Recovery Coaching Training Manual

Recovery Coaching

Recovery Coaches draw their legitimacy not from traditionally acquired educational credentials, but rather, through *experiential knowledge* and *experiential expertise.* (Borkman, 1976)

Experiential knowledge is information acquired about addiction recovery through the process of one's own recovery or being with others through the recovery process. Experiential expertise requires the ability to transform this knowledge into the skill of helping others to achieve and sustain recovery. (White & Sanders, 2006)

Many people have acquired experiential knowledge about recovery, but only those who have the added dimension of experiential expertise are ideal candidates for the role of Recovery Coach. (White & Sanders, 2006)

The dual credentials of experiential knowledge and experiential expertise are bestowed by local communities of recovery to those who have offered sustained living proof of their expertise as a recovery guide. (White & Sanders, 2006)

The Recovery Coach works within a long tradition of wounded healers - individuals who have suffered and survived an illness or experience who use their own vulnerability and the lessons drawn from that process to minister to others seeking to heal from this same condition. (White, 2000; Jackson, 2001)

Excerpted and adapted from: White, W.L. (2007). Ethical guidelines for the delivery of peer-based recovery support services. **http://www.bhrm.org/recoverysupport/EthicsPaperFinal6-8-07.pdf**. Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS) and Pennsylvania Recovery Organization -

Introduction

Welcome to the UK Recovery Walk Charity Recovery Coaching Manual.

This manual is based on the work of the McShin foundation's recovery coach manual. If this manual is widely read and helps others access the joys of recovery, we believe that thanks are very much due firstly to the Mcshin foundation for allowing us to work in partnership to create a UK friendly version and secondly to Dr. H. Westley Clark, Director of the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Treatment (SAMHSA/ CSAT), without whose support the original USA version could not have been developed.

We would also like to thank the authors of the five monographs on recovery-related topics released over the past few years by the SAMHSA/CSAT Addiction Technology Transfer Centers (ATTCs) these monographs have had a far reaching impact here in the UK also. Gratitude to (White & Kurtz, 2006; White, Kurtz & Sanders, 2006; White, 2007b; White, 2008b; White, 2009). These monographs identified three major pathways to recovery—religious, spiritual, and secular—and laid out cross-cutting principles that apply to all three broad pathways. We owe a debt of gratitude to Dr. Clark and his colleagues, and are deeply influenced by the works of William L. (Bill) White.

A word from John Shinloser of the McShin Foundation.

Welcome my UK friends to the most utilized recovery coach manual in the free world, your desire to mirror these proven methods of helping people is the greatest form of flattery know to man, it is an honour to know you choose this method of furthering recovery in your country.

To those who find this manual and read it and (who) have a passion for recovery coaching and peer leadership "I say please remember, you may be the only contact an individual will ever get to see in recovery", so please let the "Hope" (of a better life, drug free) be delivered as it was to you.

Never forget it is better to deliver recovery support services expecting nothing in return, be grateful you are chosen to be that, recovery coach, to a most vulnerable and fragile human, the addict seeking recovery.

This manual is made up of several sections which can be used as stand alone materials or in conjunction with one another.

The first section considers the role of the Recovery Coach; the skills, qualities and attributes that a Coach needs to develop; and tools and methods for building a mutually rewarding and successful coaching relationship.

Section Two considers some of the ethical decisions and dilemmas that face Recovery Coaches in their day to day work. Particularly in terms of boundaries and personal conduct; conduct with those we are coaching; conduct in relationships with local services and organisations; and conduct in relationships with the larger community.

The third section provides a sample Recovery Coach Training Curriculum, followed by some coaching tools and a glossary and dictionary of useful recovery related terms.

We hope you find the content and ideas contained in these pages both useful and practical.

Recovery Coaching is still in its relative infancy here in the UK and the intention of this manual is to provide a framework for it to grow and develop.

This manual will also be a live document , we very much welcome your feedback, so check back regularly for updated versions.

Table of Contents

Goals of this Manual

This manual is intended as a reference document for individuals who are interested in Recovery Coaching training and for individuals who have completed the training.

The manual is intended to:

⇒ Provide a clear definition of recovery coaching that differentiates it from other roles, such as sponsor or friend.

⇒ Build some of the key skills necessary to be effective as a Recovery Coach.

⇒ Offer a framework for ethical standards.

⇒ Enrich your own recovery and personal growth.

⇒ Build or ignite a passion to engage and work with those who are beginning their own recovery journeys.

⇒ Increase your awareness of the Recovery Community.

⇒ Highlight the unique power of a helping relationship involving two recovering people.

⇒ Increase your knowledge of recovery pathways other than your own.

⇒ Expand your awareness of the Recovery Movement, how you can play a role in it and of how it can play a role in the recovery of those people you coach.

The Roles of the Recovery Coach

The peer Recovery Coach is a person who is actively and authentically engaged in recovery. They exhibit a new perspective on life that has been gained through their recovery.

Coaches can clearly describe both the benefits and challenges of recovery.

They do not have all of the answers, but they do know how to listen and acknowledge what has been said, and to share from their own experience in a way that is helpful to the people they work with.

The Coach as a Fellow Traveller

One of the key ways in which a Recovery Coach differs from a drug and alcohol worker, therapist, 12-step sponsor or spiritual advisor is in the nature of the relationship of the Recovery Coach and the person being coached.

The relationship of the worker or therapist with a client or patient is one of an expert helper to an individual seeking help. The boundaries of the relationship are strictly defined - and the helper tends to have significantly more power in the relationship than the person being helped.

While the roles of sponsors and spiritual advisors are in some ways similar to that of a Recovery

Coach, both the sponsor and the spiritual advisor roles have a natural authority that the role of the Coach does not.

Like the sponsor, the Coach is a fellow journeyer who is further along the path than the person they are working with. However, unlike them, the Coach is foremost a peer and a consultant.

The Coach partners with the *coachee*, makes suggestions, shares his or her experience and assists the *coachee* in finding his or her own recovery path and following it - no matter how much it may differ from the path of the Coach.

When following their chosen path, the *coachee* may well follow particular steps or approaches.

However, these do not come from the Recovery Coach, but from sponsors, spiritual advisors and others helping the *coachee* to follow a specific recovery pathway.

The Coach as a Listener

Listening may be the Recovery Coach‘s single most important skill, but it is often taken for granted.

While the Coach does not have the answers, he or she does have empathy and a healthy level of detachment from the circumstances of the *coachee.* The coach also brings a wealth of personal experience of the challenges and rewards of recovery.

By allowing the *coachee* to tell his or her story, the Coach empowers the *coachee.* By sharing elements of his or her story when it is appropriate to do so, the Coach shares the hope of recovery in a way that helps both parties grow.

Recovery is, in part, the process of developing a narrative or story to help individuals to understand and accept the past, embrace the present, and develop a roadmap for the future.

When Coaches have good listening skills, *coachees* tend to respond, sharing more of their own stories.

Coaches with good listening skills can take in the big picture while identifying the important details that will require follow up.

The Coach as a Mirror

Recovery Coaches serve as a mirror in a number of ways. First, coaches mirror both the challenges *coachees* may have faced and their potential for recovery.

Coaches are a living testament to the fact that recovery is real, that it can and does happen - and that it is something to which *coachees* can aspire.

Coaches also mirror *coachees* through active listening, paraphrasing and confirming what *coachees* say. The Coach mirrors *coachees*‘ thinking in an effort to help them recognise issues that could get in the way of meeting their recovery goals.

In a very real sense, the main tools of Recovery Coaches are their own experience, strength and hope. By sharing some of their journey and living recovery in the moment, the Coach mirrors the potential for recovery within the *coachee*.

The Coach as a Mentor

Mentoring is another important role of the Recovery Coach. Mentors share their knowledge and experience with individuals who have not progressed as far in recovery as they have.

As mentors, Coaches don‘t have all the answers. However, they do have personal experience that may benefit *coachees* as they establish their own personal pathways to recovery.

As mentors, Coaches may want to consider providing information and advice in the way it is offered in 12-step fellowships. To *coachees,* they may want to say, “*Take what you like and leave the rest.”*

It is, in the end, the *coachee* - not the Coach - who chooses decides what they will or will not take on board and what they will or won’t do.

The Coach as a Consultant

Coaches function as consultants when they assist *coachees* in:

⇒ Formulating recovery goals

⇒ Identifying objectives that will help meet recovery goals

⇒ Establishing milestones to measure progress

⇒ Developing skills and strategies to stay on course

⇒ Creating contingency plans for times when things don‘t go as planned

It is important to understand that, as a consultant, the Coach does not *do* these things *for* the *coachee*. Instead the Coach assists the *coachee* in clearly identifying recovery goals and developing a plan to achieve them.

Basically the Coach as consultant supports the development of a plan of action, strategies and skills that support long-term recovery.

The consultant role, in fact, could well be the role most played by Coaches.

It is as a consultant that the Coach works with the *coachee* to develop a recovery plan, to assess progress and to identify and discuss what went well, what did not, what should be continued, what should not - and what new strategies, objectives or goals might make sense.

Additionally, Coaches serve as consultants when they share their knowledge of local resources and their personal experience in recovery.

The Coach as Advocate

Coaches are often called upon to serve as advocates for those the people they work with.

Generally, this advocacy does not involve public speaking, but a Coach may, from time-to-time, find it appropriate to speak to a group on behalf of a *coachee*.

Most often, however, the advocacy role of the Recovery Coach consists of simpler activities, such as phoning, speaking in person, or writing a letter to a potential landlord, employer or probation officer.

It may also involve facilitating access to services or helping with benefits issues.

When thinking about advocating on behalf of a *coachee*, Coaches who are early in their career are encouraged to consult with more experienced Coaches - or people with a background in advocacy.

These individuals can provide information about appropriate resources and help in decision-making processes. They can also help develop advocacy strategies that are likely to be successful.

The advocacy Coaches carry out on behalf of *coachees* should not be confused with broader advocacy activities which the Coach may be involved as an individual or as a member of an organisation.

This type of advocacy may play an important role in addressing stigma and the misunderstanding of addiction and recovery in the larger community. It may positively impact the individuals the Coach is working with.

It may also play a role in ensuring that the kinds of resources needed by Coaches and others in recovery are available in the community.

However, such broader advocacy is not undertaken specifically on behalf of a *coachee* and should never be confused with individual advocacy - which is part of the Recovery Coach's role.

As an advocate or champion for the wider community it may be appropriate for the Recovery Coach to speak publicly about addiction, to share his or her story of recovery or to explain the role of his or her organisation.

It is because of this the UK Recovery Walk Charity advises advocates to consider undertaking Our Stories Have Power Training. (See website resources for more info)

Finally, Recovery Coaches following a 12-step path are advised to follow the traditions of their fellowship, making it clear that what they have to say is their personal viewpoint, and that they do not and cannot speak on behalf of the 12-step fellowship(s) in which they are involved.

What a Coach is Not

It is extremely important to understanding that the role of the Recovery Coach and how it differs from other roles. A recovery coach is NOT a:

- Counsellor
- Social Worker
- Treatment Worker
- Judge
- Psychologist
- Spiritual Advisor
- Doctor
- Financial Advisor
- Marriage Counsellor

Exercise

1. Which coaching roles do you think will come to you most naturally?
2. Which might be more challenging?
3. In terms of role definition, what are some potential pitfalls for the Recovery Coach?
4. Are there other roles that Recovery Coaches may need to take?

Diverse Recovery Pathways

The "recovery community" - a term once used to refer collectively to members of local 12-Step group - has morphed into diverse "communities of recovery" who….are forming a new consciousness of themselves.

This newly emerging recovery community encompasses people from diverse recovery support groups and new recovery support institutions who are defining themselves as a community, based on their recovery status and not on the method or support group through which that recovery was achieved or maintained (White and Kurtz, 2006a).

Transcending the competition and animosity that sometimes plagued their view of each other, members of these groups are more likely today to view all successful recovery pathways as a cause for celebration (White, 2008a).

Coaches must also become familiar with diverse recovery pathways.

As the treatment and recovery field moves toward person-centred and recovery-focused approaches, Bill White argues that, “We must all become very fluent in the multiple pathways to recovery” (White, 2008).

Effectively serving individuals whose recovery paths differ significantly from their own can be challenging for Recovery Coaches. However, doing so provides an opportunity to broaden your perspectives and deepen your understanding of recovery.

Openness to diverse perspectives on addiction and recovery is essential if Coaches are to truly embrace *coachees* stories and pathways and support them in navigating their own unique recovery journeys.

Coaches must not only recognise that other recovery pathways are no more or less valid than their own pathways, but also that they will need to develop the knowledge and skills required to effectively support individuals in pursuing them.

While in practice this may be challenging, the role of the Coach is not to provide the answers that a particular path may offer, but to support individuals in following the paths that are meaningful to them.

A Word on Cultural Competency

The concept of cultural competency is increasingly taking on new dimensions in terms of recovery coaching. As the number of recovery communities and recovery pathways expands, it is becoming clear that Coaches must develop the knowledge and skills necessary to work with individuals who may differ in terms of ethnic or social backgrounds.

For example, individual *coachees* from some minority ethnic communities may only work with a Coach from their own community, or with a Coach from a community different to their own.

Similarly, individual coaches from some minority ethnic communities may insist on only working with a Coach of the same gender.

The validity and value of “talking therapies” is not recognised in some cultures and so may be a barrier to accessing appropriate psycho-social interventions - even if this may be of benefit to the *coachee*.

The Concept of Recovery Capital

Simply put, the role of the Recovery Coach is to assist *coachees* in identifying and building on their recovery capital. What exactly is recovery capital? First described by Granfield and Cloud (1999), the term recovery capital was defined by Bill White as *"the quantity and quality of both internal and external resources that a person can bring to bear on the initiation and maintenance of recovery"* (White, 2006).

Examples of internal recovery capital include skills, experience, willingness to ask for help, a sense of self-efficacy, a sense of hope and personal goals.

External forms of recovery capital include positive family relationships, employment or education , stable housing, connection with the recovering community, hobbies (especially when they involve others) and participation in mutual aid groups.

To simplify, you could say that recovery capital is everything for which the recovering individual has reason to be grateful. Your job, in part, is to help *coachees* build a solid and diversified portfolio of recovery capital that will see them through lean times while laying the foundation upon which they will build to meet their long term goals.

In effect, the Coach is an advisor who helps the *coachee* to move from the poverty of addiction to the prosperity of recovery. In this context, recovery capital is the main currency.

The recovery capital concept is particularly useful because it cuts across all recovery pathways.

A focus on recovery capital is a focus on strengths, and a focus on strengths empowers *coachees* to develop and take ownership of recovery plans that make the most of their existing recovery capital to build new capital.

The primary job of Recovery Coach is to assist *coachees* in identifying and building on their recovery capital in order to meet their recovery goals.

Recovery capital is an inexhaustible resource. We find it within us and in others in recovery, in family members and friends, in our spiritual and work lives and through our positive involvement in community.

While we all have access to reserves of recovery capital, we don‘t always use that capital fully to further our recovery. Unused recovery capital is, of course, of no value.

Coaches can help *coachees* discover the internal and external recovery capital available to them and can offer them tools to make good use of it. However, in the end, it is only the *coachee* who can access and use that capital.

Examples of Recovery Capital

Recovery capital is sometimes divided into three broad categories: Social Capital, Physical Capital, and Human Capital. These provide a useful framework for understanding recovery capital.

Social Capital

Social capital is the support, guidance, and sense of belonging, purpose and hope that comes from relating to others. It is also the connections that people can access through relationships and membership of groups or communities.

Potential sources of social capital include other people in treatment, members of the broader recovery community or a 12-Step or other mutual aid group, family, clubs or communities.

Social capital can be viewed as the web of supportive social relationships and networks that surrounds the individual in recovery.

Physical Capital

Physical capital consists resources that a person has in economic terms. It includes things like income, assets, vehicles, housing and employment.

Human Capital

Human capital is similar to social capital but it includes individuals or organisations that play specialised roles in treatment, recovery and related processes.

As a form of internal recovery capital, human capital is the knowledge, skills, confidence, and hope that one has gained through working with professionals, others with specialised expertise, peers or through taking part in a programme of recovery.

In its external form, human capital refers to a small set of individuals who are particularly important is supporting someone's recovery. These may include:

- Recovery coaches, recovering peers or sponsors
- Key workers, counsellors, teachers, social workers, doctors, nurses, or other professionals who play a key role in initiating or supporting recovery

	Social Capital	Physical Capital	Human Capital
External Capital	Family relationships Mutual aid groups Recovery communities	Employment Housing	Key worker Recovery Coach Sponsor
Internal Capital	Sense of belonging Purpose and hope from relationships	Sense of stability and security	Knowledge Skills Confidence

Some examples of recovery capital above. Building recovery capital is an essential part of our recovery journeys and each of us has the potential to both give and receive recovery capital.

Recovery Coaches offer recovery capital directly and help *coachees* discover or recognise internal and external reserves of recovery capital that can tap into to sustain and enhance their recovery.

One of the greatest benefits of serving as a Recovery Coach is that giving recovery capital does not reduce the supply; it actually increases it.

As members of Alcoholics Anonymous have long said, *"You've got to give it away to keep it*."

Exercise

Thinking back to when you first entered recovery, answer the following questions:

1. What recovery capital were you able to use to enter recovery?
2. In what areas did you have a lack of recovery capital?
3. How did you build your recovery capital?
4. Are there areas where you would benefit from additional recovery capital? If so, what are they?
5. What are some of your personal strengths and weaknesses?
6. What special contributions could you make to a team?
7. How could a team effectively support you in areas that are not your strengths?

Skills, Knowledge, Qualities, Values and Principles

Skills

The core skills necessary to successful recovery coaching can be developed. None of us has all of these skills when we begin, but we do have skills that we can build on, provided that we are open to input and coaching ourselves.

Some of the key skills required to serve effectively as a recovery coach include:

⇒ Listening empathetically (placing yourself in the *coachees* shoes and acknowledging the validity of their feelings and experiences)

⇒ Putting your own judgments and opinions to one side

⇒ Acting as a consultant to and collaborator with the *coachee*

⇒ Communicating clearly

⇒ Practicing patience and persistence

⇒ Providing practical problem-solving skills

⇒ Holding out hope and building on motivation

⇒ Recognising your own personal limitations and the boundaries of the relationship between you and your *coachee*

⇒ Detaching from the outcomes of your work, avoiding blaming yourself when things don‘t go as planned.

⇒ Advocacy

Exercise

1. What Recovery Coach skills do you see as strengths you bring to the table? *(You can include skills not listed above)*
2. What coaching skills do you need to further develop? *(You can include skills not listed above)*

Knowledge

The Greek Philosopher Socrates taught that self-knowledge is the foundation upon which all other knowledge is built.

Self-knowledge is also recognised as a starting point in many recovery pathways and religious and spiritual traditions.

One way of looking at recovery is as a movement from a dysfunctional relationship with alcohol and/or other drugs to a genuine relationship with yourself, your family and your community.

As a Recovery Coach, one of the most important tools you bring to the table is your self-knowledge, which will create an opportunity for a genuine relationship with your *coachees.*

Also important is a knowledge of, and openness to, other recovery pathways. As a Coach, you will also need a solid understanding of addiction, treatment and recovery.

You do not need to be an expert in these, but you should understand the key concepts and how treatment relates to recovery coaching and to the larger recovery process.

Additionally, you will need a strong understanding of the role of the Recovery Coach, how this relates to treatment and recovery and interpersonal boundaries and ethics as they apply to recovery coaching.

One of your key roles as a Recovery Coach is, in fact, to encourage greater self-knowledge on the part of the *coachee.*

This can be done in a number of ways, from pointing out differences between their behaviour and expressed values or goals, to increasing awareness of triggers, vulnerabilities and strengths.

Finally, as a Coach, you will need to have knowledge of a broad range of community resources, including housing, mutual aid groups and treatment, mental health and other healthcare services.

Most of us who are beginning work as Coaches will not have this knowledge and will need to develop it over time. Ideally you will be working as part of a team where you can you can rely on the knowledge of more experienced team members as you build your own knowledge.

Exercise

1. How would you describe your recovery pathway?
2. Are there other pathways that you feel uncomfortable about or which you think are philosophically incompatible with your pathway?
3. How would you feel about working with a *coachee* who is following a pathway very different to your own?
4. List the other recovery pathways that you are familiar with. How strong is your understanding of these pathways?
5. List the mutual aid groups (AA, NA, SMART Recovery, etc.) that you know about. Do you know whether or not these groups have local meetings?
6. You may need to work with people from a different social, ethnic or cultural backgrounds. Which Recovery Coaching skills do you think would be most important in such cases?
7. Can you identify local housing, employment, training, education, parenting,

Qualities

As a Coach, you are not an expert with all of the answers. Rather, you are an empathetic listener who has “been there” and a consultant or advisor who recognises that what works for you may not always work for others. You are also a mirror for *coachees*. That does not simply mean that you have had, and can relate to, similar experiences. Although this may well be the case.

It also means that you can help *coachees* see themselves more clearly and help them recognise when they are being less than honest with themselves or others or lack awareness in important areas.

You carry out this mirroring function not by confrontation, which can result in defensiveness or distrust on the part of the *coachee*, but through active listening, paraphrasing and questioning in a way that helps the *coachee* grow in awareness and honesty.

While it has a long history in addiction treatment and recovery, confrontation has proven to be one of the least effective tools for motivating change.

Choosing not to use confrontation as a tool does not mean that you are sugar-coating everything or enabling unhealthy behaviour. Rather, it means that as Recovery Coaches we are honest, but non-judgmental.

