



Recovery Coach Manual



The McShin Foundation
A Recovery Resource Foundation

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Foreword

Just as individuals in 12-Step recovery sometimes feel the need to start their own meeting, so did we feel the urge first to establish the McShin Recovery Coaching program and, later, to write this manual to share what we have learned with others. As we have come to believe from our time “in the rooms,” when a new meeting or other undertaking goes well, it must be God’s will; when it does not, it must be self-will. McShin Foundation has grown and flourished in ways we could not have imagined. It is our hope that this manual will help others lay the groundwork to share the miracle of recovery with many more than we could ever serve.

As the McShin recovery coaching program is thriving, we feel blessed. If this manual is widely read and helps others access the miracle of recovery, we believe that thanks is due first to God 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 this manual and curriculum could not have been developed. For years, Dr. Clarke has led the creation of amazing recovery projects. To some extent, the McShin Recovery Community Organization and Recovery Community Center and the McShin Foundation Peer Leadership Institute owe their existence to the work of Dr. Clark and his colleagues. Of all that SAMHSA/CSAT has given the treatment and recovery field, the five monographs on recovery-related topics released over the past few years by the SAMHSA/CSAT Addiction Technology Transfer Centers (ATTCs) have had the greatest impact on McShin Foundation (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. The McShin Foundation owes its mission and design to a combination of principles derived from these three major pathways to recovery and to the five recovery monographs published by the ATTCs. We owe a debt of gratitude to Dr. Clark and his colleagues, to William L. (Bill) White, and to the ATTC network for their hard work, inspiration, insight, and support.

Since McShin Foundation’s humble beginning, when we relied almost exclusively on friends in recovery and their families, the organization has grown to include a 35-bed recovery housing program that hosts more than 2,000 support meetings each year. McShin Foundation is self-funded. We have adopted innovative fundraising strategies and, through them, have been able to attract a diverse set of benefactors. Over the past 3 years, our annual revenue has averaged about \$500,000. The Foundation was incorporated as a 501(c3), 509(a2) public charity in July 2004.

We are proud of our recent accomplishments. McShin Foundation has certified more than 150 recovery coaches—and we did this our way, the recovery way. Additionally, we succeeded in attracting more than 5,000 persons to our annual Recovery Fest, an event celebrating recovery from substance use that takes place every September, during Recovery Month. We have also impacted decision-making and policy at the local, State, and national levels through outreach and advocacy conducted by people in recovery and their allies. In Virginia, lawmakers on a joint subcommittee studying strategies and models for substance use disorder prevention, treatment, and recovery approved some of the Foundation’s recommendations, including:

- Developing and implementing a voucher model at various treatment and recovery service provider sites;
- Fostering learning about current recovery community organizations, continuing to fund their successful programs, and developing new ones; and,
- Exploring reimbursement options for autonomous recovery community organizations.

Any group of people committed to their recovery can create and sustain a truly localized recovery community organization, as we did. The McShin model works; and this will show you how to implement it in your community.

When starting your own recovery coaching program or recovery community organization, we strongly recommend that you read White's *Slaying The Dragon: The History of Addiction Treatment and Recovery in America* (1998), the ATTC recovery monographs, and other materials about major pathways to recovery. These resources will provide an invaluable understanding of the history and current status of the recovery movement and addictions treatment and will help you frame the mission and goals of your organization within this context.

Above all, we would like to share a reminder we give ourselves daily: Your recovery is most important. Therefore, live the program you want to share with newcomers!

Thank you to McShin Foundation executive director Daniel Payne for writing the majority of this manual. Without the commitment and countless hours he devoted to this project, this manual would not exist. Thank you also to Peter Gaumond of Altarum Institute for organizing and “fleshing out” this manual; he really makes us look good. Finally, there would be no McShin Foundation without my wife and foundation cofounder Carol McDaid, the “Mc” in McShin and—by far—the best recovery coach I have ever known. (I love my recovery coach!) Simply put, there would be no McShin without the “Mc.”

John M. Shinholser

McShin Foundation cofounder and president

McShin Foundation

- 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.
- 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 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—Achieving Community Together (PRO-ACT).

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Goals of this Manual

This manual is a companion to the [McShin Coaching Curriculum](#). It is intended to serve as a reference document for individuals who are enrolled in the McShin recovery coaching training and for individuals who have completed the training. In conjunction with the McShin Recovery Coaching training, this manual is intended to:

- Provide background on the history and many pathways to recovery from addiction to alcohol or other drugs.
- Provide a clear definition of recovery coaching that differentiates it from other roles, such as sponsor, counselor, or friend.
- Build some of the key skills necessary to be effective as a recovery coach.
- Offer a framework for ethical standards.
- Enrich your recovery and personal growth.
- Build on or ignite a passion to engage and work with those who are entering the journey of recovery.
- Increase your awareness of the many helping hands of the recovering community.
- Underscore the unique power of a helping relationship involving two recovering persons.
- Increase your knowledge of recovery pathways other than your own.
- Provide information on recovery community organizations.
- Expand your awareness of the recovery movement, of opportunities to play a role in it, and of how it can play a role in the recovery of those you serve as a coach.

The Roles of the Recovery Coach

The peer recovery coach is a person who is actively and authentically engaged in a recovery

pathway. Coaches strive to meet any requirements or goals of their pathway. They exhibit a new perspective on life that has been gained through their recovery. This is referred to by many as a “spiritual awakening.” 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, to paraphrase and acknowledge what has been said, and to share from their own experience in a way that is helpful to those with whom they work.

The Coach as Fellow Journeyer

One of the key ways in which a recovery coach differs from a counselor, therapist, 12-step sponsor, or spiritual advisor is in the nature of the relationship of the coach to the *coachee*. The relationship of the counselor 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 does the *helpee*. 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 entail a natural authority that the role of the coach does not. Like the sponsor and spiritual advisor, the coach is a fellow journeyer who is somewhat further along the path than the individual with whom he or she works. However, unlike them, the coach is first and foremost a peer and a consultant.

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, to paraphrase and acknowledge what has been said, and to share from their own experience in a way that is helpful to those with whom they work.

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. Within a chosen path, the *coachee* may well

accept prescribed steps or approaches. Those prescriptions or recommendations, though, come not from the coach, but from sponsors, spiritual advisors, and others helping the *coachee* more directly in the pursuit of a specific path to recovery.

The Coach as Listener

Listening may be the recovery coach's single most important skill. It is often taken for granted. While the coach does not have the answers, he or she does have a good ear, empathy, and a healthy level of detachment from the circumstances of the *coachee*. The coach also brings a wealth of personal experience with the challenges and joys 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 through which one can understand and accept the past, embrace the present, and develop a roadmap to an envisioned 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 Mirror

Recovery coaches serve as a mirror to those they serve 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. In doing so, coaches mirror *coachees'* thinking in an effort to assist them in recognizing inconsistencies or misperceptions that could get in the way of meeting their recovery goals.

In a very real sense, the primary 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 Mentor

Mentoring is another important role of the recovery coach. Mentors share their knowledge and experience with individuals who have not progressed as far down a chosen path 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 pathways to recovery. As mentors, coaches would be well-advised to provide information and advice in the manner in which 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 decides what will or will not be taken and what will be done or left undone.

The Coach as Consultant

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

- Formulating recovery goals;
- Identifying objectives that will help meet recovery goals;

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The coach is 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.

In a very real sense, the primary tools of recovery coaches are their personal experience, strength, and hope.

- Establishing milestones to measure progress;
- Developing skills and strategies to stay on course; and,
- 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*. Rather, the coach assists the *coachee* in clearly identifying recovery goals and developing a plan for accomplishing them. In essence, 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. In offering an alternate way of thinking about things or new strategies, coaches serve as recovery consultants.

The Coach as Advocate

Coaches are often called upon to serve as advocates for those with whom they work. Generally, this advocacy does not involve public speaking, but a coach may, from time-to-time, find it appropriate to speak in a courtroom or to a group on behalf of a *coachee*. Most often, however, the advocacy role of the recovery coach consists of simpler activities, such as calling, speaking in person with, or writing a letter to a potential landlord or employer, probation or parole officer, or a judge. It may

also involve facilitating access to services or fostering collaboration among organizations that are providing services to a *coachee*.

When contemplating advocacy on behalf of a *coachee*, coaches who are early in their career are encouraged to consult with supervisors or more experienced coaches. These individuals can provide information about appropriate resources. When thinking about engaging in advocacy that goes beyond facilitating access to services, supervisors or more experienced coaches can help in the decision-making process. If the decision is made to proceed, they can also help develop advocacy strategies that are likely to be successful.

The advocacy coaches conduct on behalf of *coachees* should not be confused with any broader advocacy activities in which the coach may be involved as an individual, or even as a member of the organization through which he or she provides recovery coaching services.

Such advocacy may play an important role in addressing stigma and the misunderstanding of addiction and recovery in the larger community. It may even positively impact those with whom the coach works. 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 the advocacy in which one properly engages as a coach.

Whether as an advocate or as an ambassador to the broader community or to other organizations, the recovery coach may, from time-to-time, find it appropriate to speak publicly about addiction or, to share his or her story of recovery, or to explain the role of his or her organization and that of the recovery coach within it. Because of

Whether as an advocate or as an ambassador to the broader community or to other organizations, the recovery coach may, from time-to-time, find it appropriate to speak publicly about addiction or recovery, to share his or her story of recovery, or to explain the role of his or her organization and that of the recovery coach within it.

this, McShin advises coaches to complete the [Recovery Messaging Training](#) offered by Faces and Voices of Recovery. This training will soon be available in video format.

Finally, those recovery coaches following a 12-step path are advised to follow the traditions of their fellowship vis-à-vis public speaking, 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

We reiterate here much of what has been said before because of the importance of understanding the role of the coach and how it differs from other roles. A recovery coach is NOT a:

- Counselor.
- Social worker.
- Judge.
- Psychologist.
- Lawyer.
- Pastor, priest, rabbi, imam, or other spiritual advisor.
- Sponsor.
- Doctor.
- Case worker.
- Financial adviser.
- Loan officer.
- Marriage counselor.
- Roommate.
- Landlord.
- Best friend.

Thought 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 on when working with coachees?

A Word on Cultural Competency

The “recovery community” —a term once used to refer collectively to members of local 12-Step groups—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).

The concept of cultural competency is increasingly taking on new dimensions in the domain of recovery coaching. As the number of recovery communities and recovery pathways expands, it is becoming clear that coaches must not only develop the knowledge and skills necessary to effectively serve individuals who may differ in terms of racial and ethnic heritage or may have other cultural affiliations that set them apart from the coach; they must also become familiar with diverse recovery pathways.

Becoming culturally competent in the growing number of available recovery pathways is one of the greatest challenges facing recovery coaches.

As the treatment and recovery field moves toward person-centered and recovery-focused approaches, White argues that “we must all become very fluent in the multiple pathways to recovery” (White, 2008). Multiple recovery communities are now contributing to the national dialogue on recovery, and the range of mutual aid options is also expanding as groups, such as Women for Sobriety, Smart Recovery, and Celebrate Recovery, take a foothold in new communities.

Effectively serving individuals whose recovery paths differ significantly from theirs can be a tall order for coaches. However, doing so provides an opportunity to broaden one’s perspectives and deepen one’s understanding of recovery and of one’s own chosen recovery pathway.

Openness to diverse perspectives on addiction and recovery is essential if coaches are to truly embrace *coachees*’ stories and pathways, supporting them in authentically navigating their unique recovery journeys.

Coaches must recognize not only 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.

Coaches must recognize not only 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, in principle, it is natural to the role of the coach, which is not to provide the answers that a particular path may offer, but to support individuals in following the paths that are authentic to them.

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? Coined by Granfield and Cloud (1999),

the term “recovery capital” was defined by William 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 family relationships when they are there and still predominantly positive, employment or school enrollment, stable housing, connection with the recovering community, hobbies—especially when they involve others—and participation in mutual aid groups. To simplify, one might say that recovery capital is everything for which the recovering individual has reason to be grateful.

You may want to view the role of the recovery coach as being akin in some ways to that of a financial advisor. As a coach, you assist individuals in identifying and managing high quality assets and investments. 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 assists the *coachee* in moving from the poverty of addiction to the prosperity of recovery. In this context, recovery capital is the primary currency of the domain.

The recovery capital concept is particularly useful because it cuts across 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 leverage their existing recovery capital to build new capital. In a very real sense, the primary job of the recovery coach is to assist *coachees* in identifying and building on their recovery capital in order to meet their recovery goals.

One might say that recovery capital is everything for which the recovering individual has reason to be grateful.

Recovery capital is an inexhaustible resource. We find it within us, in fellow journeyers on the path to recovery, in family members and friends, in our spiritual and work lives, and through our positive involvement in community, including service work. While we all have access to reserves of recovery capital, we don't always use that capital to further our recovery. Unused recovery capital is, of course, of no value. The old adage that you can lead a horse to water, but you can't make it drink applies when it comes to working with a *coachee* to identify and build on recovery capital. 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 utilize that capital.

Examples of Recovery Capital

Recovery capital is sometimes divided into three broad categories: Social Capital, Physical

In a very real sense, the primary job of the recovery coach is to assist coachees in identifying and building on their recovery capital in order to meet their recovery goals.

Capital, and Human Capital. These categories 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 one can access through relationships and membership in groups or communities. Potential sources of social capital include individuals with whom one is in treatment, members of the broader recovery community or a 12-Step or other mutual aid group, family, congregations, clubs, or communities. Social capital can be viewed as the web of supportive social relationships and networks that surrounds the individual in recovery.

Examples of social capital include:

- 12-step meetings.
- Church meetings.
- Clean and sober clubs.
- Employers and/or work colleagues.
- Schools, teachers, and fellow students.
- Family, friends, and co-workers who understand and want to help or spend time with someone in recovery.
- Clean and sober events (e.g., camp-outs, picnics, convention, dances, etc.)

Physical Capital

As the name implies, physical capital consists of tangible resources, such as income, assets, vehicles, housing, food, and clothing. Examples include:

- Clean and sober housing.
- Recovery Community Organization or Recovery Community Center.
- Income—whether from employment or from public benefits.
- Food and clothing—whether purchased with employment income, donated, or acquired with public benefits.
- Temporary financial assistance from friends, family, or other allies.
- Access to reliable transportation—whether a vehicle or mass transportation.
- Employment centers.

Human Capital

Human capital is closely associated with social capital. It is primarily distinguished from the latter because it includes both external and internal resources and because the external resources are individuals or organizations that play specialized roles in treatment, recovery, and related processes.

Many forms of recovery capital are in infinite supply. Giving recovery capital does not deplete the supply; it actually increases it. As members of Alcoholics Anonymous have long said, “You’ve got to give it away to keep it.”

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 specialized expertise, or peers, or through taking part in a program of recovery.

In its external form, human capital refers to a small set of individuals who are particularly instrumental in supporting recovery or skills specific to one’s recovery. These may include:

- Recovery coaches, recovering peers, sponsors, and clergy.
- Caseworkers, counselors, teachers, social workers, doctors, nurses, or other professionals who play a key role in initiating or supporting recovery.
- Teachers, instructors, or athletic coaches.
- Probation or parole officers, judges, lawyers, wardens, or law enforcement personnel.

Recovery capital is an essential commodity throughout our recovery journey. Each of us has the potential to give and receive recovery capital. Recovery coaches both offer recovery capital directly and help *coachees* discover or recognize internal and external reserves of recovery capital that can be tapped to sustain and enhance recovery.

Many forms of recovery capital are in infinite supply. One of the greatest benefits of serving as a recovery coach is that giving recovery capital does not deplete the supply; it actually increases it. As members of Alcoholics Anonymous have long said, “You’ve got to give it away to keep it.”

Thought Exercise

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

1. What recovery capital were you able to leverage to enter recovery?
2. In what areas did you have a deficit of recovery capital?
3. How did you build recovery capital?
4. Are there areas where you would benefit from additional recovery capital right now? If so, what are they?
5. *What are some 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 & Principles

Skills

The core skills necessary to successful recovery coaching can be developed. None of us has all of these skills to the degree that would be ideal. However, we each have at least some of the rudiments of these 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 oneself in *coachees’* shoes and acknowledging the validity of their feelings and experiences.
- Placing one’s judgments and opinions on the side.
- Serving 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.
- Recognizing one’s personal limitations and the boundaries of the relationship between coach and *coachee*.
- Detaching from the outcomes of your work, avoiding blaming or self-recrimination when things don’t go as planned.
- Public speaking and advocacy on behalf of *coaches*.
- Relationship-building skills with *coachees*.

Thought 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.)
3. We can all develop our skills, but also all have different strengths and weaknesses and different aptitudes.

Knowledge

As the Greek Philosopher Socrates taught, self-knowledge is the foundation upon which all other knowledge is built. Self-knowledge is also recognized as a starting point by 12-Step recovery programs and many religious and spiritual traditions.

One way of looking at recovery is as a movement from a dysfunctional relationship with substances to a genuine relationship with one’s higher power and/or one’s fellow man. Such genuine relationships begin with self-knowledge. They require levels of self-awareness, self-acceptance, and humility that are not compatible with addiction.

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 those you serve. A corollary of this is the need for a solid understanding of your own recovery path and the ability to share it in a manner that is appropriate to the individual with whom you are working.

Also important is a knowledge of and openness to other recovery pathways, both secular and spiritual. 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, its relationship 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 gently encourage greater self-knowledge on the part of the *coachee*. This can be accomplished in a number of ways, from pointing out apparent inconsistencies between their behavior and expressed values or goals, to increasing awareness of triggers, vulnerabilities, and strengths. Your own experience and training (e.g., recovery coaching, relapse training or recovery plan development) provide you with the necessary knowledge to perform this function.

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 and advisor who recognizes that what worked for you may not always work for your coachees.

Finally, as a coach, you will need to have knowledge of a broad range of community resources, including housing, mutual aid groups, addictions, 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. As long as you are working as part of a team, which likely be the

case, this should not be a problem: You can rely on the knowledge of more experienced team members as you build your own knowledge.

Thought Exercise

1. How would you describe your recovery pathway?
2. Are there pathways with which you feel uncomfortable or which, in your view, are philosophically incompatible with your pathway?
3. How would you feel about working with a coachee who is following a pathway different from your own?
4. List other recovery pathways with which you are familiar? How strong is your understanding of these pathways?
5. List the mutual aid groups (AA, NA, SMART Recovery, etc.) with which you are familiar. Do you know whether or not the groups you identified have local meetings?
6. You may need to work with individuals from a different socio-economic, racial, ethnic, or cultural background? Which recovery coaching skills do you feel would be most important in such cases?
7. Can you identify local housing, employment, training, education, parenting, child care, transportation, and medical resources?

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 recognizes that what worked for you may not always work for your *coachees*. You are also a mirror for *coachees*. That does not simply mean that you have had and can relate to similar experiences, although this is certainly the case. It also mean that you can help *coachees* see themselves better and thereby help them recognize when they are being less than honest with themselves or others or lack awareness in

important areas. You serve 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 that helps the *coachee* grow in awareness and honesty.

While it has a long and storied history in addictions 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 one sugar-coats everything or enables unhealthy behavior. Rather, it means that as recovery *coachees*, 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.

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

Other key qualities essential to the recovery coach include:

- Open-mindedness to new pathways.
- Empathy and compassion.
- Humility.
- Humor.
- Patience.
- Assertiveness.
- Commitment to and passion for service.
- A solid sense of boundaries, including one’s own strengths and weaknesses.
- Self-acceptance and an ability to take care of oneself as called for in one’s recovery pathway.
- Understanding of the limits of one’s powers.

- A commitment to embodying one’s recovery pathway in everyday life or, as is said in 12-Step programs, a desire and commitment to “walk your talk.”

Thought Exercise

1. How would you describe your recovery pathway?
2. Are there pathways with which you feel uncomfortable or which, in your view, are philosophically incompatible with your pathway?
3. How would you feel about working with a *coachee* who is following a pathway different from your own?
4. Do you feel equally aligned with all of the values listed above? If not, with which values do you feel most and least aligned? Why do you think you feel that way?
5. Of the values with which you feel aligned, are there some that you find harder to live by or embody than others? If so, why do you think that is?
6. Are there other qualities that would be helpful in a recovery coach?

Values

Another way of looking at recovery is as the process of learning to live by core values, such as honesty, truthfulness, respect for the dignity of oneself and others, and integrity. We also learn to acknowledge the many ways in which we have betrayed ourselves and our values during our addiction and come to forgive ourselves the wrongs we have committed against ourselves and others.

The values that are implicit in that are the same values that form the foundation for recovery coaching. They include:

- Honesty with oneself and others.
- Integrity, or the striving to walk one’s talk.

- Regard for those who continue to struggle with addiction.
- Humility, including recognition that one does not have all of the answers.
- Profound respect for recovery and for the relationship between two people in recovery.
- Embrace of diverse recovery pathways.
- Openness to discovery and learning in the coach-*coachee* relationship.
- Passion for recovery and enthusiasm for one’s role as a coach.
- Community, or the recognition that we are in this together.

Principles

Principles flow from and express our values. They are inseparable from them. 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:

- Put recovery first –
- Associate with positive recovering people and put your recovery first.
- Take care of yourself physically, mentally, and spiritually.
- When working with *coachees*, emphasize the importance of putting recovery first and help them see the ways they may not be doing so.
- Remain true to your pathway and your recovery.
- Realize 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.
- Avoid prescribing your pathway; use your experience, strength, and hope to assist *coachees* in finding pathways that work for them.
- Learn by your mistakes: Have the honesty to recognize mistakes and the humility and healthy self-love to embrace and apply the lessons they bring.
- Realize 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.
- Take care of your family.

Thought Exercise

1. Which of these principles do you most like? Why?
2. Do you disagree or dislike any of these principles. If so, why is that?
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?

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. While recovery coaching does provide some of the same benefits as active involvement in a recovery program, it is in no way a replacement for it. Failing to faithfully follow your own recovery path does not simply 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 our own recovery path, we can find ourselves bringing emotional baggage into our relationships with *coachees*. This can distort our perceptions and 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 and counsel from a mentor, sponsor, spiritual advisor, or coach;
- Participating in support groups;
- Taking part in treatment or therapy.;
- Actively following your chosen spiritual path;
- Ensuring that you eat properly, get enough sleep, and exercise regularly; and,
- Carrying the message of recovery to others.

Thought Exercise

1. How well are you taking care of yourself right now?
2. Are there ways in which you could take better care of yourself?
3. Would you benefit from assistance or structure related to areas where you may not be taking care of yourself as well as you would like?
4. Do you have skills, knowledge, or experience that could help *coachees* or fellow coaches to better taking care of themselves?

Thought Exercise (Continued...)

5. If it appeared that 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 adequately?

Daily Activities of the Recovery Coach

Overview

So far, this manual has addressed recovery coaching in a very broad way. This segment 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 will likely need to address.

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 simply 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 leverages 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.
- Emphasizes that no one but the *coachee* can actually do the work of recovery.
- Provides feedback in a nonjudgmental and supportive way, recognizing 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 work is based. It is, therefore, important to “meet *coachees* where they are at” and to welcome them, letting them know that you’re looking forward to working with them. Questions that can help focus the discussion and your relationship on “where the *coachee* is at” 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 us?
- Do you have goals that your addiction has kept you from meeting?
- What does recovery mean to you?

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 clarify expectations. That is, 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 matters helps build a solid foundation for future work.

In the early stages of your work with *coachees*, you are laying the foundation upon 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. Rather, it means that you need to be mindful that your relationship with *coachees* will be the foundation of all your work with them. The coach-*coachee* relationship needs to be clearly defined and needs to center 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 and 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.

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.

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). The ideas behind the ruler, while part of Motivational Interviewing,

have their origins in Prochaska's famous Stages of Change Model (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Velicer, 1997), including the concepts measured with the readiness ruler. Created originally for use in healthcare settings, the ruler is easy to use and provides an excellent tool for helping focus on the reasons a *coachee* wants to change. When a *coachee* is hesitant or doubtful, the ruler can be especially helpful.

You may want to use the Readiness Ruler (below) as a matter of general practice or you may prefer to use it exclusively 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 and *coachees* be clear about how important *coachees* feel it is to make a specified change or take a specified action, how confident they are that they can successfully make the change or take the action, and how ready they are for the change or action.

How important is it for you to make this change?

Readiness Ruler

1 2 3 4 5 6 7 8 9 10

Not Important Important Very Important

How confident are you that you can make the change?

Readiness Ruler

1 2 3 4 5 6 7 8 9 10

Not Confident Confident Very Confident

How ready are you to make this change?

Readiness Ruler

1 2 3 4 5 6 7 8 9 10

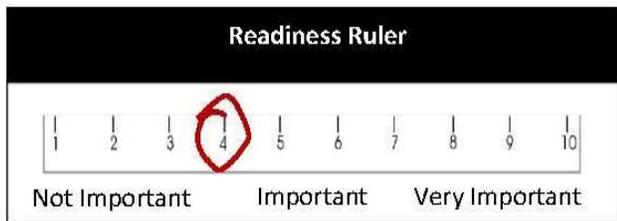
Not Ready Unsure Ready

These questions provide an excellent mechanism for eliciting what Motivational Interviewing practitioners call “change talk.” That is, 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 for your *coachee*, 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, suppose a *coachee* is continuing to spend time with using friends despite recommendations that he not do so. Suppose that, as a result of hanging out with a using friend, he relapsed and feels remorse. The coach might show the *coachee* the ruler and ask:

How important is it to you that you stop hanging out with using friends?

Let’s suppose the *coachee* rated the importance of the change as a **4**, *somewhat important*.



Let’s further suppose that the *coachee* rates his confidence in his ability to make the change as a 9, and his readiness as a 3. Faced with this response, it might be difficult for many of us not to show some level of exasperation. Most of us would naturally want to ask the *coachee* why he or he did not rate *staying away from risky people, places, and things* a 10 in importance, or lecture on the importance of not hanging out with using friends.

While this approach may sometimes work, succumbing to the temptation to argue for a desired change (e.g., staying away from risky people, places, and things) 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 clean and sober.”

Coach: “Don’t you see that you put yourself at risk every time you hang out 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. I’ve hung out with them since we were kids.”

Coach: “So these friends are more important to you than staying clean and sober and getting off probation?”

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 rather, 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 guys are about the only friends I have, I do have to admit that there is a risk for me if I hang out 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: “MMMM.... I guess so.”

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

Coachee: “I guess 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 proceed to recite 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 unless the program in which he or she serves requires 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. At McShin Foundation, we limit the coaching relationship to 90 days. However, the actual length of engagement will vary from *coachee* to *coachee*. The *coachee*’s actions are the best measure for determining when the coaching service can be discontinued. If you are working in the context of a program that does not have time limits, it would probably be a good idea to set the accomplishment of certain 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. For another *coachee*,

completion of a different set of goals might be a better marker for the point to end services.

The coaching relationship is like teaching someone to ride a bike. Initially, you run along beside the rider, stabilizing the bicycle while making recommendations and issuing warnings about dangers ahead. Then, you help them get started and watch them zigzag, lose and regain balance, crash, or nearly crash. You still shout out warnings or suggestions, but only when you feel it is necessary. 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 services are stopped, 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 at your organization, thereby shifting to the role of colleague.

What to Do in Case of Relapse

When relapse occurs, the coach helps the *coachee* get right back on that bike! The coach does not go to a bar or drug house to retrieve the *coachee*. However, it is appropriate for the coach to meet the *coachee* in a recovery environment. 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 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 self or the other. Invest your recovery capital in the *coachee*. If you do so and detach 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 perhaps be modified? Don't confront the *coachee*. Rather, note that they do not appear to be following the plan that 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 to what extent they are ready to pursue it. The readiness ruler provides an excellent tool for this purpose and can help focus the *coachee* on solutions instead of problems or doubts.

In the coaching relationship, it is important that relapse be seen as a learning opportunity and not a failure on the part of the coachee, the coach, or both.

When relapse occurs, it may be helpful to emphasize that, as a coach, you are not looking for perfection from the *coachee*, but rather a genuine effort to work toward recovery. That commitment to genuine effort sometimes includes picking back up if there has been a slip or full-blown relapse.

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 for an assessment may be appropriate.

Discuss relapse; use personal experiences and those of others when a person puts down their recovery.

When and How to Consult Supervisors

Your supervisor will give you specific guidelines regarding situations or questions that must be brought to his or her attention. He or she may also set up a regular schedule for supervisory 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 3-to-6 months as a coach. Additionally, we strongly recommend that you consult with a supervisor or more experienced coach whenever a situation arises for which your training has not prepared you. Other times to consult with a supervisor include when you are not sure how to proceed in a specific situation and when you are having difficulties in your relationship with a *coachee* or are concerned about that individual. You should also consult with a supervisor, of course, if you are having difficulties with a colleague or if you observe something that could be detrimental to a coach, a *coachee*, the organization, 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 services since other coaches will be familiar with their status 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.

Moreover, within your organization, the coaches and their supervisors should work as a team. This not only makes for a healthier environment, it also makes for better services for *coachees* and ensures that there will be someone familiar with their situation with whom they can consult when you are not available.

Ethical Considerations

As William L. White has pointed out, recovery coaching as a service is in its infancy. The role of the recovery coach, the setting in which he or she works, and the characteristics of recovery coaches vary from State-to-State and from organization-to-organization. Sometimes the service is provided through clinical organizations, and sometimes it is provided through recovery community organizations, through faith-based organizations, or in other settings.

Many recovery coaches are in recovery themselves and directly tap 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 counseling roles. The variation in the roles, organizational settings, and 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 that influence the level of vulnerability that *coachees*, coaches, and their organizations encounter:

1. Recovery coaching relationships tend to last longer than counseling relationships.
2. The coach-*coachee* relationship is less hierarchical (i.e., less differential of power and vulnerability) than the counselor-client relationship.
3. Recovery coaching involves different core functions than counseling; it is governed by different accountabilities.

4. *Coachees* may need different types of support services concurrently or at different stages of their addiction and recovery careers; coaches, therefore, need to exercise care in evaluating needs, delivering services within the boundaries of their knowledge and experience, and knowing how and when to involve others in the process.
5. Peer-based recovery support services can be an adjunct to addiction treatment—for those with high problem severity and low recovery capital—or an alternative to addiction treatment—for those with low-to-moderate problem severity and moderate-to-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. They 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.
- **Authenticity of Voice:** Represent accurately your recovery experience and the role from which you are speaking.
- **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. Accept imperfection. Honor 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. 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 (White, 2007a).

Thought Exercise

1. Do you believe the recovery values proposed by 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 the “Ethical Guidelines for Peer Recovery Support Services” and complete Table 1, the *Intimacy Continuum*. Which items were easy to categorize on the continuum and which were not? What should you do to obtain clarification or input regarding those items you found difficult to categorize?

Thought Exercise (Continued...)

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 multiple inquiries, 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 PCP* would come to light. What courses of action are open to you? Evaluate each option using the Ethical Decision Making tables 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?

* PCP (phencyclidine) is an intravenous anesthetic that was discontinued for human use because it causes agitation, delusions, irrational behavior, and violence. It is still available on the street.

The Context of Our Work

History of Addictions Treatment and Recovery Field

This section provides a brief overview of the recent history of treatment and recovery. A more comprehensive overview ([History of Addictions Treatment and Recovery Field](#)) can be found in the appendices. William L. White’s *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, of course, provides the most complete exposé available on recent history and on what preceded it.

The solution for addiction has always been and always will be RECOVERY! As you learn through your reading of *Slaying the Dragon: The History of Addiction and Recovery in America*; for decades, recovering individuals and their organizations have delivered recovery services

alongside both opportunists touting concocted treatments and medicines and dedicated professionals.

Beginning in the 1950s, as public awareness of Alcoholics Anonymous grew, there was an explosion of newcomers. The recovery community gladly enlisted the aid of medical and clinical addictions services to expand access to recovery and to support their work. Over time, this led to the medicalization and professionalization of the field, which was nearly complete by the mid-1980s.

Treatment, once was an adjunct to recovery, became the driving force in the treatment and recovery field. After treatment costs skyrocketed and long, expensive treatment episodes without linkage to recovery supports regularly resulted in relapse, the purse strings were tightened by States and by insurers in the mid-1990s.

The encapsulated episode of treatment, already largely disconnected from the recovery community became shorter and shorter. What emerged was an *acute care model*, under which brief, intense episodes of treatment followed by discharge were provided as though they were a cure. Treatment had largely lost its connection with the recovering community and, while providers often talked recovery, the focus had shifted from the recovery process to the treatment intervention.

To compound this tragedy, in an effort to protect recovering people from stigma, strict confidentiality laws were passed that, in effect, reinforced the stigma and shame associated with addictions, keeping it hidden. This made it easy for the public to forget about recovery and for addictions treatment and recovery to become ever more marginalized. While many would disagree with us, we at McShin Foundation feel that confidentiality regulations have served to preserve and reinforce stigma and thereby keep addictions and recovery in the closet. We believe this has led to the growing isolation treatment and recovery field and, most importantly, has discouraged recovering people from openly celebrating recovery and its message of hope.

While the rules remain in place, there is now debate in the field about them, principally because of the complications they may cause when attempting to create an integrated health record. Closer to home, many consumer and grass root organizations have mobilized with the goal of putting the stewardship of recovery by recovering peers front-and-center once again. Today the fate of millions battling addiction depends on the success of this recovery movement. Now is the time to make history and take back co-control of recovery and its delivery systems!

We must do this through massive education of citizens and policy makers and the mobilization of recovering people and their organizations. The goal of these efforts is to reduce the stigma associated with the disease of addiction. As that occurs, it will begin to be possible to work effectively with communities to address addiction and celebrate recovery.

As persons in recovery, it is our responsibility to ensure that our voice is heard loud and clear in the halls of power and that policy relating to addiction and recovery not be made by uninformed policymakers. It is also our responsibility to work with those in our community who continue to view addiction as shameful and wish to stay out of the spotlight, leaving the decisions to others. As their perspectives change, our movement will gain power and the voice of those in recovery will be heard more clearly.

Current Recovery Movement

William White and Ernest Kurtz, also a noted historian and writer in the field of addictions and recovery, have pointed out that the term “recovery community” once referred to the membership of local 12-Step groups. Now, however, it refers to “diverse ‘communities of recovery’ that, as they interact and come together on issues of mutual interest, are forming a new consciousness of themselves.” This emerging new recovery community “encompasses people from diverse recovery support groups and new recovery support institutions that are defining

themselves as a community based on their recovery status and not the method or support group through which that recovery was achieved or maintained” (White and Kurtz, 2006).

White argues that members of these groups have begun to move beyond the competition and animosity that sometimes characterized their relationships with each other. “Members of these groups,” White argues, “are more likely today to view all successful recovery pathways as a cause for celebration” (White, 2008).

The diversification of the recovery community and the increased cohesion among members of once disparate groups has led to the emergence of a stronger, more cohesive voice for the recovery community. This voice is perhaps best embodied through Faces and Voices of Recovery (FAVOR), a national organization “committed to organizing and mobilizing the millions of Americans in long-term recovery from addiction to alcohol and other drugs, our families, friends, and allies to speak with one voice.” FAVOR is “working to change public perceptions of recovery, promote effective public policy ... and demonstrate that recovery is working for millions of Americans.” Its mission is “to bring the power and proof of recovery to everyone in the Nation.” (FAVOR, 2010) Through its “Our Stories Have Power” media training, FAVOR has shifted the discussion from addiction to recovery, reminding participants to identify themselves in public media as persons in long-term recovery rather than as addicts and alcoholics. McShin recommends that recovery coaches take part in this training. More information can be found here on the [FAVOR website](#).

The media training helps us frame recovery in a truthful and positive light when communicating with the general public or the media. This may not be the way you communicate about your recovery in support groups or among members of the recovery community. For example, those who follow a 12-Step tradition will undoubtedly recognize that members are regularly reminded not to forget that they are addicts and/or alcoholics lest they make the mistake of “picking up the first one.” Many in the Fellowship will

say “once an addict or alcoholic, always an addict or alcoholic.” These are, of course, reminders that, in recovery, the symptoms of alcoholism or other drug addiction may be in remission, but the underlying disease is still there and will be reawakened by alcohol or drug use.

While well understood in the recovery community, these kinds of expressions are regularly misunderstood by the general public and by the media.

The media and the general public have vivid and enduring images of addiction and a distrust of addicted persons. Our role is to help them see and understand the transforming power of recovery, which benefits not only those afflicted by addiction, but their families, communities, and the Nation as a whole.

The story of recovery is one that everyone can embrace. In taking on a role as a recovery coach, consider looking upon yourself as an ambassador of the recovery community in all of its diversity.

Cultural Differences in the Perception of Alcoholism/Drug Addiction

- Religious: Sin
- Spiritual: Hunger for meaning
- Criminal: Immoral and reformation
- Medical/Disease Terms: Medically reparable
- Psychological: Mind over matter
- Socio-Cultural: Environment, oppression, trauma

Treatment, Recovery, Community

- Modern addiction treatment came of age in the 1960s and 1970s.
- Programs were birthed out of the following:
 - Representation of recovered and recovering people and their families on agency boards and advisory communities.

- Recruitment of staff from local communities of recovery.
- Exciting recovery volunteer programs.
- Regular meetings between the treatment agency and the service committees of local recovery support fellowships.

The Great Paradigm Shift

- The reliance of these groups on local funding also led to greater accountability to local Governments and service agencies.
- Professionalization, industrialization and commercialization in the 1980s shifted these “community” groups over to businesses.
- The spirit was lost...when price and accessibility of recovery was hard to reach.
- It is important to “keep the spirit” when establishing a recovery community-minded service:
- Conceptual—Shift from problem-focused to solution-focused.
- Personal/Professional—Hesitancy to accept strength of recovering community by professionals.
- Financial—Lack of finances for post-treatment support services.
- Technical—Lack of evidence-based recovery support protocol.
- Ethical—Absence of ethical codes to guide peer-based recovery services.
- Institutional—Weak infrastructures of addiction treatment organizations.

Emerging Movements

- Treatment renewal—Linking treatment to the long-term recovery process.

- Rebuilding relationships between these two groups.
- What are the benefits to treatment centers having the recovering community available and willing?
- What benefits do the long-term recovering community members have by being linked to the recovering community?
- A new recovery advocacy movement rose in reaction to re-stigmatization, de-medicalization and re-criminalization of alcohol and other drug problems from the 1980s and 1990s.
- The movement was led by organizations such as:
 - Faces and Voices of Recovery: www.facesandvoicesofrecovery.org
 - National Council on Alcoholism and Drug Dependence: www.ncadd.org.
 - Local advocacy groups

A Recovery Paradigm

Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The system in ROSC is not a treatment agency but a macro level organization of a community, a State or a Nation (White, 2008b).

The concept of recovery, of course, is deeply embedded in the history of addictions treatment and recovery in the United States. *The Big Book of Alcoholics Anonymous* characterizes the path it outlines as a “plan of recovery.” However, the use of the term “recovery” to refer to the process of overcoming alcohol dependence can be traced back much earlier than the emergence of AA in 1935.

