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Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity

William L. White

Abstract

The recent growth in peer-based recovery support services as an adjunct and alternative to addiction treatment has created heightened ambiguity about the demarcation of responsibilities across three roles: 1) voluntary service roles with communities of recovery, e.g., the role of the sponsor within Twelve Step programs, 2) clinically-focused addiction treatment specialists (e.g., certified addiction counselors, psychiatrists, psychologists and social workers), and 3) paid and volunteer recovery support specialists (e.g., recovery coaches, personal recovery assistants) working within addiction treatment institutions or free-standing recovery advocacy/support organizations. The purpose of this paper is to enhance understanding of these new recovery support roles by comparing and contrasting these three service roles.

Introduction

New service roles sprout from the soil of unmet need. In the current worlds of addiction treatment and addiction recovery, a new role is emerging to bridge the chasm between brief professional treatment in an institution setting and sustainable recovery within each client's natural environment. This role is embraced under numerous titles: recovery coach, recovery manager, recovery mentor, recovery support specialist, recovery guide, personal recovery assistant, and helping healer. This role has been described in an earlier essay on peer-based recovery support services (White, 2004b) and will be referred to generically as *recovery coach* in this essay.¹

The growing popularity of the recovery coach (RC) role is evident in both public and private mental health and addiction treatment organizations.² Peer-based service models are growing rapidly in the mental health service arena, particularly for clients with co-occurring psychiatric and substance use disorders (Mowbray, Moxley, Jasper & Howell, 1997; Davidson, Harding & Spaniol, 2005). There is a growing body of mental

¹ For additional descriptions of this role see <http://www.dawnfarm.org/articles/recoverycoach.pdf>. and www.bhmr.org/guidelines/Recovery%20Coach%20and%20Recovery%20Planning%20Manual.doc

² See http://www.cocaine-addiction.co.uk/recovery_coaching.htm , <http://www.fairbanksd.org/Coaches.htm> and <http://www.hiredpower.com/>.

health evaluation data on the benefits of peer-based recovery support services for consumers, those who provide these services, and to the mental health service delivery system (for reviews, see [Solomon, 2004](#); [Solomon & Draine, 2001](#); [Christensen & Jacobsen, 1994](#)).

The modern era of addiction treatment (dating from its key enabling legislation in 1970)³ drew from its own earlier history as well as concurrent reports on the potential effectiveness of peer-facilitated models of change in other human service arenas ([Riessman, 1965](#); [Durlak, 1979](#); [Hattie, Sharpley & Rogers, 1984](#); [Riessman, 1990](#)) to posit the recovering “paraprofessional” counselor as the central role within an expanding network of community-based addiction treatment programs ([Connett, 1980](#); [Galanter, Castaneda & Salamon, 1987](#); [Blum & Roman, 1985](#)). The original focus of this role—personal guidance into and through the recovery process and nesting each client within a larger community of individuals and families in recovery—was diminished in the subsequent professionalization of the addiction counselor but has been resurrected in the role of the recovery coach.

Evidence of this shift toward sustained peer-based recovery support services is evident in many quarters.

- The primary focus of the Center for Substance Abuse Treatment’s Recovery Community Support Program shifted in 2002 to the development of peer-based recovery support services.
- A number of states (e.g., AZ, CT, PA) are funding new peer-based recovery support projects and establishing credentialing systems that set standards for serving in this role (e.g., GA).
- Efforts to transform urban behavioral health services into recovery-oriented systems of care, such as what is occurring in the City of Philadelphia, are including an emphasis on peer-based recovery support services.
- Major accreditation bodies, such as the Joint Commission on Accreditation of Health Care Facilities, are issuing standards for peer-based recovery support services.

There are several key research findings that underscore the need for sustained recovery support services and the potential of the recovery coach role. A growing number of studies confirm that addiction recovery:

- begins prior to the cessation of drug use;
- is marked in its earliest stages by extreme ambivalence;
- is influenced by age-, gender-, and culture-mediated change processes;
- involves predictable stages, processes, and levels of change; and that
- those factors that maintain recovery are different than the factors that initiate recovery ([Waldorf, 1983](#); [Frykholm, 1985](#); [Biernacki, 1986](#); [Grella & Joshi, 1997](#); [Wechsberg, Craddock & Hubbard, 1998](#); [Klingemann, 1991](#); [DiClemente, Carbonari & Velasquez, 1992](#); [Prochaska, DiClemente & Norcross, 1992](#); [Humphreys, et al, 1995](#)).

³ The Comprehensive Alcoholism Prevention and Treatment Act of 1970 (Hughes Act) and the Drug Abuse Treatment Act of 1972.

These findings suggest that the types of needed clinical and non-clinical recovery support services differ across clinical populations and differ within the same individual across the developmental stages of his or her addiction and recovery careers.

The importance of early and sustained recovery support is further indicated by treatment-related studies confirming that:

- most people with alcohol- and other drug-related problems do not seek help through mutual aid or professional treatment (Kessler, 1994; [Cunningham, 1999](#); [Cunningham & Breslin, 2004](#)),
- less than half of those admitted to publicly funded addiction treatment successfully complete treatment (SAMHSA, 2002; [Stark, 1992](#)),
- more than 50% of individuals discharged from addiction treatment resume alcohol and/or other drug (AOD) use within the following twelve months (Wilbourne & Miller, 2003), most within 30-90 days of discharge (Hubbard, Flynn, Craddock & Fletcher, 2001),
- recoveries from severe AOD problems are not fully stabilized (point at which the risk of future lifetime relapse drops below 15%) until between four to five years of sustained remission ([Vaillant, 1996](#); [Dawson, 1996](#); [Jin, Rourke, Patterson, et al, 1998](#)) or longer for some patterns (e.g., opiate addiction) ([Hser, Hoffman, Grella, & Anglin, 2001](#)),
- the transition from recovery initiation to lifelong recovery maintenance is mediated by processes of social support ([Jason, Davis, Ferrari & Bishop, 2001](#); [Humphreys, Mankowski, Moos & Finney, 1999](#)), and
- assertive approaches to post-treatment continuing care can elevate long-term recovery outcomes in adolescents ([Godley, Godley, Dennis, et al, 2002](#)) and adults ([Dennis, Scott & Funk, 2003](#)).

People with severe AOD problems are often so deeply enmeshed in a culture of addiction that they require sustained help disengaging from this culture and entering an alternative culture of recovery (White, 1996). All of the above studies buttress the growing call for sustained pre-treatment, in-treatment, and post-treatment recovery support services (McLellan, Lewis, O'Brien, & Kleber, 2000; [White, Boyle & Loveland, 2002](#)). The role of recovery coach may well become the central mechanism through which such services are delivered.

Considerable effort is underway to answer key questions related to the recovery coaching functions (e.g., should these functions be integrated into an existing role or within a new service role?) and to determine where these functions can be best placed organizationally (e.g., are recovery support services best integrated within existing addiction treatment programs or within free-standing, peer-based recovery advocacy and support organizations?).⁴ The piloting of the recovery coach role around the country is triggering such questions and comments as: 1) “Why do people need a recovery coach if they have access to a Twelve Step sponsor?” and 2) “We don’t need recovery coaches.

⁴ Debate of this question will intensify, with many recovery advocates taking the position that the functions of professional treatment and non-clinical recovery support services need to be organizationally segregated to maintain their true peer status, while others will argue that clinical treatment and non-clinical recovery support services are best integrated within a single organizational framework. There are no studies at this point on the relationships between these respective frameworks and recovery outcomes.

These functions are already being performed by addiction counselors, outreach workers and case managers.”

