoholism and drug abuse thrust recovering people working in addiction treatment into a more complicated place as they wrestled with a change in their identity. No longer were recovering alcoholics treating alcoholism; they were asked to treat drug abuse, and vice-versa for recovering drug abusers. Three trends in the 1970's and 1980's reshaped the addictions field and the roles of recovering people: the establishment of training programs, the development of professional associations and credentialing processes at the state and national levels by what is known today as the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), and the shift to requiring recovering people to obtain degrees or credentials (White, 2000b). This rapid shift brought a need for a more diverse skill set, as paraprofessionals needed more than personal experience to work effectively. The diversity of skills required to treat addiction

problems resulted in the formation of changes at the level of policy and the creation of credentialing entities and specialized training facilities designed to increase the skills needed to treat such a challenging population (White 2006, 2012, 2014).

The evolution of the behavioral health system marked a change in the roles of paraprofessionals. Those serving in paraprofessional roles were left with a decision to either obtain credentials, thus becoming professionalized, or be forced out of the system altogether. As such, paraprofessionals directly contribute to the emergence of Peer Recovery Coaching services through the integration of coaching based concepts into behavioral health treatment paradigms Brown, 1974; White, 2000b; 2008). A brief primer on the development of coaching and the implementation of coaching principles is needed to understand the shift to Recovery Oriented Systems of Care incorporating P-BRSS.

Coaching

The coaching industry continues to see substantial growth, now numbering in the tens of thousands (Grant, 2003). Yet, like many other emerging disciplines, the coaching industry struggled with problems of definition (Ives, 2008), resulting in the industry being very fragmented (Judge & Cowell, 1997). The fragmentation of the coaching industry is in large part due to coaching being viewed in general terms (Garvey, 2004), thereby adding to the struggle of defining the purpose of coaching (Ives, 2008). Tobias (1996), and more recently Maynard (2006), noted the term coaching was used as an alternate to consulting and counseling to depict less stigmatization. It has been noted by Garvey that variations in the coaching industry include performance coaching, life coaching, and business coaching.

Coaching has long been used in business to enhance the knowledge and skills of trainees and employees regardless of the form. Coaching, as defined in business, is teaching and motivating around a skill when there is the lack of skill or knowledge related to increasing performance (Garvey, 2004; Salters, 1997). Coaching, in this sense, aims to achieve higher levels of employee performance. According to Ives (2008), most coaching approaches can broadly be grouped into personal development and performance coaching. In fact, Maynard (2006) asserted coaching has not been defined as a strategy to overcome past difficulties but rather as a strategy to assist clients to move toward their future goals. As such, cognitive-behavioral and coaching psychologies recognize how behaviors, thoughts, feelings, and the environment blend to support goal attainment (Kauffman & Scoular, 2004; McKelley & Rochlen, 2007). Similarly to coaching models, Peer Recovery Coach services focus on four domains of social support akin to the domains in cognitive-behavioral and coaching psychology (Cobb, 1976; Salzer, 2002). McKelley and Rochlen (2007) and Ives supported Garvey in proposing coaching as an umbrella term due to the broad nature of services falling under the coaching category. McKelley and Rochlen contend that coaching can encourage the use of professional help through a focus on skill building, decreasing the stigma of seeking help, addressing gender role resistance, and through providing an alternative to traditional therapy. What has become clear is the use of coaching as an intervention is aimed at focusing on clearly defined goals and avenues toward achieving these goals (Grant, 2003; Ives, 2008; Maynard, 2006; McKelley & Rochlen, 2007).

According to McKelley and Rochlen (2007) it is often difficult to identify the line between coaching, counseling, and therapy because of the overlap of techniques.

Furthermore, Ives (2008) contends psychological and counseling disciplines are designed to alleviate some form of dysfunction, whereas coaching is designed to inspire future development. Coaching primarily focuses on changing actions rather than the traditional focus of feelings in therapy (Ives, 2008). Coaching has often been described as a holistic and client-centered approach that focuses on the ability of the client to identify desired changes and make choices designed to achieve personal gratification. In addition coaches serve in a collaborative role in the process by working with clients to achieve their goals in a supportive and non-judgmental way (Maynard, 2006). Maintaining an action oriented change approach supports coaching models as well suited for non-clinical service populations (Ives, 2008).

Parallels between coaching and counseling have been supported by Salters (1997) and Scott (2003) and have specifically identified listening skills as imperative to both approaches. It has been suggested that coaching is a fit with positive psychology and strength-based approaches (Kauffman & Scoular, 2004; McKelley & Rochlen, 2007). Peer Recovery Coach services are considered to be strength-based peer services designed to focus on the relationship of the person striving to achieve recovery (SAMSHA, 2013). Ives (2008) noted coaches use techniques to provoke thought, raise awareness, and produce motivation toward meeting these goals.

Central to the role of coaching is the relationship with clients (Maynard, 2006; McKelley & Rochlen, 2007). Coaching has often been described as a holistic and client-centered approach that focuses on the ability of the client to identify desired changes and make choices designed to achieve personal gratification. Coaches serve in a collaborative

role in the process by working with clients to achieve their goals in a supportive and non-judgmental way (Maynard, 2006) Maynard described coaching as:

> An action-oriented process that promotes personal and professional development through self- initiated change, differing from therapy in that it is designed for the normal, non-clinical population that is seeking to improve their present day life, rather than heal from issues that need therapeutic intervention (p. 23)

In a coaching relationship, the coach and client collaborate to set goals and identify actions to help meet these goals (Deane, et al., 2014). The coach must be genuinely interested in the client and must be able to apply effective communication through listening and verbal skills. Additionally, coaches need to provide an encouraging and supportive space to explore strengths and weaknesses of clients as they strive to meet their goals. A commonality in the various definitions of coaching is that coaching is a relationship in which the client and the coach work together toward the development and achievement of goals created by the client. However, coaching may be seen as a more directive approach than traditional counseling as the relationship between coach and client serves a very different role than that of client and counselor (Ives, 2008). According to Deane et al., characteristics sought in potential coaches include openness to change, strong interpersonal skills, and respect from peers in the community.

Coaching is used in a variety of settings and remains unregulated. Fewer legal restrictions, in comparison to mental health care services, have provided new channels to reach clients in need of coaching services. Coaches may interact with clients outside the office setting on a regular basis (White, 2006). For example, coaches may provide services through attending meetings with clients. SAMSHA (2013) noted Peer Recovery

Coach services are provided over a wide range of service environments and provide instrumental or concrete services to help others accomplish tasks. Instrumental support may come in the form of transportation, childcare, or helping the client access community agencies (SAMSHA, 2009). Instrumental support can also come in the form of using technology for recovery-management check-ups, and as McKelley and Rochlen (2007) noted, the coaching industry has been at the forefront of integrating technology in working with clients in the forms of e-mail, telephone, and videophone.

The parallels between coaching and counseling continue as effective coaching entails coaches taking on the role of the expert, role model, trainer, motivator, supporter, encourager, and "see-er" of potential. However, a main difference between coaching and counseling is a greater risk of liability carried by counselors as they are bound by confidentiality. Moreover, there are no well-developed codes, ethical standards, and practicing guidelines in the coaching industry. Lack of clear guidelines and standards brings up questions regarding competency of those providing coaching services and mirrors questions posed in the behavioral health field with Peer Recovery Coaches (Salters, 2004). McKelley and Rochlen (2007) indicated although coaches may claim to be competent in coaching services, they may have little to no experience in working with or referring clients who have serious mental health concerns. Ives (2008) contends expert knowledge is essential to defining coaching and coaching effectiveness.

Although coaching is an intervention designed to aid clients in improving the quality of their lives and is used in a variety of contexts with a myriad of techniques, much of the research available has been focused on case studies (Grant, 2003; McKelley & Rochlen, 2007). As such, Bora et al (2010) profess that despite the popularity of

coaching models, there has been little rigorous research conducted on its effectiveness or outcomes. Maynard (2006) noted phenomenological studies attempting to develop patterns and relationships of clients' experiences with coaching have been conducted, and findings by Grant (2003) serve as preliminary evidence of the effectiveness of coaching in attaining goals, improving mental health, and enhancing quality of life. However, there appears to remain a paucity of research specific to the lived experiences of those providing coaching services.

In light of the evidence for applying coaching principles to behavioral health treatment paradigms, a detailed look at how coaching principles are incorporated into P-BRSS is warranted. The inclusion of coaching principles into P-BRSS initiatives impacts Peer Recovery Coaches in a number of areas. To better understand this impact, an in-depth discussion of fit in treatment arena, transition to Recovery-Oriented Systems of care, role perception, professional roles and responsibilities, and Recovery Coaching services is discussed.

Peer-Based Recovery Support Services

Peer-Based Recovery Support Services (P-BRSS) is now a key ingredient in the transition to recovery-oriented systems of care and the incorporation of the recovery management model. Six significant events leading to the emergence of P-BRSS: 1) the international growth of addiction recovery mutual aid, 2) the rise of a grassroots addiction recovery advocacy movement, 3) activities to build a recovery community, 4) recovery as a paradigm in addictions and mental health treatment, 5) movement away from the acute-care model to a recovery management model, 6) and recognition of the diverse pathways to recovery that exist. Paid peer helpers have been called a variety of titles over the years,

more recently they are being called recovery coaches, recovery support specialists, and peer specialists (White, 2010).

P-BRSS are services provided by peers who have lived experience in the recovery process and are found in both mental health services and addiction treatment services, and are generally considered to be further along in their own recovery (Repper & Carter, 2011). According to Daniels, Bergeson, Fricks, Ashenden, and Powell (2012), peer support services refers to structured and intentional activities provided by a person in recovery employed to offer services and support for others striving to enter recovery. Peer support services focus on recovery outcomes of increased self-efficacy, increased empowerment, improved recovery outcomes and well-being within the community setting rather than an approach targeted at mere reduction of symptomology (SAMSHA, 2013). Additionally, Bora et al. (2010) contend those with mental health concerns have traditionally been "signposted" (p. 460) to mental health services aimed at symptom reduction. Mere symptom reduction has proven to be an insufficient goal of the behavioral health care system leading to increased levels of stigma as the system acts as a revolving door for clients (Rush, et al., 2008).

Overlooking the strengths of the client through focusing on treating symptoms fails to empower clients and instill the belief of recovery within their lives. Thus, the effort to move toward a client-centered and recovery-oriented system of care has surfaced. The most recent surge in peer support services is emerging from treatment programs working to extend their continuum of care. The critical question for P-BRSS is where it fits into or connects with the existing addiction treatment continuum of care and

White (2010) also suggested that P-BRSS is an attempt to reconnect addiction treatment with addiction recovery.

Fit in Treatment Arena

P-BRSS providers are not bound by educational requirements and in most cases do not have a required credentialing standard to provide services. Daniels et al. (2012) noted a national certification for P-BRSS does not currently exist in the United States. In fact, Walker and Bryant (2013) described peer support workers as people who have survived a psychiatric disability and offer support, encouragement, and hope to others experiencing similar situations. Peer employees are those hired into peer positions and can include peer advocate, peer specialist, peer counselor, and peer support worker (Walker & Bryant, 2013) and peer recovery coaches (White, 2007). Paid and volunteer peer support services are a part of the transformation to a Recovery Oriented System of Care taking place in the United States (White, 2010). In fact, Johnson, et al. (2014) noted peer delivered services are seen in a number of program types (e.g. mental health treatment, substance abuse treatment), service structures, and funding streams.

White (2010) and Davidson et al. (2010) assert P-BRSS are delivered through at least three different contexts, each indicative of the services provided. The contexts in which the services are provided are the medical/clinical model, the community development model, and the business model, each of which features the recovery coach in a way unique to the individual model (White, 2010). In the medical/clinical model, the Recovery Coach is often a trained professional. P-BRSS in the medical/clinical model takes on a clinical orientation and offer support to the client pre-treatment, while engaged in treatment, and post-treatment. However, a weakness of the medical/clinical model is

the “peer” is most often not a peer. As the medical/clinical model works from a clinical orientation, the ‘peer’ in this model can merely be denotation of title of employment, while in actuality the “peer” is a trained professional service provider. Conversely, in the community development model, the recovery coach is someone engaged in the recovery process and is established in the recovery community. The Peer Recovery Coach in this model can be either paid or a volunteer and serves to build connections within the recovery community and to link clients to supports within the recovery community. In the business model of P-BRSS, the Peer Recovery Coach works for an independent for-profit entity. The business model makes the recovery coach a private practice service offered by people with addictions treatment and interventions backgrounds. It becomes easy to see the convoluted understanding of the role P-BRSS has in the addictions treatment field (White, 2010).

Empirical evidence has been favorable, suggesting peer based service to be effective in mental health treatment (Ostrow & Adams, 2012; Reper & Carter, 2011; Salzer et al., 2010). For example, recovery support services have a well-documented history of availability and effectiveness with mental health care, making them a logical service to include in addictions treatment. Peer support services have been successful in mental health through using the lived experiences of peers to promote empowerment with clients (Ostrow & Adams, 2012). Repper and contend there has been an exponential growth in the employment of peer services workers. Additionally, Ostrow and Adams claim the consumer-driven movement of today shows in the amount of peer support services being provided in traditional mental health and substance abuse treatment settings alongside providers. Davidson et al. (2010) noted several states (e.g. Connecticut,

Arizona, Pennsylvania, and Florida) are working to include P-BRSS into their continuum of addiction care. Research on admission rates suggest those engaging in peer support services showed reduced admission rates, allowing people to remain in the community for longer periods of time. Research has also suggested higher levels of empowerment in those who engage in peer support services and deceased recognition of stigma as a barrier to employment. Peer and non-peer providers reported peer providers had an increased level of understanding of what the client was experiencing. Additionally, recipients of peer support services noted feeling higher levels of acceptance, being understood and liked compared to traditional service providers. Peer support service workers appear to promote health and a hope and belief in the possibility of recovery more so than professionally qualified staff (Repper & Carter, 2011).

P-BRSS in the United States serves as a Medicaid billable service (Walker & Bryant, 2013). Specifically, Ostrow and Adams, (2012) noted the Centers for Medicare and Medicaid have shown increased support for peer support services, resulting in 25 states being reimbursed for peer support services in mental health treatment. Furthermore, Boisvert, Martin, Grosek and Clarie (2013) assert peer support communities are yet another peer support service becoming integrated into formal substance abuse treatment programs and are also viewed as a best-practice intervention by SAMSHA. However, potential drawbacks to Medicaid coverage of P-BRSS have also been noted, most notably the structure of supervision for peers (SAMSHA, 2012) and the professionalizing of peer support services (Ostrow & Adams, 2012).

SAMSHA (2012) indicated Peer Recovery Coaches expressed concern over a lack of supervision or supervision that does not fit within their peer role. As SAMSHA

suggested, there is a lack of senior peer staff to provide supervision and non-peer staff may not have enough understanding related to the peer role to provide support and feedback specific to the peer role. SAMSHA suggested supervisors of peer-roles needed clear guidance and training to support peers in managing workplace challenges, in supporting the peer's own recovery, and in management of cases of peer relapse. Professionalizing peer support services takes place through certification standards, operating under state standards, and accepting reimbursement, all of which are currently happening, however, peers want to remain a grassroots level movement. This confounding viewpoint has supplemented the confusion surrounding substance abuse services, P-BRSS, and the link to the recovery community. The substance abuse treatment field has long encouraged becoming a citizen in recovery through engagement with twelve-step recovery groups. Twelve-step recovery groups practice giving back to the community as an important part of engaging in long-term recovery (Ostrow & Adams, 2012). P-BRSS offers a unique opportunity to link addictions treatment with the recovery community (White, 2010).

While viewed as a strength in promoting a recovery-oriented service, P-BRSS show some potential vulnerabilities as a model. Vulnerabilities of the P-BRSS model include the danger of boundary violations and abuses of power, risk of client harm through boundary violations and incompetent care provided through P-BRSS and service organization liability due to illegal or unethical conduct of peer providers. However, vulnerabilities are also present for P-BRSS providers and include the risk of exploitation, isolation from the recovery community, and vulnerability to relapse (White, 2010).

Transition to Recovery-Oriented System of Care

P-BRSS is working to change the focus of addiction treatment from income to outcomes. Traditionally, valued outcomes in the mental health system target symptom reduction and the improvement of functioning (Daniels et al., 2012; Ostrow & Adams, 2012). Similarly, Laudet (2007) maintained recovery has historically been defined in terms of abstinence. However, symptom reduction is not always consistent with an outcome of recovery. While noting abstinence as a prerequisite for the process of recovery, Laudet asserted recovery encompasses more than abstinence from substance use or mood-altering substances. Rather, Laudet's findings suggest recovery as a process of self-improvement and movement toward, and opportunities at, a new and better life. Laudet and White (2010) posited substance abuse treatment services should introduce clients to resources and strategies that enhance their quality of life, their level of functioning, and raise their level of social responsibility rather than focusing purely on symptom reduction. Substance abuse is a chronic disorder, yet the addictions treatment field has consistently used a short-term acute medical model for treatment of substance abuse. Furthermore, recovery seems an unrealistic outcome for a chronic disorder when providing treatment within this modality (Boisvert et al., 2008)

Relapse is common in the addictions treatment field and stable recovery is usually not attained until 4-5 years of engaging in continuous recovery. Persistence of disappointing outcomes called for a paradigm shift in substance abuse treatment away from the acute-care model to a model incorporating recovery management principles befitting a chronic-care model. The inclusion of recovery support services and the recovery management approach resulted in minimized reports of relapse, as well as being

a cost-effective approach (Laudet & White, 2010). A growing consensus of supporters for developing ROSC recognize that recovery is the essential outcome of an ROSC and specific structures and processes are needed to support recovery outcomes (Ostrow & Adams, 2012).

Groshkova, Best and White (2013) asserted the need to define the concept of recovery to aide the transformation of behavioral health systems. The Betty Ford Institute Consensus Panel (2007) defined recovery as *"a voluntary maintained lifestyle characterized by sobriety, personal health, and citizenship"* (p.222). Laudet (2007) proposed the stigma of substance abuse can be reduced through showing recovery as a reality through providing hope to affected individuals and families, informing the public, and providing realistic expectations to stakeholders. The recovery community holds a unique position in educating the public leading to increased growth of grassroots organizations intended to promote changes in the perception of recovery (Laudet, 2007). However, retention was a major barrier to effective treatment as between half and two thirds of people drop out of treatment or are discharged prior to successful completion (Davidson et al., 2010) The function of Peer Recovery Coaches at multiple points of recovery may help to stabilize clients during treatment, support clients post-treatment and ultimately reduce treatment dropout and change public perception of treatment services.

Access and duration of formal treatment services are being reduced as a result of fiscal reductions. As a result, clinical outcomes may be influenced by the ability of treatment programs to help support the client's transition into post-treatment recovery (Laudet, 2007). Kidd, McKenzie, and Virdee (2014) assert the evidence for recovery-oriented interventions has generally been concentrated on community-based

interventions, resulting in uncertainty in how the system can implement integrated practices, specifically education, employment, and outreach. However, Heaps, Lurigio, Rodriguez, Lyons, and Brookes (2009) contend Recovery-Oriented Systems of Care are able to coordinate recovery focused services throughout the treatment initiation and community recovery, while helping clients return to education, employment, and family. P-BRSS is considered to be long-term, spanning pre-recovery engagement, initiation into recovery, recovery stabilization, and recovery maintenance, and as such, may serve to bridge this gap as P-BRSS relationships typically last longer than counseling relationships (Davison et al., 2010).

According to Aiken (1984) the future of treatment by those in recovery will change and may have implications for the roles in treatment programs served by those in recovery and for their acceptance in other areas of the behavioral health system. Aiken noted differences may exist in the attitudes held toward drug addiction and expectations held for clients entering the treatment process. The combination of a lack of acceptance outside the drug treatment community and pressure from within the drug treatment community may serve as predominant forces, thus warranting investigation of the phenomena. The persistence of role ambiguity may serve to hinder the development and implementation of Peer Recovery Coaching services within the substance abuse treatment system (Aiken, 1984).

Role Perception

Role perception has been a critical element to the development of P-BRSS and Peer Recovery Coaches. In order to best understand service effectiveness outcomes with the targeted treatment population, and to maintain levels of provider morale, clearly

defined roles are needed. The lack of clearly defined roles has been noted as a theme for P-BRSS staff, as well as clinically trained staff (Bora et al., 2010; Deane et al., 2014; SAMHSA, 2012; Walker & Bryant, 2013), and marks the need for closer evaluation. With the position of the Peer Recovery Coach role falling between that of the Twelve-step sponsor and the addiction counselor, a clearly defined role is needed to minimize workplace confusion.

Peer Recovery Coach services are deemed a non-clinical and recovery-focused service (SAMSHA, 2013; White, 2006) provided by peers to target recovery outcomes of improved health and wellness (SAMSHA, 2013). Recovery coaching is when a peer mentors an individual who is seeking recovery. Peer Recovery Coaches help connect clients to recovery-supportive resources, serve as an advocate and liaison to community supports (Laudet & Humphreys, 2013). Additionally, peers apply their experience-based awareness to help clients work toward recovery, by being an example of recovery in action to clients, and to exhibit maintaining levels of stability, wellness, self-sufficiency, and operating within social interactions or roles that develop in life As a result, the embodiment and demonstration of recovery by peers increases the meaningfulness of peer support. Peers are able to understand the perspectives of clients more authentically and can more effectively support clients seeking to overcome their challenges to achieve goals (Austin, Ramakrishnan & Hopper, 2014).

White (2006) described the ways in which Recovery Coaches differ from Twelve-step sponsors and addictions counselors as a means of defining the professional role and responsibilities of Recovery Coaches. Although similar in regard to being a face associated with recovery, Peer Recovery Coaches and Twelve-step sponsors differ in the

ways they provide support to the person seeking recovery. According to White, Peer Recovery Coaches and Twelve-step sponsors differ in regards to organizational context, service context, philosophical framework, scope of those served, power in the service relationship, financial remuneration, ethical guidelines and supervision, anonymity, policy advocacy, and affiliation. Sponsorship has long been a form of support utilized in Twelve-step based recovery models (i.e. Alcoholics Anonymous, Narcotics Anonymous) (White, 2006; 2007b).