Where actions or thoughts conflict with the goals or values a *coachee* has expressed or where they may put him or her at risk, Coaches can and should point this out in a constructive and non-judgmental manner.

Other key qualities essential to the Recovery Coach include:

⇒ Being open-minded about new pathways

⇒ Empathy and compassion

⇒ Humility

⇒ Humour

⇒ Patience

⇒ Assertiveness

⇒ Commitment to, and a passion for, supporting others

⇒ A solid sense of boundaries, including your own strengths and weaknesses

⇒ Self-acceptance and the ability to take care of your own recovery

⇒ Understanding of the limits of your own powers

⇒ A commitment to following your own recovery pathway in everyday life or, as is said in 12-Step programmes, a desire and commitment to “walk your talk”

Principles

Principles flow from and express our values. Principles are to values as objectives are to a mission.

While objectives spell out the steps needed to accomplish our mission, principles spell out the rules or guidelines that help us embody our values.

Key principles for the Recovery Coach include the following:

⇒ Associate with positive recovering people and put your recovery first

⇒ Take care of yourself physically, mentally, and spiritually

⇒ When working with *coachees*, emphasise to them the importance of putting their recovery first and help them see the ways they may not be doing so

⇒ Realise that your experience, strength, and hope are of far more value than your opinion

⇒ Do not ask others to do something you would not do yourself

⇒ Celebrate both the shared experience of recovery and the unique qualities of each person‘s pathway

⇒ Use your experience, strength, and hope to assist *coachees* in finding pathways that work for them

⇒ Learn from your mistakes. Have the honesty to recognise mistakes and the humility to apply the lessons they bring

⇒ Realise that we are all in this together

⇒ Remember that as you give, you receive, and as you receive, you give. Recovery is being available to give and receive

⇒ Stick to your commitments

⇒ Tell it like it is; don‘t embellish your experience

⇒ Remember that you only have today

Exercise

1. Which of these principles do you most like? Why?
2. Do you disagree or dislike any of these principles. If so, why?
3. How would you describe the principles by which you try to live?
4. Are there other principles that might be useful for a Recovery Coach?

⇒ Take care of your friends and family

Taking Care of Yourself

One of the greatest mistakes we can make is to assume that our work as a Recovery Coach can replace the work of following our recovery path.

recovery programme, it is in no way a replacement for it.

Failing to follow your own recovery path does not only put you in a hypocritical position when you suggest that *coachees* follow their paths, it puts you and your *coachees* at risk of relapse.

Your first responsibility as a Coach is to model recovery and the kind of integrity it requires. While none of us are anything close to perfect at this, it is our ongoing efforts that serve as a model for *coachees*.

Additionally, when we fail to work at our own recovery path, we can find ourselves bringing emotional baggage into our relationships with *coachees*. This can distort our judgment and can cause harm to us and our *coachees*.

Some of the things you can do to take care of yourself include:

⇒ Staying in contact with and seeking feedback from a mentor, sponsor, spiritual advisor or another Coach

⇒ Participating in support groups

⇒ Taking part in treatment or therapy

⇒ Actively following your chosen recovery pathway

Exercise

1. How well are you taking care of yourself at the moment?
2. Are there ways in which you could take better care of yourself?
3. Would you benefit from assistance in areas where you may not be taking care of yourself as well as you would like?
4. Do you have knowledge or experience that could help coachees or other Coaches to take better care of themselves?
5. If you felt a fellow Recovery Coach was not properly taking care of himself or herself, what would you do?
6. What would you want a supervisor or fellow Coach to do if you were not taking care of yourself well enough?

Daily Activities of the Recovery Coach

Overview

So far, this manual has talked about recovery coaching in a very broad way. This section will give a sense of the day-to-day activities of the Coach and also provide examples of some of the situations that a Coach may come across.

So, what does a Recovery Coach actually do? In a nutshell, the Coach:

⇒ Works with *coachees* to identify their recovery goals

⇒ Assists *coachees* in identifying and owning their recovery capital. This process does not only occur at the beginning of the coaching process, it continues throughout. One way of looking at this is as an ongoing inventory of recovery capital

⇒ Assists *coachees* in developing a recovery plan that builds on existing recovery capital and develops additional capital in order to meet their recovery goals

⇒ Communicates clearly to *coachees* that supporting their recovery is the Coach‘s top priority

⇒ Emphasises that no-one but the *coachee* can actually do the work of recovery

⇒ Provides feedback in a non-judgmental and supportive way, recognising that experience is sometimes a better teacher than even the most well-intentioned Coach

⇒ Guides the new person into the recovery community

Sitting Down for the First Time

The first meeting between Coaches and *coachees* is critically important. During that meeting, the Coach and *coachee* clarify roles and determine the nature and expectations of their relationship.

This relationship forms the foundation upon which all future work is based. It is, therefore, important to meet ***coachees*** “where they are at” and to welcome them, letting them know that you are looking forward to working with them.

Questions that can help focus the discussion include:

- What brought you here today?
- How do you feel about being here today? (e.g. anxious, hopeful, angry)
- Moving forward, we‘ll be working as a team. My goal is to help you meet your recovery goals. Do you have any questions about how we will be working together or any preferences or needs that it might be helpful for me to know about?
- What would you like to accomplish through working with together?
- Do you have goals that your addiction has kept you from meeting?

You can, of course, come up with your own questions and own approach. The key idea here is that you are laying the groundwork of a relationship that will be more like that of a consultant or partner than that of an expert.

You are helping the *coachee* find and solidify his or her own recovery pathway, rather than telling them how to follow yours. This is important to remember, even when you and the *coachee* are following the same recovery pathway.

One of the first orders of business for the Coach working with a new *coachee* is to discuss and clarify expectations.

⇒ What does the Coach expect of the *coachee?*

⇒ What can the *coachee* expect of the Coach?

⇒ What commitments are being made when Coach and *coachee* work together?

⇒ What are the limits of the relationship?

⇒ What is the Coach‘s responsibility, and what is the responsibility of the *coachee*?

Clarity in these areas helps build a solid foundation for future work.

In the early stages of your work with *coachees*, you are laying the foundation on which an ongoing relationship will be built. If the foundation is not solid, the relationship may not be stable and may not stand long.

This does not mean that you need to establish a solid foundation in one meeting, it means that you need to be mindful that your relationship with your *coachee* will be the foundation of all your work with them. The relationship needs to be clearly defined and needs to centre on the *coachee’s* recovery goals.

The Readiness Ruler

As we enter recovery we make a great number of changes, ranging from stopping substance use to avoiding people, places, and things that put us at risk of relapse, developing new friends and taking responsibility for our past and our present.

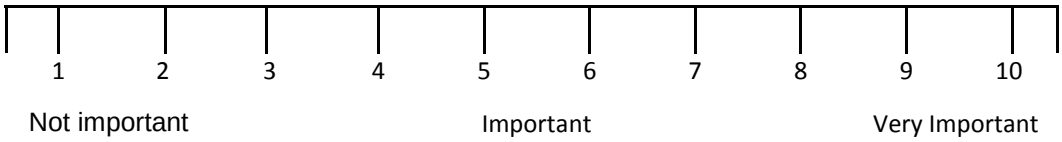
Often, when *coachees* first see Coaches they have already stopped using alcohol or other drugs for some period of time. However, there will likely be a need for many more changes to “stay stopped” and to build a new way of life.

The Readiness Ruler is a simple tool that you and your *coachees* can use to measure readiness for change. It was developed by Dr. Stephen Rollnick, who developed Motivational Interviewing with Dr. William R. Miller (Center for Substance Abuse Treatment, 2006; Miller & Rollnick, 1991, 2002).

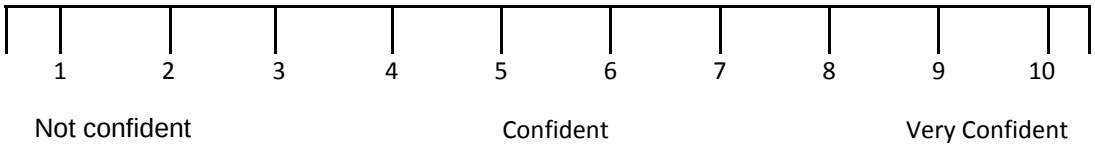
You may want to use the Readiness Ruler (below) as a matter of general practice or you may prefer to use it only when a *coachee* shows ambivalence or hesitation about recovery or what it might take to achieve or maintain it.

Simply put, the ruler helps you both be clear about how important *coachees* feel it is to make a specific change or take a particular action, how confident they are they can successfully make the change or take the action and how ready they are to do it.

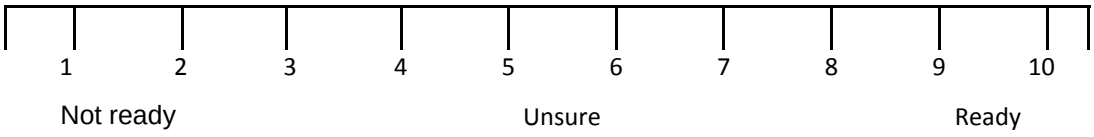
How *important* is it for you to make this change?



How *confident* are you that you can make this change?



How *ready* are you to make this change?



These questions are a great way to elicit what Motivational Interviewing practitioners call “change talk.” That is because they help the *coachee* think and talk about the reasons they want to make a positive change.

They can be especially useful when a *coachee* is hesitant about making a change. To really get the most value possible from them it is best to probe the answers in a way that is likely focus the conversation on strengths and change.

As an example of how this might be done, imagine the *coachee* is continuing to spend time with using friends despite recommendations that he or she doesn’t do this. And suppose that, as a result of spending time with these friends, he or she relapses and feels remorse.

The Coach might show the *coachee* the ruler and ask:

“How important is it to you that you stop spending your time with using friends?”

Let‘s say the *coachee* rated the importance of the change as a 4, somewhat important. And that the *coachee* rates their confidence in their ability to make the change as a 9 and their readiness as a 3.

Faced with this response, it might be difficult for many of us not to show a level of exasperation!

Most of us would naturally want to ask the *coachee* why he or she did not rate staying away from risky people, places and things a 10 in importance. Or give a lecture on the importance of not hanging out with using friends.

While this approach may sometimes work, pushing too hard for someone to change opens the door for *coachees* to recite all the reasons that they do not want to make a change.

To demonstrate, let‘s run through this scenario in a way that may not be helpful to the *coachee.*

Coach: “Why didn’t you score the importance of this higher?”

Coachee: “Well, I really don’t think this is the key to my getting and staying abstinent / in recovery.”

Coach: “Don’t you see that you put yourself at risk every time you spend time with them?”

Coachee: “Maybe, but I know people who used to use and don’t any more that hang out with them. Anyway, I live there, and it’s hard to avoid them, we’ve been friends since we were kids.”

Coach: “So these friends are more important to you than staying abstinent / in recovery?

Coachee: “You may not think much of them, but they’re all I’ve got.”

The conversation quickly takes on a pattern where the Coach argues for change, and the *coachee* argues against it.

Since it is not the Coach but the *coachee* who needs to make the change, the outcome is not likely to be good.

If, instead of asking why the *coachee* didn‘t score this item higher, the Coach turned the question on its head, it might come out like this:

Coach: “That’s interesting, why did you score the importance a 4 instead of a 2, 1 or zero?”

Coachee: “Well, even though these people are about the only friends I have, I do have to admit that there is a risk for me if I spend a lot of time with them.”

Coach: “That makes sense. What would you like to do to reduce that risk?”

Coachee: “I don’t know. Short of bringing someone with me, I’m not sure what I can do.”

Coach: "Remember when we talked about some of those get-togethers at the club? Do you think if you connected with more people in recovery, it might be easier to spend less time with them?"

Coachee: "Yes….maybe."

Coach: "Do you want to give it a try and see if it makes a difference?"

Coachee: "I suppose that makes sense…."

Coach: "Great! I definitely think it's worth a try. Let's see what's coming up."

When the question is turned on its head, the *coachee* will generally begin to talk about all the reasons he wants to make the change or feels he should do so.

Suddenly, the conversation is about making rather than not making the change. That's a conversation where you can easily be on the *coachee*'s side in helping him or her find solutions for the problem.

Even if the *coachee* rates an item a *1*, you can still ask why he or she did not rate it a *0*. A similar conversation can take place about the confidence and readiness rates the *coachee* gave you.

As this example shows, while you as the Coach may already know the solution to a problem a *coachee* is encountering, there may be times when it's most helpful to allow the *coachee* to discover or tell you the solution.

The Readiness Ruler is simply a tool; no Coach needs to use it. However, it is easy to use, very flexible, and can be help you steer clear of a tug-of-war with a *coachee*, which is almost never useful.

How Long to Work with a Coachee

There is no set length of time for the coach-*coachee* relationship. Some organisations limit the coaching relationship to 90 days. However, the actual length of time will vary from *coachee* to *coachee*.

The *coachee*'s actions are the best measure for deciding when the coaching relationship should be ended. If you are working without time limits, it would probably be a good idea to set achieving particular recovery goals as the end point.

For example, you might work with a *coachee* until he or she has a job and housing or until it seems as though recovery coaching isn't helping the *coachee* meet those goals.

The coaching relationship is like teaching someone to ride a bike. Initially, you run along beside the rider, stabilising the bicycle while making recommendations and issuing warnings about the dangers ahead.

Eventually, you watch them peddle off confidently on their own. Coaching and teaching someone to ride a bike share the same goal: assisting the other in developing the skills to proceed without you.

When the coaching relationship stops, it does not necessarily mean that your relationship with the *coachee* has come to an end. In some cases it can continue. When it does continue, the relationship shifts from the coach-*coachee* relationship to one of friendship.

The *coachee* may even become a Coach themselves and become a colleague.

What to Do in Case of Relapse

When relapse occurs, the Coach helps the *coachee* get right back on that bike!

Offer yourself and your experiences with relapse. If the *coachee* is willing to continue on the pathway to recovery, review the recovery plan with the *coachee*:

⇒ Was it followed?

⇒ Does it need to be modified?

⇒ In the future, what could the *coachee* do differently?

⇒ Is there something that you, as a Coach, might want to do differently in the future?

Relapse is an opportunity for you and your *coachee* to learn. That opportunity may be lost, however, if you or your *coachee* focus on blaming each other.

Invest your recovery capital in the coachee. If you do so, and stay detached from the results, your investment will pay off, even if the coachee does not manage to turn the corner at the time that you are working with him or her.

What to Do When Coachees do not Follow their Recovery Plans

When this occurs, don‘t panic and don‘t blame yourself or the *coachee*.

Review the plan with the *coachee*. Is it an appropriate plan for them at that point, or should it be modified?

Don‘t confront the *coachee*. Instead note that they don’t seem to be following the plan they developed with you, and ask them if there is anything that might make the plan work better for them.

If the answer is no, you may want to explore whether they are confident that they can achieve recovery and how ready they are to commit to the process. The readiness ruler provides an excellent tool for this purpose and can help focus the *coachee* on solutions instead of problems or doubts. When relapse occurs, it may be helpful to emphasise that, as a Coach, you are not looking for perfection from the *coachee*, but rather a genuine effort to work toward recovery. And that you understand that many people have slips of full blown relapses.

Ask the *coachee* if he or she is ready to take steps (or additional steps) toward recovery and would like to work with you on accomplishing them.

If the answer is yes, work with the *coachee* to establish goals, next steps and regularly scheduled check-ins on progress.

If the relapse was severe, or if there may be withdrawal issues, referral to treatment may be appropriate.

Discuss the relapse, and use personal experiences and those of others.

When and How to Consult Supervisors

Your supervisor will give you guidelines on situations or questions that must be brought to his or her attention.

He or she may also set up a regular schedule for supervision meetings. On the other hand, your supervisor might work in a more *ad hoc*, or day-to-day fashion. There is no one right way to supervise.

In general, we would recommend that you review your work with your supervisor at least weekly during your first three to six months as a Coach.

Additionally, we strongly recommend that you consult with a supervisor or more experienced Coach whenever a situation arises which your training has not prepared you for.

Other times to consult with a supervisor include when you are not sure how to proceed in a particular situation, when you are having difficulties in your relationship with a *coachee* or are concerned about that individual.

You should also consult with a supervisor if you are having difficulties with a colleague or if you observe something that could be detrimental to a Coach, a *coachee*, the organisation or anyone else.

Finally, it‘s a good idea to check regularly with colleagues and supervisors on the progress of your *coachees*, their recovery plans and any challenges they are encountering.

You should also make yourself available to discuss the progress of other *coachees* with their Coaches.

When this is done regularly two significant benefits emerge. First, the entire coaching team improves as team members gain from each other‘s insights and recommendations. Second, *coachees* have improved access to support, since other Coaches will be familiar with their situation and able to help out when you are not available.

One thing is certain, communication with your supervisor and peers should be ongoing, not simply a response to problems. That makes for a healthier, less stressful environment and allows you and your *coachees* to avoid many problems before they occur.

Ethical Considerations

As William L. White has pointed out, recovery coaching as a service is relatively new. The role of the Recovery Coach, the setting in which he or she works and the characteristics of Recovery Coaches vary.

Many Recovery Coaches are in recovery themselves and directly use their recovery experience. Others are not themselves in recovery, although many of these have entered recovery coaching because of their experience with a loved one‘s addiction and/or recovery.

Some coaching roles overlap with counselling roles. The variation in the roles, settings and the personal characteristics of Recovery Coaches makes the development of ethical standards for recovery coaching difficult.

In an effort to lay the groundwork for ethical standards, White has identified characteristics of peer recovery coaching:

1. Recovery coaching relationships tend to last longer than counselling relationships
2. The coach-*coachee* relationship is less hierarchical (more equal) than the worker-service user relationship
3. Recovery coaching involves different core functions and different responsibilities to other relationships
4. *Coachees* may need different types of support services at different stages of their addiction and recovery careers. Coaches, therefore, need to identify needs carefully and only provide support within the boundaries of their knowledge and experience i.e. they must know how and when to involve others in the process
5. Peer-based recovery support services can be in addition to addiction treatment for those with high problem severity and low recovery capital. Or an alternative to addiction treatment for those with low-moderate problem severity and moderate-high recovery capital

(White, 2007)

He then proposed a set of universal values as a framework for ethical decision making and for the development of recovery support services ethical guidelines. These are:

⇒ Gratitude and Service: Carry hope to individuals, families and communities

⇒ Recovery: All service hinges on personal recovery

⇒ Use of Self: Know thyself. Be the face of recovery. Tell your story and know when to use it

⇒ Capability: Improve yourself. Give your best

⇒ Honesty: Tell the truth. Separate fact from opinion. When wrong, admit it

⇒ Credibility: Walk what you talk

⇒ Fidelity: Keep your promises

⇒ Humility: Work within the limitations of your experience and role

⇒ Loyalty: Don‘t give up. Offer multiple chances

⇒ Hope: Offer yourself and others as living proof. Focus on the positive - strengths, assets, and possibilities - rather than problems and pathology

⇒ Dignity and Respect: Express compassion and accept imperfection. Honour each person‘s potential

⇒ Tolerance: “The roads to recovery are many” (Wilson, 1944). Learn about diverse pathways and styles of recovery

⇒ Autonomy and Choice: Recovery is voluntary. It must be chosen. Enhance choices and the making of choices

⇒ Discretion: Respect privacy. Don‘t gossip

⇒ Protection: Do no harm. Do not exploit others. Protect yourself and others. Avoid conflicts of interest

⇒ Advocacy: Challenge injustice. Be a voice for the voiceless. Empower others to speak

⇒ Stewardship: Use resources wisely

Exercise

1. Do you believe the values proposed by Bill White provide a good framework for ethical decision making as a Recovery Coach? Why or why not?
2. What areas do you think may pose the greatest challenges for you in terms of ethical decision making?
3. Read “Ethical Guidelines for Peer Recovery Support Services” and complete Table 1, the *Intimacy Continuum.* Which items were easy to categorise on the continuum and which were not? What should you do to obtain clarification or input on those items you found difficult to categorise?
4. A *coachee* has been making tremendous progress in all areas of his recovery plan, except employment. He has been a true asset, actively supporting peers in their recovery and showing gratitude, humility, dedication and enthusiasm.

After asking lots of questions the *coachee* finally reveals that he has not actually been seeking employment out of fear that an old arrest warrant for a violent crime committed under the influence of alcohol and crack cocaine would come to light. What courses of action are open to you? Evaluate each option using the Ethical Decision Making tables in the “Ethical Guidelines for Peer Recovery Support Services” document.

5. Based on this exercise, what action would you have taken had this occurred with one of your *coachees*?

Ethical Guidelines for the Delivery of Peer-based Recovery Support

Introduction

There is a long history of peer-based recovery support services for people with alcohol and other drug problems.

These peer-based recovery support roles have various titles: Recovery Coaches, Recovery Mentors, Recovery Champions etc.

Complicated ethical and legal issues can arise when carrying out these roles and there is only a limited amount of guidance available.

The following will:

- Define the core responsibilities of the Recovery Coach
- Discuss of key ethical concepts
- Outline a model of ethical decision-making that can be used by Recovery Coaches and those who supervise them
- Discuss ethical situations that can arise for Recovery Coaches related to personal conduct, conduct with those they are coaching, conduct in relationships with local services and organisations and conduct in relationships with the larger community
- Provide a sample statement of ethical principles and guidelines for Recovery Coaches

Peer-based Recovery Support Roles and Functions

Recovery support services refers to non-clinical services that are designed to help initiate and sustain individual/family recovery from severe alcohol and other drug problems and to enhance the quality of individual/family recovery.