White reports that there is evidence of the use of the term in the context of alcohol problems going back at least as far as the late 17th or early 18th century. In addition, since the inception of the

programs that led to today's treatment systems, 12-Step recovery has been a nearly ubiquitous element of treatment, either as a conceptual framework, as exemplified in the Minnesota Model, or as an essential partner to the treatment program, providing support before, during and after treatment, and often serving as a key source of treatment referrals.

While the addictions field has long laid claim to recovery as its overarching goal, systems and services have tended to center on a relatively brief, encapsulated episode of treatment, as though addictions were transitory or acute problems that could be "cured" by an episode of treatment.

In the late 1970s and early 1980s, as the mental health field moved from a primarily hospital-based approach to one that emphasized treatment in the community and the hope of recovery and that focused on supporting individual choice and personal ownership of a recovery process. The mental health field had, in effect, taken on the

mantle of recovery, using it to shape systems and services and to define the role and rights of those served in a manner that supports long-term recovery. It did this while the addictions field continued to use approaches that seemed to reflect an underlying assumption that addictions were acute disorders that could be addressed effectively through brief episodes of care.

In 1991, William Anthony, a pioneer in mental health recovery, wrote that the 1990s would be "the decade of recovery" (Anthony, 1991). At the start of the next decade, he wrote that a number of State mental health systems had "declared that their service delivery systems were based on the vision of recovery" (Anthony, 2000.) In the article published in 2000, *A Recovery-Oriented Service System: Setting Some System Standards* Anthony provided a table that detailed assumptions about mental health recovery that seem equally applicable to addictions recovery. This table can be found in the appendix under the following header: [Anthony: Assumptions about Recovery](#).

Appendices

McShin Recovery Coaching Curriculum

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

WELCOME AND INTRODUCTIONS

TIME: 30 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.

LEARNING OBJECTIVES:

- ❖ Logistics, ground rules, and nuts and bolts information
- ❖ Recovery coach and participant introductions
- ❖ Goals and objectives of training

MATERIALS:

- ❖ Desk and chairs to accommodate all trainees
- ❖ Internet-ready laptop with projector
- ❖ Pens and pencils
- ❖ *Slaying The Dragon: The History of Addiction Treatment and Recovery* by William White
- ❖ *Recovery: Linking Addiction Treatment & Communities of Recovery: A Primer For Addiction Counselors and Recovery Coaches* by William White and Earnest Kurtz, Northeast Addiction Technology Transfer Center

ADDITIONAL SUPPLIES:

- ❖ Name tags
- ❖ Pre-evaluation forms
- ❖ Sign-in sheet

WELCOME

30 minutes

The Recovery Coach should welcome participants to the training and acknowledge the time they are taking from their jobs to participate in the course. At the start of each session, the recovery coach should provide a brief overview of the training curriculum, explain the goals and ground rules of the class, and go over materials that will be handed out, such as workbooks, or exercises, and outline expectations for participants, including background reading and homework, if any is assigned.

A. LOGISTICAL, GROUND RULES, AND NUTS AND BOLTS INFORMATION:

LOGISTICAL

Room Characteristics: The classroom or group meeting room should be at least 12 feet by 20 feet, but a slightly larger room will work as well. Given the length and nature of the training, we recommend avoiding rooms that do not allow enough space for comfortable movement and the formation of dyads and larger groups. The room should be well ventilated, and it should be possible to adjust the temperature. When available, a room that offers natural light is helpful. Additionally, the room should not be subject to much ambient noise or to high levels of hallway traffic.

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 keep it for your records. It could also be useful to acquire the contact information of your participants. To ensure that everyone signs in, we recommend circulating the sheet after the class has started. However, you may prefer to request that individuals sign in prior to the start of the session. Unless you already have this information, we recommend that your sign in sheet include at least the participant's name, e-mail address, telephone number, residential address, and mailing address (if different).

Evaluation Forms: Ask participants to complete an evaluation form at the end of each day of the training. These evaluations will help you determine which session components, exercises, or approaches were most useful. They will help you identify the session's stronger areas, which you may want to expand, and the weaker areas, for which you may want to give more attention or hone your skills.

Refreshments: Given the length of the training, you may want to provide refreshments (e.g., coffee, rolls, fruit, etc.). Or, you may want to coordinate or provide lunch so that the group can stay together throughout the session.

GROUND RULES

For a successful training, create a welcoming environment in which clear expectations and ground rules are established. The tone you set during the opening can be a significant help or hindrance for the duration of the session. In view of this, 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 ROLE OF THE TRAINER IS TO PROVIDE A SAFE AND PRODUCTIVE ENVIRONMENT FOR THE TRAINEES. IT SHOULD ALSO BE A PLACE WHERE INDIVIDUALS FEEL COMFORTABLE AND SAFE TO SHARE AND PUT THEMSELVES IN THE MIX.

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 honor and 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 for your duties as a recovery coach.
- ❖ Sharing of personal experiences is welcomed but should be limited to experiences that are either specifically related to what is being learned in the class or might otherwise be useful and supportive to other participants.
- ❖ All participants should respect the beliefs of other participants and recognize their right to hold them.
- ❖ Out of respect to each other, refrain from speaking in a manner that may offend other participants 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 maximize all benefits from the training and will also help build an environment of trust.
- ❖ Personal experiences that are shared during our 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

- ❖ Cell phones may only be used during breaks and must be turned off throughout the session.
- ❖ Return from breaks on time. In a session of this size, late arrivals distract and delay the rest of the class.

Possible Posting Locations for Ground Rules and Nuts and Bolts:

- ❖ At emergency exits
- ❖ In restrooms and near water fountains
- ❖ By public telephones

B. RECOVERY COACH AND PARTICIPANT INTRODUCTIONS:

Recovery coaches should introduce themselves and describe their qualifications for instructing the course. Then, going around the room, participants should share their name, agency, clean and sober date, and what they hope to gain from taking this course.

C. GOALS AND OBJECTIVES OF TRAINING:

- ❖ Fulfill 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 one's own recovery capital and how one can leverage 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.
- ❖ Become and stay aware of the current recovery movement, advocacy efforts, and the many local, State and national recovering communities and their resources.
- ❖ Realize how you can make a difference in the lives of your peers!

NOTE TO TRAINER: It is recommended that you read *Slaying The Dragon: The History of Addiction Treatment and Recovery in America* by William White before conducting a session. While the slides in Appendix I provide an adequate overview of relevant material, greater familiarity with the material will equip you to better trace the historical narrative and respond to questions that may require knowledge beyond what is directly covered in the slides.

RECOVERY COACH TRAINING

PURPOSE: This training will begin with an overview of the historic and current contexts in which treatment and recovery have taken place in the United States. A key area of focus will be the development of Peer Recovery Support Services (PRSS). The history of treatment and recovery in the United States will be explored and provide an understanding of the diverse paths to recovery. Then, a more in-depth look at the roles coaches and *coachees* play will be clearly defined and explored.

AGENDA: Training topics are designed to fill a 60-75 minute period. We recommend a 10-minute break between sessions.

DAY 1

❖ Welcome	30 minutes
❖ Session 1: History	75 minutes
❖ Session 2: Current Recovery Movement	60 minutes
❖ Session 3: The Recovery Coach	60 minutes
❖ Lunch	60 minutes
❖ Session 4: The Recovery Coaching Process	60 minutes
❖ Session 5: Coach and <i>Coachee</i>	60 minutes
❖ Session 6: Role Play Exercise	35 minutes

DAY 2

❖ Session 1: Walking the Talk	75 minutes
❖ Session 2: Recovery Pathways	60 minutes
❖ Session 3: Team Approach	60 minutes
❖ Wrap Up	

DAY 1

I. Session 1: History of Treatment and Recovery 75 minutes

References: *Slaying The Dragon: The History of Addiction Treatment and Recovery in America* by William White (See Appendix I for slide presentation.)

Customize the session to meet the needs of the group, remaining open-minded to their perceptions of the history. Recognize that participants may possess valuable knowledge of or insights into the history and its relationship to the present.

II. Session 2: Current Recovery Movement

60 minutes

A. Cultural differences in the perception of alcoholism and drug addiction problems.

- ❖ Expand on the terms below: Engage the group so that they contribute to the ideas and terms of each thought process.
- ❖ Write related ideas and personal experiences on a board or flipchart.
 - ◆ Religious: Addiction is a sin, human failing, personal trial, gift providing opportunity for growth, etc.
 - ◆ Moral: Addiction is a character failing and exposes lack of willpower.
 - ◆ Spiritual: Addiction hints at a hunger for meaning.
 - ◆ Criminal: Addiction is a behavior that needs to be dealt with by the criminal justice system.
 - ◆ Medical/Disease: Addiction is a chronic medical condition.
 - ◆ Psychological: Addiction is symptomatic of underlying problems.
 - ◆ Socio-Cultural: Addiction is caused by the individual's environment, oppression, or trauma.
 - ◆ Other?

B. Treatment, Recovery, Community

- ❖ Modern addiction treatment came of age in the 1960s and 1970s.
- ❖ Explore the emergence of treatment programs, including:
 - ◆ Representation of recovered and recovering people and their families on agency boards and advisory communities.
 - ◆ Recruitment of staff from local communities of recovery.
 - ◆ Recovery volunteer programs.
 - ◆ Regular meetings between treatment agencies and the service committees of local recovery support fellowships.

C. The Great Paradigm Shift

- ❖ Explain the reliance on Federal, State, and local funding.
- ❖ Explore the increasing emphasis on accountability.
- ❖ Cover the professionalization and commercialization in 1980s.
- ❖ Discuss the loss of original recovery spirit.

Group Discussion:

Have the group expand on importance of the recovery spirit when establishing and providing peer recovery services. Discuss the value of a recovery community and the unique nature of services that emerge from one.

D. Emerging Movements

Treatment renewal: Explore the linking treatment to the long-term recovery process and rebuilding relationships between treatment and recovery.

Group Questions:

- ❖ How does having readily available volunteers from the recovery community benefit treatment programs?
- ❖ How do those in long-term recovery benefit by being linked with recovery community organizations, movements, or activities?
- ❖ Discuss the emergence of the Recovery Advocacy Movement and its relationship to the trends toward re-stigmatization, de-medicalization, and re-criminalization of alcohol and other drug problems during the 1980s and 1990s.
- ❖ How do the following organizations relate to the movement?
 - a. Faces and Voices of Recovery (www.facesandvoicesofrecovery.org).
 - b. National Council on Alcoholism and Drug Dependence (www.ncadd.org).
 - c. Any local advocacy group.

Notes to Trainer:

- ❖ Have Internet access with a projector available to view each of the above Web sites.
- ❖ Explore each site with the group.
- ❖ Read each organization's history and mission statement out loud to the group.
- ❖ Ask individuals in the group to share their experiences.

E. A Recovery Paradigm

- ❖ Reconnect treatment and recovery.
- ❖ How do recovery plans (RP) differ from treatment plans (TP)?

- ◆ RP is developed by the client, not treatment professional.
 - ◆ RP is based on a partnership between the professional and the client rather than a relationship between the expert and the patient.
 - ◆ RP 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.
 - ◆ RP consists of master plan of long-term recovery goals, marking progress along the way.
 - ◆ RP draws strength and strategies from the collective experience of the recovering community.
- ❖ Explore obstacles, resistance, and pitfalls of peer-based services (i.e., recovery coaching).
- ◆ Conceptual: Understand the shift from problem-focused to solution-focused.
 - ◆ Personal/professional: Professionals are hesitant to accept the strength of the recovering community.
 - ◆ Financial: Low funds are available for post-treatment support services.
 - ◆ Technical: Few evidence-based recovery support protocols exist.
 - ◆ Ethical: Ethical codes for guiding peer-based recovery services are absent.
 - ◆ Institutional: Addiction treatment organizations have weak infrastructures.

References:

Borkman, T. (1997) “Is recovery planning any different from treatment planning?” *Journal for Substance Abuse Treatment*. 15 (1), 37-42.

III. Session 3: The Recovery Coach

60 minutes

A. Discussion: Define your role:

- ❖ What do you see yourself as?
- ❖ What is the job of a recovery coach?
- ❖ What skills are necessary to be an effective recovery coach?

Examples:

- ◆ Empathy: Ability to understand and share the *coachee*'s feelings and perceptions.
 - ◆ Listening: Ability to set aside one's thoughts and opinions to hear what the *coachee* is really saying.
 - ◆ Understanding of one's own recovery pathway.
 - ◆ Communication: Ability to combine listening with thoughtful responses, sharing, and suggestions that are sensitive to the coach'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 coaches and to 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 does the recovery coach have?
- ◆ 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.
 - ◆ Recovery-minded with awareness that addiction is a disease.
 - ◆ Ability to provide constructive feedback.
- ❖ Values: The importance of personal ideas.
- ◆ Walk the walk, not talk the talk.
 - ◆ Do what you say, not what I say.
 - ◆ Live by recovery.
 - ◆ Have integrity.
 - ◆ Recognize boundaries.
- ❖ Principles: The truth that serves as your foundation.
- ◆ 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.
- ❖ Certain demographics and personal experiences may only enhance and build on your skills, qualities, values, and principles.

Exercise:

- ❖ What are the opposites of the above?
- ❖ Discuss co-dependency, enabling, friendship, and the risks these represent for the 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: 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 many 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.
- ❖ Use capital to assist in a *coachee's* pathway, a great measurement.

Proven Coaching Techniques:

- ◆ Strength-based approach
 - Emphasize 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.

Lunch: Round table discussion on the Pathways to Recovery (List and define). 60 minutes

D. Session 4: Structure of the Recovery—The Coaching Process 60 minutes

❖ Role Play with Scenario:

- ◆ Role play using actual scenarios between coach and *coachees*.
- ◆ Define certain areas in which the trainee did well and other areas in which the trainee has an opportunity for growth.

An example of role playing could be:

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 1 year. He lives with his mother and 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 jail 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.

- ◆ What worked and what didn't? What’s the learning process?
- ◆ List the strengths and needs recognized in the first meeting/intake of the recovery coach and *coachee*:
 - Take inventory of strengths, needs, and goals.
 - Develop recovery action plan based on inventory of individual's needs.
 - Communication/Expectations: Discuss coach and peer role and boundaries

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

E. Session 5: Revisiting Coach and *Coachee* Relationship 60 minutes

- ❖ Define and emphasize boundaries.
- ❖ At what lengths and how willing are you to go to help?
- ❖ Who does the recovery coach “answer” to? Discuss the supervisor’s role.

F. Session 6: Role Play—Coach and *Coachee* 35 minutes

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. He 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 be very mean, and the coach does not want to hurt his feelings.

- ◆ What would YOU do?
- ◆ 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.
- ◆ Use several examples, some of which may be the “right” way.

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

- ❖ Recommendation: Go to the evening activity, a mutual aid meeting: Take care of yourself by practicing your program of recovery.

DAY 2

A. Session 1, Day 2: Greetings/Walking Your Talk 75 minutes

- ❖ Discuss the mutual aid group attended previous evening. Who went where?

Walking Your Talk

- ❖ REMEMBER: Your recovery comes first.
 - ◆ Go around the room to discuss what everyone did last night?
 - ◆ Cover the following topics:
 - Getting “burned out.”
 - Remedies.
 - Maintaining balance.
 - Checking out.

- Realizing 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 for experiences on all the above topics.

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

B. Session 2: Recovery Pathways

60 minutes

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 explain the role of your local recovery community organization, another link in the recovery chain.

C. Session 3: Team Approach

60 minutes

- ❖ Use other recovery coaches (Remember linkages).
- ❖ 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 coaches.
- ❖ Allow flexibility.
- ❖ Prevent burn out
- ❖ Take care of high maintenance clients.
- ❖ Work together, as we do in our own recovery.

D. Wrap Up

Exercises

Role Play I (60 minutes)

Role play using actual scenarios between coach and *coachees*.

Define certain areas in which the trainee did well and areas in which the trainee has an opportunity for growth.

An example of role playing could be:

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 1 year. He lives with his mother and 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 jail 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.

- ◆ What worked and what didn't? What's the learning process?
- ◆ List the strengths and needs recognized in the first meeting/intake of the recovery coach and *coachee*:
 - Take inventory of strengths, needs, and goals.
 - Develop recovery action plan based on inventory of individual's needs.
 - Communication/Expectations: Discuss coach and peer role and boundaries
 - How do you stay linked? Explore options and factors, such as reminder calls, driving, checking in, and the recovery community organization environment. Offer other examples.

Revisiting the Coach and *Coachee* (60 minutes)

- ❖ Define and emphasize boundaries.
- ❖ At what lengths and how willing are you to go to help?
- ❖ Who does the recovery coach “answer” to? Discuss the supervisor’s role.

Role Play 2 (60 minutes)

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. He 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 be very mean, and the coach does not want to hurt his feelings.

- ◆ What would YOU do?
- ◆ 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.
- ◆ Use several examples, some of which may be the “right” way.

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

- ❖ Recommendation: Go to the evening activity, a mutual aid meeting, “Take Care of Yourself.”

Walking Your Talk

- ❖ REMEMBER: your recovery comes first!
- ❖ Go around the room to discuss what everyone did last night?
- ❖ Cover the following topics:
 - ◆ Getting “burned out.”
 - ◆ Remedies.
 - ◆ Maintaining balance.
 - ◆ Checking out.
 - ◆ Realizing 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 for experiences on all the above topics.

NOTE TO TRAINER: Make sure to emphasize that the coach-*coachee* relationship is different with each *coachee* and changes over time. The intensity of the types of support offered, the boundaries, style, and the duration of the relationship varies across *coachees* and over time.

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

- ❖ Recommendation: Go to the evening activity, a mutual aid meeting, “Take Care of Yourself.”

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 explain the role of your local recovery community organization, another link in the recovery chain.

Team Approach

- ❖ Discuss the many benefits of practicing a team approach:
 - ◆ Use other recovery coaches (Remember linkages).
 - ◆ 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 coaches.
 - ◆ Allow flexibility.
 - ◆ Prevent burn out
 - ◆ Take care of high maintenance clients.
 - ◆ Work together, as we do in our own recovery.

Anthony: Assumptions about Recovery

Table 1—Assumptions about Recovery

FACTORS / ITEMS	REASONS
1. <i>Recovery can occur without professional intervention.</i>	Professionals do not hold the key to recovery; consumers do. The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumer's natural support system.
2. <i>A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.</i>	Seemingly universal in the recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to "be there" in times of need.
3. <i>A recovery vision is not a function of one's theory about the causes of mental illness.</i>	Recovery may occur whether one views the illness as biological or not. The key element is understanding that there is hope for the future, rather than understanding the cause in the past.
4. <i>Recovery can occur even though symptoms reoccur.</i>	The episodic nature of severe mental illness does not prevent recovery. As one recovers, symptoms interfere with functioning less often and for briefer periods of time. More of one's life is lived symptom-free.
5. <i>Recovery is a unique process.</i>	There is no one path to recovery, nor one outcome. It is a highly personal process.
6. <i>Recovery demands that a person has choices.</i>	The notion that one has options from which to choose is often more important than the particular option one initially selects.
7. <i>Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.</i>	These consequences include discrimination, poverty, segregation, stigma, and iatrogenic effects of treatment.

Adapted from Anthony (1993).

National Summit on Recovery

Principles of Recovery

There are many pathways to recovery. Individuals are unique with specific needs, strengths, goals, health attitudes, behaviors, and expectations for recovery. Pathways to recovery are highly personal. Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources, which provide support for sobriety.

Recovery is self-directed and empowering. The person in recovery is the “agent of recovery” and has the authority to exercise choices and make decisions based on his or her recovery goals. The process of recovery leads individuals toward the highest level of autonomy of which they are capable.

Recovery involves a personal recognition of the need for change and transformation. Individuals must accept that a problem exists and be willing to take steps to address it.

Recovery is holistic. Recovery is a process through which one gradually achieves greater balance of mind, body, and spirit.

Recovery has cultural dimensions. Each person’s recovery process is unique and impacted by cultural beliefs and traditions. A person’s cultural experience often shapes the recovery path that is right for him or her.

Recovery exists on a continuum of improved health and wellness. Recovery is not a linear process. It is based on continual growth and improved functioning. It may involve relapse and other setbacks, which are a natural part of the continuum, but not inevitable outcomes.

Recovery emerges from hope and gratitude. Individuals in or seeking recovery often gain hope from those who share their search for or experience of recovery.

Recovery involves a process of healing and self-redefinition. Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.

Recovery involves addressing discrimination and transcending shame and stigma. Recovery is a process by which people confront and strive to overcome stigma.

Recovery is supported by peers and allies. A common denominator in the recovery process is the presence and involvement of people who contribute hope and support and suggest strategies and resources for change. Peers, as well as family members and other allies, form vital support networks for people in recovery.

Recovery involves (re)joining and (re)building a life in the community. Recovery involves a process of building or rebuilding what a person has lost or never had due to his or her condition and its consequences. Recovery involves creating a life within the limitations imposed by one’s condition.

Recovery is a reality. It can, will, and does happen.

Elements of ROSC

Person-centered. Recovery-oriented systems of care will be person-centered. Individuals will have a menu of stage-appropriate choices that fit their needs throughout the recovery process. Choices can include spiritual supports that fit with the individual's recovery needs.

Family and other ally involvement. Recovery-oriented systems of care will acknowledge the important role that families and other allies can play. Family and other allies will be incorporated, when appropriate, in the recovery planning and support process.

Individualized and comprehensive services across the lifespan. Recovery-oriented systems of care will be individualized, comprehensive, stage-appropriate, and flexible. Systems will adapt to the needs of individuals, rather than requiring individuals to adapt to them. They will be designed to support recovery across the lifespan and will change from an acute episode-based model to one that manages chronic disorders over a lifetime.

Systems anchored in the community. Recovery-oriented systems of care will be nested in the community for the purpose of enhancing the availability and support capacities of families, intimate social networks, community-based institutions and other people in recovery.

Continuity of care. Recovery-oriented systems of care will offer a continuum of care, including pretreatment, treatment, continuing care and support throughout recovery. Individuals will have a full range of stage-appropriate services from which to choose at any point in the recovery process.

Partnership-consultant relationships. Recovery-oriented systems of care will be patterned after a partnership-consultant model that focuses more on collaboration and less on hierarchy. Systems will be designed so that individuals feel empowered to direct their own recovery.

Strength-based. Recovery-oriented systems of care will emphasize individual strengths, assets, and resiliencies.

Culturally responsive. Recovery-oriented systems of care will be culturally sensitive, competent, and responsive. They will recognize that beliefs and customs are diverse and can impact the outcomes of recovery efforts.

Responsiveness to personal belief systems. Recovery-oriented systems of care will respect the spiritual, religious, and/or secular beliefs of those they serve and provide linkages to an array of recovery options that are consistent with these beliefs.

Commitment to peer recovery support services. Recovery-oriented systems of care will include peer recovery support services. Individuals with personal experience of recovery will provide these valuable services.

Inclusion of the voices and experiences of recovering individuals and their families. People in recovery and their family members will contribute to the design and implementation of recovery-oriented systems of care. They will be included in decision making, and will be prominently and authentically represented on advisory councils, boards, task forces, and committees at the Federal, State, and local levels.

Integrated services. Recovery-oriented systems of care will coordinate and/or integrate efforts across service systems to achieve an integrated process that responds effectively to the individual's unique constellation of strengths, desires, and needs.

Systemwide education and training. Recovery-oriented systems of care will ensure that concepts of recovery and wellness are foundational elements of curricula, certification, licensure, accreditation, and testing mechanisms and will provide continual training, at every level, to reinforce the tenets of recovery-oriented systems of care.

Ongoing monitoring and outreach. Recovery-oriented systems of care will provide ongoing monitoring and feedback with assertive outreach efforts to promote continual participation, re-motivation, and reengagement.

Outcomes driven. Recovery-oriented systems of care will be guided by recovery-based process and outcome measures. These measures will be developed in collaboration with individuals in recovery. Outcome measures will reflect the long-term global effects of the recovery process on the individual, family, and community, not just remission of biomedical symptoms.

Research based. Recovery-oriented systems of care will be informed by research. Additional research on individuals in recovery, recovery venues, and the processes of recovery, including cultural and spiritual aspects, is essential.

Adequately and flexibly financed. Recovery-oriented systems of care will be adequately financed to permit access to a full continuum of services, ranging from detoxification and treatment to continuing care and recovery support. In addition, funding will be sufficiently flexible to permit unbundling of services, enabling the establishment of a customized array of services that can evolve over time in support of an individual's recovery.

Glossaries

White, W. (2002). An addiction recovery glossary: The languages of American communities of recovery. First posted at www.bhrm.org.

The Languages of American Communities of Recovery

Health and social problems are usually studied by examining their sources, patterns and consequences. The rationale for this approach is that understanding such factors will lead to effective prevention and intervention strategies. While this approach has led to remarkable breakthroughs in certain areas of medicine (e.g., infectious disease), the promises of similarly striking breakthroughs in understanding and treating historically intractable problems like addiction remain unfulfilled. Since Benjamin Rush's 1784 treatise on chronic intoxication, generations of addictionologists have authored texts and articles about the pathology of addiction. Studying addictive drugs, studying why people use them, generating speculative essays on why some people can't stop using them, and describing and evaluating countless efforts to punish or treat those with alcohol and other drug problems are all part of the multi-billion dollar, problem-focused addiction industry.

There is another approach—one that focuses not on the sources of addiction, but on the successful solutions that already exist in the lives of hundreds of thousands of individuals, families and communities. These solutions are of two types: people with great access to alcohol and other drugs who do not use such substances or who use but do not develop alcohol and other drug (AOD) problems, and people who have achieved a sustained resolution of AOD problems across a wide spectrum of problem severity. This second approach assumes that the study of resiliency and recovery may hold keys to more effective strategies for preventing and managing AOD problems—strategies quite different than those flowing from the pathology perspective.

Two fledgling movements are adding momentum to this shift from a pathology paradigm to a resiliency and recovery paradigm. The first is a New Recovery Advocacy Movement that is challenging the growing restigmatization, demedicalization and recriminalization of addiction and pushing pro-recovery social policies and recovery-focused service programs (White, 2000, 2001a). By bringing recovered and recovering people and their families into the forefront of policy advocacy, this movement is shifting the policy agenda from the nature of the problem (i.e., “alcoholism is a disease”) and rationales for intervention effectiveness (“treatment works”) to the recognition of the existence of lived solutions (i.e., “recovery is everywhere”) and the nature of those solutions (“there are many pathways to recovery”).

There are also signs of a Treatment Renewal Movement whose focus is on improving the clinical technology of addiction treatment, elevating the ethical practice of addiction treatment and reconnecting addiction treatment agencies to the communities out of which they were born (White, 2002a). This movement promises to shift addiction treatment from a model of serial episodes of acute treatment (assess, admit, treat, discharge) to a model of sustained recovery management and support (White, Boyle & Loveland, 2002).

The shift from a pathology perspective to a resiliency and recovery perspective requires new ways of thinking and a new language to frame the sources and solutions to alcohol and other drug problems. In earlier essays, I traced the history of the language used to frame AOD problems (White, 2004), called for the rejection and or refinement of much of the traditional language used to depict alcohol and other drug problems and their resolution, and began to articulate a pro-recovery rhetoric (White, 2001b). This paper builds on this earlier work by cataloguing and discussing some of the emerging recovery-related terms and concepts.

What follows is a glossary of the words and ideas that are central to the recovery experience of hundreds of thousands of individuals and families. It is not intended to be a glossary of the people and institutions

that make up the history of the recovery cultures that have surrounded that experience. It is focused instead on accurately and respectfully conveying the key words and ideas that have initiated and anchored recovery across the boundaries of gender and ethnicity, the sacred and the secular, and the varying goals and methods of problem resolution

There are two intended audiences for this paper. The first audience includes those in recovery who experientially know the recovery tradition of which they have been a part, but may know little, and may have many misconceptions about, the central ideas of other recovery traditions. The second audience includes those working in addiction treatment who, compared to earlier decades, are less likely to be in personal recovery or to have direct knowledge about mutual aid groups. The goal is to help treatment professionals and recovery advocates understand the many recovery styles and traditions that are flourishing in America. The goal is to help the treatment professional and recovery advocate become multilingual in their efforts to widen the doorways of entry into recovery.

The glossary contains language used within diverse communities of recovery in America and the language applied to these groups and their practices by the scholars who have studied them. Some terms have emerged from formal studies on the processes involved in addiction recovery. Where these have been drawn from published sources, I have tried to provide citation of sources, particularly where a particular concept may stir controversy. Some terms are part of the vernacular of local recovery support groups, recovery advocacy organizations, and recovery-oriented treatment programs. I have tried to summarize the most common meaning of these terms as I have encountered them in my travels across the U.S. Other terms included here are part of the emerging lexicon of the Behavioral Health Recovery Management (BHRM) project (www.bhrm.org) that I have worked within the past three years. My BHRM colleagues—Michael Boyle, David Loveland, Pat Corrigan, Russell Hagen, Mark Godley, and Tom Murphy, have helped sharpen my own thinking about many of the terms and concepts discussed here.

Several people provided helpful critiques of early drafts of this paper. The following deserve thanks for their detailed responses: Alex Brumbaugh, Ana Kosok, Mark Sanders, Bob Savage, and Brian Young. I also wish to express special appreciation to Ernie Kurtz for his continued mentorship and his helpful review of this paper.

A Recovery Glossary

Abstinence-based Recovery...

is the resolution of alcohol- and other drug-related problems through the strategy of complete and enduring cessation of the non-medical use of alcohol and other drugs. The achievement of this strategy remains the most common definition of recovery, but the necessity to include it in this glossary signals new conceptualizations of recovery that are pushing the boundaries of this definition (See **partial recovery**, **moderated recovery**, **serial recovery**).

Acts of Self-Care...

constitute one of the four daily **rituals of recovery**. These rituals, which involve efforts to reverse the damage of addiction and establish new health-oriented habits, can also be thought of as acts of self-repair. Care of the “self” in recovery transcends the self-centeredness that is the cumulative essence of addiction. Acts of self-care might more aptly be described as acts of responsibility—responsibility not just to self and to family and community.

(Unpaid) Acts of Service...

are activities that aid other individuals or the community. They constitute one of the four core activities within the culture of recovery. Acts of service fulfill at least two functions: they constitute generic acts of restitution for the addiction-related harm to others, and, by piercing the narcissistic encapsulation of the recovery neophyte, they open up opportunities for authentic connection with others. Acts of service come in many forms: Such acts are done for their intrinsic value and not for profit or hope of acknowledgment.

Acultural Style (of recovery)...

is a style of recovery in which individuals initiate and sustain recovery from addiction without significant involvement with other people in recovery. The term *acultural* refers specifically 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 the auspices of local churches as part of their ministry to their local community. The growth in addiction ministries, particularly within African American communities, constitutes one of the most significant developments in the modern history of recovery support structures.

Affiliated (or Assisted) Recovery (versus solo recovery)...

is 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 one's personal identity and story style.

Alexithymia...

is the inability to cognitively label and express one's own feelings and experiences. The term has relevance here as a metaphor for the experience of people for whom traditional words and ideas do not accurately depict their problematic alcohol/drug relationships or serve as a catalyst for change. While this condition is often attributed simply to a person's failure to "get it," the solution is usually found in an alternative set of words, metaphors and relationships that do fit their experience and needs and that do incite change. (See **Metaphors of Transformation**)

(Making) Amends...

are acts of restitution performed by recovering people for the wounds they inflicted on others during the pre-recovery years. Making amends--repaying the literal and symbolic debts accrued in addiction--diminishes guilt and anchors recovery upon the values of responsibility, justice and citizenship. This process also opens up the potential for atonement and forgiveness. (See **Restitution**)

Amplification Effect...

is the strengthening of treatment and/or recovery support services by combining or sequencing particular interventions, activities, or experiences. These combinations and sequences interact synergistically 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...

is the tradition within Twelve Step programs to not link one's full name to AA/NA at the level of "press, radio, and films" (and one would assume television and the Internet). This did not preclude many early prominent AA members' involvement in advocacy activities. Several AA members, including co-founder Bill Wilson, testified before 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 organization. Anonymity is a tradition limited to Twelve Step groups and is not practiced in such organizations as Secular Organization for Sobriety or Women for Sobriety. Going public with one's recovery status is viewed in some cultural contexts as an important dimension of recovery (Williams, 1992).

Assisted Recovery....

is the use of professionally-directed treatment services or participation in mutual aid groups to initiate or sustain recovery from addiction (See **Solo Recovery**, **Natural Recovery**).

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

is a mythomagical personification of addiction--the compulsion to use and the voice self-talk) that feeds that compulsion. The "Beast" is a prominent metaphor within the philosophy of Rational Recovery. Externalizing thoughts that support addiction in the persona of the Beast provides a mechanism of control over such self-talk. Rational Recovery promotes a particular technique (addiction voice recognition training--AVRT) to identify and self-manage such thoughts (Trimpey, 1989). References to "Chasing the Dragon" and "Sleeping with the Devil" as metaphors for addiction, and references to "Battling with the Demon," "Grappling with the Monster" and "Slaying the Dragon" as metaphors for addiction recovery date back more than a century (Dacus, 1877; Arthur, 1877; Parton, 1868). Such terms reflect the process through which the recovering person castigates and degrades a previously loved object in order to create distance between themselves and the poisonous object of their affection.

Bicultural Style (of recovery)...

is a style of recovery in which individuals sustain their recovery through simultaneous involvement in the culture of recovery and the larger "civilian" culture (activities and relationships with individuals who do not have addiction/recovery backgrounds). A bicultural style of recovery implies the possession of subcultural and cultural skills to fluidly move in and out of the activities and relationships in the recovery culture and activities and relationships with individuals in the larger society (White, 1996).

Born Again...

is a phrase used to depict the state of Christian conversion. In the context of recovery, it refers to a type of quantum change characterized by egocide (death of the old self), a new Christ-centered identity, deliverance from desire (craving) and entry into membership in a sober, faith-based community. (See **Conversion** and **Redeemed**)

Centering Rituals...

are regular, alone-time activities that help keep one recovery-focused. Praying, meditating, reading pro-recovery literature, journaling, 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, are those “emotional deformities” that have hurt alcoholics and those close to them. These liabilities include pride, greed, lust, anger, gluttony, envy, and sloth (the “Seven Deadly Sins”). They include obsession (“instincts gone astray”) with sex, power, money, and recognition. They include self-centeredness, self-pity, intolerance, jealousy, and resentment. The A.A. program suggests that if identified and disclosed (via the Fourth and Fifth Steps), these “ghosts of yesterday” would be replaced by a “healing tranquility.” (*Twelve Steps and Twelve Traditions*, 1981, pp. 42-62).

Character Reconstruction...

is the process of bringing one’s personal character into congruence with the aspirational values imbedded within recovery frameworks, whether these be Twelve Step groups, secular support structures, religious organizations or cultural revitalization movements. Character reconstruction underscores that full recovery from severe alcohol and other drug problems entails more than the removal of alcohol and other drugs from an otherwise unchanged life. It entails instead 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 volition and human will in addiction recovery. As treatment has taken on a coercive nature in past decades, the admonition that “recovery is a choice” is a reaffirmation that treatment can be coerced but that the state of recovery is a doorway that can only be entered through one’s own act of choice. It is in exercising this ultimate power of choice that one moves from the self-conscious and oft-uncomfortable state of not using to the state of being free to not use.

Chronic Diseases....

are disorders that cannot be cured with existing medical technologies and whose symptoms wax and wane over an extended period of time. These disorders often spring from multiple, interacting etiological roots; vary in their onset from sudden to gradual; and are highly variable in their course (pattern and severity) and outcome. The prolonged course of these disorders places a sustained strain on the adaptational resources of the individual and his or her family and friends. Chronic addictive disorders call for a process of sustained **recovery management** (See Disease Concept).

Circles of Recovery...

are 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)

Clinical versus Community Populations...

distinguishes the recovery prospects and processes of those with AOD problems in community studies from those with AOD problems who seek mutual aid and professionally-directed treatment services. Compared to the former, the latter present with greater problem severity, greater physical and psychiatric co-morbidity, and fewer family and social supports (Dawson, 1996; Ross, et al, 1999). These differences underscore the problem in attempting to transfer recovery research findings across these two quite different populations.

Cocoon...

is a metaphor of the personal transformation process. It portrays a stage of recovery marked by the need to draw into oneself—to move into a period of isolation and metamorphosis. It is often within this metaphoric cocoon that the business of identity and character reconstruction occurs. It is informative that some of the most powerful transformation experiences in the history of recovery occurred within such isolation. Jerry McAuley’s conversion in Sing Sing Prison (White, 1998), Bill Wilson’s “Hot Flash” in Charles Towns Hospital (Kurtz, 1979), the transformation of “Detroit Red” into Malcolm X in a jail cell (Malcolm X with Haley, 1964) all offer vivid testimony to the power of this cocoon phenomenon. The death-rebirth experiences of the Native Americans who led prophetic, abstinence-based cultural revitalization movements also reflect this cocoon-like process of personal transformation and recovery (Coyhis and White, 2003).

Cognitive Reappraisal...

is 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 reappraisal is a common precursor to the initiation of recovery.

Commitment...

is a (usually public) declaration of one’s recovery goal. Such declarations, whether in the nineteenth century ritual of “signing the pledge” or through one’s 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). (See **Developmental Models of Recovery**) Commitment can also take the form of religious pledges. Muslims with a history of excessive drinking who decide to quit drinking 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....

is 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...

is 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. Brumbaugh (1994) has pointed out an important distinction between the acknowledgement of such transgression within religious and non-religious frameworks of recovery. In the former, the person receiving the confession is "not vested with the power of absolution;" "atonement is not a function of forgiveness (by another person) but lies in the process of disclosure itself."

Continuity of Contact...

is a phrase used to underscore the importance of sustained, consistent support over the course of recovery. Such support can come from living within a community of shared experience and hope. The phrase also refers to the reliability and endurance relationship between the recovery coach (recovery support specialist) and the individual being provided recovery management services. Such sustained continuity is in marked contrast to the transience of relationships experienced by those who have moved through multiple levels of care or undergone multiple treatment relationships (See **Recovery Support Services**).

Conversion...

is the initiation of recovery through a climactic physical/emotional experience. The potential role of religious conversion in remitting 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 vividness (intensity), suddenness (unintentional), positiveness and permanence of effect. The history of recovery in America is replete with such powerful transformation experiences: Handsome Lake, John Gough, Dr. Henry Reynolds, Bill Wilson, to name just a few. The behavioral changes elicited in such conversion experiences touch the very core of personal identity and values (See **Born Again, Cocoon, Surrender**).