Traditional Twelve-step models of sponsorship are based heavily on one person abstaining from the use of mood-altering substances to help another person to abstain from the use of mood-altering substances. The Twelve-step sponsorship model does not take into account the multiple pathways to recovery supported by Peer Recovery Coaches. Rather, the Twelve-step model focuses solely on abstinence, and specifically works within a particular program of recovery as a one-on-one mentoring relationship. In contrast, Peer Recovery Coaches work within formal service organizations, bound by accreditation, licensing, and organizational guidelines (White, 2006).

Peer Recovery Coaches work within a treatment team, requiring collaboration with other treatment professionals. Working as a treatment team member allows Peer Recovery Coaches to focus their efforts on the multiple frameworks of recovery available to the person seeking recovery. Moreover, Twelve-step sponsors are typically in control of the amount of sponsees they choose to mentor, the time given to the sponsees, and the location at which sponsorship activities will take place (White, 2006). Peer Recovery Coaches share no such control. The inclusion of Peer Recovery Coaches into behavioral health treatment organizations results in the organization dictating the amount of clients,

time, and location in which the Peer Recovery Coach will provide services. Peer Recovery Coaches, unlike Twelve-step sponsors, are governed by the ethical and legal duties of the counseling profession and subject to punishment for breaches of those legal and ethical duties (White, 2006).

Other noted areas of importance are related to anonymity, policy advocacy, and affiliation. Twelve-step sponsors abide by the Twelve Traditions of Alcoholics Anonymous [AA] (Alcoholics Anonymous, 2001) and as such experience parameters around anonymity, advocacy, and affiliation. Anonymity is a foundational cornerstone of Twelve-step affiliation and is applied to policy advocacy and affiliation, essentially keeping program affiliation silent when interacting with outside agencies or other organizations (White, 2006). Anonymity appears to safeguard the Twelve-step program name and members from the actions of those still using mood-altering substances. In contrast, Peer Recovery Coaches do not share a similar attitude with anonymity as a formal representative of a treatment organization. Peer Recovery Coaches are expected to engage in advocacy on behalf of the client as a way to address the barriers to recovery initiation and maintenance and may act on behalf of their organization to expand local recovery support networks (White, 2006).

Financial remuneration is also a point of contrast between Twelve-step sponsors and Peer Recovery Coach roles. According to the Twelve Traditions of AA, accepting money to serve in the role of a Twelve-step sponsor goes against the stated traditions of Twelve-step program (White, 2006). In fact, Tradition eight clearly states, “Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ

special workers" (Alcoholics Anonymous, 2001, p.562). The Twelve traditions further elaborate this stance:

> Alcoholics Anonymous should remain forever non- professional. We define professionalism as the occupation of counseling alcoholics for fees or hire. But we may employ alcoholics where they are going to perform those services for which we might otherwise have to engage nonalcoholics. Such special services may be well recompensed. But our usual A.A. "12 Step" work is never to be paid for. (Alcoholics Anonymous, 2001, pp. 564-565)

The prevailing belief is that guidance toward recovery should be freely given within the recovery community. Peer Recovery Coaches may either serve as paid employees of an organization or in a volunteer capacity. Although similar in serving to support movement away from the use of mood-altering substances and into recovery, Twelve-step sponsors and Peer Recovery Coaches serve in very different capacities, each having its niche within the recovery arena (White, 2006).

Diminishing role ambiguity also requires clarity specific to the differences between addictions counselors and Peer Recovery Coaches. The role of the Peer Recovery Coach differs from that of addictions counselors in the following areas: service goals, education and training, use of self, service relationship, locus of delivery system, service philosophy, duration of contact, core competencies, service delivery framework, service language, and non-possessiveness (White, 2006). Although deemed a non-clinical service, a substantial amount of overlap appears to exist between the Peer Recovery Coach role and that of the addictions counselor (Beckett, 2012; SAMSHA, 2009; White, 2006, 2007, 2011). The breadth of service demarcation between Peer Recovery Coaches

and addictions counselors warrants a focused discussion of how these practitioners differ specific to these areas.

Addictions counselors have traditionally served as a direct treatment professional for clients seeking a change in their substance abusing behaviors, typically in residential or outpatient settings. Peer Recovery Coaches serve to help initiate the recovery process by helping clients increase their level of motivation to seek recovery (White, 2006). Oftentimes, Peer Recovery Coaches are the initial contact for clients seeking recovery, and contacts can take place in a variety of locations (i.e. community, residential treatment settings, out-patient treatment settings). Related to differences in service goals and timing, White noted clear differences in the use of self, service relationship, and duration of contact between Peer Recovery Coaches and addictions counselors. According to White (2006), addictions counselors are discouraged from self-disclosure or the use of self within counseling services. However, use of self is an important feature in Peer Recovery Coach services. White contends through using personal experiences of recovery, Peer Recovery Coaches are able to enhance the quality of services provided through connecting the power and reality of recovery with the client. The use of self results in disparities in the service relationship of Peer Recovery Coaches as compared to addictions counselors. The Peer Recovery Coach relationship with clients is much less hierarchical than that of the addictions counselor, in large part due to the use of self, and duration of the service relationship (White, 2006).

Differences in duration service relationship duration point out a key difference in the roles of Peer Recovery Coaches and addictions counselors. The duration of services provided by addictions counselors has a clear beginning point, middle, and ending point,

often determined by third party payer or organizational policy. Peer Recovery Coaches face far less restrictions in regards to service duration. As White noted, Peer Recovery Coaches initiate contact with clients prior to treatment engagement and continue contact with clients following the completion of treatment. Peer Recovery Coach services extend post-treatment to provide recovery check-ups, support, recovery education, and as a link to the recovery community (White, 2006).

A distinct difference between Peer Recovery Coaches and addictions counselors centers on education and training and adds to the non-clinical separation of Recovery Coaching services. Addictions counselors are, most often, formally educated and credentialed through certification or licensure. However, Peer Recovery Coaches often lack the level of formal education and training garnered by addictions counselors (White, 2006). Rather, Peer Recovery Coaches, credibility comes through lived experience of recovery and the knowledge accumulated through those experiences. Although there has been an increase in Recovery Coach training and certification (White, 2004), the gap in clinical service knowledge and third party reimbursement is considerable.

There are a number of important differences in roles related to core competencies, and service delivery framework. Addictions counselors are trained in addictions counseling and knowledge and provide clinical services including screening, assessment, treatment planning, individual, group and family counseling, clinical documentation, and referral (White, 2006). Peer Recovery Coaches provide no such clinical services and operate under competencies of the long-term recovery process through experiential knowledge. Peer Recovery Coaches core knowledge consists of client engagement, motivational enhancement, links to the recovery community, and policy advocacy as a

result of this experiential knowledge base. Differences in core competencies results in differences of the service delivery framework Peer Recovery Coaches and addictions counselors work from. The major difference in service delivery framework is that addictions counselors work from professionally developed treatment plans as a result of clinical assessment data, where as Peer Recovery Coaches work with the client to develop a client-generated recovery plan that is more community and recovery focused (SAMSHA, 2013; White, 2006; 2007b)

Walker and Bryants' (2013) qualitative study on the experiences of peer support workers identified themes of low pay and few hours, negative or rejecting non-peer staff attitudes, being treated as "patients" by non-peer staff, need for supervision from support workers as opposed to non-peer staff, and a clear job description to reduce role confusion and peer staff anxiety. Furthermore, SAMSHA (2012) noted similar findings including a lack of peer-focused supervision creating workplace confusion due to role confusion and lack of clear job descriptions, low pay and lack of career advancement opportunities, and workplace culture being non-conducive to peer roles. Deane et al. (2014) suggested successful implementation of ROSC is associated with the values and tasks of the organization, practitioners and service consumers. Humpreys, Noke and Moss (1996) surmise due to the varied educational backgrounds and diverse disciplines recovering staff come from, treatment professionals should not consider being in recovery implies a particular perspective on treatment. Consequently, individual beliefs will affect the goals and activities of the program, especially as staffs attempt to implement their own perspectives on clients. Thus, Davidson et al. (2010) suggested three principles necessary to integrating P-BRSS into behavioral health systems of care: 1) P-BRSS and

professional addictions treatment services are complimentary rather than competitive, 2) they value the contributions each can make to the recovery process, 3) and they must respect the boundaries of their competency. Understanding some services are better provided by clinically trained professionals and some by the lived experiences of P-BRSS aide in integrating P-BRSS into the treatment system. Bora et al. (2010) contend, in order for a coaching culture to emerge, contributions need to come from leaders such as role models and managers to adopt coaching philosophy as a cultural change in ROSC.

Professional Role and Responsibilities

White (2006) defined the Recovery Coach through a multitude of descriptive terms including motivator and cheerleader, ally and confidant, truth-teller, role model and mentor, problem solver, resource broker, advocate, community organizer, lifestyle consultant, and friend. The Peer Recovery Coach is not a sponsor, therapist, nurse, physician, or clergy member. As such, the varied roles fulfilled by Peer Recovery Coaches can be seen as both a strength and weakness (White, 2006). While it appears the Peer Recovery Coach serves in a myriad of capacities, the lack of clearly defined roles may lead to role ambiguity on behalf of the Peer Recovery Coach and clinical staff.

The professional role and responsibilities of Peer Recovery Coaching vary from one organization to another. However, at its very core, Peer Recovery Coaches serve to assist clients with the undertaking of moving into active recovery and recovery maintenance, thus, the professional role and responsibilities are directly related to recovery. Peer Recovery Coaches assist clients with recovery related tasks like setting recovery goals, developing recovery action plans, helping to create strategies to manage the ongoing challenges of recovery maintenance (Beckett, 2012; Hill & Johnson, 2012;

SAMSHA, 2009; SAMSHA, 2012; White, 2004a; White, 2004b; White, 2006), and developing new relationships and recovery community networks (White, 2004a; White, 2004b; White, 2006; White, 2012a; White 2012b). Peer Recovery Coach services are built upon four types of social supports (Beckett, 2012; Cobb, 1976; Hill & Johnson, 2012; Salzer, 2002; SAMSHA, 2009) identified as useful in providing P-BRSS. Furthermore, Salzer (2002) noted social support as being a particularly important component of providing peer services. The four social support concepts Peer Recovery Coaches work from include emotional support, informational support, instrumental support, and affiliational support.

Emotional support is described as demonstrating empathy, caring, or concern to strengthen the clients' self-esteem and confidence to move into recovery (Hill & Johnson, 2012; Salzer, 2002; SAMSHA, 2009). According to SAMSHA (2009), emotional support can come in the form of one-to-one peer mentoring or peer-led support groups, but is focused on activities built on a shared experience of recovery. SAMSHA describes peer-led support groups can be structured as support groups or as a form of recovery education for clients and can cover a spectrum of topics important to maintaining recovery. Peer Recovery Coaches encourage and inspire change through exhibiting faith in the clients' ability to change. Emotional support is oftentimes connected to the informational social support component in work with clients (White, 2004).

Informational support is described as sharing knowledge and information, skills building (Hill & Johnson, 2012; SAMSHA, 2009), and help with problem solving and evaluation of behavior and alternative action (Salzer, 2002). Informational support is provided by Peer Recovery Coaches in the form of wellness seminars, parenting classes,

barriers of re-reentering the community after incarceration, relapse prevention strategies, financial and budgeting information, and information to connect the client to community resources (SAMSHA, 2009). Informational support comes in many forms and is designed to help the client gather information to address the challenges he or she may experience in seeking recovery. Informational support remains aligned with the P-BRSS notion of multiple paths to recovery and allows clients the freedom to choose the path they feel is the best fit.

Instrumental support serves as a key concept in Peer Recovery Coach services. Instrumental support is described as concrete assistance to help clients accomplish tasks (Hill & Johnson, 2012; SAMSHA, 2009). Instrumental supports provided by Peer Recovery Coaches comes in the form of transportation, connection to the recovery community, linking to health and social services (SAMSHA, 2009). Additionally, developing client-driven recovery plans, advocacy and recovery management check-ups also provided by PRC"s. Peer Recovery Coaches work one-on-one to help clients develop their client-driven treatment plan. Client-driven treatment plans address such domains as individual goals and aspirations; resources, strengths and skills, and barriers and problems to achieve recovery (Beckett, 2012; Hill & Johnson, 2012). Moreover, developing a client-driven treatment plan allows the Peer Recovery Coach to serve in the capacity of motivator and cheerleader, ally and confidant, truth-teller, role model and mentor, problem solver, resource broker, advocate, community organizer, lifestyle consultant, and friend as a result of the connection the Peer Recovery Coach has developed with the client. Working one-on-one with clients provides the Peer Recovery Coach the arena to use their experiential knowledge of recovery to help clients identify

the supports they will need in pursuing recovery, identifying the barriers that may prevent recovery, and provide feedback to help the client problem solve how to overcome identified barriers to move into recovery (White, 2006).

Lastly, Peer Recovery Coaches provide affiliational support to clients as they transition into recovery. Affiliational support is described as linking the client with the recovery community to produce a sense of belonging, facilitate social learning and recreational skills, and to create a community for the client to maintain recovery (Hill & Johnson; Salzer, 2002; SAMSHA, 2009; White, 2006). Peer Recovery Coaches acknowledge that at some point treatment will end, but the needs of maintaining recovery will continue. Through providing affiliational support, Peer recovery Coaches are able to help clients connect clients to the natural supports within his or her community to garner the supports needed to maintain his or her recovery (Beckett, 2012; Cobb, 1976; Hill & Johnson, 2012; Salzer, 2002; SAMSHA, 2009).

The professional role and responsibilities of Peer Recovery Coaches is to serve in multiple capacities with their clients to promote and support recovery. Movement of the treatment arena implementing a coaching model places increased emphasis on developing the clients strengths and resilience of what they are recovering “towards”, thereby separating building a life in recovery apart from their illness (Bora et al., 2010). The notion of recovering “towards” appears in direct opposition of the traditional acute model of symptom reduction of recovering “from”. Peer Recovery Coaches providing services under the umbrella of the four social supports discussed bolsters the idea of recovering “towards” of ROSC models. This being said, a detailed description of Peer Recovery

Coaches, previous literature describing Peer Recovery Coaches, and the need for continued research regarding Peer Recovery Coaching services is provided

Recovery Coach

Over the last decade there has been a movement to incorporate Peer Recovery Coaches into traditional addictions treatment due to perceived deficiencies (White, 2004) in the existing treatment model. White (2006) noted Peer Recovery Coaches emerged from recognition that addiction treatment needed to be reconnected to the process of addiction recovery. Peer Recovery Coaches serve as a logical link to the community for substance abusers and those experiencing co-occurring disorders to support sustained recovery. Thus, Peer Recovery Coaches are a natural bridge between treatment and recovery. Peer Recovery Coach services highlight the differences between recovery and treatment, as Peer Recovery Coach services are recovery focused and less time limited than treatment services provided by professional staff. Peer Recovery Coach services go to the client, rather than the client having to go to the service ("New Jersey's recovery mentor", 2006), meaning Peer Recovery Coach services meet clients where they are located in the continuum of care.

Peer Recovery Coaches stem from the "wounded healer" motif (White 2000a, 2000b, 2006) espousing a belief in the power of support given by those who have experienced and overcome similar adversity. Peer Recovery Coaches highlight their own lived experiences as a way to enhance the commitment to keeping recovery first and meeting clients "where they are" (Reif et al., 2014). The Center for Substance Abuse Treatment (2009) asserts Peer Recovery Coach services are a one-to-one relationship where a peer leader has more recovery time than the person being served. Reif et al.

contend the use of peers in treatment is accepted as a part of the continuum of care for promoting recovery from substance abuse. In fact, several states (e.g., Connecticut, Arizona) have implemented recovery support services into their continuum of care, while other states (e.g., Pennsylvania) are looking at credentialing procedures (White, 2004). The field of addictions treatment has traditionally been infused with counselors in recovery themselves (White, 2006, 2012, 2014), making Peer Recovery Coaches a new level of a traditional model. White (2006) noted the role of a Peer Recovery Coach incorporates and refines elements of case management and outreach work, thus positioning the Peer Recovery Coach role between twelve-step recovery sponsor and addiction counselor. Being positioned between these two well-established duties has lead to uncertainty in the Peer Recovery Coach role.

As noted earlier, an extensive body of literature (Beckett, 2012; SAMSHA, 2009; White, 2006, 2007, 2011) has clearly distinguished the role differences of Peer Recovery Coaches, Twelve-step sponsors, and addictions counselors. Peer Recovery Coaches use their story of recovery as a motivating tool to guide others to seek a life in recovery. Peer Recovery Coaches assist peers with setting recovery goals, developing recovery action plans, solving problems directly related to recovery, and with collateral problems (Reif et al., 2014; SAMSHA, 2009; White, 2006, 2007, 2011). Peer Recovery Coaches also serve as advocates for the client and the recovery community at large (Reif et al., 2014). Peer Recovery Coaches often maintain contact with clients for a longer period of time than a counselor would because Peer Recovery Coach services engage clients both in pretreatment and post-treatment. Social support has been shown to support a better quality of life with both substance abusers and those with mental health concerns

(Boisvert et al., 2013; Repper & Carter, 2011; Swarbrick, Murphy, Zechner, Spagnalo & Gill 2011). Social support in the form of peer group attendance increased self-confidence, social skills, employment, and decreased drug and alcohol use. Furthermore, the more support clients experienced from a greater number of people, the less the clients were associated with substance use (Laudet et al., 2000).

Daniels et al. (2012) outlined a series of "Pillars of Peer Support Services" (p.63) in which they suggested a core set of principles for the success of P-BRSS. Their suggested principles include: clear job and service descriptions, ongoing continuing education, professional advancement opportunities, expanded employment opportunities, a program support team, a research and valuation component, peer workforce development, comprehensive stakeholders training program for non-peer staff, and competency-based training for supervisors. These suggestions are a meager representation of the principles outlined by Daniels et al., however, they comprise areas specific to the focus of this study.

A majority of the body of Peer Recovery Coach research has focused on the creation of Peer Recovery Coach services through ROSC initiatives (Baird, 2012; Cotter 2009; Flaherty, 2009; Humphreys & Lembke, 2014; SAMSHA, 2012; Slade et al., 2014; White, 2006; 2010), the separation of the Peer Recovery Coach role from that of 12-step sponsor and addictions counselor (Beckett, 2012; Reif et al., 2014; SAMSHA, 2009; White, 2006, 2007, 2011) and the effectiveness of Peer Recovery Coach services over multiple domains (Davidson, et al., 2010; Ostrow & Adams, 2012; Reper & Carter, 2011; Salzer et al., 2010). However, paucity in research of the lived experiences of those providing Peer Recovery Coach services remains. In fact, the lone study to address the

experiences of Peer Recovery Coaches on any level simply asked Peer Recovery Coaches in Pennsylvania, Connecticut, and Texas what they get out of the service process (White, 2007b). Developing a greater understanding of the experiences of Peer Recovery Coach providers will serve to help generate new information to describe the lived experiences of Peer Recovery Coaches.

Summary

In summary, this chapter reviewed the literature encompassing Peer Recovery Coach services. Paraprofessionals in counseling services were discussed as a framework for the inclusion of coaching concepts in the development of peer services. A discussion of the historical roots of coaching and the translation of these services into counseling services through recovery support services followed, specifically their part in the development of coaching services. Peer-Based Recovery Support Services, their fit in the treatment arena, transition to recovery-oriented systems of care, the elements of the recovery management model incorporated into these systems of care, challenges related to role perception, and the professional roles and responsibilities of Peer Recovery Coaches was discussed. A review on the development and implementation of Recovery Coaches followed. Currently, paucity exists describing the lived experience of those providing services as Peer Recovery Coaches, specifically in substance abuse treatment services. One study was found to address the experiences of Peer Recovery Coaches, albeit only asking what the Peer Recovery Coach personally gets out of the service process (White, 2007b). However, the research concerning the implementation of recovery support services and recovery coaching is consistent with movement toward a recovery-oriented system of care. Despite implementing Peer Recovery Coaching as part

of a recovery-oriented system of care, the focus on the lived experiences of those working as Peer Recovery Coaches is absent.

CHAPTER 3: METHODOLOGY

The purpose of this qualitative study was to gain insight into the lived experiences of working as a Substance Abuse Peer Recovery Coach. The study aimed to identify the motives for entering the Peer Recovery Coaching profession, factors identified as challenging in working as a Peer Recovery Coach, and the contribution of working as a Peer Recovery Coach on his or her life trajectory. This chapter is divided into seven subsections. The first subsection describes the research questions guiding the current study. The second subsection will outline the design of the study. The third subsection describes the qualitative inquiry of phenomenology and its function in this study. The fourth subsection discusses participant recruitment and selection, and data collection procedures. The fifth subsection illustrates the researcher's data analysis procedures. The sixth subsection details the strategies taken by the researcher to ensure quality; including the researchers' reflexivity statement and bracketing procedure Lastly, the seventh subsection describes the potential benefits and risks of study participation.

Research Question

The overarching focus of this study was to address the phenomenological research question "What are the lived experiences of individuals working as Substance Abuse Peer Recovery Coaches?" Moustakas (1994) stated that there are two primary phenomenological interview questions, while noting the possibility for others. These two primary research questions were:

1. What have you experienced in terms of the phenomenon?

    For the purposes of this study: "What are your experiences related to working as a Peer Recovery Coach?"

2. What events influenced your experience of this phenomenon?

    For the purposes of this study: "What events led you to working as a Peer Recovery Coach?"