There are four main types of support:

Emotional support: demonstrations of empathy, love, caring and concern in such activities as peer mentoring and recovery coaching, as well as recovery support groups.

Informational support: provision of health information, educational assistance and help in acquiring new skills, ranging from life skills to employment readiness and citizenship

Instrumental support: concrete assistance to achieving particular tasks, especially with stressful or unpleasant tasks such as filling out applications and obtaining benefits. Or providing child care, transportation to support-group meetings etc.

Companionship: helping people in recovery feel connected to others, ie social activities in alcohol and drug free environments. This assistance is especially needed in early recovery.

Part of what makes the ethical delivery of recovery support so challenging in the addictions context is that the Recovery Coach performs so many roles. A Recovery Coach can be:

An Outreach Worker: identifies and engages hard-to-reach individuals; offers living proof of the transformative power of recovery; makes recovery attractive

A Motivator: shows faith in people's capacity for change; encourages and celebrates recovery achievements; mobilises internal and external recovery resources; encourages self-advocacy and economic self-sufficiency

Ally and Confidant: genuinely cares and listens; can be trusted with confidences

Truth-teller: provides honest feedback on recovery progress

Role Model and Mentor: offers his/her life as living proof of the transformative power of recovery; provides stage-appropriate recovery education

Planner: facilitates the transition from a professional-directed treatment plan to person-developed and person-directed personal recovery plan

Problem Solver: helps resolve personal and environmental obstacles to recovery

Resource Broker: links individuals/families to sources of housing, employment, health and social services and recovery support; matches individuals to particular support groups/meetings

Monitor: processes each client's response to professional services and mutual aid exposure to enhance service/support engagement, reduces attrition, resolves problems in the service/support relationship and facilitates development of a long-term, sobriety-based support network; provides periodic face-to-face, telephone or email-based monitoring of recovery stability and, when needed, provides early re-intervention and recovery re-initiation services

Tour Guide: introduces newcomers into the local culture of recovery; provides an orientation to recovery roles, rules, rituals, language and etiquette; opens opportunities for broader community participation

Advocate: helps individuals and families navigate complex services

Educator: provides information about the stages of recovery; informs professionals, the community, and potential service users about the pathways and styles of long-term recovery

Community Organiser: helps develop and expand available recovery support resources; enhances co-operative relationships between professional services and community-based recovery support groups; cultivates opportunities for people in recovery to volunteer and other acts of service to the community

Lifestyle Consultant/Guide: helps individuals/families to develop sobriety-based rituals of daily living; encourages activities (across religious, spiritual and secular frameworks) that enhance life meaning and purpose

Friend: provides sober companionship; a social bridge from the culture of addiction to the culture of recovery
(White, 2004a)

Role Boundary Integrity

The Recovery Champion is NOT a:	You are moving beyond the boundaries of the Recovery Coach role if you:
Sponsor (or similar role)	Perform AA/NA or any other mutual aid group service work in your Recovery Coach Role Guide someone through the steps or principles of any recovery programme
Drug or Alcohol Worker/ Counsellor/Therapist	Diagnose Provide counselling or refer to your support activities as “therapy” or “counselling” Focus on problems, issues or trauma as opposed to recovery
Nurse or Doctor	Suggest or express disagreement with medical diagnoses Offer medical advice Make statements about prescribed medication beyond the boundaries of your training or experience
Priest	Promote a particular religion/church Offer absolution/forgiveness Interpret religious doctrine

People serving as Recovery Coaches, rather than necessarily having traditional qualifications, draw on *experiential knowledge* and *experiential expertise* (Borkman, 1976).

Experiential knowledge is information learned about addiction recovery through the process of a person’s own recovery or being with others through the recovery process.

Experiential expertise is the ability to transform this knowledge into the skill of helping others to achieve and sustain recovery.

Many people have acquired experiential knowledge about recovery, but only those who have the

added dimension of experiential expertise are ideal candidates for the role of Recovery Coach.

The Recovery Coach works within a long tradition of *wounded healers* - individuals who have suffered and survived an illness or experience who use their own vulnerability and the lessons drawn from that process to help others seeking to heal from this same condition (White, 2000a,b; Jackson, 2001).

Recovery coaching at its best offers recovery support that is not available from other service roles. People who have had a Recovery Coach were asked what they contributed to their early recovery experiences. Here are some of their responses:

"My Recovery Coach builds me up and makes me feel like I am someone and I can accomplish anything I set my mind to. He provides his experience in recovery and his strength and hope."

"Support. It's comfortable to have someone behind me - I don't think I could do it on my own. They always help me to look at things differently."

"My Recovery Coach is 100% real. She has been there and done that. She understands me and knows where I'm at in this point in my life. She knows exactly what to say and do for me to build me up and keep me strong. It's like we are on the same level and she is here to help me move on and get to the next step in my recovery and in my life.."

"He gave me self esteem. He asked me, was I ready? I was able to share my past."

"Recovery Coaching has helped me set goals in my life. It has also taught me to be accountable for my actions. The Coach didn't really give advice, more like guidance to make better decisions on my own."

"She helped me paint a picture that I am not alone, and that there are a lot of recovering addicts out there and they actually have a lot of clean time. I didn't know that before."

"I wanted to become a responsible daughter and mother and a respected and productive member of the community. I started doing anything and everything for my recovery. "

"His demeanour of recovery showed me I could get what he has."

Recovery Coaches, particularly those working as volunteers, are also quite clear about what they get out of this process:

"I like working with people and being able to offer encouragement and support. Its very rewarding to see people start getting their lives back. Sometimes I see people who don't make the right choices and that can be frustrating, because I remember what that was like and I feel for them. It helps me to remain grateful for how much better my life is now that I'm in recovery and I try to pass that message on to them. I am a part of a wonderful process and helping others helps me

“In helping individuals build and rebuild recovery capital, I have learned not only a lot about these people but a lot about myself.”

“Today I know that I don’t know. In letting someone in on that secret it reassures them that it is okay not to be all knowing and all powerful.”

“In being a Recovery Coach I am able to make a small dent in the world around me and a huge change in my own life.”

“Personally, I love what I do. I have been helping people in recovery since the beginning of my recovery in 1989. I have been blessed to have such a great appreciation for helping others that it has become a part of me. There is no greater feeling to help someone out of the gutter where I came from and see them grow.”

“I feel I am giving back by helping assist others in their recovery process. By practicing what I preach, I am able to build and nurture areas of spiritual growth in my life. I am able to maintain a sense of integrity and character. Working as a Recovery Coach has helped me evaluate my strengths and weaknesses and improve my listening skills. I feel trusted and valued as a mentor when people allow me to help them reach their goals. I feel special.”

“When that light comes on it is so exciting to witness. I do recovery coaching for selfish reasons - I’m looking for more light”

Recovery coaching is still at an early stage. The role is being defined differently based on the needs of particular communities and particular clients.

That variability is both a source of strength (responsiveness to the particular needs of individuals, families and communities) and a source of vulnerability (the lack of consistent role definition).

Orientation, training and supervision frameworks for Recovery Coaches are at an early stage of development.

The excitement about the Recovery Coach role is tempered by concerns about potential conflicts with other service roles and concerns about harm that could come to people who receive poor recovery support.

These are concerns that apply to all health and human service roles but there are several characteristics of recovery support services that make them more vulnerable.

First, recovery support needs span the periods of engagement and stabilisation, preparation for change, active change, & completion. (Strang et all 2012).

his means that these relationships can last far longer than treatment worker relationships that are the core of addiction treatment, are far more likely to be delivered in the client‘s natural

Second, recovery support relationships are less hierarchical (more equal) than the worker-client relationship, involve different core functions and are governed by different accountabilities.

Because of this, the ethical guidelines that govern the addiction worker are often not applicable to the Recovery Coach.

Because of this ethical guidelines for Recovery Coaches must flow directly from the needs of those seeking recovery and from the values of local communities of recovery.

Third, users of peer-based recovery support services differ in the kind of non-clinical support they need, and it is not uncommon for the same person to need different types of support services at different stages of his or her addiction and recovery careers.

This requires considerable care in evaluating support needs, delivering services within the boundaries of one‘s knowledge and experience and knowing how and when to involve other services.

Fourth, peer-based recovery support can be in addition to addiction treatment (for those with high problem severity and low recovery capital) or an alternative to addiction treatment (for those with low-moderate problem severity and moderate-high recovery capital).

This requires considerable expertise in determining an individual’s needs, skill in making necessary referrals in a timely manner and providing services only within the boundaries of your own competence.

All of these conditions underscore the need for a clear set of ethical values and standards to guide the delivery of peer-based recovery support services.

Ethics: A Brief Primer

The topic of ethics may be a relatively new one for Recovery Coaches and we must understand what we mean by saying that an action of a Recovery Coach is ethical or unethical.

At its most basic level being ethical means preventing harm and injury to those to whom we have pledged our loyalty.

This meaning is revealed through four terms: *Iatrogenic, Fiduciary, Boundary Management* and *Multi-party Vulnerability.*

Iatrogenic means unintended, treatment-caused harm or injury. It means that an action taken, possibly with the best of intentions, to help someone actually results in injury or death.

Can you think of an example of such an action? There is a long history of such actions in the history of addiction treatment, e.g., mandatory sterilisations, withdrawal using electroconvulsive

shock therapies, psychosurgery and treating morphine addiction with cocaine.

It is easy today to look back on such ‘treatments’ and wonder, “What were they thinking?!” But history tells us that it is hard to see such potential injuries at the time.

Given the newness of recovery coaching, we must be vigilant to quickly weed out actions done with good intentions that harm one or more parties. This potential for harm also underscores the importance of getting guidance from other Recovery Coaches and from supervisors.

Fiduciary is a term describing relationships in which one person has assumed a special duty and obligation for the care of another.

The word is a reminder that the relationship between the Recovery Coach and those to whom he or she provides services is not a relationship of completely equal power.

Fiduciary implies that one person in this relationship enters with increased vulnerability requiring the objectivity, support and protection of the other - like a relationship we would have with a doctor or nurse.

While the power difference between the Recovery Coach and those he or she coaches is less than that between a surgeon and his or her patient, the Recovery Coach can still do injury by what he or she does - or fails to do.

Boundary Management encompasses decisions about intimacy within a relationship. This is an area of potentially considerable conflict between recovery support specialists and service professionals.

Traditional helping professions (doctors, nurses, psychologists, social workers and addiction workers) emphasise detachment and distance, peer-based services rely on reciprocity and minimising social distance between the helper and those being helped (Mowbray, 1997).

While addiction professionals and peer-based recovery support specialists both have boundaries they may differ considerably.

We can view the relationship between the Recovery Coach and those they serve as an *intimacy continuum*, with a zone of safety in which actions are always OK, a zone of vulnerability in which actions are sometimes OK and sometimes not OK and a zone of abuse in which actions are never OK.

The zone of abuse involves behaviours that show too little or too much involvement. Examples of behaviours across these zones are listed in the chart below.

Place a tick for each behaviour based on whether you think this action as a Recovery Coach would be always OK, sometimes OK but sometimes not OK or never OK.

Recovery Coaching: An Intimacy Continuum

Behaviour of the Recovery Coach	Zone of Safety (Always OK)	Zone of Vulnerability (Sometimes OK, Sometimes Not OK)	Zone of Abuse (Never OK)
Giving Gifts			
Accepting Gifts			
Lending Money			
Borrowing or Accepting Money			
Giving a Hug			
“You’re a very special person”			
“You’re a very special person to me”			
Invitation to Dinner			
Sexual Relationship			
Sexual Relationship with *coachees* family member			
Giving your mobile phone number			
Swearing			
Using Drug Culture Slang			
“I’m going through a bad divorce myself too”			
“You are very attractive”			
Attending a mutual aid meeting together			
Offering to let the person stay at your house			

Multi-party Vulnerability is a phrase that conveys how other people can be injured by what a Recovery Coach does or fails to do. This includes the person receiving recovery support, that person‘s family and close social network, the Recovery Coach, the organisation the Recovery Coach is working for, the recovery support services field, the larger community of recovering people and the community at large. It is easy for organisations providing recovery support to make assumptions about ethical behaviour and misbehaviour that turn out to be disastrously wrong. Let‘s consider five such assumptions:

Assumption 1: People who have a long and by all appearances, quality, sobriety can be counted on to act ethically as Recovery Coaches.

Fact: Recovery, no matter how long and how strong, is not perfection; we are all vulnerable to errors in judgment, particularly when we find ourselves in situations unlike any we have faced before.

Assumption 2: People working as Recovery Coaches will have common sense.

Fact: “Common sense” means that people have shared experience that allows a reasonable prediction of what they will do in a particular situation.

The diversity of cultural backgrounds and life experiences of people working as Recovery Coaches means there is no such common foundation. And behaviour that is “common sense” in one cultural context might be an ethical breach in another.

Assumption 3: Breaches in ethical conduct are made by bad people. If we only involve good people, we should be okay.

Fact: Most breaches in ethical conduct within the health and human service field are made by good people who often didn‘t even know they were in a situation that required ethical decision-making.

Protecting recipients of recovery support requires far more than excluding “bad people”. It requires improving the ethical decision-making abilities of good people.

Assumption 4: Following existing laws and regulations will assure a high level of ethical conduct.

Fact: The problem with this is that what is legal and what is ethical are not always the same. There are many breaches of ethical conduct about which are not against the law, and there could even be extreme situations when to do what is legally correct would be breach of ethical conduct - resulting in harm or injury to the *coachee.*

It is important to look at issues of law, but we must avoid reducing the question, “Is it ethical?” to the question, “Is it legal?”

Assumption 5: Ethical standards governing clinical roles (e.g. psychiatrists, psychologists, social workers, nurses, addiction workers) can be directly applied to the role of Recovery Coach.

Fact: There are lots of areas of overlap between ethical guidelines for various helping roles, but standards governing clinical work do not uniformly apply to the Recovery Coach role. This is mainly due to the nature of the relationship between Recovery Coaches and their coachees.

Assumption 6: Formal ethical guidelines are needed for Recovery Coaches in full-time paid roles, but are not needed for Recovery Coaches who work as volunteers for only a few hours each week.

Fact: Potential breaches in ethical conduct in can happen in both paid and voluntary roles. The question remains whether volunteer and paid Recovery Coaches should be covered by the same or different ethical guidelines.

Assumption 7: If a Recovery Coach gets into vulnerable ethical territory, he or she will let us know. If the supervisor isn't hearing anything about ethical issues, everything must be OK.

Fact: Silence is not golden within the ethics arena. There are many things that could contribute to such silence, and all of them are a potential problem.

The two most frequent are the inability of a recovery coach to recognise ethical issues that are arising, or his or her failure to bring those issues up for fear it will reflect negatively on them.

The best Recovery Coaches **regularly** bring ethical issues up for consultation & guidance.

Core Recovery Values and Ethical Conduct

Traditional professional codes of conduct for the helping professions have been heavily influenced by law and have also drawn heavily from medical ethics.

In setting forth a model of ethical decision-making , we noted the importance of group conscience within the history of particular communities of recovery and that judgments of behaviour would likely differ across these recovery communities.

Second, we looked across recovery traditions (religious, spiritual and secular) and at the collective experience of organisations providing recovery support - and found a set of core values shared across these organisations.

These core values and the obligations they represent for those providing recovery support are:

Gratitude and Service Carry hope to individuals, families, and communities.
Recovery All service hinges on personal recovery.
Use of Self Know thyself; Be the face of recovery; Tell your story; Know when to use your story.

Capability

Improve yourself; Give your best.

Honesty

Tell the truth; Separate fact from opinion; When wrong, admit it.

Authenticity of Voice

Accurately represent your recovery experience.

Credibility

Walk what you talk.

Fidelity

Keep your promises.

Humility

Work within the limitations of your experience and role.

Loyalty

Don‘t give up; Offer multiple chances.

Hope

Offer self and others as living proof; Focus on the positive—strengths, assets and possibilities rather than problems.

Express compassion

Accept imperfection; Honour each person‘s potential.

Dignity and Respect

Express compassion; Accept imperfection; Honour each person‘s potential.

Tolerance

“The roads to recovery are many” (Wilson, 1944); Learn about diverse pathways and styles of Recovery.

Autonomy and Choice

Recovery is voluntary; It must be chosen; Enhance choices and choice making.

Discretion

Respect privacy; Don‘t gossip.

Protection

Do no harm; Do not exploit; Protect yourself; Protect others; Avoid conflicts of interest.

Advocacy

Challenge injustice; Be a voice for the voiceless; Empower others to speak.

A Peer-Based Model of Ethical Decision-Making

A model of ethical decision-making is simply a guide to sorting through the complexity of a situation and a way to determine the best course of action to take in that situation.

We suggest that there are four questions to ask to guide decision-making.

Step One: Who has the potential of being harmed in this situation and how great is the risk for harm?

This question is answered by assessing the vulnerability of the party listed in the table below and determining the potential for, and severity of, injury.

Where multiple parties are at risk of moderate or significant harm, it is best not to make decisions alone and to consult with others.

Vulnerable Party	Significant risk of harm	Moderate risk of harm	Minimal risk of harm
Individual or Family being served			
Recovery Coach			
Organisation			
Recovery Support Field			
Recovery Community			
Wider Community			

Step Two: Are there any core recovery values that apply to this situation and what course of action would these values suggest taking?

Core Value	Yes/No	Suggested Action
Gratitude and Service		
Recovery		
Use of Self		
Capability		
Honesty		
Authenticity of Voice		
Credibility		
Fidelity		
Humility		
Loyalty		
Hope		
Dignity and Respect		
Tolerance		
Autonomy and Choice		
Discretion		
Protection		
Advocacy		
Stewardship		

Step Three: What laws, organisational policies or ethical standards apply to this situation and what actions would they suggest?

Step Four: Where risk of injury is to multiple parties, document: What I considered; Who I consulted; What I decided and did; The outcome of the decisions I made and actions I took.

Ethical Situations

Ethical issues can crop up in a number of situations related to the delivery of peer-based recovery support. This section highlights such issues within five areas:

1) being of service to others
2) personal conduct of the recovery coach
3) conduct in service relationships
4) conduct in relationships with other service providers
5) conduct in relationships with local recovery communities

Being of Service to Others

Exploitation of Coaches

Organisation ABC visibly promotes itself as providing peer-based recovery support services, but their reputation is being hurt by key practice decisions.

ABC employs people as Recovery Coaches who are in early recovery .

The legitimacy of a Recovery Coach comes from experiential knowledge and experiential expertise. **Where there is no or little experience, there is no legitimacy.**

Recovery Coaches should be employed who have established a personal programme of recovery marked by duration and quality. Minimum recovery requirements for Recovery Coaches currently range from one to two years, with many Recovery Coaches having more than five years of continuous recovery. This minimum requirement is for the protection of those receiving, and the people and organisations providing, recovery support.

ABC does little to orient, train or supervise their Recovery Coaches.

Failure to provide the Recovery Coach with the necessary orientation, training and supervision affects their capabilities, their credibility, the safety of the Recovery Coach and the person receiving recovery support.

The quality of screening, training, initial supervision and ongoing supervision are the foundation for the delivery of effective and ethical recovery support.

The delivery of Recovery Coach services, particularly volunteer-based services, requires more supervision than clinical services provided within an addiction treatment context - because non-clinical recovery support services often lack some of protection built into the delivery of treatment services, e.g., prolonged training and qualifications, a formal informed consent process, office-based service delivery.

Developing clear policies governing the delivery of recovery support and establishing monitoring procedures can help assure that the delivery of Recovery Coach services will be covered within the sponsoring organisation's liability insurance.

ABC pays Recovery Coaches a pittance while asking them to work excessive hours that often interfere with their own recovery support activities.

This is a form of financial exploitation of recovering people that contributes to Recovery Coach burnout, high Recovery Coach turnover and erosion in the quality of recovery.

It reflects poor stewardship of the Recovery Coach resource by displacing the recovery support needs of clients in favour of other activity.

Screening Practices

DEF is a grassroots recovery advocacy organisation that provides recovery coaching services through a group of volunteers from the recovery community.

A man notorious for his predatory targeting of young women entering NA arrives at DEF and announces that he would like to volunteer as a Recovery Coach.

How should DEF respond to this request?

The screening of volunteers and staff for recovery support roles is designed in part to protect the organisation and its service users.

This protection function must be assured at the same time as ensuring standards of fairness in their selection procedures, e.g. not excluding someone based only on second-hand gossip.

Selection for Recovery Coach roles is unique in that a past addiction-related criminal conviction (followed by a long and stable recovery career) can be seen as a positive rather than grounds for disqualification.

On the other hand, a reputation for exploitive behaviour within the recovery community could be grounds for disqualification.

The purpose of this disqualification would be the protection of service users and the protection of the reputation of the recovery support organisation e.g. assuring that people will feel safe and comfortable seeking services at the organisation.

White and Sanders (2006) describe how the credential of experiential expertise is established:

Experiential expertise is granted through the community "wire" or "grapevine" (community story-telling) and gives credibility that no university can grant.

It is given only to those who are able to offer sustained living proof of their expertise as a

recovery guide the community.

The community can withhold as well as give the credential of experiential expertise, and it can grant such expertise with conditions e.g. using the individual described as a closely supervised Recovery Coach, working only with men.

Personal Conduct

Self-Care

John brings great passion to his role as an Recovery Coach, but models very poor self-care.

He is overweight, smokes excessively and has chronic health conditions that he does not manage well.