Crosstalk...

is the use of direct responses (feedback, suggestions) to disclosures within a mutual aid meeting. Crosstalk is contrasted with **sharing**, in which meetings consist of serial monologues. Recovery groups vary widely on their practices regarding sharing and crosstalk. Most Twelve Step groups discourage crosstalk. Other groups, like LifeRing Secular Recovery, allocate time for both functions with most of the time devoted to sharing. Some groups such as Moderation Management encourage crosstalk (see **Sharing**).

Cultural Pathways of Recovery...

are culturally or subculturally prescribed avenues 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 constitute those socially accepted ways in which 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 and folkways have become corrupted and illness-producing. Cultural healing involves a return to wellness-promoting ancestral traditions or reformulation and reapplication of ancestral traditions to contemporary life (Simonelli, 2002).

Cultural Revitalization Movement...

is a sobriety-based social movement that, while seeking to renew and revitalize a culture through the reaffirmation of lost values and ceremonies, also provides a therapeutic framework for recovery from addiction and the development of health and wholeness. Such movements most often arise within historically disempowered communities. The roots of organized recovery in America actually begin with the abstinence-based, cultural and religious revitalization movements within Native American tribes in the eighteenth century (White, 2001a; Coyhis & White, 2003)

Culture of Recovery (Recovery Culture)...

is a social network of recovering people that collectively nurtures and supports long term recovery from behavioral health disorders. This culture has its own recovery-based history, language, rituals, symbols, literature, institutions (places), and values. It helps facilitate the reconstruction of personal identity and social relationships for those extracting themselves from deep enmeshment within drug and criminal subcultures.

Decolonization...

is the process through which formerly colonized peoples seek political, economic and cultural emancipation. Decolonization can spur recovery movements via cultural revitalization movements that castigate alcohol and other drugs as tools of political and psychological colonization. In the framework of these movements, abstinence from alcohol and other drugs is an act of personal **resistance** and an act of cultural survival. Decolonization calls for protest and community building as an alternative to self-anesthesia and self-destruction (See **Freedom, Genocide, Liberation**).

Dependency Transfer...

is the substitution of a positive addiction for a negative addiction. In *Alcoholics Victorious*, for example, recovery is viewed as a process of transferring dependence upon alcohol and other drugs to a dependence upon Christ.

Developmental Models of Recovery...

are conceptualizations of the stages and processes involved in long term recovery from addiction. Such models assume that there are discrete 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, DiClemente, and Norcross (1992). What these models imply 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). (See **Stage One**

Recovery, Stage Two Recovery, Complete Recovery, Disengaged Recovery, Recovery Career)

Disease (Concept)...

is a term used to depict 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 conceptualization 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 designation (Kurtz, In Press).

Disease Management (Distinguished from Recovery Management)...

is the management of severe behavioral health disorders in ways that enhance clinical outcomes and reduce social costs. Its focus is on developing technologies of 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 emphasizes a person-focused rather than disease-/cost-focused service orientation.

Disengaged (style of) Recovery...

is the initiation of recovery through professionally-directed treatment, mutual aid participation or both, followed by the subsequent maintenance of that recovery without significant participation in addiction recovery mutual aid groups. Such an individual might be referred to as a recovery graduate in the sense that alcohol and drug problems and their resolution constituted a chapter in their lives which is now closed, leaving them free to move forward and write new chapters of their lives. Tessina (1991) has referred to this stage of moving beyond addiction recovery as the “real thirteenth step.”

Desist/Desistance...,

in the Islamic tradition, is the rejection of Al-Khamr (all things intoxicating). When the Prophet Mohammed attacked strong drink and drunkenness as an “infamy of Satan’s handiwork” and asked a crowd, “Will you then desist?” they responded, “We have desisted O Allah” (Badri, 1976, p. 3-5)

Drift...

is a sociological term that depicts how some addicted people simply “go with the flow,” only to find that events and circumstances lead to a drift away from drugs and the culture in which drug use was nested (see Waldorf, 1983; Biernacki, 1986, 1990; Granfield and Cloud, 1999). This style of problem resolution is not planned or even conscious, and such resolution may occur without the individual embracing either an addiction or recovery identity. The fact that this has been noted in studies of natural recovery from opiate addiction but not in comparable studies for alcoholism or nicotine addiction suggests that drift may be less possible when one’s primary drug is physically and culturally ever-present.

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. The addiction literature is replete with the tales of people who shed one drug only to develop an equally destructive or more destructive relationship with one or more other drugs. The observation of this risk drawn from treatment and mutual aid populations who present with high severity and chronicity is tempered by a growing number of research studies documenting how 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 dissipates in most individuals after 12-18 months (Biernacki, 1986; Christo, 1998; McIntosh and McKegany, 2002).

Drunkalogue...

is an oft-repeated, presentation of one's drinking career. Such presentations are known for their rote delivery and for the grandiosity they often contain. While drunkalogues seem to serve a recovery maintenance function for some individuals, the negative aspects of the drunkalogue (wallowing in the "what we were like" phase of one's story) have led groups (e.g., LifeRing Secular Recovery) to promote "soberlogues" as an alternative: a presentation that focuses on one's current life in sobriety rather than in the past (Handbook of Secular Recovery, 1999, p. 31). It is important, however, not to underestimate the therapeutic functions (problem acceptance, identity affirmation, recommitment) that such periodic recounting serves for some individuals in recovery.

Dual Recovery (see Serial Recovery)

The Ecology of Recovery...

is a phrase intended to reinforce the idea that there are ecosystems that can nourish recovery experiments and ecosystems that can crush recovery experiments. 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 conceptualizations of addiction and recovery see the former emerging "organically" from a sick social system and view recovery as contingent upon creating a healthier social system that makes recovery possible (see Tabor, 1970)

Eleventh Step Groups...

are organized groups that help A.A. members who share a religious commitment pursue continued work on Step Eleven: "Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out." Two of the oldest Eleventh Step groups are the Calix Society and Jewish Alcoholics, Chemically Dependent People and Significant Others (JACS). Eleventh Step groups usually serve as adjuncts rather than alternatives to A.A. participation (White, 1998).

Emancipation/emancipated...(See Freedom from Slavery)

Emotional Sobriety...

is 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.” See **Wellbriety**.

Empowerment...

is the experience of having a some power and control over one’s own destiny. Within the recovery context, there are two quite different relationships to power. Among the culturally empowered (those to whom value is ascribed as a birthright), addiction-related erosion of competence is often countered by increased grandiosity and preoccupation with power and control. It should not be surprising then that transformative breakthrough of recovery is marked by a deep experience of surrender and an acceptance of powerlessness. In contrast, the culturally disempowered (those for whom value has been systematically withheld) are often attracted to psychoactive drugs in their quest for power, only to discover over time that their power has been further diminished. Under these conditions, the initiation of recovery is often marked by the assumption of power and control rather than an abdication or surrender of such power. This point is well-illustrated by the first statement of Women for Sobriety (“I have a life-threatening problem that once had me”), and the “first act of resistance” of the Afrocentric model of recovery pioneered by Rev. Cecil Williams in San Francisco (“I will gain control over my life”). In Williams’ words, “a black person hears the call to powerlessness as one more command to lie down and take it” (1992, p. 9). Similar sentiments can be found in Native adaptations of the Twelve Steps, e.g., Step Two: “We came to believe that a power greater than ourselves could help us regain control” (Coyhis, 1999). Empowerment is inspiring, horizon-raising, energizing, and galvanizing. The concept of empowerment applies to communities as well as individuals. It posits that the only solution to the problem of addiction in disempowered communities lies within those very communities. Empowerment occurs, in part, when people impacted by addiction cast aside their victimhood and become active participants in healing themselves, their families and their communities. (See **Hope-based Interventions** and **Resistance**)

Enabling,...

in the addiction treatment/recovery arena, the act of “enabling” has come to mean any intervention 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/drugging, increase the likelihood of continued addiction. The concept led family members and counselors 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 “codependency,” the most basic acts of human kindness toward others were framed not as evidence of compassion but of psychopathology.

Enmeshed Style (of recovery)...

Refers to the initiation and maintenance of recovery while almost completely sequestered within the culture of recovery. Such enmeshment serves to isolate the individual from the culture of addiction and can also, at least for a time, isolate one from the larger “civilian” culture.

Evidence-based Practices (EBP)...

are 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. One reviewer offered the observation that the growing preoccupation with EBP marks a shift in focus from subjective experience to objective outcome, raising the possibility that important dimensions of recovery could be lost if healers are transformed into procedural technicians. The concern expressed here is that there may be important aspects of the recovery experience that are not measurable.

Ex-Addict...

is 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 narcotics). The term is noteworthy in its depiction of the status (identity) of addict in the past tense—something one was but no longer is—in contrast to the ritual self-introduction in NA, “My name is ___ and I’m an addict.” This distinction hinges on the question, “Once addicted, does one ever cease being an addict?” There are recovery frameworks that answer this question quite differently (see **Recovered/Recovering, Disengaged Recovery, Styles of Recovery**).

Excessive Behavior....

refers to the propensity of those recovering from severe alcohol and other drug problems to experience problems with other excessive behavior, particularly during their early recovery years. Excessive relationships with secondary drugs, work, money, sex, food, risk (e.g., gambling), and religion are common in early recovery. Working through this propensity for excessive behavior (even excessive work on recovery) is a normal part of the recovery process, and underscores the importance of such values as harmony and balance in the transition from the early to the middle stages of recovery (White, 1996). Excessiveness may even be an ally in the early recovery process (See **Preferred Defense Structure**).

Expectancy Factors...

refer to one’s view of the future with or without drugs—views that change dramatically in the transition from addiction to recovery. Recovery is marked by changes in addiction expectancies and recovery expectancies. Opportunities for recovery increase when the expected pleasure of drug use diminishes and the perception of the likelihood of incapacitating consequences shifts from a remote possibility to likely and imminent. Recovery opportunities also increase when recovery rewards are seen as significant and immediate (Fiorentine & Hillhouse, 2000; Burman, 1997).

Faith-based Recovery...

is 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 serve as adjuncts to traditional recovery support programs or serve as alternatives to such programs.

Family....

is the inner social network that surrounds the individual experiencing a severe alcohol or other drug problem. In most recovery circles, family is defined more by function than by blood.

Family-centered Care...

refers to a treatment philosophy in which the family, rather than the individual, is the primary “client.” Such philosophies are usually implemented by offering family members clinical services that focus on their problems and needs.

Family Illness....

refers to the way in which all members of the family and the family unit as a whole are wounded by the addiction of one of its members.

Family Recovery...

has three dimensions: the healing of individual family members, the healing of family subsystems (adult intimacy needs, parent-child relationships, and sibling relationships), and achieving recovery-conducive boundary transactions with people and institutions outside the family. While the order in which these subsystems heal can vary, family research (Brown and Lewis, 1999) suggests that individual recovery of family members must precede the recovery of the family as a unit (see **Trauma of Recovery**).

Freedom (from Slavery)...

is a metaphor used to confront addiction in the lives of historically colonized or enslaved peoples (particularly African Americans) (See the liberation theology of Cone, 1984; Williams, 1992). Such framing posits the role of alcohol and drugs as a tool of the colonizer to both wound and anesthetize the colonized. This metaphor can be heard in the rhetorical teachings of many African American Leaders. James Baldwin (1962) reflected these sentiments when he declared that the streets of Harlem would be flowing with blood but for the anesthesia of booze, dope and religion. He challenged African Americans to “throw off the chains of the slavemaster” by refusing to drink his alcohol and use his dope. Slavery (to sin) as a metaphor for addiction and freedom (deliverance, liberation) as a metaphor for recovery can also be found within many religious traditions. For example, the “FREE-N-ONE” ministry in Chicago is a Christian fellowship of men and women who have “emerged victoriously” from their addiction to alcohol and/or other drugs. Their only requirement for membership is a “desire to be FREE.” (FREE-N-ONE, ND)

Genocide (as a recovery metaphor)...

is traditionally defined as a planned scheme to destroy a race or otherwise defined group of people. Genocide attacks the very foundations upon which a group of people exist—their physical safety, their family and kinship structures, their language, their cultural, economical and political institutions and their dignity and spirit. The term takes on meaning in the context of addiction recovery when alcohol and other drugs become viewed as tools of such genocide and abstinence becomes viewed as an act of resistance—an act of personal and cultural pride and survival. Such a shift in worldview, long noted as a potential dimension of recovery, involves a redefinition of self, a reconstruction of family and social relationships, a new perception of the order of the universe, and a new understanding of alcohol or other drug problems (Kennedy and Humphreys, 1994). Such shifts in worldview provide a metaphor for understanding one’s

addiction and recovery in a larger historical and political context. Such worldviews shifts have been particularly important in inciting or anchoring recovery among disempowered peoples. In this shift, AOD use once experienced as an act of rebellion—a refusal to be acculturated—suddenly is seen as an imposed scheme of personal and cultural suicide. In this shift, radical abstinence becomes an act of purification and a refusal to die physically, psychologically, or culturally. The link between genocide and addiction is a theme found in abstinence-based, Native American cultural revitalization movements and among some African American groups. Black Panther Michael Tabor (1970) called dope a “form of genocide in which the victim pays to be killed.”

Giving It Away...

is 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...

is the experience of ultimate reprieve—the gift of one’s own life. It is the source of such recovery values as humility and service.

Guidelines/Limits...

constitute a moderation-based technology of alcohol problem resolution. For members of Moderation Management (or those who are seeking a solo approach to moderating their drinking), guidelines provide a framework that defines the meaning of drinking (“a small, enjoyable part of life”), the frequency of drinking (not every day), the frequency of non-drinking (at least 4 days per week), what to do in combination with drinking (eating), what not to combine with drinking (driving or other potentially dangerous situations), and the quantity of drinking (not more than 3 drinks per day for women and 4 drinks per day for men). Those within MM who cannot consistently adhere to these guidelines are encouraged to develop abstinence as a personal goal (Kosok, 2001).

Habilitation...

is the process of constructing a recovery identity from new rather than old building blocks. Rather than retrieving what one lost through addiction; it is building recovery from that which one never had. (See **Recovery**)

Habit-breaking...

in the context of recovery, is the conceptualization of alcohol and other drug problems as an acquired habit and the resolution of these problems through the application of techniques used to cease long-standing habits (Dorsman, 1991).

Harm Reduction (as a stage of recovery)...

is the term used to depict 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.

Healing Forest...

is a metaphor used in *The Red Road to Wellbriety* (2002) suggesting that healthy seeds cannot

grow in diseased soil and that injured seeds need a healing forest in which they can be repaired and flourish (see **Ecology of Recovery**).

High Bottom Recovery...

refers to the initiation of recovery through a breakthrough of awareness of all that one 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 (see **Low Bottom Recovery**).

Higher Power...

is, 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 the “God as we understood Him,” Higher Power is the personified antidote to the **Beast**.

Hitting Bottom...

is an addiction-related experience of complete anguish and despair. Studies have long affirmed the role of this “hitting bottom” experience (heightened AOD-related consequences and threat of greater consequences) and/or (a dramatic breakthrough in self-perception) in the initiation of recovery. The experience has been characterized 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), a “crossroads” (Klingemann, 1991, 1992), and an “epistemological shift” (Shaffer and Jones, 1989).

Hope-based (as opposed to pain-based) Interventions...

are interventions into the lives of people with severe alcohol- and other drug-related problems that rely not, on enhancing a pain-based crisis, but on enhancing a hope-inspired leap into recovery. Where traditional pain-based interventions rely on amplifying the experience of alcohol- and other drug-related consequences, hope-based interventions rely on living proof (role models) of what is possible, encouraging change, expressing confidence in the individual’s ability to change, and providing concrete steps of how the recovery journey can begin. Pain-based interventions rely on threats of what we will do **TO** you; hope-based interventions are based on a promise of what we will do **WITH** you. Hope-based interventions are particularly important for historically disempowered and personally victimized people who have developed massive capacities for physical and psychological pain and who exhibit chronic, self-defeating styles of interacting with professional helpers.

Identity Realignment...

is the process of retrieving a pre-addiction identity, salvaging and fully developing an identity not spoiled by addiction, or creating a new post-addiction identity. Such realignment represents a new or refined definition of who one is (one’s identity) and what one does (one’s role) (Biernacki, 1986). The hope that a spoiled identity can be repaired or replaced is a crucial dimension of the experience of hope for recovery. The successful rehabilitation of “self” is crucial to the consolidation of recovery (McIntosh and KcKeganey, 2002). The early stages of this identity realignment are marked by self-loathing, self-examination, confession and forgiveness, identity reconstruction, restitution, purging of toxic emotions, and mastery of self-defeating behavior (White, 1996).

Idolatry...

in the context of recovery, is the framing of addiction as the sin of worshiping a false god. Such references can be found within many religious traditions. In Islam, for example, alcoholism is viewed as a fruit of the tree of *Jahiliyyah* (ignorance/idolatry) (Badri, 1976).

Illness Self-management...

is the mastery of knowledge about one's own illness and assumption of primary responsibility for alleviating or managing the symptoms and limitations that result from it (Corrigan, 2002). Such self-education and self-management shifts the focal point in disease management from the expert caregiver to the person with the illness. (See **Empowerment and Recovery Management**)

Indigenous Healers and Institutions...

are people and organizations in the natural environment of the recovering person who offer words, ideas, rituals, relationships and resources that help initiate and/or sustain the recovery process. They are distinguished from professional healers and institutions by training and purpose as well as by relationships that are culturally-grounded, enduring, reciprocal and non-commercialized.

Initiating Factors (“Triggering Mechanisms”)...

are those factors that spark a commitment to recovery and an entry into the personal experience of recovery. Factors which serve this recovery priming function are often quite different than those factors that later serve to sustain recovery (Humphreys, et al, 1995). Recovery-initiating factors can exist within the person and within the individual's family and social environment. These factors can include pain-based experiences, e.g. despair, exhaustion and boredom with addictive lifestyle; AOD-related death of someone close; pressure to stop using; a humiliating experience; health problems. They can also include hope-based experiences: exposure to recovery role models, a new intimate relationship, marriage, parenthood, a religious experience, or a new opportunity. This synergy of pain and hope creates a sequence in relationship to recovery: The experience of pain (I need to do this); the desire to change (I want to do this); belief in the possibility of change (I can do this); commitment (I am going to do this); experiments in abstinence (I am doing this); and move from sobriety experiment to stable sobriety and recovery identity (I have achieved this; this is who I now am) (See Prochaska, et al, 1992)

Intervention...

is a 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 behavior on family, friends and co-workers.

Inventory...

is a process of auditing one's 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 mechanisms for the alleviation of guilt shame as well as for character reconstruction.

Liberation... (See Freedom, Slavery, Decolonization)

can be a powerful metaphor for recovery among historically disempowered peoples. It is in this context that the phrase "liberation by any means necessary" takes on personal as well as political meaning (Tabor, 1970).

Low Bottom Recovery...

refers to 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 (see **Hitting Bottom**).

Maintenance Factors...

are those activities and influences that serve to stabilize, consolidate and strengthen long term recovery from alcohol and other drug problems (Humphreys, et al, 1995). Recovery maintenance factors include geographical/social disengagement from the culture of addiction; negotiation of entry into the straight world; development of a sobriety-based social support system; institutional re-connection (family, church, school, workplace, pro-social community organizations); non-drug-related leisure activity; resolution of family distress/conflict; improved relationships with parents or children; positive response from significant others, family and friends; a stable economic support system; solidification of new identity; and the use of "justifying rhetorics" (personal rationales for abstinence) (Schasre, 1967; Moos, et al, 1979; Tuchfield, 1981; Granfield and Cloud, 1999; Sobell, Ellingstad, and Sobell, 2000; McIntosh and McKeganey, 2002). Overall, recovery maintenance factors are generated through the diminishment of pain and global improvements in multiple areas of life functioning, including the enhancement of meaningful and pleasurable activities and relationships (Blomqvist, 1999; Larimer and Kilmer, 2000; Humphreys et al, 1995; Tucker et al, 1994; King and Tucker, 1998). The number and quality of pro-recovery relationships is predictive of recovery maintenance (Margolis et al, 2000; Gordon and Zrull, 1991; Stall and Biernacki, 1986; Laudet and Savage, 2000).

Manual-guided Recovery...

depicts the growing trend toward proceduralizing the steps of addiction recovery so that such recoveries can be self-initiated and self-managed over time without the use of professionally-directed treatment services or involvement in formal mutual aid societies. (See **Solo Recovery**)

Mass Abstinence...

is the resolution and prevention of alcohol and drug addiction through the collective decision of a people/community/culture to reject all consumption of alcohol and other drugs (Badri, 1976). Such mass action has often been the result of broad social movements (the American temperance

movement), cultural revitalization movements within disempowered communities (See Willie, 1979; Chelsea and Chelsea, 1985; Taylor, 1987; and Williams, 1992), or through religious reformation movements.

Maturing Out (See Natural Recovery)

Medication-assisted Recovery...

is the use of medically-monitored, pharmaceutical adjuncts to support recovery from addiction. These include detoxification agents (e.g., clonidine), stabilizing agents (e.g., methadone), aversive agents (e.g., disulfiram), antagonizing agents (naloxone), and anti-craving agents (acamprosate, naltrexone). They also include medications used to lower risks of relapse via symptom suppression of one or more co-occurring physical or psychiatric disorders. The use of such medications in the context of treatment is known as pharmacotherapy. 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 to have people in medication-assisted recovery recognized as legitimate members of the recovery community.

Medicine Wheel...

is a Native American system of teaching and healing that includes the four directions, the four elements (earth, fire, air and water), the four peoples (Red, White, Black and Yellow), and the four directions of growth. Medicine wheel teachings, with their emphasis on interconnectedness and harmony, have figured prominently in Native American recovery frameworks (The Red Road to Wellbriety, 2002)

Meeting...

is the basic unit of interaction and mutual identification within the culture of recovery in America. In spite of the dramatic differences between AA, WFS, SOS, LifeRing Secular Recovery, Moderation Management, Alcoholics Victorious, and other mutual aid groups, they all share the “meeting” as the central ritual of commitment and communication. The importance of this ritual is intriguing in light of the fact that “meetings” per se are not talked about in most of the basic texts of these groups. Some recovery frameworks such as Rational Recovery (Now AVRT—Addictive Voice Recognition Training) no longer utilize meetings as a recovery support mechanism.

Meeting Types and Formats...

refers to the boundaries of inclusion and exclusion of meetings (open versus closed; gender mixed or men/woman only; young people, smoking/non-smoking) and the style and content of a mutual aid meetings, e.g., speaker meetings, discussion meetings, or study meetings (texts, steps/principles).

Metaphors of Transformation...

are personally and culturally meaningful words and ideas that serve to catalyze or crystallize recovery efforts. Such metaphors are highly variable within and between cultures and draw their power from personal/cultural fit rather than scientific validity. Words, ideas, metaphors,

symbols, and rituals that incite change in one personal (e.g., gender, age) or cultural (ethnic, class) context may provide no such catalyzing effects in other contexts. White and Chaney (1993) have described critical differences in the dominant metaphors within recovery programs evolving out of men's experience versus those that have evolved out of women's experiences. The latter programs emphasize empowerment rather than powerlessness, internal rather than external resources, divided attention rather than focused attention, shame rather than guilt, self-esteem rather than humility, and place great emphasis on physical and psychological safety and on body image.

Mirroring Rituals...

are activities that bring us into relationship with other people who share our aspirational values. In the context of recovery, they are rituals of fellowship in which recovery identities and recovery communities are solidified through the acts of storytelling and mutual support. Mirroring rituals (sharing, listening, observing, laughing) constitute one of the four core activities within the culture of recovery.

Moderated Recovery (Moderated Resolution)...

is the resolution of alcohol or other drug problems through reduction of alcohol or other drug consumption to a subclinical level (shifting the frequency, dosage, method of administration, and contexts of drug use) that no longer produces harm to the individual or society. The concept takes on added utility within the understanding 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 AOD problems, heightened problem severity, the presence of co-occurring psychiatric illness, and low social support (Dawson, 1996; Cunningham, et al, 2000; Vaillant, 1996). The most common example of moderated resolution can be found in studies of people who develop alcohol and other drug-related problems during their transition from adolescence to adulthood. Most of these individuals do not go on to develop enduring AOD-related problems, but instead quickly or gradually moderate their AOD through the process of maturation and the assumption of adult responsibilities (Fillmore, et al, 1988).

Moderation Societies...

are mutual aid societies that seek to resolve alcohol-related problems by moderating rather than ceasing alcohol consumption. More specifically, these societies set limits for their members on the quantity, pacing, frequency, location and rituals involved in alcohol consumption. Such societies date from the sixteenth century in Europe (Germany) and the nineteenth century in the United States (Cherrington, 1928). The core themes of the currently most popular moderation society in the United States, Moderation Management (Kishline, 1994) are moderation, balance, self-control (“self-management”) and personal responsibility.

Motivational Interviewing...

is a non-confrontational approach to eliciting recovery-seeking behaviors that was developed by William Miller and Stephen Rollnick. The approach emphasizes relationship-building (expressions of empathy), heightening discrepancy between an individual’s personal goals and present circumstances, avoiding argumentation (activation of problem-sustaining defense structure), rolling with resistance (emphasizing 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 recovery). As a technique of preparing people to change, motivational interviewing is an alternative to waiting for an individual to “hit bottom” and an alternative to confrontation-oriented intervention strategies (Miller and Rollnick, 1991).

Multiple Pathways of Recovery (Multiple Pathway Model)...

reflect the diversity of how individuals resolve problems in their relationship with alcohol and other drugs. Multiple pathway models contend that there are multiple etiological 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 structures (White, 1996). Multiple pathways models have moved from the addiction arena into the recovery advocacy arena. Groups like the Santa Barbara, CA Community Recovery Network openly proclaim themselves:

...an advocacy organization whose primary purpose is to fully represent the recovery community in its diversity. As such, we have no bias or formal opinion concerning the manner or means by which people achieve or maintain recovery.
(The Nature of Recovery, 2002)

Mutual Aid Groups...

are groups of individuals who share their experience, strength and hope about 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 (See **Indigenous Healers and Institutions**).

Natural Recovery...

is a term used to describe those who have initiated and sustained recovery from a behavioral health disorder without professional assistance or involvement in a formal mutual aid group. This type of resolution of alcohol and other drug problems has been variously christened “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...

depicts the collective efforts of grassroots organizations of recovered/recovering people and their families whose goals are to 1) provide an unequivocal message of hope about the potential of long term recovery from behavioral health disorders, and 2) to advocate for public policies and programs that help initiate and sustain such recoveries. 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, and 7) recovery research (White, 1999).

Paradox...

the extraction of 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.

Partial Recovery...

is 1) the failure to achieve full symptom remission (abstinence or the reduction of AOD use below problematic levels), but the achievement of a reduced frequency, duration, and intensity of use and reduction of personal and social costs associated with alcohol/drug use, or 2) the achievement of complete abstinence from alcohol and other drugs but the failure to achieve parallel gains in physical, emotional, relational, and spiritual health. Partial recovery may precede full recovery or constitute a sustained outcome (See **Emotional Sobriety, Wellbriety**).

Partnership Model...

is the term used to distinguish the nature of the service relationship in the **recovery management** model from traditional “expert” models of problem intervention. Partnership implies a more enduring relationship and one with greater mutuality of rights and responsibilities.

Pathways (to Addiction and Recovery)...

is a phrase that connotes 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 one’s 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 singular approach to recovery management. Single pathway models are being replaced by **multiple pathways models**: there are many etiological pathways to alcohol and other drug problems; these problems unfold in highly diverse patterns and vary considerably in their course; different types of AOD problems respond to different intervention approaches; and there are multiple pathways and styles of resolution for AOD problems. (See **Roads to Recovery**)

Peyote Way (Peyote Road; Tipi Way)...

is a sobriety-based ethical code of conduct associated with the Native American Church. Having been used as a recovery support structure by Native Americans for more than a century, the Peyote Way demands certain practices: faithfulness in marriage, fulfillment of kinship duties, brotherly love, hard work, generosity, and abstinence from alcohol (LaBarre, 1976; Slotkin, 1956).

Powerlessness...

is 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.

Prayer (See Centering Rituals)

Preferred Defense Structure...

is a concept first proposed by John Wallace (1974). Wallace was an early proponent of the idea that there are developmental stages in the transition between alcoholism and long-term recovery. It was his observation that some forms of the primitive defense mechanisms used to sustain addiction (denial, minimization, projection of blame, "either-or" thinking) were needed to get through early recovery, but that these same mechanisms (collectively christened, "preferred defense structure") had to be given up for long-term recovery. He suggested that interventions that were effective at one stage of recovery might be ineffective or even harmful at other stages. For example, interventions that weakened this preferred defense structure in early recovery could inadvertently increase the risk of relapse.

Program...

has come to have many meanings within American communities of recovery. It has come to be synonymous with Twelve Step recovery, as "How long have you been in the Program?" and with the Twelve Steps, as in "I've been in AA for quite a while but I've only been working the Program (the Steps) this past year." Program has also taken on a more generic meaning for any codified approach to addiction recovery. The Handbook of LifeRing Secular Recovery suggests that there are two broad approaches to recovery frameworks: the big-P through which a person addicted to alcohol or other drugs surrenders themselves to the prescriptions others have earlier followed to achieve recovery, and the little-p that creates an environment of safety and mutual support within which each person works out his or her own, highly personalized approach to recovery (A Handbook of Secular Recovery, 1999).

Program Tripper...

is a person who is simultaneously or sequentially involved in two or more recovery support programs. While the term was used to disparage such practice, there is considerable evidence that such combinations are common, e.g., members of AA also involved in psychotherapy, members of WFS, SOS, and MM also involved in AA, and members of these groups who later attend support groups for problems other than addiction (See **serial recovery**).

(The) Promises...

refer to the fruits of recovery that could 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 materialize if we work for them. (Alcoholics Anonymous, p. 96, first edition)

Public Health Model...

is an approach to the resolution of alcohol and other drug problems that shifts the focus from the personal arena (recovery) to the environmental (economic, political, cultural) arena, e.g., lowering total per capita drug consumption within a population via product taxation, limiting number of outlets, restricting product promotional activity, public education, etc. Public health model proponents address many contextual issues historically ignored by the treatment and recovery communities.

Purification...

is a ritual of cleansing long associated with Native American alcoholism recovery practices. Purification rituals include isolation, fasting, sexual abstinence, purging, and sweating.

Qualify...

is the term used to describe the process of disclosing one's addiction and recovery experiences within the context of a recovery mutual support group.

Quantum Change (See Conversion)

Rebirth... (See Born Again)

Recovered / Recovering... (Abstracted from White, 2001b)

are 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. Achieving both utilities may require that one language be used inside recovery circles while

another language is used to speak publicly. 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 congruent with 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 depict those who have achieved an extended period of symptom remission. The period used to designate people recovered from other chronic disorders is usually five years without active symptoms.

Recovery....

is 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 have 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 one’s life was at before addiction altered one’s life course. For those who never had such a prior level of functioning, the term recovery may be more aptly framed “procovery” or “discovery”—the movement toward that which is new. For those wounded by childhood victimization, the term “uncovery” may be an apt description of the early healing process (White and Chaney, 1993). This reaching back and reaching forward represent two very different positions from which recovery is initiated, and mark the differences between treatment approaches based on rehabilitation versus those based on **habilitation**.

Recovery Activism...

is the use of personal recovery experiences as a springboard for economic, political and social change. Recovery activism seeks redress of environmental conditions that contribute to addiction or constitute a barrier to recovery.

Recovery Advocacy...

is the process of exerting influence (power) toward the development of pro-recovery social policies and programs. Recovery advocacy activities include: 1) portraying alcoholism and addictions as problems for which there are viable and varied recovery solutions, 2) providing living role models that illustrate the diversity of those recovery solutions, 3) countering any attempt to dehumanize and demonize those with AOD problems, 4) enhancing the variety, availability, and quality of local/regional addiction treatment and recovery support services, 5) removing environmental barriers to recovery, including the promotion of laws and social policies that reduce AOD problems and support recovery for those afflicted with AOD problems, and 6) enhancing the viability and strength of indigenous communities of recovery.

Recovery Assets (see Recovery Capital)

Recovery-bonded Relationships...

are relationships that are grounded on the shared experience of recovery. They elevate and deepen the recovery experience, and serve as a replacement for the pathology-bonded relationships that often existed as a centerpiece of the addiction experience. These special people go by many names: sponsor, mentor, role model, and, most importantly, friend (White, 1996).

Recovery Capital...

is 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 (See **Habilitation**).

Recovery Career...

is a way of conceptualizing 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 is an extension of this application and 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 Celebration...

is an event in which recovered and recovering people assemble to honor the achievement of recovery. Such celebrations serve both therapeutic and mutual support functions but also (to the extent that such celebrations are public) serve to combat social stigma attached to addiction by putting a human face on addiction and by conveying living proof of the enduring resolution of alcohol and other drug problems.

Recovery Coach (Recovery Support Specialist)...

is a person who helps remove personal and environmental 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 mobilizing volunteer resources within the recovery community, or provided by the recovery coach where such natural support networks are lacking.

Recovery Community (Communities of Recovery)...

is 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 include both professionals working in the behavioral health fields as well as recovery supporters within the wider community. Recovery management is based on the assumption that there is a wellspring of untapped hospitality and service within this recovery community that can be mobilized to aid

those seeking recovery for themselves and their families. “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 reciprocity of “fit.” The growth of these divergent communities reflects the growing varieties of recovery experiences (Kurtz, 1999).

Recovery Consultant (see Recovery Coach)

Recovery Deficits...

are the specific internal and external obstacles that impede initiating or maintaining a solution for AOD-related problems. The notion of recovery assets and deficits suggests two very different approaches to the process of **recovery priming**. One focuses on reducing obstacles to recovery; the other focuses on increasing internal and external recovery resources.

Recovery Demography...

is the study of populations of people who have resolved alcohol and other drug-related problems. Such studies are generally done through population surveys, surveys of recovery mutual aid societies or recovery advocacy organizations, and through longitudinal follow-up studies of people who have been treated for alcohol and other drug problems. The major purposes of such surveys are to measure the incidence and prevalence of recovery and the variations in recovery across various demographic and clinical categories. (See www.recoveryadvocacy.org for a sample of a recent recovery survey.)

Recovery Environment...

is a term that stands as a reminder that 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. The growing sober house movement and the creation of drug free zones within public housing projects are examples of efforts to create sober sanctuaries for the newly recovering (See **Ecology of Recovery**).

Recovery Home...

is a self-managed, self-funded communal living environment for people in stage one recovery. The Oxford Houses are the best known and researched system of recovery homes in the United States (Jason, Davis, Ferrari, and Bishop, 2001)

Recovery Identity...

is the degree to which one 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 (See **Affiliated Recovery, Solo Recovery**).

Recovery Management...

is the provision of engagement, stabilization, education, monitoring, support, and re-intervention technologies to maximize the health, quality of life and level of productivity of persons with

severe 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 (see Illness **Self-Management**).

Recovery Needs Assessment...

is the solicitation of information on the needs of people at different stages of recovery. While the identification of such needs can be done through formal surveys, they are most frequently conducted by focus groups hosted by local recovery advocacy organizations or through interviews conducted by outreach workers.

Recovery-oriented Systems of Care...

are 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 from behavioral health disorders.

Recovery Outcomes...

refers to the degree of benefits achieved as a consequence of recovery from addiction. Discussions of recovery outcome 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 Porn”...

is a term of contempt for items or services aggressively marketed to people in recovery with the primary purpose being the profit of the seller rather than the recovery of the buyer. The term is a reminder that there are moneychangers in the temple of recovery, and that people in recovery need to protect themselves from potential exploitation.

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. Recovery plans were pioneered within the “social model” programs of California (Borkman, 1998).

Recovery Priming...

is the process of helping someone move from an addiction career to a recovery career. It is the sudden or cumulative achievement of recovery momentum. Within stages of change theory, it is moving someone from a precontemplation stage of change to an action stage of change. It most often involves exposure to recovery role models with whom one can identify, the removal of recovery obstacles, the affirmation of hope in recovery and the expression of confidence in the individual’s ability to recovery (see **Developmental Models of Recovery**). It also refers to the process through which mastery of one self-destructive behavior (alcoholism) enhances the prospects of resolving other destructive behaviors (e.g., nicotine addiction).

Recovery Progression...

Is the idea that there are natural stages within the addiction recovery process (see Developmental Model). 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 bodies and their involvement in the design, delivery, and evaluation of addiction treatment and recovery support services.

Recovery Research (Agenda)...

is 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 cartography 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. (See **Recovery Demography**)

Recovery Rights...

address problems of discrimination against people in addiction recovery. Issues included within this arena span discrimination in housing, employment, access to public services, health and life insurance, and scholarship funds for vocational training and college and universities.

Recovery Rituals...

are 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)...

are 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. See White 1998 & 2001a for a history of such groups in the United States.

Recovery Support Services...

are services designed to 1) remove personal and environmental obstacles to recovery, 2) enhance identification and participation in the recovery community, and 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 Support Specialist (See Recovery Coach)...

Recovery Values...

are those virtues that have come to be associated with recovery from addiction. Variable across recovery pathways, a sampling of such values can be found in Native adaptations of the Twelve Steps: honesty, hope, faith, courage, integrity, willingness, humility, forgiveness, justice, perseverance, spiritual awareness, and service (Coyhis, 2000).

Red Road to Sobriety...

is a Native American Framework of recovery developed by Gene Thin Elk (Lakota-South Dakota). The term, “Red Road” has come to mean a style of sober living that, rather than just the absence of drinking, reflects internal peace and living with respect and in harmony with others and the earth (see **Wellbriety**).

Redeemed/Redemption Repented/Repentance...

is the resolution of alcohol and other drug problems through an experience of rebirth. In this model of understanding, the addicted self dies, and the new drug-free self is born. (“Therefore, if any man is in Christ, he is a new creation, old thing have passed away; behold, all things have become new.” 2 Corinthians 5:17)

Relational culture (power)...

is an organizing principle used by some recovery advocacy groups to mobilize the recovery community. The principle is based on enhancing mutual identification by consciously exploring (cultivating mindfulness) the shared experiences and needs of people who have been impacted by addiction. The strategy involves conducting series of intentional conversations designed to enhance the consciousness of people in recovery and bring such people together for joint reflection and action.

Religion...

is a system of beliefs about the nature of the universe, the nature of ultimate concerns in life and the, meaning of personal destiny, all of which are affirmed through creeds, prescriptions for living, and rituals of worship. Religions of many varieties have provided, and will continue to provide, a framework for addiction recovery. While some people use religious experience to initiate recovery, others use religious affiliation and worship to sustain and enrich their recovery.