These two questions provided the basis for textural and structural descriptions. Exploratory research questions included:

3. What was the decision to work as a Peer Recovery Coach.

4. What has been challenging in working as a Peer Recovery Coach.

5. What has been rewarding in working as a Peer Recovery Coach.

6. In what ways has working as a Peer Recovery Coach contributed to a career trajectory?

Design

This study employs an epistemology from an interpretivist viewpoint, as the study focuses on understanding the experiences of working as a Peer Recovery Coach. To date, research has focused on the importance of defining the differences in functions of peer recovery services in comparison to addiction counselors and Twelve-step sponsors (Beckett, 2012; SAMSHA, 2009; White, 2006, 2007, 2011), the creation of Peer Recovery Coach services through Recovery Oriented Systems of Care initiatives (Baird, 2012; Cotter 2009; Flaherty, 2009; Humphreys & Lembke, 2014; SAMSHA, 2012; Slade et al., 2014; White, 2006; 2010) and the effectiveness of Peer Recovery Coach services (Davidson, et al., 2010; Ostrow & Adams, 2012; Reper & Carter, 2011; Salzer et al.,

2010). Additionally, research findings suggest programmatic challenges experienced by Peer Recovery Coaches through low pay and lack of career advancement opportunities, feeling unsupported by program structures, supervision, and clear job descriptions and expectations (SAMSHA, 2012) has caused many Peer Recovery Coaches to seek professional credentials to move into different roles providing behavioral health services. Yet, a gap remains in describing why peer providers seek Peer Recovery Coach positions. As addictions treatment initiatives and program focuses change, it has become necessary to explore the perceptions and the lived experiences of those providing services as Peer Recovery Coaches. The current study and findings contribute to the literature by adding insight into understanding the programmatic support needs of those providing Peer Recovery Coaching services, increased understanding of the challenges faced by those providing Peer Recovery Coach services, and in what ways working as a Peer Recovery Coach affects his or her life trajectory.

Method

Phenomenology

Phenomenological designs target lived experiences and lends to rich descriptions of what the participants share in common as it relates to the phenomenon of study (Creswell, 2013). The primary focus of this study was to gain insight into the experiences of individuals working as substance abuse Peer Recovery Coaches. Phenomenology was befitting the development of a deep understanding of the participants' perspectives on the phenomenon of working as a substance abuse Peer Recovery Coach; therefore, a phenomenological methodology was the best research paradigm for this type of study

The phenomenological design does not develop theory; rather, it provides insight into the lived experiences and living world of the participants. Specifically, phenomenology seeks to understand the individual and collective internal experiences of the phenomenon and how participants think about their experiences (Hays & Wood, 2011). As Moustakas (1994) noted, the universal description or essence consists of *what* the participant experienced and *how* the participant experienced it. Phenomenology emphasizes the human experience and counselors tend to draw insight from understanding the experiences and meanings of those experiences on an individual level as well as forming a collective essence for future work with clients (Van Manen, 1997). This philosophical foundation corresponds with the research question "what are the lived experiences of peer recovery coaches"?

Procedures

The original methodological plan for this study was to interview participants recruited out of the Community Service Boards (CSB) constituting Planning Partnership Region (PPR) 3 of the Southwestern Region of Virginia as defined by the Virginia Association of Community Services Boards (VACSB) (2014). These CSB sites are where the participant is currently employed, was previously employed, volunteers, or otherwise provides Peer Recovery Coach services. The CSB sites were identified and chosen for this study for a number of reasons. Given the focus of the study on those providing recovery coach services, identifying a single site to capture a large enough sample proved difficult. An additional area of note was the geographic make-up of the target area as the southwestern PPR region as defined by DBHDS (2014) expands to cover a catchment area of 17 counties. Due to the expanse of these regions, each CSB site identified for

participation in this study served as a centralized service location for each individual CSB's catchment area, making the sites convenient as meeting locations to conduct interviews with research participants. Furthermore, the CSB sites were conveniently located in proximity to the researcher and employed the needed sample of Peer Recovery Coaches, thus serving as suitable locations for the collection of interview data. However, a total of two participants were recruited for the study from the Planning Partnership Region (PPR) three of the state of Virginia.

As the original plan to recruit participants proved ineffective, the recruitment plan was modified to include the entire CSB system of the state of Virginia. As a whole, the CSB system in the state of Virginia constitutes a total of 41 CSB locations (VACSB, 2014). Due to the expanse of the sites, the Peer Support Manager with the Virginia Department of Behavioral Health and Developmental Services was contacted via telephone to narrow the potential CSB sites offering Peer Recovery Coaching Services within substance abuse treatment programs. As such, the number of sites was reduced to a total of 14 CSB locations identified as suitable sites for this study. This attempt resulted in the inclusion of Erica, Katie, Riley, and Greg.

Those previously employed, as Peer Recovery Coaches were recruited using snowball sampling (Goodman, 1961). Snowball sampling is often useful in reaching populations that are inaccessible or difficult to find, which was the case in recruiting participants who formerly worked as Peer Recovery Coaches. Snowball sampling was completed through substance abuse clinical directors forwarding the recruitment email to those who previously worked at their CSB site in the Peer Recovery Coach role. This resulted in the inclusion of Avery, and Audrey.

Substance abuse clinical directors of the 14 CSBs in the state of Virginia were contacted via telephone and email and invited to participate in the study if they employed Peer Recovery Coaches. The substance abuse clinical directors were emailed the participation letter to be completed and returned prior to the site being included in the study. Upon receiving the signed letter of participation from sites the recruitment email (Appendix A) was sent to the substance abuse clinical directors and they were asked to forward the recruitment email to those working in Peer Recovery Coach positions to invite them to participate in the study. Peer Recovery Coaches meeting the inclusion criteria contacted the researcher via email and a time was scheduled to speak with them via telephone to verify eligibility verbally to participate in the study, discuss participation in the study, and schedule a time to conduct the interview. The researcher handled any questions regarding the study.

Each participant received an emailed packet detailing the purpose of the study and informed consent (Appendix E). Before the interview began, the researcher 1) discussed informed consent with each participant, 2) asked each participant to read and sign the consent form via DocuSign computer application, 3) confirmed that they met eligibility guidelines for the study (Appendix B), and 4) collected demographic information (Appendix D). The Docusign computer application was utilized due to the proximity of the participants in comparison to the researcher. Once questions were answered and informed consent was signed the interview was conducted.

As a result of the study expanding to include the 14 CSB sites in the state of Virginia offering Peer Recovery Coaching services, interviews were conducted either in-person or via telephone as a result of the participants location in proximity to the

researcher. Semi-structured face to face interviews were conducted with two participants (Erica and Katie) in a private office at the research site. The remaining four interviews were conducted with participants (Audrey, Avery, Riley, and Greg) via telephone due theirsite being in excess of 100 miles in proximity to the researcher. The initial plan was to conduct face-to-face interviews with each participant; however, it was not possible due to financial and travel considerations.

After several weeks passed, and no additional participants were identified, the recruitment email was resent to the remaining CSBs that had not responded to the initial inquiry. Upon completing interviews for the six participants of this study, a final recruitment email (Appendix K) was sent to substance abuse clinical directors noting recruitment for this study would discontinue effective July 17, 2015. No new sites or participants were identified for this study and recruitment was discontinued.

A number of technological mediums were employed to record each interview. A Sony digital recorder was used in each interview. A Tape-a-Call application was purchased for the Apple iPhone and utilized to record interviews conducted via telephone. Telephone interviews were placed on the speaker function and the Sony digital recorder was placed beside the phone to record the interview. The Tape-a-Call application was also used as a back-up recorder for each telephone interview. Once all of the interviews were transcribed Coliazzi's (1979) seven-step approach to analyze phenomenological data guided the data analysis. Each participant was given a pseudonym to protect his or her confidentiality. Research questions focused on the experiences leading participants to working as Peer Recovery Coaches and the participants' experiences related to working as a Peer Recovery Coach.

Participants

This study used a purposive sample of participants recruited based on their similar attributes of working as Peer Recovery Coaches in the state of Virginia. This sampling method allowed the researcher to describe the participants' experiences in-depth (Patton, 1990). The researcher conducted interviews with six participants who met the following criteria: 1) identified as a person in recovery from substance abuse, 2) having no less than one year of abstinence from mood-altering substances, and 3) as a person who is currently working or formerly worked as a Peer Recovery Coach, and the ability to schedule a 60-90 minute interview during the summer of 2015.

Five participants self-identified as female and one self-identified as male. Also, five of the participants self-identified as Caucasian, and one as African-American. Participants' ages at the time of the interviews ranged from twenty-eight to fifty-six years of age. Participants' amount of reported time in recovery from substance abuse at the time of the interviews ranged from two years to ten years and six months. This information is summarized in Appendix D. Following is a brief description of each participant.

Erica is a thirty-one year-old Caucasian female with 2 children. She has been in recovery for five years and five months and working as a Peer Recovery Coach for seven and half months. Prior to working as a Peer Recovery Coach, Erica worked as an administrative assistant. She holds a Bachelor's degree in Human Services and is currently pursuing a Master of Education in Counseling and Human Development.

Audrey is a thirty-four year-old Caucasian female with two children. She has been in recovery for ten years and six months and formerly worked as a Peer Recovery Coach

for four years and ten months before leaving the position to focus on graduate school. Prior to working as a Peer Recovery Coach, Audrey worked in the food services industry. She holds a Bachelor's degree in Psychology and is currently pursuing a Master's degree in counseling.

Katie is a thirty-seven year-old Caucasian female that has been in recovery for eight years. She has been working as a Peer Recovery Coach for seven years. Katie has completed three years of college but has not returned to complete the requirements for graduation yet. Prior to working as a Peer Recovery Coach, She worked in the natural resources field.

Avery is a forty-three year-old Caucasian female. She has been in recovery for nine years and six months and formerly worked as a Peer Recovery Coach for two years before leaving the Peer Recovery Coach position to move into a clinical position. Prior to working as a Peer Recovery Coach, Avery was employed in the education industry. Avery holds a Bachelor's degree in general studies. She is currently working to meet the requirements needed to become a Certified Substance Abuse Counselor (CSAC) in Virginia and expressed future plans to return to school to pursue as Master's degree.

Riley is a twenty-eight year-old Caucasian female. She has been in recovery for two years and three months and working as a Peer Recovery Coach for five months. Prior to working as a Peer Recovery Coach, Riley worked in the food services industry. She has completed three years of high school but has not returned to complete the requirements for graduation yet.

Greg is a fifty-six year-old African-American male with three children. He has been in recovery for two and a half years and working as a Peer Recovery Coach for a

total of twenty years. He has been employed seven months as a paid employee providing Peer Recovery Coaching services in the CSB system of Virginia. Prior to working as a Peer Recovery Coach, Greg worked in the metals industry. He holds a Bachelors degree in Psychology.

Data Collection Procedures

Participants were asked to participate in one 60-90 minute semi-structured audio-recorded interview (Appendix C) taking place in face-to-face format or via telephone. Telephone interviews were conducted if the participant was employed or lived in excess of 100 miles to the proximity of the researcher. A total of six interviews were conducted for this study. Interviews were audio-recorded for review and transcription. All interviews conducted via telephone were conducted in the researcher's home office. A smartphone was used and employed the TapeACAll application to record the interviews on the smartphone used in conducting the interview. Conducting each interview in a face-to-face format was preferred, as it is believed it would have increased the ability to establish rapport and acknowledge verbal cues. However, this was not possible due to the multiple locations of the participants and their proximity to the primary investigator.

The researcher adhered to the ethical principles of human science research. All interviews were conducted in an informal, open-ended and conversational style. Qualitative research using an open-ended format and verbatim recording of participant answers highlights the participants lived experience and can establish previously unidentified topics and processes (Laudet et al., 2009). Knaack (1984) contends the researcher must engage the participant in "cooperative dialogue" (p. 110), in kind making the participant a type of co-researcher. The interview format allowed for direct, verbal

interaction with the participant designed to evoke detailed narratives of their experiences thus creating this cooperative dialogue.

An appropriate sample size in qualitative studies is one that adequately answers the research question. The question of sample size is largely dependent on the nature of the research problem and the potential yield of findings (Wertz, 2005). The number of required participants becomes apparent as the study progresses, as new categories, themes or explanations cease emerging from the data (data saturation) (Bogdan & Biklen, 2007; Ponterotto & Greiger, 2007). Data saturation is achieved when data collection becomes redundant (Bogdan & Bilken, 2007). Thus, phenomenological research expresses no predetermined number of participants, rather seeking data saturation through repetition of themes and limited variation being added by participants. For this study, data saturation was reached at six participants.

Upon reaching data saturation through interviewing the participants, data analysis of the transcribed interviews took place. The primary researcher carried out transcription of the each interview upon completion. Each completed transcription was sent to the participant for content verification and feedback. All six participants verified the context of their interviews. Erica was the only participant to add to her original interview statement. Per participant verifications, no statements or context was removed from the original interviews. After the participant verified the transcription reflected what they intended to share during the interview, the digital file was erased. Furthermore, upon participants' transcript confirmation, all identifiable information from the transcripts was removed. In addition, another set of data containing pseudonyms and redacted information was created and used for data analysis.

Data Analysis

For the purpose of this study the primary researcher adopted a seven-step process as outlined by Colaizzi (1978) to guide the analysis. For this study the primary researcher:

1. Organized, read in entirety, and filed all transcripts in the order they were conducted. The primary researcher re-read each transcript to get a general sense of the entire transcript. I then sent password protected transcript files to participants for member checking. Member checking was used to validate if the analysis captured the lived experience of the participant. Lincoln and Guba (1985) posit member checking is "the most crucial technique for establishing credibility' (p. 314) and is echoed by Cho and Trent (2006). If modifications were made to the data during member checking it was incorporated into the final product.
2. Extracted significant statements that directly pertained to the investigated topic. These statements were recorded on a separate sheet noting their pages and line number. The significant statements extracted were the basis for themes. Meanings were formulated as they emerged from the data through using creative insight, while remaining faithful to the original data. An independent second coder completed the same task independently.
3. Once completed, the primary researcher and secondary coder met to compare themes emerging from the transcript. This process took place following the completion of each individual interview transcription. Consensus between the researcher and the second coder was reached in order for the theme to be included in the results section of the study.

4. Repeated the above process for each individual transcript and organized extracted statements into categories, clusters of themes, and themes.
5. Integrated the results of the analysis into an exhaustive description of the investigated topic.
6. Formed the exhaustive descriptions into concepts to describe how the participants experienced the phenomenon. The essence of the experience emerged through this process.
7. Presented the essence of the experience through narration and tables.

Strategies for Quality

Reflexivity is often used in qualitative research and is viewed as a central strategy to increase credibility and rigor of qualitative studies (Dowling, 2006). Lincoln and Guba (1985), contend trustworthiness as a key to establishing findings reflects the meanings as described by the participants as closely as possible. In this sense, trustworthiness reflects the importance of researcher reflexivity in constructing authentic meaning of the phenomena experienced by the participant. Reflexivity requires researchers to operate on multiple levels (Ethrington, 2004), necessitating the researcher be aware of the internal and external responses being influenced by the relationship the researcher has with the topic and participants (Dowling, 2006). Furthermore, reflexivity is described as a process occurring throughout the research (Leitz et al., 2006). As such, the researcher engaged in continuous self-appraisal and was able to describe how his own experience had or had not influenced the research process.

Researcher's Reflexivity Statement

I am a Caucasian, male third year doctoral student pursuing a Ph.D. in Counseling from the University of North Carolina at Charlotte. I received my Master's Degree in Counseling and Human Development from Lindsey Wilson College and my Bachelor's Degree in Psychology from Concord University. I currently hold licensure in the states of Tennessee and Virginia as a Licensed Professional Counselor (LPC) and national licensure as a Nationally Certified Counselor (NCC).

My interest in the experiences of Peer Recovery Coaches was brought about through my experiences of working as both a Peer Recovery Coach and, later, a supervisor of peer recovery coaches. I identify as a person in recovery and view my experience as critical in helping shape my continued recovery process and future direction in the counseling field. I entered my undergraduate education as a psychology major, as I had always been interested in working in the field of psychological and counseling services to help others. While working toward completion of my B.A. in psychology, I struggled with substance abuse, leading to multiple treatment episodes including stays in residential treatment facilities, participation in residential recovery communities, and twelve-step based recovery communities. It was during this time I was able to gain insight into my career trajectory and identified my passion for substance abuse treatment.

Having identified the population I felt passion to serve aided my pursuit of remaining in recovery from substance abuse and working toward achieving my goals of becoming a counseling professional. I began to research how I could best be in a position to help those struggling with substance abuse and found a Master's degree in counseling

as necessary to being able to provide individual and group therapy to this population. My pursuit of graduate education served two purposes; to keep me focused on goals only achievable through my ability to further my personal recovery process, and to allow me to move into a position to be of service to those struggling with moving into his or her own recovery processes.

My induction into the human services field began as a recovery coach upon graduating with my bachelor's degree. I continued working in the role of a recovery coach while pursuing my master's degree in counseling. I took on the recovery coach role to obtain employment in my field of study and to gain experience to further my future trajectory in the counseling field. Upon completion of graduate school, I served as a substance abuse counselor, and later as the lead counselor in an addictions treatment program, as well as the direct supervisor to a number of staff, including four Peer Recovery Coaches. It was during this experience I began to have conversations with the Peer Recovery Coaches about why they pursued these positions, the challenges they experienced in their roles, and how working as a Peer Recovery Coach influenced their future life trajectories. Through these conversations I found some commonalities in these experiences, while also realizing a difference in how the Peer Recovery Coach role factored into his or her future life trajectories.

It is my belief the combination of my training and experience as a higher education professional and counselor combined with my experiences as a person in recovery from substance abuse for the past ten years and as a former peer recovery coach enabled me to be successful as the primary researcher in this study. My interest in this phenomenon is in alignment with an interpretivist paradigm and seeks to increase

understanding of Peer Recovery Coaches on a qualitative level as the body of literature in this area is lacking. It is my hope that capturing the experiences of Peer Recovery Coaches serves to bridge the gap in our understanding of the experience of working as a Peer Recovery Coach.

Reflexivity Through Bracketing

Bracketing in phenomenological research is used to maintain objectivity. A proponent of bracketing, Husserl (2001) described the process as a conscious and active process of stripping away prior experiential knowledge and bias about the phenomenon of study. As such, bracketing allows the researcher to leave his or her world behind and to fully enter into the experiences of the participant through written description (Giorgi, 1999; Husserl, 2001; Wertz, 2005). Thus, the goal of bracketing aims to make the researchers' assumptions of the phenomena or experience idle (Giorgi, 1999; Husserl, 2001; Knaack, 1984). To support promoting reflexivity, the primary researcher engaged in journaling throughout the duration of this study. Journaling supplements reflexivity as it serves to locate the self in the research process (Koch & Harrington, 1998). The researcher employed a three-step process of reflexive journaling as proposed by Wall, Glenn, Mitchinson, & Poole (2004). The three-step process was used as follows:

1. Bracketing Pre-action: The first stage required the researcher engage in pre-reflective preparation. The researcher set aside time prior to each interview to raise awareness of the specific issues requiring bracketing.

2. Bracketing In-action: The second stage required the researcher to reflect on situations that arose during interviews and with methodology. These situations required immediate bracketing to prevent interference with the emerging phenomenon. This stage

was addressed through the inclusion of an independent second coder and was addressed in steps 2-4 of the data analysis.

3. Bracketing On-action: The researcher identified how this new learning can be utilized during later interviews.

Risk, Benefits, and Ethical Considerations

There were minimal risks to participants in this study. However, participants could feel discomfort in being audiotaped during the interview. In order to alleviate the effects of this discomfort the primary researcher helped concerned participants explore any discomfort. During the interview, unpleasant feelings could arise as a result of the topic of the study and/or the questions asked by the researcher. The primary researcher checked with the participants about their wellbeing at the conclusion of the interview and debriefed with participants as needed. If concerns were not alleviated and the participant required further services, the researcher conferred with the participant's supervisor. However, this did not take place with this study.

There is no immediate benefit to the subjects of this study. The benefits to the counseling profession include: increased understanding of why persons chose to pursue Peer Recovery Coach positions, the challenges those in Peer Recovery Coach positions face, and how the Peer Recovery Coach role fits within their future path of life. Understanding the aforementioned factors can allow counselors, supervisors, and program directors to increase their understanding of targeted, evidenced based services to support Peer Recovery Coaches in their roles and future life goals.

Summary

This chapter presented a rationale for using a method of qualitative inquiry, phenomenology, to explore the lived experiences of those working as Peer Recovery Coaches. Further, this study seeks to gain insight into their perceptions of factors that facilitated and impeded their work as Peer Recovery Coaches. This chapter also presented in-depth information on the methodology of the proposed study, including a description of participants, data collection and analysis, the risks and benefits of participating in the study, and strategies to help ensure rigor throughout this study.

CHAPTER 4: RESULTS

This chapter presents an overview of the results of the current study. The purpose of this phenomenological study is to describe the experiences of substance abuse peer recovery coaches related to their career motivation and professional experiences. Semi-structured interviews with six participants ($N = 6$) currently working or who formerly worked as Peer Recovery Coaches offered insights into their experiences associated with what led them to work in the role and their experiences while working in the role. The following research questions guided this study: (a) What events led you to working as a Peer Recovery Coach? And, (b) What are your experiences related to working as a Peer Recovery Coach? Seven themes and eight subthemes emerged from the data.

What Led to Working as a Peer Recovery Coach

The first research question explores the types of life experiences or factors that led the participants to work as a Peer Recovery Coach. Participants discussed several factors and life experiences that contributed to his or her decision to serve as a Peer Recovery Coach.. As a whole, their responses reflect four themes: (a) a desire to give back and instill hope, (b) encouragement from someone within the recovery community, (c) an improved career outlook, and (d) job stability and benefits package.

A Desire to Give Back and Instill Hope

An ardent sense of desire to help others seeking recovery emerged through participant discussions. All six participants shared a desire to give back and help those

seeking recovery as an important factor leading to working as a Peer Recovery Coach. This desire to give back and instill hope is rooted in his or her personal story of recovery from substance abuse and recovery engagement within the recovery community. Moreover, the desire to give back and instill hope was sparked at different points during his or her personal recovery. The overall recovery community consists of multiple recovery organizations (White & Kurtz, 2006) and includes the likes of Twelve-step recovery groups, faith-based recovery groups, community coalitions, peer-run recovery programs, substance abuse treatment programs, and the natural recovery supports existing in the participants' community.