To what extent are these ethical issues related to his performance as a Recovery Coach? How do private behaviours link to John's performance as an Recovery Coach?

Private behaviour of the Recovery Coach is just that - private - *until* there is a clear link between private behaviour and a person's performance as a Recovery Coach.

In this case, John's poor self-care does potentially impact his effectiveness as an Recovery Coach.

The expectation here is not to be perfect, but for there to be a reasonable amount of similarity between what people say and what people do.

Part of the job of the Recovery Coach is to make recovery attractive - to make recovery as contagious as addiction in the local community.

To become a Recovery Coach requires being not only a face and voice of recovery but also a person whose character and lifestyle others would choose to copy.

Our ability to achieve that is enhanced by self-care training that should be built into the overall Recovery Coach orientation and training programme.

Personal Impairment

Mary has functioned as an exceptional RC for the past two years, but is currently going through a very difficult divorce.

The strain of the divorce has resulted in sleep difficulties, a significant loss of weight and concern by Mary about the stability of her sobriety and sanity.

When do such events in our personal lives become professional practice issues? What should Mary and her supervisor do in response to these circumstances?

Again, events in our personal lives are of concern when they ripple, and only when they ripple, into how we perform our roles. All of us undergo difficult times in our lives that may mean we

need to focus on self-care and may mean that, for a short time, we are less capable of helping and supporting others.

Mary and her supervisor need to consider what would be best for her, for those she coaches and for the organisation.

One option is for Mary to decrease her hours or the number of people she coaches and to get increased supervisory or peer support (e.g. team coaching) for a period of time.

Another option would be for Mary to take a sabbatical to focus on getting her own health back in order.

For Mary to raise this issue in supervision is not something to be ashamed of, but the mark of service excellence - making sure that our own temporary difficulties do not spill into the lives of those we are committed to helping.

Lapse

Richard, who has worked as an Recovery Coach for more than a year, experienced a short lapse while attending a friend's wedding.

Because the lapse was so short, Richard plans not to disclose the relapse to the organisation through which he provides Recovery Coach services.

What ethical issues are raised by this situation? What should Richard do? What should the organisation's/supervisor's response be if this situation is brought to their attention? What organisational policies need to be established to address the issue of lapse/relapse?

There are several core values that apply to this situation, e.g. honesty, credibility and primacy of recovery. All of these values suggest a course of action that would begin with Richard's disclosure of the lapse to his supervisor and focusing on re-establishing the stability of his personal recovery.

The organisation should follow the guidelines/ protocols it has established to respond to such an event.

Options might include Richard taking a break from his Recovery Coach responsibilities, performing activities that do not involve direct coaching responsibilities and later easing back into

Recovery Coach responsibilities via co-coaching and more intensive supervision.

Personal Bias

Lisa has many assets that would make her an excellent Recovery Coach, but when interviewing her for a Recovery Coach position, you are concerned about one potential problem.

Lisa passionately believes that AA's Twelve Step programme is the only pathway for long-term addiction recovery, and she expresses considerable negativity towards alternatives to AA.

What ethical issues could arise if Lisa brought her biases into her role as a Recovery Coach?

The core value of tolerance asserts respect for diverse pathways and styles of long-term recovery. Bill Wilson (1944) was one of the first to advocate such diversity.

If Lisa cannot develop such tolerance, she may be better suited to being a sponsor within a Twelve Step programme than the role of Recovery Coach, which works with multiple programmes of recovery.

The same principle would apply to those using recovery programmes other than the Twelve Steps who believe theirs is only one true way to recovery.

What we know from research on recovery is that *all* programmes of recovery have optimal responders, partial responders, and non-responders (Morgenstern, Kahler, Frey, & Labouvie, 1996).

Tolerance for multiple pathways of recovery can be achieved by training and exposure to people in long-term recovery representing diverse recovery pathways.

Pre-existing Relationships

Dave's supervisor has given him a new person to work with. Dave recognises the name as a person who he sold drugs to in his earlier addicted life.

Who could be harmed in this situation? What should Dave do? Does Dave have a responsibility to report this to his supervisor?

Lots of people are potentially at risk here: Dave, his coachee, the coachee's family and Dave's organisation.

Dave should disclose the relationship and request another assignment. If the alternative is Dave or no service (e.g. Dave might be the only Recovery Coach in that community), Dave and his supervisor should explore additional options or explore how Recovery Coach services could be provided while minimising harm to all parties.

The most critical factor here is maximising the comfort and safety of the individual/family receiving services.

It is best if Recovery Coaches are expected to immediately declare if they have any pre-existing relationship with those who they may be coaching.

Use of Information across Roles

Rebecca is a natural listener. Everyone talks to her - in her Recovery Coach role and outside her Recovery Coach role. Rebecca is also very active in the local Twelve Step community. Today, a person Rebecca is coaching mentions the name of a new boyfriend that Rebecca recognises as a man with whom one of her sponsees is involved.

The relationship between the sponsee and this man has been a major source of sabotage to the sponsee's recovery and the sponsee also contracted an STD from this man.

Can Rebecca use information gained from roles in her personal life in her role as a Recovery Coach? How should she handle this situation?

This situation caused considerable disagreement among the recovery support organisation representatives who reviewed it.

Opinions split into two camps. The first group suggested that Rebecca could, and had a duty to, disclose this information as long as it was judged to be reliable and as long as no anonymity was violated related to the disclosure.

The other camp took the position that disclosing this information would violate AA etiquette ("What's said here, stays here."), that it was not Rebecca's role to disclose this information, and that Rebecca needed to stay supportive through whatever unfolded within this relationship.

A good general guideline is: moving information from one role into another role (e.g. using information gained at a Twelve Step meeting into your Recovery Coach activities) is full of potential harm and should be brought into supervisory discussion before information is used in this way.

Advocacy

Many Recovery Coaches are also involved in recovery advocacy activities in their local communities.

Are there any situations that could arise in an advocacy role that could conflict with your role as a Recovery Coach? Could any of these situations involve potential harm to others?

This would depend on the nature of the recovery advocacy activities. There are many Recovery Coaches who are also very involved in the new recovery advocacy movement who experience very little conflict in these roles.

Conflicts could arise if the Recovery Advocate/Coach:

⇒ Used the Recovery Coach role to push those they coached into advocacy activities

⇒ Used the Recovery Coach role to push particular ideological propositions

⇒ Took such extreme, controversial positions that individuals and families were not comfortable having the individual serve as their Recovery Coach

Such potential conflicts are best dealt with via supervision.

Conflict of Interests

Tony works as a Recovery Coach and also owns Recovery Housing. In his Recovery Coach role, Tony frequently comes across people who need sober housing.

How could Tony best handle any real or perceived conflicts of interest? What organisational policies should address the issue of conflicts of interest?

Referring clients to his own recovery housing raises potential conflicts between the client's best interests and Tony's own financial interests.

Even the *perception* of bias could hurt Tony's reputation as a Recovery Coach and the reputation of the organisation he is working for.

Tony would be better advised to refer his clients to other recovery housing or to offer a list of all available resources without any interventions that would direct individuals to his own housing.

In addition, Tony may want to assign a "manager" to do all screening for potential residents to his housing, so he not only doesn't refer his own clients, but also doesn't make decisions related to their suitability.

At a minimum, Tony will want to make sure that the people he serves always have a choice of resource options and that he does nothing to steer people toward institutions in which he has a financial interest.

Role Integrity

Andrea is in long-term recovery, works as a volunteer Recovery Coach and also works full time as a drug worker.

What problems could be posed by Andrea bringing a clinical approach from her worker role into her volunteer role as a recovery coach? How can the organisation/supervisor help "workers as peers" keep their professional and coaching roles separate?

There are lots of potential problems in this situation.

First, if Andrea drifts into her worker role as a volunteer, she could be providing counselling without the client protections and supports built into traditional treatment agencies, e.g. informed consent, legal confidentiality, clinical documentation, clinical supervision and liability insurance.

Assuming Andrea's client is still in treatment, the therapy Andrea provides may be counterproductive to the therapy the client is already receiving.

And perhaps most importantly: during the time Andrea is doing counselling, the client is not receiving needed recovery support.

Compassion Fatigue

Elizabeth has volunteered as an Recovery Champion for the past 2 ½ years, supporting the recovery processes of individuals with very severe, complex and long-term substance use disorders.

In recent months, she has noticed that she is bringing less energy and enthusiasm to her

volunteer work and is dreading seeing some of those with the greatest needs.

How should Elizabeth respond to this fall in motivation for Recovery Coaching?

Elizabeth is exhibiting signs of burn out, which need to be acknowledged and addressed in supervision.

Elizabeth may need a break in her coaching activities, might consider reducing hours, an altered level of problem severity of those with whom she works or might want to consider co-coaching for a period of time.

It might also be a good time for Elizabeth to refresh her stress management skills via training or her own personal coaching.

Those volunteering as Recovery Coaches need the option of taking sabbaticals, but they also have a responsibility to recognise this need early enough to plan an orderly transition process for those with who they are working with.

Conduct in Coaching Relationships **Choice/Autonomy**

Jenny works as a Recovery Coach in a women's programme that is known for its assertive, some say aggressive, style of outreach to women referred from the child welfare system.

The women Jenny attempts to engage in treatment and recovery support are very ambivalent in the early stages of engagement - not wanting to see her one day, thrilled to see her the next.

The question is: When does no really mean no? What is the line between assertive outreach and stalking? How do we balance a person's right to choose with the knowledge that rational decision making is often destroyed through the process of addiction?

The ethical tension here is between the values of autonomy and choice versus paternalism and domination.

What complicates resolving this tension is working with people who, because of their addiction, may not be able to make sound choices leaves the Recovery Coach questioning whose free choice they should listen to "Dr.Jekyll's or Mr Hyde's."

In short, what do we do with someone who one moment wants recovery and the next minute doesn't?

The Recovery Coach's job - particularly in terms of outreach - is to create motivation for recovery where little exists and to guide the person through the early stages of recovery until they can make choices that support their own best interests.

At a practical level, that means that "no" ("I don't want you to contact me anymore") has to be said several times to different people on different days before we give up on someone for the time being.

If after a reasonable period of time the answer is still “no” then we leave, but with the assurance that we will be available in the future if the person should *choose* to get in touch.

If we accept that recovery is voluntary this means not only freedom to choose different pathways of recovery but also the freedom to choose not to recover.

Choice/Autonomy

Carl has been assigned as a Recovery Coach for Steve, but four weeks into this process, Steve asks to change his Recovery Coach as he is having difficulty relating to Carl.

Do those receiving recovery coaching have the right to select their own Recovery Coach?

Mismatches between Recovery Coaches and their *coachees* are inevitable, just as mismatches occur between workers and service users.

A match between a Recovery Coach and those who they work with may be even more important because of the increased time spent together and the potential length of the relationship.

Mismatches are best acknowledged early and either resolved through changes in coaching style or reassignment to a new Recovery Coach.

The effects of recovery coaching come from personal influence, not from any power or authority in the role. An essential principle of peer-based recovery support is that those receiving it get to define what they want in a “peer.”

Evaluating and resolving potential mismatches is a key part of good supervision. It is important that Recovery Coaches are supported through these situations.

Emotional Exploitation

Pete is a highly sought out Recovery Champion. He is charismatic and works very hard in his support activities.

As his supervisor, you have one area of concern about Pete. He is emotionally possessive of those he works with, very critical of other service providers who don‘t live up to his standards and competitive with the sponsors of those he coaches.

Many people Pete works with do very well in their recovery, but they seem to see the source of their recovery as Pete more than from a programme of recovery.

You are worried that the people Pete works with have developed an emotional dependency in their relationship with him. What ethical issues are raised by this situation?

There are several core values that apply to this situation, e.g., humility, respect, tolerance, autonomy, capability.

Cultivating dependency actually weakens people’s capacity for self-sustained recovery. Such a style may meet Pete’s needs, but not the needs of those he coaches.

This approach harms clients, overshadows other Recovery Coaches who may be doing much more effective work and often end up harming the organisations credibility.

A degree of dependence is normal early in the Recovery Coach relationship, but it is vital to encourage people to transfer this dependency from an individual to developing a larger and more sustainable recovery support network.

Friendship

Mark volunteers as a Recovery Coach and shares a lot in common with Tom, the person who Mark works.

Over a period of months, Mark and Tom have developed quite a friendship and now share some social activities (e.g. fishing) beyond the hours in which Mark works as Tom's Recovery Coach.

Are there any ethical issues raised by this friendship?

Friendships may develop within the context of recovery coaching, but the thing that distinguishes the Recovery Coach relationship from other social relationships is the service dimension.

This means that recovery coaching relationships are not fully two-way, in the way that friendships are.

Recovery coaching is about focusing on the need of the person being coached. Because of this ethical problems could arise if:

1. The friendship was initiated by Mark to meet his needs and not Tom's needs
2. Problems in the got in the way of Mark's ability to provide effective coaching support
3. The friendship with Mark stops Tom from developing other supportive relationships within the recovery community and the larger community

Recovery coaching relationships will, by definition, be less hierarchical and more two-way than will relationships between an addiction worker and his or her client.

It's not that one is right and the other is wrong; it's that the boundaries must be role-appropriate.

Where a developing friendship is getting in the way of effective Recovery Coaching , it is the responsibility of the Recovery Coach to raise this concern with his or her supervisor. And to review this situation with the Recovery Coach, the supervisor, and the client.

One potential option is to assign and transition the client to another Recovery Coach to avoid potential problems with a dual relationship.

Sexual Exploitation

You supervise Recovery Coaches and it comes to your attention that Josh, one of your Recovery Coaches, is sexually involved with a person he is coaching.

How would these issues differ depending on:

1. *The age or degree of impairment of the person receiving support?*
2. *Whether this was a person currently receiving, or a person who had previously received, recovery support?*
3. *The time that had passed since the coaching relationship was ended?*

Would you view this situation differently if the relationship was not with the main client, but with a family member or friend who was involved in the support process? Could the Recovery Coach or organisation face any legal problems related to this relationship?

The relationship between the Recovery Coach and *coachee* is not a relationship of completely equal power.

The vulnerability of those seeking coaching support and the power of the Recovery Coach role offer situations where a Recovery Coach could exploit the relationship for his or her personal, emotional, sexual or financial gain.

It is that power difference that makes an intimate relationship between an Recovery Coach and those they work with ethically inappropriate.

The harm that can come from such relationships ranges from injury to the person/family being served, injury to the reputation of the Recovery Coach and damage to the reputation of the organisation.

The prohibition against intimate relationships between a Recovery Coach and service recipient extends to the family and intimate social network of the person being coached.

As for relationships with people who previously received Recovery Coaching, services are setting a period of time (mostly in the two year range) in which such relationships would still be improper.

The key here is to evaluate *exploitive intent*.

For example, a Recovery Coach could be involved with someone he or she met in the recovery community who they discover once received coaching support Recovery Coach's organisation.

The Recovery Coach did not work at the organisation at the time, never served as the person's Recovery Coach, had no knowledge of the person's status as a service recipient and did not use the influence of their role to initiate the relationship. In short, there was no exploitive intent.

Financial Exploitation

Alisha is providing Recovery Coaching services to a very wealthy individual and his family.

She has repeatedly turned down the family's offers of money for her services and communicated that her services are provided without charge.

When Alisha arrives for her coaching session today , the family announces they have discussed it among themselves and that they want to pay Alisha‘s tuition fess for College.

What should Alisha consider in her response to this offer?

Money changes relationships. Accepting this offer would threaten the integrity of the coaching relationship.

Alisha should express her appreciation for the family’s offer, but explain that she must say no, because accepting of this gift while the recovery coaching is still going on could affect that relationship.

The family’s feelings can be further protected if Alisha can inform them that there is an organisational policy that prevents any Recovery Coach from accepting any gifts of substantial value.

The situation might be viewed differently if, some time after the support relationship was ended, this same family wanted to donate money to Alisha’s education or to the organisation.

The key here is that the vulnerability or gratitude of the family is not used in an exploitive manner.

All offers of gifts to a Recovery Coach during or following a support relationship should be discussed with the supervisor.

Gifts

Marie works as a Recovery Coach for an addiction treatment service. Her job is to provide recovery support to people discharged from addiction treatment.

She works mainly with people from BME backgrounds and most of her work is done through home visits.

The family she is visiting presents her with an elaborate gift as a token of their appreciation for her support, as is normal within their culture.

The problem is the service that Marie works for prohibits any staff member accepting a personal gift.

Marie is concerned about the consequences of accepting the gift, but is also concerned that refusing the gift could harm her relationship with the family.

What are the ethical issues here? What should Marie do?

Ethical decision-making must take into account different cultures. What this means is that the pros and cons of any action must be evaluated in the cultural context in which it occurs.

What might be unethical in one cultural context (e.g. accepting a gift) might be not only ethical but essential in maintaining the support relationship in another.

In this case, Marie could accept the gift in the name of the service, rather than for herself, not breaking the service policy, and leaving the coaching relationship intact.

Marie could report the gift to her supervisor and display the gift in a common area of the service for all to enjoy.

What would be equally appropriate would be for Marie to raise the broader issue of the need for more flexible interpretations of this particular policy when working with different cultural groups.

Recovery Coaches working across cultural contexts need policy flexibility and good supervision to protect the support relationship.

Boundaries of Competence

During a visit today with Claire, a person you are coaching, she asks you what you think about the effects of anti-depressant medications on recovery from alcoholism.

She is clearly not sure about the medication she is being prescribed, and your first inclination is to tell her to forget the medication and get to more meetings.

What are the ethical issues in this situation? How would you respond?

It is quite appropriate for the Recovery Coach to listen to Claire's concerns about her medication, encourage her to talk to her GP about these concerns and link her to resources to get additional information about recovery and anti-depressant medications. It is not appropriate for the Recovery Coach to offer their opinion or advice about any prescribed medication. To do so would be to move beyond the Recovery Coach's education, training and experience. Even if the Recovery Coach is medically trained, their responsibility in coaching role is to link Claire to medical resources that she can consult about this question, rather than to provide that information directly.

Under no circumstances should an Recovery Coach ever advise anyone to stop taking a prescribed medication.

If the Recovery Coach has concerns about the effects of some medications on Claire's recovery, their role is to link Claire to someone with expertise to discuss these issues, e.g. a doctor trained in addiction medicine.

When to Refer

Lucy has attempted to engage Joanna in the recovery coaching process for the past five weeks, but the chemistry between the two of them seems to have gone from bad to worse.

All efforts to work through these difficulties in supervision have not improved the situation.

At what point should Lucy acknowledge this situation to her supervisor and Joanna and try to get another Recovery Coach for assigned to Joanna?

The value of honesty means that Lucy needs to acknowledge to Joanna and her supervisor her concerns about the relationship difficulties, and raise the question of whether Joanna would be

better supported by a new Recovery Coach.

This question should first be raised with the supervisor and, if efforts to improve the relationship fail, then a meeting between Lucy, Joanna and the supervisor may be in order.

The agenda is to avoid harm to Joanna from a relationship mismatch and to establish a more effective coaching relationship, but to also avoid any feelings of abandonment Joanna might experience by the suggestion of a new Recovery Coach.

Discretion

Amanda works as an Recovery Coach for women and their families who are participating in a local women's treatment program.

Amanda frequently hears from those she coaches things like, "I want to tell you something, but you can't tell my family" or "I want to tell you something important about Sarah, but I don't want you to tell her I told you."

What ethical issues are raised by the Recovery Coach being in the middle of such communications? How should Amanda handle such communications?

Communication ground rules need to be set at the beginning of the coaching relationship.

The values of discretion, respect and fidelity demand that the Recovery Coach does not disclose information beyond those established ground rules.

Those ground rules include a review of circumstances in which disclosures will be made, for example supervision, medical emergencies, imminent threat of harm to self or others.

Before agreeing to the requested promises above, Amanda should review these communication ground rules and the disclosure exceptions.

Discretion versus Duty to Report

A person for you are supporting as a Recovery Coach discloses to you that he has been using the past week with another person who lives with him in a local recovery house. The disclosure makes it clear that the other person provides the drugs and may be dealing in the house and in the wider community. Further complicating the situation is the fact that the manager of the recovery house is a member of your board of directors.

Do you have an ethical responsibility to protect this disclosure or to report it to the house manager?

Would a Recovery Coach have a similar responsibility to report a doctor who is over-prescribing in the community, when the source of that information was from those he or she was coaching?

Such information could not be ethically reported without permission for such disclosure.

In both cases, the Recovery Coach could discuss with the disclosing individual whether they think that the information should be passed on to responsible authorities, and whether the individual is comfortable passing it on themselves or if they would want you to do it (without disclosing his or her identity as the source).

This process would address the threat to the recovery house environment and the community without breaking the promise of confidentiality.

Threat to Community

When you arrive for a home visit with Joe Smith, a person you are coaching, you find him drunk. He says he can't talk to you now because he has to return to the pub he just left to pay off a debt. Joe has his car keys in his hand. What do you do?

Use all of your persuasion skills to keep Joe out of the car. Ask Joe to give you the car keys and let him know that, if he gets in the car, you will have no option but to call the police.

If he gets in his car and drives away, call the police and informing them that you observed a drink man by the name of Joe Smith get in a car, and give a description of the car and your location.

Do not identify yourself as Joe's Recovery Coach and do not identify Joe as a service recipient of the organisation. The challenge here is to address the threat to public safety without disclosing Joe's status as a service user.