If it is to survive, a new service role must stake out its distinctive turf and justify its existence, and it must do so in the context of other roles claiming the same or adjoining territory. The recovery coach role incorporates and refines some dimensions of existing roles (e.g., outreach worker, case manager) and is positioned between two other recovery support roles: the recovery support group sponsor⁵ and the addiction counselor. The purpose of this essay is to differentiate the recovery coach, sponsor, and addiction counselor roles and to discuss the importance of clearly defining and maintaining the boundaries of these roles. We will begin with a brief history of the evolution of voluntary and paid service roles that have guided people into and through the process of recovery from severe alcohol and other drug (AOD) problems.

The Evolution of Specialized Recovery Support and Service Roles: A Brief History⁶

The ancient art of Thebes and Egypt portrays the slaves of those addicted to alcohol caring for their masters by administering medicines and other physical treatments (Crothers, 1893). People specializing in helping those recovering from the acute and chronic effects of addiction are as old as humankind, but there is a distinctive history of these roles in the United States dating from the eighteenth century. As alcohol problems rose among Native American tribes and within colonial communities, abstinence-based social and personal reform movements rose up that contained the first specialized roles whose purpose was to ignite and sustain the recovery process. These earliest American recovery movements involved the first recovery mutual aid societies and America’s first addiction treatment institutions (inebriate homes, inebriate asylums, addiction cure institutes, religious missions, and inebriate colonies).

The Washingtonian revival of the 1840s enticed more than 400,000 alcoholics to sign a temperance pledge and participate in regular “experience sharing” meetings for those who had pledged to remain sober. The new role of the reformed temperance leader challenged the authority of physicians and clergy who had served as the early leaders of the American temperance movement. Reformed men like John Gough and John Hawkins traveled from community to community giving charismatic speeches, offering personal consultations to alcoholics and their family members, and helping establish local recovery support groups. The financial payment these early recovery missionaries received from donations at their speeches or from the salaries they were paid by temperance organizations became a point of considerable controversy as mainstream members of these early recovery societies accused these leaders of profiteering. The Washingtonian societies collapsed within a decade and were replaced by fraternal temperance societies and ribbon reform clubs. Many of these groups lost their vitality over time via restrictive membership criteria (limiting membership “only to drunkards of good repute”) and by loss of their outreach and community service functions.

Competing with these early recovery support groups for ownership of AOD problems were two other groups: the physicians who headed the newly formed inebriate

⁵ The term sponsor here will refer to both this specific role within Twelve Step recovery programs as well as the counterpart to this role in other recovery support frameworks.

⁶ This history is drawn from White, 1998 and White, 2001.

asylums and addiction cure institutes and the lay religious figures who were organizing urban missions and rural inebriate colonies. Mainstream physicians and clergy looked with suspicion or outright disdain at the growing numbers of reformed persons who were beginning to organize their own institutions for the care of the addicted. Controversies over recovering people serving as paid helpers raged both within recovery mutual aid societies and within professional treatment organizations.

Dr. T. D. Crothers, Editor of the *Journal of Inebriety*, wrote an 1897 editorial attacking the idea that personal experience of addiction was a credential for understanding and treating addiction. He claimed that those who cared for inebriates following their own cures were incompetent by reason of organic defects of the higher mentality, and caring for inebriates heightened the recovering person's vulnerability for relapse. Most of this debate over the source of special expertise to help persons wounded by alcoholism and other addictions was lost in the larger collapse of addiction treatment institutions in the opening decades of the twentieth century.

From the ashes of this collapse rose an effort in 1906 by the Emmanuel Church in Boston to integrate religion, psychology, and medicine in the treatment of mental disorders. Quickly developing a specialty in the treatment of alcoholism, the Emmanuel Clinics pioneered the use of lay alcoholism psychotherapists, a sober social club (the Jacoby Club), and the use of "friendly visitors" (established recovering members making home visits with newer members). Lay therapists such as Courtenay Baylor, Francis Chambers, and Richard Peabody became quite well known through their clinical practices and their writings, but lay therapists were routinely threatened with lawsuits for providing medicine without a license.

The founding of Alcoholics Anonymous (AA) in 1935 led to the emergence of several new service roles in the 1940s. The AA sponsor role and the core of today's sponsorship rituals emerged from the explosive growth of AA in Cleveland following a series of local newspaper articles on AA published in 1939⁷; AA physicians and nurses worked with new "AA Wards" in hospitals in Akron, New York and Philadelphia; AA members offering peer support to others with alcohol problems led to paid positions as the first industrial alcoholism specialists in the 1940s (the pre-cursor to today's employee assistance programs); and AA entrepreneurs began opening "AA Farms" and "AA Retreats".

The tension between peer support and professional care was played out repeatedly in this early history in response to such events as AA co-founder Bill Wilson's offer to work as a lay therapist at Charles Towns Hospital in New York City. There were impassioned debates over the distinction between and relative importance of psychological treatment on the one hand and AA spirituality and fellowship on the other.⁸ The result was a delineation of guidelines (particularly AA's Twelve Traditions) governing how AA members should and should not perform certain roles within a re-emerging alcoholism treatment industry. Other Twelve-Step programs and alternative

⁷ The original AA sponsorship pamphlet written by Clarence S. in 1944 defined the key aspects of sponsorship as it emerged: 1) qualify yourself as an alcoholic; 2) tell your story; 3) inspire confidence in AA; 4) talk about "plus" values (happiness, peace of mind, material benefits); 4) show importance of reading the Big Book; 5) explain qualities required for success in AA; 6) introduce faith; 7) listen to the prospect's story; 8) introduce the prospect to several meetings; 9) explain AA to prospect's family; and 10) prepare the prospect for the hospital experience.

⁸ See Marty Mann's eloquent distinction quoted in [White, 1998, p. 174.](#)

recovery support groups utilized or emulated these AA guidelines. Such guidelines did not completely eliminate the personal and professional double bind that recovering people experienced working in the treatment field.

There were several threads in the emergence of the modern addiction counselor role. There was the continuation of the lay therapist tradition with such model programs as the clinics operated by the Yale Center for Studies in Alcohol in the 1940s and 1950s. There was the codification of the “counselor on alcoholism” role within the “Minnesota Model” of alcoholism treatment pioneered at Pioneer House, Hazelden, and Willmar State Hospital. There was the “community alcoholism consultant” role of those working within the 1960s anti-poverty programs and within some state programs (a role that focused more on community resource development than clinical assessment and treatment). There were those ill-defined roles of those working within the rising halfway house movement of the 1950s and 1960s. And there were the “ex-addict counselors” working within the growing network of therapeutic communities and methadone maintenance programs. As funding first increased for treatment services in the 1960s, a lively debate ensued over the question of whether formal education or recovery experience qualified one to treat the alcoholic and addict (see [Krystal & Moore, 1963](#)). While this debate was going on in professional circles, recovery support societies raised concerns that the quantity and quality of their own service work was weakening in tandem with the growth of the professional treatment industry.⁹

The “paraprofessional” roles of “alcoholism counselor” and “drug abuse counselor” of the 1970s, birthed within the earlier lay therapy tradition, were rapidly professionalized and modeled on the roles of psychiatrist, psychologist and psychiatric social worker. Education and training requirements rapidly escalated in tandem with certification and licensing systems as addiction counselors defined themselves as a “new profession.” Personal recovery became de-emphasized, and many programs prohibited recovering counselors from sharing that status with their clients. The same was true for recovering people serving other professional roles in the treatment field, e.g., physicians, nurses, psychologists, and social workers. As the percentage of treatment professionals in recovery declined, recovering people continued to work in other non-clinical service roles within the treatment field, e.g., outreach worker, case manager, house manager, residential aide, detox tech, research assistant (trackers, interviews and case managers), and follow-up worker.

The emergence of the recovery coach role in the past decade has emerged from the recognition of the need to reconnect addiction treatment to the more enduring process of addiction recovery, to effectively link clients from treatment institutions to indigenous communities of recovery, and to address complex co-occurring problems that inhibit successful recovery. These recognitions are part of a larger shift in the design of addiction treatment from a focus on acute biopsychosocial stabilization to a focus on sustained recovery management. The recovery coach is a:

- motivator and cheerleader (exhibits bold faith in individual/family capacity for change; encourages and celebrates achievement),
- ally and confidant (genuinely cares, listens, and can be trusted with confidences),

⁹ Concerns about the erosion of service and the “downgrading of sponsorship” were expressed in the AA *Grapevine* beginning in the late 1960s; see Sponsorship: Source of Wisdom, May, 1967.