The concept of giving back to others seeking recovery from substance abuse is a long-standing tradition within the recovery community. The desire to give back and instill hope was described as arising in two separate levels of recovery. The first level was shared in the form of being initiated into the recovery process. For participants, simply experiencing recovery triggered the desire to give back and instill hope. Greg noted experiencing the desire to give back as a result of receiving formal treatment services, "so I went to treatment at [the employer] and from then I just knew that I wanted to give back" (Greg). Likewise, Riley shared it was her experience in recovery that contributed to realizing her desire to give back to others, "…after being in recovery I realized I could use my recovery to help other people" (Riley).

The second level was shared as direct result of experiencing sustained personal recovery. Participants described feeling empowered to help others seeking recovery resulting from personal recovery engagement in Twelve-step groups and serving as a Twelve-step sponsor. The result of both of these experiences was an awareness of the

desire and ability to use his or her personal recovery experience to provide hope. Interestingly, the desire to give back and instill hope was often described in terms of a sense of obligation for participants. Avery stated:

> The decision to come and be a part of this came from working the twelve-steps and giving back…that helps me remember the pain and misery of where I was and where I don't want to go back to and that was a big part of the decision. (Avery)

It appears that this sense of obligation stems from a healthy respect for the power of addiction, and the propensity to relapse by those engaged in recovery helps to fuel the desire to help others. This sense of obligation stems from the constant reminder of the power and destruction of addiction through working with clients seeking to engage in the recovery process. Moreover, feeling obligated to help is also in response to empathize with the agony of active addiction. Empathy alters the focus of personal recovery making the healing process larger than an intimate individual experience. Personal recovery grows to include supporting others in seeking recovery. Uniting the internal desire to engage in recovery with feeling an obligation to help others seeking recovery often results in maintaining long-term personal recovery through being of service to others. As such, giving back and instilling hope carried a multifaceted meaning for participants of this study. Internally, giving back supports a higher level of personal recovery through making past struggles meaningful and finding purpose. Externally, giving back and instilling hope supports people seeking recovery while simultaneously strengthening personal recovery.

Encouragement from Someone Within the Recovery Community

Interaction with someone within the recovery community was consistently referenced in identifying Peer Recovery Coach job openings and supporting participants in applying for these positions. Five of the six participants expressed receiving

encouragement from someone within the recovery community as a factor that led them to working as a Peer Recovery Coach. Receiving encouragement from others working personal recovery programs provided participants with the message he or she can be valuable in serving others seeking recovery.

Decreased feelings of self-worth and self-esteem often accompany entrance into the process of recovering from substance abuse. As such, receiving the message of encouragement from others in the recovery community was paramount in validating personal change further inspiring participants to seek Peer Recovery Coach positions. Members of the recovery community were described as Twelve-step sponsors and Twelve-step group members who were employees of the participants' respective future site of employment, previous treatment providers, and Twelve-step group members with no connection to the participants' respective site of employment. Interestingly, the message of encouragement and belief that the participant had something to offer to those seeking recovery was more important than the person providing the message. Participants described how receiving the message of encouragement left an impression with them, regardless of the specific person providing the message. Avery described receiving the message of encouragement from her Twelve-step sponsor.

> I was working at the treatment center I graduated from last time…I heard that [the employer] had some positions open as Recovery Coaches, Peer Specialists and that we could work with people in recovery and take them to meetings and that kind of stuff. My sponsor told me about it because she also worked at [the employer] in a different department. She said you know why don't you try it why don't you put in for that job. That would be a great opportunity. I did put in for it and interviewed. (Avery)

Moreover, two participants' experiences of encouragement came from members of the recovery community whose names they could not recall. Riley described the recovery

community member as a fellow Twelve-step group member who was also employed with her current employer. Riley recalled the following:

> One of the ladies that already worked for the company I work for attends my home group. So after a meeting one Saturday she came up to me and said 'I've seen how much you grown and how serious you are about your recovery'. She said 'one of my coworkers mentioned they are hiring for a recovery coach and I think you would be wonderful for the position'. (Riley)

Similarly, Audrey was also unable to recall the name of the specific person providing the message of encouragement. However, she was able to recall the person being a member of the professional treatment system. Audrey stated, "…I had given my testimony at a [recovery community] picnic one year. So when the job came open in [county of residence] county…somebody approached me and asked me if I was interested" (Audrey).

The power within the message was the confidence and trust conveyed by members of the recovery community in the ability of the participants to guide others seeking recovery. Additionally, the meaningful part of this experience described by participants of this study was being recognized by members of the recovery community as a valued example of recovery. As each of the participants had lived experience with substance abuse treatment, most often in the form of being a former client of services, receiving encouragement helped construct a purpose in their recovery experience and strengthened the desire to give back and instill hope. This inspired not only an increased level of confidence in trusting in his or her ability to be of help to those seeking recovery, but also served as validation of the changes he or she aspired to make through engaging in recovery. As such, messages of encouragement from someone in the recovery community were described as significant experiences in pursuing Peer Recovery Coach positions.

Improved Career Outlook

Improved career outlook served as another supporting factor for three of the six participants in seeking Peer Recovery Coach positions. Coinciding with the desire to give back and instill hope was the opportunity to to also improve his or her career outlook. Unemployment, little job stability or the absence of job stability were factors in participants viewing Peer Recovery Coach opportunities as a vehicle to an improved career outlook. At the heart of being motivated to pursue the chance to experience an improved career outlook was the challenge of finding stable work. Katie described her circumstances prior to pursuing a Peer Recovery Coach position, "so I didn't have a job. I was drawing unemployment. I ended up losing my home and had to move back home with my parents" (Katie). Similarly, Riley shared an experience of unemployment or little job stability as a result of the legal history she accumulated while in active addiction. Riley stated, "I accumulated like 12 felonies which does not make it easy for me to get certain jobs which I always wanted to in the helping profession…" (Riley).

The decision to pursue an improved career outlook significantly outweighed the lack of employment or stability currently being experienced in their job, regardless of the potential outcome. Furthermore, taking this chance not only led to the prospect of career stability but also offered the opportunity of putting the passion to help others into practice. Additionally, the development of future career goals and aspirations was stimulated through an improved career outlook.

> …I just never thought I would be in this position or this type of field. I just never seen myself in that. I guess it has just opened up the idea of other options as far as where you can go career wise. (Katie)

Improved career outlook had as much to do with feeling like a valued member of the workforce as it did offering job stability. As such, an improvement in career outlook had

long reaching effects in aiding the progress of recovery by offering an alternative to viewing a professional career as unattainable.

Job Stability and Benefits Package

Five of the six participants described being attracted to the Peer Recovery Coach positions due to the perception of job stability and receiving a benefits package (i.e. health insurance, sick pay, vacation, holiday pay) as significant factors. The inclusion of benefits was shared early in the first interview as being equally important, if not more important than rate of pay and offered a different viewpoint to this study. Specifically the benefits package served as an enticing bonus to the Peer Recovery Coach position not offered through participants' previous employers.

Stability was another important factor shared in pursing Peer Recovery Coach positions. As a whole, stability emerged to include job stability, personal stability, and increased stability in caring for family members. Stability is an important component of recovery and often those seeking recovery sense little stability in major areas of life, especially early in the process. Riley illustrated the importance of stability, "it was good to think well I will have a 9-5 job for the most part you know I will get 40-hours a week, I will get benefits, I'm sold on that" (Riley). Moreover, Erica depicted the impact of stability on multiple levels through the inclusion of a benefits package.

> The fact that I would have insurance and paid holidays, and vacation, and sick days, cause you know, it hurts when you have holidays you have to miss and you don't get paid and its Christmas and you need the money. So yeah, that was part of the appeal too. (Erica)

Interestingly, job stability and the benefits package appeared to supersede the importance of rate of pay for participants in this study. Although rate of pay was shared as a challenging aspect of remaining in the Peer Recovery Coach position, it did not appear to

be a significant factor in preventing participants from seeking Peer Recovery Coach positions. This notion lends to the interpretation of the opportunity for stability and an ability to care for personal and family needs as critical elements to those pursuing Peer Recovery Coach positions.

In summary, the factors leading to participants working as Peer Recovery Coaches were similar. Participants shared being led to the position through an internal desire to give back and help those struggling with addiction to transition into a life of recovery. Encouragement from someone within the recovery community was a factor in identifying Peer Recovery Coach position openings and leading the participants to pursue working as Peer Recovery Coaches. Additionally, an opportunity for an improved career outlook, job stability, and the inclusion of a benefits package were significant factors for participants to pursue Peer Recovery Coach positions.

Experiences Related to Working as a Peer Recovery Coach

The second research question explored the types of experiences participants had while working as a Peer Recovery Coach. Participants discussed a number of consistent experiences while working as a Peer Recovery Coach. As a whole, these experiences can best be categorized into two themes (a) professional experiences, and (b) personal experiences.

Professional Experiences

Participants illustrated major aspects of his or her professional work as Peer Recovery Coaches. In this study, professional experiences were loosely defined as the experiences of participants while serving the functions of their paid roles as Peer Recovery Coaches. Six themes emerged in the participants' descriptions of their professional experience as a Peer Recovery Coach: (a) serving as an agent bridging the

gap, (b) adjusting to the Peer Recovery Coach role, (c) duality of role and identity, (d) the workplace environment, and (e) pursing a professional career opportunity.

Serving as an agent bridging the gap. Five of the six participants shared experiences of their work as Peer Recovery Coaches *bridging the gap* between clinical services and the recovery community. Bridging the gap can loosely be defined as being the intermediary contact for clients transitioning to and from clinical services into support from the recovery community. However, serving as an agent to bridge the service gap was described as more than merely being a bridge from formal treatment services to recovery support in the community, rather it is serving in the capacity of showing recovery as a possibility with clients and professional staff alike. Participants shared that a large part of their role as a Peer Recovery Coach was helping clients to believe recovery is an attainable goal. A sense of pride emanated from participants in being able to serve as an example of recovery for clients. Accompanying this pride was an increase in confidence to serve in bridging the gap of understanding the process of recovery through lived experience for clients through. Participants consistently shared the power of identifying as someone in recovery represented an ally for clients they rarely felt with professional treatment providers. In this respect serving as an agent to bridge the gap presented a treatment alternative attractive to clients. Katie described this experience.

> You can almost see the relief on their [the client] face when you go meet with them the first time and they are considering recovery…you say 'I totally know what you're going through, I've been there'. And they are like 'what do you mean?' And you say, 'well I'm actually in recovery myself' and you can see the relief of like 'oh my gosh, they get it'. (Katie)

In this sense being an agent to bridge the gap is about much more than service continuity designed to keep clients engaged in the recovery process. In fact, participants shared experiences aligning more with being a beacon of hope of recovery being possible for

each of the clients they work with. Bridging the gap in this sense asserted removing the preconceived notion of clients, that professional staff will not understand the challenges persons seeking recovery traverse. Again, the pride and confidence to be of service to clients through the participants lived experience of recovery emerged as important to serving as an agent to bridge the gap.

> My role is someone who has been there done that…cause even when I was in treatment I had counselors that said they didn't do drugs and they drank once in a while. My thought was 'how the hell are you gonna help me?' You know, how you going to tell me? I know better now but that was my thought then. From what the clients tell me that is their thought too. They need someone who actually understands. Somebody who has been in it to understand the craziness of the desire, who are on the fence to relapse, the lost feeling. The feelings that I just keep messing up. (Greg)

Similarly, this sense of pride and confidence in serving as an agent to bridge the gap was shared through the participants' ability to navigate the language barriers that exist between professional staff and clients.

> Sometimes I feel like an interpreter too because of clients not understanding the big words coming out of the therapists mouth and they are just looking like 'what are they talking about', so I break it down. Or they [professional staff] are not understanding what the client is saying so I have to put it into technical terms for them and I'm like this is harder than translating Spanish. (Riley)

Peer providers are often able to speak the language of both professional treatment and from a client perspective because often peer providers have been recipients of treatment services at some point. Providing the ability to traverse language barriers between professional staff and clients amplifies the feeling of confidence in being an integral component to bringing the gap that exists between treatment and the recovery community.

Adjusting to the peer recovery coach role. Adjusting to the Peer Recovery Coach role posed its own set of challenges. There appeared to be a transitional period present for

those making the change from being a part of the recovery community to becoming a part of a professional treatment system. Four of the six participants shared adjusting to the Peer Recovery Coach role as a challenging aspect of working in the role. Strong reference was made to the lack of a clearly defined job description affecting boundary recognition, and the contribution of Peer Recovery Coach training in transitioning into the role.

The absence of a clear job description resulted in many challenging experiences and was described as vexing and anxiety producing for participants of this study. Peer Recovery Coaches described experiencing the job description dilemma in a number of capacities that included the initial development and application of services, job performance evaluation, and staff understanding of the role and service. Katie spoke on the vexing experience of having little direction to create and provide Peer Recovery Coaching services:

> So when I started here there wasn't anything prior to that for me to say they [Peer Recovery Coaches] did this, this and this. So I would look at the grant and say 'so what should I do' …(Katie)

The absence of a clear direction for the program placed an increased amount of stress on Katie. She was faced with both adjusting to the role while simultaneously creating the services provided within the role. This experience elevated an already fragile and developing belief in the ability to perform within the role. Additionally, an unsettling feeling of how job performance is evaluated was consistently described. Riley offered an illustration of this point.

> …finding that balance of what my position is…what my job performance entails or what my job description entails as far as, and this has been trial and error because we are new in my company or we are newer than a lot of places. So nobody really knows how to utilize us so, including ourselves, but we are learning…(Riley)

Moreover, confusion in the role of Peer Recovery Coaches expanded to professional staff, further complicating the frustration of Peer Recovery Coach service providers. Katie described role confusion with professional staff in stating, “I have had new employees come and ask what do you do exactly?” (Katie).

Each of these notions becomes immensely important; as participants described the need for direction and feedback about the competence demonstrated in providing Peer Recovery Coaching services. In sum, these experiences led to uneasiness in participants’ understanding of how to provide Peer Recovery Coaching services. It was increasingly frustrating for peer providers to understand the scope of service for the Peer Recovery Coach role bereft of a clear job description. This frustration was also exacerbated by the confusion of professional staff regarding the role and services of Peer Recovery Coaches.

Although the role of Peer Recovery Coach has been defined by comparing Peer Recovery Coach service to that of a professional counselor or a Twelve-step sponsor (White, 2006), varied job descriptions remain throughout the state of Virginia. The presence of different job descriptions blurs the boundaries distinctive to each of these roles. Adjusting the to the Peer Recovery Coach role is challenging and this challenge is magnified as a result of the absence. Adjusting to the role becomes increasingly challenging without the presence of a clearly defined job description. A clearly defined role is critical to adjusting to the Peer Recovery Coach role. Lacking a clearly defined job description complicated how participants were able to decipher the boundaries central to the Peer Recovery Coach role. Avery revealed the challenge in maintaining the Peer Recovery Coach role versus that of Twelve-step sponsor.

> The most challenging was finding where the boundaries lay. As a clinician you have absolute boundaries. As a recovery coach, having to figure out that you can't be someone's sponsor as a recovery coach but you still want to be, you know, you want them [the client] to know that you are on their side. (Avery)

Greg further supported the challenge posed in the similarities of the Peer Recovery Coach role and Twelve-step sponsors.

> I'm not working in a sponsor role but it's not a whole lot different. There isn't a big difference between being a sponsor and a recovery coach, but there is a difference…it is not as personal. As a sponsor I got more personal with my sponsees. I got more emotionally attached for one thing. As a recovery coach I try to stay in my lane. I'm just direct with it. As a sponsor I was more into going over the steps with them. I don't go over the steps as a Recovery Coach. We might go over them in group but that is not my job to work the steps with them. That is a sponsor's job. They are not going to call me at 12:00 at night. They don't have my personal number. So that element is different. After work hours I don't have any contact with them. Even if I see them in meetings, if they don't come up to me I am not going to come up to them. There is separation there. (Greg)

Similarly, Greg illuminated the challenge of recognizing the contrast of the Peer Recovery Coach role and that of counselors. Subtle and friendly reminders by professional staff of the role and services provided within the role supported remaining within the invisible boundaries separating the roles.

> Not being a counselor. They [the staff] jokingly call me a junior counselor and they tell me not to get into that role because that is not what I am there for. I am there to be a Recovery Coach. I am there to coach the clients in their recovery path, to share my experiences, my strength and hope with these people. (Greg)

Moreover, an accepting workplace environment and staff contributed to addressing the role boundaries of working as a Peer Recovery Coach.

Deciphering the boundaries of working in a Peer Recovery Coach role coinciding with the power differential implicit to being associated with the professional treatment system was frustrating for participants. A delicate balance existed between being perceived as an authority figure as a result of working in the professional treatment system and being able to build relationships based on a shared experience of recovery

with clients that is inherent to being a peer provider. Often, this experience was bewildering to the participants and further complicated adjusting to the Peer Recovery Coach role. Arising within the bewilderment was a sense of frustration in addressing the power differential persistent with clients in working as a Peer Recovery Coach.

> My position is to be a peer and not an authority figure because people tend to not want to open up to you when you have turned into that authority figure to them. That's come with trial and error and that has come from my supervisor who is like "absolutely you are not there to tell them what to do in groups, you are there to build a relationship with these people". So that was kind of challenging…(Riley)

Similarly, Erica shared a sense of frustration in managing the obstacle posed by the presence of the power differential existing with clients:

> …I am a peer in the sense that I am not a counselor…but I am not a peer at the same time. Many of them [clients] see me as something above them. Or if they tell me something they will get in trouble…it's hard sometimes. I know they are lying and you have to walk around it and sometimes it's difficult. (Erica)

Negotiating the power differential accompanying the Peer Recovery Coach role as a part of the professional treatment system appeared to be a difficult experience. Finding footing to surmount this challenge resides in receiving training specific to working as a Peer Recovery Coach. Additionally, an accepting work environment is vital to aiding adjustment to the Peer Recovery Coach position and the functions therein.

The Peer Recovery Coach role is complex and often becomes entangled with professional treatment providers and Twelve-step sponsors. By its very nature, the Peer Recovery Coach straddles the line between multiple roles. The boundary lines become increasingly invisible to Peer Recovery Coaches due to the absence of a clearly defined job description to aide the adjustment to working in the role.

The absence of a clearly defined job description placed an increased emphasis on the importance of providing appropriate training opportunities to assist in adjusting to this

new role. Training is a principle need of those working in Peer Recovery Coaching positions. Training was shared as a necessary component to feeling increasingly confident in the role and to provide the services pertinent to the Peer Recovery Coach role. Training contributed to an overall sense of feeling capable to provide the services fundamental to the PRC position. Training was valuable in helping identify and maintain the boundaries associated with the Peer Recovery Coach role, and induced feelings of confidence in being capable of providing services. Audrey described the contribution of training on her transition to the role, "it was really great. It helped me understand more about what I was actually doing" (Audrey). Likewise, those without formal Peer Recovery Coach training felt unprepared to work as a Peer Recovery Coach and lacked confidence in their ability to be of help to clients. Erica stated, "…I have been working as a recovery coach for almost eight months and I have not had the recovery coach training. I feel I was thrown into it without much training" (Erica).

Lacking Peer Recovery Coach training is a burdensome experience for those working in the role. In fact, lacking specific training intensified the already present process of questioning his or her ability to work with clients as a Peer Recovery Coach. Erica described this in stating, "…sometimes I feel ill equipped to help certain people when maybe they have another issue" (Erica). Viewed in conjunction with the absence of a clear job description, Peer Recovery Coaches described feeling a lack of direction in how to provide the service and feeling little confidence in being effective within the role. This fluctuation in their confidence directly contributed to their struggling to managing the multiple roles and identities as a Peer Recovery Coach.

Duality of role and identity. Duality of role and identity refers to the meshing of being in recovery and working as a Peer Recovery Coach. Working as a Peer Recovery Coach resulted in a shift in participants' recovery identity. Specifically, movement into the Peer Recovery Coach role blurred the lines of recovery engagement as a peer in contrast to being viewed as a treatment professional. Four of the six participants described experiences of how working as a Peer Recovery Coach role made navigating these dual roles and identities challenging. Straddling the line as a member of the recovery community and a member of a professional services system brought about a challenging intersection of community recovery engagement while working in the Peer Recovery Coach role. As such, working in a Peer Recovery Coach role influenced how participants were received in the recovery community.

> …in the beginning there for a minute with the twelve-step thing, I had people constantly reminding me that my job was not my recovery. I think I had a couple people kind of for a few minutes get kind of weird on me thinking, I guess, if I was going to act like I was better than them now or how it was because I wasn't just a member of the twelve-step group or whatever. I was caught in the middle. I felt like I didn't fit in anywhere for a minute because now I am one of them, like, one of the people that try to fix us. I don't know. It was weird. It was really weird for a minute. (Riley)

Moreover, the experience of attending recovery support groups where clients were also in attendance was a common experience shared by participants. This further complicated the struggle of navigating dual roles and identities. Participants described dual roles and identities as complicating the balance of recovery engagement and developing dual relationships with clients. Although this was a common experience, it created an intricate dilemma for those working in Peer Recovery Coach roles.

> That happens a lot. Even now as a clinician I have clients that come into the same meeting that I am at and its ok…I may not necessarily talk at a meeting about anything personal or what is going on with myself if a client or somebody is there unless I feel like it is not too personal or it's an experience I have had I may share

> it. But if I am going through something I may wait and share that at a meeting that a client is not at. (Avery)

Often, responsibility rests with the Peer Recovery Coach to accompany clients to recovery-focused meetings within the community. Attending recovery community meetings in the Peer Recovery Coach role restricted the participants ability to share about their personal recovery needs as a recovering group member. Additionally, carrying dual roles and identities placed Peer Recovery Coaches in a sensitive situation in regard to ethical decision-making. Peer Recovery Coaches are charged with abiding by the same ethical boundaries as professional staff through being a professional employee. Maintaining confidentiality and anonymity of clients is at the core of ethical standards. However, participants described being faced with ethical dilemmas regarding client confidentiality and anonymity as a result of accompanying clients to meetings within the community. Participants were torn with the ethical dilemma of reporting to staff treatment relevant information shared by clients during these meetings. Riley shared her experience with such a situation.