Personal Bias

Scott has worked hard to educate himself about medication-assisted recovery since starting as a Recovery Coach. But he still has very negative feelings about methadone in spite of all the research he has read about it. It's not a head thing; it's a gut thing.

Karen, another Recovery Coach, has similar negative feelings about very religious pathways of recovery because of the number of people she has known in AA for who religion alone did not work as a framework for recovery.

Describe how the personal biases of the Recovery Coaches could result in harm or injury to multiple parties.

How could Scott separate what he knows about methadone (the facts) from his feelings (opinions) about methadone?

We may have all sorts of biases about different addiction treatments, but in the Recovery Coach role we have a responsibility to outline *all* the choices available as objectively as possible and support each persons choice of the option that seems best for them at this *moment.*

Being negative about a particular method of treatment or recovery pathway could prevent a client from finding what works most successfully for them. Scott and Karen should continue to acknowledge and discuss their biases with their supervisor.

Scott and Karen may not need more information and training on alternative treatments and pathways to recovery as much as they need direct contact with people who have successfully used these methods to achieve long-term recovery.

As experiential learners, many Recovery Coaches won't accept research findings unless they experience this evidence face-to-face.

Conduct in Relationships with other Service Providers

Responding to Unethical Conduct

Susan, a person for whom you have been supporting as a Recovery Coach for the past month, discloses to you today that she is in a sexual relationship with the worker she is seeing at a local addiction treatment service.

What are the ethical issues presented by this situation? How would you respond?

There are several issues raised in by this situation. The first is to acknowledge to Susan that such a relationship is a breach of professional ethics, to ask whether she wants a referral to a different treatment service or worker and whether she wants to file a formal complaint.

Linking Susan to such resources would be a natural Recovery Coach function, as would supporting Susan through this process.

Depending on the policies of your organisation you may also need to let Susan know that you will have to report this disclosure to your supervisor who may also be bound to report it further, with Susan's name or without it.

All reports of ethical breaches by service professionals in the community that come to the Recovery Coach's attention should be communicated to the Recovery Coach's supervisor.

Representation of Credentials

Gary works as a Recovery Coach doing post-treatment telephone monitoring. Gary has said in his interactions with the larger community that he is working as a "counsellor". He also makes mentions a lot his plans to do a post-graduate degree, but Gary only completed two years of his College course and has not been involved in any kind of education for more than ten years.

What ethical issues are raised by this situation?

The values of honesty and credibility mean that a Recovery Coach should be truthful about their level of education, training and experience.

The supervisor should tell Gary that he or she has heard about what he has been saying and stress why it is important that, if true, these communications stop and be replaced with an accurate description of Gary's role and educational qualifications.

This could be accompanied with a broader discussion of how Recovery Coaches establish credibility and legitimacy within the larger community.

Would you view the situation above any differently if Gary accurately represented his role and education, but misrepresented the length of his recovery and his level of involvement in AA, NA or another recovery mutual aid group?

Both would undermine his capability and credibility as an Recovery Coach, the value of authenticity of voice is important here.

The following guideline is recommended: "Filter decisions related to disclosure of your addiction history, your recovery status and your pathway(s) of recovery initiation and maintenance through the values of honesty (tell the truth), discretion (protect your privacy), and for those in Twelve Step recovery, the tradition of anonymity at the level of press." (White, 2006b)

Role Clarity/Integrity

George has worked as Larry's Recovery Coach for the past two months. Today, Larry asks George if he will be his NA sponsor.

George has a long history in NA and a long history of sponsorship activities, but agreeing to this would mean that he would be both Larry's Recovery Coach and sponsor.

What harm and injury (if any), and to who, could result from such a dual relationship?

Failure to maintain boundary separation between the roles of Recovery Coach and sponsor could harm Larry, George, others receiving coaching services, the relationship between George's organisation and the local recovery community and the larger community.

The effect of dual relationships is often to "water down" both relationships.

Here are some suggested operating principles (Excerpted from White, 2006c).

1. Performing sponsorship functions (e.g., making a Twelve Step call as an AA member, meeting with sponsees) during coaching sessions is a violation of Twelve Step Traditions and professionally inappropriate (beyond the scope of most Recovery Coach job descriptions and explicitly prohibited in many).
2. Performing sponsorship functions through the Recovery Coach role could weaken local sponsorship practices and diminish community recovery support resources by replacing such natural support with the formal support of local services.
3. Seeking reimbursement for sponsorship functions performed while recovery coaching is, at best, a poor stewardship of community resources and, at worst, fraud.

4. Unclear roles and a conflict resulting from a mixing of sponsorship and coaching functions could inflict injury on clients/families, service workers, services and the community.

5. The Recovery Coach role is a form of connecting tissue between professional systems of care and communities of recovery, and between professional helpers and sponsors. When people abandon this middle ground and move too far one direction or the other, the connecting function is lost.

Conduct in Relationships with Local Communities of Recovery

Role Clarity/Integrity

Phil, who is a paid Recovery Coach, has a practice of linking the people he coaches to recovery communities by taking them to, and participating with them in, 12 step meetings.

A complaint has come to the organisation agency about Phil "getting paid" for the time he is in meetings and that this constitutes accepting money for Twelve Step work.

What are the ethical issues here? How could Phil more clearly separate his paid job from his NA service work?

The values of stewardship require that Recovery Coaches carefully allocate their time.

Phil should be careful to separate recovery coaching hours from hours spent in recovery support meetings so as not to receive payment for time spent in meetings.

The Recovery Coach function stops at the doorway of recovery support meetings so Phil should introduce his client to other recovery support group members for 12 stepping.

Discretion

You are working as a Recovery Coach attached to a treatment agency. You take an client, Anna, to a local recovery support meeting and also stay for the meeting.

At the meeting, Anna discloses information she has not told her worker. Is the information you have heard confidential, or do you have an obligation to report it to the worker?

Information disclosed at the meeting may not be shared outside the meeting. To do this would violate recovery mutual aid values and place the Recovery Coach in the role of "undercover agent" at such meetings.

You could encourage Anna to share this information with her worker.

This is another example of the strong need for ongoing supervision and support to help the Recovery Coach deal with complex issues regarding his or her role.

Discretion

Rob has been in and out of treatment and NA multiple times and has an on-off relationship with you as a Recovery Coach.

Today, you bump into Alan, one of Rob's former NA sponsors. Alan's first comment to you is, "How's is Rob doing?"

How do you respond? Would this be an appropriate disclosure or simply gossip?

Do the confidentiality guidelines that cover treatment relationships (and which would not allow any disclosure to Alan's question) also apply to the recovery coaching relationship?

Your response should be guided by your policies on confidentiality and discretion and the agreement about disclosure of information you negotiated with Rob at the beginning of your coaching relationship.

The key thing here is the value of fidelity: to keep our promises.

Anonymity

Hugh is a long-time AA member, a recovery advocate and has recently gained employment as a Recovery Coach.

In his earlier recovery advocacy work, Hugh has always been very careful in identifying himself publicly as a "person in long-term recovery" without mentioning his AA affiliation.

Today, Hugh is on a panel at a local conference to talk about the pilot Recovery Coaching project in which he works.

The conference is being covered by local media who ask to interview Hugh. One of the reporters asks Hugh if he is a member of AA.

What are the ethical issues involved in this situation? How should Hugh respond? How would this be different if Hugh was in different mutual aid group that did not have a tradition of anonymity?

Hugh should *not* disclose his membership of AA. This would violate AA's anonymity tradition as well as potentially be seen as a personal endorsement of a particular mutual aid group.

Such a disclosure, and the potential controversy coming from it, could interfere with Hugh's service relationships, isolate Hugh from the local AA community and harm the relationship between Hugh's organisation and the local AA community.

If Hugh was not in AA or another Twelve Step programme, there would be no explicit anonymity guideline, but he would still need to be cautious in any disclosures at the level of press

Predatory Behaviour

Helen works as a Recovery Coach for women who are just finishing rehab. One of her responsibilities includes linking these women to local recovery mutual aid meetings.

Many of the women Helen works with have been sexually abused as well as having long histories of violent relationships. Helen is aware that predatory behaviour ("Thirteenth Stepping") is common in some recovery meetings.

To what extent is Helen responsible for preparing the women to deal with such behaviour or protecting them through linking them to meetings with a strong group conscience?

Helen needs to recognise the potential of her clients to be harmed in groups with little "group conscience." She should assist her client in finding meetings with a climate that is safe and supportive.

Potential Iatrogenic (unintended harm) effects of Recovery Coaching

Ellen, a highly respected elder in the local AA community, is expressing criticism of Recovery Coaches and the broader recovery support services offered by a local organisation.

It is Ellen's position that such roles and services will undermine the importance of sponsorship and weaken the service ethic within the local recovery community. How do you respond?

Ellen should be invited to discuss her views on recovery coaching and shown the statistics and local experience related to the role of recovery coaching in successful long-term recovery.

Ellen should also be asked to contribute her ideas on how the Recovery Coach role could be designed and supervised to make sure it enhances, rather than undermines, the service ethic within the local AA community.

Role Integrity

Martin is an elder statesman in AA who offers to volunteer as a Recovery Coach.

Martin's approach to coaching is to do what he does as a sponsor - help people work the steps and develop a life of sobriety and serenity.

What harm, if any, could come from this merger of the sponsor and Recovery Coach roles?

The primary harm in this merger of Recovery Coach and sponsor roles would be to broader recovery support needs e.g. housing, medical needs, that would be covered in a fully developed Recovery Coach role, but not addressed in the sponsor role.

Harm to the client could also result from the role confusion between the Recovery Coach and sponsor roles.

Summary

This paper describes a model of ethical decision-making for Recovery Coaches and their supervisors and identifies some of the emerging ethical issues in the delivery of peer-based recovery support.

Approaches to ethical decision-making will continue to evolve as recovery support services become more formalised and the collective experience of Recovery Coaches and their organisations grows.

Taken from a paper by William L. White, MA & the PRO-ACT Ethics Workgroup: Howard “Chip” Baker, Babette W. Benham, Bill McDonald, Allen McQuarrie, Skip Carroll, John Carroll, Beverly J. Haberle, Heidi Gordon, Kathy McQuarrie, Maura Farrell, Harvey Brown, Marilyn Beiser, Deborah Downey, Esq., Carole Kramer, Fred D. Martin, Leslie M. Flippen, Nadine Hedgeman, D.C. Clark, Jerri T. Jones, Larrissa M Pettit, Darryl Chisolm, LeeRoy Jordon, and Hassan Abdul Rasheed. With a discussion of legal issues by Renée Popovits & Elizabeth Donohue.

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Recovery Coaching Curriculum

By engaging the many facets of the recovering community, we awaken the spirit of peer coaching (J. Daniel Payne, 2009).

PREPARATION

Materials:

⇒ Laptop with projector

⇒ Pens and paper

⇒ Name tags

⇒ Evaluation forms

⇒ Sign-in sheet

Room Characteristics: The room should have enough space for comfortable movement and the formation of larger groups.

Class Size: Sessions should include a minimum of 4 and maximum of 18 trainees.

Sign-in Sheet: Create a sign-in sheet to track attendance and get contact information for the participants. Unless you already have this information, we recommend that your sign in sheet include at least the participant‘s name, e-mail address and phone number.

Evaluation Forms: Ask participants to complete an evaluation form at the end the training.

Refreshments: Given the length of the training, yous should provide refreshments and lunch so that the group can stay together throughout the session.

TIMETABLE

Welcome	**20 minutes**	**10.00 to 10.20**
The Recovery Coach	**50 minutes**	**10.20 to 11.10**
Break	**20 minutes**	**11.10 to 11.30**
The Coaching Process One	**50 minutes**	**11.30 to 12.20**
The Coaching Process Two	**40 minutes**	**12.20 to 1.00**
Lunch	**45 minutes**	**1.00 to 1.45**
Walking the Talk	**45 minutes**	**1.45 to 2.30**
Recovery Pathways	**45 minutes**	**2.30 to 3.15**
Break	**15 minutes**	**3.15 to 3.30**
Team Approach	**45 minutes**	**3.30 to 4.15**
Wrap Up	**15 minutes**	**4.15 to 4.30**

WELCOME AND INTRODUCTIONS

TIME**:** 20 minutes

PURPOSE: Provide participants with an overview of the workshop and give them an opportunity to begin to develop a rapport with the trainer(s) and with each other. This time also sets the tone for the entire training by identifying the goals and objectives of the course.

RECOVERY COACH AND PARTICIPANT INTRODUCTIONS:

Trainer(s) should introduce themselves and describe their qualifications for instructing the course. Then, going around the room, participants should share their name and what they hope to gain from taking this course.

GROUND RULES

Create a welcoming environment in which clear expectations and ground rules are established. Think carefully about how you will create this welcoming environment, what the session‘s ground rules and expectations will be, and how you will communicate them.

The following ground rules are suggested:

⇒ There are no right or wrong answers to questions or approaches to exercises

⇒ Our experience, strength, and hope qualify each of us to be here

⇒ We honour respect each other and encourage openness and honesty

⇒ If you are hesitant to participate, we challenge you to actively join in the process

⇒ If you are inclined to speak more often or more forcefully than others, or to argue with others regarding their viewpoints, instead, try to participate in a manner that will welcome input from others, including those with whom you may disagree

⇒ Respectful listening is as, or more, important than verbal participation

⇒ Actively engage in the session exercises so that you can practice the skills needed as a Recovery Coach

⇒ Sharing personal experiences is welcomed but should be limited to experiences that are specifically related to what is being learned or might otherwise be useful and supportive to other participants

⇒ All participants should respect the beliefs of other participants and recognise their right to hold them

⇒ Out of respect to each other, refrain from speaking in a manner that may offend others or from sharing experiences that another participant might feel are inappropriate to share in this setting

⇒ Be open-minded throughout the training. It will help you maximise the benefits from the training and will also help build an environment of trust

⇒ Personal experiences that are shared during the training should not be shared or discussed with individuals who are not participating in this training, unless the individual who shared them expressly gives you permission. As a rule, when it comes to personal experiences, what is said here stays here

NUTS AND BOLTS

⇒ Mobile phones should only be used during breaks and should must be turned off throughout the session unless absolutely necessary

⇒ Return from breaks on time. Late arrivals distract and delay the rest of the participants.

GOALS AND OBJECTIVES OF TRAINING

⇒ Fulfil personal growth through enhancing recovery capital

⇒ Gain an expanded knowledge of recovery resources available to peers

⇒ Identify and develop the skills necessary to be effective as a Recovery Coach

⇒ Understand your own recovery capital and how you can use it to help others

⇒ Give effective expression to your passion for recovery by engaging and serving others who are seeking a pathway to recovery

⇒ Experience the value of one recovering person helping another.

⇒ Carry the message of recovery - the true hope and faith recovery has to offer those we encounter - more effectively

⇒ Replace stigma with a helping hand, hope for the future, and a vision of recovery

⇒ Become aware of the many helping hands of the recovering community.

⇒ Gain more knowledge of the many pathways to recovery and how to incorporate it all into a peer‘s recovery action plan

⇒ Realise how you can make a difference in the lives of your peers!

SESSION ONE: THE RECOVERY COACH

TIME**:** 50 minutes PURPOSE: To provide participants with an overview of the role of the Recovery Coach and the skills and qualities that are required.

EXERCISE: DISCUSSION

⇒ **What is the job of a Recovery Coach?**

⇒ **What skills are necessary to be an effective recovery coach?**

⇒ **What skills do you think you can bring to the role?**

Examples:

- Empathy: Able to understand and share the *coachee's* feelings and perceptions
- Listening: Able to set aside your thoughts and opinions to hear what the *coachee* is really saying
- Understanding of your own recovery pathway
- Communication: Able to combine listening with thoughtful responses, sharing and suggestions that are sensitive to the *coachee's* perceptions, feelings and level of awareness
- Constancy: Ability to stick with a *coachee* through thick and thin without judgment
- Problem-solving: Ability to explore problems with *coachees* and work with them to develop solutions
- Strength Orientation: Focus on the positive, recovery capital and solutions and opportunities as opposed to problems and barriers. See and communicate not only what is, but what can be

⇒ **Qualities: What distinct characteristics qualities should a Recovery Coach have?**

Examples:

- Open-mindedness to see new pathways
- Experience and involvement in your own pathway
- Inward qualities, such as care, giving, love and compassion
- Honestly willing to serve recovery
- Ability to provide constructive feedback

⇒ **Values: The importance of personal ideas**

Examples:

- Walk the walk, not talk the talk
- Do what you say, not what I say
- Live by recovery

- Have integrity
- Recognise boundaries

⇒ **Principles: The truth that serves as your foundation**

Examples:

- Live by all of the above (i.e., skills, qualities, values)
- Stand by your beliefs
- Remain true to your pathway and your recovery
- Recovery first
- Positive living

⇒ **Please expand:**

The lists provided here is merely a starting point. Personal experiences may only enhance and build on your skills, qualities, values, and principles.

EXERCISE: DISCUSSION

⇒ **What are the opposites of the above?**

⇒ **Discuss co-dependency, enabling, friendship, and the risks these represent for the Recovery Coach**

⇒ **What are the legitimate roles of a Recovery Coach?**

⇒ **How will I know when I'm not doing the above?**

⇒ **What should I do if I see other Recovery Coaches not following the above guidelines?**

⇒ **What would I want other Recovery Coaches to do if they saw me not following the above guidelines?**

The Role of the Recovery Coach: To assist and advocate for recovery

- Use situational examples to assist an individual in building recovery capital

Definitions:

Recovery Capital: Long-term recovery provides us with recovery capital, which - to name a few - includes friends, allies, supports, relationships, careers, knowledge, education, and spiritual experiences.

Social Capital: Presence of a social network or social support group and the people or groups willing to provide social support.

Physical Capital: Tangible resources, such as material wealth and transportation.

Human Capital: Education, spiritual experience and vocational skills.

Proven Coaching Techniques

Strength-based approach

Emphasise an individual‘s recovery capital strengths and use it to build and improve areas for growth.

Think of recovery capital as a tree trunk. Strengthen it to grow limbs of other capital.

Person-centered approach

Embrace personal views of the individual, allowing them to provide input into their own recovery.

Consider using the **Readiness Ruler** to assist *coachees* in resolving problems

What does a Recovery Coach do?

- Define: How far do you go to help a person in recovery?
- Boundaries: Defining boundaries in-depth, which is covered later in the training, is very important.
- How are Recovery Coaches matched with *coachees*?
- Consider gender, race, religion, and age. Even if it is not a perfect match, it depends on the Recovery Coach‘s open mind.
- Who is to say that these are barriers of recovery?
- What are the personal preferences?
- It has been proven that opposites work in recovery.
- Work on a case-by-case basis.

SESSION TWO: THE COACHING PROCESS ONE

TIME**:** 50 minutes

PURPOSE: To provide participants with experience of a coaching relationship and to introduce recovery planning.

How do Recovery Plans differ from Treatment Plans?

- Recovery Plan is developed by the client, not treatment professional.
- Recovery Plan is based on a partnership between the professional and the client rather than a relationship between the expert and the patient.
- Recovery Plan is broader in scope, bringing - in addition to drug and alcohol problems - such areas as physical health, education, employment, finances, legal, family, social life, intimate relationships and spirituality.
- Recovery Plan consists of master plan of long-term recovery goals, marking progress along the way.
- Recovery Plan draws strength and strategies from the collective experience of the recovery community.

EXERCISE: ROLE PLAY WITH SCENARIO

Coachee: Ben, who is 19 years old, has been able to achieve no more than 45 days of abstinence/recovery but has repeatedly relapsed for a period of one year.

He lives with his mother, continuously visits his “old friends” and hangs out in places where drug use is apparent.

Ben typically attends 12-step recovery meetings twice each week. He has expressed a desire for recovery.

When he last used, he was charged with possession and is now facing prison time.

He expresses his concerns that he won‘t find friends in recovery and that he has no job.

He continuously focuses on the differences between him and other people in recovery.

(Remember, this is just one example; the training may consist of a variety of real-life examples. The trainer should use his or her experiences)

⇒ **What worked and what didn't? What‘s the learning process?**

⇒ **List the strengths and needs recognised**

⇒ **Take inventory of strengths, needs, and goals**

⇒ **Develop a recovery action plan based on inventory of individual's needs.**

⇒ **How do you stay linked? Explore options and factors, such as reminder calls, checking in, and the recovery community organisation environment. Offer other examples**

⇒ **Define and emphasise boundaries**

⇒ **What lengths are you willing to go to help?**

⇒ **Who does the Recovery Coach "answer" to? Discuss the supervisor's role**

SESSION THREE: THE COACHING PROCESS TWO

TIME**:** 40 minutes

EXERCISE: ROLE PLAY WITH SCENARIO

Following an initial meeting, the relationship between the Recovery Coach and Ben has grown.

Ben has now been in recovery for more than 30 days. He is staying clean but heavily reliant on the Coach.

The Recovery Coach picks Ben up for meetings and buys him coffee and, sometimes, dinner.

Ben frequently asks the Coach for money. The coach has "loaned" Ben more than £100.

The Coach sees certain areas of Ben's life in which he is beginning to fall back into his old ways.

The Coach will not say anything to Ben because Ben can get very angry, and the Coach does not want to hurt his feelings.

(Remember, this is just one example; the training may consist of a variety of real-life examples. The trainer should use his or her experiences)

⇒ **What would *you* do?**

⇒ **Discuss several examples, some of which may be the "wrong" way and some the "right" way**

NOTE: Make sure to emphasise that the relationship and extent of support given to the *coachee*, the boundaries etc. are always different depending on each situation.