- truth-teller (provides a consistent source of honest feedback regarding self-destructive patterns of thinking, feeling and acting),
- role model and mentor (offers his/her life as living proof of the transformative power of recovery; provides stage-appropriate recovery education and advice),
- problem solver (identifies and helps resolve personal and environmental obstacles to recovery),
- resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support),
- advocate (helps individuals and families navigate the service system assuring service access, service responsiveness and protection of rights),
- community organizer (helps develop and expand available recovery support resources),
- lifestyle consultant (assists individuals/families to develop sobriety-based rituals of daily living), and
- a friend (provides companionship).

Equally important, the RC is NOT a:

- sponsor (does not perform AA/NA service work on “paid time”),
- therapist (does not diagnose, probe undisclosed “issues”; does not refer to their support activities as “counseling” or “therapy”),
- nurse/physician (does not make medical diagnoses or offer medical advice), or a
- priest/clergy (does not respond to questions of religious doctrine nor proselytize a particular religion/church) (Excerpted from White, 2004b).

The words most frequently used to describe what the RC does include the following: identify, engage, encourage, motivate, share, express, enhance, orient, help, identify, link, consult, monitor, transport, praise, enlist, support, organize, and advocate. The fact that the RC fulfills all of these functions is a strength and vulnerability of the RC role.

The Lessons of History

There are a number of observations and lessons that could be drawn from this brief history that are relevant to our continued exploration of the recovery coach role.

Recovery and Community: Professionalizing recovery support can inadvertently undermine the quantity and quality of natural support for recovery that exists within families and social networks, peer-based recovery support groups, and the larger community (McKnight, 1995). When diminished or lost, this service commitment can be rekindled through internal renewal processes. Such a renewal process is occurring within many AA and NA groups who are re-dedicating themselves to carrying a message of hope to those who are still suffering. Great care must be taken in the emergence of new structures and roles not to undermine the natural recovery capital¹⁰ that exists within local

¹⁰ Recovery capital is a term introduced by Granfield and Cloud (1999) to describe the internal and external assets required for successful recovery initiation and recovery maintenance.

communities. The goal of such structures and roles should be to elevate and supplement natural recovery support, not replace it.

Community Connection and Disconnection: Recovery support roles that emerge with very close connections to communities of recovery are prone to disconnect from those communities over time as the persons filling those roles come to see the primary source of their power and authority coming from within themselves and from their professional organizations. Staying connected to communities of recovery and the larger communities in which they are nested is critical to the sustained integrity of recovery support roles.

Problem Source and Solution: Approaches to the resolution of AOD problems vacillate between clinical models that place the sources and solutions to AOD problems within the individual and models that view the sources and solutions to AOD problems rooted in the relationship between the individual, family and community. The former focuses on clinical diagnosis and treatment of the individual; the latter focuses on development of individual, family, and community recovery capital and emphasizes strategies of cultural renewal and community development. The recovery coach role bridges these dichotomized views via its emphasis on reconnection to community as an important healing force (For broader recognition of the healing power of community, see [Jason & Kobayashi, 1995](#) and [White, 2002](#)).

Ambiguity and Conflict: There is a long history of role competition and conflict between human service generalists and addiction specialists and between particular specialty roles within the addictions field. These conflicts are rooted in different conceptions of the sources and solutions to AOD problems and the question of whether those helping people with severe AOD problems should be credentialed by experience or by formal education. They are also rooted in efforts to protect the legitimacy of particular roles and the personal/institutional financial interests imbedded within them.

Essence of Recovery Support Relationship: Helping roles in the addictions field are historically distinguished from helping roles in other health and human service fields by:

- theoretical foundations (e.g., belief that severe and persistent AOD problems constitute a primary disorder rather than a superficial manifestation of other problems),
- emphasis on the use of self in the helping process via belief in the power of “wounded healers”—the recognition that experiencing and overcoming an affliction can engender knowledge that can be used to help others similarly afflicted,
- service relationships built on a foundation of moral equality and emotional authenticity, and
- belief in the healing powers of connection to communities of recovery whose members are bound by their experience, strength and hope ([White, 2004a](#)).

Profiteering: Recovery movements can be used as a platform for personal and institutional profiteering. This happens when resources that should flow into the community to support recovery initiation and maintenance are diverted to support service organizations and their leaders. This potential can be checked by elevating stewardship

of community resources as a core organizational value and by holding the organization and its service workers accountable to local communities of recovery.

Personal Vulnerability/Exploitation: Historically, those filling recovery support roles are vulnerable for exploitation and work-related distress. Recovery support specialists have at times been ill chosen and provided inadequate orientation, training and supervision. Recovery support specialists have also found themselves marginalized and isolated—cut off from the sources of natural support for their own recoveries, while not being fully accepted by other members of the interdisciplinary teams to which they were loosely connected. The resulting role ambiguity, role conflict, and inadequate role support has sometimes set the stage for the recovery specialist's own relapse (White, 1979; Wilson, 1984). Adding to this vulnerability is a history of recovering people being financially exploited by treatment institutions via excessive work schedules, inadequate compensation and benefits, the highest risk work assignments, and a lack of support for career development.

Service Relationship Transformation: There is a tendency via processes of professionalization to move recovery support relationships that are natural, reciprocal, enduring, and non-commercialized to relationships that are hierarchical, transient, commodified, and highly commercialized. These relationships may also move from a voluntary to a coerced status under the influence of external control agents such as the criminal justice and child protection systems. When role occupation occurs, new service roles rise that emulate the lost qualities of the former service relationship. The industrialization and professionalization of a service field also tends to shift the focus of the field and the service roles from the needs of those being served to the needs of the institution and the profession. Ironically, the recovery coach role re-elevates many of the functions and relationship dimensions of the early alcoholism counselor that were lost on the road to professionalization. There is also a tendency within recovery mutual aid societies to experience a weakening of their governing service ethic over time. When this occurs, new mutual aid structures and service roles emerge to recapture that lost focus.

Service Ethics: Those served by non-clinical recovery support roles are vulnerable to both exploitation and injury from well-intended but poorly chosen or poorly executed service interventions. The potential for exploitation and injury rises in tandem with the discrepancy of power between the service provider and service consumer. There is a need for standards of ethics and etiquette governing non-clinical recovery support services. The purposes of such standards are to protect service consumers, service providers and their families, service organizations, the service field, and the community.

Role Viability: The fates of recovery support roles are closely tied to the fates of the larger movements of which they are a part. The social stigma attached to addiction and the probationary status of addiction treatment as a cultural institution have contributed to earlier collapses of the field, weak organizational infrastructures, role instability and a transience of the service workforce. The fate of recovery support roles and institutions is contingent upon advocacy efforts that challenge stigma and reaffirm cultural beliefs about the potential for recovery from severe AOD problems. The recovery coach role is sustainable only in communities committed to creating and maintaining the physical, psychological, and social space where recovery can occur.

A Service and Support Continuum

It is time to step back from this brief history of recovery support roles to look at the broader picture of the resources that can be drawn upon to support addiction recovery. These resources constitute an ecological onion. At the center circles of this onion are resources within the self and resources within each individual's family and social network. That intimate network is in turn embraced by resources from the immediate environment--neighborhoods, schools, churches, workplaces, health clinics. Here, one can find sources of lay and professional advice as well as formal recovery mutual aid societies and the special support relationships that exist within them, e.g., sponsors. Beyond this second ring lies the volunteer and paid recovery support specialists who are the service tentacles of addiction treatment agencies, and the physicians, nurses, and counselors who deliver the clinical services at those agencies. These organizations are often connected to a large world of non-specialty health and human services filled with physicians, psychiatrists, psychologists, and social workers as well as such social control agents as judges, probation officers, child welfare workers, and professional licensing boards.