> …I tell them that when I am in a meeting, even if I take people to meetings, I will lead you to the door but when I walk through this door I take my badge off and I am here as another recovering addict and I am here if you need support from another recovering addict and not just as your recovery coach. So from the moment I walk in a meeting I sorta set that boundary with my clients because I do need that and I stress to them about anonymity and their confidentiality. (Riley)

Similarly, Erica addressed how this dual role and identity impacts her clients.

> …I am a peer in the sense that I am not a counselor…but I am not a peer at the same time. Many of them [clients] see me as something above them. Or if they tell me something they will get in trouble. (Erica)

Additionally, participants described duality of role and identity extending into the workplace. Sharing an identity of recovery along with being an employee of a professional treatment workplace posed a different set of obstacles. These entangled roles

and identities were described as perplexing for both Peer Recovery Coaches and professional staff. Adding to the abstruse nature of this dual presence is the Peer Recovery Coaches fixed identity in recovery.

> …I think sometimes because of my role and because of changes I have made sometimes I think maybe they [the staff] forget I am a recovering addict and sometimes they speak out…they don't associate me with as like well she is in recovery because it is not the typical person they are used to dealing with because I have made changes. (Katie)

Katie added,

> …you'll hear, you know, jokes and little comments made [about clients]. It's very condescending, you know, and that's really hard for me sometimes because I'm trying to see it from both sides of the fence. From the treatment side and understand well they're just speaking from frustration. (Katie)

Although participants described these experiences as inadvertent, they remained profoundly demeaning. Furthermore, it placed sole responsibility of managing dual roles and identities on the Peer Recovery Coach. Being in recovery was shared as the participants' primary identity. Working as a Peer Recovery Coach was consistently described as the work role participants engage in as a result of being in recovery. Working as a Peer Recovery Coach carried the potential for staff to overlook the peer support worker's fixed identity in recovery. However, staff cognizance of identity in recovery decreases the added pressure felt by the participants to delineate these dual roles and identities, especially given the complicated experience of adjusting to the Peer Recovery Coach role described earlier.

The workplace environment. The workplace environment emerged as a critical element to providing Peer Recovery Coaching services. Workplace environments were described as (a) exhibiting acceptance of Peer Recovery Coaches or (b) not showing

acceptance of Peer Recovery Coaches. All six participants shared similar experiences corresponding with acceptance or non-acceptance within the workplace environment.

Accepting environment. Four of the six participants expressed the importance of an accepting workplace environment as paramount in feeling included as a member of the treatment services programs. An accepting environment included feeling embraced as a peer provider by staff and program leadership. Additionally, an accepting environment promoted engagement and inclusion in client decision making as a part of the professional treatment team. Feeling accepted is a significant factor in adjusting to the Peer Recovery Coach role and engaging in Peer Recovery Coaching services as a part of the team, rather than feeling overwhelmed and directionless within the role or being treated as a client. Overwhelmingly, the experience of being included as a part of the treatment program was an unexpected development for those working in accepting environments.

> …I was pleasantly surprised at how much they actually valued my opinion. They would actually ask me questions about certain things or if I had input they would take that input into consideration. That they actually made me a part of the treatment team rather than saying ‘well you're not a counselor so you don't get to be a part of this’. (Audrey)

Acceptance emerged in many forms for the participants, but can best be explained in the context of positive interactions with professional staff. Participants who experienced an accepting workplace environment cited invitations from professional counseling staff to share lived experiences, viewpoints, the identity of blind spots professional staff may be missing in working with clients. In fact, the power of including peer staff in treatment programs is in providing an alternate perspective to the process of substance abuse recovery by those with lived experiences.

> My contribution is as I just said. It's knowing. It's that experience. I call it on the job training. I have been there. What they [co-workers] tell me is that experience is invaluable to them. Actually that is why I got hired. Because I relapsed and I struggled for a little while but I stayed in it and they hope that is what I can pass along to the clients…they ask me questions. If we are in group and a clinician is leading the group she will ask me '[Greg], what do you have to say'? She is waiting for me to jump in there. She wants my input. After groups are over we will sit in the office and we will bounce off each other how group went. They want my input and ask my input as to which direction should we go with a certain client. How do I think the group went? What do you think about so-and-so? What should we do about so-and-so? Do I have any suggestions? And when I give suggestions they use them. (Greg)

Similarly, Riley stated,

> …I have a couple of coworkers who will say thanks for being in my group. You shared really good on this or that and your position is really important and we know that it is needed here and I am grateful that you are here. The way they include me in things or ask my opinion on things or what I have experience myself. Sometimes I feel like they probe me so they can understand the client. (Riley)

Avery further elaborated on feeling accepted by being approached by professional staff to explore her recovery experience in an effort to gain an increasingly diverse perspective to helping clients.

> …I can say some of the experiences that I have had and some of them [the staff] have come to me later and said 'I never thought of it that way' and 'thank you for saying that'. I know they have learned from us as well. (Avery)

In essence, an accepting environment was characterized by the willingness of professional staff to include Peer Recovery Coaches as a resource in constructing a clearer picture of the client's recovery experiences and treatment needs. In fact, not being treated as clients was critical in the experience of feeling heard as a Peer Recovery Coach.

> I think the number one thing that they [the staff] did was to treat me like I was one of them, you know. They didn't treat me different. They didn't treat me like I was a client… they didn't treat me any different than another person who was an actual counselor or a case manager. (Audrey)

Similarly, Greg shared,

> …they [the staff] have embraced me…I have not been grouped up, boxed up or anything. I haven't had any instances of 'oh here he comes' or anything like that. There's none. It's a very open and warm feeling. I am very accepted. (Greg)

Lastly, accepting workplace environments both supported and promoted the continued recovery needs of Peer Recovery Coaches. Coinciding with the emergence of duality of role and identity, Peer Recovery Coaches seek to remain vigilant in maintaining personal recovery while working in the peer role. As discussed previously, remaining active in personal recovery while working as a Peer Recovery Coach comes with a multitude of challenges. Environments expressed as accepting welcomed an effort to assist Peer Recovery Coaches in meeting their recovery needs. Accepting environments remained conscious to the fact that Peer Recovery Coaches required focus on recovery and self-care despite working in the role, especially considering the high rate of burnout in the counseling profession in conjunction with the possibility of relapse. In fact, continued self-care was identified as a critical component of an accepting workplace environment. Riley illustrated how an accepting environment promoted continued self-care.

> …we have two twelve-step meetings in the location that I actually work at…my boss has made it to where I can attend two of them because she realizes that I can't; I have made it known that I can't give if I'm not getting stuff put back in and I have to work on my recovery as well as helping other people with theirs. They're very open to stuff like that and I am glad I can express my needs because that better helps me. (Riley)

Similarly, Audrey stated, "well that was one thing about the place that I worked that was really good. They were really big on self-care so that was major for me" (Audrey). As such, an accepting environment is open to the inclusion of peers as a part of the treatment team and pursues peer experiences and perspectives with recovery to supplement client

services. Accepting environments value the experiences provided by peer providers and treat peer providers as a part of the staff rather than as a client. Additionally, an accepting environment is willing to aid Peer Recovery Coaches in maintaining recovery and promoting self-care.

Non-accepting environment. Conversely, three of the six participants cited experiences corresponding to a non-accepting workplace environment. A non-accepting workplace environment included the presence of a staff hierarchy within the substance abuse treatment program, and the prominence of unaddressed biased beliefs held by treatment staff toward people seeking recovery. Often, these biases appeared overtly in conversations with treatment staff, and through Peer Recovery Coaches feeling an absence of voice as a part of the treatment team or client decisions.

Non-accepting workplace environments exhibited a dismissal of the Peer Recovery Coach position as valuable to the treatment program. Often, this dismissal appeared in the form of adhering to an unspoken hierarchy existing within treatment staff. Experiencing the hierarchical nature of treatment staff was incredibly disheartening to participants working as Peer Recovery Coaches. People seeking recovery from substance abuse are frequently met with skepticism as a result of the devastation caused through engaging in active addiction. This is a widely accepted stance taken by society until proven otherwise through active change in recovery. However, participants were surprised to experience such skepticism and defensiveness from treatment staff while working as a Peer Recovery Coach. On some occasions this hierarchy was openly directed toward Peer Recovery Coaching staff.

> …I have had one or two instances where I have had a clinician, well one of the therapists…I lead a twelve-step group and one of the groups I am in they allow

> the recovery coaches with experience to lead the step-group and one of the clients was like 'you're a great counselor. You are so good at this.' and before I was able to correct the man, she was like 'she is not a clinician, she is a recovery coach' and did it all nasty and kinda downplaying what I am. (Riley)

Feeling discounted as a part of the treatment staff due to the presence of a hierarchical attitude had significant ramifications on peer staff. Feeling demeaned by professional staff leads to a lack of feeling accepted within the workplace environment by Peer Recovery Coaches and led to feelings of irrelevance in working to support the recovery of clients. Professional staff were described as not being interested in recovery perspectives based on lived experience. Erica illuminated this perspective.

> It's concerning when some people who work in SA [substance abuse] don't seem to value my opinion. Not my personal opinion, but my opinion as a person in recovery. Because if they are working with SA, I hope they think that people can get better. (Erica)

As a whole, participants envisioned feeling unheard as a consequence of differing levels of education, credentials, and being viewed by professional staff as essentially little more than someone in recovery.

> …I didn't feel like I was being heard cause my position wasn't taken as serious as the other ones. I think that is mainly because of the schooling or that you can't bill for my position. Because you are not getting paid and can't bill Medicaid for my position that you don't really want to hear me, that I am just another, you know, one of the addicts they let in the door to make themselves look good. (Riley)

Encountering unaddressed biases and stigmatized beliefs held by professional treatment staff and being omitted from the treatment team elevated the feeling of being discounted and insignificant to the treatment staff. Non-accepting environments promoted a message on exclusion not lost on Peer Recovery Coaches. Erica supported the feeling of the Peer Recovery Coach role not being taken seriously in sharing her exclusion from being a part of the treatment team. Erica described this experience in stating "well I don't really have a whole lot of say so on anything…I think about drug court and the treatment team. I'm

not on the treatment team" (Erica). Katie also expounded on this feeling, "It's like you're part of the treatment team, but, and this sounds really horrible, but then it's like but you're just the recovering addict that deals with the other recovering people" (Katie). Moreover, experiencing this exclusion was disappointing to those working as Peer Recovery Coaches who pursued the role out of a desire to help others succeed in their recovery process. Additionally, it was perceived as an insult considering the amount of time invested in clients through interacting in the Peer Recovery Coach role.

> The treatment team goes in to meet over drug court and I don't go in to that but I spend more time with these clients than any of these people. I know more about these clients than any of these people. (Katie)

In fact, Peer Recovery Coaches described feeling as though the role holds more value than simply placating the shift to ROSCs through hiring workers with lived experience in recovery. Non-accepting environments fail to see the intrinsic value and abilities of Peer Recovery Coaches to engage in promoting recovery in a multitude of ways. Katie illustrated this feeling.

> I know there are certain things you need to have trainings and a certain level of education to do but I guess sometimes I feel like I'm more than just a recovering addict. There are more things I am capable of and more things I can be involved in or give my input with. (Katie)

Non-accepting workplace environments display a hierarchical nature, overtly show biased attitudes of peer staff, fail to include Peer Recovery Coaches on treatment teams or in client decisions, and struggle to recognize the abilities of those working as Peer Recovery Coaches. Participants experienced non-accepting environments as promoting feelings of being irrelevant, discounted, and little more than figureheads for recovery as opposed to integral element of promoting recovery.

Pursuing a professional career opportunity. Pursuing a professional career was a common experience shared by five of the six participants. Pursuing a professional career opportunity refers to seeking a stable and respectable professional career by obtaining training and credentials. Five of the six participants of this study described the necessity of training and credentials in securing job stability and the potential for career advancement. Participants described contrasting views in terms of desired career trajectory; however, there was a clear consistency in progressing toward a better work opportunity in the future. Pursuing training and credentials captures progressing toward meeting the standards required to experience potential career stability and future work opportunities. Participants alluded to becoming increasingly aware of the necessity to obtain training and credentials while working as Peer Recovery Coaches.

Specific to Peer Recovery Coaching, participants discussed the importance of current changes in the state of Virginia to require a standard of training and certification be met in order to work as a Peer Recovery Coach. Surprisingly, these impending requirements were viewed as positive steps in obtaining career stability. Peer Recovery Coaching positions are largely grant-funded positions. As a result participants felt instability in the Peer Recovery Coaching position being a viable career option upon the end of the grant term. However, participants alluded to the reshaping of the current system resulting in Peer Recovery Coaching becoming a Medicaid billable service. Including Peer Recovery Coaching as a billable service decreased feelings of fear and uncertainty over potentially recycling back into career instability. Riley described how completing certification meant a future career.

> Within the next two months I will be certified and that opens the door for us to be billable through Medicaid when they [the state of Virginia] do finally approve all

> of it because that is what they are working towards. My position at the moment is funded through my job, which is funding they got to pay for it…like they can't bill for our services. I know with the certification will be job security more than likely. That I don't have to worry about what are they [the employer] going to do after three years or will I ever get a raise type deal. It will make our positions more secure. (Riley)

Further, Riley more specifically stated that training and certification represented an increased sense of career stability through learning a marketable skill set, thereby decreasing the feeling of her future being bound to one employer.

> I am getting the training. I am getting experience. I am getting the certification and I won't feel stuck at one job. Once you are certified and you are trained for something it opens the doors for other companies if that is ever something I wanted to do. Versus just feeling like these are the people who gave me an opportunity and I need to stay here…(Riley)

Transitioning to a billable service was also viewed as a legitimatization of the Peer Recovery Coach service and role. However, the meaning behind becoming a legitimate service was a point of contention for the participants of this study. The meaning behind not being recognized as a billable service for one participant was directly related to an earlier discussion of non-accepting workplace environments. For Erica, working in a non-billable role led to feeling that the Peer Recovery Coach position was artificial and without purpose. She further stated, "…recovery coach in SA [substance abuse] is not billable to Medicaid. It almost feels like a useless service because no one will pay for it" (Erica). Similarly, Riley noted, "…realizing that my position is being taken seriously whenever the state comes together and makes the certification for it" (Riley). Although Riley described the importance of Peer Recovery Coaching becoming a billable service, her description shares similarities to Erica's in alluding to the service holding little value in the eyes of professional treatment and only being taken seriously upon becoming a

financial contributor. With respect to the meaning of career stability, the career goals of participants are also noteworthy.

Participants descriptions of future career goals varied in clarity and concreteness. Participants described varied career plans ranging from concrete plans to move into a clinical role to meeting more immediate goals to remain in the Peer Recovery Coach position. Regardless of goal clarity, participants all described a common desire to move forward and hope for a better work opportunity. They acknowledged moving forward meant pursuing training and credentials, and depending on the career trajectory of the participant, increased educational requirements. However all six participants described moving forward in the Peer Recovery Coach role as being limited.

Interestingly, the message of moving forward suggested an underlying meaning of confidence in not only pursuing training and credentials, but also being successful in obtaining them. The presence of this level of confidence was unexpected in comparison to the vacillating levels of confidence participants described in their ability to provide services as a Peer Recovery Coach. For instance, participants described a desire to increase the scope of his or her role. In the context of these discussions, participants described any reluctance experienced in terms of the time required to meet the standards rather than a lack of confidence in ability. Greg's description of his thought process of pursuing these standards illuminates this point.

> I want to up my role. I want to stay in the recovery business. I am trying to decide if I am going to go back and get my license, but I've gotta be sure I can use it. I'm [age] years old. I'm not trying to build up a whole lot of debt that I can't do nothing with. (Greg)

The meaning behind these context specific fluctuations in confidence can best described in terms of moving forward in achieving a goal in contrast to feeling compelled to justify

inclusion into the professional treatment system. In this case, moving forward represents career stability and a continued role in a respectable professional career. Moreover, the meaning of this experience was not limited to participants with higher levels of education, reported time in recovery, or experience working in the Peer Recovery Coach role.

Personal Experiences

Participants also discussed personal experiences they had while working as a Peer Recovery Coach. Participants illustrated the ways working as a Peer Recovery Coach contributed to personal growth, development, and confidence in maintaining recovery. Three themes emerged in the participants' descriptions of their professional experience as a Peer Recovery Coach, (a) personal growth and contribution to recovery, (b) validation of change, and (c) belief in belonging.

Personal growth and contribution to recovery. Personal growth and contribution to recovery refers to the experiences of personal enrichment and recovery development arising from working as a Peer Recovery Coach. Not surprisingly, the participants discussed several personal experiences that contributed to personal growth and recovery enhancement. It became clear working as a Peer Recovery Coach offered more to participants than the opportunity to engage with clients seeking recovery. Four of the six participants described personal experiences in working as a Peer Recovery Coach.

Personal growth highlights the areas being augmented through the experience of working as a Peer Recovery Coach. Although the specific areas varied for most of the participants, an overall enhancement of personal awareness was consistent among participant experiences. Participants engaged in deep personal introspection to identify

these personal growth experiences. Personal growth included the development of personal boundaries, heightening personal accountability, and developing a sense of purpose.

Developing and maintaining healthy boundaries is a vital element to sustained recovery. Transitioning into being a member of professional treatment brings about an entirely new set of boundaries, especially within the Peer Recovery Coach role. Self-disclosure of lived experiences in recovery is essential to working in the Peer Recovery Coach role. As such, those working within the role are charged with being able to develop and maintain healthy boundaries. Interestingly, one participant discussed how working as a Peer Recovery Coach enhanced her ability to develop and maintain healthy boundaries.

> When I started working as a Recovery Coach I really learned more about why I did what I did. I really learned more about protecting me as a person and protecting my recovery. I learned more about having healthy boundaries because to be honest, that was something I struggled with. (Audrey)

Audrey suggested working in the Peer Recovery Coach role taught her more about the actions she engages in and the reasons behind those actions. Engaging in an introspective approach due to her experiences as a Peer Recovery Coach supported personal growth by illuminating her thoughts and actions and resulted into the development of a critical skill.

Participants also described personal growth in heightened personal accountability emerging through working as a Peer Recovery Coach. Personal accountability is critical to recovery and was enhanced by working as a Peer Recovery Coach. Heightened personal accountability aided Peer Recovery Coaches in remaining vigilant in meeting personal recovery needs in large part due to recognizing the obligation they have to

clients receiving peer support services. Riley made a poignant comment that summarizes being accountable to her recovery needs.

> It's absolutely made me stay on top of my game because I can't be distracted and not going to meetings or I can't be not doing my step-work or not engaging in my own recovery if I think I am going to help someone else in theirs. (Riley)

Katie also spoke about growth in personal accountability; however, her comment directly addressed her obligation to clients as a Peer Recovery Coach.

> I guess it gave me more accountability because you are not just letting yourself or your family down. You have these ten people that look to you for advice and do you really want to let these people down. (Katie)

In addition to the personal growth experiences, participants described a sense of purpose that emerged through working as a Peer Recovery Coach. Existential questions of purpose permeate the transition into recovery. Engaging in recovery typically requires changing all the people, places, and things known in active addiction. Working as a Peer Recovery Coach supported personal growth through developing a sense of purpose. Greg described feeling a purpose in the work he provides as a Peer Recovery Coach.

> The whole thing about it is that I finally feel like I am somewhere I am supposed to be. I finally feel like I am doing a job that has purpose. To me that is the most rewarding thing of all. I just feel like I have a purpose now. (Greg)

Finding purpose through working as a Peer Recovery Coach helped participants feel that their experience of active addiction was worthwhile and served a higher purpose that remained out of reach prior to engaging in this role.

Additionally, participants shared that working in the Peer Recovery Coach role contributed to their personal recovery. Specifically, working in the role helped participants remain engaged in the recovery process during times of stagnation and served as a reminder of what awaits them in the event of a relapse. Vital in contributing to recovery is the presence of tangible experiences participants had to navigate.

Stagnation is common to long-term recovery. Stagnation often appears through pulling away from Twelve-step meetings and engagement in the recovery community, and often results in returning to the people, places, and things connected to active addiction. Participants described working as a Peer Recovery Coach preventing the emergence of stagnation and remaining actively involved in recovery. In fact, working as a Peer Recovery Coach provided a fresh perspective for remaining engaged in recovery.

> I often question whether I would have done as well without this position. It's not that I didn't have the desire or the want but I just think by focusing on doing meetings, starting stuff in the community, I think it just got me more involved in my own program and kept me on that track. It kinda helped me surround myself with a whole different set of people and different activities because I think it would have been easier for me to go back if I didn't have anything something to kinda keep me busy in a positive way. (Katie)

Likewise, forgetting the pain and suffering experienced in active addiction increases the further away the experience becomes during recovery. Minimizing the impact of active addiction often results in a return to active addiction and revisiting the challenges and difficulty in re-engaging in the recovery process. Moreover, there is never a guarantee of a return to recovery as death is a potential outcome of any relapse scenario. Working as a Peer Recovery Coach served as a preventative measure to relapse through consistently engaging with clients seeking recovery. Moreover, participants described remaining aware of the commonalities shared with clients as an additional safeguard from a relapse episode.

> I see myself in a lot of people and they are actually helping me as much as I am helping them because it constantly reminds me of how real this addiction thing is. I jokingly tell them that I don't have to relapse because they keep doing it for me. So I don't need to go back out and explore it anymore.

Addressing relapse in this direct manner serves two purposes common to recovery and working as a Peer Recovery Coach. First, it holds the potential for relapse in the forefront

of the mind of those working as Peer Recovery Coaches. It also served as confirmation that a return to active addiction will be met with intense challenges and possibly death. Secondly, it offers the opportunity to share lived experiences as examples of recovery being attainable for each client. The crux of the Peer Recovery Coach position is to serve as an example of recovery in the hope that clients will gravitate toward engagement.