LUNCH : Round table discussion on the Pathways to Recovery (list and define) 45 minutes

SESSION FOUR: WALKING THE TALK

TIME**:** 45 minutes

PURPOSE: To discuss and emphasise the importance of self-care and maintaining your own recovery. And to explore the differences between coaching and mutual aid meetings.

REMEMBER: Your recovery comes first.

EXERCISE: IN GROUPS DISCUSS

⇒ **Getting "burned out"**

⇒ **Remedies**

⇒ **Maintaining balance**

⇒ **Checking out**

⇒ **Realising that recovery coaching is not just meetings or sponsorship**

⇒ **Understanding that peers are not "sponsored" individuals**

⇒ **How recovery coaching can enrich and support your recovery but is not a replacement for personal recovery**

⇒ **Understanding that peers are not support groups**

Have open conversations on experiences on all the above topics.

NOTE OF CAUTION: Isolation can occur when working with people in recovery on a daily basis. People may want a break from recovery (or addiction). But, we cannot take a break from our own recovery!

SESSION FIVE: RECOVERY PATHWAYS

TIME**:** 45 minutes

PURPOSE: To explore and gain an understanding of different recovery pathways.

Invite some speakers to bring the spirit of different pathways to the training.

⇒ **Discuss scenarios of the *coachee* following a pathway to recovery that is different from the recovery coach's pathway. What do you do?**

⇒ **How do you facilitate recovery coaching effectively? Remember skills, qualities, values and principles.**

⇒ **Define and explore what is available in your local recovery community**

SESSION SIX: TEAM APPROACH

TIME**:** 45 minutes

PURPOSE: To explore the benefits of taking a team-based approach to recovery coaching.

⇒ **Use other Recovery Coaches**

⇒ **Pass the *coachee* around!**

⇒ **Explore more pathways (e.g., reliant, self-reliant, and autonomy)**

⇒ **Have team meetings**

⇒ **Help more than one coach to become familiar with everyone**

⇒ **Teach peers the sense of fellowship**

⇒ **Keep peers from becoming attached to one person.**

⇒ **Match the coach with other *coachees***

⇒ **Allow flexibility**

⇒ **Prevent burn out**

⇒ **Take care of high maintenance clients**

⇒ **Work together, as we do in our own recovery**

SESSION SEVEN: WRAP UP

⇒ **Revisit training objectives**

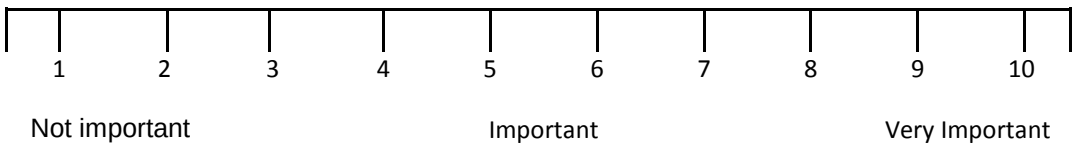
⇒ **Evaluation Forms**

APPENDIX ONE

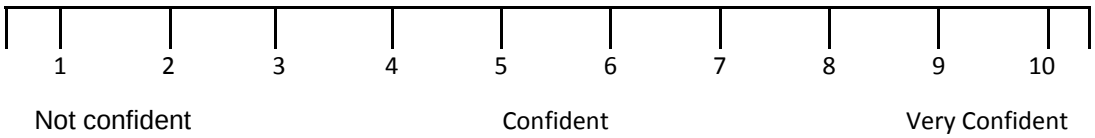
The Readiness Ruler

The ruler helps you both be clear about how important *coachees* feel it is to make a specific change or take a particular action, how confident they are they can successfully make the change or take the action and how ready they are to do it.

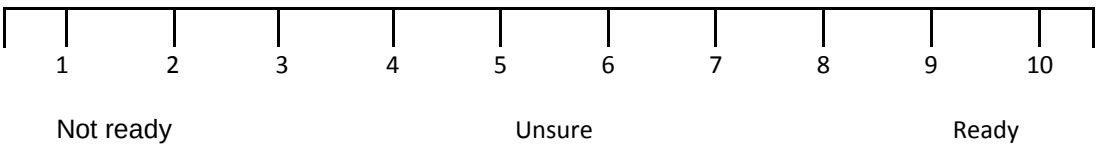
How *important* is it for you to make this change?



How *confident* are you that you can make this change?



How *ready* are you to make this change?



APPENDIX TWO

An Intimacy Continuum

Behaviour of the Recovery Coach	Zone of Safety (Always OK)	Zone of Vulnerability (Sometimes OK, Sometimes Not OK)	Zone of Abuse (Never OK)
Giving Gifts			
Accepting Gifts			
Lending Money			
Borrowing or Accepting Money			
Giving a Hug			
“You’re a very special person”			
“You’re a very special person to me”			
Invitation to Dinner			
Sexual Relationship			
Sexual Relationship with *coachees* family member			
Giving your mobile phone number			
Swearing			
Using Drug Culture Slang			
“I’m going through a bad divorce myself too”			
“You are very attractive”			
Attending a mutual aid meeting together			
Offering to let the person stay at your house			

APPENDIX THREE

A Peer-Based Model of Ethical Decision-Making

Step One: Who has the potential of being harmed in this situation and how great is the risk for harm?

This question is answered by assessing the vulnerability of the party listed in the table below and determining the potential for, and severity of, injury.

Where multiple parties are at risk of moderate or significant harm, it is best not to make decisions alone and to consult with others.

Vulnerable Party	Significant risk of harm	Moderate risk of harm	Minimal risk of harm
Individual or Family being served			
Recovery Coach			
Organisation			
Recovery Support Field			
Recovery Community			
Wider Community			

Step Two: Are there any core recovery values that apply to this situation and what course of action would these values suggest taking?

Achieving Community Together (PRO-ACT).

Core Value	Yes/No	Suggested Action
Gratitude and Service		
Recovery		
Use of Self		
Capability		
Honesty		
Authenticity of Voice		
Credibility		
Fidelity		
Humility		
Loyalty		
Hope		
Dignity and Respect		
Tolerance		
Autonomy and Choice		
Discretion		
Protection		
Advocacy		
Stewardship		

Step Three: What laws, organisational policies or ethical standards apply to this situation and what actions would they suggest?

Step Four: Where risk of injury is to multiple parties, document: What I considered; Who I consulted; What I decided and did; The outcome of the decisions I made and actions I took.

A Recovery Glossary

Abstinence-based Recovery

The resolution of alcohol and other drug-related problems through completely stopping the non-medical use of alcohol and other drugs on an ongoing basis. Abstinence remains the most common definition of recovery, but the necessity to include it in this glossary shoes that new concepts of recovery that are pushing the boundaries of this definition.

Are one of the four daily rituals of recovery. These rituals, which involve efforts to reverse the damage of addiction and establish new, healthy habits, can also be thought of as acts of self-repair. Care of the “self” in recovery overcomes the self-centeredness that is the heart of addiction. Acts of self-care might more correctly be described as acts of responsibility - responsibility not just to self but also to family and community.

(Unpaid) Acts of Service

Activities that aid other individuals or the community. They are one of the four core activities within the culture of recovery. Acts of service fulfil at least two functions: they are indirect amends for the addiction-related harm done to others and they are opportunities for authentic connection with others. Acts of service come in many forms and are done for their intrinsic value i.e. not for profit or hope of acknowledgment.

Acultural Style (of recovery)

A style of recovery in which individuals initiate and sustain recovery from addiction without significant involvement with other people in recovery. The term *acultural* particularly refers to a lack of identification with a larger recovery community, e.g. involvement in a culture of recovery (White, 1996).

Addiction Ministry

Refers to the outreach, treatment and recovery support services offered through local churches as part of their ministry to their local community. The growth in addiction ministries, particularly within African American communities, is one of the most significant developments in the modern history of recovery support structures.

Affiliated (or Assisted) Recovery (versus solo recovery)

A style of recovery in which the initiation and maintenance of recovery is achieved through relationships with other individuals in recovery. Affiliated recovery also reflects incorporating the status of addiction and recovery into your personal identity.

(Making) Amends

Acts of restitution performed by recovering people for the wounds they inflicted on others during the pre-recovery years. Making amends - repaying the “debts” built up in addiction--diminishes guilt and bases recovery upon the values of responsibility, justice and citizenship. This process also opens up the potential for atonement and forgiveness.

Amplification Effect

The strengthening of treatment and/or recovery support services by combining or sequencing particular interventions, activities or experiences. These combinations and sequences work together to produce changes of greater intensity than would be achieved if the same elements were used in isolation from each other or in less effective sequences. For example, an individual in Twelve Step recovery may get greater benefit from combining active step work, meeting attendance, service work and extra-meeting social activities than by doing any one of these activities in isolation.

Anonymity

The tradition within Twelve Step programmes to not link your full name to AA/NA at the level of press, radio, and films (and one would assume television and the internet!). This did not stop many early prominent AA members‘ involvement in advocacy activities. Several AA members, including co-founder Bill Wilson, testified before US Congress in support of specific legislation, making certain to clarify that they were speaking as individuals in recovery and not on behalf of AA as an organisation. Anonymity is a tradition limited to Twelve Step groups and is not practiced in such organisations as SMART Recovery. Going public with your recovery status is viewed in some contexts as an important dimension of recovery (Williams, 1992).

Assisted Recovery

The use of professionally-directed treatment services or participation in mutual aid groups to initiate or sustain recovery from addiction.

The Beast (a.k.a. Monster, Dragon, Demon, Devil)

A personification of addiction, the compulsion to use and the voice (self-talk) that feeds that compulsion. The “Beast” is a prominent within the philosophy of Rational Recovery where externalising thoughts that support addiction in the persona of the Beast give a mechanism to control such self-talk. Rational Recovery promotes a particular technique (addiction voice recognition training–AVRT) to identify and manage such thoughts (Trimpey, 1989). References to “Chasing the Dragon”, and “Battling with the Demon” and “Slaying the Dragon” as metaphors for addiction recovery date back more than a century (Dacus, 1877; Arthur, 1877; Parton, 1868). These terms reflect the process by which the recovering person degrades a previously loved object to create distance between themselves and it.

Bicultural Style (of recovery)

A style of recovery in which individuals sustain their recovery through being involved both in the culture of recovery and the larger "civilian" culture (activities and relationships with people who do not have addiction/recovery backgrounds). This style of recovery suggests the person possesses the cultural skills to fluidly move in and out of the activities and relationships in the recovery culture and activities and relationships with individuals in larger society (White, 1996).

Born Again

A phrase used to describe a Christian conversion. In the context of recovery, it refers to a massive change characterised by death of the old self, a new Christ-centred identity, deliverance from desire (craving) and entry into membership in a sober, faith-based community.

Centering Rituals

Regular activities that help keep people recovery-focused. Praying, meditating, reading recovery literature, setting daily goals and taking an end-of-day inventory, and carrying/wearing sacred objects/symbols are common centering rituals of people in recovery. Other such rituals within the history of recovery include fasting, sweating, seclusion, aerobic exercise (running, swimming), chanting, singing, dancing, artistic expression and pilgrimages to sacred places.

Character Defects

Within Twelve Step recovery these are "emotional deformities" that have hurt alcoholics and those close to them. These include pride, greed, lust, anger, gluttony, envy, and sloth (the "Seven Deadly Sins"). They include obsession with sex, power, money and recognition. They include self-centredness, self-pity, intolerance, jealousy and resentment. The A.A. programme suggests that if identified and disclosed (via the Fourth and Fifth Steps), these "ghosts of yesterday" will be replaced by a "healing tranquillity." (*Twelve Steps and Twelve Traditions*, 1981, pp. 42-62.

Character Reconstruction

The process of bringing one's personal character into line with the aspirational values embedded within recovery frameworks, whether these are Twelve Step groups, secular support structures or religious organisations. Character reconstruction highlights that full recovery from severe alcohol and other drug problems is more than the removal of alcohol and other drugs from an otherwise unchanged life. Instead it involves the transformation of the whole person - creating a character and a lifestyle in which alcohol and other drugs have no place.

Choice (versus coercion)

Refers to the role of a person's own will in addiction recovery. As treatment has often taken on a coercive nature in past decades, stating that "recovery is a choice" is a reaffirmation that people

can be forced into treatment but recovery is a doorway that can only be entered through choice. It is by using this ultimate power of choice that a person moves from the often uncomfortable state of not using to the state of being free to not use.

Chronic Diseases

Disorders that cannot be cured with existing medical technology and whose symptoms come and go over a long period of time. These disorders often spring from multiple, interacting roots, vary in their onset from sudden to gradual and are highly variable in their course (pattern and severity) and outcome. The prolonged length of these disorders places an ongoing strain on the individual and his or her family and friends. Chronic addictive disorders call for a process of sustained recovery management.

Circles of Recovery

Places where people from many recovery traditions can come together for sharing and healing. Recovery circles, which began in Native American communities in the eighteenth century, continue in those communities today (Coyhis, 1999)

Cognitive Reappraisal

A conscious assessment of the pros and cons of continued alcohol and other drug use and the assessment of the pros and cons of ceasing such use. Such an assessment is a common as a stage before the initiation of recovery.

Commitment

A (usually public) declaration of person‘s recovery goals. Such declarations, whether in the nineteenth century ritual of “signing the pledge” or through self-introduction at a mutual aid meeting, mark a shift from the contemplation and preparation stages of change to the action stages of change (Prochaska, et al, 1992). Commitment can also take the form of religious pledges. Muslims with a history of excessive drinking who decide to stop, often do so by performing ablution (cleansing of the body) and, with their hand on the Holy Qur‘an, pledging, “By Allah the Great and His Book, I will never touch kmamr (alcohol) again” (Badri, 1976).

Complete Recovery

A phrase used by Dr. Michael Picucci (2002) to describe an advanced state of recovery marked by global health, a heightened capacity for intimacy, serenity and self-acceptance.

Confession

Acknowledging in the presence of another flawed human being one‘s transgressions, imperfections, personal failings and misdeeds. Some people believe that a Higher Power is present in such events. Confession in its various forms has been an element of nearly all frameworks of addiction recovery.

Continuity of Contact

A phrase used to highlight the importance of sustained, consistent support over the course of recovery. Such support can come from being part of a community of shared experience and hope. The phrase also refers to the reliability relationship between a Recovery Coach (recovery support specialist) and the individual being provided with recovery support. Such continuity is in marked contrast to the short-term nature of relationships experienced by those who have moved through multiple levels of care or undergone multiple treatment relationships.

Conversion

The initiation of recovery through a climactic physical/emotional experience. The potential role of religious conversion in alcoholism has been long noted (Rush, 1784; James, 1902). Miller and C‘ de Baca (2001), have recently referred to such dramatic experiences as “quantum change” and noted that this type of recovery experience was marked by high intensity, suddenness, unintentional, positivity and permanence of effect. The history of recovery is full of such powerful transformation experiences. The behavioural changes caused by such conversion experiences touch the very core of personal identity and values.

Crosstalk

The use of direct responses (feedback, suggestions) within a mutual aid meeting. Crosstalk is contrasted with sharing. Recovery groups vary widely on their practices regarding sharing and crosstalk. Most Twelve Step groups discourage crosstalk. Other groups, like SMART Recovery, encourage crosstalk.

Cultural Pathways of Recovery

Are cultural or sub cultural pathways through which individuals can resolve alcohol and other drug problems. For example, in societies in which alcohol is a celebrated drug, particularly among men, cultural pathways of recovery are the socially accepted ways a man can abstain from
alcohol and maintain his identity and manhood within that society. Across varied cultural contexts, that pathway might be medical (an alcohol-related health problem), religious (conversion and affiliation with an abstinence-based faith community), or political (rejection of alcohol as an “opiate of the people”).

Cultural Recovery

Refers to the healing of a culture whose values have become corrupted and illness-producing. Cultural healing involves a return to wellness - promoting ancestral traditions or reforming and reapplying ancestral traditions to contemporary life (Simonelli, 2002).

Culture of Recovery (Recovery Culture)

This culture has its own recovery-based history, language, rituals, symbols, literature, institutions (places) and values. It helps people reconstruct their personal identity and social relationships and remove themselves from deep involvement with drug and criminal subcultures.

Developmental Models of Recovery

Models that explain the stages and processes involved in long term recovery from addiction. Such models assume that there are separate stages of recovery, that certain tasks and milestones within one stage must be completed before one can progress to the next stage and that the types of treatment and support services differ considerably across these developmental stages. Those who have developed such models of recovery include Wallace (1974); Brown (1985); Biernacki (1986); and Prochaska, DiClimente, and Norcross (1992). What these models suggest is that treatment interventions and recovery support activities that are effective at one stage of recovery may be ineffective or even harmful at another stage of recovery. Such models have gone by many names including the “cycle of sobriety” (Christopher, 1989, 1992).

Disease (Concept)

A term used to describe the nature of addiction. The “disease concept”, the source of which is often misattributed to A.A. (Kurtz, In Press), is an esteem-salvaging, guilt-assuaging metaphor for many people in recovery from severe alcohol and other drug-related problems. The concept identifies those in recovery as sick people in the process of getting well as opposed to bad people trying to be good. A.A. co-founder Bill Wilson suggested that Silkworth‘s ideas of alcoholism as an allergy “explains many things for which we cannot otherwise account” (Alcoholics Anonymous, 1976). Much the same could be said for “disease” although early A.A. leaders avoided using such a description (Kurtz, In Press).

Disease Management (Distinguished from Recovery Management)

The management of severe health problems in ways that improve clinical outcomes and reduce social costs. Its focus is on dealing with symptom suppression and reducing the number, intensity and duration of needed service interventions. Recovery management, while potentially achieving these same goals, focuses not on the disease and its costs but primarily upon the person and their needs and potentials. Recovery management is person-focused rather than disease/cost-focused.

Drug Substitution

Has two meanings in the context of recovery. The first is the long recognition of vulnerability for drug substitution in the recovery process. Addiction literature is full of cases of people who stopped using one drug only to develop an equally destructive or more destructive relationship with one or more other drugs. This risk is balanced by a growing number of research studies which show that many individuals with alcohol or other drug problems in the general population use substitute drugs to manage craving and to phase themselves out of the addictive lifestyle.

While noting the potential risk of secondary drug dependence, most of these studies report that secondary drug use in most individuals stops after 12-18 months (Biernacki, 1986; Christo, 1998; McIntosh and McKegany, 2002).

The Ecology of Recovery

A phrase intended to reinforce the idea that there are ecosystems that can nourish recovery and ecosystems that can crush recovery. The study of the ecology of recovery focuses on the way in which an individual‘s relationship with his or her physical and social environment influences the viability and quality of recovery. The phrase suggests a possible integration between clinical models that focus on the individual and public health models that focus on the drug and the context and consequences of drug-taking or drug-abstaining decisions. More radical concepts see addiction “organically” from a sick social system and view recovery as dependent upon creating a healthier social system that makes recovery possible (see Tabor, 1970).

Emotional Sobriety

A phrase coined by A.A. co-founder Bill Wilson (1958) to describe a state of emotional health that far exceeded simply the achievement of not drinking. Wilson defined emotional sobriety as —real maturity...in our relations with ourselves, with our fellows and with God.

Enabling

In the addiction treatment/recovery arena, the act of “enabling” has come to mean anything that, with the intention of helping the alcoholic/addict , inadvertently results in harm. It is thought that actions that protect the person not yet in recovery from the consequences of his or her drinking/ drug use , increase the likelihood of continued addiction. The concept led family members and workers alike to fear accusations that they were “enabling” or had become “enablers.” That fear escalated even further in the late 1980s. At the peak popularity of “co-dependency,” the most basic acts of human kindness toward others were framed not as evidence of compassion but of enabling.

Evidence-based Practices

Clinical and service practices that have scientific support for their efficacy (work under ideal conditions) and effectiveness (work under real conditions). Advocacy of evidence-based practice is a commitment to use those approaches that have the best scientific support, and, in areas where research is lacking, a commitment to measure and use outcomes to promote those practices that have the greatest impact on the quality of life of individuals, families and communities. The concern expressed here is that there may be important aspects of the recovery experience that are not measurable.

Ex-Addict

A term that was commonly used in the therapeutic communities of the 1960s and 1970s to refer to those individuals who had successfully recovered from addiction to drugs (usually. The term is noteworthy because it describes in its depiction of the status (identity) of addict in the past tense - something someone was but no longer is - in contrast self-introduction in fellowships like NA - “My name is____ and I‘m and addict.” This distinction hinges on the question, “Once addicted, does one ever stop being an addict?” There are recovery frameworks that answer this question quite differently.

Faith-based Recovery

The resolution of alcohol and other drug problems within the framework of religious experience, beliefs, rituals and within the mutual support of a faith community. Faith-based recovery frameworks may be in addition to traditional recovery support programmes or serve as alternatives to such programmes.

Giving It Away

A phrase that captures one of the many paradoxes of recovery: that the methods and fruits of recovery cannot be fully experienced and understood until they are given to someone else.

Gratitude

The experience of ultimate reprieve - the gift of one‘s own life. It is the source of such recovery values as humility and service.

Harm Reduction (as a stage of recovery)

The term used to describe strategies aimed at reducing the personal and social costs of alcohol and other drug use. Often viewed as an alternative to, and even antagonistic to recovery, harm reduction approaches can also be viewed as a strategy for protecting the individual, family and community while enhancing recovery readiness.

High Bottom Recovery

The initiation of recovery through a breakthrough of awareness of all that a person could lose through continued alcohol and other drug use. References to “high bottom alcoholics” refer to people who entered recovery without having suffered major losses due to their drinking.