As AOD problems become increasingly enmeshed in other problems, individuals with these problems interact with roles at all levels of this service ecosystem. In fact, those with the most severe, chronic, and complex problems interact repeatedly with these resources, often without measurable effects on the trajectory of their problems. The problem is how we move from these isolated roles and fragmented service systems to an integrated circle of recovery support. One of the functions of the recovery coach (similar to the role played by case managers in the last 20 years) is to provide the connecting tissue that can turn a categorically segregated service system into a more holistic system of care by linking multiple episodes of care, integrating the resources of multiple formal and informal resources, and supporting individuals and families in recovery over time.

There are several broad principles of collaboration that can help guide the relationships between lay, volunteer, and professional helpers.

1. Lay and professional helpers should not do anything for the individual or family members over time that they are capable of doing for themselves.
2. Professional agencies and roles should not provide services to the community in response to needs that can be met within the client's natural support system.
3. Professional helpers should avoid creating barriers to client contact with local communities of recovery, e.g., scheduling service activities at times that conflict with community recovery meetings, restrictive visitation policies that prevent contact while individuals are in residential treatment modalities.
4. Persons occupying all roles should accurately represent their education, training and experience as well as the basis upon which their recommendations are being made.
5. Conflicts between those filling these roles are best resolved within a framework of mutual respect.

6. All recovery support roles share a commitment to help those they serve and to not exploit this relationship for personal or institutional gain. All parties have a responsibility to immediately confront such exploitation if it occurs.

The question is not, “Which of these roles is THE most important in the recovery process?” Each contributes different ingredients to the recovery process at different stages of individual and family recovery. The question is, “How can such resources be bundled and sequenced in ways that widen the doorway of entry into recovery and enhance the quality of recovery?” Achieving that vision requires the availability of multiple support roles that are accessible at key points within one’s addiction and recovery careers as well as the careful delineation of the boundaries of these roles.

One of the sources of role ambiguity and conflict between sponsors and recovery coaches is the commonalities that are shared by these roles. Persons filling both roles:

- are credentialed by experience rather than formal education and training¹¹,
- establish non-hierarchical (or minimal-hierarchy) relationships based on a mutuality of shared experience,
- rely on self-disclosure and advice,
- focus on removing obstacles of recovery and building recovery capital
- model core recovery competencies¹², and
- maintain continuity of contact over time with those needing recovery guidance and support.

In spite of such commonalities, there are distinct differences in the roles of Twelve Step sponsor and recovery coach.

How Recovery Coaching Differs from Sponsorship

It is something of a challenge to compare the roles of recovery coach (RC) and sponsor. The former is now emerging in different forms across the country and has yet to be codified; the latter, while existing for more than 60 years, has been governed more by oral tradition than written procedures.¹³ There are numerous ways the role of RC is being defined and performed, many different styles of Twelve Step sponsorship¹⁴ within local Twelve Step groups, and many variations in the counterpart to the sponsor role in religious and secular recovery support groups. The following observations are drawn from the author’s study of the history of sponsorship and from observations of the RC role across the country. Seen as a whole, the RC role, as it is emerging in the United

¹¹ Recovery coaches, sponsors and those they serve are all members of an “exclusive club”—“exclusive because each one has paid the highest entrance fee that can be paid.” (A Sponsor is..., A.A. Grapevine, January, 1970, p. 29.)

¹² Such competencies include modeling of core recovery values (e.g., tolerance, acceptance, gratitude), the capacity for self-observation, self-expression, sober problem-solving; recovery-based reconstruction of personal identity and interpersonal relationships; freedom from coercive institutions; economic self-sufficiency; positive citizenship and public service.

¹³ There is AA conference-approved literature on sponsorship (See Questions and Answers on Sponsorship pamphlet) and popular books on Twelve Step sponsorship (see Hamilton B., 1996).

¹⁴ See A.A. Grapevine, Sponsorship Relationships, September, 1975.

States in the opening decade of the twenty-first century, differs from the role of Twelve Step sponsor and its counterparts in a number of distinct and important ways.

Organizational Context: Where the sponsor serves as a representative of a voluntary, financially self-supported recovery mutual aid society, the RC works as a representative of a formal service organization bound by accreditation, licensing, and funding guidelines that shape accountabilities within the RC role that are not present in the sponsor-sponsee relationship. Those different accountabilities are reflected, in part, in service documentation responsibilities that can range from minimal to excessive for the RC and which do not exist for the sponsor.

Service Context: Where the sponsor-sponsee relationship occurs in relative isolation from professional helpers, the RC service relationship often occurs within the context of a multidisciplinary service team and a formal treatment plan or recovery plan. Many decisions that are the sole purview of the sponsor (e.g., the number of individuals to work with at one time, the physical settings in which service activities occur, when to terminate the service relationship) are dictated to the RC by the organization for which he or she works. There are professional peer accountabilities and collaboration skills required in the RC role that are not present in the sponsor role.

Philosophical Framework: Where the sponsor provides support **within** a particular program of recovery, the RC provides recovery support **across** multiple religious, spiritual, and secular frameworks of recovery.¹⁵ The sponsor emphasizes the viability and superiority of the Twelve Step program as a framework for successful recovery (“It works if you work it”); the RC emphasizes a philosophy of choice that recognizes the legitimacy of multiple pathways of long-term recovery. The operational motto of the best RCs is “recovery by any means necessary.” It matters little to them whether recovery is initiated without professional assistance (solo or natural recovery), with peer-assistance or professional treatment (affiliated or assisted recovery), or is initiated via peer and professional supports but maintained without such assistance (disengaged recovery) (White and Kurtz, 2005). The focus is on the goal, not the method.

The practical implications of this orientation are that the RC:

- conveys the legitimacy of multiple pathways to those with whom he or she serves,
- understands the language, catalytic metaphors¹⁶, and rituals reflected within these pathways,
- works to expand the variety of recovery support structures within the communities he or she serves, and
- develops collaborative relationships with the individuals and groups representing these pathways.

Scope of Those Served: Where the sponsor’s services are limited to those who have “a desire to stop drinking” and to those who have sought help within a local recovery support program, the RC serves a larger group of people, including those who may not yet have a desire to stop drinking and those who are seeking recovery but are opposed to participation in a particular recovery program. As a representative of a

¹⁵ I am aware that some RCs emphasize only one pathway of recovery (e.g., Twelve Steps, Christian conversion), but such singularity of focus is the exception in my visits with RCs across the country.

¹⁶ Catalytic metaphors are concepts that spark breakthroughs in perception of self and the world at such a profound level that they incite change in beliefs, behavior, identity and relationships.

particular recovery program, the sponsor begins from the position of “If you want what we have...”. In contrast, the RC works with individuals who are not yet at that point or who may want it but continue to relapse. Where sponsors may terminate sponsorship of those who continue to relapse, the recovery coach continues to provide *recovery priming* under such circumstances. The RC engages clients prior to recovery initiation and prior to first contacts with mutual aid groups, continues those contacts even in the face of relapse, and sustains contact (via recovery check-ups) after some clients will have disengaged from active participation in mutual aid groups. In general, the RC role is much more assertive than the role of sponsor in engaging individuals whose character traits (including self-defeating styles of interacting with lay and professional helpers), problem complexities, and environmental obstacles to recovery pose significant challenges to recovery initiation.