Validation of change. An additional personal experience discussed by participants emerged as validation of personal change. Four of the six participants shared how working as a Peer Recovery Coach validated personal changes they made through transitioning to a recovery-oriented life. Experiences of validation included being hired as an employee in a program they once attended as clients, being publicly visible as members of recovery, and witnessing the continual pain and suffering caused by addiction through working with clients as a Peer Recovery Coach.

Receiving an offer to work as a Peer Recovery Coach carried powerful meaning for two participants of this study. For these participants being a former recipient of substance abuse services at the same location in which they are now employed as a Peer Recovery Coach served as validation of change. Receiving validation through an invitation of employment communicated a message of trust from the very same treatment providers who witnessed these participants in active addiction. Being recognized by former treatment providers as an example of stability in recovery provided a significant internal experience of validation. Erica described this experience "…it's been really rewarding to be a client with these same people and to be a co-worker later has really boosted my self-worth and self-acceptance" (Erica).

Experiencing validation of change was also described as a result of being publicly visible as a recovering person through working as a Peer Recovery Coach. Inherent to the Peer Recovery Coach role is publicly sharing personal stories of the lived experience of addiction and recovery. Often communities meet those with lived experience in recovery with a sense of skepticism. The sense of skepticism often results in communities holding fast to images of active addiction and being slow to develop new opinions of those engaging in recovery. One participant described being viewed differently in the community through her outreach as a Peer Recovery Coach validated the changes she had made. Erica stated, "the positive involvement in the community as far as being seen…so for people to see me in a different light was always, that was really encouraging for me" (Katie).

Additionally, experiencing validation of change was also shared through direct work with clients as a Peer Recovery Coach. One participant stated that seeing and hearing the pain and suffering experienced by clients in active addiction validated the changes she had made. Unfortunately, addiction is ripe with episodes of relapse and a return to the misery offered in active addiction. Being reminded of the frightening nature of addiction through working with clients as a Peer Recovery Coach significantly contributed to experiencing validation of change. Riley's internal experience of gratitude when confronted with these client experiences help to ground and validate the changes she has been able to make in recovery. Riley shared "hearing other people's stories never lets me forget how serious the disease of addiction is. Hearing the struggles people come in with reminds me of where I've come from and keeps me grateful at all times" (Riley).

Participants discussed experiences of how working as a Peer Recovery Coach personally validated the changes made in recovery. Validating experiences were essentially cathartic for participants and served as motivating forces to continue in pursuit of personal recovery. While all participants discussed validating experiences, Greg provided a succinct summary of the experience of validating change. Greg shared, "…my boss was my counselor and for him to see that much in me to offer me the job was a pretty powerful statement of where I have come from because he saw me when I was a mess" (Greg). Similarly, Riley stated, "it was very inspirational for them to be able to hire us…I just thought it was awesome" (Riley).

This theme captured participants discussion of the personal messages received in being invited to work as a Peer Recovery Coach. Participants seemed to acknowledge these experiences as validating the changes they made through recovery. Participants reported growth in personal recovery as a result of these experiences while working as a Peer Recovery Coach.

Belief in belonging. An additional personal experience resulting from working as a Peer Recovery Coach was the development of a belief in belonging. Participants discussed how working in the Peer Recovery Coach role reinforced a growing assurance of their ability to provide recovery support services to clients. Participants shared discarding apprehensive feelings of how they would assimilate to working as a part of the professional treatment environment and questions of competence to work as a service provider. Participants shared feelings of apprehension as being a normal feeling during the recovery transformation from active addiction to actively engaging in recovery.

Overcoming the internal feelings of fear and intimidation emerging in working alongside educated and trained professionals is a difficult challenge for Peer Recovery Coaches.

> It was scary because I didn't know. I was always the one that messed up. I didn't finish high school. I had to get a GED. I'm in here in an office with people who have college degrees. They've got bachelors and masters…and at first I felt kinda less than. (Riley)

Erica shared a similar experience, however, Erica described this initial feeling dissipated as she acquired more service time in the position.

> It was kinda challenging to take that position and to work with people I felt like were so above me. I'm not feeling quite so much that way months later but at first it was like whoa these guys are up here and I'm down here. (Erica)

Interestingly, Riley and Erica share a similar length of service working as Peer Recovery Coaches and might explain the initial feelings of intimidation. However, it is important to note a distinct gap exists in the level of education and reported time in recovery of Riley and Erica (See Appendix D). These differences might explain the accelerated pace described by Erica in comparison to Riley in overcoming feeling of intimidation in working with professionally trained staff.

Participants also discussed work as a Peer Recovery Coach serving to strengthen levels of self-esteem and self-worth resulting in believing they belong in the role. This change was in large part due to the ability of participants to view themselves as something other than an addict. Working as a Peer Recovery Coach created an opportunity to reconstruct self-perceptions for the participants of this study and eventually led to feelings of adequacy and belonging.

> I believe I had poor self-image and poor self-esteem because of my past in addiction that even though I came out of addiction and had been clean and sober for five years when I started working at the facility that I still saw myself as an addict. (Audrey)

The experience of continuing to internally hold on to the addict identity is not uncommon, especially for participants nurturing their recovery in Twelve-step programs. Identifying as an addict is common vernacular used in Twelve-step meetings as a means of always remembering the chronic nature of addiction. However, as Audrey addressed, holding steadfast to this can result in deceased self-image and pose long-standing challenges in feeling adequate as a service provider. In fact, transitioning into the Peer Recovery Coach role aligns more with identifying as actively engaged in recovery rather than identifying as an addict. Moreover, developing a belief of belonging requires speaking in terms of the power of recovery as opposed to the negative connotations often attached to the word addict.

In summary, participants of this study were increasingly able to let go of the internal resentments they held through the cathartic nature of personal experiences identified while working as a Peer Recovery Coach. Attendance to taking an introspective approach to these experiences offers personal growth opportunities while working in the Peer Recovery Coach role. Additionally, validation of change is experienced in working as a Peer Recovery Coach and serves as a motivating force for continued recovery engagement. Finally, the descriptions of personal growth and contribution to recovery were independent of the workplace environment as a contributing factor.

Conclusion

Chapter four provided the results and themes obtained through semi-structured interviews with current and former Peer Recovery Coaches. Experiences leading participants to work as a Peer Recovery Coach were reported, including a desire to give

back and instill hope, encouragement from someone within the recovery community, an improved career outlook, and financial security and benefits. This was followed by reporting the professional experiences participants' had related to working as Peer Recovery Coaches. Professional experiences while working as a Peer Recovery Coach include serving as an agent to bridge the gap, adjusting to the Peer Recovery Coach role, duality of role and identity, the workplace environment, and pursuing a professional career. Chapter four concluded by reporting the personal experiences described by participants while working as a Peer Recovery Coach. Personal experiences while working as a Peer Recovery Coach include personal growth and contribution to recovery, validation of change, and belief in belonging.

CHAPTER 5: DISCUSSION

The purpose of this qualitative study was to determine the essence of the experiences of working as a Peer Recovery Coach. Incorporating a qualitative approach to this study presented rich descriptions of the lived experiences of participants to accurately define the phenomena. This study generated findings consistent with research concerning the inclusion of Peer Recovery Coaches into substance abuse treatment paradigms.

The conclusion of phenomenological research should include a comparison of the study findings with the literature reviewed at the beginning of the study (Moustakas, 1994). Relating the findings to previous research allows connections to be made prior to presenting the implications of this study. However, the paucity of research specific to the experiences of Peer Recovery Coaches working within the Peer Recovery Coach role requires this study to be compared to multiple elements addressed within the review of literature. As such, this comparison will narrow in perspective through situating the literature reviewed for this study in relation to the themes that emerged.

Discussion of Findings

Research Question One: Leading to Working as a Peer Recovery Coach

Desire to give back and instill hope. The current study established the desire to give back and instill hope is linked to a multidimensional sense of obligation in helping others transition to a life in recovery. This finding mirrors that of previous studies in that

participants reported the desire to give back and instill hope developed into finding meaning in past personal struggles (Laudet & White, 2010), maintaining personal recovery (Ostrow & Adams, 2012), instilling hope for the attainment of recovery (Bora et al., 2010; White, 2010) and representing a better future to clients (Repper & Carter, 2011). Participants described the desire to give back and instill hope as vital in leading them to pursue Peer Recovery Coach positions.

The desire to give back and instill hope emerged as a critical element leading to working as a Peer Recovery Coach. Participants described the development of the desire to give back and instill hope as being deeply rooted in personal recovery and arising at different points in the recovery process. The desire to give back and help was discussed as resulting from personal experiences with substance abuse treatment and engaging in Twelve-step based recovery work. These experiences led to feelings of empathy and compassion and supported growth of a sense of obligation to help others seeking recovery. Participants' descriptions of giving back to others seeking recovery is aligned with the Twelve-step recovery program suggestion of giving back as a means of maintaining long-term recovery (Ostrow & Adams, 2012). As such, participants viewed working in a Peer Recovery Coach position offered the platform to act on the desire to give back while also promoting continued maintenance of personal recovery. This finding may have implications in how employers recruit candidates for Peer Recovery Coach positions.

Encouragement from someone within the recovery community. Encouragement from someone within the recovery community was a vital experience leading to working as a Peer Recovery Coach. This message of encouragement carried a strong meaning to

participants and increased confidence to pursue Peer Recovery Coach positions. Specifically, encouragement emerging from the recovery community validated their personal recovery and being trusted as a valuable recovery asset. Interestingly, participants described the person in the recovery community whom provided the message as secondary to receiving the message of encouragement itself in pursuing Peer Recovery Coach positions.

This finding is unique to this study because it has not been addressed in the literature reviewed for this study. In fact, the most closely related studies assert Peer Recovery Coaches are 'vetted' through their work in a local community of recovery (White, 2010), and Peer-Based Recovery Support Service providers are generally further along in their own recovery (Repper & Carter, 2011). This can be loosely connected to participant's experiences considering messages of encouragement from the recovery community were largely shared as a result of changes displayed in personal recovery. However, outside of the 'vetting' process the message of encouragement received by participants is largely absent within the literature reviewed for this study. This finding appears to be absent from the reviewed literature in that a considerable amount of research on Peer-Based Recovery Support Services focused on the transition of the substance abuse field to the ROSC model (Daniels et al, 2012; Laudet, 2007; Laudet & White, 2010; Ostrow & Adam, 2012), defining the role of Peer Recovery Coaches (Austin et al., 2014; SAMSHA, 2013; White, 2006), and the service delivery Peer Recovery Coaches provide (Beckett, 2012; Hill & Johnson, 2012; SAMSHA, 2009; SAMSHA, 2012; White, 2004a; White, 2004b; White, 2006). This finding may also have

implications how employers approach recruiting candidates for Peer Recovery Coach positions.

Improved career outlook. The current finding mirrors that of previous studies in that participants reported the prospect of employment (Walker & Bryant, 2013), stability in employment (Laudet & White, 2010), and feeling like a valued member of the workforce (Laudet & White, 2010; Repper & Carter, 2011) as key components in their pursuit of Peer Recovery Coach positions. Although focused on mental health peer support workers, Walker and Bryant (2013) identified the prospect of employment was viewed as a stepping-stone to increased stability and reintegration into the community. Similarly, participants viewed Peer Recovery Coach positions as an avenue toward feeling like and being viewed as a valuable member of the workforce and community. As such, experiencing an improved career outlook removed internally preconceived barriers to a career and made a career an attainable pursuit.

Improved career outlook was described as a significant contributor leading participants to work as Peer Recovery Coaches. Improved career outlook largely developed as the result of experiencing unemployment, job instability or the absence of job stability. Peer Recovery Coach positions were viewed as an opportunity for job stability and the potential for an improved career outlook. Moreover, the current study illuminated the unique internal and external impressions of value an improved career outlook held for participants. In this sense Peer Recovery Coach positions offered the opportunity for participants to experience stable and meaningful work while altering internally held perceptions of professional careers being unattainable. This finding may

have implications in how employers approach recruiting candidates for Peer Recovery Coach positions.

Job stability and benefits package. Peer Recovery Coach positions meant an increased sense of job stability and extended into increased potential of personal and family stability. The inclusion of a benefits package was described as a determinant leading to working as a Peer Recovery Coach. Receiving a benefits package meant an increased ability to address personal and family needs for participants and supported overall stability in major life categories.

The findings of job stability and benefits package as factors leading to working as a Peer Recovery Coach are largely absent from the literature reviewed for this study. In fact, the mention of benefits only emerged once in the literature reviewed for this study (Johnson et al., 2014). Benefits appeared as a negative comment within a survey of Peer Support Services workers conducted by Johnson et al. The finding of this study is in contrast to that of Johnson et al. The inclusion of a benefits package was shared as a significant factor in pursuing Peer Recovery Coach positions within the current study. Additionally, employment has been identified as a priority in seeking recovery (Laudet & White, 2010; Johnson et al., 2014; White, 2006). However, the concept of job stability has yet to emerge in previous studies. This finding appears to be absent to be absent from the literature reviewed as this study is uniquely focused on capturing the common experiences leading to working as a Peer Recovery Coach.

Research Question Two: Experiences Related to Working as a Peer Recovery Coach

Professional Experiences

Serving as an agent bridging the gap. Participants described serving as an agent to bridge the gap as more than bridging formal treatment and the recovery community. Serving as an agent to bridge the gap meant being an example of recovery as a possible outcome to clients and professional staff. Emergent in participant descriptions was an increased sense of pride through recognizing the value of their lived experiences to both clients and professional staff. Accompanying this sense of pride was an increased sense of confidence in being uniquely able to bridge the differences in language and perceptions shown by clients and professional staff. In fact, openly sharing commonalities of lived experiences with clients was described as unique to the Peer Recovery Coach position and significant in serving as an agent to bridge the gap.

The current finding mirrors that of previous studies in that participants reported a sense of pride in being a representation of recovery as attainable (Bora et al., 2010; White, 2006), feeling valuable through being able to understand client experiences because of lived experiences (Austin et al., 2014), and being an example of recovery (Repper & Carter, 2011). However, the current study augments the previous research on serving as an agent to bridge the gap specifically related to client and professional staff language and perceptions. Serving as an agent to bridge the gap in this respect represents an area not explicitly discussed in the review of research applied to this study. This finding may have implications in the development of planning, training, and educational opportunities detailing the Peer Recovery Coach role and integration into professional treatment programs.

Adjusting to the peer recovery coach role. Working as a Peer Recovery Coach involves a challenging transitional period for participants. Specifically, the absence of a clearly defined job description complicated transitioning into the role. The current study identified inconsistent job descriptions throughout the state of Virginia (See Appendices I-K). The absence of a clearly defined job description affected participants' feelings of confidence and competency in providing Peer Recovery Coaching services. Additionally, participants described confusion in deciphering the boundaries within the role and expressed clear frustration in navigating the presence of a power differential. This power differential was described as the result of the role straddling being a client advocate and a member of professional treatment. Participants noted experiences of conflict in advocating for clients through being viewed as an authority figure rather than a peer. Participants also identified Peer Recovery Coach training, specifically training received through the SARRA center, as beneficial in adjusting to the role.

The current finding mirrors that of previous studies in that participants reported boundary recognition (Walker & Bryant, 2013), and boundary management complicated adjustment and management of dual relationships with clients (Hecksher, 2007; White & Evans, 2014) inherent to the Peer Recovery Coach role, and the need for clearly defined roles and job descriptions (Bora et al., 2010; SAMSHA, 2012; Walker & Bryant, 2013) in aiding adjustment to the Peer Recovery Coach role. Moreover, the numerous roles of working as a Peer Recovery Coach (White, 2014), absence of a clear job description (SAMSHA, 2012; White, 2006) and measuring job performance (SAMSHA, 2012) were discussed as limitations to feeling confidence or competence in providing peer support services.

Lastly, the formation of a power differential (Repper & Carter, 2011) was cautioned in mental health peer support services as the result of pay, training, and the presence of titles, and appears to carry over into substance abuse Peer Recovery Coaching services. The current finding contrasts that of previous studies (SAMSHA, 2012; White, 2006) in that participants reported the presence of a power differential in client relationships. The presence of a power differential diminished clarity in the boundaries of the Peer Recovery Coach role and resulted in participants experiencing contradictions in how to engage in client advocacy while working as a Peer Recovery Coach. This finding may have implications in the development a clearly defined and consistent job description throughout the state of Virginia.

Duality of role and identity. The current finding mirrors that of previous studies in that participants reported experiencing the effect of dual roles and identities within the recovery community (Hecksher, 2007; Repper & Carter, 2011; White, 2006; White, 2014), in ethical decision making about client confidentiality and anonymity (Hecksher, 2007; White, 2007), and in considering the potential of Peer Recovery Coaches to disconnect from the recovery community (White, 2006). The presence of dual roles and identities in the recovery community and workplace environment made adjusting to the Peer Recovery Coach role increasingly difficult. In fact, the complexities presented within these dual roles and identities placed participants in precarious situations regarding engagement in personal recovery, protecting client confidentiality and anonymity, and managing a fixed identity in recovery within a workplace environment where it is often forgotten or overlooked.

Dual identity as a member of recovery and the treatment system posed a challenge to acceptance within the recovery community, especially when accompanying clients to recovery community meetings. Accompanying clients to recovery community meetings while working in the role affected engagement in personal recovery and also risked the confidentiality and anonymity of their clients. More specifically, client confidentiality was placed at risk through being accompanied to the meeting by a representative of professional treatment. Additionally, client anonymity was placed at risk based on what the client may share within the meeting that may be pertinent to the client's treatment. Participants described being faced with ethical decision-making dilemmas as a result of possessing dual roles and identities. Ethical dilemmas arose in the form of breaking client anonymity to share pertinent information with treatment staff to address treatment needs or withholding information in order to hold true to the stated traditions of Twelve-step recovery meetings.

Central to duality of role and identity is Peer Recovery Coach participation in Twelve-step recovery groups. Participation in Twelve-step Recovery meetings was also noted to place Peer Recovery Coaches and clients in compromising situations. Participants described three approaches used in managing dual roles and identities. These three approaches align with knowing when and where to share and censoring sharing (Hecksher, 2007) and potentially disconnecting from the recovery community (White, 2006). These approaches were (a) addressing the situation with clients early in the development of the Peer Recovery Coach relationship, (b) choosing to withhold sharing in these settings, or (c) choosing to share in these settings as an example of engaging in active recovery. Each of these approaches possesses strengths and weaknesses in being

able to fully engage in personal recovery needs and the potential effect on clients. Participants who chose to diminish their activity in the recovery community also reported longer periods of overall time in recovery compared to participants who chose to be more active in recovery community meetings. This is important to note as those reporting longer overall time in recovery might be at a different emotional level due to their personal recovery work and require less focus on maintaining personal recovery within this setting.

The workplace environment. The current finding mirrors that of previous studies in that participants reported a non-accepting workplace environment (SAMSHA, 2012), differences in perception of recovery as a reality conveyed by professional staff (Aiken, 1984; Repper & Carter, 2011), and the presence of negative or rejecting staff attitudes (Walker & Bryant, 2013) as critical to defining the Peer Recovery Coach experience. The workplace environment emerged as a critical component in the experience of working as a Peer Recovery Coach. Participants' descriptions of the workplace environment were categorized as accepting or non-accepting and significant differences within these environments emerged from participant discussions. Accepting environments included a feeling of inclusion and feeling heard, being treated as a co-worker rather than a client, and being supportive of continued engagement in recovery. In contrast, non-accepting work environments included a staff hierarchy, excluded participants and left him or her feeling absent of voice, and showed unaddressed bias in coworker attitudes. The most closely related study identified the development of a program support team (Daniels et al., 2012) as a need in successfully implementing peer support services.

The workplace environment carries enormous power to support Peer Recovery Coaches in developing personally and professionally. Supportive environments accomplish this by helping Peer Recovery Coaches build self-worth and feeling valued, and by promoting the message of a belief in recovery to clients through nurturing and respecting the Peer Recovery Coach role. Participants experienced supportive environments as a benefit to personal recovery and the provision of Peer Recovery Coaching services to support the needs of clients. However, non-supportive workplace environments placed Peer Recovery Coaches at risk of feeling dismissed, demeaned, devoid of value, and discounted by staff. Moreover, non-supportive environments do not convey a belief in recovery as attainable through excluding Peer Recovery Coaches voices in addressing client needs. Non-accepting environments also presented demeaning and biased staff attitudes of recovery (SAMSHA, 2012; Walker & Bryant, 2013) and failed to promote a recovery-focused atmosphere, making work as a Peer Recovery Coach challenging. Considering the aforementioned experiences of adjusting to the Peer Recovery Coach role and the presence of duality in role and identity, the workplace is a critical element to a successful experience while working as a Peer Recovery Coach. As such, this finding may have implications in how program leadership cultivates a workplace conducive to providing Peer Recovery Coach services.

Pursuing a professional career opportunity. Pursuing a professional career opportunity represented seeking a stable and respectable professional career by obtaining training and credentials. Common to this experience is movement forward and toward a better future work opportunity. All participants shared examples of the intention to continue moving forward through discussing long-term and immediate goals. Through

sharing these varied goals, participants exuded a clear confidence in the ability to be successful in meeting the standards required to move forward. Moving forward in this sense appeared to represent a continued process of growth both personally and in recovery.

Interwoven into this experience is the upcoming transition of Peer Recovery Coach services to a Medicaid billable service. Recognition as a billable service appeared to contribute to redefining the personal meaning of working as a Peer Recovery Coach as it was noted by one participant as "being taken seriously". Securing funding through being recognized as a billable service offers the continued opportunity to promote recovery across multiple frameworks (i.e. employer setting, community setting). Moreover, "being taken seriously" meant increased stability within the Peer Recovery Coach role and the opportunity to continue moving forward within a respectable and personally valued career (Daniels et al., 2012). Interestingly, the description of being legitimized through being recognized as a billable service is in stark comparison to assertions of Peer Recovery Coaches being legitimized through experiential knowledge and experiential expertise rather than education and credentials (White, 2007).