Higher Power

In the Twelve Step tradition, the personification of a positive power “greater than ourselves” that can restore sobriety and sanity to the addicted. Referred to as “God as we understood Him” a Higher Power is the personified antidote to the Beast.

Hitting Rock Bottom

An addiction-related experience of complete anguish and despair. Studies have long affirmed the role of this “hitting rock bottom” experience and/or a dramatic breakthrough in self-perception in the initiation of recovery. The experience has been characterised as an “existential crisis” (Coleman, 1978), a “naked lunch” experience (Jorquez, 1993), a “brief developmental window of opportunity” (White, 1996), a “turning point” (Ebaugh, 1988) and a “crossroads” (Klingemann, 1991, 1992).

Intervention

Process of precipitating a change-eliciting crisis in the life of a person experiencing a substance use disorder by conveying the consequences of his or her behaviour on family, friends and co-workers.

Inventory

A process of auditing your assets and deficits of experience and character. In Twelve Step-guided recovery, this process is linked to three other processes (confession, acts of restitution, and acts of service) that serve as ways to alleviate guilt and shame as well as for character re-construction.

Low Bottom Recovery

The initiation of recovery by individuals in the latest stages of addiction who have experienced great losses related to their drinking and drug use. Low bottom recovery is associated with the experience of anguish and desperation - a choice between recovery on the one hand or insanity and death on the other.

Medication-assisted Recovery

The use of medically-monitored, pharmaceutical treatment to support recovery from addiction. These include detoxification agents, stabilising agents, aversive agents, antagonising agents and anti-craving agents. The stigma attached to medication-assisted recovery (e.g. methadone) is being countered by wider dissemination of the research supporting its scientific efficacy as well as through the growing participation in recovery advocacy activities of people who have successfully achieved medication-assisted recovery. One goal of such advocacy is for people in medication-assisted recovery recognised as legitimate members of the recovery community.

Moderated Recovery (Moderated Resolution)

The resolution of alcohol or other drug problems through reduction of alcohol or other drug use to a level that no longer produces harm to the individual or society. The concept suggests that alcohol and other drug problems exist on a wide continuum of severity and widely varying patterns of acceleration and deceleration. Early members of Alcoholics Anonymous made a clear distinction between themselves and other heavy drinkers and problem drinkers, suggesting

that moderation was an option for some problem drinkers but not alcoholics like themselves.

The following two excerpts reflect their beliefs about the issue of moderation:

Then we have a certain type of hard drinker. He may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason - ill health, falling in love, change of environment, or the warning of a doctor - becomes operative, this man can also stop or moderate, although he may find it difficult and troublesome and may even need medical attention (p. 31, first edition).

If anyone, who is showing inability to control his drinking, can do the right-about-face and drink like a gentleman, our hats are off to him. Heaven knows we have tried hard enough and long enough to drink like other people! (p. 42, first edition)

The prospects of achieving moderated recovery diminish in the presence of lowered age of onset of alcohol or other drug problems, problem severity, the presence of co-occurring mental health issues and low social support (Dawson, 1996; Cunningham, et al, 2000; Vaillant, 1996). The most common example of moderated recovery can be found in studies of people who develop alcohol and other drug problems during their transition from adolescence to adulthood. Most of these individuals do not go on to develop enduring problems, but instead quickly or gradually moderate their alcohol or other drug use through the process of maturation and the assumption of adult responsibilities (Fillmore, et al, 1988).

Motivational Interviewing

A non-confrontational approach to encouraging recovery-seeking behaviours that was developed by William Miller and Stephen Rollnick. The approach emphasises relationship-building (expressions of empathy), heightening discrepancy between an individual‘s personal goals and present circumstances, avoiding argumentation (activation of problem-sustaining defence structure), rolling with resistance (emphasising respect for the individual experiencing the problem and their necessity and ability to solve the problem), and supporting self-efficacy (expressing confidence in the individual‘s ability to recovery and expressing confidence that they will recover). As a technique of preparing people to change, motivational interviewing is an alternative to waiting for an individual to “hit rock bottom” and an alternative to confrontation-oriented intervention strategies (Miller and Rollnick, 1991).

Multiple Pathways of Recovery (Multiple Pathway Model)

Reflects the diversity of how individuals resolve problems in their relationship with alcohol and other drugs. Multiple pathway models contend that there are multiple pathways into addiction that unfold in highly variable patterns, courses and outcomes; that respond to quite different treatment approaches; and that are resolved through a wide variety of recovery styles and support.

Mutual Aid Groups

Groups of individuals who share there experience, strength and hope for recovery from addiction. Often called “self-help” groups, they more technically involve an admission that efforts at self-help have failed and that the help and support of others is needed (Miller and Kurtz, 1994). Mutual aid groups are based on relationships that are personal rather than professional, reciprocal rather than fiduciary, free rather than fee-based, and enduring rather than transient.

Natural Recovery

A term used to describe those who have initiated and sustained recovery without professional assistance or involvement in a formal mutual aid group. This type of resolution of alcohol and other drug problems has been variously called “maturing out” (Winick, 1962, 1964); “autoremission” (Vaillant, 1983; Klingeman, 1992); “self-initiated change” (Biernacki, 1986); “unassisted change” (McMurran, 1994; “spontaneous remission” (Anthony and Helzer, 1991); “de-addiction” (Klingeman, 1991); “self-change” (Sobell, Sobell, and Toneatto, 1993); “natural recovery” (Havassey, Hall and Wasserman, 1991; “self-managed change” (Copeland, 1998) and “quantum change” (Miller and C‘de Baca, 2001).

The New Recovery Advocacy Movement

The collective efforts of grassroots organisations of recovering people and their families whose goals are to:

1) provide a message of hope about the potential of long term recovery
2) to advocate for public policies and programs that help initiate and sustain such recovery

The core strategies of the New Recovery Advocacy Movement are:

1) recovery representation
2) recovery needs assessment
3) recovery education
4) recovery resource development
5) policy (rights) advocacy
6) recovery celebration
7) recovery research

(White, 1999)

Paradox

Finding meaning from an apparent incongruity is a common recovery experience, e.g., to get it, you must give it away; when you think you‘re looking good, you‘re looking bad; you can find serenity when you stop looking for it. Such qualitative dimensions of recovery defy capture in the rush to bridge the gap between clinical research and clinical practice in addiction treatment.

Pathways (to Addiction and Recovery)

Phrase that describes the movement into and out of addiction and into (and potentially out of) recovery. The image of pathways conveys the notion of choices that ultimately shape personal destiny. There have been many advocates of single pathway models of addiction and recovery: addiction is caused by one thing, unfolds in a highly predictable and homogenous pattern, responds to a narrow approach to treatment, and remains in remission through a single approach to recovery management. Single pathway models are being replaced by multiple pathways models: there are many pathways to alcohol and other drug problems; these problems unfold in very diverse patterns and vary considerably in their course; different problems respond to different approaches; and there are multiple pathways and styles of resolution for alcohol and other drug problems.

Powerlessness

The acknowledgement of one‘s inability to control the frequency and quantity of alcohol or drug intake and its consequences through an act of personal will.

(The) Promises

The fruits of recovery that can be expected by working the Twelve Steps of Alcoholics Anonymous: *If we are painstaking about this phase of our development, we will be amazed before half through! We are going to know a new freedom and happiness. We will not regret the past nor wish to shut the door on it. We will comprehend the word serenity and know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and of economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us. We will suddenly realize that God is doing for us what we could not do for ourselves.*

Are these extravagant promises? We think not. They are being fulfilled among us -- sometimes quickly, sometimes slowly. They will always materialise if we work for them. (*Alcoholics Anonymous*, p. 96, first edition).

Recovered / Recovering (Abstracted from White, 2001b)

Terms used to describe the process of resolving, or the status of having resolved, alcohol and other drug problems. The former is drawn primarily from recovery mutual aid groups; the latter is drawn primarily from the treatment industry. Recovered is drawn primarily from the individuals who have resolved such problems have been referred to as *redeemed (or repentant) drunkard, reformed drunkard, dry drunkard, dry (former) alcoholic, arrested alcoholic, sobriate, ex-addict, and ex-alcoholic*.

They have been described as *sober, on the wagon, drug-free, clean, straight, abstinent*, *cured, recovered*, and *recovering*. Modern debate has focused on the last two of these terms. While *recovering* conveys the dynamic, developmental process of addiction recovery, *recovered* provides a means of designating those who have achieved stable sobriety and better conveys the real hope for a permanent resolution of alcohol and other drug problems.

The terms “seeking recovery”, “in recovery” and “recovering” could be used to depict individuals who are making concerted efforts to remove destructive patterns of alcohol and other drug use from their lives. This usage would be similar to how we speak of people responding to other chronic conditions and illnesses. The language assumes both commitment and progress rather than a complete absence of symptoms. In a similar manner, the term “recovered” could be used to describe those who have achieved an extended period of remission. The period used to designate people recovered from other chronic disorders is usually five years without active symptoms.

Recovery

The experience of a meaningful, productive life within the limits imposed by a history of addiction to alcohol and/or other drugs. Recovery is both the acceptance and transcendence of limitation. It is the achievement of optimum health - the process of rising above and becoming more than an illness (Deegan, 1988, 1996; Anthony, 1993). Recovery, in contrast to treatment, is both done and defined by the person with the problem (Diamond, 2001). “Recovery” implies that something once possessed and then lost is reacquired. The term recovery promises the ability to get back what one once had and as such holds out unspoken hope for a return of lost health, lost esteem, lost relationships, lost financial or social status. Recovery, in this sense, is congruent with the concept of rehabilitation - the reacquisition of that which was lost. For those who had pre-existing levels of functioning that were lost to addiction, there is in the term recovery the promise of being able to reach back and pick up the pieces of where your s life was before addiction altered its course.

Recovery Activism

The use of personal recovery experiences as a springboard for economic, political and social change. Recovery activism seeks to tackle the conditions that contribute to addiction or constitute a barrier to recovery.

Recovery Advocacy

The process of exerting influence (power) toward the development of pro-recovery social policies. Recovery advocacy activities include:

⇒ portraying addiction as a problem for which there are realistic and varied recovery solutions

⇒ providing living role models that illustrate the diversity of those recovery solutions,

⇒ removing barriers to recovery, including promoting laws and policies that reduce alcohol and other drug problems and support recovery

⇒ enhancing the viability and strength of indigenous communities of recovery

Recovery Capital

The quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery from a life-disordering condition (Granfield & Cloud,1999). In contrast to those achieving natural recovery, most clients entering addiction treatment have never had much recovery capital or have dramatically depleted such capital by the time they seek help.

Recovery Career

A way of conceptualising the stages and processes involved in long term addiction recovery. The concept of “career” has been used to describe the process of addiction (Frykholm, 1985) and to conceptually link multiple episodes of treatment (Hser, et al, 1997). Recovery career refers to the evolving stages in one‘s identity, one‘s relationships with others, and, in some cases, styles of involvement with mutual aid groups. There could, for example, be significant changes in the perceived meaning and application of AA‘s Twelve Steps over the long course of a recovery career.

Recovery Coach (Recovery Support Specialist)

A person who helps remove obstacles to recovery, links the newly recovering person to the recovery community and serves as a personal guide and mentor in the management of personal and family recovery. Such supports are generated through mobilising volunteer resources within the recovery community, or provided by the Recovery Coach where these support networks are lacking.

Recovery Community (Communities of Recovery)

A term used to convey the sense of shared identity and mutual support of those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends and a larger circle of “friends of recovery” that includes both professionals working in the health field as well as recovery supporters within the wider community. “Communities of recovery” is a phrase coined by Ernest Kurtz to convey the notion that there is not one but multiple recovery communities and that people in recovery may need to be introduced into those communities where the individual and the group will experience a “fit”. The growth of these communities reflects the growing varieties of recovery experiences (Kurtz, 1999).

Recovery Deficits

The specific internal and external obstacles that impede initiating or maintaining a solution for

alcohol and other drug problems. The notion of recovery assets and deficits suggests two very different approaches to the process of recovery. One focuses on reducing obstacles to recovery; the other focuses on increasing internal and external recovery resources.

Recovery Environment

Recovery flourishes in communities that build the physical, psychological and social space where healing can occur. It stands as a reminder that communities can intervene in alcohol and drug problems at the community level as well as the level of families and individuals (See Ecology of Recovery).

Recovery Identity

The degree to which a person self-identifies with the statuses of addiction and recovery and the degree to which one initiates and sustains recovery in isolation from or in relationship with other recovering people.

Recovery Management

The provision of engagement, stabilisation, education, monitoring, support and re-intervention processes to maximise the health, quality of life and level of productivity of people with alcohol and other drug problems. Within the framework of recovery management, the “management” of the disorder is the responsibility of the person with the disorder. The primary role of the professional is that of the recovery consultant.

Recovery-oriented Systems of Care

Health and human service institutions that affirm hope for recovery, exemplify a strengths-based (as opposed to pathology-focused) orientation, and offer a wide spectrum of services aimed at support of long term recovery.

Recovery Outcomes

The degree of benefits achieved as a consequence of recovery from addiction. Discussions of recovery outcomes rest on the understanding that not all recoveries are the same and that the term “recovery” embraces everything from the removal of alcohol and drugs from an otherwise unchanged person to the total transformation of personal identity, character and lifestyle. Recovery outcomes might also be referred to as recovery-generated assets.

Recovery Planning and Recovery Plans

The recovery plan, in contrast to a treatment plan, is developed, implemented, revised and regularly evaluated by the client. Consisting of a master recovery plan and weekly implementation plans, the recovery plan covers ten domains: physical, employment, finances, legal, family, social life, drinking, personal, education and spiritual (Borkman, 1998).

Recovery Progression

The idea that there are natural stages within the addiction recovery process. Simonelli (2002) has suggested that this progression moves from addiction to sobriety to recovery to wellness.

Recovery Representation

Refers to the involvement of recovering people and their family members in addiction-related public policy and their involvement in the design, delivery and evaluation of addiction treatment and recovery support services.

Recovery Research (Agenda)

An effort to balance problem-oriented research activity with solution-oriented research activity. A recovery research agenda could document the prevalence of recovery, create a map of pathways and styles of recovery, define the stages of long term recovery, identify those support services most crucial to long term recovery, measure dose and matching effects of such services, document variations in recovery patterns across various demographic and clinical subpopulations and document the social and economic benefits of recovery.

Recovery Rights

Addressing problems of discrimination against people in addiction recovery. Issues included are discrimination in housing, employment and access to public services for example.

Recovery Rituals

Activities through which recovery from addiction is enhanced. The multiple pathways of recovery often share four core daily activities: centering rituals, mirroring rituals, acts of self-care, and unpaid acts of service.

Recovery Support Groups (Mutual Aid Groups)

Groups of recovering people who meet regularly for fellowship and mutual support. See www.bhrm.org/Guide.htm for a recovery mutual aid guide developed and maintained by Ernest and Linda Kurtz.

Recovery Support Services

Services designed to:

1. remove personal and environmental obstacles to recovery,
2. enhance identification and participation in the recovery community
3. enhance the quality of life in recovery

They include outreach, intervention and engagement services; “case management” (problem-solving and service coordination) services; post-treatment monitoring and support; sober housing; transportation; child care; legal services; educational/vocational services; linkage to

pro-recovery leisure activities; and recovery coaching (stage appropriate recovery education and support.

Recovery Values

Virtues that have come to be associated with recovery from addiction. Variable across recovery pathways: honesty, hope, faith, courage, integrity, willingness, humility, forgiveness, justice, perseverance, spiritual awareness, and service (Coyhis, 2000).

Roads to Recovery

A phrase first used by Bill Wilson to convey the diversity of ways used to escape alcoholism. When some AA members criticised the inclusion of a story in the A.A. Grapevine of a celebrity writer who achieved solo recovery (no involvement in AA), Wilson responded by declaring, “The roads to recovery are many” and that the resolution of alcoholism by any method should be a cause for celebration by A.A. members (Wilson, 1944).

Service Committees

The structures within mutual aid societies through which members support the organisational work of the societies and help to those still suffering from addiction.

Sharing

The stylised form of communication common within many recovery mutual aid societies. It is well described in the Handbook of Secular Recovery.

“Sharing” has a very definite meaning in self-help groups...The person talks, everybody else listens. Then the next person talks, and everybody listens. Then the next. At no point is anybody‘s “share” an answer or other direct response to anyone else‘s. Each share stands entirely on its own, complete and sufficient unto itself....The “no response” rule of sharing protects the speaker from having their statement judged, criticised, ridiculed or otherwise attacked. This in turn promotes the fullest possible openness and honesty….(Handbook of Secular Recovery, 1999, pp. 30-31).

Spiritual (Spirituality)... Abstracted from White, 1992

A heightened state of perception, awareness, performance or being that personally informs, heals, empowers, connects or liberates. For people in recovery, it is a connection with resources within and outside the self. There is a spirituality that springs from pain, a spirituality that springs from pleasure, and a spirituality that can flow from the simplicity of daily life. The power of the spiritual to draw us beyond our normal range of experience is evident in the language of non-ordinary experience: awakening, rapture, peak experience, defining moment, epiphany and re-birth. The spirituality of fully experiencing the subtlety and depth of the ordinary is depicted in such terms as harmony, balance, centeredness, bliss, serenity, and tranquillity. All of these can be part of the multi-layered experience of addiction recovery.

Spiritual Awakening

The progressive changes in character and relationships that recovering people experience through the stages of recovery, also commonly described as a spiritual “experience.”

Sponsorship

The practice of mentoring between one recovering person and another. It has a long tradition dating to the Washingtonians (1840s), has been most institutionalised within Alcoholics Anonymous and Narcotics Anonymous, and is also found within many faith-based recovery groups.

Traditions

The principles that govern the group life of Twelve Step organisations. Such principles, which have been cited as a source of A.A.‘s resilience (White, 1998), have varied by their presence or absence and their content in recovery mutual aid societies. Most recovery mutual aid societies have evolved toward a tradition of singleness of purpose and non-affiliation, while there are significant differences across these societies on issues related to such things as anonymity, service expectations and length of expected active membership.

(The) Twelve Steps

The actions taken by the early members of Alcoholics Anonymous that resulted in their continued sobriety and which were subsequently suggested as a programme of recovery for other alcoholics. The Twelve Steps are reproduced in virtually all A.A. literature and have been adapted for application to a wide spectrum of human problems.

Virtual Recovery

The achievement or maintenance of recovery through Internet support groups and with little or no participation in face-to-face support meetings.

Wellbriety

A term coined by Don Coyhis (1999) that depicts recovery as more than just symptom suppression. The term implies the pursuit or achievement of global (physical, emotional, intellectual, relational, and spiritual) health, or “whole health.” (*Red Road to Wellbriety*, 2002). It is also analogous to what AA co-founder, Bill Wilson, described as “emotional sobriety” (Wilson, 1958).

Witness

The act of telling your story as an act of service, whether the target of that story is an individual, a community or a culture.

Wounded Healers

People who, having survived a life-threatening and life-transforming illness/experience, help guide others through this same illness/experience. There is a rich tradition of wounded healers that reaches far beyond the history of addiction recovery (White, 2000a, 2000,b).

Addictionary

A....

ABSTINENCE: Not using by choice, especially drugs and alcohol

ACCEPT: To agree, consider, or hold to be true. To regard as true; to believe in

ACCEPTANCE: The mental attitude that something is believable and should be accepted as true. Belief in something

ACHIEVE: To get by means of one‘s own efforts. To attain with effort or despite difficulty

ACKNOWLEDGE: To admit the truth or existence. To admit the existence, reality, or truth of

ACTIVE LISTENING: The ability to use all of one‘s senses to hear what someone is conveying, not just hearing.

ACQUIRE: To get, especially by one‘s own efforts, or efforts or gain through experience

ACTION: The doing of something or having something done

ACTIVE: Producing or involving action or movement

ADDICT: A person who has an obsessive and compulsive need for something, such as drugs or alcohol

ADDICTION: A physical, mental and spiritual condition characterised by an obsession to use the things that are destroying us, followed by a compulsion that forces us to continue

ADMISSION: Voluntary acknowledgment of something that has not been proven. Voluntary acknowledgment of truth

ADMIT: To make known, usually with some unwillingness

ADVERSITY: Hard times

AFFIRMATION: Replacing the negative, random thoughts of self-condemnation and limitation with expansive good thoughts that help orient ourselves to a better, happier, and healthy life

ALIENATE: To cause to become withdrawn or unresponsive; isolate, or dissociate emotionally

ALIENATION: The act of alienating, or one who has been alienated

ALTRUISM: Without taking anything from those who depend on you, giving freely with no expectation of return for the purpose of making the world a better place

AMENDS: Something done or given by a person to make up for a loss or injury one has caused. To better one's conduct; reform

ANGUISH: Great pain or trouble of body or mind

ANONYMOUS: Not named or identified; equal in status and importance

ANTI-SOCIAL: Hostile toward society; unfriendly. Behaving in a manner that violates the social or legal norms of society

ANXIETY: Fear or nervousness about what might happen

APATHY: Lack of feeling or of interest; indifference

APPARENT: Appearing to be real or true. Readily understood; clear or obvious

APPRECIATION: The awareness or understanding of the worth or value of something. An expression of gratitude

APPROVAL-SEEKING: Seeking to be accepted as satisfactory

ARROGANCE: A sense of one‘s own importance that shows itself in a proud and insulting way

ASPECT: A certain way in which something appears or may be thought of. A way in which something can be viewed by the mind

ASPIRATION: A strong desire to achieve something good

ASSURANCE: The state of being certain or having confidence in yourself

ATTACHMENT: Connection by feelings of affection or regard or the connection by which one thing is joined to another

ATTITUDE: A feeling or opinion about a certain fact or situation. An arrogant or hostile state of mind

ATTRACTION: The state of being attracted or pleased or something that attracts or pleases

ATTRIBUTE: A quality belonging to a particular person or thing

AUTONOMOUS: Self-governing, free from outside control

AWAKENING: The state of becoming aware

AWARE: Having or showing understanding or knowledge of something

B....