Degree of Reciprocity and Power in the Service Relationship: Where the sponsor-ponsee relationship is based on a reciprocity of need (the sponsor is there in part to support his or her own sobriety)¹⁷, the recovery coach has a fiduciary relationship with those he or she serves—a relationship governed by ethical/legal duties and obligations. Where there is minimal power differential in the sponsor-ponsee relationship (there are definite exceptions to this¹⁸), there is at least moderate power differential in the recovery coach service relationship. The long-term sponsorship relationship often evolves into an enduring friendship and a form of mutual sponsorship (AAWS, Inc, 1983, p. 25), but such sustained reciprocity is less appropriate in the RC service relationship. The vulnerability of persons served within the RC relationship is protected through the use of safeguards that are not present in the sponsor-ponsee relationship (e.g., informed consent, legally governed confidentiality, professional supervision, complaint and redress procedures). At an organizational level, agencies delivering recovery support services via a volunteer model have fiduciary responsibilities to carefully screen, orient, train and supervise RC candidates, as well as discipline or discharge RC volunteers who are not able to competently and ethically deliver services.

Service Menu: Where the primary focus of the sponsor is on the use of Twelve Step Tools (personal story sharing, meetings, step work, literature, sober social activities), the RC works within a formal service continua and is specifically trained to access a broader range of recovery-supportive services (education, employment, health care, housing, day care, transportation, counseling for co-occurring problems, etc.). AA is very clear on the singularity of purpose of the sponsor: “A sponsor is simply a sober alcoholic who helps the newcomer solve one problem: *how to stay sober*” (AAWS, Inc., 1983, p. 10).

Financial Remuneration: Where accepting money for sponsorship or other Twelve Step service work would be a violation of AA’s Eighth Tradition¹⁹, recovery coaching may be provided on either a volunteer or paid basis.

¹⁷ AA is very clear on this point: “In A.A., sponsor and sponsored meet as equals...” (AAWS, Inc., 1983, p. 7).

¹⁸ The potential for such power differential is reflected in references in *AA Grapevine* articles about possessive and controlling sponsorship styles (see *My Sponsor, My Friend* August, 1982; *A Sponsor Can’t be My Higher Power*, May, 1972), and in references to the potential for exploitation in texts on sponsorship (see Hamilton B., 1996).

¹⁹ AA Tradition Eight: “Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.”

Ethical Guidelines and Supervision: Where the primary sources of guidance on sponsorship rest with historical and contemporary practice as expressed through literature on sponsorship and God as expressed in a group conscience, most recovery coaches are held accountable via formal organizational codes of ethics governing their service relationships and through professional supervision of their service relationships and activities.²⁰ Mutual confidentiality may be negotiated in the sponsor-sponsee relationship, but there are no legal protections related to such disclosures. In contrast, there are ethical and legal requirements for RC confidentiality and punishments (including jail) for breaches of confidentiality. These ethical codes and supervision processes are designed to protect multiple parties: those receiving recovery coaching, those serving as recovery coaches, the service organization, the professional field, and the community. It is very important that persons in dual relationships (e.g., a recovery coach and fellow recovery mutual aid members) scrupulously maintain the separation of these roles. This would mean, for example, that information heard in the context of a recovery support group meeting could not be shared back to the treatment agency within which one works, nor could information acquired in the treatment setting be shared outside of that setting (e.g., to a sponsor) without the client's written permission.

Anonymity: Where personal anonymity is usually maintained in the sponsor's interactions with outside agencies and the press that could potentially occur as part of his or her sponsorship activities²¹, the RC has no such anonymity as a formal representative of the agency for whom he or she volunteers or works. RCs may self-identify themselves as persons in recovery, but generally refrain from identifying themselves with a particular program of recovery at the level of press.

Policy Advocacy: Where policy advocacy in one's role as a Twelve Step sponsor is prohibited by Tradition Ten²², advocacy to access needed service and to address systems barriers to recovery initiation and maintenance are an expected part of the RC role.

Affiliation: Where brokering formal affiliations with other organizations as a sponsor is prohibited by Tradition Six²³, the RC may act on behalf of their agency to negotiate formal affiliations and collaborations with other organizations toward the goal of expanding local recovery support networks.

It can be seen from this review that significant differences exist between the roles of sponsor and recovery coach. These distinctions are important for several reasons.

²⁰ Efforts are underway to develop ethical guidelines specific to those providing peer-based recovery support services.

²¹ AA Tradition Twelve: "Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities."

²² AA Tradition Ten: "Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy."

²³ AA Tradition Six: "An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose."

1. Performing sponsorship functions (e.g., making a Twelve Step call as an AA member, meeting with sponsees) on time one is working as an RC is a violation of Twelve Step Traditions and professionally inappropriate (beyond the scope of most agency RC job descriptions and explicitly prohibited in many).
2. Performing sponsorship functions through the RC role could weaken local sponsorship practices and diminish community recovery support resources by replacing such natural support with the formal support of local treatment agencies.
3. Seeking reimbursement for sponsorship functions performed by a recovery coach is, at best, a poor stewardship of community resources and, at worst, fraud.
4. Role ambiguity and conflict resulting from a mixing of sponsorship and RC functions could inflict injury on clients/families, service workers, service agencies, and the community.
5. The RC role represents a form of connecting tissue between professional systems of care and indigenous communities of recovery and between professional helpers and sponsors; when those filling this role abandon this middle ground and move too far one direction or the other, that connecting function is lost (Bass & Calori, 2006).

How Recovery Coaching Differs from Addiction Counseling

The recovery coach (RC) role sits among multiple roles on the recovery support continuum. Its functions are positioned between those of the sponsor and those of the addiction counselor, with key aspects of the RC role approaching the activities of those performed by sponsors and counselors. The RC role is distinguished from the addiction counselor role by the following role dimensions.

Service Goals and Timing: Where the primary role of the addiction counselor is in facilitating the process of recovery initiation for those who have reached a point of readiness to change, the RC's role (at this point in its historical development) is more focused on preparing the soil in which recovery can grow, using motivational enhancement strategies to regularly tip the scales of ambivalence toward a recommitment to recovery, transferring credibility from themselves to other helping professionals, and facilitating the ongoing lifestyle reconstruction that is crucial for successful long-term recovery.

Education and Training: Where most addiction counselors today are formally educated and institutionally credentialed via certification or licensure, the legitimacy and credibility of the RC springs from experiential knowledge and experiential expertise. The former involves direct experience with personal/family addiction and recovery, and the latter requires demonstrated ability to use this knowledge to affect change in self or others. This does not explicitly require that all RCs be recovered or recovering, but it does require that those filling this role know addiction and recovery from close proximity. The credential of experiential expertise is granted through the community "wire" or "grapevine" (community story-telling) and is bestowed only on those who have demonstrated their wisdom and skills as a recovery guide within the life of the

community. Some RCs may be professionally trained, but their authority comes not from their preparation but from their character, relationships, and performance within the community (White and Sanders, 2004; Borkman, 1976).²⁴

Use of Self: Where self-disclosure has become increasingly discouraged in the addictions counselor role, it is an important dimension of the RC role. The use of self (using one's own personal/cultural experiences to enhance the quality of service) is an inherent part of both the RC and addictions counselor roles, but the use of self by the latter has changed dramatically over the past four decades. In the "paraprofessional" era of addiction counseling (the 1950s-early 1970s), disclosing one's status as a recovering person and using selected details of one's personal addiction/recovery history as a teaching intervention were among the most prominent counselor interventions. This dimension of the counselor role was based in great part on the role these dimensions played in successful sponsorship within AA. Through the 1980s and 1990s, such disclosure came to be seen as unprofessional and a sign of poor "boundary management." Where self-disclosure by the counselor has been discouraged or discredited, such self-disclosure has been re-elevated in the role of the recovery coach. The recovery coach uses his or her own story and ability to connect the client to the stories of others as a means of offering testimony to the reality and power of recovery and to offer the recovery neophyte guidance on how to live as a person in recovery.