The current finding supports that of previous studies in that participants reported the Peer Recovery Coach position increased self-esteem and re-shaped their view of future career goals (Johnson et al., 2014), discussed the importance of developing funding streams for Peer Recovery Coaching services (SAMSHA, 2012; White & Evans, 2014), addressed potential career stability and mobility (Davidson et al., 2010; Solomon, 2004), and increased the viability of working as a Peer Recovery Coach in the future (White, 2006). The current study also highlighted the importance of maintaining a

trajectory of moving forward through working as a Peer Recovery Coach. Moving forward for participants of this study aligned with the concept of recovering toward a new life identified in mental health recovery coaching (Bora et al., 2010) signifying a clear difference in clinical recovery and personal recovery. Moreover, the identification of moving toward a career goal as an area of professional growth for mental health peer support workers (Solomon, 2004) supports the importance of moving forward described by Peer Recovery Coaches. These categories may be used to help guide future exploration of how to support service development within the agency and community, and the creation and hiring of increased Peer Recovery Coach positions.

Personal Experiences

Personal growth and contribution to recovery. Working as a Peer Recovery Coach was noted as supporting personal growth and contributing to personal recovery experiences. The areas of personal growth noted by participants included boundary development, attention to self-care, personal accountability, and a sense of purpose. None of the participants in this study shared a focus on mere symptom reduction. Rather, descriptions of personal growth noted by participants each aligned with the concept of self-improvement and led to self-efficacy (Johnson et al., 2014).

Likewise, participants described the contribution of working as a Peer Recovery Coach to their personal recovery. Working as a Peer Recovery Coach was shared as making significant contributions to personal recovery in two ways: (a) remaining engaged in recovery during times of recovery stagnation, and (b) viewing relapse through a preventative lens. In fact, participants clearly described their interactions with clients through the Peer Recovery Coach role kept them engaged in pursuing recovery. Client

interactions offered an opportunity to measure their current engagement in personal recovery needs, reminded them of the suffering associated with a relapse, and developed a sense of purpose behind their personal recovery and Peer Recovery Coach work.

Recovery is suggested to be a process of self-improvement, leading toward new opportunities and a new and better life (Laudet, 2007). The current finding supports the previous research in that participants identified self-efficacy (Johnson et al., 2014), increased self-confidence (Solomon, 2004), and contributions of working as a Peer Recovery Coach to recovery experiences (White, 2007). Additionally, peer providers' benefiting from peer recovery support services was identified as an area of needed research (Reif et al., 2014). This study adds to the previous literature through providing concreteness to the areas of personal benefit experienced by participants.

Validation of change. Participants described experiencing validation of change through working as a Peer Recovery Coach. Validation of change was discussed through multiple experiences including being hired as an employee in a program once attended as a client, being publicly visible as members of recovery, and being reminded of the misery of active addiction. Each of these experiences offered an alternative perspective to the skewed perception of personal recovery often held by those in recovery. Two entwined commonalties existed within participant descriptions of validation of change: (a) an external stimulus provoked personal introspection and was experienced as a result of working as a Peer Recovery Coach, and (b) participants received validation from former providers within the community through the Recovery Coach role and through interactions with clients.

This finding is unique to the current study, as it has not been addressed in the literature reviewed for this study. The most closely related study describes validation in terms of self-help groups validating one another's experiences (Laudet et al., 2000). The participants descriptions of validation of change for this study can be compared with validating one another's experiences in that being reminded of the power of addiction resulted from shared lived experiences of addiction with clients. However, the external validation of change experienced through being hired as a Peer Recovery Coach where participants were once clients and being publicly viewed in a different context are experiences absent from previous studies. This is unique to this study as the focus of the experiences of working as a Peer Recovery Coach offered the opportunity to capture the internal and external representations of participants' personal experience working as a Peer Recovery Coach. This finding may have implications in supporting the continued recovery needs of Peer Recovery Coaches through structured supervision.

Belief in belonging. Belief in belonging was the culmination of coming to believe in the ability to provide Peer Recovery Coaching services in addition to being a valuable component of a substance abuse treatment program. Peer Recovery Coaching directly contributed to developing a belief in belonging through challenging participants to redefine their internalized view as an addict to an identity of recovery. Redefining this internalized view strengthened self-worth and increased confidence to work as a Peer Recovery Coach. Likewise, it allowed participants to overcome the intimidation of working in a highly professionalized system and produced a belief in belonging.

This finding of the current study can loosely be compared to increased knowledge about recovery producing increased confidence in working as a Peer Support Specialist

(Johnson et al., 2014). Although the descriptions of belief in belonging shared an increased level of confidence as described by Johnson et al., this increase in confidence was described as emerging from altering an internalized view for the participants of this study in comparison to increased knowledge about recovery. As such, this finding is unique to the current study. This finding may have implications in structuring and supporting supervision needs of Peer Recovery Coaches.

Implications of the Findings for Employers

It is evident working as a Peer Recovery Coach with others seeking recovery is close to the hearts of those within the role. This study offers insights into the experiences of working as a Peer Recovery Coach. Specifically, this study identified the following implications that included: 1) factors important to consider in recruiting and retaining Peer Recovery Coaches, 2) an accepting and inclusive workplace environment is crucial to Peer Recovery Coaching services development, 3) creating a clearly defined job description, and 4) the need for the creation of a relapse plan of action for Peer Recovery Coach positions.

Recruiting and Retaining Peer Recovery Coaches

Peer Recovery Coaches shared a passion and desire about their work. However, participants also shared feeling they had little time to effectively work with all clients in need of the service. The overarching notion was the need to hire more employees into Peer Recovery Coach positions to be able to provide the service in the way it was intended. Those working in Peer Recovery Coach roles found out about the positions as a result of being encouraged from someone within the recovery community. Likewise, their decision to apply was often the result of encouragement by those they share the recovery

community with or by previously established connections with staff as former clients. Employer activity in recovery community functions (e.g.. housing the function, financial support, staff presence) helps to identify potential Peer Recovery Coach position applicants. Recruiting in this way serves two purposes: (a) it identifies a pool of potential future employees, and (b) it strengthens the connection of the treatment system with the recovery community and allows those working as Peer Recovery Coaches to become an agent to bridge the gap. The continued presence of societal stigma about addiction and recovery makes identifying suitable candidates a difficult task. Traditionally, the recovery community has been closed off to those outside of recovery. However, transitioning the treatment system to incorporate a recovery-oriented structure may open doors and strengthen connections with the recovery community, making identification of potential candidates less difficult.

Retention of Peer Recovery Coaches requires employers to assess multiple aspects of peer support service programs. The decision to move into a clinical role was in large part due to a lack of opportunities within the peer support services program. In its current form, those working as Peer Recovery Coaches have the option to seek movement from a part-time position into a full-time position that represents the plateau of advancement opportunity. Although financial security and benefits serve as incentive for those working within the role, the prevalence of low pay and little job security due to Peer Recovery Coach Positions being grant-funded, offers little stability to remain within the role. Most often, Peer Recovery Coaches seek further education to move into clinical roles that offer increased stability, higher rates of pay, and increased opportunity for advancement. Being recognized as a billable service within the state of Virginia will

likely increase feelings of job security for Peer Recovery Coaches and lead to higher rates of retention. However, if the pay structure is also not addressed retention rates will not likely change. Lastly, training and certification opportunities are important in retaining Peer Recovery Coaches, especially in light of changes taking place in the state of Virginia. The Peer Recovery Coaches of this study recognized the changes taking place and realize they have limited options if their employer does not support them in receiving training and certification to remain in the Peer Recovery Coach role.

Accepting Environment and Program

Supports within the workplace environment are critical in developing Peer Recovery Coaching providers and services. The current study identified the challenges experienced by Peer Recovery Coaches of continued engagement in personal recovery within the community as a result of dual roles and identities. The transition of adjusting to being a part of a large professional treatment organization is difficult for Peer Recovery Coaches. Feeling less-than due to disparities in education and credential attainment compared to professional staff further complicates this transition. A part of the recovery process is the transition from viewing oneself as an addict to viewing oneself as something more (Laudet, 2007; Johnson et al., 2014; Solomon, 2004; White, 2007). An accepting workplace environment meets the needs of Peer Recovery Coaches through promoting self-care and continued engagement in their personal recovery. This can be accomplished through the development of on-site recovery focused meetings for the Peer Recovery Coach staff, through the option to be included in Twelve-step meetings taking place at the site of employment, through increased training opportunities for Peer Recovery Coach workers and non-peer staff, and through supervision.

Furthermore, employers and programs need to address the inclusion of Peer Recovery Coach voices into treatment team meetings and client decision-making. The current study identified experiences of exclusion from treatment teams, and feeling their voices were not being heard pertaining to client decision-making. Peer Recovery Coaches work with clients in a different capacity than that of professional service providers. The services provided by Peer Recovery Coaches span a longer time frame (White, 2006) and are on a more personal level than that of professional treatment staff. As such, Peer Recovery Coaches can offer valuable perspectives, information, and voice as a part of the treatment team. However, this requires a desire on behalf of program staff in wanting to understand the role and responsibilities of Peer Recovery Coach workers to better utilize the service for their clients. These two concerns could be addressed through a top-down approach where program leadership promotes and models an accepting and inclusive atmosphere. This could possibly be accomplished through offering trainings seminars and activities to staff in regard to the role and services provided by those working as Peer Recovery Coaches.

Clearly Defined Role

A key in developing Peer Recovery Coaches to provide the intended service is to have clearly defined roles. Clearly defining the role serves programs in multiple ways: it gives direction to Peer Recovery Coach service providers, it helps professional staff to understand and utilize Peer Recovery Coach positions, it gives clear definition to how job performance is measured by the organization, it helps clients to understand the boundaries of the Peer Recovery Coach in comparison to professional providers. Peer Recovery Coach job descriptions are inconsistent throughout the state of Virginia (See

Appendices I-K). As such, Peer Recovery Coach services are offered in a number of ways within treatment programs. The challenge of Peer Recovery Coaches struggling to determine the scope of their role and the workplace environment struggling with utilizing Peer Recovery Coaches appears cyclical as described in the experiences of participants. This cyclical nature puts into question how Peer Recovery Coaches can understand the scope of their role working within a system with little understanding of how to utilize them. The creation of a clearly defined role is suggested in order to help Peer Recovery Coaches and the professionals they work with to better understand the framework of Peer Recovery Coaching services and maximize the strengths of the service.

Employer Relapse Plan

Lastly, participants mentioned the lack of knowledge of a relapse plan having been created with the employer. In fact, participants had no knowledge of what would happen if they were to relapse. Although not emerging as a theme within this study, this issue holds important implications for employers to consider. Relapse is a very real possibility for those in recovery, regardless of working as a Peer Recovery Coach or being a client receiving services. It would behoove employers to evaluate how they will react to a relapse instance, how they will meet the wishes of the Peer Recovery Coach who relapsed, how they plan to support the Peer Recovery Coach transitioning back into recovery, and ultimately, what the outcome of his or her employment status will be.

Implications of the Findings for Counselors and Counselor Educators

Whereas the process of recovery is unique to each individual, the results of this study do have general implications for professional counselors working in substance abuse treatment systems, as well as counselor educators training counselors to work in

substance abuse treatment. The substance abuse treatment system is transitioning from an acute-care model to a chronic-care model (Laudet & White, 2010) through creating a Recovery-Oriented System of Care (White, 2010). Resulting in this transition is the inclusion of Peer Recovery Coaches (White, 2007) into substance abuse treatment systems. As such, it is important counselors and counselor educators understand this shift and increase their awareness of how Peer Recovery Coaches fit into the treatment paradigm.

Counselors working within substance abuse treatment systems will likely work alongside a Peer Recovery Coach as a result of this shift. Counselors may support this transition through seeking training specific to understanding the roles and services of peers within the treatment system. Counselors are required to complete a designated amount of continuing education credits as a means of holding onto professional credentials. Incorporating training specific to the inclusion of peer support services can be a good use of continuing education credits. In doing so, counselors not only support the transition into a Recovery-Oriented System of Care, but also learn how to best support their clients' transition into recovery. Counselors must also recognize the different paths to recovery available to their clients. Substance abuse treatment has often looked to abstinence as the clear option to engaging in recovery. Working alongside Peer Recovery Coaches and discussing their lived experience in recovery can offer an alternative perspective to the many doors to recovery that exist. Also, it can reshape the way counselors view the recovery process and those seeking to move into recovery. Additionally, working with a Peer Recovery Coach can also challenge counselors to identify and challenge their own biased views of substance abusers or recovery.

Counselor educators are charged with training students to move into the field and work as counseling professionals. The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) program objectives under foundation of Professional Identity should "reflect current knowledge and projected needs concerning counseling practice in a multicultural and pluralistic society" (p. 8). *S*pecific to Clinical Mental Health Counseling standards, CACREP states under Foundations, section A, Knowledge number three:

> Understands the history, philosophy, and trends in clinical mental health counseling, as well as understands the roles and functions of clinical mental health counselors in various practice settings and the importance of relationships between counselors and other professionals, including interdisciplinary treatment teams (p. 29).

Moreover, CACREP requires counseling students to complete at least one course specific to addiction counseling and states under Addiction Counseling, Section A, Foundations number 1:

> Understands the history, philosophy, and trends in addiction counseling. (p.17)

Counselor educators teaching within CACREP accredited programs are expected to teach current trends taking place within the counseling field. The transition to ROSC and the inclusion of Peer Recovery Coaches within that system is a current trend that is taking place in substance abuse treatment. Several participants shared the importance of an accepting workplace environment in their ability to provide services within the role. Counselor educators discussing the trend of Peer Recovery Coach in the substance abuse system can serve to support the position as those graduating from counselor training

programs and moving into the substance abuse treatment system will already have an awareness of the peer role as well as addressed any biased views held toward those in recovery.

Limitations of the Study

The current study had multiple limitations. Although generalizability is not a focus of qualitative studies (Creswell, 2011), the sample size of participants interviewed for this study should be met with caution. The generalization of these findings should also be met with caution, as the participants within the sample constitute sites within Health Planning Region (HPR) three in the state of Virginia CSB system. As such, the question of the similarities to the findings between those working as Peer Recovery Coaches in other regions of the state of Virginia arose. However, the researcher identified the emergence of themes through data analysis based upon the similarities of the participants' lived experiences.

Another limitation to this study was the inclusion of only one male participant. This was unavoidable as only one male responded to the participant recruitment email. However, this does raise the question of whether the findings of this study are applicable to males working within the Peer Recovery Coach role. Secondly, five of the six participants in this study identified as Caucasian, while only one identified as African-American. This limitation raised the question of whether the findings of this study are applicable to other ethnicities working as Peer Recovery Coaches throughout the state of Virginia. Lastly, the demographic make-up of the participants in this study resulted in the absence of Caucasian male participants; again, this was unavoidable as only one male responded to the participant recruitment email. However, this limitation raised the

question of whether the findings of this study are applicable to Caucasian males working in Peer Recovery Coach positions.

The initial plan to identify participants focused on the southwestern Planning Partnership Region of the state of Virginia. When the identified sample size was found to not exist within this region of the state the researcher made the decision to open the study to the fourteen Community Services Boards in the state of Virginia offering Peer Recovery Coach services. The researcher contacted Substance Abuse Program Directors to describe the focus of the study and to identify potential study participants. This experience raised two concerns for the researcher: Participants might have felt uncomfortable being contacted by his or her Program Director in regard to the study. Additionally, a response bias might have occurred in that participants felt required to participate in the study.

Another limitation of this study was four of the six interviews were conducted via telephone. Due to the financial and logistical considerations of the study, it was not feasible to conduct all participant interviews in a face-to-face format. Therefore, it is possible the researcher missed non-verbal cues or was unable to establish rapport due to the use of the telephone. Other forms of technology were considered for use in the study, however, were dismissed as the use of other forms of technology were not feasible due to technical difficulties in using the technology considering the geographic locations of the participants and the increased requirements of the participants to download software.

An additional limitation was the use of a voice recording application purchased to use through the telephone for recording participant interviews taking place over the telephone. Speaking and recording quality were affected by using the telephone resulting

in difficulty in hearing some of the participants, the need for repetitious questions and answers due to the sound capabilities of the telephone, and answers that were inaudible on the recording making the transcription process increasingly difficult.

Lastly, the subjectivity of the researcher should also be considered a limitation to this study. As stated in chapter three, I identify as a person in recovery as well as a person having the experience of working in a Peer Recovery Coach role prior to moving into a clinical position. Therefore, reflecting on how my experiences as a person in recovery, having formerly worked in a Peer Recovery Coach role in the state of Virginia impacted my life, and how I share similar experiences of the participants related to working within the role was imperative to limit the influence of my experiences on data interpretation. To do so I kept a reflective journal of my involvements with the participants and checked my interpretations against the analysis completed by my independent coder. Although my knowledge of recovery and Peer Recovery Coaching can be a benefit to this study, it should also be considered a limitation.

Suggestions for Future Research

Several participants indicated their supervisor was an integral part of their support system while working as a Peer Recovery Coach. Although this did not emerge as a theme, it is noteworthy as supervision appeared as an important support while adjusting to working within the Peer Recovery Coach role. Moreover, several participants indicated experiencing their role as a Peer Recovery Coach being at the low-end of the treatment system hierarchy. Future research investigating the perception of Peer Recovery Coaching within the hierarchy of substance abuse treatment services by those supervising Peer Recovery Coaches might further add to this study. Moreover, lack of supervision or

supervision that does not match the role designed for Peer Recovery Coaches was identified as an area of concern in a survey of Peer Specialists within mental health services (SAMSHA, 2012).

Several participants indicated transitioning into the Peer Recovery Coach role as challenging. The current study identified the presence of dual roles and identities complicate this transition. Moreover, participants indicated a need for increased hiring of Peer Recovery Coaches due to the size of their catchment area and the emotional demands of the position. Future research measuring job stress of Peer Recovery Coaches and influence on relapse might help identify factors associated with relapse experiences while working within this position. Future research in this area might identify the tasks and functions being provided by Peer Recovery Coaches and in what ways these tasks influence relapse situations. Moreover, identifying these factors would add to understanding the stresses involved with working as a Peer Recovery Coach and offer direction in supporting the personal recovery needs of Peer Recovery Coach workers, as well as other recovering staff.

Several individuals who self-selected to participate in this research indicated no knowledge of a relapse plan in place with their employer. Future research should focus on how employers manage relapse incidents involving Peer Recovery Coaches. Exploring how employers support Peer Recovery Coaches who experience a relapse would further add to this study.

Finally, one participant indicated a change in her relationship with the recovery community as a result of working as a Peer recovery Coach. For this participant, the message offered by the recovery community was to remember her recovery was not her

paid job. It appears members of the recovery community viewed her movement into the Peer Recovery Coach role inconsistently. The importance of this experience cannot be understated as it can leave those working as Peer Recovery Coaches bereft of the supports needed to engage in or maintain personal recovery. Further research examining the interaction of a lack of acceptance outside the substance abuse treatment community and pressure from within the drug treatment community on those in recovery working within the treatment programs has been previously suggested (Aiken, 1984). Although this did not emerge as a theme in this study, it is a perspective warranting further research specific to the Peer Recovery Coach role.

Conclusion

This final chapter presented discussion and practical implications of study results. The findings of this study identified the experiences leading to working as a Substance Abuse Peer Recovery Coach, and the professional and personal experiences of working as a Substance Abuse Peer Recovery Coach. Next, the limitations present in the current study were presented. Lastly, an overview of implications for counselor education and future research was discussed.

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APPENDIX A: RECRUITMENT E-MAIL

Dear Potential Participant,

You are invited to participate in a research project entitled A Phenomenological Study of the Experiences of Substance Abuse Peer Recovery Coaches Career Motivation and Professional Experiences. I (Aaron Hymes) am a doctoral candidate in the Counseling Department at UNC-Charlotte, and the principle investigator and Dr. John R. Culbreth serves as the responsible faculty member for this study. Through this study I want to understand the lived experiences those entering and working as Peer Recovery Coaches in the substance abuse treatment system. The purpose of this study is to help gather information to highlight the challenges and support factors in substance abuse treatment system experienced by Peer Recovery Coaches. Additionally, this study aims to identify in what ways working as a Peer Recovery Coach contributes to your life trajectory. Information gathered from this study has the potential to inform future training of mental health counselors, mental health services administrators, and counselor education and supervision faculty.

I am asking Peer Recovery Coaches who meet the following criteria to participate in one 60 – 90 minute interview:

- Identify as a person in recovery from substance abuse
- Identify as have no less than one year of abstinence from mood-altering substances
- Identify as a person currently working as a Peer Recovery Coach

The audio reordered interview would take place in a confidential space at the Community Services Board site. Upon completion of the interview, you will be sent the transcript of your interview for content approval prior to analysis of the data. You will be asked to confirm the transcript as is or to submit changes to the primary researcher via the Word document if changes are needed; this process is expected to last 30 minutes. All information will be confidential and all identifying information will be removed; no one will be informed that you participated in the study and you will be provided with a pseudonym for reporting purposes in the text of the study. This study has been approved by the University of North Carolina at Charlotte Institutional Review Board for Research with Human Subjects.

If you choose to participate in the study, you will be asked to review and agree to an informed consent. You may withdraw your consent for research participation at any time. If you are interested in participating in this study I ask that you contact me by e-mail at ahymes@uncc.edu or via phone at [redacted] to inform me of your interest. I will contact you shortly thereafter to verify your eligibility in the study and to set up an interview time if all inclusion criteria are satisfied.

Thank you.