Renounce/Renunciation (see Commitment)

Reprieve (versus Cure)...

is one way of understanding the means through which recovery is attained. In this understanding, recovery is a daily suspension of addiction contingent upon recovery self-management: doing what is necessary to, and avoiding what would undermine, the stability and durability of recovery. There is a second and broader meaning to the term reprieve. In confronting the imminence of death through the experience of addiction, there is often an awareness that every day of life is a reprieve, regardless of one’s health status. What that awareness encourages is a fidelity to personal priorities and the achievement of meaning and pleasure within the confines of each day. When recovering people characterize their addiction as

a hidden blessing, it is often in gratitude for this kind of awareness

Resistance (Recovery as an act of)...

is the framing of addiction, not as an act of surrender, but as an act of personal and cultural assertion. It is a refusal to be silenced by self-destruction. In this framework, recovery is a conscious entry into struggle on behalf of oneself and a larger cultural community (See **Genocide**).

Resolution (versus Recovery)...

is a term preferred by some for the process of solving alcohol and other drug problems. *Resolution*, *resolving* and *resolved* are less medicalized terms. For those who wish to reserve use of the term recovery to the reversal of severe AOD problems or to abstinence-based recovery, the term *resolution* might be a more preferable term applied to those who work out non-abstinent solutions to less severe and less enduring AOD problems. (See **Moderated Recovery**) Another use of the term “resolution can be found in Dr. William Silkworth’s (1937) distinction between a resolution not to drink and a decision not to drink. Silkworth noted that a resolution was a “momentary emotional desire to reform,” whereas a decision is an attitude-transforming mental conclusion and conviction that one must never drink again. He suggests that resolutions based on appeals to emotion must be replaced with decisions made with one’s mind.

Responsibility...

is the acceptance of accountability for past, present and future actions. This value has importance in the context of recovery as the antidote for projection of blame and other strategies of defense characteristic of active addiction.

Restitution...

is the process of rectifying wounds inflicted on individuals and the community (see **Amends**)..

Resurrection (as a metaphor of recovery)...

dates to the Washingtonian Temperance Society, which was also sometimes referred to as the Lazarus (or Resurrection) Society. References to the resurrection of addicted people through the act of recovery continue into the present era (see Williams, 1992, p. 81).

Rituals of Recovery...

Include **centering rituals**, **mirroring rituals**, **acts of responsibility**, and **acts of service**.

Roads to Recovery...

is a phrase first used by Bill Wilson to convey the diversity of ways used to escape alcoholism. When some AA members criticized 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) (see **Pathways to Recovery**).

Secular Recovery...

is a style of recovery that does not involve reliance on any religious or spiritual ideas (God or Higher Power), experiences (conversion), or religious rituals (prayer). Groups providing support for a secular style of recovery include Secular Organization for Sobriety, LifeRing Secular Recovery, and Rational Recovery.

Serial Recovery...

is the process through which individuals with multiple concurrent or sequential problems resolve these problems and move toward optimum level of functioning and quality of life. Serial recovery refers to the process of sequentially shedding two or more drugs or recovering from two or more different conditions. It refers to the overlapping processes involved in recovering from addiction and other physical or behavioral/emotional disorders. (See **Sobriety Date**)

Service Committees...

are the structures within mutual aid societies through which members support the organizational work of the societies and render help to those still suffering from addiction.

Service Work...

see (**Acts of Service**)

Sharing...

is the stylized 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 time protects the speaker from having their statement judged, criticized, ridiculed, or otherwise attacked. This in turn promotes the fullest possible openness and honesty...” (Handbook of Secular Recovery, 1999, pp. 30-31). (See **Crosstalk**)

Sin...

is a designation of the state of addiction as defined by groups like Alcoholics for Christ: “We agree that drunkenness is a sin and we believe that alcoholism is a disease with spiritual origins. We rejoice that Jesus forgives us of our sins and heals us of our diseases.”

Slogans...

are a shorthand method of communicating to oneself and others in recovery. They are phrases that have come to embody certain recovery principles and prescriptions. While they inspire some and irritate others, they have become a visible symbol of American communities of recovery, widely heard in recovery dialogue and widely seen on posters and bumper stickers. They represent a form of meditative mantra (self-talk) at the same time they serve as a kind of in-group code through which recovering people find each other when mixed with civilians.

Sober House Movement...

refers to the dramatic expansion of recovery communes (self-run residences where people (often in early recovery) can live in a recovery-supportive living environment. (See **Recovery Home**)

Sobriety-based Support Structure...

is a social network of people who share and support recovery from alcohol and other drug problems. Such affiliation, whether religious (churches), spiritual (A.A./N.A.) or secular (W.F.S., S.O.S), offers a “program” of recovery that includes reasons and methods of altering one’s pattern of alcohol/drug consumption within a larger change in one’s philosophy of living.

Sobriety Date...

is traditionally defined as the anniversary date of one’s last drink or episode of drug use. Such calculations are not always clear-cut. Let’s take an individual who was addicted to methamphetamine, stopped using it completely after a near-death experience at age 21, increased cannabis use for 18 months and then stopped that out of concern that it was getting to be a problem, developed an alcohol problem following a divorce at age 34, and stopped a 2-pack a day nicotine addiction at age 45. From age 22 on, they have also been episodically treated for depression. What is this individual’s sobriety/recovery date? This not atypical story reveals the way in which many recovering people peel drugs out of their lives over a period of time and manage recovery from addiction in tandem with recovery from other co-occurring problems. While a sobriety date provides a quantitative measure of the length of symptom remission for one problem, it misrepresents the often complex processes involved in recovery and provides little information on the quality of sobriety measures. Families in recovery often speak of recovery date rather than sobriety date, although such a date is often difficult for families to pinpoint. Some family members place their recovery date at a crisis that led to their decision to get help, a moment of breakthrough during a counseling session or an Al-Anon meeting, or a period in which they began to see and tell the truth about what was happening in their family. (See **Serial Recovery**).

Sobriety Priority...,

in Secular Organization for Sobriety and LifeRing Secular Recovery, is the decision to never use alcohol/drugs again in one’s life, *no matter what* (Christopher, 1988, 1992; Handbook of Secular Recovery, 1999). It is analogous to what in Rational Recovery is called the “Big Plan” (Trimpey, 1989).

Sobriety Sampling...

is an experimental period of abstinence designed to test one’s capability for, and the experience of, abstinence. It is an action stage of problem resolution that stops short of, but can potentially lead to, a lifetime commitment to abstinence (Miller and Page, 1991) (See **Tapering Down** and **Trial Moderation**)

Solo Recovery...

is the initiation and maintenance of recovery from addiction without involvement in professionally-directed treatment or recovery mutual aid societies (see **Natural Recovery**).

Spheres (Zones, Domains) of Recovery...

are the life arenas through which the recovery process is expressed. One can thus speak of physical recovery, family and relational recovery, social recovery, economic recovery, etc. (Ron Coleman).

Spiritual (Spirituality)... (Abstracted from White, 1992)

is 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, rebirth, ecstasy (see **Hitting Bottom, Conversion**). The spirituality of fully experiencing the subtlety and depth of the ordinary is depicted in such terms as harmony, balance, centeredness, bliss, serenity, and tranquility. All of these can be part of the multi-layered experience of addiction recovery.

Spiritual Awakening...

refers to the progressive changes in character and relationships that recovering people experience through the stages of recovery. Such an incremental process of change is also commonly described as a spiritual “experience.” This gradual awakening stands in contrast to a sudden **conversion**).

The Spirituality of Imperfection...

is a recognition that human beings are flawed and make mistakes of various kinds. It is in this recognition and deep acceptance of one’s own imperfection that a new awareness emerges—the recognition and acceptance of the imperfection of others. It is in this second step that the alcoholic finds a framework for identification and relationship with the larger body of humanity (Kurtz, 1999).

Sponsorship...

is the practice of mentorship between one recovering person and another. It has a long tradition dating to the Washingtonians (1840s), has been most institutionalized within Alcoholics Anonymous and Narcotics Anonymous, and is also found within many faith-based recovery groups. The latter refer to sponsorship as the “ministry of encouragement.”

Stability/Durability (of recovery)...

refers to the duration of time at which recovery and its continuation become quite likely, and the risk of relapse grows quite remote. The concepts of stability and durability are to distinguish true recovery from the self-imposed respites from alcohol and other drug use that are a normal part of addiction careers. Research studies have generally defined 3-5 years as this point of predictive stability and durability (Vaillant, 1996; Nathan and Skinstad, 1987; De Soto, et al, 1989; Dawson, 1996; and Jin, et al, 1998)

Stage One Recovery...,

according to Ernie Larsen who coined the Stage One–Stage Two distinction, is the process of

breaking a primary addiction (Larsen, 1985, p. 4). Picucci (2002) describes it as the early years of reducing chaos, achieving stability, learning to accept help from others, and clearing out the wreckage of the past.

Stage Two Recovery...

(according to Larsen) involves “rebuilding the life that was saved in Stage I” (Larsen, 1985, p. 15). Stage Two Recovery transcends the early concern with the addictive behavior and instead focuses on a reconstruction of personal character, identity, and worldview and a reconstruction of personal relationships. Story Construction / Story Telling...is the process through which the recovering individual reconstructs their identity and shares their experience with others as acts of self-healing and service. Nearly all recovery stories—sacred and secular—follow a three-part sequence of the development of addiction, the turn-around-experience, and an account of life in recovery (White, 1996) (See **Witness/Testify**).

Styles of Recovery...

is a phrase that reflects the many varieties of ways people successfully approach the management of behavioral health disorders. These styles reflect the different ways in which identification with the disease and the recovery process becomes part of one's identity and the degree to which one relates to other people who share this recovery process (See **acultural, bicultural and enmeshed**). Styles also reflect temporal variations in recovery: recovery as a sudden transformational process (“Quantum Change”, Miller and C’ de Baca, 2001) versus incremental change (Procahska, et al, 1992)

Surrender...,

according to Dr. Harry Tiebout’s (1949) classic paper on the subject, is the collapse of “the unconscious forces of defiance and grandiosity” and “accepting without reservation or conflict the reality of his condition and his need for help.” Tiebout noted that such a collapse could mark the beginning of a process of continuing change or could be an ephemeral experience followed by a rigid, primitive hold on sobriety or a return to drinking and the resurgence of defiance and grandiosity. He noted that true surrender was followed not just by sobriety but “internal peace and quiet.” While experiences of acceptance, powerlessness and surrender mark the very core of the change process in Twelve Step recovery, recovery programs for historically disempowered groups often emphasize the self-assertion rather than surrender (see **Empowerment**).

Tapering Down...

is a strategy of lowering frequency and quantity of drug consumption either as an end in itself or in preparation for a final quit date. The strategy is designed to lower pharmacological tolerance, ease acute withdrawal at the point of quitting, and serve as a recovery priming experience (Miller and Page, 1991).

Temple (Body as)...

is a Christian recovery concept in which the human body is viewed as the temple of God. The concept calls for respect for that temple via refusal to defile that temple with poisons (alcohol and other drugs).

Traditions...

are the codified principles that govern the group life of Twelve Step organizations. 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.

Trauma of Recovery...

is a phrase coined by Stephanie Brown and Virginia Lewis (1999) to depict the strain of unfreezing the adaptive mechanisms used to maintain family homeostasis in the face of active addiction and the resulting impairment of other family members. The phrase vividly conveys the enormous changes in family structure and process that unfold with recovery. It conveys that the achievement of family health following the initiation of recovery is best measured in years rather than months, and it conveys the family's need for support during these critical points in the recovery process.

Trial Moderation...

is a strategy used with persons who reject abstinence as a necessary goal. The strategy consists of establishing a test period in which an individual seeks to consume within prescribed guidelines of frequency, quantity and contexts. A long-term (3-8 year) follow-up study of such trials among problem drinkers revealed that more than half eventually choose abstinence (Miller and Page, 1991; Miller et al, 1992). This strategy was actually recommended in the book *Alcoholics Anonymous*:

We do not like to brand any individual as an alcoholic, but you can quickly diagnose yourself. Step over to the nearest barroom and try some controlled drinking. Try to drink and stop abruptly. Try it more than once. It will not take long for you to decide, if you are honest with yourself about it. It may be worth a bad case of jitters if you get a full knowledge of your condition (p. 43, first edition)

Triggering mechanisms...

In contrast to the oft-noted relapse triggers, are experiences that spark the initiation of sobriety experiments (Humphreys, et al, 1995). These may build cumulatively toward stable recovery or be unleashed in a single, conversion-like experience (See **Developmental Stages of Recovery, Conversion; Initiating Factors**).

The Twelve Concepts...

depict the service structure within Alcoholics Anonymous, particularly the relationships between the A.A. World Services Office, the General Service Board and Conference, and local A.A. groups.

Twelve Principles...

are the values imbedded within the Twelve Steps. There have been several efforts to briefly catalogue these values/virtues/experiences. One version is: 1) Surrender, 2) Hope, 3) Commitment, 4) Honesty, 5) Truth, 6) Willingness, 7) Humility, 8) Reflection, 9) Amendment, 10) Vigilance, 11) Attunement, and 12) Service. Another version is: 1) Honesty, 2) Hope, 3)

Faith, 4) Courage, 5) Integrity, 6) Willingness, 7) Humility, 8) Brotherly Love, 9) Justice, 10) Perseverance, 11) Spiritual Awareness, and 12) Service.

(The) Twelve Steps...

are the actions taken by the early members of Alcoholics Anonymous that resulted in their continued sobriety and which were subsequently suggested as a program 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. .

Twelve Traditions (See Traditions)

Varieties of Recovery Experience...

is a term Ernest Kurtz adapted from William James writings to convey the growing diversity of recovery styles within A.A. as well as the growth in alternative (non-Twelve-Step) frameworks of addiction recovery.

Virtual Recovery...

is the achievement or maintenance of recovery through Internet support groups and with little or no participation in face-to-face support meetings.

(Achieving) Visibility (or Voice)...

is the process through which historically disempowered people become seen and heard as they take responsibility for their own recovery. Recovery thus becomes an antidote to silence and invisibility. Visibility is achieved by standing as a witness and offering testimony to one's return to life (Williams, 1992). (See **story construction / story telling**).

Wellbriety...

is 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 analogous to what AA co-founder, Bill Wilson, described as "**emotional sobriety**" (Wilson, 1958)

Witness (testify, testimony)...

is the act of telling one's story as an act of service, whether the target of that story is an individual, a community or a culture.

Wounded Healers...

are 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).

Zones (or Domains) of Recovery...

are the arenas in which recovery processes unfold. These have been differentiated as zones of action and experience. The zones include physical recovery, psychological recovery, spiritual recovery, relational recovery, and lifestyle (occupational, financial, recreational) recovery (White, 1996),

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Addictionary

A . . .

ABSTINENCE: Not using by choice, especially drugs.

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.

ACCLAMATION: Enthusiastic approval, without dissent.

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.-Involving or requiring physical exertion and energy.

ADDICT: A person who has an obsessive and compulsive need for something, such as drugs.

ADDICTION: A physical, mental, and spiritual disease that is characterized by an obsession to use the drugs 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.

ADVICE: Suggestions about a decision or action. Opinion about what could or should be done about a situation or problem.

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. Usually in the form of short, well-phrased sentences.

AFRAID: Filled with fear. Having feelings of aversion or unwillingness in regard to something.

AGE: Measurement from the time from birth to a specified time.

ALIENATE: To cause one who used to be friendly or loyal to become unfriendly or disloyal. To cause to become withdrawn or unresponsive; isolate, or dissociate emotionally.

ALIENATION: The act of alienating, or one who has been alienated. Emotional isolation or dissociation.

ALTERNATIVE: A chance to choose between things or one of the things between which a choice can be made. The choice between two mutually exclusive possibilities or a situation presenting such a choice.

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.

ANGER: A strong feeling of displeasure and often with active opposition to an insult, injury, or injustice. A strong feeling of displeasure or hostility.

ANGUISH: Great pain or trouble of body or mind. Agonizing physical or mental pain; torment.

ANONYMITY: The state of having set aside personal considerations of being named or identified for some greater good, practicing principles before personalities.

ANONYMOUS: Not named or identified; equal in status and importance.

ANTIDOTE: Something used to reverse or prevent the action of a poison. A remedy or other agent used to neutralize or counteract the effects of a poison.

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.

APPRAISAL: The act of setting a value on something. The classification of someone or something with respect to its worth.

APPRECIATION: The awareness or understanding of the worth or value of something. An expression of gratitude.

APPROPRIATE: Especially suitable. Suitable for a particular person, condition, occasion, or place; fitting.

APPROVAL_SEEKING: Seeking to be accepted as satisfactory.

ARISE: To come into existence.

ARRESTED: The state of having the progress stopped, as with a disease.

ARROGANCE: A sense of one's own importance that shows itself in a proud and insulting manner.

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 high or great. A strong desire for high achievement.

ASSUME: To pretend to have or be. To be arrogant or pretentious.

ASSURANCE: The state of being certain or having confidence in oneself. Excessive self-confidence.

ATMOSPHERE: A surrounding influence or set of conditions. A dominant intellectual or emotional environment or attitude.

ATTACHMENT: Connection by feelings of affection or regard or the connection by which one thing is joined to another. A bond, as of affection or loyalty; fond regard.

ATTEMPT: To try to do something. An effort or a try.

ATTITUDE: A feeling or opinion about a certain fact or situation. An arrogant or hostile state of mind or disposition.

ATTRACTION: The state of being attracted or pleased or something that attracts or pleases. The quality of arousing interest; being attractive or something that attracts.

ATTRIBUTE: A quality belonging to a particular person or thing. A quality or characteristic.

AUTONOMOUS: Self-governing, free from outside control. .

AVOID: To keep away from.

AWAKE: To become conscious or aware of something.

AWAKEN: To awake.

AWAKENING: The state of becoming awake.

AWARENESS: Having or showing understanding or knowledge of something.

B . . .

BAFFLED: Defeated or held in check by confusion. Perplexed by many conflicting situations or statements; filled with bewilderment.

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.

BEHAVIOR: The way in which one conducts oneself. The manner in which one behaves.

BELIEF: Something that one thinks is true. Something believed or accepted as true.

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.

BOREDOM: The state of being weary and restless when things are uninteresting. The feeling of being bored by something tedious.

BUGABOOS: Something that one is afraid of. An object of an obsessive nature, usually exaggerated fear or anxiety.

BUOYANT: Light-hearted and cheerful.

BURDEN: Something that is hard to take. Something that is emotionally difficult to bear.

BUT: Term expressing a comparison or difference between general theory and personal application.

C . . .

CARING: A heavy feeling of interest, concern, or responsibility.

CARRY THE MESSAGE: To demonstrate with words and actions the benefits of living the program of Narcotics Anonymous.

CHANGE: To make or become different, alter from a former state. To become different or undergo alteration.

CHAOS: A state of complete confusion and disorder in which one can become physically stimulated. A state of extreme confusion and disorder.

CHARACTER DEFECTS: Those things that drain us of all our time and energy while causing pain and misery all our lives.

CHARACTERISTIC: A special quality or appearance that is a part of a person's overall character. A distinguishing quality.

CLEAN: Total abstinence from all drugs, no exceptions.

CLING: Remaining emotionally or intellectually attached to something that one believes is harmful to oneself. Remaining emotionally or intellectually attached to something that one believes harmful to oneself.

CLOSE-MINDEDNESS: The state of being unwilling to consider the suggestions or explanations of others as possible or feasible with regard to oneself.

CLOUDS: Anything that distorts our ability to see or distinguish reality.

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. The state of being bound emotionally or intellectually to a course of action or to another person or persons.

COMMON BOND: Recovery from addiction.

COMMON DENOMINATOR: Our failure to come to terms with our addiction prior to coming to Narcotics Anonymous.

COMMON WELFARE: Our individual survival is directly related to the survival of the group and the Fellowship.

COMMUNICATE: To make known. To express oneself in such a way that is readily and clearly understood.

COMPASSION: The state of deep awareness and sympathy for and a desire to help another who is suffering. Deep awareness of the suffering of another, coupled with the wish to relieve it.

COMPEL: To make someone do something by the use of physical, moral, or mental pressure.

COMPLACENCY: A feeling extreme calm and satisfaction with one's life or situations that hinders the process of seeking change. The feeling you have when you are satisfied with yourself.

COMPREHEND: To understand fully.

COMPROMISING: To reach an agreement over a dispute with all parties changing or giving up some demands.

COMPULSION: Once 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: The admission of truthfulness of something. To acknowledge, often reluctantly, as being true, just, or proper; admit.

CONCEIVABLE: The state of being possible to conceive, imagine, or understand. Capable of being conceived, imagined, or understood.

CONCERN: A caring condition shown by a willingness to help others. Interest in, or care for, any person or thing.

CONCEPT: An idea that is generally accepted. An abstract idea or notion.

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. Something essential to the appearance or occurrence of something else.

CONDUCTING: Choosing to behave in a certain manner. To comport (oneself) in a specified way.

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. Come face-to-face with, especially with defiance or 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. Intentionally conceived or done; deliberate.

CONSEQUENCE: The result of an action. Something that logically or naturally follows from an action or condition.

CONSISTENT: Sticking to one way of thinking or acting. Reliable; steady,

CONTENTMENT: Freedom from worry or restlessness. Happiness with one's situation in life.

CONTINUE: To do the same thing without changing or stopping. To go on with a particular action or in a particular condition; persist.

CONTRADICT: To deny the truth of a statement. To assert or express the opposite of.

CONTRARY: The state of being opposed or unwilling to obey or behave well. Opposed, as in character or purpose.

CONTRIBUTE: Giving along with others to have a share in something. Give something to a common purpose.

CONTROL: To have power over. Authority or ability to manage or direct.

CONVINCE: To argue with someone to convince them to agree with or believe in certain things. To bring by the use of argument or evidence a firm belief or a course of action.

COPE: To struggle with or try to manage something. To contend with difficulties and act to overcome them.

CORE: The central or innermost part of something. The basic or most important part; the essence.

COURAGE: The strength of mind that makes one able to meet danger and difficulties with firmness. That quality of mind which enables one to encounter danger and difficulties with firmness, or without fear.

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 criticize especially in an unfavorable way. Characterized by careful, exact evaluation and judgment.

CRUCIAL: Being necessary to accomplish something. Of extreme importance; vital to the resolution of a crisis.

CULT: A select group of people recognize by its exclusive nature. An exclusive group of persons sharing an esoteric, usually artistic or intellectual interest.

CURE: The complete elimination of a disease. Something that corrects or relieves a harmful or disturbing situation.

D . . .

DAILY: Occurring, done, produced, or issued every day. Happening or done every day.

DANGEROUS: Anything that is able to or likely to cause injury. Being able or likely to do harm.

DECEIT: Misleading a person or causing them to believe that which is false with a statement or act. Deliberate and misleading concealment; false declaration.

DECEPTION: The statement or act that deceives. The state of being deceived or misled.

DECISION: The act of making a choice.

DECLARATION: The act of making a statement as if certain.

DECLARE: To make a statement as if certain. State emphatically and authoritatively.

DEFAME: To maliciously attack the reputation of another.

DEFECTS: Things that we determine are interfering with our process of recovery.

DEFIANT: Showing a willingness to resist. Boldly resisting authority or an opposing force.

DEGRADATION: The state of being lowered from one level to a lower level. Being lowered from one level to a lower level.

DELUSION: A false belief that we continue to hold in spite of the facts.

DEMOLITION: The act of ruining completely.

DEMORALIZATION: The act of weakening the discipline or spirit of a person.

DENIAL: The refusal to admit the truth of a statement or the refusal to accept or believe in someone or something.

DENY: To declare something not true or disowning something. To refuse to believe; reject.

DEPEND: Trust and reliance on others.

DEPENDENT: A person who depends upon another for support to an unhealthy degree. Unable to exist or sustain oneself, or unable to act appropriately or normally without the assistance or direction of another.

DEPRAVITY: An act or practice that is morally bad or corrupt. Impairment of virtue and moral principles.

DEPRESSION: Low spirits, a common by-product of addiction that typically occurs during withdrawal.

DERELICTION: The neglect of or failure in meeting personal responsibilities.

DESIRE: A strong wish made known.

DESPAIR: A feeling of complete hopelessness. Complete loss of hope.

DESPERATION: The state of feeling complete hopelessness that leads to recklessness. Recklessness arising from despair.

DESTRUCTION: The act of putting an end to something or the results of such acts.

DEVELOP: To make the possibilities more clear and usable gradually.

DILEMMA: A situation in which a person has to choose between things that seem to be all bad or unsatisfactory. A situation that requires a choice between options that are or seem equally unfavorable or mutually exclusive.

DIRECT: Going from one point to another without turning or stopping. Straightforward and candid.

DIRECTION: The path along which something moves, lies, or points. An instruction or series of instructions for doing or finding something.

DISAGREEMENT: The act or fact of having unlike ideas or opinions. A failure or refusal to agree.

DISASTER: Something that happens suddenly and causes suffering or loss.

DISCLOSURE: The act of making known.

DISCRETION: The power of having good sense in making decisions for oneself. Ability or power to decide responsibly.

DISEASE: A change in a person that interferes with normal functioning.

DISAPPOINTMENT: The act or condition of failing to satisfy the hope or expectation of. A feeling of dissatisfaction that results when your expectations are not realized.

DISHONESTY: The lack of honesty or the quality of not being honest or trustworthy.

DISILLUSION: To free from mistaken beliefs or foolish hopes.

DISQUALIFY: To make or declare something unfit or not qualified. Make unfit or unsuitable.

DISSEMBLING: The process of revealing parts of something in a particular manner to give a specific interpretation of the facts. Pretending with intention to deceive.

DISTORT: To tell in a way that is misleading.

DISTRACTING: Drawing someone's mind or attention to something else or upsetting someone's mind to the point of confusion. To cause to turn away from the original focus of attention or interest; divert.

DISTURBING: Making confused or troubling the mind. To trouble emotionally or mentally; upset.

DIVERSITY: The condition or fact of not being the same and the qualities that distinguish our differences.

DIVINE: Of or relating to God or a god. Godlike; heavenly; excellent in the highest degree; supremely admirable; apparently above what is human.

DOGMA: Something firmly believed. An authoritative principle, belief, or statement of ideas or opinion, especially one considered to be absolutely true.

DOMINATED: The state of someone or something having a commanding position or controlling power over oneself. Controlled or ruled by superior authority or power.

DYNAMIC: Full of energy. Characterized by continuous change, activity, or progress.

DYNAMICS: Any of the various forces, physical or moral, at work in a situation.

E . . .

EAGER: Desiring very much; impatient. Having or showing keen interest, intense desire, or impatient expectancy.

EAGERLY: Acting with great desire, impatiently. In an eager manner.

EFFICIENCY: The quality or degree of being capable of bringing about a desired result with as little waste as possible. The production of desired effects or results with minimum waste of time, effort, or skill.

EFFORT: A serious attempt. The use of physical or mental energy to do something.

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.

EMBARRASSED: Feeling confused or distressed. Caused to feel self-conscious or ill at ease.

EMBARRASMENT: The state of causing or feeling confused or distressed or those things that cause confusion or distress. The shame you feel when your inadequacy or guilt is made public.

EMOTIONS: Mental and bodily reactions accompanied by strong feelings. The part of the consciousness that involves feeling; sensibility.

EMOTIONAL: Expressing emotion.

EMPATHY: Having an intellectual or emotional identification with another. Identification with and understanding of another's situation, feelings, and motives.

EMPTINESS: Containing nothing. Lacking purpose or substance; meaningless.

ENCOURAGE: To give courage, spirit, or hope to another. To inspire with hope, courage, or confidence.

ENCOURAGEMENT: The act of, the state of, or things giving courage, spirit, or hope. The expression of approval and support.

ENDANGER: Risk. To expose to harm or danger; imperil.

ENDANGERED: The state of being or that which is at risk. To put to hazard; to bring into danger or peril; to expose to loss or injury.

ENDORSE: To give one's support to something.

ENDURE: To put up with patiently or firmly, such as pain. To continue to exist.

ENEMIES: Something or someone that harms or threatens. One hostile to another; one who hates, and desires or attempts the injury of another.

ENTHUSIASM: A strong feeling in favor of something. Great excitement for or interest in a subject or cause.

ENTIRELY: Completely.

ENVY: The feeling of discontent at another's good fortune with a desire to have the same good fortune for oneself. To long after; to desire strongly; to covet.

EQUAL: One having the same rank as another. Being the same for all members of a group.

ESOTERIC: Understood by only a chosen few.

ESSENTIAL: Forming or belonging to the basic part of something. Basic or indispensable; necessary.

EVENTUALLY: Coming at some later time.

EVIDENT: Clear to the sight or to the mind. Easily seen or understood; obvious.

EXACT: Showing close agreement with fact; accurate. Strictly and completely in accord with fact; not deviating from truth or reality.

EXAMINE: To question or look at closely or carefully.

EXCEPT: To leave out from the whole, exclude.

EXERT: To put oneself into action or a tiring effort; struggle. Make a great effort at a mental or physical task.

EXHAUST: To tire out or deplete one's resources.

EXIST: To continue to live. To have actual being; be real.

EXISTENCE: The state of being alive. The fact or state of existing; being.

EXPECTATION: A desire that one places upon himself or another to accomplish.

EXPERIENCE: Something that one has actually done or lived through. The effect upon the judgment or feelings produced by any event, whether witnessed or participated in.

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 center or its opposite. Far beyond the norm in views or actions.

F . . .

FAILED: Having been unsuccessful. To err in judgment; to be mistaken; to be unsuccessful.

FAILURE: A lack of success or a person who fails. The inability to function or perform satisfactorily.

FAITH: An individual's system of beliefs. Confident belief in the truth, value, or trustworthiness of a person, idea, or thing.

FAULTS: Weaknesses in character. A character weakness, especially a minor one.

FEAR: A strong unpleasant feeling caused by being aware of danger or expecting something bad to happen. A painful emotion or passion excited by the expectation of evil, or the apprehension of impending danger.

FEARLESS: Taking necessary actions in the midst of one's fears. Oblivious of dangers or perils or calmly resolute in facing them.

FEEBLE: Lacking in strength or endurance. Pathetically lacking in force or effectiveness.

FEELINGS: The state of a person's emotions. An affective state of consciousness, such as that resulting from emotions, sentiments, or desires.

FELLOWSHIP: A group with similar interests or goals. A close association of friends or equals sharing similar interests.

FESTER: To become painfully sore. To be inflamed; to grow virulent, or malignant; to grow in intensity; to rankle.

FIRM: Showing no weakness. Not subject to change; fixed and definite.

FOCUS: To concentrate attention or energy on the center of activity or interest.

FOCUSED: The state of being in the center of activity or interest. To direct toward a particular point or purpose.

FONDNESS: The state of liking or loving something. Warm affection or liking.

FOREVER: For a limitless time. For everlasting time; eternally.

FORGIVE: To stop feeling angry at or hurt by. To cease to feel resentment against, on account of wrongs committed.

FORGIVENESS: The act of forgiving or the state of being forgiven. Compassionate feelings that support a willingness to forgive.

FORMAL: Following established form, custom, or rule. Following traditional standards of correctness.

FORTUNE: Favorable results that come partly by chance. Fate; destiny.

FOUNDATION: The support upon which something depends. The basis on which something stands or is supported; a base.

FRACTURED: Damaged or injured.

FREEDOM: The condition of being released from or no longer suffering from something unpleasant or painful. The capacity to exercise choice; free will.

FRIEND: A person who has a strong liking for and trust in another person. A person you know well and regard with affection and trust.

FRIGHTENED: Experiencing fear. Thrown into a state of intense fear or desperation.

FRUSTRATION: The feeling of disappointment or defeat. The condition that results when an impulse or an action is thwarted by an external or an internal force.

FUNCTION: To serve a certain purpose. The actions and activities assigned to or required or expected of a person or group.

G . . .

GENDER: Either of the two divisions of living things especially human beings, 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. Something that is bestowed voluntarily and without compensation.

GIVING: Handing over with the expectation of it being kept. To bestow without receiving a return.

GOAL: That which a person tries to accomplish. The final purpose or aim.

GOD: A being conceived of as supernatural, immortal, and having special powers over people and nature.

GOD-AWARENESS: The mental acceptance of or belief in God.

GOODNESS: The state of being honest and upright. Moral excellence.

GRAFTED: To join one thing to another.

GRATIFICATION: The act of, the state of, or something giving pleasure or satisfaction to. That which gives pleasure.

GRATIFY: To give pleasure or satisfaction to. Make happy or satisfied.

GRATITUDE: The state of being consciously thankful for the things in one's life. The state of being grateful; thankfulness

GRIEF: Very deep sorrow. Pain of mind on account of something in the past; mental suffering arising from any cause, as misfortune, loss of friends, misconduct of oneself or others, etc.

GRIM: Harsh in appearance. Shockingly repellent; inspiring horror.

GROUND: To instruct in basic knowledge or understanding. To instill or teach by persistent repetition.

GROUP CONSCIENCE: The will of a 12-Step group. This is generally arrived at through an informal polling process. Group conscience represents a consensus view that is used to make decisions about things that affect members or the 12-Step Fellowship.

GROUPS: Addicts who come together to have recovery meetings, some may follow the 12 Traditions.

GROWTH: The process of being able to live and develop. Full development; maturity.

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 behavior.

GUILT: The fact or feeling of having done something wrong that causes one to feel shame or regret. Remorseful awareness of having done something wrong; or self-reproach for supposed inadequacy or wrongdoing.

H . . .

HABIT: A way of acting or doing that has become fixed by being repeated often. A recurrent, often unconscious, pattern of behavior that is acquired through frequent repetition.

HAPPEN: To occur or come about by chance.

HAPPINESS: The state of enjoying one's condition, content. State of well-being characterized by emotions ranging from contentment to intense joy.

HARMED: the state of having physical or mental damage. Having had pain or loss or suffering inflicted.

HEAL: To return to a sound or healthy condition. To restore (a person) to spiritual wholeness.

HEARTILY: With sincerity or enthusiasm. With gusto and without reservation.

HELP: To provide someone with what is useful in achieving an end. To be of service; give assistance.

HELPLESSNESS: Not able to help or protect oneself. Powerlessness revealed by an inability to act.

HIGHER: Greater than average, having more than usual importance.

HIT: Occur. A dose of a narcotic drug.

HONEST: Not given to cheating, stealing, or lying. Characterized by such qualities as integrity or fairness and straightforwardness in conduct, thought, and speech.

HOPE: A desire for something together with the expectation of getting what is wanted. To wish for something with expectation of its fulfillment.

HOPELESS: Having no hope. Without hope because there seems to be no possibility of comfort or success.

HOPELESSNESS: The condition of having no hope. The despair you feel when you have abandoned hope of comfort or success.

HORRIBLE: Causing great and painful fear, dread, or shock. Very unpleasant; disagreeable.

HORROR: Great and painful fear, dread, or shock. Intense and profound fear.

HOSTAGE: A person given or held to make certain that promises will be kept.

HOSTILITY: An unfriendly state, attitude, or action. A state of deep-seated ill will.

HUG: Encircling another with our arms, embrace. To clasp or hold closely, especially in the arms, as in affection; embrace.

HUMAN: Of, relating to, being, or characteristic of people as distinct from lower animals. Subject to or indicative of the weaknesses, imperfections, and fragility associated with humans.

HUMBLE: Accepting oneself as one actually is.

HUMBLY: Asking or doing with humility; in a humble manner.

HUMILITY: The state of being humble. Freedom from pride and arrogance; a modest estimate of one's own worth.

I . . .

I: The person speaking or writing.

IDEAL: A standard of perfection, beauty, or excellence. A conception of something in its absolute perfection.

IDENTIFICATION: The act of or state of being exactly alike or equal. A person's association with the qualities, characteristics, or views of another person or group.

IDENTIFY: To think of as being exactly alike or equal. To make to be the same; to unite or combine in such a manner as to make one; to treat as being one or having the same purpose or effect; to consider as the same in any relation.

IDLE: To spend time doing nothing. To move lazily and without purpose.

IGNORANCE: The state of not knowing. The condition of being uneducated, unaware, or uninformed.

IGNORING: Paying no attention to. To refuse to take notice of; to shut the eyes to; not to recognize; to disregard willfully and causelessly.

ILLNESS: Sickness. An unhealthy condition of body or mind.

ILLUSION: The state or fact of being lead to accept as true something unreal or imagined. Perception of something objectively existing in such a way as to cause misinterpretation of its actual nature.

IMPLY: To express indirectly, suggest rather than state plainly.

IMPROVE: To make or become better.

IMPULSE: A sudden stirring up of the mind and spirit to do something. A sudden desire.

INABILITY: The condition of being unable to do something. Lacking the power to perform.

INCAPABLE: Not able to do something. One who is morally or mentally weak or inefficient.

INCLINATION: A usually favorable feeling toward something. An attitude of mind especially one that favors one alternative over others.

INCONSIDERATE: Careless of the rights or feelings of others. Lacking regard for the rights or feelings of others.

INCORPORATING: Joining or uniting closely into a single mass or body. To cause to merge or combine together into a united whole.

INCREASE: To make or become greater. Become bigger or greater in amount.

INCURABLE: Impossible to cure. Impossible to cure or unalterable in disposition or habits.

INDEPENDENCE: The quality or state of not being under the control or rule of someone or something. Freedom from control or influence of another or others.

INDICATION: The act of stating or expressing briefly. Something that points to or suggests the proper treatment of a disease, as that demanded by its cause or symptoms.

INDIFFERENT: Showing neither interest nor dislike. Having no particular interest or concern; apathetic.

INDIRECT: Not having a plainly seen connection. Not straightforward or upright; unfair; dishonest; tending to mislead or deceive.

INDISPENSABLE: Essential. Absolutely necessary.

INFERIOR: Of little or less importance, value, or merit.

INFLICTED: Caused.

INFLUENCES: The act of, the person who, or something that, has the power of producing an effect without apparent force or direct authority. The powers affecting a person, thing, or course of events.

INJURE: To cause pain or harm to.

INNERMOST: Farthest inward. Most intimate.

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.

INSTANT: Happening or done at once. Occurring with no delay.

INSTRUMENT: A way of getting something done. The means whereby some act is accomplished.

INTANGIBLE: Not possible to think of as matter or substance. Lacking substance or reality; incapable of being touched or seen.

INTEGRITY: Total honesty and sincerity. Moral soundness; honesty; freedom from corrupting influence or motive.

INTENSELY: Having very strong feelings.

INTENSITY: The degree or amount of a quality or condition.

INTENTIONALLY: Acting on a determination to act in a particular way. Done deliberately.

INTENTIONS: A determination to act in a particular way.

INTOLERANT: Not putting up with something that one sees as being harmful or bad. Unwilling to tolerate a difference of opinion.

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: What finally happens. A personal problem or emotional disorder.

J...

JEALOUSY: Demanding complete faithfulness to someone or something. Painful apprehension of rivalry affecting one's happiness.

JOURNEY: Going from one place to another. A process or course likened to traveling; a passage.

JUDGE: To form an opinion or evaluation after careful consideration or a person with the experience to give a meaningful opinion.

JUDGMENTAL: Having an opinion or estimate formed by examining and comparing. Inclined 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: Keep in a particular or desired state. To keep in an existing state; preserve or retain.

MAINTENANCE: All that is necessary to keep something in a particular or desired state.