Service Relationship: Both the addiction counselor and RC service relationships are fiduciary relationships: both imply specialty knowledge and skills, governance by legal and ethical mandates and an inequality of power in the service relationship that can be misused for emotional, financial or sexual exploitation. In examining the different relationships that clients experience with sponsors, RCs and counselors, the differences are not in power equality versus inequality but in degrees of power inequities (there is vulnerability within all three relationships) and degrees of vulnerability for injury (with that vulnerability progressively increasing across the sponsor, RC, and addiction counselor service continuum). The fact that the RC maintains a much less hierarchical relationship with most of his or her clients and maintains these relationships for much longer periods of time suggests that the ethical standards that guide the addiction counselor may not be appropriate to guide the RC service relationship. For example, such behaviors as accepting a gift from a client, maintaining phone or email contact with a client following his or her discharge from treatment, having dinner with a client, and giving a client a ride to a recovery support meeting would now be deemed unacceptable in the counselor-client relationship, but may be accepted and crucial to the delivery of long-term recovery support services.

Locus of Service Delivery: Where the addictions counselor asks, "How do I get this individual into and through a treatment experience?" the recovery coach asks, "How can the process of recovery be initiated and anchored within the client's own natural environment?" or, when facing an environment in which recovery is improbable, "What alternative environment is available within which the client can initiate and sustain a life

²⁴ The recovery coach is closer to the sponsor in this regard than today's addiction counselor, in that the former roles are more experientially based. The sponsor's source of authority (what enables the sponsor to provide help) is not professional training but "personal experience and observation" (AAWS, Inc, 1983, p. 10). The same could be said for the RC, although the RC does draw upon specialized training befitting their role.

in recovery?” Where counseling services tend to be institution- and office-based, the preferred site for the delivery of recovery coaching is in the client’s world. Neighborhood-based and home-based service delivery is the norm for the RC.

Service Philosophy (Ecology of Recovery): Where the addiction counselor and the larger professional treatment team tend to view recovery as something that happens inside the client and focuses on breaking the physical person-drug relationship, modifying the client’s perceptions, thoughts, and actions, RCs tend to see recovery as something that happens in one’s relationship with self, God, family and community. RCs devote considerable time to modifying the client’s environment to one that is recovery conducive. This is done through a greater focus on family and social systems interventions, efforts to stimulate and support abstinence-based processes of cultural renewal and work to expand indigenous recovery support structures within the client’s environment. The RC role demands much greater skills in community development and community organization than does the addiction counselor role.

Duration of Contact: Where the addiction counselor has a relationship characterized by a clear beginning, middle and end (spanning an ever-briefer period of time), the RC is expected to sustain contact with most clients for months and years following the completion of primary treatment. The purpose of this contact is to provide ongoing contact (check-ups) and support, stage-appropriate recovery education, assertive linkage to communities of recovery, active problem solving of obstacles to recovery and, when needed, early re-intervention.

Core Competencies: Where the core competencies of addiction counseling include knowledge of addiction and skills to perform such clinically-oriented functions as screening, assessment, treatment planning, individual/group/family counseling, clinical documentation and referral, the core competencies of the RC are much more oriented toward a knowledge of the long-term recovery process and indigenous recovery support systems and such functions as crisis intervention, client engagement, motivational enhancement, linkage to treatment resources, recovery education, client/family linkage to indigenous communities of recovery, early re-intervention, community resource development, and policy advocacy.

Service Delivery Framework: Where the addiction counselor utilizes a problem generated from the assessment data to generate a professionally-directed treatment plan, the RC facilitates the development of a client-generated recovery plan (master plan and regular updates) that is much broader in scope and more community- and recovery-focused than traditional treatment plans (Borkman, 1997).

Service Language: Where the addiction counselor teaches the client a new language (e.g., organizing metaphors drawn from a particular treatment philosophy) with which the client can construct a recovery-based personal story, the recovery coach tends to use the client’s own language and the language of the client’s culture to help construct such stories.

Non-possessiveness: One final way that the RC role differs from both the sponsor role and the addiction counselor role is the dimension of non-possessiveness. Where the sponsor and counselor are prone to take “ownership” of an individual (e.g., “my sponsee” “my client”), the RC encourages those they work with to fully engage with other sources of recovery support. The “prize” to which the RC role is affixed is not the adoration and

eternal gratitude of those they have coached, but the recovery of these individuals within a broad network of recovery support relationships.

A Role Collaboration Case Study

This essay has sought to distinguish the roles of the addiction counselor, recovery coach and sponsor within the engagement, treatment, and recovery processes. In closing, we will explore how these roles complement one another in the lives of people seeking recovery and how these roles blend differently according to each client's problem severity/complexity and degree of recovery capital. The following case study illustrates how such collaboration occurs in real life.²⁵

Ms. C. was a 22 year-old African American woman when her delivery of a cocaine-exposed infant brought her to the attention of the state child protection agency. Ms. C.'s problems were numerous, severe, and chronic. In addition to her history of drug dependence, she had a history of psychiatric illness (diagnosed at different times as depression, bipolar disorder and borderline personality) and a history of innumerable encounters with authority figures and coercive institutions. Ms. C. was a survivor of childhood sexual abuse with multiple traumagenic factors (early age of onset, long duration, multiple perpetrators, perpetrators drawn from within the family/kinship network, failure of maternal protection following disclosure) and had a history of turbulent relationships with men, distrust and hostility towards other females, and what she later self-described as "addiction to chaos".

In response to what was viewed as "intergenerational transmission of substance dependence and child neglect", the child welfare authorities threatened to take custody of Ms. C.'s baby if she did not enroll in and successfully complete addiction treatment. Ms. C. informed the workers in less than delicate language that her baby was being cared for by her grandmother, that treatment was for "losers" and that she wasn't going to do any of the things being demanded of her. In response, the workers, with little expectation of positive outcome, placed Ms. C. on a "contact list" for outreach services provided through a new multi-agency consortium serving addicted women and their children.

Jean, the assigned recovery coach, made repeated efforts to engage Ms. C. Jean was able to work through considerable resistance using her own recovery story and her knowledge of the neighborhood culture to facilitate relationship building. What she saw in Ms. C. was not pathology but a "miracle of survival"—a "diamond in the rough." Jean slowly developed a relationship with Ms. C., primarily through sustained listening, brief self-disclosures, responses to occasional crises and an unrelenting process of checking in via phone calls and an occasional "thinking of you" card. Where everyone else in Ms. C.'s life was threatening her with what was going to happen if she didn't change, Jean offered

²⁵ This case study is a composite drawn from the author's work as evaluator of Project SAFE, an innovative, gender-specific treatment program that integrated the resources of multiple agencies into a sustained recovery management team (See White, Woll & Webber, 2003). All identifying information in this composite has been altered.

“living proof” of the potential to change and the encouragement and expectation that Ms. C. would change. After seven weeks of Jean’s “recovery priming,” Ms. C. agreed to be assessed for entry into an intensive outpatient treatment program for women. When Ms. C. was later asked how her recovery started, she responded, “I couldn’t get rid of that woman [Jean]. I think she would have followed me into Hell and brought me back. I guess in some ways, she did.”

In the early transition into treatment, Jean provided traditional case management services to remove obstacles to participation (e.g., transportation) and served as mediator between Ms. C., Ms. C.’s primary counselor and the other women in treatment with whom Ms. C. had numerous verbal altercations. In addition to helping defuse the chaos in Ms. C.’s environment, Jean intervened daily to decompress the latest emotional outburst and threat to leave treatment, while simultaneously convincing program staff that Ms. C. should not be thrown out of treatment for early episodes of drug use and her verbal outbursts. During this middle engagement stage, Jean and the addictions counselor worked through their own issues of competition and conflict (sparked in part by Ms. C.’s skills at splitting them) and somehow kept Ms. C. involved in treatment.