BAFFLED: Defeated or held in check by confusion. Confused by many conflicting situations or statements

BALANCE: To make things equal or the state of equality. A stable mental or psychological state; emotional stability

BECOME: To grow to be. Enter or assume a certain state or condition

BEHAVIOUR: The way in which one conducts oneself. The manner in which one behaves

BLAMING: The state of placing responsibility on others for something

BOND: A force or influence that brings or holds together. A uniting force or tie

BURDEN: Something that is hard to take. Something that is emotionally difficult to bear.

C....

CARRY THE MESSAGE: To demonstrate with words and actions the benefits of living a 12 Step programme

CHAOS: A state of complete confusion and disorder

CHARACTER DEFECTS: Those things that drain us of all our time and energy while causing pain and misery

CHARACTERISTIC: A special quality or feature that is a part of a person‘s overall character

CLEAN: Total abstinence from all drugs

CLING: Remaining emotionally or intellectually attached to something that you know is harmful to you

CLOSE-MINDEDNESS: The state of being unwilling to consider the suggestions or explanations of others as possible or feasible

COME TO BELIEVE: The process through which one develops their system of belief about a Higher Power

COMMITMENT: To pledge oneself to a certain course of action

COMPASSION: The state of deep awareness and sympathy for, and a desire to help, another who is suffering

COMPLACENCY: A feeling extreme calm and satisfaction with one‘s life or situations that hinders the process of seeking change

COMPREHEND: To understand fully

COMPROMISING: To reach an agreement over a dispute with all parties changing or giving up some demands

COMPULSION: Having started the process with one fix, one pill or one drink, we cannot stop through our own power of will

COMPULSIVE: The state of acting on a compulsion

CONCEDE: To acknowledge, often reluctantly, as being true, just, or proper; admit

CONCEIVABLE: Capable of being imagined or understood

CONCLUSION: A final decision that is reached by reasoning or the ending of something. The result or outcome of an act or process

CONDEMN: To declare to be wrong. To express strong disapproval of

CONDITION: Something that is agreed upon as necessary if some other thing is to take place

CONFIDENCE: A feeling of trust and belief. Trust or faith in a person or thing

CONFRONT: To face or meet issues that occur in our lives, simply and without hostility

CONFUSED: Experiencing a mental fog or feeling uncertain. Being unable to think with clarity or act with understanding and intelligence

CONFUSION: The state of being confused. Impaired orientation with respect to time, place, or person; a disturbed mental state.

CONSCIOUS: The mental awareness of facts or one‘s inner feelings

CONSEQUENCE: The result of an action. Something that logically or naturally follows from an action

CONSISTENT: Sticking to one way of thinking or acting. Reliable; steady

CONTENTMENT: Freedom from worry or restlessness. Happiness with one's situation in life

CONTRIBUTE: Giving along with others to have a share in something

CONTROL: To have power over. Authority or ability to manage or direct

COPE: To struggle with or try to manage something. To contend with difficulties and act to overcome them.

CORE: The basic or most important part; the essence

CREED: A statement of a set of guiding rules or beliefs, usually of a religious faith. A system of belief, principles or opinions

CRITICAL: Being inclined to criticise especially in an negative way

CRUCIAL: Being necessary to accomplish something. Of extreme importance; vital to the resolution of a crisis

CULT: A relatively small group of people having religious beliefs or practices regarded by others as strange or as imposing excessive control over members

D....

DECEIT: Deliberate and misleading concealment; false declaration

DEFECTS: Things that we determine are interfering with our process of recovery

DELUSION: A false belief that we continue to hold in spite of the facts

DENIAL: The refusal to admit the truth of a statement or the refusal to accept or believe in someone or something

DEPENDENT: Unable to exist or sustain oneself, or unable to act appropriately or normally without the assistance of substances

DEPRESSION: Low spirits, a common by-product of addiction that typically occurs during withdrawal

DERELICTION: The neglect of or failure in meeting personal responsibilities.

DESPAIR: A feeling of complete hopelessness

DESPERATION: Recklessness arising from despair

DILEMMA: A situation in which a person has to choose between things that seem to be all bad or unsatisfactory

DISCLOSURE: The act of making known

DISTORT: To tell in a way that is misleading.

DISTRACTING: Drawing someone‘s mind or attention to something else. To cause to turn away from the original focus of attention

DIVERSITY: Not being the same and the qualities that distinguish our differences

DOGMA: A principle, belief, or statement of ideas or opinion, especially one considered to be absolutely true whether others disagree or not

DYNAMIC: Full of energy. Characterised by continuous change, activity or progress

E....

EGO: The individual‘s awareness of self that is used to control us in all sorts of subtle ways. An inflated feeling of pride, in your superiority to others, or your consciousness of your own identity

EGOCENTRIC: Viewing everything in relation to oneself. Caring only about oneself; selfish.

EMPATHY: Having an intellectual or emotional identification with another. Identification with and understanding of another's situation, feelings, and motives

ENDANGER: Risk. To expose to harm or danger

ENDORSE: To give one‘s support to something

ENDURE: To put up with patiently or firmly, such as pain

ENVY: The feeling of discontent at another‘s good fortune with a desire to have the same good fortune for oneself

ESOTERIC: Understood by only a few people

EVIDENT: Easily seen or understood; obvious

EXERT: To put oneself into action or a tiring effort; struggle. Make a great effort at a mental or physical task

EXPECTATION: A desire that one places upon himself or another to accomplish

EXPERIENCE: Something that one has actually done or lived through

EXPOSURE: An act of making something known publicly. The disclosure of something secret.

EXTERNAL: Something situated on the outside of or related to the outside of a thing. Outside of or separate from ourselves

EXTREME: Something as far as possible from a centre or its opposite. Far beyond the norm in views or actions

F . . .

FAITH: An individual‘s system of beliefs. Confident belief in the truth, value, or trustworthiness of a person, idea or thing

FAULTS: A character weakness, especially a minor one

FELLOWSHIP: A group with similar interests or goals. A close association of friends or equals sharing similar interests

FESTER: To grow in intensity; to rankle

FOCUS: To concentrate attention or energy or the centre of activity or interest

FOUNDATION: The basis on which something stands or is supported; a base

G . . .

GENDER: Male and female. Sexual identity, especially in relation to society or culture

GENUINE: Being just what it seems to be. Free from hypocrisy or dishonesty; sincere

GIFTS: Things which are given voluntarily and without expectations

GIVING: Handing over with the expectation of it being kept. To bestow without receiving a return.

GRATIFICATION: Something giving pleasure or satisfaction

GRATITUDE: The state of being consciously thankful for the things in your life

GROUND: To instruct in basic knowledge or understanding

GROUP CONSCIENCE: The will of a 12-Step group. Group conscience represents a consensus view that is used to make decisions about things that affect members or the 12-Step Fellowship.

GROWTH: The process of being able to live fully and develop

GUIDANCE: The act of showing the way. Something that provides direction or advice as to a decision or course of action

GUIDE: A person who leads, directs or shows the right way. To instruct and influence intellectually or morally

GUIDELINES: A written set of rules or principles that provide boundaries and guidance necessary to practicing appropriate behaviour

GUILT: The fact or feeling of having done something wrong that causes one to feel shame or regret

H...

HABIT: Doing something that has become fixed by being repeated often. A recurrent, often unconscious, pattern of behaviour that is acquired through frequent repetition

HEAL: To return to a sound or healthy condition. To restore (a person) to spiritual wholeness

HELPLESSNESS: Not able to help or protect oneself. Powerlessness revealed by an inability to act

HOPE: A desire for something better

HOPELESSNESS: The condition of having no hope. The despair you feel when you have abandoned hope of comfort or success

HUMBLE: Accepting yourself as you actually are

HUMBLY: Asking or doing with humility; in a humble manner

HUMILITY: The state of being humble. Freedom from pride and arrogance

I . . .

IDEAL: A standard of perfection, beauty, or excellence

IDENTIFICATION: A person's association with the qualities, characteristics or views of another person or group

IGNORANCE: The state of not knowing. The condition of being uneducated, unaware or uninformed

ILLUSION: The state or fact of being lead to accept as true something unreal or imagined

IMPLY: To express indirectly, suggest rather than state plainly

IMPULSE: A sudden desire to do something

INABILITY: The condition of being unable to do something

INDEPENDENCE: The quality or state of not being under the control or rule of someone or something

INDIFFERENT: Showing neither interest nor dislike. Having no particular interest or concern; apathetic

INDISPENSABLE: Absolutely necessary

INFLICTED: Caused

INSANITY: Repeating the same mistakes and expecting different results

INSECURITY: The state of not feeling or being safe. Lacking self-confidence; plagued by anxiety

INSIDIOUS: More dangerous than seems evident. Developing so gradually as to be well established before becoming apparent.

INSIGHT: The power or act of seeing what‘s really important about a situation. Understanding, especially an understanding of the motives and reasons behind one's actions.

INTEGRITY: Total honesty and sincerity. Moral soundness; honesty; freedom from corrupting influence or motive

INVENTORY: The act or process of making a list of items or such items. A list of traits, preferences, attitudes, interests or abilities that is used in evaluating personal characteristics or skills

INVOLVEMENT: Being drawn into a situation. The act of sharing in the activities of a group

ISOLATION: The act or condition of placing or keeping oneself apart from others.

ISSUE: A personal problem or emotional disorder

J....

JOURNEY: Going from one place to another. A process or course likened to travelling; a passage

JUDGMENTAL: to make judgments, especially moral or personal ones

JUSTIFY: A character defect that is demonstrated in efforts to prove or show to be just, right or reasonable. Defend, explain, clear away, or make excuses for by reasoning

K....

KINDNESS: The quality or state of wanting or liking to do good and to bring happiness to others. The quality of being warm-hearted, considerate, humane and sympathetic

KNOWLEDGE: Understanding and skill gained by experience. Direct and clear awareness

L....

LEND: To give to someone usually for an agreed time period. To afford; to grant or furnish in general; as, to lend assistance; to lend one's name or influence.

LIABILITIES: Something that works to one‘s disadvantage. Something that holds one back; a handicap.

LIMITATIONS: The quality or act of having a point beyond which a person or thing cannot go. A shortcoming or defect.

LIMITLESS: Having no limits.

LITERATURE: Written works having excellence of form or expression and ideas of lasting and widespread interest. Published writings in a particular style on a particular subject.

LONELINESS: The state of feeling alone. A feeling of depression resulting from being alone.

LOVABLE: Deserving of love. Having characteristics that attract love or affection.

LOVING: To feel warm affection for and show it. Feeling or showing love and affection.

M....

MAINTAIN: To keep in an existing state; preserve or retain

MAINTENANCE: All that is necessary to keep something in a particular or desired state

MEDITATE: To think or reflect, especially in a calm and deliberate manner

MOOD-ALTERING: Something that changes a person‘s state, mood or frame of mind

MORAL: Acting on or through one's moral nature or sense of right and wrong

MOTIVATE: The act of encouraging someone to do something positive

MOTIVE: The reason for doing something

N....

NATURE: The essential characteristics and qualities of a person or thing

NEWCOMER: Someone who has recently arrived; a beginner

O....

OBSESSION: A disturbing or fixed and often unreasonable idea or feeling that cannot be put out of the mind. That fixed idea that takes us back time and time again to our particular drug, or some substitute, to recapture the ease and comfort we once knew

OBVIOUS: Easily found, seen or understood

OPEN: Generally refers to a type of recovery meeting at which those who are not addicts are permitted to attend and observe a meeting

OPEN-MINDEDNESS: Having a mind that is open to new ideas

ORIENTED: Becoming acquainted with an existing situation or environment

P....

PARADOX: A statement that seems to be the opposite of the truth or of common sense and yet is perhaps true

PARANOIA: A mental disorder characterised by extreme, irrational distrust of others

PERSEVERENCE: Steady persistence in adhering to a course of action, a belief, or a purpose; steadfastness

PERSONALITY: The qualities, such as moods or habits that make one person different from others

PITFALL: A danger or difficulty that is hidden or is not easily recognised

POWERLESSNESS: The state or acceptance of feeling that one has no control, authority or influence over something

PRIDE: A high opinion of one‘s own worth that results in a feeling of being better than others

PRIMARY: Most important

PRINCIPLES: A general or basic truth on which other truths or theories can be based

PROCESS: A series of actions leading to some result, such as practicing the principles in the Steps. A natural, progressively continuing operation or development marked by a series of gradual changes that succeed one another in a relatively fixed way and lead toward a particular result or end

PROCRASTINATION: To put off doing something until later, especially out of laziness

PROFOUND: Feeling deeply or showing great knowledge and understanding

PROGRAMME: The plan of action that people follow and the tools used to achieve a goal, such as the Twelve Steps and Twelve Traditions

PROGRESS: To move toward a higher, better, or more advanced stage

PROJECTION: To place one‘s own expectations and desires in place of what is really happening

PROMOTION: A message issued on behalf of some product or cause or idea, person or organisation with the goal of selling it or creating a positive public perception of it

PROMPTLY: Done at once, with little or no delay

PROVEN: Convincing others of the truth, of something by showing the facts. Something established beyond doubt

PURPOSE: A goal to be achieved

R....

RATIONALISATION: Finding believable but untrue reasons for one‘s conduct.

REACTION: A response of the body or mind to a stimulus, such as a situation or stress

READINESS: The state of being prepared for use or action

RECIPROCAL: Done, felt, or given in return. Given and received

RECOVERY: The act, process, or an instance of regaining normal health, self-confidence or position. The act of regaining or returning toward a normal or healthy state

REGRET: Sorrow aroused by events beyond one‘s control. Pain of mind on account of something done or experienced in the past, with a wish that it had been different

RELAPSE: To slip or fall back into a former condition after a change for the better such as using drugs or drinking again

REMORSE: Deep regret for one‘s sins or for acts that wrong others

REMOVE: To get rid of or take away

RENEW: To make, do or begin again

REPARATION: The act of making up for a wrong

RESENTMENT: A feeling of angry displeasure at a real or imaginary wrong, insult, or injury

RESPONSIBLE: Able to make moral or rational decisions on one's own and therefore answerable for one's behaviour

REVEAL: To make known (that which has been concealed or kept secret)

REVERT: To go back to a previous state.

RIGHTEOUSNESS: The state of doing or being what is right

RIGOROUS: Demanding strict attention to rules and procedures

ROOT: Source. The place where something begins

S....

SANCTION: A consideration, influence or principle that dictates an ethical choice

SELF-CENTRED: Limited to or caring only about yourself and your own needs

SELF-ESTEEM: Belief in yourself. Pride in yourself; self-respect

SELFISHNESS: Taking care of yourself without thought for others, which leads a person to direct their purposes to advancing their own interest, power or happiness, without regarding those of others

SELF-PITY: A feeling of sorrow (often self-indulgent) over your own sufferings

SELF-RIGHTEOUS: Being strongly convinced of the rightness of your own actions or beliefs

SELF-SEEKING: Taking advantage of opportunities without regard for the consequences for others

SERENITY: Calmness of mind; evenness of temper. The absence of mental stress or anxiety

SERVICE: Doing the right thing for the right reason

SETBACK: A slowing of progress, a temporary defeat

SHAME: A painful emotion caused by having done something wrong. Or one caused by a strong sense of guilt, embarrassment, unworthiness or disgrace

SHORTCOMING: The acting out of a character defect

SPIRIT: A force within a human being thought to give the body life energy, and power

SPIRITUAL: Of, relating to, or consisting of spirit

SPONSOR: A recovering addict who agrees to guide another recovering addict through the 12 Steps and Traditions

SUBCONSCIOUS: Existing in the mind, but not immediately available to consciousness. Affecting thought, feeling and behavior without entering awareness

SUBSTITUTION: The act of putting one thing or person in the place of another

SUFFER: To feel or undergo pain of body or mind

SUFFERING: Troubled by pain or loss

SUFFICIENT: Enough to achieve a goal or fill a need

SUPPORT: To give moral or psychological support, aid or courage to someone

SUPPRESS: To put down or hold back

SURRENDER: The act of giving in

T ....

TEMPERED: Made into a more useful state

THANKFULNESS: Feeling grateful or showing thanks

THERAPEUTIC: Having a healing power or quality

THOROUGH: Careful and accurate.

TOLERANCE: Willingness to recognise and respect the beliefs or practices of others

TRADITIONS: A set of 12 principles laying out the ground rules of the Fellowships

TRAITS: Distinguishing features

TRUSTWORTHY: Deserving trust, confidence, or belief

U....

UNCONDITIONAL: Without any exceptions, conditions or limitations

UNDERLYING: Present but not obvious

UNIQUE: Being the only one of its kind

UNITY: The state of being in full agreement

UNMANAGEABLE: Hard or impossible to manage. Difficult to keep under control or within limits

USER: One who uses addictive substances

V....

VIGILANCE: The process of paying close and continuous attention

VIRTUE: A desirable quality, such as truth. The quality of doing what is right and avoiding what is wrong.

VOID: Containing nothing.

Z....

ZEAL: Eager desire to get something done or see something succeed. Enthusiastic devotion to a cause, ideal or goal

APPENDIX SIX

SERVICE SPECIFICATIONS

1. Population Needs

1.1 National/local context and evidence base

In *xxx* the treatment population includes *xxx* opiate users, xxx non-opiate users and xxx dependent drinkers. There is an established expert consensus and growing evidence base for the effectiveness of peer led interventions generally, and recovery Coaching specifically, in initiating and supporting long term recovery from substance misuse.

This expert consensus and evidence base includes the following:

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.

Hser, Y., Anglin, M., Grella, C., Longshore, D. & Prendergast, M. (1997) Drug treatment careers: A conceptual framework and existing research findings. *Journal of Substance Abuse Treatment* 14(3):1-16.

White, W.L. (2007a). Ethical guidelines for the delivery of peer-based recovery support services. http://www.bhrm.org/recoverysupport/EthicsPaperFinal6-8-07.pdf. Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS) and Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT).

White, W.L. (2007b). *Perspectives of Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-oriented System of Care.* Great Lakes Addiction Technology Transfer Center. Chicago.

White, W.L. (2008b). *Recovery Management and Recovery-Oriented Systems of Care.* Northeast Addictions Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W.L. (2009) *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation.* Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W.L., & Kurtz, E. (2006). *Linking addiction treatment and communities of recovery: A primer for addiction counselors and recovery coaches. Pittsburgh, PA: IRETA/Northeast Addiction Technology Transfer Center.*

White, W.L., Kurtz E., Sanders, M. (2006). *Recovery Management.* Great Lakes Addiction Technology Transfer Center. Chicago.

2. Key Service Outcomes

2.1 Insert any locally agreed outcomes and quality requirements which are NOT Quality Outcomes Indicators which should be set out in Appendix (*Quality Outcomes Indicators*)

Recovery Coaching will operate within a framework of the values and principles outlined in the UK Recovery Coaching Training Manual, which is available at:
http://www.ukrecoverywalk.org/uk-recovery-coach-manual/

3. Scope

3.1 Aims and objectives of service

The aim of recovery coaching is to assist clients to identify, own and build on their recovery capital to meet their recovery goals

The specific objectives include:

⇒ Identifying and formulating goals for the Recovery Plan

⇒ Identifying objectives to meet the Recovery Plan goals

⇒ Agreeing milestones to measure progress

⇒ Supporting the development of appropriate skills and strategies to meet the Recovery Plan goals

⇒ Developing contingency plans

3.2 Service description/pathway

A Recovery Coach is a person who is actively and authentically engaged in recovery who shares their own wealth of personal experience of the challenges and rewards of recovery to assist and support others to find their own recovery path and follow it

Recovery Coaching will be available for any individuals in the following stages of treatment:

⇒ Preparation for change

⇒ Active change

⇒ Treatment completion

⇒ Post treatment

Recovery Coaching will be recorded on NDTMS (core data set J – adult) as “Recovery support sub-intervention: peer support involvement”

3.3 Population covered

All opiate, non-opiate and alcohol clients currently receiving structured treatment interventions and those who have successfully completed treatment in the last 6 months

3.4 Any acceptance and exclusion criteria and thresholds

None

3.5 Interdependencies with other services

Recovery Coaching can be provided alongside other Care Coordination, Pharmacological, Psychological and Recovery Support interventions

4. Applicable Service Standards

4.1 Applicable national standards eg NICE

NICE Quality Standard for Drug Use Disorders (QS23)

Quality statement 7: Recovery and reintegration - people in drug treatment are offered support to access services that promote recovery and reintegration including housing, education, employment, personal finance, healthcare and mutual aid

Quality statement 9: Continued treatment and support when abstinent - People who have achieved abstinence are offered continued treatment or support for at least 6 months

4.2 Applicable local standards

Recovery Coaches are required to have the skills, knowledge and personal qualities specified in the UK Recovery Coaching Training Manual

Recovery Coaches are required to receive adequate supervision as specified in the UK Recovery Coaching Training Manual

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