MANAGE: To achieve what one wants to do. To succeed in accomplishing or achieving, especially with difficulty.

MANIFEST: Clear to the senses or to the mind, easy to recognize.

MANIPULATING: Managing skillfully especially with the intent to deceive.

MANNERISMS: Habits (such as looking or moving in a certain way) that one notices in a person's behavior. A distinctive behavioral trait.

MEANINGLESS: Having no meaning, importance, direction, or purpose.

MEDITATE: To spend time in quiet thinking. To think or reflect, especially in a calm and deliberate manner.

MEDITATION: The act or instance of meditating.

MEMBER: One of the individuals making up a group. One of the persons who compose a social group (especially individuals who have joined and participates in a group organization).

MEMBERSHIP: Participating fully as a member.

MENTAL: Of, or related to, the mind and specific thought patterns.

MINDED: Greatly interested in a specific thing. To become aware of; notice.

MIRACLE: An extraordinary, rare, unusual, or wonderful event taken as a sign of the power of God. Any amazing or wonderful occurrence.

MISERY: Suffering or distress due to being poor, in pain, or unhappy. A feeling of intense unhappiness.

MODERATE: Neither very good nor very bad or neither too much nor too little. Being within reasonable or average limits; not excessive or extreme.

MONOTONOUS: Boring from always being the same. Tediously repetitious or lacking in variety.

MOOD-ALTERING: That which changes one's state or frame of mind. Producing mood changes.

MORAL: Concerned with or relating to those things that a given society defines as right and wrong in human behavior. Acting upon or through one's moral nature or sense of right.

MOTIVATE: The act of providing someone with a reason for doing something.

MOTIVE: The reason for doing something. Something (as a need or desire) that causes a person to act.

MUST: A requirement.

N . . .

NARCOTICS ANONYMOUS: A 12-step fellowship or society of men and women seeking recovery from the disease of addiction.

NATURE: The basic character of a person or thing. The essential characteristics and qualities of a person or thing.

NECESSARY: Needing to be had or done. Absolutely essential.

NEGATIVE: Not positive. Something that lacks all positive, affirmative, or encouraging features.

NEWCOMER: Someone who has recently arrived; a beginner.

NONPROFESSIONAL: Members are simply addicts of equal status freely helping one another regardless of personal professional status.

NONSENSE: Foolish or meaningless words, actions, or things of no importance or value.

O . . .

OBLIVION: An act of forgetting or the fact of having forgotten. The act or an instance of forgetting; total forgetfulness.

OBSESSION: A disturbing or fixed and often unreasonable idea or feeling that cannot be put out of the mind, such as resuming the use of drugs to feel better. 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.

OBSTINATE: Sticking stubbornly to an opinion or purpose that is difficult to overcome or remove. Stubbornly adhering to an attitude, an opinion, or a course of action.

OBVIOUS: Easily found, seen, or understood.

OMNIPOTENCE: The state of having power or authority without limit.

ONGOING: Being in progress or movement. Currently happening.

ONLY: A single fact or instance and nothing more or different. In one manner or degree; for one purpose alone.

OPEN: Generally refers to a type of recovery meeting at which those who are not addicts are permitted to attend and observe a meeting in which participation remains open only to self-admitted addicts.

OPEN-MINDEDNESS: Having a mind that is open to new ideas. Having or showing receptiveness to new and different ideas or the opinions of others.

OPINION: A belief based on experience and on seeing certain facts but not amounting to sure knowledge. A belief stronger than impression and less strong than positive knowledge.

ORIENTED: Becoming acquainted with an existing situation or environment. Adjusted or aligned.

OTHERS: Those people around a specific person that is the center of attention, generally includes oneself. People aside from oneself.

OUR: Of, or relating to, us, both individually and collectively.

OUTRAGEOUS: Going far beyond what is accepted as right, decent, or just.

OVERPOWERING: To subdue by being too strong or forceful. So strong as to be irresistible.

OWN: Belonging to oneself or itself.

P . . .

PANIC: A sudden overpowering fear especially without reasonable cause.

PARADOX: A statement that seems to be the opposite of the truth or of common sense and yet is perhaps true.

PARALLEL: Having agreement in many or most details. A comparison made; elaborate tracing of similarity.

PARANOIA: A mental disorder characterized by systemized delusions such as grandeur or especially persecution. Extreme, irrational distrust of others.

PATIENT: Putting up with pain or troubles without complaint while showing calm self-control. Capable of calmly awaiting an outcome or result; not hasty or impulsive.

PATTERNS: Those things that are clear to ourselves and others because of their repetitive occurrences.

PEACE: The freedom from upsetting thoughts or feelings. A state of quiet or tranquility; freedom from disturbance or agitation.

PERCEIVE: To become aware of or understand through one's senses and especially through sight.

PERCEPTION: The grasping of something such as meanings and ideas with one's mind or a judgment formed from information grasped. Recognition and interpretation of sensory stimuli based chiefly on memory.

PERISH: To become destroyed or die.

PERSEVERENCE: The state or power of one who keeps trying to do something in spite of difficulties. Steady persistence in adhering to a course of action, a belief, or a purpose; steadfastness.

PERSISTENT: Continuing to act or exist longer than usual. Never ceasing.

PERSONAL: Relating to a particular person or their qualities. Concerning or affecting a particular person or his or her private life and personality.

PERSONALITY: The qualities, such as moods or habits that make one person different from others. The pattern of collective character, behavioral, temperamental, emotional, and mental traits of a person.

PITFALL: A danger or difficulty that is hidden or is not easily recognized. An unforeseen, unexpected, or surprising difficulty.

PLAGUED: Stricken or afflicted with disease or distress. A cause of annoyance; a nuisance.

POSSIBLE: Within the limits of one's abilities. Capable of happening or existing.

POTENTIAL: Existing as a possibility. Capable of being, but not yet in existence.

POWER: The possession of control, authority, or influence over something. The ability or capacity to perform or act effectively.

POWERLESSNESS: The state or acceptance of feeling that one has no control, authority, or influence over something. The quality of lacking strength or power; being weak and feeble.

PRACTICAL: Of, relating to, or concerned with action and practice rather than ideas or thought.

PRACTICE: Actual performance. A habitual or customary action or way of doing something.

PRAYER: A request addressed to God. Communicating concerns to a Power greater than ourselves.

PRECONCEIVED: Already being in the state of having formed an idea of, imagining, or understanding. To form (an opinion, for example) before possessing full or adequate knowledge or experience.

PRELIMINARY: Something that comes before the main part. Coming before and usually serving as a temporary or intermediate step to something.

PREPARATION: The act of making ready beforehand for some special reason.

PRIDE: A high opinion of one's own worth that results in a feeling of being better than others. A sense of one's own proper dignity or value; self-respect, or an excessively high opinion of oneself; conceit.

PRIMARY: Most important.

PRINCIPLES: A general or basic truth on which other truths or theories can be based.

PRIVILEGE: A right or liberty granted. A special advantage or benefit not enjoyed by all.

PROCESS: A series of actions, motions, or operations 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 habitual carelessness or laziness.

PRODUCTIVE: Having the power to produce plentifully. Bringing into being; causing to exist.

PROFOUND: Feeling deeply or showing great knowledge and understanding.

PROGRAM: The plan of action that one follows and the tools that we use to achieve a goal, such as the Twelve Steps and Twelve Traditions.

PROGRESS: To move toward a higher, better, or more advanced stage. Gradual improvement or growth or development.

PROGRESSIVE: Taking place gradually and consistently. Moving forward; advancing.

PROJECTION: To place one's own expectations and desires in place of what is actually happening. A prediction made by extrapolating from past observations.

PROMISE: A statement by a person as to what they will or will not do. To make a declaration assuring that something will or will not be done.

PROMOTION: An effort to improve an individual, organization, idea, or product's public image, position, or rank. A message issued on behalf of some product or cause or idea or person or institution with the goal of selling it or of creating a positive public perception of it.

ROMPTLY: Done at once, with little or no delay.

PROTECTED: Covered or shielded from something that would destroy or injure.

PROVEN: Convincing others of the truth, of something by showing the facts. Something established beyond doubt.

PURPOSE: Something set up; a goal to be achieved.

PURSUED: To follow with an end in view.

Q...

QUESTION: Something asked. To analyze; examine.

QUINTESSENTIAL: The most perfect manifestations of a quality or a thing. Representing the perfect example of a class or quality.

R...

RACE: One of the great divisions based on an easily seen thing, such as skin color, into which human beings are usually divided.

RATIONALIZATION: Finding believable but untrue reasons for one's conduct. A defense mechanism by which your true motivation is concealed by explaining your actions and feelings in a way that is not threatening.

REACTION: A response of the body or mind to a stimulus, such as a situation or stress. A response that reveals a person's feelings or attitude.

READINESS: The state of being prepared for use or action.

READY: Prepared for use or action.

REALITY: Actual existence. All of your experiences that determine how things appear to you.

REALM: The field of activity or influence.

REBELLION: Open opposition to authority.

RECAPTURED: To experience again. The act or condition of having been retaken or recovered.

RECEIVE: To take or get something that is given, paid, or sent.

RECIPROCAL: Done, felt, or given in return. Done by each to the other; interchanging or interchanged; given and received.

RECKLESS: The state of being given to wild careless behavior. Marked by unthinking boldness; with defiant disregard for danger or consequences.

RECOGNITION: The act or state of being willing to acknowledge. The form of memory that consists in knowing or feeling that a present object has been met before.

RECOGNIZE: To be willing to acknowledge. To know or identify from past experience or knowledge.

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.

REGULARLY: Steadily in practice or occurrence while following established usages or rules. Steadily in practice or occurrence while following established usages or rules.

RELAPSE: To slip or fall back into a former condition after a change for the better such as using drugs again.

RELATIONSHIP: A state of being connected by a common bond. A particular type of connection existing between people related to or having dealings with each other.

RELIEVING: Freeing partly or wholly from a burden or distress. Freeing from pain, anxiety, or distress.

RELIGION: The service or worship of God. A strong belief in a supernatural power or powers that control human destiny.

RELY: To place faith or confidence in someone or something. To place faith or confidence in someone or something.

REMAIN: To be something yet to be done or considered. To continue unchanged in place, form, or condition, or undiminished in quantity.

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. Compensation (given or received) for an insult or injury.

REPRIEVE: To delay the punishment or the consequences of one's actions. A (temporary) relief from harm or discomfort.

REQUIRED: Necessary. Needed; essential.

RESENTMENT: A feeling of angry displeasure at a real or imaginary wrong, insult, or injury. Indignation or ill will felt as a result of a real or imagined grievance.

RESERVATIONS: The act of keeping something available for future use. A limiting qualification, condition, or exception.

RESPECT: To consider worthy of high regard. Courteous regard for people's feelings.

RESPONSIBLE: Having the credit or blame for one's acts or decisions. Able to make moral or rational decisions on one's own and therefore answerable for one's behavior.

RESTORATION: The act of being put or brought back into an earlier or original state. A returning to a normal or healthy condition.

RESULTS: Something that comes about as an effect or end of. A favorable or concrete outcome or effect.

REVEAL: To show clearly. To make known (that which has been concealed or kept secret)

REVERT: To go back to a previous state.

RIDICULE: To make fun of. Language or behavior intended to mock or humiliate.

RIGHTEOUSNESS: The state of doing or being what is right.

RIGOROUS: Hard to put up with, harsh. Demanding strict attention to rules and procedures.

RISK: Possibility of loss or injury. The possibility of suffering harm or loss; danger.

ROOT: Source. The place where something begins.

S . . .

SANCTION: Approval. A consideration, influence, or principle that dictates an ethical choice.

SEARCHING: To go through thoroughly in an effort to find something. Examining closely or thoroughly.

SELF-ABSORPTION: Great interest or engrossment in one's own interests, affairs, etc. Preoccupation with yourself to the exclusion of everything else.

SELF-APPRAISAL: Estimating the quality of one's own life.

SELF-ASSESSMENT: See self-appraisal, above.

SELF-CENTERED: Concerned only with one's own affairs, selfish. Limited to or caring only about yourself and your own needs.

SELF-ESTEEM: Belief in oneself. Pride in oneself; self-respect.

SELFISHNESS: Taking care of oneself without thought for others. That supreme self-love or self-preference which leads a person to direct his purposes to the advancement of his own interest, power, or happiness, without regarding those of others.

SELF-PITY: Pity for oneself. A feeling of sorrow (often self-indulgent) over your own sufferings.

SELF-RIGHTEOUSNESS: Being strongly convinced of the rightness of one's actions or beliefs. Moralistic.

SELF-SEEKING: Seeking to mainly further one's own interest. Taking advantage of opportunities without regard for the consequences for others.

SENSITIVE: Easily or strongly affected, impressed, or hurt.

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. An unfortunate happening that hinders or impedes.

SHAME: A painful emotion caused by having done something wrong or improper. Or, one caused by a strong sense of guilt, embarrassment, unworthiness, or disgrace.

SHARE: Belonging to one person. To participate in, use, enjoy, or experience jointly or in turns.

SHARING: Using, experiencing, or enjoying something jointly with others.

SHORTCOMING: The acting out of a character defect.

SHY: Not wanting or able to call attention to oneself because of not feeling comfortable around people. Lacking self-confidence.

SINCERELY: Being what it appears to be; genuine. Without pretense.

SOLUTION: The act, process, or result of finding an answer. A method for solving a problem.

SOURCE: The cause or starting point of something. The place where something begins, where it springs into being.

SPIRIT: A force within a human being thought to give the body life, energy, and power or the active presence of God in human life. A fundamental emotional and activating principle determining one's character.

SPIRITUAL: Of, relating to, or consisting of spirit, not material.

SPOIL: To do harm to the character, nature, or attitude of another by over-solicitude, overindulgence, or excessive praise. Ruin.

SPOILS: Stolen goods.

SPONSOR: A recovering addict who agrees to guide another recovering addict through the Steps and Traditions.

STAGNATE: To become inactive. Be idle; exist in a changeless situation.

STEADFAST: Unchanging, loyal. Firm and dependable.

STRENGTH: The quality of being strong. Capacity for exertion or endurance, whether physical, intellectual, or moral.

SUBCONSCIOUS: Occurring with little or no conscious perception on the part of the individual. Existing in the mind, but not immediately available to consciousness. Affecting thought, feeling, and behavior without entering awareness.

SUBSEQUENT: Following in time, order, or place. Coming or being after something else at any time, indefinitely.

SUBSTITUTION: The act, process, or thing that takes the place of something else. The act of putting one thing or person in the place of another.

SUCCESSION: A series of persons or things that follow one after another. The act or process of following in order.

SUFFER: To experience something unpleasant; to bear loss or damage. To feel or undergo pain of body or mind.

SUFFERING: The state or experience of one that suffers. Troubled by pain or loss.

SUFFICIENT: Enough to achieve a goal or fill a need. Of a quantity that can fulfill a need or requirement but without being abundant.

SUGGEST: To offer as an idea.

SUICIDE: The act of killing oneself purposefully.

SUPERIOR: Feeling that one is more important than others.

SUPPORT: To keep going; sustain. To give moral or psychological support, aid, or courage to someone or something.

SUPPRESS: To put down, subdue. Control and refrain from showing.

SURRENDER: The act of giving up or yielding oneself or something into the possession or control of someone else. Acceptance of despair.

SURVIVE: To remain alive. To carry on despite hardships or trauma.

SYMPTOMS: Noticeable changes in the body or its functions that are typical of a disease. Signs or tokens; that indicate the existence of something else.

SYSTEMATICALLY: Carrying out a plan with thoroughness, regularity, or using step-by-step procedures.

T...

TEMPERED: Made into a more useful state.

TEMPTATIONS: That which makes one think of doing wrong. That which is attractive or inviting.

TENSIONS: A state of mental unrest. Mental, emotional, or nervous strain.

TERMINAL: Resulting in the end of life. Causing, ending in, or approaching death; fatal.

TERRIFIED: Frightened greatly. Thrown into a state of intense fear or desperation.

THANKFULNESS: Feeling grateful or showing thanks. Warm friendly feelings of gratitude.

THERAPEUTIC: Healing. Having a healing power or quality.

THOROUGH: Careful about little things. Painstakingly careful and accurate.

THRASHING: To move about violently. Moving about wildly or violently.

THREAT: A showing of an intention to do harm. An expression of an intention to inflict pain, injury, evil, or punishment or something that is a source of danger.

TOLERANCE: Sympathy for or acceptance of feelings or habits, which are different from one's own. Willingness to recognize and respect the beliefs or practices of others.

TOLERANT: Showing tolerance. Showing respect for the rights or opinions or practices of others.

TOPIC: The focus of discussion. The subject matter of a conversation or discussion.

TORTUROUS: Having many twists and turns. Extremely painful.

TRADITIONS: A set of 12 principles laying out the ground rules of the Narcotics Anonymous Fellowship.

TRAITS: Qualities that set one person or thing off from another. Distinguishing features.

TRUST: Firm belief in the character, strength, or truth of someone or something. Firm reliance on the integrity, ability, or character of a person or thing.

TRUSTWORTHY: Deserving trust, confidence, or belief.

U...

UNCONDITIONAL: Without any special exceptions. Without conditions or limitations; absolute.

UNDERLYING: Forming the foundation of. Present but not obvious; implicit.

UNDERSTANDING: Knowing thoroughly or having reason to believe. Anything mutually understood or agreed upon.

UNIFORMITY: The quality, state, or an instance of having always the same form, manner, or degree—not changing. Conforming to one principle, standard, or rule; consistent.

UNIQUE: Being the only one of its kind. Radically distinctive and without equal.

UNITY: The state of those who are in full agreement. The state or quality of being in accord; harmony.

UNLIMITED: Having no restrictions or controls. Having or seeming to have no boundaries.

UNMANAGEABLE: Hard or impossible to manage. Difficult to keep under control or within limits.

UNPARALLELED: Having no equal. Radically distinctive and without equal.

URGENCY: The quality or state of calling for immediate action. Pressing importance requiring speedy action.

USELESSNESS: The feeling of being of or having no use. Incapable of functioning or assisting.

USERS: One who consumes as drugs. One who uses addictive drugs.

V . . .

VARIOUS: Of many different kinds purposefully arranged but lacking any uniformity.

VICTIM: A person who is cheated, fooled, or hurt by another. A person who suffers injury, loss, or death as a result of an intentional undertaking or an act of God (e.g., robbery, deceit, flood, or earthquake).

VIGILANCE: Staying alert especially to possible danger. The process of paying close and continuous attention.

VIGILANT: Alert especially to avoid danger. Carefully observant or attentive; on the lookout for possible danger.

VIGOROUS: Having strength or energy of body or mind. Characterized by forceful and energetic action or activity.

VIOLENT: Showing very strong force. Acting with, marked by, or resulting from great force, energy or emotional intensity.

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 and tireless diligence in its furtherance.

History of the Addictions Treatment and Recovery Field

As noted earlier, the solution for addiction has always been and always will be **RECOVERY!** As you learned through your reading of White's *Slaying the Dragon: The History of Addiction and Recovery in America*, for decades, recovering individuals and their organizations have delivered recovery services alongside both dedicated professionals and opportunists touting concocted treatments, medicines, and "cures." The present day treatment system, in fact, had its origins in the work of persons in recovery endeavoring to help others battling addiction as they once had. In some respects, the treatment field began as a recovery field.

White noted that "addiction treatment systems seem to rise out of the energy generated by mutual aid movements." Beginning as an adjunct to mutual aid intended "to broaden the entry to personal recovery," treatment systems have historically gained power through professionalization and have then turned mutual aid movements into their adjuncts. Over the course of history, the collapse of a treatment system and its culture seems to be marked by a period of time when the system/culture "begins to conceive of itself as the power that initiates personal recovery" (White, 1998). Our current treatment systems and cultures seem to bear this thesis.

The most recent trend toward the professionalization and medicalization of treatment began in the 1950s and continues to this day. Over time, with the expansion of Medicaid coverage and private insurance, physicians, nurses, psychologists, social workers and other trained professional helpers began to play a greater role in the field. Additionally, certification criteria were developed for counselors, the primary front-line workers in the treatment field. Like the field itself, counselor certification standards, program licensing criteria, and even funding were bifurcated into separate alcohol and drug treatment systems. In most locales, drug abuse and alcoholism treatment systems only merged in the early 1990s. This is when separate drug and alcohol counselor certification standards were dropped in favor of a single addictions counselor standard.

As counselor certification standards were implemented in the 1980s and 1990s, many who had worked for years as counselors found themselves faced with the requirement to become certified if they wished to continue serving as a counselor. In some jurisdictions, experienced counselors were grandfathered into certification. In others, they found themselves confronting a deadline for obtaining certification. Some individuals with extensive experience as counselors did not obtain certification, either because they chose not to pursue it or because they were not eligible despite their experience due to educational requirements. In other cases, experienced counselors were simply not successful in their efforts to pass certification tests.

During the 1980s, increasing costs related to the treatment of addictions through both private and public sources and a broader movement to contain healthcare costs and coordinate services through managed care models created pressures to shorten the average length of treatment and reduce its average costs. Workers were required to provide extensive documentation to payers justifying admission and continuing stay. Payers' primary incentive, of course, was typically to reduce costs rather than to optimize services. The pressure to document "medical necessity" and to meet payer credentialing requirements further marginalized the role of the recovery community in treatment.

One result of managed care was a trend toward reduced intensity and duration of services. This trend was accelerated by the frequent "carve out" of coverage for addictions or for all behavioral health services from other healthcare. Under "carve out" plans, addictions or behavioral health benefits were managed separately from other services, were subject to different criteria, and capped in a manner that other services were not.

Addictions have historically been viewed and treated differently from other health conditions. In the context of managed care, this often manifested itself in annual and lifetime service eligibility limitations that did not apply to other conditions. Even today, with parity legislation enacted and with health reform in the early stages of implementation, addictions services are largely segregated from the rest of healthcare. They are managed apart from the rest of healthcare. In both the public and private sectors resources to support addictions services are becoming an ever smaller portion of both behavioral healthcare and general healthcare resources.

Over time, medicalization and professionalization of the field led the treatment field to develop an increasingly tenuous relationship with the recovery community. The system had become, in effect, an acute care system in which the primary goal was to treat and discharge. As such, it was ill-equipped to effectively treat addictions and support recovery. Practitioners of the 1980s onward would almost universally affirm that addictions are chronic conditions and that individuals with addictions were subject to relapse in the same manner as individuals with other chronic conditions. Yet, their work has most often taken place in the context of programs and service systems and program settings that are inconsistent with chronic care approaches.

Even today, many treatment programs are structured, funded, regulated, and evaluated in a manner suggesting that treatment is a cure. This not only conflicts with the notion that addictions are chronic conditions, but also fails to recognize recovery as a foundational construct and long-term goal as a larger foundation. This view fails to recognize that treatment is only one possible gateway to recovery.

One product of this focus on treatment as opposed to recovery, or on the intervention rather than the outcome is that relapse tends to be viewed implicitly as the individual's failure. The possibility that the treatment system, provider, or program may have failed the individual seeking services is rarely considered.

Perceived treatment failure was often greeted by one of two refrains: If continued drug use or a relapse occurred during treatment, the assumption was that the individual was not ready for recovery. If relapse occurred after discharge, the providers assume that the individual is not using the tools they gave him or her to help achieve recovery.

The treatment field adopted the concept of "readiness" from the 12-Step culture. This is hardly surprising given the prevalence of recovering individuals in the field and of the Minnesota model and other 12-step facilitation approaches. In the treatment context, however, the concept may have had some unanticipated negative impacts.

In 12-Step programs, readiness is apparent when an individual "hits bottom" and surrenders. This marks the point at which he or she asks for help and can begin to honestly and effectively work toward recovery. A key difference between 12-Step programs and treatment programs is that the former only requires that individuals have "a desire to stop drinking or using." The latter often address the needs of individuals who do not display that desire but are mandated to services. These individuals may not even have a desire to stop using or drinking.

What makes the readiness concept even more problematic in the treatment domain is the way in which the field often responded to relapse. In 12-Step programs, when relapse occurs, the individual is encouraged to keep returning and trying. In the treatment arena, however, relapse could result in exclusion from services. As White has pointed out, for no other disorder would individuals be involuntarily discharged from treatment for exhibiting symptoms of the disorder for which they were being treated. Imagine, what would happen if healthcare providers began declining to serve diabetic

individuals who did not consistently take their medication or effectively manage their nutrition! There would undoubtedly be a public outcry, accompanied by wall-to-wall press coverage, political involvement, and swift action to rectify the situation. Tellingly, this has occurred routinely in the addictions field for many years and has gone unnoticed by the public. Any problems achieving or maintaining recovery during or after treatment have most often been considered a personal failing. In the military context, relapse after the receipt of treatment has often been characterized as willful misconduct and met with serious repercussions that could include a less than honorable discharge.

The acute care approach is, by design, ill-equipped to assist individuals in learning the skills of recovery in the community. When responsibility for poor treatment outcomes is placed on the shoulders of the individuals served, parties vested in the systems that didn't work for them are not only excused, but are free to maintain the dysfunctional status quo. In the early 1970s, Senator Harold Hughes, the political progenitor of our current treatment systems, would often say that alcoholism was the only disorder for which treatment failure was blamed on the patient (White, 1998).

Recovery Community & Modern Treatment Movement

Modern addiction treatment came of age in the 1960s and 1970s, benefitting greatly from the work of such national pioneers as Harold Hughes and Marty Mann. Throughout the history of addictions treatment in the United States, the recovery community has had a relationship with treatment systems. As noted elsewhere, White has argued that treatment systems seem to emerge as a result of vibrant recovery movements that have the goal of broadening the gateway to recovery. However, treatment systems have historically consolidated resources and power, moving from being an adjunct to the recovery community to using the recovery community as a support for their work.

On the local level, treatment programs came from collaboration among recovered and recovering people, their families, and other allies. This collaboration included advocacy for services and participation on advisory committees and agency boards. Paid staff was typically recruited from local communities of recovery, and the programs provided exciting recovery volunteer opportunities. Regular meetings convened between treatment providers and local recovery community service committees. Through this relationship, treatment programs and the recovery community were closely linked in a shared endeavor.

Over time, as the treatment field became more professionalized and medicalized, its approaches became more nuanced and science-based. This came at a cost, as professionalization undermined the treatment programs' links with recovering communities and the relationship between the two. Through this shift, treatment programs began to shift from being community groups or community organizations to being commercial enterprises. While treatment had long been a business in the private sector, it became one in the public sector as well.

The traditional medical practices of diagnosis—the identification of the pathology and disease—and treatment—the response to the pathology and disease—began to make treatment problem-focused rather than solution-focused. This was natural since the Western allopathic medicine tradition is based on the identification and treatment of pathology. While recovery remained a goal, treatment—a response to pathology—became the primary focus.

In this context, resources for post-treatment support were very limited, and resources for services that might be offered instead of treatment were virtually non-existent. Barriers to providing funding for recovery support service resources included lack of research evidence on the efficacy of such services, lack of ethical and legal guidelines for their delivery, doubts and liability concerns among practitioners and program administrators, and chronic under-funding of treatment programs. Low funds for treatment programs resulted in limited organizational capacity and a mentality that individuals are “lost” if they do

not go to treatment programs. Generally, systems had to operate in crisis mode instead of thinking creatively about how best to serve their communities.

Current Recovery Movement

Beginning in the 1980s a newly invigorated recovery movement began to take shape. It emerged, partly, in response to increasing stigma that was associated with growing public support for the criminalization of addiction and a movement away from medical or public health perspectives. In the 1980s and 1990s, however, what emerged was not a movement away from problem-focused medical approaches toward solution-focused perspectives, but an emphasis on quick and easy problem elimination. By taking addicted individuals off of the street and by shifting blame onto them, the criminalization of drug addiction represented just such a quick fix.

The new policies, which included mandatory sentencing guidelines and exclusion from future benefit eligibility were euphemistically described as “getting tough on drugs.” These policies emerged as part of a larger “get tough on crime” ethos, which removed sentencing discretion from judges and created mandatory sentencing guidelines. This ethos was also reflected in “three strikes and you’re out” laws, under which three felony convictions (which could be relatively minor in nature and separated by decades) would result in a mandatory life sentence. These laws caught many addicted persons in their sweep as these individuals were prone to commit minor crimes to support their habits. In a perverse twist, these laws could result in an individual with three relatively minor offenses serving a sentence that vastly exceeded that of an individual convicted of a terrible crime.

In response to this growing and evolving recovery movement, SAMHSA established the Recovery Community Support Program (RCSP) in 1998. It was intended to support communities of recovery in advocating and impacting policy and services. As growing numbers of RCSP grantees began to make the case for peer services, the program’s focus shifted from recovery community empowerment to peer services, and the program was renamed the Recovery Community Services Program. Since that time, RCSP has been a springboard for diverse peer recovery support organizations across the Nation.

The wide range of recovery community organizations that have been supported by RCSP reflects the diversity of the current recovery movement and of the recovery communities from which it has emerged. They include organizations focused on the needs of individuals in medication-assisted treatment, ones tailored to the needs of specific ethnic communities, and ones inspired by 12-Step and other philosophies.

As White and Kurtz have pointed out, the term “recovery community” once referred to the membership of local 12-Step groups. Now, it refers to “diverse communities of recovery who, as they interact and come together on issues of mutual interest, are forming a new consciousness of themselves.” This emerging new 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 the method or support group through which that recovery was achieved or maintained” (White and Kurtz, 2006a).

White argues that members of these groups have begun to move beyond the competition and animosity that sometimes characterized their relationships with each other. “Members of these groups,” White says, “are more likely today to view all successful recovery pathways as a cause for celebration” (White, 2008).

The diversification and increased cohesion of the recovery community has led to the emergence of a stronger, more unified voice for the recovery community. A common theme across the many grass roots and national organizations involved in the current recovery renaissance is the need to actively engage the recovering community in services and to reinforce the role of its membership as stewards of

recovery. Accomplishing this will require massive outreach and education efforts aimed at our communities, policy makers, and Nation. As the stigma of addiction is reduced and the recovering community is better embraced at these levels, we will begin to serve as stewards of recovery in ever broadening contexts. As individuals in recovery, we must educate policy makers and perhaps become policy makers. Otherwise, politics and stigma will continue to have undue influence on drug and alcohol policy.

On a national level, the broad emerging recovery coalition is perhaps best embodied through Faces and Voices of Recovery (FAVOR), an organization “committed to organizing and mobilizing the millions of Americans in long-term recovery from addiction to alcohol and other drugs, our families, friends, and allies to speak with one voice.” FAVOR is “working to change public perceptions of recovery, promote effective public policy...and demonstrate that recovery is working for millions of Americans.” Its mission is “to bring the power and proof of recovery to everyone in the Nation” (FAVOR, 2010). Through its “Our Stories Have Power” media training, FAVOR seeks to shift the discussion from addiction to recovery, reminding participants to identify themselves in public media as individuals in long-term recovery rather than as addicts and alcoholics.

Those who follow a 12-Step tradition will undoubtedly recognize that, for their recovery, they are reminded to never forget that they are drug addicts or alcoholics. While the media and general public often remember this quite well, they usually do not see or understand the transforming power of recovery, which affects not only those afflicted by addiction, their families, and communities, but also the Nation as a whole. In taking on a role as a recovery coach, consider thinking of yourself as an ambassador for this broad recovery community in all of its diversity. Our national motto, *e pluribus Unum*, could well serve as the motto of this movement – *Out of many, One*.

Cultural differences in the perception of alcoholism/drug addiction problems

Drug and alcohol problems often evoke strong responses. Their impact on individuals, families, and communities is complex and pervasive. There is variation in how addiction and substance use problems are viewed and addressed both across and within cultures. These portrayals include:

- Moral failing or sin.
- Personal weakness.
- Effort to fill a spiritual void or to search for meaning or connection.
- Symptom of shame, guilt, depression or hopelessness.
- Disease.
- Result of personal trauma.
- Effect of poverty and cultural or economic oppression.
- Self-medication.
- Maladaptive behavior pattern.
- Uncontrollable condition.
- Problem that can be solved if one puts “mind over matter.”

Recovery coaches should be aware of their own views and assumptions regarding addictions. Listen closely to *coachees* in order to understand how they view their substance use problems.

A Recovery Paradigm

Recovery-oriented systems of care (ROSC) are networks of formal and informal services developed and mobilized to sustain long-term recovery for individuals and families impacted by severe substance use disorders. The system in ROSC is not a treatment agency but a macro level organization of a community, a State or a Nation (White, 2008).

The concept of recovery, of course, is deeply embedded in the history of addictions treatment and recovery in the United States. *The Big Book of Alcoholics Anonymous* characterizes the path it outlines as a “plan of recovery.” However, the use of the term “recovery” to refer to the process of overcoming alcohol dependence can be traced back much earlier than the emergence of AA in 1935.

White reports that there is evidence of the use of the term in the context of alcohol problems going back at least as far as the late 17th or early 18th century. In addition, since the inception of the programs that led to today’s treatment systems, 12-Step recovery has been a nearly ubiquitous element of treatment, either as a conceptual framework, as exemplified in the Minnesota Model, or as an essential partner to the treatment program, providing support before, during and after treatment, and often serving as a key source of treatment referrals.

While the addictions field has long laid claim to recovery as its overarching goal, systems and services have tended to center around a relatively brief, encapsulated episode of treatment, as though addictions were transitory or acute problems that could be “cured” by an episode of treatment.

In the late 1970s and early 1980s, as the mental health field moved from a primarily hospital-based approach to one that emphasized treatment in the community and the hope of recovery and that focused on supporting individual choice and personal ownership of a recovery process. The mental health field had, in effect, taken on the mantle of recovery, using it to shape systems and services and to define the role and rights of those served in a manner that supports long-term recovery. It did this while the addictions field continued to use approaches that seemed to reflect an underlying assumption that addictions were acute disorders that could be addressed effectively through brief episodes of care.

In 1991, William Anthony, a pioneer in mental health recovery, wrote that the 1990s would be “the decade of recovery.” (Anthony, 1991) In 2000, he wrote that a number of State mental health systems had “declared that their service delivery systems were based on the vision of recovery.” Anthony’s 2000 article, *A Recovery-oriented Service System: Setting Some System Standards*, included a table summarizing assumptions about mental health recovery that seem equally applicable to addictions recovery (Anthony, 2000).

A recovery perspective began to re-emerge in the addictions field with RCSP and with the emergence of the Recovery Management approach under the Behavioral Health Recovery Management project led by Chestnut Health Systems and Fayette Companies in Illinois in the late 1990s. In 2002, White referred to the changes taking place in the treatment field that accompanied grass roots activities among recovery advocates as the treatment renewal movement. He identified three emerging goals of the movement:

- Refocus and refine the historical missions, core values, and ethical standards of addiction treatment agencies.
- Forge a meaningful integration of two ways of knowing—the scientific knowledge development process and the experiential one that emerges over time from both clinical and recovery experience.
- Rebuild the relationship between treatment agencies and the communities and constituencies they serve (Counselor Magazine, January, 2002).

Arguably, the SAMHSA/CSAT National Summit on Recovery, which took place in Washington, DC in December 2005, represents a key milestone for the treatment renewal movement. The term “recovery-oriented systems of care” (ROSC) first gained widespread prominence in the addictions field following the release of the National Summit report. Elements of ROSC emerged from the Summit, as it presented the first “broad-based consensus on guiding principles of recovery and elements of recovery-oriented systems.” It broadly describes ROSC as “comprehensive, flexible, outcomes-driven, and uniquely individualized, offering a fully coordinated menu of services and supports to maximize choice at every point in the recovery process.” It further stated that ROSC need to provide “genuine, free and independent choice” (SAMHSA, 2004) among an array of treatment and recovery support options and that services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering individuals.

Summit participants recognized that there are many pathways to recovery, and affirmed that not all pathways include treatment. They stressed that ROSC needed to offer a wide array of services, including non-clinical services and supports and emphasized that treatment can be neither the sole gateway to services nor a requirement of service receipt. [When reframing a key principle of the SAMHSA/CSAT National Treatment Plan (Center for Substance Abuse Treatment, 2000), the Summit participants asserted, “there will be no wrong door to recovery.” In a sense, one might argue that the Summit demonstrated how the treatment field had become the treatment and recovery field and how the foundation of this expanded field was recovery, a lifelong process that may or may not include treatment.

The Principles of Recovery and Elements of Recovery-oriented Systems of Care developed through the Summit can be found [here](#) in the appendices.

Supplemental Materials

American Society of Addiction Medicine (ASAM) Recovery Support Services (RSS) Questionnaire

RSS Question Domains

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Interviewer Notes:

Life Safety: This instrument includes a question (Hous_3) about current verbal, physical and sexual abuse. Your organization should have clear policies for responding to reports of current abuse that comply with state and federal laws. You or a representative of your organization may be legally required to notify child welfare or law enforcement agencies if violence or threats of violence are reported to you by a client. If your organization is not a professional service organization, you may wish to consider ensuring that an appropriately credentialed professional is on call and readily available by telephone to directly advise the client in such cases and to contact appropriate authorities if appropriate. You may also want to ensure that you have in place linkages with domestic violence shelters and have written policies that outline how to proceed when current abuse is reported. State and local government authorities may be able to assist you in developing procedures that comply with applicable law and that protect you, your organization, and those you serve.

Language: The RSS Questionnaire can be completed in a language other than English if the interviewer is fluent in both English and the language of the interviewee. It can also be administered with help from an interpreter, provided the interviewee consents to the participation of the interpreter in the interview.

Comment Fields: The Questionnaire includes at least one comment field in each section. The comment fields are optional and can be used flexibly. Their purpose is to provide a mechanism for clarifying or expanding on responses. You may use them to record observations, referral ideas, or other information that helps you better serve the interviewee. The RSS Questionnaire reporting functions can be set to include or skip comment fields when interview summaries are generated.

What to do when the questionnaire asks about services that are not available: We recommend that you not skip questions that ask about service needs you cannot meet. Instead, at the beginning of the interview you may want to tell the interviewee that you will be asking about some services that may not be available. This gives you a chance to explain that it is important to have a complete picture in order to be most helpful to them. You may also want to point out that it is often possible to find a different service or strategy that can meet the same need as a service that is not available. Finally, you can explain that information on the number of people who need services that are not available is used by organizations and funders to decide what kind of services should be developed.