In the late engagement stage, the street-hardened veneer of Ms. C. cracked as she “bared her soul” and grew increasingly dependent upon her primary counselor. In the weeks that followed, Ms. C. explored every corner of her life and began to develop hope for her future. Jean stayed involved through this period but took on a secondary role in all the work on “issues” that was going on. The counselor built on the platform of hope that Jean had constructed and helped Jean extend her fragile capacity for trust. This stage was followed by Ms. C. finally remaining drug free, disengaging from drug-enmeshed relationships, continuing to explore her life story, and bonding with other women in treatment. Jean continued to provide daily encouragement and offer normative information on the experience of early recovery. Jean also became the human link between Ms. C. and her initial exposure to N.A. and A.A. During this early exposure, Ms. C. resisted all encouragements to get a sponsor but did finally get a sponsor after several months of making meetings.

As the sponsor relationship strengthened, Jean’s role shifted to one of lifestyle reconstruction (helping Ms. C. establish a sober lifestyle in the community), periodic crisis intervention (usually involving an encounter with a man), and assistance in preparing for Ms. C.’s caretaking of her daughter. A critical role in the latter was Jean’s support of the grandmother who seemed to be sabotaging Ms. C.’s efforts to re-assume care of her child. Involving other family members helped the grandmother to in turn help Ms. C. assume her maternal role. While the sponsor remained focused on Ms. C.’s early recovery experience, Jean focused on the periphery of this process, addressing such issues as safe and drug-free housing, parenting training/coaching, and helping Ms. C. get further disentangled from people and institutions that reinforced her “sick role.”

Eight months following her admission, Ms. C. “graduated” from treatment and her daughter moved in with her. Jean’s primary role here was one of parental coaching and building in supports (e.g., child care arrangements) that allowed Ms. C. to continue attending recovery support meeting activities. During this period,

the addiction counselor's role ended (other than an occasional phone consult or single session to respond to some emotional crisis), and the role of the sponsor dramatically increased. The sponsor played numerous functions at this time. She helped lead Ms. C. into the local Twelve Step recovery community, coaxed Ms. C. through the Twelve Steps, and offered concrete advice about how not to "pick up". The sponsor assumed some of the earlier "lifestyle consultant" functions performed by the recovery coach and moved more to the emotional center of Ms. C.'s life. There were times Jean, Ms. C., and her sponsor met together at a local coffee shop during this period for a "progress meeting" and to re-clarify who was helping with what.

As Ms. C.'s recovery gained time and depth, Jean remained involved as a foundational source of support via periodic phone calls and home visits. When Jean was contacted by Ms. C. in a crisis, Jean encouraged Ms. C. to re-engage support from her family and sober friends, her sponsor and on a few occasions, her addiction counselor. As Ms. C.'s recovery stabilized through support of her sponsor, family and a new recovery-based relationship, Jean's contact reduced to a quarterly recovery checkup.

Interestingly, there was one additional transition in which Jean later played a significant role. Ms. C. became involved in a faith-based recovery ministry two years into her recovery and became increasingly active in the church that sponsored this ministry. As this occurred, her N.A. participation was important but no longer the centerpiece of her recovery. Ms. C. found herself experiencing a loyalty conflict between N.A. and her N.A. sponsor on the one hand, and her church and her pastor on the other. Jean affirmed for Ms. C. that this was not an either/or choice, and that she needed to create a combination of supports that worked for her and to be assertive in communicating that preference to others who were trying to define what her recovery needed to look like. As an advocate of recovery, but not a particular flavor of recovery, Jean was in a position to help Ms. C. focus on what worked best for her. As a result, Ms. C. was able to work out a style that utilized both recovery support structures.

A few years later and in between the annual call to Ms. C. that Jean was now making, Ms. C. called Jean to announce that she wanted Jean's job. Ms. C. had decided it was time to go to work, and there was only one job she'd ever seen that she really wanted to do and that was to work as a recovery coach helping women like herself. Ms. C. enrolled in school and later began working in the same system in which she was once admitted as a client with a "poor prognosis for recovery." Imagine the power of her story when delivered to a client who unknowingly declares to her, "But you couldn't possibly understand." Telling her story today is possible because three different but complimentary roles were there when she needed them.

We must be careful in our training and supervision of those working as recovery coaches that we do not commercialize Twelve Step service work and that we do not replace the "language of the heart" with professional jargon or replace experiential authenticity and intuitive helping abilities with clinical technique.²⁶

²⁶ See Caplin, 2000, p. 22-23 for a discussion of the dangers of professionalizing peer helpers.

Summary

This essay has tried to identify those qualities that distinguish the peer-based recovery support specialist (referred to in this paper as “recovery coach”) from two allied roles: the peer guide within recovery mutual aid groups (referred to generically in this paper as “sponsor”) and the role of the professional addictions counselor. As with any new service role, the RC role takes on a different character within different organizations and cultural communities. At the moment, the fact that the RC role is defined somewhat differently between agencies may be less important than having the role clearly defined within each agency. A clearer definition of the role will emerge from the collective experience of those working as and supervising RCs. This evolving role needs to be supported in a number of critical ways via key technologies, including:

- further role definition and standards to assure its peer integrity,
- model criteria for screening, interviewing and hiring RCs,
- model compensation and benefit packages and career ladders,
- RC orientation, training and supervision models,
- a model RC code of ethical conduct, and
- manualized, evidence-based RC service protocol.

In Texas, efforts are underway to develop an association of peer-based recovery support organizations. The purpose of the association would be to generate core principles, service methods and ethical standards that would define the unique nature of these services (Bass & Calori, 2006). Other states are utilizing or exploring the use of their independent addiction counselor certification board to assume responsibility for developing and administering certification standards for recovery coaches. Recovery advocates raise concerns that, if given governance over the recovery coach role, traditional certification boards will over-emphasize educational degrees and de-emphasize recovery experience and natural helping abilities (PRO-ACT Focus Group, April, 2006).

The fate of the recovery coach role will be influenced by the forces that shaped those roles that came before it: the future evolution of professional treatment organizations and recovery mutual aid societies, evolutions in the design of addiction treatment (e.g., from acute care models to models of sustained recovery management), trends in service reimbursement policies, and what may be the inevitable professionalization of the RC role. It will be hard to retain the role’s recovery focus, but history tells us that if this focus is lost, new roles will eventually emerge to recapture this focus. At the moment, the role of RC holds promise in elevating long-term recovery outcomes through the provision of pre-recovery, recovery initiation/stabilization and recovery maintenance support services and by expanding the quantity and variety of recovery support services in local communities. To fulfill that potential, those serving as recovery coaches will need to carefully distinguish their functions from those of the sponsor and the addiction counselor while exhibiting deep respect for these allied roles.

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References

- AAWS. Inc. (1983). *Questions and Answers on Sponsorship*. NY: Alcoholics Anonymous World Services, Inc.
- B., Hamilton. (1996). *Twelve Step Sponsorship: How It Works*. Center City, MN: Hazelden Publishing.
- Bass, B., & Calori, C. (2006). *Community Recovery Support: Peer Recovery Support Service Organizations*. El Paso, Texas: El Paso Alliance, Inc.
- Biernacki, P. (1986). *Pathways from heroin addiction: Recovery without treatment*. Philadelphia: Temple University Press.
- Blum, T., & Roman, P. (1985). The social transformation of alcoholism intervention: Comparison of job attitudes and performance of recovered alcoholics and non-alcoholic alcoholism counselors: A survey. *Journal of Health and Social Behavior*, 26(4), 365-378.
- Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50, 445-456.
- Borkman, T. (1997). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, 15(1), 37-42.
- Caplan, G. (2000). Principles of community psychiatry. *Community Mental Health Journal*, 36(1), 7-24.
- Christensen, A., & Jacobson, N. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science*, 5(1), 8-14.
- Connett, G. (1980). Comparison of progress of patients with professional and paraprofessional counselors in a methadone maintenance program. *The International Journal of the Addictions*, 15(4), 585-589.
- Crothers, T. D. (1893). *The Disease of Inebriety from Alcohol, Opium and Other Narcotic Drugs: Its Etiology, Pathology, Treatment and Medico-legal Relations*. NY: E.B. Treat, Publisher.
- Crothers, T. D. (1897). Reformed men as asylum managers. *Quarterly Journal of Inebriety*, 19, 79.
- Cunningham, J. A. (1999). Untreated remission from drug use: The predominant