APPENDIX B: PARTICIPANT SCREENING

Information Collected Pre-Interview as Demographic Information

1. Name:
2. Age:
3. Sex:
4. Ethnicity:
5. Educational level completed:
6. Amount of time in recovery:
7. Number of years working as a Peer Recovery Coach:
8. Other career/profession prior to becoming Peer Recovery Coach:
9. Paid employee or Volunteer:
10. Currently employed or formerly employed as a Peer Recovery Coach:
11. If formerly employed, why did you leave the Peer Recovery Coach position?
12. Rate of pay while working as a Peer Recovery Coach:
13. Size of caseload:

I confirm that I:

14. Identify as a person in recovery from substance abuse ☐ **Yes** ☐ **No**
15. Identify as have no less than one year of abstinence from mood-altering substances ☐ **Yes** ☐ **No**
16. Identify as a person who is currently working or formerly worked as a Peer Recovery Coach ☐ **Yes** ☐ **No**

APPENDIX C: INTERVIEW PROTOCOL

Semi-Structured Interview Questions

1. Tell me about yourself.

2. "In as much detail as possible, please share your experience of what led you to working as a Peer Recovery Coach?"

3. "In as much detail as possible, please describe your experience related to working as a Peer Recovery Coach?"

    Follow up (if not addressed)

    a) In as much detail as possible, please describe your experience of personal growth while working as a Peer Recovery Coach?
    b) Describe your experience of attending meetings in the recovery community that clients also attend?

4. "In as much detail as possible, please describe your decision to work as a Peer Recovery Coach."

5. "In as much detail as possible, describe your experience of what has been challenging in working as a Peer Recovery Coach."

    Follow up (if not addressed)

    a) In as much detail as possible, please describe your experience related to how you practiced personal wellness while working as a Peer Recovery Coach?

6. "In as much detail as possible, tell me bout your experience related to what has been most rewarding for you as a Peer Recovery Coach."

7. "What is your current plan for the future?"

8. "In what ways has working as a Peer Recovery Coach contributed to your career trajectory?"

    Follow up (if not addressed)

    a) Please describe any training you received specific to working as a Peer Recovery Coach?

b) Please describe any certifications you received specific to Peer Recovery Coaching?
c) Please describe your experience of any opportunities fro advancement while working as a Peer Recovery Coach?

9. "In as much detail as possible, please describe what experiences led you to leave the Peer Recovery Coach position."

10. "How would you describe the current substance abuse treatment system?"

11. "How would you describe the fit of Peer Recovery Coaches into the substance abuse treatment system?"

    Follow up (if not addressed)

    a) Please describe your experience of being a part of the treatment component or the treatment team?
    b) Please describe your experience of your opinion as a person in recovery being valued by your co-workers?
    c) Please describe your experience of any instances of stigma you experienced while working as a Peer Recovery Coach?

12. "Is there anything you think I should know that I have not asked or anything else you would like to share?"

**Follow-up questions will be based on the participants' responses.

APPENDIX D: PARTICIPANT DEMOGRAPHICS

Name	Age	Sex	Ethnicity	Level of Education Completed	Time in Recovery	Years working as Peer Recovery Coach	Current or formerly employed	Reported Size of Caseload
Erica	31	F	Caucasian	B.A.	5 years 5 months	7.5 months	Current	30
Audrey	34	F	Caucasian	B.A.	10 years 6 months	4 years 10 months	Former	70
Katie	37	F	Caucasian	3 years of College	8 years	7 years	Current	78
Avery	43	F	Caucasian	B.A.	9.5 years	2 years	Former	20
Riley	28	F	Caucasian	3 years of High School	2 years 3 months	5 months	Current	8
Greg	56	M	African-American	B.A.	2.5 years	20 years as volunteer/ Paid for 7 months	Current	74

APPENDIX E: INFORMED CONSENT

Department of Counseling
College of Education Building Suite 241
9201 University City Boulevard, Charlotte, NC 28223
t/ 704-687-8960 f/ 704-687-1636
www.counseling.uncc.edu

Informed Consent for A Phenomenological Study of the Experiences of Substance Abuse Peer Recovery Coaches Career Motivation and Professional Experiences

Project Title and Purpose of the study:

You are invited to participate in a research study entitled *A Phenomenological Study of the Experiences of Substance Abuse Peer Recovery Coaches Career Motivation and Professional Experiences.* The purpose of this phenomenological study is to describe the lived experiences of those working as Peer Recovery Coaches in substance abuse treatment systems.

Investigator(s):

This study is being conducted by Aaron Hymes, M.Ed., LPC-MHSP, NCC, ACS, a doctoral candidate in the Department of Counseling. Dr. John R. Culbreth, Professor in the Department of Counseling, is serving as the chair of the dissertation committee and is the Responsible Faculty member for this study.

Description and Length of Participation:

You will be asked to participate in one audio-recorded interview that is expected to last 60 - 90 minutes. Interviews will be conducted at the participant's site of employment; alternative arrangements can be made at the request of the research participant. Upon completion of the interview, you will be sent the transcript of your interview for content approval prior to analysis of the interview data. You will be asked to confirm the transcript as is or submit changes to the primary researcher via the Word document if changes are needed; this process is expected to last 30 minutes. If you decide to participate, you will be one of 5-7 subjects in this study.

Risks and Benefits of Participation:

The risks of participation in this study are minimal. It is possible that negative thoughts, emotions, and experiences of working as a Peer Recovery Coach will resurface during the interview process. To prevent against this risk, the primary goal of the researcher is for the participants to exit the interview at the same emotional level or better than when they arrived for the interview. This will be achieved by debriefing with each participant for as long as necessary.

This phenomenological study seeks to add to the research community by providing firsthand accounts of the factors associated with working as a Peer Recovery Coach in a substance abuse treatment system. The long-term implications of the study will enhance the existing literature on Peer Recovery Coaches through a comprehensive understanding based on the rich descriptions of the experiences of those currently working within the Peer Recovery Coach role. Lastly, results gained have the potential to provide information for substance abuse treatment systems to review their protocols with the goal of increasing supportive environments for Peer Recovery Coaching services.

Volunteer Statement:

Your participation is entirely voluntary and you may choose to withdraw, without penalty, from this study at any point. If you choose not to participate in this study, this too will carry no penalty. Regardless of your decision to participate, not participate, or withdraw from the study, you will not be treated any differently.

Confidentiality:

Any information about your participation, including your identity, will be kept confidential to the extent possible. The following steps will be taken to ensure this confidentiality: To prevent against identity disclosure, participants will be given pseudonyms and other potentially identifiable information will not be disclosed. It is possible that a transcription service will be used to transcribe the recorded interview. Whereas no identifying information will be provided by the researcher to the service, it is possible that other identifying information may be relayed in the interview. A confidentiality agreement will be signed with any transcription service prior to transcription occurring. The digital audio files from the interviews will be deleted once transcription has been completed and verified by you the participant. The transcribed data will only be identified with your study pseudonym and will be stored on a password protected USB flash drive. It is possible that results gained from this study will be published or presented at a conference but your identifying information will not be used.

After you have completed your interview and it has been transcribed, the interview verification and feedback process will take place via e-mail. Please note that although the transcript will be de-identified and your name will not be on it, e-mail is not considered a confidential means of communication. The researcher will send you a transcription verification file that will read like a script of the interview. The verification file will be de-identified, not containing any identifying information about you as the participant nor will this file contain your pseudonym, rather it will be identified as Speaker 1 and Speaker 2. You will either confirm the transcription is accurate or indicate the need for correction to the researcher by returning the de-identified verification file with the needed corrections.

If you have any questions at this point in time or at a later point in this study, please do not hesitate to ask them.

Fair Treatment and Respect:

UNC-Charlotte wants to make sure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office at 704.687.1871 if you have any questions about how you are treated as a study participant. If you have any questions about the project, please contact Aaron S. Hymes (Principal Investigator) at [redacted] or Dr. John R. Culbreth (Responsible Faculty) at 704.687.8973.

This form was approved for use on *(04/06/2015)* for a period of one (1) year.

Participant Consent:

I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age, and I agree to participate in this research project. I understand that I will receive a copy of this form after it has been signed by me and the Principal Investigator.

_____	_____
Participant Name (PRINT)	DATE
_____	_____
Participant Signature	DATE
_____	_____
Investigator Signature	DATE

APPENDIX F: INSTITUTIONAL REVIEW BOARD APPROVAL

UNC CHARLOTTE

Research and Economic Development

Office of Research Compliance

9201 University City Blvd, Charlotte, NC 28223-0001

t/ 704.687.1876 f/ 704.687.0980 http://research.uncc.edu/compliance-ethics

Institutional Review Board (IRB) for Research with Human Subjects

Certificate of Approval

Protocol #	**15-02-18**		
Protocol Type:	**Expedited**	**7**	
Title:	**A Phenomenological Study of the Experiences of Substance Abuse Peer Recovery Coaches Career Motivation and Professional Experiences**		
Initial Approval:	**4/6/2015**		
Responsible Faculty	**Dr. John**	**Culbreth**	**Counseling**
Research Assistant	**Mr. Adam**	**Carter**	**Counseling**
Investigator	**Mr. Aaron**	**Hymes**	**Couseling**

After careful review, the protocol listed above was approved by the Institutional Review Board (IRB) for Research with Human Subjects under 45 CFR 46.111. This approval will expire one year from the date of this letter. In order to continue conducting research under this protocol after one year, the "Annual Protocol Renewal Form" must be submitted to the IRB. This form can be obtained from the Office of Research Compliance web page http://research.uncc.edu/compliance-ethics/human-subjects.

Please note that it is the investigator's responsibility to promptly inform the committee of any changes in the proposed research prior to implementing the changes, and of any adverse events or unanticipated risks to subjects or others.

Amendment and Event Reporting forms are available on our web page at: http://research.uncc.edu/compliance-ethics/human-subjects/amending-your-protocol.

M. Lyn 4/20/15

Dr. M. Lyn Exum, IRB Chair Date

APPENDIX G: INSTITUTIONAL REVIEW BOARD ADDENDUM

UNC CHARLOTTE

Research and Economic Development

Office of Research Compliance

9201 University City Blvd, Charlotte, NC 28223-0001

t/ 704.687.1876 f/ 704.687.0980 http://research.uncc.edu/compliance-ethics

Institutional Review Board (IRB) for Research with Human Subjects

University of North Carolina at Charlotte

Approval of Amendment

Protocol #	**15-02-18**		
Title:	**A Phenomenological Study of the Experiences of Substance Abuse Peer Recovery Coaches Career Motivation and Professional Experiences**		
Date:	**6/10/2015**		
Investigator	**Mr. Aaron**	**Hymes**	**Couseling**
Research Assistant	**Mr. Adam**	**Carter**	**Counseling**
Responsible Faculty	**Dr. John**	**Culbreth**	**Counseling**

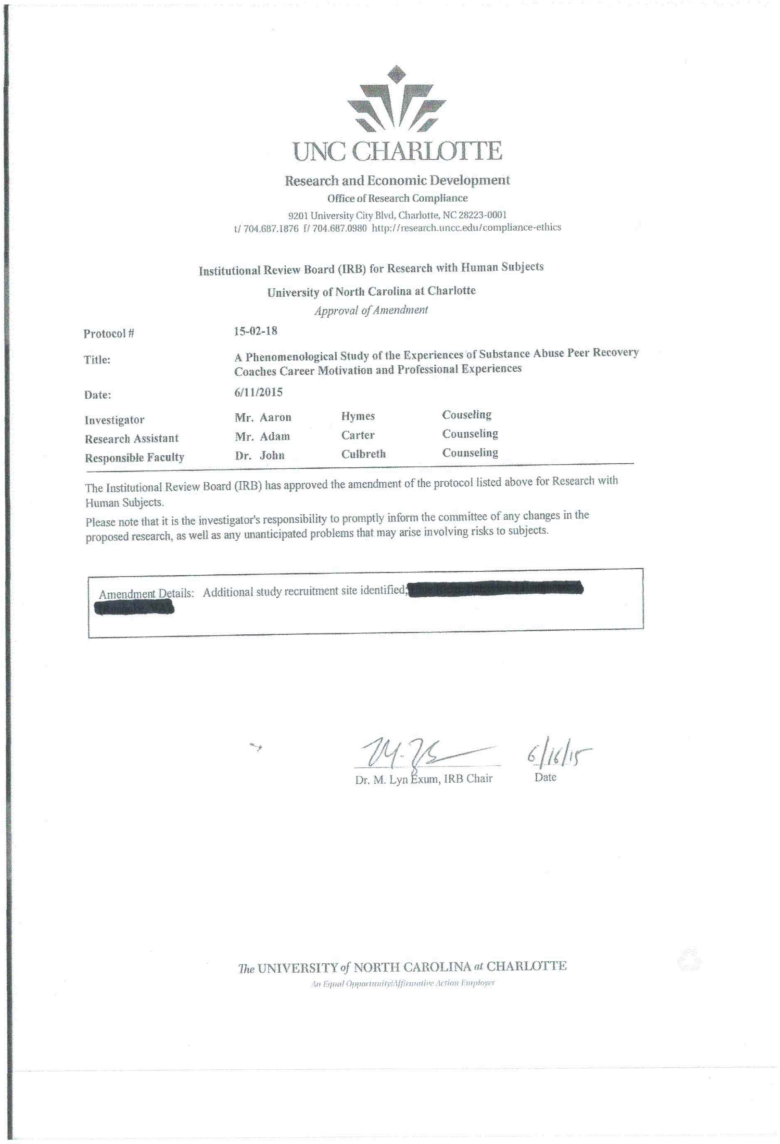
The Institutional Review Board (IRB) has approved the amendment of the protocol listed above for Research with Human Subjects.

Please note that it is the investigator's responsibility to promptly inform the committee of any changes in the proposed research, as well as any unanticipated problems that may arise involving risks to subjects.

Amendment Details: Interview protocol revised to include additional demographic questions and an additional interview question.

Dr. M. Lyn Exum, IRB Chair — Date 6/11/15

APPENDIX H: INSTITUTIONAL REVIEW BOARD ADDENDUM



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Institutional Review Board (IRB) for Research with Human Subjects

University of North Carolina at Charlotte

Approval of Amendment

Protocol #	**15-02-18**		
Title:	**A Phenomenological Study of the Experiences of Substance Abuse Peer Recovery Coaches Career Motivation and Professional Experiences**		
Date:	**6/11/2015**		
Investigator	**Mr. Aaron**	**Hymes**	**Couseling**
Research Assistant	**Mr. Adam**	**Carter**	**Counseling**
Responsible Faculty	**Dr. John**	**Culbreth**	**Counseling**

The Institutional Review Board (IRB) has approved the amendment of the protocol listed above for Research with Human Subjects.

Please note that it is the investigator's responsibility to promptly inform the committee of any changes in the proposed research, as well as any unanticipated problems that may arise involving risks to subjects.

Amendment Details: Additional study recruitment site identified: [redacted]

6/16/15

Dr. M. Lyn Exum, IRB Chair — Date

The UNIVERSITY of NORTH CAROLINA at CHARLOTTE

An Equal Opportunity/Affirmative Action Employer

APPENDIX I: JOB DESCRIPTION

Job Title:	Recovery Coach
Education and Experience:	High School Diploma or GED required. A minimum of 18 months in sustained recovery from alcohol and other drugs; personal experience in working a 12-step recovery program; experience in employment or other activities that have developed good interpersonal and communication skills.
Licensure /Certifications:	Certification program as a Recovery Coach preferred.
Population Served:	Adults with substance dependence, who may or may not have a co-occurring mental illness.
Description:	The Recovery Coach functions as a member of the team to provide expertise about the recovery process, symptom management, and the persistence required by clients to have a satisfying life. Collaborates to promote a team culture that recognizes, understands and respects each client's point of view, experiences, and preferences. The Recovery Coach is responsible for maximizing client choice, self-determination, and decision-making in the planning, delivery, and evaluation of treatment. Provides peer counseling and consultation to individual clients, families and team staff; acts as a liaison with other [the employer] programs and community resources; carries out rehabilitation and support functions; and assists in mental health/substance use treatment, education, support, and consultation to families, and crisis intervention under the clinical supervision of staff.
Knowledge, Skills, and Abilities:	Recovery Coach must have, at a minimum, qualifications that are documented or observable to include knowledge of: 1. Have personally experienced a substance disorder; the Recovery Coach assists the other team members to understand the client's perspective and subjective experience. Prefer completion of certification for Certified Recovery Coach. 2. Is or has been a recipient of substance related disorder services, and has acquired and uses the skills for chronic disease management. 3. Provide support services by transporting and accompanying clients to 12-step meetings, appointments associated with health or benefits, job fairs and recovery-oriented community events. 4. Documents direct services as well as collateral contacts

	on Anasazi system to meet Medicaid and licensure requirements. 5. Provides advocacy, coaching and education for individuals and groups of current or prospective [the employer] service recipients. 6. Build relationships with recovery-supportive community organizations and providers (eg, housing, employment, services, and 12-step fellowships). 7. Must have valid Virginia driver's license and a driving record that meets the standards of the agency's insurance company
Experience	A minimum of 18 months in sustained recovery from alcohol and other drugs; personal experience in working a 12-step recovery program; experience in employment or other activities that have developed good interpersonal and communication skills.

APPENDIX J: JOB DESCRIPTION

Job Title:	Part-time Recovery Coach
Education and Experience:	High School Diploma or GED required.
Population Served:	Adults receiving services for addiction
Description:	Individual needed for a Part-time Recovery Coach position. Will be involved in supporting a variety of recovery-focused projects for adults receiving services for addiction. The individual will work within [the county] area, and will work up to 27 hours per week. Will assist in creating a recovery environment and acting as an advocate for the needs and rights of individuals. Act as lead staff in support groups, teaching/training recovery information and recovery tools, and post-discharge recovery check-ups. Must model personal responsibility, self-advocacy, and hopefulness by assisting individuals in telling their recovery story, how needs are respectfully met, and how a belief in oneself in maintained. Model and practice recovery principles in all activities including hope, empowerment, responsibility, mutuality and self-determination. Transport or escort individuals to various activities to and from programming when assigned by supervisor.
Position Requirements:	High school diploma or equivalent required. Individual must also have personal knowledge and lived experience as a recipient of substance abuse treatment services, as well as on-going involvement in an addiction recovery plan including self-help environment. Also requires the ability and willingness to share personal experiences as part of providing peer support to adults with addiction issues. Training and on-going supervision required and provided as part of employment. Candidates must pass all [the employer] background screenings.

APPENDIX K: JOB DESCRIPTION

Job Title:	Recovery Coach
Education and Experience:	High School graduate or equivalent Recovery Coach has lived experience with serious mental illness or substance abuse based on minimum of ongoing Axis I diagnosis for at least one year and demonstrated ongoing adherence to treatment of own illness. Recovery Coach has demonstrated stability in own recovery for a significant period of time and demonstrates a willingness to identify as a person in recovery.
Licensure /Certifications:	Must have or complete Peer Specialist training program at the next available training or within one year.
Description:	Provides peer support services to persons in recovery under direct supervision. Supports the treatment planning and treatment implementation of persons in recovery through orientations, peer-to-peer services and participation/leadership in wellness activities. Functions as a role model to peers, exhibiting competency in recovery concepts and use of coping skills. Serves as a consumer advocate providing consumer information and peer support for persons in outpatient and inpatient settings. Assists persons in regaining independence within the community and mastery over their own recovery process.
Knowledge, Skills, and Abilities:	1. Orients persons in recovery to the agency and programs. 2. Develops meaningful relationships with persons in recovery. 3. Provides support to persons in recovery and family members. 4. Role models good self-care, coping skills, self-help strategies, and the regular use of wellness tools. 5. Demonstrates knowledge of and commitment to Recovery Philosophy. 6. Assists staff in providing Recovery training. 7. Demonstrates commitment to continued education on Wellness and Recovery. 8. Participates in required meetings and trainings as determined by supervisor. 9. Assists consumers in discussing and identifying personal goals for recovery. 10. Shares own experiences and the skills, strengths, supports, and resources that may be helpful. 11. Shares own recovery story and demonstrates how he/she

	has directed their on recovery. 12. Assists professional staff in identifying program environments that are conducive to recovery; lend own unique insight into mental illness and what makes recovery possible. 13. Attend relevant seminars, meetings, and in-service trainings, including out-of-town trainings, as directed. 14. Provides assistance to professional staff in linking individuals to services and helping individuals obtain services such as Social Services, medical services, housing, etc. 15. Responsible for working independently in individual homes, office setting, or other community location.

APPENDX L: FINAL RECRUITMENT EMAIL

[Add Name]

Good afternoon. This is the final call for participants to participate in the research project entitled A Phenomenological Study of the Experiences of Substance Abuse Peer Recovery Coaches Career Motivation and Professional Experiences. Again, my name is Aaron Hymes. I am a doctoral student from the University of North Carolina at Charlotte. I am conducting this research to fulfill the requirements for a doctorate in counselor education and supervision. Participant recruitment will end this Friday, July 17, 2015.

The purpose of the study is to enhance our understanding of the lived experiences of those entering and working or who formerly worked as Peer Recovery Coaches in the substance abuse treatment system. The purpose of this study is to help gather information to highlight the challenges and support factors in the substance abuse treatment system as experienced by Peer Recovery Coaches. Additionally, this study aims to identify in what ways working as a Peer Recovery Coach contributes to his or her life trajectory. The Institutional Review Board at the University of North Carolina at Charlotte has approved this study.

The results of this study will be used to inform future training of mental health counselors, mental health services administrators, and counselor education and supervision faculty and possibly provide a gateway for future studies in our field. Any participant has the right to opt out of this study at anytime. Thank you again.

The participant recruitment email is attached. Please forward it to your Peer Recovery Coaches who might be interested in participating in this study. I would like to thank you all for your support and for helping me to obtain participants for this study. It has been a pleasure. Once again everyone is welcome to the results of the study and I will be happy to send you an executive summary upon the completion of the study. I can be reached at ahymes@uncc.edu or via telephone at [redacted]

Sincerely,

Aaron Hymes, M.Ed., LPC-MHSP (TN), LPC (VA), NCC, ACS
Doctoral Candidate | Counselor Education and Supervision
Graduate Assistant
UNC-Charlotte | Dept. of Counseling College of Education Building
9201 University City Blvd. | Charlotte, NC 28223