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Welcome	<p><i>Good morning/afternoon/evening. Thank you for coming in today. My name is _____ and I'll be asking you questions about your goals and needs for the next 30 minutes or so. My goal is to help you find the services that will best support you in recovery. If you have questions at any time during our conversation, please don't hesitate to ask.</i></p> <p><i>Do you have any questions before we start?</i></p>	
Name	<p><i>All right, then. Could I get your name?</i></p> <p><i>Last: _____, Middle: _____ First: _____</i></p>	
DOB	<p>What is your date of birth? YYYY/MM/DD</p>	
	<p>Interviewer:</p> <p><i>Please check here <input type="checkbox"/> if you are unable to conduct the interview due to the client's intoxication level and/or mental status.</i></p>	
Goals & Motivation		
	<p>OK. I'm going to ask you some questions about the reason you're here today, how you feel about being here, and your goals.</p>	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Goals_1	What brought you here today? <ul style="list-style-type: none"> • Self-referral • Court • Corrections • Family • Child Welfare • School • Employer • Physician • Treatment Provider • Recovery Support Services Provider • Church/Congregation • Other (Specify)_____ 	
Goals_2	How do you feel about being here today? <i>(Check all that apply.)</i> <ul style="list-style-type: none"> • Anxious • Angry • Uncertain • Hopeful • Excited • Resigned • Determined • Other 	
Goals_3	What would you like to accomplish through working with us? <i>(Check all that apply – at least one answer is required.)</i> <ul style="list-style-type: none"> • Stop Using Drugs/Alcohol • Reduce/Manage Alcohol/Drug Use • Get support in recovery • Connect with others in recovery • Meet legal requirements • Improve relationship with spouse/partner family • Keep spouse/partner/family • Get spouse/partner family back • Maintain custody of children • Regain custody of children • Keep job • Get job • Avoid jail • Obtain food, clothing or housing • Other (specify)_____ 	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Goals_4	<p>You said your goal(s) in working with us is/are to <i>(restate goal[s] from Reason_2, above)</i>.</p> <p>Interviewer: If more than one goal is identified, ask the interviewee the following question: <i>Which of these goals is most important to you?</i></p> <p>Interviewer: If three (3) or more goals are identified, ask the following Question: <i>Which of these goals are the second and third most important to you?</i></p> <p>Enter goals in order of priority in the fields below, leaving any unneeded goal fields blank:</p> <p>Goal 1:_____ Goal 2:_____ Goal 3:_____</p>	
	<p><i>Great! Now I'm going to ask you about how confident you are that you will be able to accomplish your goal(s).</i></p>	
Goals_5	<p><i>On a scale of 1-10 with (10) being Very Confident and (1) being Not Confident at All, how confident are you that you will be able to accomplish these goals?</i></p> <ul style="list-style-type: none"> ▪ 1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6 ▪ 7 ▪ 8 ▪ 9 ▪ 10 	
	<p>Now I'm going to change the question a little bit: I'm going to ask you how ready you are to start working your goal(s) today. OK?</p>	
Goals_6	<p>On a scale of 1-10, with 10 being Very Ready and 1 being Not Ready at All, how ready are you to start working on your goal(s) today?</p> <ul style="list-style-type: none"> ▪ 1 ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6 ▪ 7 ▪ 8 ▪ 9 ▪ 10 	
Comments:		

RSS Category	Question	Skip Patterns / Notes
Transportation		
	OK, our next topic is transportation.	
Transp_1	Do you have a valid driver's license? <ul style="list-style-type: none"> ▪ No ▪ Yes 	If YES, skip to Trans_4
Transp_2	Would you like help getting a driver's license? <ul style="list-style-type: none"> • No • Yes 	If NO, skip to Trans_4
Transp_3	Is there anything that might keep you from getting a driver's license? <ul style="list-style-type: none"> • No • Yes (<i>Specify: _____</i>) 	
Transp_4	Do you have a reliable way to get around? <ul style="list-style-type: none"> ▪ Yes, has reliable car ▪ Yes, can walk or bike to where I need to go. ▪ Yes, has access to public or private transportation, reliable car or can reliably get ride ▪ No, limited or no access to public transportation ▪ No money for transportation ▪ Transportation unavailable or unreliable 	
Transp_5	Do you have any special transportation needs? <ul style="list-style-type: none"> ▪ No ▪ Needs wheelchair/handicap access ▪ Special needs due to physical mobility restrictions ▪ Special needs due to visual impairment ▪ Special needs due to hearing impairment ▪ Other (specify) _____ 	
Transp_6	Would you like help lining up dependable transportation? <ul style="list-style-type: none"> ▪ No ▪ Yes 	
Comments:		
Employment		
	So far so good? Interviewer: If the interviewee has concerns or questions, please respond to them before proceeding. Now I have some questions about employment.	
Empl_1	Do you have a job? <ul style="list-style-type: none"> • No • Yes 	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Empl_2	Which of these describe your situation? <i>(Check all that apply.)</i> <ul style="list-style-type: none"> • I was laid off. • I was fired. • I quit my job. • I have been out of work for 3 months or more. • I am actively looking for work. • I want to work, but have given up on finding a job. • I choose not to work. • I am a full-time student. • Someone supports me. • I am retired. • I am unable to work due to a disability. • I can't find a job due to legal problems. • I recently got out of jail or another controlled environment. • Other <i>Specify</i>: _____ 	Skip if Empl_1=YES
Empl_3	Which of these describe your situation? <i>(Check all that apply.)</i> <ul style="list-style-type: none"> ▪ I work full time (35+ hours per week) ▪ I work part time (regular hrs) ▪ I work part time (irregular hrs or day work) ▪ I am in the military or another service ▪ I do volunteer work only ▪ I like my job ▪ I don't like my job ▪ I am looking for a new job ▪ My job doesn't pay well enough to make ends meet ▪ I have more than one job • My job is good for my recovery • My job is not good for my recovery • My job situation does not affect my recovery 	Skip if Empl_1=NO

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Empl_4	<p>What skills or experience do you have that might help you if you wanted to find or keep a job? <i>(Check all that apply.)</i></p> <ul style="list-style-type: none"> ▪ Child Care ▪ Customer Service ▪ Healthcare ▪ Landscaping or Gardening ▪ Business Management ▪ Office Management ▪ Profession (e.g., accounting, law, social work, nursing, etc.) ▪ Retail Sales ▪ Retail Management ▪ Sales ▪ Supervision ▪ Warehouse ▪ Delivery ▪ Trucking ▪ Trade ▪ Other <i>(Specify: _____)</i> 	
Empl_5	<p>Are there skills that you would like to develop or experience that you'd like to gain? <i>(Check all that apply.)</i></p> <ul style="list-style-type: none"> ▪ Computer skills/technology ▪ Office skills ▪ Child care ▪ Sales ▪ Speaking skills ▪ Trade skills (plumbing, electrical, construction etc) ▪ Commercial drivers license ▪ Math /Science ▪ Writing skills ▪ Supervisory/management skills ▪ Language/ESL <p>Other <i>(Specify: _____)</i></p>	
Empl_6	<p>Is your job situation in jeopardy, meaning that you could lose your job at any time?</p> <ul style="list-style-type: none"> ▪ No ▪ Yes <i>(Please Explain)</i> _____ 	Ask only if Empl_1 = YES
Empl_7	<p>What responsibilities do you have outside of work?</p> <ul style="list-style-type: none"> • Child care • Care of elderly, disabled or ill family member • School and homework • Household chores • Mandatory reporting requirement (probation, case worker, etc.) • Other <i>(Specify: _____)</i> 	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Empl_8	Do you think your responsibilities and schedule will 1) help you reach your recovery goals, 2) get in the way of reaching them, or 3) not affect them one way or the other? <ul style="list-style-type: none"> • Help me reach goals • Get in the way of reaching goals • Not affect my ability to achieve my goals • Unsure 	
Empl_9	What responsibility or scheduling issue would most get in your way? <ul style="list-style-type: none"> • Child care • Care of elderly, disabled or ill family member • School and homework • Household chores • Mandatory reporting requirement i.e. probation, case worker, etc. Other (<i>Specify:</i> _____)	Skip if Empl_8 is <u>not</u> “Get in the way of reaching goals”
Now, I’m going to ask you to rate your need for employment-related services.		
Empl_10	On a scale of (1-10), with (10) meaning you have immediate and extensive need for employment services and (1) meaning you have no need-for employment services, how would you rate yourself? <ul style="list-style-type: none"> ▪ 1= No needs ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6 ▪ 7 ▪ 8 ▪ 9 ▪ 10=immediate and extensive need for employment counseling 	
Empl_11	Would you like help with any employment or work-related matters? (<i>Check all that apply.</i>) <ul style="list-style-type: none"> ▪ No ▪ Yes 	Skip if Empl_10=1
Empl_12	What kind of help would you like? <ul style="list-style-type: none"> ▪ Vocational assessment ▪ Help finding a job or maintaining employment ▪ Employment barriers related to a felony conviction ▪ Developing a resume ▪ Arranging job interviews ▪ Interviewing skills ▪ Disability evaluation ▪ Disability – work rehabilitation ▪ Getting a promotion, better job or skills ▪ Other (<i>Specify:</i> _____) 	Skip if Empl_10=1 Skip if Empl_11 = NO

RSS Category	Question	Skip Patterns / Notes
Comments:		
School & Training		
	OK, I have some questions about school and training.	
Train_1	<p>Would you like help finding English as a second language classes?</p> <ul style="list-style-type: none"> ▪ No ▪ Yes ▪ Not applicable <p>Interviewer: Only ask this question if English is a second language for the interviewee and English as a second language classes might be helpful. Otherwise, check “Not Applicable.”</p>	
Train_2	<p>What is the highest level of education you have finished, whether or not you received a degree?</p> <ul style="list-style-type: none"> ▪ Never Attended ▪ 1st Grade ▪ 2nd Grade ▪ 3rd Grade ▪ 4th Grade ▪ 5th Grade ▪ 6th Grade ▪ 7th Grade ▪ 8th Grade ▪ 9th Grade ▪ 10th Grade ▪ 11th Grade ▪ 12th Grade/High School Diploma/Equivalent ▪ College Or University/1st Year Completed ▪ College Or University/2nd Year Completed/Associates Degree (Aa, As) ▪ College Or University/3rd Year Completed ▪ Bachelor’s Degree (Ba, Bs) Or Higher ▪ Voc/Tech Program After High School But No Voc/Tech Diploma ▪ Voc/Tech Diploma After High School ▪ Declined ▪ Don’t Know 	GPRA Question
Train_3	<p>Are you currently in school or other training?</p> <ul style="list-style-type: none"> ▪ No ▪ Yes 	<i>GPRA Question</i>
Train_4	<p>Which best describes your situation?</p> <ul style="list-style-type: none"> ▪ Enrolled, full time ▪ Enrolled, part time ▪ Other (Specify) _____ ▪ Declined ▪ Don’t know 	<p><i>GPRA Question (Part 2)</i></p> <p><i>Skip if Train_3 = NO</i></p>

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Train_5	Do you think additional training or education would help you in your recovery? <ul style="list-style-type: none"> No Yes 	
Train_6	Are you interested in getting help with any of the following? <i>(Check all that apply.)</i> <ul style="list-style-type: none"> Earning a GED Academic counseling or tutoring Grants, loans or scholarships for additional training or schooling Finding or applying to schools Aptitude and achievement testing Technical or vocational training Literacy training Going back to school Other <i>(Specify: _____)</i> 	Skip if Train_5 = NO
Comments:		
Housing & Recovery Environment		
	Our next topic is your living environment.	
Hous_1	Who do you live with? <ul style="list-style-type: none"> 1 – With spouse/domestic partner and child/children 2 – With spouse/domestic partner alone 3 – With child/children alone 4 – With parent(s) 5 – With other family 6 – With friends 7 – Alone 8 – In a controlled environment (e.g., community corrections / work release program) 9 – Homeless or no stable arrangements 10 – Temporary arrangements 11 – In a group living facility 	
Hous_2	Do you rent or own the place where you live? <ul style="list-style-type: none"> Rent Own Other (Specify: _____) 	Skip if Hous_1 = 8, 9, 10, 11
Hous_3	Are you concerned about losing your housing? <ul style="list-style-type: none"> No Yes – Eviction Yes – Foreclosure Yes – Other (Specify: _____) 	Skip if Hous_1 = 8, 9, 11

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
<i>Hous_4</i>	<p>Which of the following best describes your living situation?</p> <ul style="list-style-type: none"> ▪ The people I live with are in recovery or will actively support my recovery. ▪ The people I live with will permit, but not support, my recovery ▪ The people I live with will not be very supportive of my recovery. ▪ The people I live with may keep alcohol or drugs in the house, use alcohol or drugs in my presence, sell drugs, or actively discourage my recovery. 	SKIP if Hous_1 = 7, 8 or 9
<i>Hous_5</i>	<p>Is anyone in your environment threatening, intimidating or harming you, your children, or anyone else in your household verbally, physically, or sexually?</p> <ul style="list-style-type: none"> ▪ No ▪ Yes 	
<i>Hous_6</i>	<p>Which of these describe the situation? (check all that apply)</p> <ul style="list-style-type: none"> ▪ Threatening ▪ Intimidating ▪ Verbally abusing ▪ Physically abusing ▪ Sexually abusing ▪ Interviewee did not want to respond <p>Interviewer: If the interviewee reports threats, intimidation, or any kind of verbal, physical or sexual abuse, please refer to the <i>Interviewer Notes</i> at beginning of questionnaire.</p>	Skip if Hous_5 = NO
<i>Hous_7</i>	<p>OK. Now I'm going to ask you to use a 10-point scale to describe how safe you feel in your living situation and neighborhood:</p> <p>On a scale of (1-10), where 1 means your home or living environment is safe and 10 means that you are in a dangerous environment where you or a member of your family could be hurt at any time, how would you rate your home environment and neighborhood?</p> <ul style="list-style-type: none"> ▪ 1=Safe ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6 ▪ 7 ▪ 8 ▪ 9 ▪ 10=Dangerous 	
<i>Hous_8</i>	<p>So, your living environment is not safe. Would you like help finding a safer place to live?</p> <ul style="list-style-type: none"> • No • Yes 	Skip if Hous_7=1-5

RSS Category	Question	Skip Patterns / Notes
Hous_9	<p>I'm going to read some statements about the neighborhood where you live Let me know which of these apply to your situation. You can choose as many as apply. OK?</p> <ul style="list-style-type: none"> • My neighborhood feels safe to me. • My neighborhood is a good place to start or continue my recovery • My neighborhood is dangerous or stressful to live in. • There are many drug dealers or liquor stores in my neighborhood. • I regularly see people I used or drank with in my neighborhood • My neighborhood is <u>not</u> a good place to start or continue my recovery. • Other (<i>Specify:_____</i>) 	Skip if Hous_1= 8 or 9
	<p>Now I'm going to ask you to use a 10-point scale again. This time I'm going to ask you to tell me how supportive of recovery you think your current environment is. By living environment I mean those who live with you, the building you live in if you're in an apartment building, and the neighborhood where you live. OK?</p>	
Hous_10	<p>On a scale of (1-10), where 1 means your living environment is supportive of recovery and 10 means your living environment puts you at a high risk of using drugs or alcohol, how would you rate your home environment and neighborhood?</p> <ul style="list-style-type: none"> ▪ 1=Supportive of recovery ▪ 2 ▪ 3 ▪ 4 ▪ 5 ▪ 6 ▪ 7 ▪ 8 ▪ 9 ▪ 10=Risk of relapse 	
Hous_11	<p>So, you feel that your living environment is not supportive of your recovery. Would you like help finding a more recovery-friendly place to live?</p> <ul style="list-style-type: none"> • No • Yes 	Skip if Hous_8=1-5
	<p>There are different kinds of housing and housing assistance. I'm going to tell you about some kinds of help that are available. Let me know if any of these are of interest to you or if you would like a different kind of help related to housing. OK?</p>	
Hous_12	<p>Are you interested in learning about help related to any of the following?</p> <ul style="list-style-type: none"> ▪ Emergency or temporary housing ▪ Recovery home, Oxford House or other clean & sober housing ▪ Independent Stable housing (including Housing First) ▪ Housing barriers related to a felony conviction ▪ Supported independent living ▪ Help finding subsidized housing ▪ Other (<i>Specify:_____</i>) 	

RSS Category	Question	Skip Patterns / Notes
Comments:		
Recovery Status		
	<p>Now, I'm going to ask you some questions about your recovery status and services that might help you in recovery.</p> <p>What's important to remember here is that I'm here for you and you don't need to tell me what you think I might want to hear. OK? We'll work with you from wherever you're at. The better we understand that, the better we can be of help you. OK?</p>	
Recov_1	<p>Which of the following statements best describes where you are at personally?</p> <ul style="list-style-type: none"> ▪ I do not have an alcohol or drug problem. ▪ I'm in recovery and have not used for alcohol or other drugs one year or more. ▪ I'm in early recovery and have not used for 3 months or more. ▪ I have not used for one week or more. ▪ I have used at least one substance during the past week. ▪ <i>I am actively using one or more substances.</i> 	
Recov_2	<p>Do you have a recovery plan?</p> <ul style="list-style-type: none"> ▪ No ▪ <i>Yes – Up-to-date</i> ▪ <i>Yes– Needs to be updated</i> 	
Recov_3	<p>Would you like help creating a plan?</p> <ul style="list-style-type: none"> ▪ No ▪ <i>Yes</i> 	<i>Skip if Recov_2 = YES– Up-to-date or YES– Needs to be updated</i>
Recov_4	<p>Would you like help updating your plan?</p> <ul style="list-style-type: none"> • No • Yes 	Skip if Recov_2 = NO or YES– Up-to-date
Recov_5	<p>Do you have a case manager, recovery support services coordinator, recovery coach, or other person who helps you meet your recovery goals?</p> <ul style="list-style-type: none"> • No • Yes (<i>Specify: _____</i>) 	
Recov_6	<p>Is there a friend, family member, pastor or other community member you look to when you need help?</p> <ul style="list-style-type: none"> ▪ No ▪ Yes (<i>Specify: _____</i>) 	If NO, Skip to Recov_4
Recov_7	<p>Are you interested in connecting with someone in recovery who has had similar experiences to yours and might be able to help you in recovery?</p> <ul style="list-style-type: none"> • No • <i>Yes</i> 	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Recov_8	Do you know of a recovery organization or recovery events in your neighborhood? <ul style="list-style-type: none"> • No • Yes (Specify)_____ 	
Recov_9	Would you like to connect with recovering people or take part in recovery events? <ul style="list-style-type: none"> • No • Yes 	
Recov_10	Do you think treatment or recovery services might help you reach your recovery goals? <ul style="list-style-type: none"> ▪ No ▪ Yes ▪ Unsure 	
Recov_11	Would you like to learn about the kinds of treatment and recovery services that are available? <ul style="list-style-type: none"> ▪ No ▪ Yes 	
Recov_12	<i>Are there any specific kinds of treatment or recovery services that you think might be helpful for you?</i> <ul style="list-style-type: none"> • No • Yes (Specify:_____) 	Skip if Recov_10 = NO
Recov_13	Would you like to learn about the different kinds of support groups in your area or how to locate a group? <ul style="list-style-type: none"> ▪ No, already involved ▪ No, not interested ▪ Uncertain or ambivalent ▪ Yes <p>Interviewer: You may need to give examples of support groups, such as AA, NA, CA, Smart Recovery, Secular Organizations For Sobriety (SOS), LifeRing, Women for Sobriety, Celebrate Recovery, or White Bison. It is important to have information on the full range of support groups available in the communities you serve.</p> <p>It is also helpful to have knowledge of the continually growing array of online treatment, recovery support, and mutual aid resources.</p>	If No, skip to Recov_16
Recov_14	Would you like someone who attends those groups to call you so you can learn more first-hand? <ul style="list-style-type: none"> • No • Yes (Specify:_____) 	
Recov_15	Do you smoke? <ul style="list-style-type: none"> ▪ No ▪ Yes 	

RSS Category	Question	Skip Patterns / Notes
Recov_16	Would like help to quit smoking? <ul style="list-style-type: none"> ▪ No ▪ Yes 	Skip if Recov_15=NO
Recov_17	Have you discovered things that help you to enter or stay in recovery? Interviewer: You may read the list below to provide examples if that would help the interviewee. <ul style="list-style-type: none"> ▪ No ▪ Other people in recovery ▪ friends ▪ recovery/ support groups ▪ work ▪ volunteer work ▪ faith or spiritual groups/practices ▪ cultural activities/groups ▪ meditation/relaxation ▪ leisure activities ▪ Other (<i>Specify</i>_____) 	
Comments:		
Talents, Recreation & Leisure		
	The next set of questions is about hobbies, sports, and other activities that you enjoy.	
Tal_1	Are there hobbies or recreational or leisure activities that you enjoy or would like to try? <ul style="list-style-type: none"> ▪ No ▪ Yes Tell me about these activities. [Interviewer: List activities discussed, including any ideas, comments, or recommendations: _____.	
Tal_2	Are you involved in any of these activities right now? <ul style="list-style-type: none"> ▪ No ▪ Yes, involved in all ▪ Yes, involved in some, but not all (<i>Specify</i>:_____) 	Skip if Tal_1=NO
Tal_3	Do you know how you could get involved in those activities or hobbies? <ul style="list-style-type: none"> ▪ No ▪ Yes 	Skip if Tal_1=NO Skip if Tal_1=YES, INVOLVED IN ALL
Tal_4	Would you like help getting involved in those activities or hobbies? <ul style="list-style-type: none"> ▪ No ▪ Yes 	Skip if Tal_1=NO Skip if Tal_1=YES, INVOLVED IN ALL

RSS Category	Question	Skip Patterns / Notes
Comments:		
Spiritual		
	OK. I have two questions about spirituality and religion.	
Spirit_1	Some spiritual and religious groups have organized to offer support to people in recovery. Are you interested in learning about spiritually or faith-based support and/or services? <ul style="list-style-type: none"> ▪ No ▪ Yes 	If NO, Skip to Culture_1
Spirit_2	Is there a specific faith tradition or spiritual practice you think might help you achieve your recovery goals? <ul style="list-style-type: none"> ▪ No ▪ Yes (Please specify: _____) 	
Comments:		
Culture, Gender & Sexual Orientation		
	Now I'm going to ask you about some personal preferences, about military service and experience in a war zone, and about your heritage/ethnic background.	
Cultur_1	Do you have a preference about the culture, race/ethnicity or sex of the individuals from whom you receive services? <ul style="list-style-type: none"> ▪ No Preference ▪ Language ▪ Culture, Ethnicity, Race ▪ Gender ▪ Sexual Orientation ▪ Veteran's Status ▪ Other (Specify _____) 	
Cultur_2	Do you have a preference about the type of organization or community where you receive services? <ul style="list-style-type: none"> ▪ No Preference ▪ Language ▪ Culture, Ethnicity, Race ▪ Language ▪ Gender ▪ Sexual Orientation ▪ Veteran's Services ▪ Community-based ▪ Other (Specify _____) 	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Cultur_3	How important are those preferences? <ul style="list-style-type: none"> ▪ Not very important ▪ Somewhat important ▪ Important ▪ Very Important 	Skip if Cultur_1 and Cultur_2 = NO PREFERENCE
Cultur_4	Would you like help finding services that match your preferences? <ul style="list-style-type: none"> • No • Yes 	Skip if Cultur_1 and Cultur_2 = NO PREFERENCE
Cultur_5	Are you a veteran or a member of the armed forces? <ul style="list-style-type: none"> • No • Active Duty • Veteran • Current Guard or Reserve Member • Former Guard or Reserve Member 	
Cultur_6	Have you served, worked or lived in a war zone? <ul style="list-style-type: none"> • No • <i>Yes, as member of military</i> • <i>Yes, in contractor role</i> • <i>Yes, as civilian</i> 	
Cultur_7	As a current or former member of the armed services, do you know what services you are entitled to and how you can access them? <ul style="list-style-type: none"> ▪ No ▪ Yes 	Skip if Cultur_5=NO
Cultur_8	Would you like special assistance for issues related to your experience in a war zone or your return to the community? <ul style="list-style-type: none"> • No • Yes 	Skip if Cultur_6 = NO
Cultur_9	Are you Hispanic or Latino? <ul style="list-style-type: none"> ▪ No ▪ Yes ▪ Declined 	If NO or DECLINED, skip to Cultur_11
Cultur_10	What is your heritage? (You may select to more than one) <ul style="list-style-type: none"> ▪ Central American ▪ Cuban ▪ Dominican ▪ Mexican ▪ Puerto Rican ▪ South American ▪ Other (<i>Specify _____</i>) 	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Cultur_11	What is your sex? <ul style="list-style-type: none"> ▪ Male ▪ Female ▪ Declined ▪ Other (<i>Specify</i>_____) 	If Male, skip Med_6, Med_6a, and Med_7
Cultur_12	What is your race or ethnicity? (You may select more than one.) <ul style="list-style-type: none"> ▪ Black or African American ▪ Asian ▪ Native Hawaiian or other Pacific Islander ▪ Alaska Native ▪ White ▪ American Indian ▪ Arab American or Middle Eastern ▪ Declined ▪ Other: _____ 	
	At this point I'd like to ask you about your sexual orientation and a related matter. If the questions make you uncomfortable you can tell me you'd prefer not to answer. OK?	
Cultur_13	Do you consider yourself 'straight' (heterosexual), 'gay' (homosexual, lesbian) or bisexual? <ul style="list-style-type: none"> • Straight/heterosexual • Gay/Lesbian/homosexual • Bisexual • Not Sure • Declined 	
Cultur_14	Would you describe yourself as transgendered? <ul style="list-style-type: none"> • No • Yes • Declined 	
Comments:		
Medical		
	OK. Now we're moving to some questions about medical services.	
Med_1	Do you believe you are currently receiving the medical care and services that you need? <ul style="list-style-type: none"> ▪ No ▪ Yes ▪ Not sure <p>Interviewer: Do not include any alcohol, drug or psychiatric service needs with this item.</p>	

RSS Category	Question	Skip Patterns / Notes
Med_2	Do you have a doctor or clinic you can go to? <ul style="list-style-type: none"> • 1 - Yes, satisfied with current situation • 2 - Yes, but would like help finding a new provider • 3 - No, would like help finding a provider • 4 - No, does not want help • 5 - Other (Specify: _____) 	
Med_3	I'm going to read a list of few medical services. Would you let me know if you need any of these or any other medical services? <ul style="list-style-type: none"> ▪ 1 - Treatment or medication for a condition you have ▪ 2 - Physical Exam/Checkup ▪ 3 - Help with physical mobility ▪ 4 - Help with hearing problem ▪ 5 - Dental Care ▪ 6 - Glasses or other visual assistance ▪ 7 - None ▪ 8 - Not Sure ▪ 9 - Other (Specify: _____) 	
Med_4	Interviewer: Specify the known condition(s) for which treatment is needed. Do not include treatment for substance use and mental health/psychiatric conditions. <ul style="list-style-type: none"> • High blood pressure • Diabetes • High cholesterol • Asthma • Heart disease • Hepatitis • HIV • TB • Cirrhosis • Atherosclerosis (hardening of the arteries) • Declined • Other (Specify: _____) 	Skip if Med_3 = 2-9
Med_5	Do you need help with (check all that apply) <ul style="list-style-type: none"> ▪ Getting free or low-cost health care? ▪ Applying for Medicaid, SSI/SSDI, or health benefits? 	
	I'd like to ask a personal question now. Please let me know if you'd prefer not to answer, OK?	
Med_6	Do you know whether or not you are HIV positive? <ul style="list-style-type: none"> ▪ Yes, positive ▪ Yes, negative ▪ No ▪ Not sure ▪ Declined to Answer ▪ Skip question (interviewer) 	If NO, NOT SURE, DECLINED, or SKIP, go to Med_8 for females and Med_11 for males

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Med_7	<p>Would you like help with any of the following related to your HIV condition?</p> <ul style="list-style-type: none"> • Obtaining medications • Keeping on schedule with or managing medications • Access to and payment for HIV-related care • Transportation to and from appointments • Education about HIV and about safer sex practices • Support groups • In-home care or support • Residential care • Other (<i>Specify</i>_____) 	If NO, skip to Med_8 for females and Med_11 for males
Med_8	<p>Are you pregnant?</p> <ul style="list-style-type: none"> ▪ No ▪ Yes ▪ Not sure 	Skip if Culture-2=Male
Med_9	<p>Would you like to take a pregnancy test so that you can get prenatal care if you need it?</p> <ul style="list-style-type: none"> ▪ No ▪ Yes ▪ Not sure 	<p>Skip if Culture-2=Male</p> <p>Skip if Med_8=NO or YES</p>
Med_10	<p>Would you like help with:</p> <ul style="list-style-type: none"> ▪ Setting up prenatal care ▪ Obtaining pregnancy/childbirth education ▪ Obtaining newborn/lactation education ▪ Getting to appointments ▪ No help needed ▪ Other (<i>Specify</i>_____) 	<p>Skip if Culture-2=Male</p> <p>Skip if Med_8=NO or UNSURE</p>
Med_11	<p>Would you like to talk to someone about whether or not you should be tested for infectious or communicable diseases such as TB, Hepatitis C or sexually transmitted diseases?</p> <ul style="list-style-type: none"> ▪ No ▪ Yes ▪ Other (<i>Specify</i>_____) 	
Med_12	<p>Do you think psychiatric and/or mental health services might help you in your recovery?</p> <ul style="list-style-type: none"> ▪ No ▪ Yes ▪ Unsure ▪ Not applicable ▪ Declined <p>Interviewer: Do not include any alcohol or drug service needs with this item.</p>	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Med_13	Are you receiving psychiatric or mental health services now? <ul style="list-style-type: none"> • No, would like help finding services • No, does not want psychiatric or mental health services • Yes, satisfied with current situation • Yes, but would like to find a new provider • Declined 	
Med_14	Are there specific kinds of psychiatric or mental health services that you think might help you in your recovery? <ul style="list-style-type: none"> ▪ No ▪ Treatment for known condition(s) ▪ Psychiatric evaluation ▪ Medication evaluation ▪ Medication ▪ Counseling ▪ Therapy ▪ Not sure ▪ Other (<i>Specify:</i> _____) 	Skip if Med_12 = NO, NOT APPLICABLE, or DECLINED
Med_15	Interviewer: Specify known condition(s): _____	
Med_16	Would you like help finding psychiatric or mental health services or getting an evaluation to see if they might help? <ul style="list-style-type: none"> • No • Yes, services • Yes, evaluation 	Skip if Med_12 = NO, NOT APPLICABLE, or DECLINED
Med_17	Are you currently receiving the dental care that you need? <ul style="list-style-type: none"> ▪ No ▪ Yes 	
Med_18	Would you like help getting dental care? <ul style="list-style-type: none"> ▪ No ▪ Yes 	Skip if Med_16=YES
Comments:		
Financial & Legal		
	The next set of questions is about financial or legal problems that might get in the way of your recovery.	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Finan_1	Do you have money or legal issues that might make it hard for you to achieve your recovery goals? <i>(Check all that apply.)</i> <ul style="list-style-type: none"> • No • Criminal history • Bankruptcy • Alimony/child support • Immigration status • Insufficient income • No income • Owing too much money • No health insurance • Discrimination • Paying for medicine • Other <i>(Specify_____)</i> 	
Finan_2	Do you think help from a lawyer or other advocate with any of the following might make it easier for you to meet your recovery goals? <ul style="list-style-type: none"> ▪ Divorce ▪ Child custody ▪ Obtaining child support payments ▪ Alimony ▪ Discrimination ▪ Probation problems ▪ Legal defense ▪ Immigration status ▪ Other <i>(Specify_____)</i> 	
Finan_3	Do you need help getting: <ul style="list-style-type: none"> ▪ Food stamps / WIC services ▪ Delivered meals (for shut-ins) ▪ Clothing ▪ Personal care items ▪ Other: <i>(Specify_____)</i> 	
Finan_4	Are there other money or legal problems that might get in the way of your recovery? <ul style="list-style-type: none"> • No • Yes <i>(Specify_____)</i> 	
Comments:		
Family Status & Parenting		
	We're most of the way done. I'm going to ask you about your family status and related matters.	

<i>RSS Category</i>	<i>Question</i>	<i>Skip Patterns / Notes</i>
Parent_1	Which best describes your family status? <ul style="list-style-type: none"> • 1- Single - no dependent children • 2 - Single - dependent children • 3 - Married - no dependent children • 4 - Married - dependent children • 5 - Divorced - no dependent children • 6 - Divorced - dependent children • 7 - Committed relationship, but not married - no dependent children • 8 - Committed relationship, but not married - dependent children • 9 - Widowed – no dependent children • 10 - Widowed – dependent children 	
Parent_2	Are you responsible for parenting children who live with you? <ul style="list-style-type: none"> ▪ No ▪ Yes 	
Parent_3	Do you have children who have been taken from you by the courts (child welfare)? <ul style="list-style-type: none"> • No • Yes <p>[Interviewer: This item does not refer to custody issues stemming from a divorce settlement.]</p>	
Parent_4	Are you concerned that your child/children could be taken by child welfare? <ul style="list-style-type: none"> • No • Yes, child welfare already involved • Yes, child welfare not involved at this time 	<i>Skip if Parent_1=1, 3, 5, 7, 9</i>
Parent_5	Would you like help getting your life back together so that you can regain or keep custody of your children? <ul style="list-style-type: none"> • No • Yes 	<i>Skip if Parent_3=NO and Parent_4=NO</i>
Parent_6	Would child care services help you reach your recovery goals?" <ul style="list-style-type: none"> • No ▪ Access to free or low-cost services ▪ Logistical help (getting interviewee or children to or from daycare, school, or after-school activities) ▪ Other <i>Specify</i> _____ 	<i>Display if Parent_2 = YES</i>
Parent_7	Would you like help with any of the following: <ul style="list-style-type: none"> • Parenting skills ▪ Joining a parent group ▪ Other 	Display if Parent_2 = YES
Parent_8	Would you like to receive family counseling? <ul style="list-style-type: none"> ▪ No ▪ Yes 	

RSS Category	Question	Skip Patterns / Notes
<i>Comments:</i>		
Recovery Wrap Up		
	There are three questions left. We ask these questions to make sure that we have covered everything to make sure we understand what is important to you.	
Wrap_1	Can you think of anything we haven't already talked about that could hold you back from reaching your recovery goals? <ul style="list-style-type: none"> ▪ No ▪ Scheduling difficulties ▪ Having to attend groups ▪ Having to take medications ▪ Having to take drug tests ▪ Other <i>Specify</i> _____ 	
Wrap_2	Of everything that we've discussed today, are there one or two things that you think are most important to achieving your recovery goals? <ul style="list-style-type: none"> • No • Treatment • Housing • Employment • Recovering Peers • Spiritual Support • Mental Health Services • Medical Services • Family Counseling/Therapy • Benefits • Transportation • Other (Specify _____) 	
Wrap_3	Is there anything we have not mentioned so far that would make it easier for you to reach your recovery goals? <ul style="list-style-type: none"> ▪ No ▪ <i>Yes Specify</i> _____ 	
<i>Comments:</i>		

Thank you for taking the time to speak with me today.

Ethical Guidelines for the Delivery of Peer-based Recovery Support

Ethical Guidelines for the Delivery of Peer-based Recovery Support Services

William L. White, MA
&

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Prepared for the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBHMRS) & Pennsylvania Recovery Organization—Achieving Community Together (PRO-ACT)

Introduction

There is a long history of peer-based recovery support services within the alcohol and other drug problems arena, and the opening of the twenty-first century is witnessing a rebirth of such services (White, 2004a). These services are imbedded in new social institutions such as recovery advocacy organizations and recovery support centers and in new paid and volunteer service roles. These peer-based recovery support roles go by various titles: recovery coaches, recovery mentors, personal recovery assistants, recovery support specialists, and peer specialists. Complex ethical and legal issues are arising within the performance of these roles for which little guidance can be found within the existing literature.

The twin purposes of this article are 1) to draw upon the collective experience of organizations that are providing peer-based recovery support services to identify ethical issues arising within this service arena, and 2) to offer guidance on how these issues can best be handled. Toward that end, we will:

- define the core responsibility of the peer recovery support specialist (here referred to generically as *recovery coach*),
- provide an opening discussion 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 vignettes that can arise for recovery coaches related to personal conduct, conduct in service relationships, conduct in relationships with local service professionals and agencies, and conduct in service relationships with the larger community, and
- Provide a sample statement of ethical principles and guidelines for recovery coaches.

An appended paper also identifies the extent to which current laws governing roles in addiction treatment (e.g., confidentiality, duty to warn, personal/organizational liability) are applicable to recovery coaches and their organizations. We have two intended audiences for these discussions: individuals who are in a position of responsibility to plan, implement, and supervise peer-based recovery support services

and individuals who are working in either paid or volunteer roles as a recovery coach. This paper is designed for adaptation for the training of recovery coaches and their supervisors. The paper will remain in public domain and may be used without request by other recovery support organizations as a reading resource or adapted as a training aid. We encourage use of the decision-making model and the ethical case studies in the paper for the orientation and training of recovery coaches.

Peer-based Recovery Support Roles and Functions¹

Recovery support services, as the term is used here, 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. The Center for Substance Abuse Treatment's Recovery Community Support Program identified four types of recovery support services:

- **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 and wellness information, educational assistance, and help in acquiring new skills, ranging from life skills to employment readiness and citizenship restoration.
- **Instrumental support** - concrete assistance in task accomplishment, especially with stressful or unpleasant tasks such as filling out applications and obtaining entitlements, or providing child care, transportation to support-group meetings, and clothing closets.
- **Companionship** - helping people in early recovery feel connected and enjoy being with others, especially in recreational activities in alcohol- and drug-free environments. This assistance is especially needed in early recovery, when little about abstaining from alcohol or drugs is reinforcing.

(Source: <http://rcsp.samhsa.gov/about/framework.htm>)

Some of the service activities now provided within the rubric of recovery support services include activities performed in earlier decades by persons working as outreach workers, case managers, counselor assistants, and volunteers. Recovery support services may be provided by clinically-trained professionals as an adjunct to their clinical (assessment and counseling) activities, or they may be delivered by persons in recovery who are not clinically trained but who are trained and supervised to provide such support services. They are being provided as adjuncts to other service roles or as a specialty role. They are being provided by persons working in full and part-time paid roles and by persons who provide these services as volunteers.

Peer-based recovery support roles are growing rapidly in the mental health and addiction service arenas. While there are specific issues related to peer-based services that are distinct within these fields, the fields have much they can learn from each other.²

¹ This section excerpts material from White, W. (2004). Recovery coaching: A lost function of addiction counseling? *Counselor*, 5(6), 20-22.

² Particularly recommended are the following three resources from the mental health field: 1) Mowbray, C.T., Moxley, D.P., Jasper, C.A., & Howell, L.A. (Eds.) (1997). *Consumers as providers in psychiatric rehabilitation*. Columbia, MD: International Association of Rehabilitation Services, 2) Davidson, L., Harding, C., & Spaniol, L. (Eds.) (2005). *Recovery from severe mental illness: Research evidence and implications for practice*. Boston: Center for Psychiatric Rehabilitation, and 3) Spaniol, L., Gagne, C., & Koehler, M. (Eds.) (1997). *Psychological and social aspects of psychiatric rehabilitation*. Boston: Center for Psychiatric Rehabilitation.