- pathway. *Addictive Behaviors*, 24(2), 267-270.
- Cunningham, J. A., & Breslin, F. C. (2004). Only one in three people with alcohol abuse or dependence ever seek treatment. *Addictive Behaviors*, 29(1), 221-223.
- Davidson, L., Harding, C., & Spaniol, L. (Eds.) (2005). *Recovery from Serious Mental Illnesses: Research Evidence and Implications for Practice—Volume I*. Boston: Center for Psychiatric Rehabilitation.
- Dawson, D. A. (1996). Correlates of past-year status among treated and untreated persons with former alcohol dependence: United States, 1992. *Alcoholism: Clinical and Experimental Research*, 20(4), 771-779.
- Dennis, M.L., Scott, C.K., and Funk, R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning*, 26(3), 339-352.
- DiClemente, C. C., Carbonari, J. P., & Velasquez M. M. (1992). Alcoholism treatment mismatching from a process of change perspective. In R. R. Watson, (Ed.), *Drug and Alcohol Abuse Reviews, Vol. 3: Alcohol Abuse Treatment*, (pp 115-142). Totowa, NJ: The Humana Press.
- Durlak, J. (1979). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, 86, 80-92.
- Frykholm, B. (1985). The drug career. *Journal of Drug Issues* 15(3), 333-346.
- Galanter, M., Castaneda, R., & Salamon, I. (1987). Institutional self-help therapy for alcoholism: Clinical outcome. *Alcoholism: Clinical and Experimental Research*, 11(5), 424-429.
- Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R., & Passeti, L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23(1), 21-32.
- Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.
- Grella, C. E., & Joshi, V. (1999). Gender differences in drug treatment careers among clients in the national drug abuse treatment outcome study. *American Journal of Drug and Alcohol Abuse*, 25(3), 385-406.
- Hattie, J. A., Sharpley, C. F., & Rogers, H. J. (1984). Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin*, 95, 534-541.
- Hser, Y., Hoffman, V., Grella, C., & Anglin, D. (2001). A 33-year follow-up of narcotics addicts. *Archives of General Psychiatry*, 58(5), 503-508.
- Hubbard, R. L., Flynn, P. M., Craddock, G., & Fletcher, B. (2001). Relapse after drug abuse treatment. In F. Tims, C. Leukfield, & J. Platt (Eds.), *Relapse and Recovery in Addictions* (pp. 109-121). New Haven: Yale University Press.
- Humphreys, K., Mankowski, E., Moos, R., & Finney, J. (1999). Do enhanced friendship networks and active coping mediate the effect of self-help groups on substance abuse? *Annals of Behavioral Medicine*, 21(1), 54-60.
- Humphreys, K., Moos, R. H., & Finney, J. W. (1995). Two pathways out of drinking problems without professional treatment. *Addictive Behaviors*, 20(4), 427-441.
- Jason, L., Davis, M., Ferrari, J., & Bishop, P. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education*, 31(1), 1-27.

- Jason, L. A., & Kobayashi, R. B. (1995). Community building: Our next frontier. *The Journal of Primary Prevention, 15*(3), 195-208.
- Jin, H., Rourke, S. B., Patterson, T. L., Taylor, M. J., & Grant, I. (1998). Predictors of relapse in long-term abstinent alcoholics. *Journal of Studies on Alcohol, 59*(6), 640-646.
- Kessler, R. C. (1994). The National Comorbidity Survey of the United States. *International Review of Psychiatry, 6*(4), 365-376.
- Klingemann, H. (1991). The motivation for change from problem alcohol and heroin use. *British Journal of Addiction, 86*(6), 727-744.
- Krystal, H., & Moore, R. (1963). Who is qualified to treat the alcoholic? *Quarterly Journal of Studies on Alcohol, 27*, 449-59.
- McKnight, J. (1995). *The Careless Society: Community and its Counterfeits*. New York: Basic Books.
- McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association 284*(13), 1689-1695.
- Mowbray, C. T., Moxley, D. P., Jasper, C. A., & Howell, L. L. (Eds.) (1997). *Consumers as Providers in Psychiatric Rehabilitation*. Columbia, MD: International Association of Psychiatric Rehabilitation Services.
- Prochaska, J., DiClemente, C., & Norcross, J. (1992). In search of how people change. *American Psychologist, 47*(9), 1102-1114.
- Questions and Answers on Sponsorship*. (ND). New York: Alcoholics Anonymous World Service.
- Riessman, F. (1965). The "helper" therapy principle. *Social Work, 10*(2), 27-32.
- Riessman, F. (1990). "Restructuring help": A human service paradigm for the 1990s. *American Journal of Community Psychiatry, 18*(2), 221-230.
- Solomon, P. (2004). Peer support / peer provided services: Underlying processes, benefits and critical ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-400.
- Solomon, P., & Draine, J. (2001). The state of knowledge of the effectiveness of consumer provided services. *Psychiatric Rehabilitation Journal, 25*(1), 20-27.
- Stark, M. (1992). Dropping out of substance abuse treatment: A clinically oriented review. *Clinical Psychology Review, 12*(1), 93-116.
- Substance Abuse and Mental Health Services Administration Office of Applied Studies (2002). *Treatment Episode Data Set (TEDS): 1992-2000. National Admissions to Substance Abuse Treatment Services*, DASIS Series: S-17, DHHS Publication No. (SMA) 02-3727, Rockville, MD, 2002.
- Vaillant, G. E. (1996). A long-term follow-up of male alcohol abuse. *Archives of General Psychiatry, 53*(3), 243-249.
- Waldorf, D. (1983). Natural recovery from opiate addiction: Some social-psychological processes of untreated recovery. *Journal of Drug Issues, 13*, 237-280.
- Wechsberg, W. M., Craddock, S. G., & Hubbard, R. L. (1998). How are women who enter substance abuse treatment different than men?: A gender comparison from the Drug Abuse Treatment Outcome Study (DATOS). *Drugs & Society, 13*(1/2), 97-115.
- White, W. (1979). *Relapse as a phenomenon of staff burnout in recovering substance*

- abusers working as addiction counselors*. Rockville, MD: HCS, Inc.
- White, W. (1996). *Pathways from the culture of addiction to the culture of recovery*. Center City, MN: Hazelden.
- White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.
- White, W. (2001). Pre-AA alcoholic mutual aid societies. *Alcoholism Treatment Quarterly*, 19(1), 1-21.
- White, W. (2002). A lost vision: Addiction counseling as community organization. *Alcoholism Treatment Quarterly*, 19(4), 1-32.
- White, W. (2004a). The historical essence of addiction counseling. *Counselor*, 5(3), 43-48.
- White, W. (2004b). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC.
- White, W., Boyle, M., & Loveland, D. (2002). Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, 20(3/4), 107-130.
- White, W. & Kurtz, E. (2005). The varieties of recovery experience. In White, W. Kurtz, E. & Sanders, M., *Recovery Management*. Chicago: Great Lakes Addiction Technology Transfer Center; Also in press, *International Journal of Self Help and Self Care*.
- White, W., & Sanders, M. (2004). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. In W. White, E. Kurtz, & M. Sanders, , *Recovery Management*. Chicago: Great Lakes Addiction Technology Transfer Center. Also Posted at www.bhrm.org.
- White, W., Woll, P., & Webber, R. (2003). *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.
- Wilbourne, P., & Miller, W. (2003). Treatment of alcoholism: Older and wiser? In T. McGovern, & W. White (Eds.), *Alcohol Problems in the United States: Twenty Years of Treatment Perspective* (pp. 41-59). New York: Haworth Press.
- Wilson, D. (1984). Impaired counselor: The ignored problem of the new profession. *Counselor*, July/August, p. 5.