Part of what makes the ethical delivery of recovery support services so challenging in the addictions context is that the recovery coach performs so many roles. In service organizations piloting this role, the recovery coach is being described as a(n):

- outreach worker (identifies and engages hard-to-reach individuals; offers living proof of transformative power of recovery; makes recovery attractive),
- motivator and cheerleader (exhibits faith in capacity for change; encourages and celebrates recovery achievements; mobilizes 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 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 consumer-developed and consumer-directed personal recovery plan),
- problem solver (helps resolve personal and environmental obstacles to recovery),
- resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support; 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, reduce attrition, resolve problems in the service/support relationship, and facilitate development of a long-term, sobriety-based support network; provides periodic face-to-face, telephonic 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 service systems),
- educator (provides each client with normative information about the stages of recovery; informs professional helpers, the community, and potential service consumers about the prevalence, pathways, and styles of long-term recovery),
- community organizer (helps develop and expand available recovery support resources; enhances cooperative relationships between professional service organizations and indigenous recovery support groups; cultivates opportunities for people in recovery to participate in volunteerism and other acts of service to the community),
- lifestyle consultant/guide (assists individuals/families to develop sobriety-based rituals of daily living; encourages activities (across religious, spiritual, and secular) frameworks that enhance life meaning and purpose), and
- friend (provides sober companionship; a social bridge from the culture of addiction to the culture of recovery) (White, 2004a).

- problem solver (helps resolve personal and environmental obstacles to recovery),
- resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support; 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, reduce attrition, resolve problems in the service/support relationship, and facilitate development of a long-term, sobriety-based support network; provides periodic face-to-face, telephonic or email-based monitoring of recovery stability and, when needed, provides early re-intervention and recovery re-initiation services),
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- friend (provides sober companionship; a social bridge from the culture of addiction to the culture of recovery) (White, 2004a).

The fact that these functions overlap with other helping roles including that of the addictions counselor raises the potential for role ambiguity and conflict. Agencies experimenting with these new roles insist that the recovery coach is NOT a:

- sponsor,
- therapist/counselor,
- nurse/physician, or a
- priest/clergy (does not respond to questions of religious doctrine nor proselytize a particular religion/church) (See White, 2006a,c).

Role Boundary Integrity: The RC is NOT a:	You are moving beyond the boundaries of the recovery coach role if you:
Sponsor (or equivalent)	<ul style="list-style-type: none"> • Perform AA/NA or other mutual aid group service work in your RC role • Guide someone through the steps or principles of a particular recovery program
Therapist/counselor	<ul style="list-style-type: none"> • Diagnose

	<ul style="list-style-type: none"> • Provide counseling or refer to your support activities as “counseling” or “therapy” • Focus on problems/“issues”/trauma as opposed to recovery solutions
Nurse/Physician	<ul style="list-style-type: none"> • Suggest or express disagreement with medical diagnoses • Offer medical advice • Make statements about prescribed drugs beyond the boundaries of your training & experience
Priest/Clergy	<ul style="list-style-type: none"> • Promote a particular religion/church • Interpret religious doctrine • Offer absolution / forgiveness • Provide pastoral counseling

Persons serving as recovery coaches, rather than being legitimized through traditionally acquired education credentials, draw their legitimacy from *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. 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 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, 2000a,b; Jackson, 2001).

Recovery coaching at its best offers dimensions of recovery support not available from other service roles. We asked individuals from three states (Pennsylvania, Connecticut, and Texas) who had experienced a recovery coach what these recovery coaches 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 a little self esteem. He asked me, was I ready? I was able to share my past. He helped place me in the Mentor Plus program. He walked me through. He told me it would not be easy.

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. One of the most important things was that I got mentors for the Mentor Plus program. They came to see me every week, eventually twice a week. They gave me direction and were there to support me.

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

Recovery coaches, particularly those serving in this capacity as volunteers, are also quite explicit in what they get out of this service process.

I like working with people and being able to offer encouragement and support. It's 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 more than I can say.

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 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 at a frontier stage. The role is being defined differently around the country based on the unique needs of particular communities and particular client populations. 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 and prerequisites). Orientation, training, and supervision protocols 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 recipients of recovery support services due to incompetence or personal impairment— concerns that apply to all health and human service roles. There are several characteristics of recovery support services that influence the vulnerability of consumers and providers of peer-based recovery support services.

First, recovery support needs span the periods of pre-recovery engagement, recovery initiation, recovery stabilization, and recovery maintenance. As such, these service relationships last far longer than counseling relationships that are the core of addiction treatment, are far more likely to be delivered in the client's natural environment, and often involve a larger cluster of family and community relationships.

Second, recovery support relationships are less hierarchical (less differential of power and vulnerability) than the counselor-client relationship, involve different core functions, and are governed by different accountabilities. As such, the ethical guidelines that govern the addiction counselor are often not applicable to the recovery coach. Efforts to impose ethical standards from traditional helping professionals could inadvertently lead to the over-professionalization and commercialization of the role of recovery coach and recreate the very conditions that spawned peer-based recovery support services. 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, individual consumers of peer-based recovery support services differ in the kind of non-clinical support services needed, 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 service needs, delivering those services within the boundaries of one's knowledge and experience, and knowing how and when to involve other service roles.

Fourth, peer-based recovery support services can constitute an adjunct 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 vigilance in determining service needs, skill in making necessary referrals in a timely manner, and providing services only within the boundaries of one's 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 who have never worked within or received services from an addiction-related service agency. Before proceeding to a discussion of how best to make decisions in the face of ethical dilemmas, we must further enhance our understanding of what we mean by saying that an action of a recovery coach is ethical or unethical. At its most primitive level, aspiring to be ethical involves sustained vigilance in 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 resulted in injury or death. Can you think of an example of such an action? There is a long history of such insults in the history of addiction treatment, e.g., mandatory sterilizations, withdrawal using chemo- and electroconvulsive shock therapies, psychosurgery and

all manner of drug insults (e.g., treating morphine addiction with cocaine). It is easy today to look back on such “treatments” and wonder “What were they thinking?!” And yet history tells us that it is hard to see such potential injuries close up. Given the new frontier 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 our supervisor.

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 equal power—it is not solely a supportive friendship. 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 our own physician or attorney. While the power differential 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. As such, these relationships are held to a higher level of obligation and duty than would be friendships that are reciprocal in nature.

Boundary Management encompasses the decisions that increase or decrease intimacy within a relationship. This is an area of potentially considerable conflict between recovery support specialists and traditional service professionals. Where traditional helping professions (physicians, nurses, psychologists, social workers, addiction counselors) emphasize hierarchical boundaries and maintaining detachment and distance in the service relationship, peer-based services rely on reciprocity and minimizing social distance between the helper and those being helped (Mowbray, 1997). While addiction professionals and peer-based recovery support specialists both affirm boundaries of inappropriateness, they may differ considerably in where such boundaries should be drawn.

We could 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 okay, a zone of vulnerability in which actions are sometimes okay and sometimes not okay, and a zone of abuse in which actions are never okay. The zone of abuse involves behaviors that mark too little or too great a degree of involvement with those we serve. Examples of behaviors across these zones are listed in the chart below. Place a checkmark for each behavior based on whether you think this action as a recovery coach would be always okay, sometimes okay but sometimes not okay, or never okay.

Table 1: Recovery Coaching: An Intimacy Continuum

Behavior of Recovery Coach in Recovery Support Relationship	Zone of Safety (Always Okay)	Zone of Vulnerability (Sometimes okay; Sometimes not okay)	Zone of Abuse (Never Okay)
Giving gift			
Accepting gift			
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 holiday dinner			
Sexual relationship			
Sexual relationship with a mentee’s family member			
Giving cell phone number			
Using profanity			
Using drug culture slang			
“I’m going through a rough divorce myself right now.”			
“You’re very attractive.”			
Addressing person by their first name			
Attending recovery support meeting together			
Hiring person to do work at your home.			

Ethical issues that can arise in situations like the above will be explored later in this paper.

Multi-party Vulnerability is a phrase that conveys how multiple parties can be injured by what a recovery coach does or fails to do. These parties include the person receiving recovery support services, that person’s family and intimate social network, the recovery coach, the organization for which the recovery coach is working, the recovery support services field, the larger community of recovering people, and the community at large.

It is easy for organizations providing recovery support services to make assumptions about ethical behavior and misbehavior that turn out to be disastrously wrong. Let's consider five such assumptions to open our discussion.

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 isolated errors in judgment, particularly when we find ourselves isolated in situations unlike any we have faced before.

Assumption 2: *People hired as recovery coaches will have common sense.*

Fact: "Common sense" means that people share a body of historically shared experience that would allow a reasonable prediction of what they would do in a particular situation. The diversity of cultural backgrounds and life experiences of people working as recovery coaches provides no such common foundation, and behavior that is common sense in one cultural context might constitute an ethical breach in another.

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

Fact: Most breaches in ethical conduct within the health and human service arena are made by good people who often didn't even know they were in territory that required ethical decision-making. Protecting recipients of recovery support services requires far more than excluding and extruding "bad people." It requires heightening the ethical sensitivities and ethical decision-making abilities of good people.

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

Fact: The problem with this assumption is that what is legal and what is ethical do not always coincide. There are many breaches of ethical conduct about which the law is silent, and there could even be extreme situations in which to do what is legally mandated would constitute a breach of ethical conduct resulting in harm or injury to the service recipient. 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 counselors) can be indiscriminately applied to the role of recovery coach.*

Fact: There are considerable areas of overlap between ethical guidelines for various helping roles, but ethical standards governing clinical work do not uniformly apply to the RC role. This potential incongruence is due primarily to the nature of the RC service relationship (e.g., less hierarchical, more sustained, broader in its focus on non-clinical recovery support service needs) and in its delivery in a broader range of service delivery sites.

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 the RC role span both paid and voluntary roles. The question recovery support organizations are now wrestling with is whether volunteer and paid RCs 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 okay.*

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 recognize ethical issues that are arising or his or her failure to bring those issues up for fear it will reflect negatively on their performance. The latter is a particular problem where supervision is minimal or of a punitive nature. The best recovery coaches regularly bring ethical issues up for consultation and 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 and ethical guidelines for recovery support specialists, we sought to look not beyond the recovery community but within the history of American communities of recovery, from traditional Twelve Step communities to religious and secular recovery communities. Two conclusions were drawn from that exercise. First, we noted the importance of group conscience within the history of particular communities of recovery and that judgments of behavior would likely differ across these recovery communities. That suggested to us the importance of establishing a local council of persons in recovery representing diverse recovery experiences that could offer collective guidance on ethical issues as they arise. Second, we looked across recovery traditions (religious, spiritual, and secular) and within the collective experience of organizations providing recovery support services and found a set of core values shared across these organizations. We felt these values could provide a helpful filter for ethical decision-making and that it was important to evaluate actions of the recovery coach by these shared values rather than the values of any one recovery community. These core values and the obligations we felt they imposed on those providing recovery support services are listed below.

- Gratitude & 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 and the role from which you are speaking.
- 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 and pathology.

- Dignity and Respect

--Express compassion; Accept imperfection; Honor each person's potential.

- Tolerance

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

- Autonomy & 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.

- Stewardship

--Use resources wisely.

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 an aid in determining the best course of action that one could take in that situation. We propose that those providing recovery support services ask three questions to guide their decision-making.

Question 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 parties listed in the table below and determining the potential and severity of injury to each. Where multiple parties are at risk of moderate or significant harm, it is best not to make the decision alone but to seek consultation with others given the potential repercussions of the situation.

Vulnerable Party	Significant Risk of Harm (√)	Moderate Risk of Harm (√)	Minimal Risk of Harm (√)
Individual/Family Being Served			
Recovery Coach			
Service Organization			
Recovery Support Services Field			
Image of Recovery Community			
Community at Large			

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

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

In the next section, we will explore a wide variety of ethical dilemmas that can arise in the context of delivering recovery support services and illustrate how this three-question model can be used to enhance decision-making.

X	Core Recovery Value	Suggested Course of Action
	Gratitude & Service	
	Recovery	
	Use of Self	
	Capability	
	Honesty	
	Authenticity of Voice	
	Fidelity	
	Humility	
	Loyalty	
	Hope	
	Dignity and Respect	
	Tolerance	
	Autonomy & Choice	
	Discretion	
	Protection	
	Advocacy	
	Stewardship	

Ethical Arenas

Ethical issues can crop up in a number of arenas related to the delivery of peer-based recovery support services. In this section, we will present and discuss case vignettes to highlight such issues within four arenas: 1) service context, 2) personal conduct of the recovery coach, 3) conduct in service relationships, 4) conduct in relationships with other service providers, and 5) conduct in relationships with local recovery communities. The vignettes and discussion were developed in consultation with the PRO-ACT Ethics Workgroup and other organizations delivering recovery support services. The responses to the vignettes are not intended to generate rules for behavior; they are intended to convey the evolving sensitivities on key ethical issues within the growing recovery support services movement.

Service Context

Exploitation of Service Ethic: Agency ABC visibly promotes itself as providing peer-based recovery support services, but their reputation is being hurt by key practice decisions.

____ ABC hires people as recovery coaches who have minimal sobriety time.

The legitimacy of each RC is derived from experiential knowledge and experiential expertise. Where there is no or little experience, there is no legitimacy. Recovery coaches should be hired who have established a personal program of recovery marked by duration and quality. Minimum recovery requirements for recovery coaches are currently ranging from one to two years, with many recovery coaches possessing more than five years of continuous recovery. This minimum requirement is for the protection of those receiving and for the persons and organizations providing recovery support services.

____ ABC does little to orient, train, or supervise their recovery coaches.

Failure to provide the RC with the needed orientation, training, and supervision affects their capabilities, their credibility, and the safety of the RC and the person receiving recovery support services. The quality of screening, training, intense initial supervision, and ongoing supervision constitute the foundation for the delivery of effective and ethical recovery support services. The delivery of RC services, particularly volunteer-based RC services, requires more supervision than clinical services provided within an addiction treatment context because non-clinical recovery support services often lack some of the mechanisms of protection built into the delivery of treatment services, e.g., prolonged training and credentialing, a formal informed consent process, office-based service delivery. Developing clear policies governing the delivery of recovery support services and establishing monitoring procedures to oversee the delivery of those services also can help assure that the delivery of RC services will be covered within the sponsoring organization's liability/malpractice insurance.

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

This practice constitutes a form of financial exploitation of recovering people that contributes to RC burnout, high RC turnover, and erosion in the quality of recovery support services. Adequate support for volunteers, adequate salaries, advancement opportunities for RCs in paid roles, and setting limits on hours

worked for both volunteers and paid support specialists are crucial in sustaining the quality of peer-based recovery support services.

___ ABC assigns volunteer recovery coaches to perform counselor functions and then bills for these services.

This practice is a breach of ethical principles (honesty & fidelity), a breach of law, and a practice that violates the integrity of both the counselor role and the RC role. RCs are not cost free labor; substantial expense should be incurred in the infrastructure to support volunteer recovery coaches via recruitment, screening, selection, orientation, ongoing training, ongoing supervision and events celebrating the service work of RC volunteers.

___ ABC assigns recovery coaches to work in isolation delivering home-based services in drug and crime saturated neighborhoods.

RCs assigned to home-based services, particularly those delivering pre-treatment engagement and support (outreach) services need elevated supports to counter the particular stressors inherent in this role. Such supports include special training related to safety management, team-based service delivery (cocoaching), technical supports (cell phones, two-way radios), neutral sites to meeting in high risk neighborhoods, etc.

___ ABC uses recovery coaches almost exclusively to recruit clients into treatment.

This practice, when it involves using the RC role to “fill beds” or outpatient “slots,” constitutes an exploitation of the RC role for the financial benefit of the organization. It reflects poor stewardship of the RC resource by displacing the recovery support needs of clients for the financial interests of the organization.

Screening Practices: DEF is a grassroots recovery advocacy organization that provides recovery coaching services through a cadre of volunteers from the recovery community. Today, a man notorious for his predatory targeting of young women entering NA arrives at DEF announcing 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 hiring agency and its service constituents. This protection function must be assured at the same time the agency practices standards of fairness in their selection procedures, e.g., not excluding someone based only on second-hand gossip. Selection for RC roles is unique in that a past addiction-related felony conviction (followed by a long and stable recovery career) might be viewed as more a credential than grounds for disqualification. On the other hand, a history of and reputation for exploitive behavior within the recovery community could be grounds for disqualification. The purpose of such disqualification would be the protection of service recipients and the protection of the reputation of the recovery support organization, e.g., assuring that people will feel safe and comfortable seeking services at the organization. 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 bestows credibility that no university can grant. It is

bestowed only on those who offer sustained living proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes not from their preparation but from their character, relationships and performance within the community. (p. 69)

The community will can withhold as well as bestow the credential of experiential expertise, and it can grant such expertise with conditions, e.g., using the individual in the above role as a closely supervised RC, but only with men.

Personal/Service Conduct

Self-Care: Jerome brings great passion to his role as an RC, 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? What is the nexus between such private behaviors and Jerome's performance as an RC?

Private behavior of the RC is just that—private, UNTIL there is an inextricable nexus (link) between private behavior and one's performance as an RC. In this case, Jerome's poor self-care does potentially impact his effectiveness as an RC. The expectation here is not one of perfection, but one of reasonable congruence between one's espoused values and the life one is living. In this case, Jerome is modeling potentially lethal behaviors that those he coaches may well integrate into their own lifestyles, e.g., "It is okay for me to smoke because Jerome smokes." Part of the job of the RC 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 emulate. Our ability to achieve that is enhanced by self-care training that is built into the overall RC orientation and training program.

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 in the service arena. All of us undergo developmental windows of vulnerability that require focused self-care and temporarily diminish our capacities for service to others. Mary and her supervisor need to consider what would be best for her, for those she coaches, and for the agency. One option is for Mary to decrease her hours or number of people served 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 periodic difficulties do not spill into the lives of those we are committed to helping.

Lapse: Ricardo, who has worked as an RC for more than a year, experienced a short lapse while attending an out-of-town wedding. Because the lapse was of such short duration, Ricardo plans not to disclose the relapse to the organization through which he provides RC services. What ethical issues are

raised by this situation? What should Ricardo do? What should be the organization's/supervisor's response if this situation is brought to their attention? What organizational 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, primacy of recovery. All of these values suggest a course of action that would begin with Ricardo's disclosure of the lapse to his supervisor and focusing on reestablishing the stability and quality of his personal recovery program. The organization should rigorously follow the guidelines/protocols it has established to respond to such an event. Options might include Ricardo taking a break from his RC responsibilities, performing activities that do not involve direct coaching responsibilities, and later phasing back into RC responsibilities via co-coaching and more intensive supervision.

Personal Bias: Zia has many assets that would qualify her as an excellent RC, but in interviewing her for an RC position, you are concerned about one potential problem. Zia passionately believes that AA's Twelve Step program is the ONLY viable framework of long-term addiction recovery, and she expresses considerable disdain for alternatives to AA. What ethical issues could arise if Zia brought her biases in this area into her functioning as an RC?

The core value of tolerance asserts the legitimacy of and respect for diverse pathways and styles of long-term recovery. Bill Wilson (1944) was one of the first advocates of such diversity. If Zia cannot develop such tolerance, she may be better suited to the service role of sponsor within a Twelve Step program than the role of RC that works with multiple programs of recovery. The same principle would apply to those using recovery programs other than the Twelve Steps who believe there is only one true way to recovery. What we know from research on recovery is that ALL programs 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: Barry's supervisor has assigned a new contact for Barry to visit in his RC role. Barry recognizes the name as a person to whom Barry once sold drugs in his earlier addicted life. Who could be harmed in this situation? What should Barry do? Does Barry have a responsibility to report this pre-existing relationship to the supervisor?

Multiple parties are potentially at risk here: Barry, his contact, the contact's family, and Barry's agency. Barry should disclose the relationship and request another assignment. If the alternative is Barry or no service (e.g., a situation where Barry might be the only recovery coach in a community), Barry and his supervisor should explore additional options or explore how these RC services could be provided while minimizing harm to all parties. The most critical factor here is maximizing the comfort and safety of the individual/family receiving services. It is best if RCs are expected to immediately declare the existence of any pre-existing relationship with those to whom they have been assigned.

Use of Information across Roles: Rebecca is a natural listener. Everyone talks to her—in her RC role and outside her RC 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 recognizes 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 an RC? How should she handle this situation?

This vignette generated considerable disagreement among the recovery support agency 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 one’s RC activities) is fraught with potential harm and should be brought into supervisory discussion before such information is used in this manner.

Advocacy: Many RCs are also involved in recovery advocacy activities in their local communities. Are there any situations that could arise in one’s advocacy role that could conflict with one’s role as an RC? 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 minimal conflict in these roles. Conflicts could arise if the recovery advocate/coach:

- *Used the RC context to zealously recruit those they coached into advocacy activities,*
- *Used the RC role to push particular ideological propositions, or*
- *Took such extreme, controversial positions that individuals and families were not comfortable having the individual serve as their RC. Such potential conflicts are best processed with one’s supervisor.*

Conflict of Interests: Raphael works as a recovery coach and also owns a recovery home. In his RC role, Raphael frequently encounters people who need sober housing. What ethical issues could arise from Raphael referring people to the recovery home that he owns? How could Raphael best handle any real or perceived conflicts of interest? What organizational policies address the issue of conflicts of interest?

Referring clients to his own recovery home raises potential conflicts between the client’s best interests and Raphael’s own financial interests. Even the PERCEPTION of bias relating to this linkage process could injure Raphael’s reputation as an RC and the reputation of the organization for which Raphael is working. Raphael would be better advised to refer his clients to other recovery homes or to offer a list of all available resources without any accompanying interventions that would direct individuals to his own facility. In addition, Raphael may want to assign a “manager” to do all screening for potential residents to his home, so he not only doesn’t refer his own clients, but also doesn’t make decisions related to their entrance. At a minimum, Raphael will want to make sure that those 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: Marcella is in long-term recovery and works as a volunteer recovery coach and also works full time as a certified addictions counselor. What problems could be posed by Marcella bringing the clinical orientation from her counselor role into her volunteer role as a recovery coach? How can the organization/supervisor

help “counselors as peers” relinquish their clinical orientation?

The potential problems in this situation are numerous. First, if Marcella drifted into her counseling role as a volunteer, she would be providing counseling without the client protections and supports built into traditional treatment agencies, e.g., informed consent, legal confidentiality, clinical documentation, clinical supervision, and agency liability insurance. Assuming Marcella’s client is still in treatment, the therapy Marcella provides may be counterproductive to the therapy the client is already receiving. And perhaps most importantly: during the time Marcella is doing counseling, the client is not receiving needed recovery support services.

Compassion Fatigue: Elizabeth has volunteered as an RC 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 diminished motivation for recovery coaching?

The danger here is a process of emotional and physical disengagement that could do a great disservice to those in need of recovery support services. Elizabeth is exhibiting signs of burnout, which need to be acknowledged and addressed in supervision. Elizabeth may need a break in her coaching activities, might consider reducing hours or 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 from this service work, but they also have a responsibility to recognize this need early enough to plan an orderly transition or termination process for those with whom they are working. Not disengaging when they need to and precipitous disengagement both present potentials of harm to those receiving recovery support services.

Conduct in Service Relationships

Choice/Autonomy: Charise works as a recovery coach in a women’s program that is known for its assertive, some would say aggressive, style of outreach to women referred from the child welfare system. The women Charise attempts to engage in treatment and recovery support services 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 reconcile a person’s right to choose with the knowledge that volitional will is compromised if not destroyed through the process of addiction?

The ethical tension here is between the values of autonomy and choice versus paternalism and outright domination. What complicates resolving this tension is working with people who by definition (addiction) have compromised capacities for free choice, leaving the RC 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 wants to get high? The answer is that we recognize that addiction is a disease of the will and that recovery involves a progressive rehabilitation of the will. The RC’s job—particularly in the outreach function—is to jumpstart 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 disengage with the assurance that we will be available in the future if the person should CHOOSE to call us. The proposition that recovery is voluntary means not only freedom to choose different pathways of recovery but also the freedom to choose not to recover.

Choice/Autonomy: Roberto has been assigned as a recovery coach for Oscar, but four weeks into this process, Oscar requests a change in recovery coaches on the grounds that he is having difficulty relating to Roberto. Do those receiving RC services have the right to select their own recovery coach?

Mismatches in the assignment of recovery coaches are inevitable, just as mismatches occur in the assignment of counselors. A match between a recovery coach and those with whom they serve may be even more important because of the increased time spent together and the potential duration of the relationship. Occasional mismatches are best acknowledged early and either resolved via alterations in coaching style or reassignment of a new recovery coach. The affects of recovery coaching result from personal influence, not from any power or authority ascribed to the role. An essential principle of peer-based recovery support services is that those receiving the service get to ultimately define who qualifies as a “peer.” Evaluating and resolving potential mismatches is an integral part of good supervision. It is important that RCs be supported through these situations.

Emotional Exploitation: John is a highly sought out RC. He is charismatic and unrelenting in his support activities. As his supervisor, you have one area of concern about John: he is emotionally possessive of those he works with, hypercritical of other service providers who don't live up to his standards, and competitive with the sponsors of those he coaches. Many of those John serves do very well in their recovery, but they seem to see the source of their recovery as John more than a program of recovery. You are troubled that those John works with seem to have developed an excessive 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. The style described above, by cultivating dependence and emotionally rewarding crises, actually weakens people's future capacities for self-sustained recovery. Those served end up feeling progressively better about John, but worse about themselves. Such a style may meet John's needs, but ill-serves those he coaches. Such styles harm clients, overshadow other RCs who may be doing much more effective service work, and often end up harming the community agency's credibility in the long run. A degree of dependence is normal early in the RC relationship, but such dependence is best transferred to development of a larger and more sustainable sobriety-based support network.

Friendship: Raymond volunteers as a recovery coach for a recovery community organization (a freestanding organization unaffiliated with any treatment organization that provides recovery support services). Raymond shares a lot in common with Barry, a person to whom Raymond has been assigned to serve as a recovery coach. Over a period of months, Raymond and Barry have developed quite a friendship and now share some social activities (e.g., fishing) beyond the hours in which Raymond serves as Barry's recovery coach. Are there any ethical issues raised by this friendship?

Friendships may develop within the context of recovery coaching, but there is one thing that distinguishes the recovery coach relationship from other social relationships, and that is the service dimension of that relationship. This means that recovery coaching relationships are not fully reciprocal, whereas friendships are. The RC has pledged that the focus of the RC relationship is on

the needs of the person being coached. In that light, ethical problems could arise if: 1) the friendship was initiated by Raymond to meet his needs and not Barry's needs, 2) problems in the friendship interfered with Raymond's ability to provide effective coaching services, or 3) the friendship with Raymond prevents Barry from developing other sobriety-supportive relationships within the recovery community and the larger community. RC relationships will, by definition, be less hierarchical and more reciprocal than will relationships between an addiction counselor and his or her client. It's not that one boundary demarcation is right and the other is wrong; it's that boundaries are maintained that are role-appropriate. In other arenas of peer-based services, their effectiveness has been attributed in great part to the lack of professional detachment and distance (Fox & Hilton, 1994). Where a developing friendship is getting in the way of effective RC services, it is the responsibility of the RC to raise this concern with his or her supervisor, and to potentially review this situation with the RC, the supervisor, and the client. One potential option is to assign and transition the client to another RC to avoid potential problems with a dual relationship.

Sexual Exploitation: You supervise recovery coaches for a local recovery advocacy and support organization. It comes to your attention that Joshua, one of your RCs, is sexually involved with a person to whom he is delivering recovery support services. What are the ethical issues involved in this situation? How would these issues differ depending on: 1) age or degree of impairment of the person receiving services? 2) whether this was a person currently receiving or a person who had previously received recovery support services? 3) the time that had passed since the service relationship was terminated? Would you view this situation differently if the relationship was not with the primary "client" but with a family member or friend who was involved in the service process? Could the recovery coach or the agency face any regulatory or legal liabilities related to this relationship?

The RC service relationship is not a relationship of equal power. The vulnerability of those seeking RC services and the power of the RC role offer situations where an RC could exploit service relationships for his or her personal, emotional, sexual, or financial gain. It is that power discrepancy that makes an intimate relationship between an RC and those they work with ethically inappropriate. The harm that can come from such relationships spans injury to the person/family being served (emotional trauma, severance of services, resistance to seeking future services), injury to the reputation of the RC and damage to the reputation and financial solvency of the service organization (via litigation against the organization for improper hiring, training, supervision, etc.). The prohibition against intimate relationships between an RC and service recipient extends to the family and intimate social network of the person being coached who are involved in the service process. As for relationships with persons who previously received RC services, agencies are defining a period of time (mostly in the two year range) in which such relationships would still be improper. The key here is to evaluate situations that might arise based on the issue of exploitive intent. For example, an RC could be involved with an individual he or she met within the recovery community who they discover once received RC services from the RC's organization. The RC did not work at the organization at the time, never served as the person's RC, had no knowledge of the person's status as a service recipient, and did not use the influence of their RC role and organizational affiliation to initiate the intimate relationship. In short, there was no exploitive intent.

Financial Exploitation: Alisha is providing RC services to a very socially prominent and 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 through a federal grant and are available to all local citizens without charge. It has casually come up in conversations that Alisha is saving money to begin taking courses at the local community college. When Alisha arrives for her visit today, the family announces that they have

discussed it among themselves and that they want to pay Alisha's tuition to return to college. What should Alisha consider in her response to this offer?

Money changes relationships. Accepting this gracious offer would threaten the integrity of the coaching relationship. Alisha should express her appreciation for the family's offer, but explain that she must decline because acceptance of this gift while the recovery coaching is in process could affect that relationship. The family's feelings can be further protected if Alisha can inform them that there is an agency policy that prevents any RC from accepting any gifts of substantial value. The situation might be viewed differently if some time after the service relationship was ended, this same family wanted to donate money to Alisha's education or to the service organization. The key here is that the vulnerability or gratitude of the family is not used in an exploitive manner. All offers of gifts to an RC during or following a service relationship should be discussed with the supervisor.

Gifts: Marie works as an RC in an addiction treatment unit within a local community hospital. Her job is to provide recovery support services to those discharged from addiction treatment. She serves a predominately Native American population and conducts most of her work via home visits on two reservations. When she arrives for one of her visits today, the family she is visiting presents her with an elaborate, culturally appropriate gift as a token of their appreciation for her support. The problem is that Marie works in a hospital whose personnel code prohibits any staff member from accepting a personal gift. Marie is concerned about the consequences of accepting the gift, but is also concerned that refusal of the gift could harm her relationship with the family and the tribe. What are the ethical issues here? What should Marie do?

Ethical decision-making must be culturally grounded. 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 service relationship in another. In this case, Mary could accept the gift in the name of the hospital, protecting herself from the hospital policy, and leaving the RC relationship intact. Mary could report the gift to her supervisor and display the gift in a common area of the hospital for all to enjoy. What would be equally appropriate would be for Mary to raise the broader issue of the need for more flexible interpretations of this particular policy when working in this tribal context. Ironically, a policy designed to protect patients could actually result in injury to patients, severance of the service relationship, and damage to the reputation of the service institution. RCs working across cultural contexts need policy flexibility and good supervision to protect the service relationship.

Boundaries of Competence: During a visit today with Camella, 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 ambivalent 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 RC to listen to Camella's concerns about her medication, encourage her to talk to her physician about these concerns, and link her to resources to get additional information about recovery and anti-depressant medications. It is not appropriate for the RC to offer their opinion or advice about any prescribed medication. To do so would be to move beyond the boundaries of the RC's education, training, and experience. Even if the RC was a physician volunteer, their responsibility in the RC role would be to link Camella to medical resources she could consult about this question rather than to provide that information directly. Under no circumstance

should an RC ever advise anyone to stop taking a prescribed medication. If the RC has concerns about the effects of particular medications on Camella’s recovery (e.g., prescribed sedatives or narcotic analgesics), the RC’s role is to link Camella to someone with expertise to discuss these issues, e.g. a physician trained in addiction medicine.

When to Refer: Martha has attempted to engage Rita 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 Martha acknowledge this situation to her supervisor and Rita and seek to get another recovery coach assigned to Rita?

The value of honesty dictates that Martha acknowledge to Rita and to Martha’s supervisor her concerns about the relationship difficulties, and raise the question of whether Rita would be better served with a new RC. This question should first be raised with the supervisor, and if efforts to improve the relationship fail, then a meeting between Martha, Rita, and the supervisor may be in order. The agenda is to avoid harm to Rita from a relationship mismatch, to establish an effective coaching relationship, but to also avoid any feelings of abandonment Rita might experience by the suggestion of a new RC.

Discretion: Maria serves as an RC for women and their families who are participating in a local women’s treatment program. Maria frequently hears from those she coaches, “I want to tell you something, but you can’t tell my family” or “I want to tell you something important about Jennifer, but I don’t want you to tell her I told you.” What ethical issues are raised by the RC being in the middle of such communications? How should Maria handle such communications?

Communication ground rules need to be established at the beginning of the RC relationship. The values of discretion, respect, and fidelity demand that the RC not disclose information beyond those established ground rules. Those ground rules include review of circumstances in which disclosures will be made, e.g., supervision, medical emergencies, imminent threat of harm to self or others. Before agreeing to the requested promises above, Maria should again review those communication ground rules and the disclosure exceptions.

Discretion versus Duty to Report: A person for whom you are serving as recovery coach discloses to you that he has been using the past week with another person who lives with him in a local recovery home. The disclosure makes it clear that the other person provides the drugs used and may be dealing in the home and in the larger community. Further complicating the situation is the fact that the owner of the recovery home is a member of your board of directors. Do you have an ethical responsibility to protect this disclosure or to report the content of the disclosure to the house manager or owner of the recovery home? Would a recovery coach have a similar obligation to report the presence of a “script doctor” who was pumping massive quantities of prescription opiates into 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 RC could discuss with the disclosing individual whether they thought that information should be conveyed to responsible authorities, if the individual was comfortable making such a report, or if they would want you to make such a report without disclosing his or her identity as the source. Using this process would address the threat to the recovery home environment or the community without violating the promise of confidentiality.

Threat to Community: When you arrive for a home visit with Joe Martin, a person you are coaching, you find him intoxicated. Joe says he can't talk to you right now because he has to return to the bar 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 forfeit the car keys, and let him know that if he gets in the car, you will have no recourse but to call the police. If he gets in his car and drives away, call the police informing them that you observed an intoxicated man by the name of Joe Martin get in a car and provide the vehicle description and location. Do not identify yourself in your service role and do not identify Joe as a service recipient of the organization. The challenge here is to address the threat to public safety without disclosing Joe's status as a service recipient.

Personal Bias: Fred has worked hard to educate himself about medication-assisted recovery since he was first hired as an RC, but he still has very negative feelings about methadone in spite of the research literature he has read about it. It's not a head thing; it's a gut thing. Marcy, another RC, has similarly negative feelings about explicitly religious pathways of recovery because of the number of people she has known in AA for whom religion alone did not work as a framework for recovery. Describe how the personal biases of the RC could result in harm or injury to multiple parties. How could Fred separate what he knows about methadone (the facts) from his feelings (opinions) about methadone?

As individuals, we may have all manner of biases about different addiction treatments, but in the RC role, we have a responsibility to outline the choices available to those we serve as objectively as possible and support each person's choice of the option that seems best for them at this moment. Discouragement of a particular method of treatment could prevent a client from getting the "one" treatment method that might be most successful. Fred and Mary should continue to acknowledge and discuss their biases with their supervisor. Fred and Mary 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 RCs won't credit the research findings until 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 serving as an RC for the past month, discloses to you today that she is in a sexual relationship with the counselor she is seeing at a local addiction treatment agency. The counselor is a very prominent person in the local recovery community and is very active in the state addiction counseling association. What are the ethical issues presented by this situation? How would you respond?

There are several needs raised in this situation. The first is to acknowledge to Susan that such a relationship is a breach of professional ethics, to request whether she would want a referral to a different treatment agency, and whether she wants to file a formal complaint with the state counselor certification board or seek other legal redress. Linking Susan to such resources would be a natural RC function, as would supporting Susan through this process. Depending on the policies of your agency, you may also let Susan know that you will need to report this disclosure to your supervisor who may also be bound to report it to the state certification board either with Susan's

name or without it. All reports of ethical breaches by other service professionals in the community that come to the RC's attention should be communicated to the RC's supervisor.

Representation of Credentials: Samuel works as a recovery coach doing posttreatment telephone monitoring. Samuel has represented in his interactions with the larger community that he is working as a “counselor.” He also makes periodic mention of his plans to “get back” to graduate school, but Samuel has only completed two years of college and has not been in school for more than ten years. What ethical issues are raised by this situation?

The values of honesty and credibility call upon the RC to accurately represent their education, training, and experience. The supervisor should acknowledge that he or she has heard the above reports and emphasize why it is important that, if true, these communications stop and be replaced with an accurate description of Samuel's role and educational credentials. This might well be accompanied with a broader discussion of how RCs establish credibility and legitimacy within the larger service community.

Representation of Credentials: Would you view the situation above with Samuel any differently if he accurately represented his role and education, but misrepresented the length of his own recovery and his degree of current involvement in AA, NA, or another recovery mutual aid group?

No, both would undermine his capability and credibility as an RC. The value of authenticity of voice is paramount here. The following guideline is recommended: “Filter decisions related to disclosure of your ATOD use 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 RC for the past two months. Today, Larry asks George if George would be his NA sponsor. George has a long history in NA and a long history of sponsorship activities, but agreeing to this arrangement would mean that he would be both Larry's RC and sponsor. What harm and injury (if any) and to whom could result from such a dual relationship?

Failure to maintain boundary separation between the roles of RC and sponsor could harm Larry, George, others receiving RC services, the relationship between George's organization 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) on time one is working as an RC is a violation of Twelve Step Traditions and professionally inappropriate (beyond the scope of most agencies' RC job descriptions and explicitly prohibited in many).*
- 2. Performing sponsorship functions through the RC role could weaken local sponsorship practices and diminish community recovery support resources by replacing such natural support with the formal support of local treatment agencies.*
- 3. Seeking reimbursement for sponsorship functions performed by a recovery coach is, at best, a poor stewardship of community resources and, at worst, fraud.*

4. *Role ambiguity and conflict resulting from a mixing of sponsorship and RC functions could inflict injury on clients/families, service workers, service agencies, and the community.*
5. *The RC role represents a form of connecting tissue between professional systems of care and indigenous communities of recovery and between professional helpers and sponsors; when those filling this role abandon this middle ground and move too far one direction or the other, that connecting function is lost.*

Conduct in Relationships with Local Communities of Recovery

Role Clarity/Integrity: George, who is a salaried RC, has a practice of linking those he coaches to recovery communities by taking them to and participating with them in particular recovery support meetings. A complaint has come to the agency about George “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 George more clearly delineate his paid activity from his NA service work?

The values of stewardship require that the RC carefully allocate their time. George should be careful to separate RC hours from hours spent in recovery support meetings so as not to receive payment for meeting time. The RC function stops at the doorway of recovery support meetings: George should introduce his client to other recovery support group members and “hand him off” for 12 stepping.

Discretion: You are working as a recovery coach attached to a treatment agency. You take an assigned client, Troy, to a local recovery support meeting and also stay for the meeting. At the meeting, Troy discloses information that he has not told his counselor at the treatment program. Is this information you have heard confidential or do you have an obligation to report it to the counselor?

The information disclosed at the meeting may not be revealed outside the meeting. To do so would violate recovery mutual aid values and place the RC in the role of “undercover agent” at such meetings. You could encourage Troy to go to take the information to his counselor. This is another example of the strong need for ongoing supervision and support to help the RC deal with complex issues regarding his or her role.

Discretion: Claude has been in and out of treatment and NA multiple times and has an off and on again relationship with you as a recovery coach. Today, you run into Rudy, one of Claude’s former NA sponsors with whom you collaborated, in the mall. Rudy’s first comment to you is, “How’s our boy 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 prohibit any disclosure to Rudy’s question) extend to the recovery coach relationship?

If you are in an organization (e.g., treatment agency) covered by federal confidentiality regulations, you may not respond to that question or even acknowledge that Claude is a client at your organization unless you had a signed release to talk to Rudy about Claude. If you are in an organization not covered by federal confidentiality regulations (e.g. a freestanding recovery support organization, a recovery ministry within a church, etc.), your response should be guided by your policies on confidentiality and discretion and the agreement about permitted disclosures of communications negotiated with Claude at the beginning of the RC relationship. The key thing here is the value of fidelity: to keep our promises.

Anonymity: Ernest is a long-time AA member, recovery advocate, and recently hired recovery coach. In his earlier recovery advocacy work, Ernest has always been very careful in identifying himself publicly as a “person in long-term recovery” without noting his AA affiliation. Today, Ernest is on a panel at a local social service 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 Ernest after the panel. One of the reporters follows up Ernest’s report of his recovery status and its duration with the question, “Are you a member of AA?” What are the ethical issues involved in this situation? How should Ernest respond? How would this be different if Ernest was in an alternative recovery support group that did not have a tradition of anonymity?

Ernest should NOT disclose his membership to AA. This would violate AA’s anonymity tradition as well as be potentially viewed as a personal endorsement of a particular mutual aid group. Such a disclosure and the potential controversy spawned by it could interfere with Ernest’s service relationships, isolate Ernest from the local AA community, and harm the relationship between Ernest’s organization and the local AA community. If Ernest was not in AA or another Twelve Step program, there would be no explicit anonymity guideline, but Ernest would still need to be cautious in any disclosures at the level of press.

Predatory Behavior: Felicia works as a recovery coach for women who are just entering intensive outpatient treatment and who are living in a women’s recovery home. One of Felicia’s responsibilities includes linking these women to local recovery mutual aid meetings. Many of the women Felicia works with have histories of sexual victimization as well as long histories of toxic intimate relationships. Felicia is aware that predatory behavior (“Thirteenth Stepping”) is common in some local recovery meetings. To what extent is Felicia responsible for preparing the women she refers for such behavior or protecting them via linking them to meetings with a strong group conscience?

Felicia needs to honor 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 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 recovery advocacy agency. 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. Ideas should also be solicited from Ellen about how the recovery coach role could be designed and supervised to assure that it enhances rather than undermines the service ethic within the local AA community.

Role Integrity: Mel is an elder statesman in AA who offers to volunteer as a recovery coach. Mel’s orientation 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 RC and sponsor roles would come from the broader recovery support needs (e.g., sober housing, medical needs, transportation, day care, etc.) that would be

addressed in the fully developed RC role but not addressed in the RC as sponsor role. Harm to the client could also result from the role confusion between the RC and sponsor roles.

Summary

This essay has described a model of ethical decision-making for recovery coaches and their supervisors and identified some of the emerging ethical issues in the delivery of peer-based recovery support services. Ethical sensitivities and approaches to ethical decision-making will continue to evolve as recovery support services become more formalized and the collective experience of recovery coaches and their sponsoring organizations grows. This growing foundation of experience will spawn formal ethical guidelines for recovery coaches and more formal approaches to ethical decision-making. PRO-ACT has created a peer services ethics advisory panel and a set of ethical guidelines for its peer specialists that we expect will become more refined in the coming years. We have included a description of the advisory panel and these guidelines as appendices to this paper.

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Appendices

A. Ethical Decision-making Worksheet

B. PRO-ACT Peer Specialist Code of Ethics

C. The Law and Peer-Based Recovery Support Services Prepared by: Renée Popovits and Elizabeth Donohue

Ethical Decision-making Worksheet

Vulnerable Party	Significant Risk of Harm (√)	Moderate Risk of Harm (√)	Minimal Risk of Harm (√)
Individual/Family Being Served			
Recovery Coach			
Service Organization			
Recovery Support Services Field			
Image of Recovery Community			
Community at Large			

Step One: Who is vulnerable for harm in this situation and what is the degree of such harm?

Step Two: What core recovery values apply to this situation and what action would they suggest be taken?

___ Gratitude & 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). ___ 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 and role). ___ 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 living proof; Focus on the positive). ___ Dignity and Respect (Express compassion; Accept imperfection; Honor potential). ___ Tolerance ("The roads to recovery are many.")(Wilson, 1944) ___ Autonomy & Choice (Recovery is voluntary; it must be chosen). ___ Discretion (Respect privacy; don't gossip). ___ Protection (Do no harm to and protect self and others; Avoid conflicts of interest). ___ Advocacy (Challenge injustice; be a voice for the voiceless; empower others). ___ Stewardship (Use resources wisely).

Step Three: What laws, standards or historical practices could guide our conduct in this situation?

Step Four: Where risk of injury is great 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:

PRO-ACT *Peer Specialist/Recovery Coach Principles and Guidelines

Preamble

PRO-ACT acknowledges its duty and obligation to those individuals, families, and communities it serves to assure the delivery of peer support according to recovery-focused guidelines, principles and values. Toward that end, we have: **1)** defined a code of conduct within a value driven decision-making process that will guide delivery of our services and our service relationships; **2)** developed a Peer Specialist Review Panel; **3)** established ethical guidelines for the delivery of peer-based recovery support services provided through PRO-ACT; and **4)** outlined the process for recruiting and screening of potential peer specialists, training requirements both initial and ongoing, ongoing support, and supervision.

Value Oriented Decision-making Process

All PRO-ACT staff and volunteers shall follow the recovery guidelines and principles when making decisions involving complex choices, choices in which one or more parties could be injured by what we do or fail to do. They will develop the ability to recognize an ethical dilemma using the PRO-ACT decision-making questions to clarify their choices.

1. Recognize when a situation arises that is a value related issue.
2. Use the PRO-ACT value driven decision making questions to clarify your choices.
3. Seek consultation from supervisor and consider guidance from the Peer Specialist Panel to make the best possible decision.
4. Communicate what you did, your rationale for what you did, and the outcome of the decision to your supervisor for purposes of review and documentation.
5. Debrief the experience with others at PRO-ACT to enhance the sensitivities and ethical decision-making abilities of others.

Principle Decision-making Questions

All PRO-ACT staff and volunteers shall answer three questions as part of their process of ethical decision-making:

1. Who has the potential of being harmed in this situation and how great is the risk for harm?
2. Are there any core recovery values that apply to this situation and what course of action would these values suggest be taken?
3. What laws, organizational policies, or ethical standards apply to this situation, and what actions would they suggest or dictate?

Peer Specialist Panel

The Peer Specialist Panel consists of three to five individuals who volunteer their talents and time to assist PRO-ACT in analyzing and responding to complex value related questions or dilemmas. This committee/panel will be made up of individuals in long-term recovery (with more than four years continuous recovery) who are widely known in the recovery community for their personal integrity, who can analyze and respond to complex principle dilemmas, and offer guidance in a timely and consistent manner when complex value issues arise.

Each panel member serves a yearly term that may be extended by mutual agreement between each panel member and PRO-ACT. The Panel must meet on a routine basis to set up their operational guidelines and to also be available in a timely fashion to respond to Peer Specialist complex principle or guideline dilemmas.

The Peer Specialist Review Panel will have input into the continuing education and training requirements of peer specialists based in part on the principle and guideline dilemmas that are presented to assure a continuous learning process is available for all parties.

All proceedings of the Peer Specialist Panel shall be recorded by the chair of the panel and records of these meetings shall be kept for at least five years in confidential locked files.

Process for Recruiting, Screening, Training, and Supervision needs of Peer Specialists

PRO-ACT will use non discriminatory practices to recruit members of the Recovery Community representing a broad spectrum of recovery pathways. PRO-ACT will screen all applicants in order to assure the safety of all involved. All Peer Specialists and their supervisors are required to attend initial and ongoing trainings to enhance their job performance. PRO-ACT will develop trainings to enhance the various skills required, and will also focus on creating trainings to enhance Peer Specialists' cultural sensitivity and other issues of importance to the Recovery Community. PRO-ACT will provide opportunities to share and discuss complex principle or guideline dilemmas.

*In this document the titles Recovery Mentor, Peer Specialist, and Recovery Coach are interchangeable. For brevity, the Peer Specialist terminology will be utilized.

PRO-ACT Principles and Guidelines for Peer Specialists

As a Peer Specialist, I understand that my sole mission is to help individuals and families recover from addiction and its related problems. To that end, I will help remove or overcome all obstacles to recovery and help each individual and family find resources within and beyond themselves to both initiate and sustain the recovery process. My actions will be guided by the following core recovery values and service guidelines.

Gratitude & Service

I understand that my service to others is a sacred trust and that my actions flow from myself, from PRO-ACT, and from the larger recovery community. I offer my experience, strength, and hope to assist others in recovery out of gratitude to those who assisted me in my recovery.

Personal Recovery

I will work on my recovery so that I may be beneficial to those who depend on me for recovery support.

Face and Voice of Recovery

I will be a good example of recovery for those I serve.

Self –Improvement

I will foster self-improvement.

Honesty

I will tell the truth and when wrong, I will promptly admit it.

Authenticity

I will carry the recovery message in word and in deed.

Keeping Promises

I promise to keep my promises.

Humility

I will work within my limitations, handle disagreements respectfully, and seek help when I need it.

Loyalty

I will serve others as others served me and promote the recovery mission of PROACT.

Hope

I will help others focus on their assets, strengths, and recovery possibilities.

Respect

I will honor the imperfections of others and myself and treat those seeking recovery with dignity.

Acceptance

I accept all pathways to recovery however diverse, even those opposite my own.

Recovery Integrity

I can carry the message, but I cannot carry the person. I help others by empowering the recovery of others.

Protection

I do no harm by respecting privacy and refraining from gossip. I avoid all forms of exploitation or harassment of those I serve. Our relationship is a sanctuary of safety.

Advocacy

I confront injustice when necessary on behalf of those who have not been empowered but never do for others what they can do for themselves.

Stewardship

I use or create resources in the wisest way possible to provide benefits others need to achieve recovery.

ADDENDUM

The Law and Peer-Based Recovery Support Services

Prepared by: Renée Popovits and Elizabeth Donohue

OVERVIEW

While the peer-based recovery support services trend within the addiction treatment community is not new, these services have rapidly expanded in recent years under various names, such as recovery coaches, recovery mentors and peer specialists. Furthermore, these roles do not fit neatly within the “traditional” addiction treatment field, and little guidance can be found concerning the complex ethical and legal issues that arise when providing peer recovery support services.

Since this is uncharted territory, we have created this Addendum with the goal of providing a brief analysis of some common legal issues that addiction treatment providers address daily, and how these issues may or may not affect those providing peer recovery support services. Specifically, this article addresses the following issues:

- The application of 42 C.F.R. Part 2
- The application of the Health Insurance Portability and Accountability Act (HIPAA)
- Mandatory Child Abuse Reporting
- Informed Consent
- Organizational Liability

FEDERAL CONFIDENTIALITY CONSIDERATIONS

Confidentiality protections exist to encourage people to seek treatment for addiction to alcohol or other drugs or a mental illness. Mental health confidentiality is generally governed by state law as well as the federal HIPAA Privacy Standards. On the other hand, addiction treatment programs meeting certain criteria are governed by very stringent federal regulations (42 C.F.R. Part 2), which, in most cases, are far more protective of patient confidentiality than the HIPAA Privacy Standards.

Several providers furnishing recovery support services have questioned whether 42 C.F.R. Part 2 (“Part 2”) applies to such services. To assist in determining the applicability of Part 2 to recovery support services, this article includes a decision making diagram contained in Exhibit A. The key questions a recovery support provider needs to consider are:

- Is the service a federally assisted “program” or part of a program within the meaning of Part 2?
- Is the service rendered by an employee or a volunteer of a “program”?
- Has a “program” contracted with a Recovery Support Specialist to render services as part of its continuing care?
- Is the person to whom you are providing recovery support services a “patient” within the meaning of Part 2?
- What are the services furnished by the Recovery Support Specialist, and are these services covered by Part 2?
- Do you receive or have access to “patient identifying information” protected by Part 2?

These questions are explored more fully below.

Are You A Federally Assisted Program?

The first legal consideration is the obligation to comply with the confidentiality restrictions imposed under federal law and regulations (42 U.S.C 290dd and 42 C.F.R. Part 2, respectively). The federal regulations prohibit “federally assisted substance abuse treatment programs” from communicating patient identifying information unless the regulations expressly authorize such disclosures for the purpose of treating substance use disorders, making a diagnosis for that treatment, or making a referral. A “federally assisted substance abuse program” is defined as an addiction treatment program that is:

- 1 Conducted in whole or in part by any department or agency of the United States;
- 2 Is carried out under a license, certification or registration or other authorization including certification under the Medicare program; authorization to conduct methadone maintenance treatment; or registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of addiction;
- 3 Is supported by funds provided by any department or agency of the United States, including receipt of Federal financial assistance in any form including assistance from the State or a local government unit who in turn receives Federal funds that could be used for addiction treatment; or
- 4 Is an IRS tax-exempt entity.

Federally assisted programs, as used in Part 2, includes programs funded by the federal government, as well as programs conducted under a license, certification, registration, or other authorization granted by any federal department or agency, including Medicare certification or authorization to conduct methadone maintenance treatment. Federal assistance also includes tax exemption granted by the IRS. Even if the program does not meet the definition of a federally assisted program, state law or state licensure regulations may require adherence to Part 2. This is because states can impose the same or more stringent requirements than Part 2. For instance, in Illinois, recovery homes have to comply with Part 2 via the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse licensure regulations. If this state licensure mandate did not exist, recovery homes would not be subject to Part 2 because they do not provide treatment services within the meaning of Part 2.

Are You An Employee of a Federally Assisted Program?

If the program meets the definition of a “federally assisted substance abuse program”, then the individual who is providing peer recovery support services through the covered program must also decide whether they would be considered an employee of the program for the purposes of Part 2, and would therefore need to comply with these regulations. Generally, if the Recovery Support Specialist is employed directly by the program and is receiving reimbursement by the program for the services they provide, they would be considered an employee. This applies even though a Recovery Support Specialist is not providing direct addiction treatment services to clients. If the Recovery Support Specialist is an employee, and has access to protected information through their work, in whatever capacity, with the program, then the Specialist must comply with Part 2 (see 42 C.F.R. 2.12).

Do You Have A Contractual Relationship With A Program?

However, if the Specialist is not directly employed or affiliated with the program, but provides services to the program as part of a “continuum of care”, most often through a contractual arrangement, then the Specialist would be considered a “Qualified Service Organization” (QSO) of the program. A QSO provides contractual services to the program that includes access to information protected by Part 2. A QSO Agreement would be executed between the program and the Specialist and would contain provisions requiring the Specialist to protect the information received in the course of the work the Specialist is doing with the program.

Are You A Volunteer Of A Program?

If the Recovery Support Specialist is providing services on a strictly volunteer basis, and is receiving no reimbursement for the services they provide, then the Recovery Support Specialist must determine whether they would have access to protected information, and if they are providing services to a covered program. If the answer to these questions is yes, then the Recovery Support Specialist must comply with Part 2.

Is The Person You Are Providing Support To A Patient?

Part 2 strictly governs the disclosure of any information, whether recorded or not, that would identify a client as a person with an alcohol or other drug problem either directly or indirectly. Protection is afforded to “patients” in a program, meaning any individual who has applied for or been given diagnosis or treatment for alcohol- or other drug-related problems at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as having an alcohol- or drug-related problem in order to determine that individual’s eligibility to participate in a program.

Under Part 2, the confidentiality protections extend to “patients” in a program. Once an individual becomes a patient, all individually identifiable information about that patient is protected. Applicants for addiction treatment services are patients even if not admitted to the program. However, a person who does not show up for an appointment for an assessment to determine whether a substance-related problem exists is not a patient. Former patients and deceased patients remain protected as well.

Are You Providing Services To The Patient?

In some cases, Recovery Support Specialists will be employed by, or work with, a Recovery Community Organization (RCO) that provides non-clinical recovery support services through paid and volunteer staff and act as “drop-in centers”, service hubs and places of fellowship. Remember, Part 2 applies only to programs, and those individuals who are employed by, or affiliated with, those programs. If the RCO does not meet the definition of a covered program, then Part 2 will not apply, unless there are more stringent State licensing or funding regulations. Additionally, however, the RCO and/or the Recovery Support Specialists will need to make a determination whether the support they provide meets the definition of a “covered service” under Part 2. Some questions to be asked include:

- 1 Does the RCO provide “diagnosis” for clients? A diagnosis is defined as “any reference to an individual’s alcohol or drug abuse, or a condition which is identified as having been caused by that abuse, which is made for the purpose of treatment or referral for treatment.” However, this is not limited to assessments by medical professionals. An evaluation or assessment carried out by a counselor would be considered a “diagnosis” covered by the regulations. However, a “screen” or “prescreen” to identify individuals who may need to be referred to a specialist for a diagnosis would not be covered by Part 2.
- 2 Are targeted prevention services aimed at individuals who have been identified as having substance-related problems provided? If so, these services are covered by Part 2.
- 3 Is a referral for an individual for addiction treatment made after an assessment or diagnosis has been made? A referral for services alone is not enough to be covered by Part 2, but if the referral is made after a “diagnosis” that identifies the person as suffering from a substance use disorder, then Part 2 applies. A referral for housing, medical care, or other similar services would not trigger Part 2.

For an in-depth discussion of each type of service rendered by a Recovery Support Specialist, consult the Legal Action Center’s analysis in their newsletter *Of Substance*, entitled “Recovery Support Services – Are They Covered by the Confidentiality Regulations? Part I” (Vol. 26, No.3 May/June 2005).

Do You Have Access To Protected Information?

The drug and alcohol confidentiality regulations restrict both the disclosure and the use of information about individuals in federally assisted addiction treatment programs. 42

C.F.R. 2.3(a). Records of the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with the performance of any program or activity relating to alcohol dependence or alcohol abuse or in connection with the performance of any drug abuse prevention function, which is conducted, regulated or directly or indirectly assisted by any department or agency of the United States, must be kept confidential. 42 C.F.R. 2.12(a) and (b).

Patient identifying information is defined broadly to include any information whereby the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The Privacy Standards also protect information that identifies or could reasonably be used to identify an individual. The Privacy Standards contain many of the same “identifiers” as Part 2, as well as numerous additional identifiers which are afforded protection (i.e. client ID numbers). See the glossary for definitions of Protected Health Information (PHI) under HIPAA and patient identifying information under Part 2. It is also worthy to note that Part 2 covers any information (written or oral) relating to a patient that is received or acquired by a federally assisted addiction treatment program. The Privacy

Standards cover PHI about an individual (oral, written, etc.) only when maintained, collected, used, or disseminated by or for a covered entity.

Records are broadly defined to include verbal communications as well as what is typically thought of as written medical records. Therefore, patient records include any information relating to the patient, written or oral. In addition to disclosing any of the patient identifying information above, there are other ways of disclosing patient information (for example, giving written records with a patient's name on it, or answering a telephone and informing the caller that the person to whom the caller wishes to speak is present).

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to provide better access to health insurance and to toughen the law concerning health care fraud. Additionally, it created national standards to facilitate the electronic exchange of health information and protect the privacy of any patient-identifying health information.

An addiction treatment “program” required to comply with Part 2 is not automatically a covered entity under the Privacy Standards of HIPAA. A covered entity is a health plan; health care clearinghouse; or a health care provider who transmits any health information in electronic forms in connection with a covered transaction.

The Privacy Standards establish a federal floor of safeguards to protect the confidentiality of medical information by limiting the disclosure of PHI. PHI is any individually identifiable health information in **any** form: electronic, written, oral and any other form. Protected health information may not be used or disclosed except as authorized by the patient or as permitted by the regulations. In other words, if the provider does not transmit any health information electronically, the provider is not a covered entity under the Privacy Standards. If the provider transmits health information in connection with covered transactions (see glossary) electronically via the Internet, an extranet, private networks, e-mail or by transmissions that are physically removed from one location to another using magnetic tape, disk or compact disk, etc. then the privacy standards apply, even if all other information is kept in paper form.

Therefore, assuming the treatment agency is both a “program” under Part 2 and a “covered entity” under the HIPAA Privacy Standards; PHI becomes protected upon its creation or receipt by the substance abuse provider³. The person does not have to be admitted as a patient. If a person calls and makes an inquiry and the addiction treatment abuse agency documents identifying information about the individual, the information would be considered PHI. This protection applies to any PHI in any form and remains protected for as long as the covered entity transmits or maintains it.

However, we should note that, based on the functions and services provided by RCOs, we believe it very unlikely that HIPAA would apply to RCOs since RCOs would not be engaging in electronic healthcare transactions. Therefore, the RCO would not meet the definition of a “covered entity” under HIPAA. Additionally, based on a review of the functions and duties of Recovery Support Specialists, we have concluded that Recovery Support Specialists are not engaging in electronic healthcare transactions that would make them a covered entity under the HIPAA.

How Do You Share Protected Information?

There are a number of ways to share protected health information without breaching a client's confidentiality. The most obvious is to use de-identified information or to disclose the information without identifying the person as a recipient of substance abuse treatment services. If you need to include patient identifying information, you may legally disclose: (1) with written patient authorization; (2) with a valid court order; (3) to staff within the program; (4) to a qualified service organization; (5) under a child abuse reporting exception; (6) to law enforcement for a crime on program premises or against program personnel; (7) to health care personnel for medical emergencies; (8) for research; and (9) for audit/evaluation activities.

³ In cases where the 42 C.F.R Part 2 and the Privacy Standards apply and conflict, the more stringent of the two laws will apply.

Patient identifying information includes the name, address, social security number, fingerprints, voiceprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. (42 C.F.R. Section 2.11). In order to release this information, the regulations require the execution by the patient of a valid consent. Consents for disclosure are governed by the federal confidentiality regulations (42 C.F.R. Section 2.31) and must be in writing. To make a disclosure in accordance with these regulations, the following elements must be included in the written consent:

- (1) Name of patient
- (2) Name or general designation of program making the disclosure
- (3) Kind of information and amount of information to be disclosed
- (4) Name or title of person or organization to which disclosure is to be made
- (5) Purpose for disclosure
- (6) Date on which consent is signed
- (7) Signature of patient
- (8) Signature of parent or guardian, if applicable
- (9) Statement that the consent is subject to revocation (except to the extent program has relied upon it)
- (10) Statement that the consent will terminate upon a specific date, event or condition

The federal confidentiality statutes and regulations, as discussed above, govern consent for disclosure. Prior to making a disclosure, a written consent form (containing the required elements of 42 C.F.R. 2.31) should be signed by the patient.

MANDATORY CHILD ABUSE REPORTING

All fifty states have provisions for mandatory reporting of physical and/or sexual abuse of children. These statutes are based on the premise that the potential harm to children from abusive acts outweighs the potential harm that could occur through the violation of client confidentiality. The ethical command is to assure that abuse does not recommence and to assure the safety of other potential victims. The key question will be whether Recovery Support Specialists fall within a state's definition of a mandated reporter. If that is the case, there are three approaches the Recovery Support Specialist may follow.

The first approach takes the position that the Specialist should report only those cases of abuse that clearly fall under the definition of legally mandated reporting. This option makes compliance with the law the framework for ethical conduct. The risk here is twofold: first, that cases may arise in which there is an ethical mandate to protect which falls outside the legal requirement to report, and, second, that actions taken to protect— mandatory reporting—may, in some unique circumstances, do harm to those targeted for protection.

The second approach takes the position that the Specialist should report only in those circumstances where there is a legal obligation to report AND when the action of reporting is judged by the Specialist to be the best available vehicle capable of protecting the innocent parties and supporting the long-term health and safety of all parties involved. A judgment to not report with this option is an implicit assumption of responsibility and legal liability by the Specialist for the welfare of those involved, but one deemed justifiable under certain circumstances. In fact, in some states, failure to report child abuse or neglect by a mandated reporter is typically a misdemeanor, and also grounds for disciplinary action by applicable licensing boards if the Recovery Support Specialist possesses any such licenses. To further encourage reporting, some states also have immunity provisions for those who report abuse and neglect.

The third approach posits that the specialist should report not only those cases that fall under the definition of legally mandated reporting, but also cases where the Specialist feels an ethical duty to protect but circumstances are not of such severity as to legally require reporting. The risk in this option is in unduly violating client confidentiality and in adding non-critical work to an already overburdened child protection system. Once again, if the specialist reports in “good faith”, some state statutes provide immunity for such reporting.

For example, the Pennsylvania Consolidated Statutes, Title 23 (Domestic Relations), Chapter 63, states that any persons who come into contact with children in the course of their employment, occupation or practice of their profession, shall report a reasonable suspicion of child abuse. Mandatory reporters include “social services workers”, “child care workers”, and “mental health professionals”. Also, child care services are defined to include “early intervention and drug and alcohol services for children”.

Therefore, if the Recovery Support Specialist is also a mental health professional, the Recovery Support Specialist is a mandated reporter and must report child abuse under the statute. However, if a Recovery Support Specialist in Pennsylvania is not also engaged in a profession which is defined as a mandated reporter, there would not be a legal duty to report child abuse under the statute, but there may be an ethical duty to report governed by professional codes of conduct.

When in doubt, a Recovery Support Specialist should report child abuse. As stated above, most states have immunity provisions for those who report child abuse in good faith. Additionally, the Recovery Support Specialist could face greater liability for not reporting. Furthermore, if the Recovery Support Specialist is not covered by Part 2, they will not be restricted by those regulations in what information they may disclose in connection with a suspicion of child abuse.

To reconcile the client's right to confidentiality with the duty to report, it is crucial that each agency clearly defines how it operationalizes both of these mandates within the span of the three positions noted above. Once that position has been determined, clients can be told of the exceptions to confidentiality in language precise enough to allow them to make informed choices regarding likely responses to their disclosures.

There are numerous variations on abuse situations that make it more difficult to sort out one's legal and ethical duties. The agency/specialist response to each situation can be discussed using the following questions:

- Does the situation, as presented, warrant suspension of confidentiality and reporting to an outside authority? If yes, which outside authority?
- What actions in addition to, or as an alternative to, external reporting would enhance the protection of safety in the situation?
- Who will benefit and who will be potentially harmed by the proposed action?
- Which ethical values should guide our response to the situation?

PERSONAL OR ORGANIZATIONAL LIABILITY

In general, courts have required that the patient be told: (1) the nature and purpose of the procedure; (2) the risks and consequences; (3) the alternatives; and (4) the risks of no treatment. Failure to disclose risk is the most common source of liability. This concept is known as informed consent. Because of the nature of Recovery Support Services, this concept of informed consent does not appear to apply. Nonetheless, persons providing such services have questioned under what circumstances personal or organizational liability could accrue.

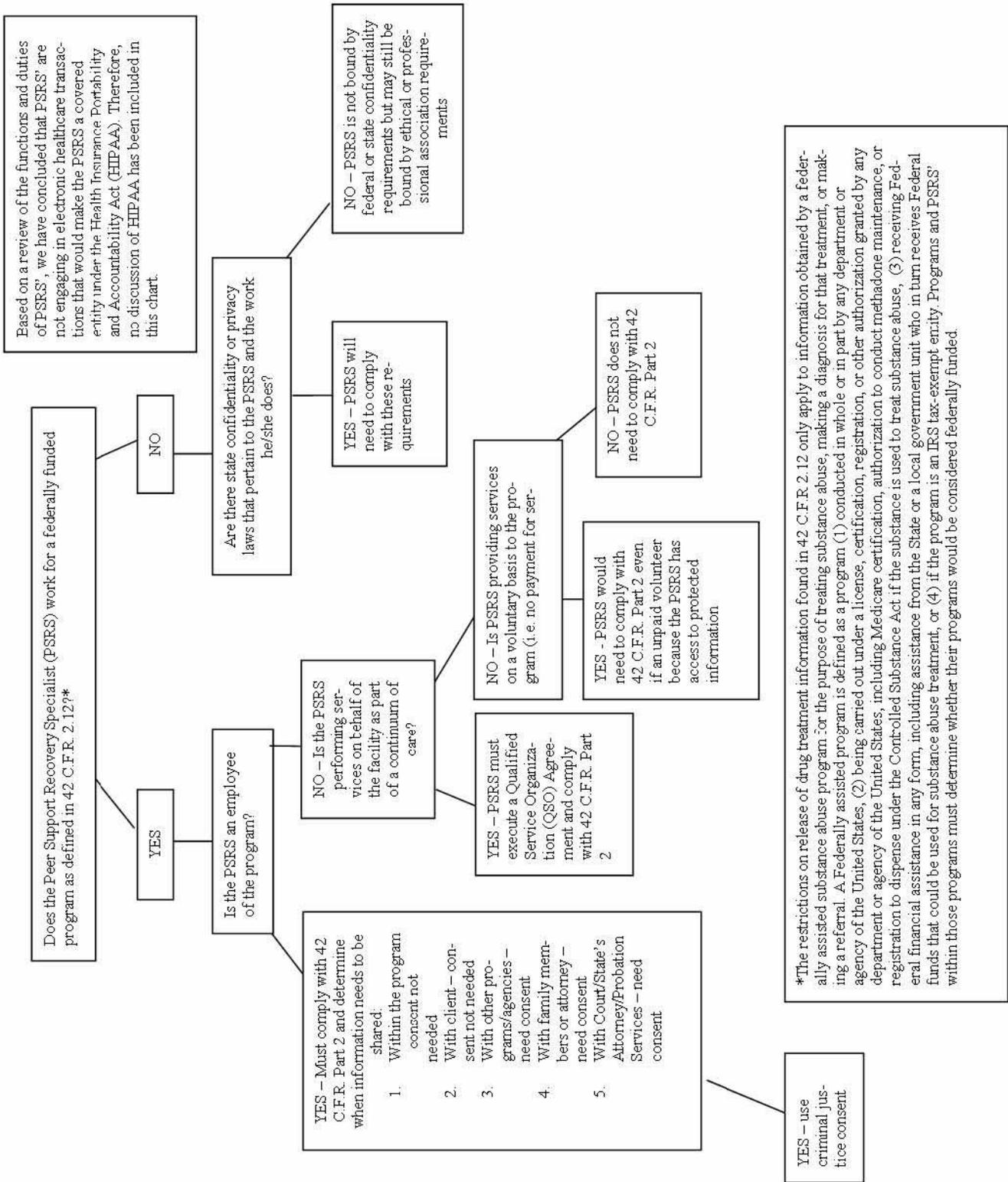
To determine whether a professional practice standard was breached, courts would look to the standards of what a reasonably prudent Recovery Support Specialist in the community would do in exercising reasonable care as well as any statutory or regulatory requirements to determine the “appropriate standard of care”. Liability in these cases is typically imposed on the individual as well as the agency under negligence theories. Thus, the plaintiff would be required to prove that the peer specialist had a duty, breached the duty, and that the client suffered injury as a result of the breach (meaning the peer specialist caused the client’s injury), and damages were sustained. The key question in these cases is often whether the patient can prove that had the risk been disclosed, he or she would not have consented to the procedure or treatment. Additionally, liability could be imposed on the agency for failure to meet certain standards of care with respect to negligent hiring, training, supervision or retention of staff. Some of the licensure, business, legal, and employment considerations that could impact these decisions and standards of care are:

- Will licensure regulations be modified to address this new role and the minimum standards for the state’s seal of approval?
- Will funding agencies impose requirements on agencies employing this new role?
- Will these peer support roles be perceived as members of the “treatment team”; are they volunteers, are they interventionists; are they case managers/outreach workers? Where do these roles fit in the continuum of care and supervision of the clinical team?
- Will reimbursement mechanisms for these new services drive the standards of care and associated breaches of those duties?
- Will certification agencies establish the standards of care and associated breaches of those duties?
- Will credentialing and other regulatory bodies establish the minimum credentials of those qualified to render services thus imposing the corollary obligation to engage in appropriate recruitment, orientation, training and supervision of the peer support specialists?
- What responsibilities will be imposed on Recovery Support Specialists to document their services?
- Will the existence of documentation change the role, expectations and assumed liability of these peer support specialists?

- Will agency approaches to minimum sobriety “guidelines” impact the success of recruiting qualified peer support recovery specialists?
- Will agency codes of ethics relating to peer relationships with fellow clients affect “bright line prohibitions” of professional behaviors in the employment context?
- What similarities exist with Recovery Support Specialists and consumer employees in the mental health field? What challenges have been encountered and lessons learned from that field that can be replicated for these positions?
- Will restrictions need to be imposed walling off Recovery Support Specialists from information in a client record (including but not limited to joint clinical staffing to discuss client issues, the written medical record, the electronic information in clinical and billing systems) to preserve client’s rights to confidentiality from fellow employee/fellow clients?
- With the Recovery Support Specialists presumably being involved with the clients for longer terms to support life-long recovery, how does that impact the definitions of “clients” for purposes of determining whether a relationship can occur between a peer support recovery specialist and a “former client”?

At the present time, Recovery Support Services are deemed neither clinical nor medical procedures for which informed consent is required, and therefore there is a minor risk of liability. However, even as we speak, several states are modifying their licensure regulations to address Recovery Support Specialist services. Funding agencies will not be far behind. This public policy shift will have a huge impact on the nature of the services Recovery Support Specialists provide. As Recovery Support Specialists become an integral part of the treatment team and/or the continuum of care, we will witness licensing and funding authorities creating standards to govern these services to justify reimbursement for these services as well as to create minimum levels of expectations. Once these standards are imposed, patients will have a greater ability to prove a breach of these standards and successfully sue Recovery Support Specialists for various types of liability.

Although standards professionalize the service and establish minimum public safety thresholds as well as hold recipients of government funding accountable, mandated standards have contributed to survival strategies driving the addiction treatment field to focus on documentation, certifications, credentials and reimbursement rather than peer-based recovery concepts necessary for sustaining life-long recovery. This reality resulted in the peer-based recovery movement. Once federal, state and local governmental authorities impose standards on these innovative recovery support services, they may very well destroy the effectiveness of the interventions that they chose to govern.



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Mutual Aid & Advocacy Groups

12-Step Programs

Adult Children of Alcoholics (ACOA): <http://www.adultchildren.org/>. (This 12-Step recovery program is for persons who grew up in alcoholic or similarly dysfunctional family settings.)

Alanon; Alateen: <http://www.al-anon.alateen.org/>. (This 12-Step support groups are for family members of alcoholics.)

Alcoholics Anonymous: <http://www.aa.org/>.

Cocaine Anonymous: <http://www.ca.org/>.

Crystal Meth Anonymous: <http://www.crystallmeth.org/>.

Double Trouble in Recovery: <http://www.doubletroubleinrecovery.org/>. (This 12-Step mutual aid group is for persons in recovery from both substance use and mental health problems)

Dual Recovery Anonymous: <http://draonline.org/>. (This 12-Step mutual aid group is for persons in recovery from both substance use and mental health problems.)

Heroin Anonymous: <http://www.heroin-anonymous.org/haws/index.html>.

Marijuana Anonymous: <http://www.marijuana-anonymous.org/>.

Methadone Anonymous Support: <http://www.methadonesupport.org/>.

Narcotics Anonymous: <http://www.na.org/>.

Naranon: http://www.nar-anon.org/Nar-Anon/Nar-Anon_Home.html. (These 12-Step support groups are for family members of addicted persons.)

Nicotine Anonymous: <http://www.nicotine-anonymous.org/>.

Pills Anonymous: <http://www.pillsanonymous.org/>.

Sober 24: <http://www.sober24.com/>. (This is an online-only 12-step support group combined with 'Virtual Fellowship' and recovery management tools.)

Other Approaches

16-Steps for Recovery: <http://www.charlottekasl.com/site/16-step-program>.

Alcoholics Victorious: <http://www.alcoholicsvictorious.org/>. (This group is for recovering people who recognize Jesus Christ as their "Higher Power." It combines the 12 Steps and the Alcoholics Victorious Creed.)

Celebrate Recovery: <http://www.celebraterecovery.com/>. (This Christian recovery program meets nationally.)

Jewish Alcoholics, Chemically Dependent Persons and Significant Others: <http://www.jacsweb.org/>.

LifeRing: <http://lifering.org/>. (This is an abstinence-oriented secular recovery program.)

Moderation Management: <http://www.moderation.org/>. (This non-abstinence-based program is for problem drinkers who are not dependent.)

Rational Recovery: <https://rational.org/>.

Secular Sobriety: <http://www.sossobriety.org/>. (This group has anonymous secular recovery meetings.)

Sinclair Method: <http://www.sinclairmethod.com/>.

SMART: <http://www.smartrecovery.org/>. (This is a 4-Point Recovery Program.)

White Bison - <http://www.whitebison.org/>. (This is a Native American Recovery Program.)

Women for Sobriety: <http://www.womenforsobriety.org/>

Advocacy & Networking Organizations

Advocates for the Integration of Recovery and Methadone, Inc. (AFIRM): <http://www.afirmfwc.org/>. (This organization promotes Methadone Anonymous, a 12-step program, and integrates a 12-step philosophy into traditional methadone treatment modalities.)

Buddhist Recovery Network: <http://www.buddhistrecovery.org/>.

Faces and Voices of Recovery: <http://www.facesandvoicesofrecovery.org/>. (This is a national advocacy organization.)

Gay & Lesbian Alcoholics Recovery Support: <http://www.gayalcoholics.com/>

In the Rooms: <http://www.intherooms.com/>. (This online social networking site is for those struggling with addiction, those seeking help for addiction, those in recovery, including their family and friends.)

National Alcohol and Drug Addiction Recovery Month: <http://www.recoverymonth.gov/>. (This annual event is for diverse communities and stakeholders to join and carry the message of recovery.)

National Alliance for Medication Assisted Recovery: <http://www.methadone.org/>.

National Association for Christian Recovery: <http://www.nacronline.com/>.

National Council on Alcoholism and Drug Dependence (NCADD): <http://www.ncadd.org/>. (This is a national advocacy organization with local chapters.)

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