

Customizing Recovery Coaching Training

One Size May Not Fit All

By Courtney Kibble, PsyD, LP, LPC, CADC,
and Mary McClure, EdD, LPC



The Recovery Coach (RC) has become a widely used resource in the treatment of and recovery from substance use disorders (SUD), as well as for many mental and physical health issues requiring long-term management. RC programs are increasingly customized to meet integrated care needs of populations with specific comorbid conditions (Myrick & del Vecchio, 2016). The RC provides non-clinical peer support that assists in removing personal and situational obstacles to recovery, links the recovering person with social and other support services, and serves as a personal mentor in the recovery process (CSAT, 2009; Kaplan, 2008). Despite continued growth and support for RC services, research into their effectiveness has been limited and research results are complicated by the lack of consistent educational requirements and role definition for RC, as their function evolves across service environments (Eddie et al., 2019; Myrick & del Vecchio, 2016). Given this dynamic context, effective utilization of RC support requires that organizations intentionally define desired RC functions and outcomes, the required RC knowledge and skills to support these, and how this RC role will be integrated within the larger organization.

What is a Recovery Coach?

The RC is a non-clinical peer support professional who has often received some level of training and certification. Where clinical professionals provide mental and physical health treatment services based primarily upon knowledge and expertise gained in formal education, training, and licensure processes, the RC provides peer support services based largely upon personal experience and knowledge gained while working through their own recovery processes. This peer support is typically focused on establishing a collaborative relationship, removing barriers to recovery, and building connection to community resources and activity. Also called Peer Recovery Support Specialist, Wellness Support Specialist, or similar titles, the RC role is often unfamiliar to organizations, resulting in role confusion and boundary issues (CSAT, 2009; Eddie et al., 2019; Kaplan, 2008). Upon introduction, the role should be distinguished from that of the more familiar Alcoholics Anonymous (AA) sponsor, noting that the RC maintains a collaborative and non-directive style not associated with AA's 12 Steps. Clarification that clinical mental health, medical diagnosis, or treatment – as well as spiritual or religious guidance – are all outside the scope of RC activity is also appropriate. Educating the organization on intended RC functions and interfaces can allay concerns that it may encroach on other positions' responsibilities (Loveland & Boyle, 2005).

Though there is no national consensus on RC training and certification processes, the National Certified Peer Recovery Support Specialists (NCPRSS) credential developed by the National Certification Commission for Addiction Professionals (NCC AP) is increasingly supported as a nationally recognized credential. The NCC AP, under the auspices of NAADAC, the Association for Addiction Professionals, has operated as an independent body for all matters involving the Association's SUD counselor certification and endorsement opportunities at the national and international level. Established in 1990, the NCC AP has independent

autonomy in the development and promulgation of standards for testing, including who qualifies for the exams, content, administration, scoring, and appeals, as well as establishing appropriate policies for acquiring and maintaining the national credentials.

The lack of national consensus on RC training or core competencies is explained in part by the 2007 Centers for Medicare and Medicaid Services directive that peer support training and certification requirements be defined by state (Myrick & del Vecchio, 2016). State requirements vary and evolve, often supporting multiple RC certifications. A 2018 compendium of RC certification requirements by state (UMASS, 2018) indicates that most states require RC applicants be high school graduates and obtain 40 to 50 hours of RC training, while a few states require 100 or more hours of RC training. Supervised RC role experience of 500 hours is often specified, as well as some type of personal experience in recovery. The nature of this recovery experience can vary; Oregon, for example, permits self-identification as receiving mental health services in the past or present, being in recovery from an addictive disorder with a two-year abstinence if substances are involved, being in recovery from problem gambling, or having a family member who received mental health services in the past or present (OHA, n.d.).

The Illinois Certification Board (ICB), in addition to offering various RC support specialist certifications, recently released Accreditation Standards for a Peer Recovery Support Training Program. Organizational requirements for this comprehensive program include provision of 110 topic-specified classroom training hours, 300 contact hours of supervised internship experience, and compliance to rigorous administrative and professional standards (ICB, 2020). This accreditation establishes clear guidelines—, and a high bar—, for quality and scope of training content and delivery mechanisms. For example, organizational applicants will provide education, experience, and licensure credentials of educators and supervisors, which will preferably include existing certification by ICB. In doing this, ICB targets to ensure high quality recovery support training by forming partnerships with the educational institutions that

Also called Peer Recovery Support Specialist, Wellness Support Specialist, or similar titles, the RC role is often unfamiliar to organizations, resulting in role confusion and boundary issues.

have designed training programs specifically to prepare students to work in recovery support roles.

RC role activity generally falls into four categories: emotional, informational, instrumental, and affiliational. Emotional role activity includes development of the empathic client relationship, mentoring, and inspiring positivity and hope. Informational role activity includes sharing personal knowledge, as well as resource connections or conducting life skills training on topics such as vocational skills, communications, and wellness. Instrumental role activity includes providing concrete assistance such as childcare, transportation, or help gaining access to community support services; this may extend to family and significant others of the client. Affiliational role activity includes building client community contacts to promote greater socialization and connectedness within organizations such as recovery centers, support meetings, sports, and recreational centers (CSAT, 2009; Kaplan, 2008).

However, specific RC role definition tends to be inconsistent as role responsibilities are designed to meet the unique needs of the organization

and recovering individual. The RC may also fill a service gap as clients transition through levels of care. For example, an RC working with acute SUD issues in an emergency room setting may need specific training to help clients in a traumatic situation understand treatment options available to them given their diagnostics, location, and insurance situation; specific training may also be necessary when working with distraught families. In contrast, RCs working with populations seeking to maintain post-treatment long-term recovery may emphasize relapse prevention, wellness plan development, relationship building, goal setting, and problem solving (CSAT, 2009; Eddie et al., 2019).

Creating the RC Role within Your Organization

As a first step in determining how a RC role could best fit organizational needs, decision makers need to gain foundational knowledge of RC approaches and roles, as discussed above. In addition to formal training programs there is a wealth of information on RC and recovery support services available through government organizations, such as the Substance Abuse and Mental Health Service Administration (SAMHSA). RC education materials developed by publicly funded agencies—such as that by Bennet & Bellack (2015), Loveland & Boyle (2005), and McShin Foundation (2017)—are also valuable resources and include references to respected source materials.

Leadership must decide whether the RC position will be maintained in-house or provided in coordination with an external agency. Larger organizations offering a full scope of treatment and long-term recovery support may be in a better position to maintain an internal RC function that can serve clients throughout all stages. On the other hand, partnering with a community social service agency that is a part of a Recovery Oriented System of Care (ROSC) network offers the advantage of allowing for continuity of RC service, as the client may move between service facilities, and builds client ties to the community (CSAT, 2009; Eddie et al., 2019).

There are different perspectives as to whether the RC position must be filled by peers who are in recovery themselves. Coaches having personal experience with SUD can share their own recovery experience in their mentoring roles. Conversely, persons in recovery may not have achieved overall wellness, or may have developed paternalistic and highly directive dispositional attitudes from their own treatment. Requiring a personal lived recovery experience may prove difficult as RC service extends to integrated care environments (CSAT, 2009; Eddie et al., 2019).

Educating the Recovery Coach

Education that encourages a person-centered, strength-based, and collaborative approach is critical to the overall effectiveness of the RC. This is difficult for some trainees who may have to change advice-giving and judgmental habits. The goal is to help trainees grasp the empowering impact of empathic connection, genuineness, and acceptance in client relationship building; this requires the repetition of habits until they become second nature (Kaplan, 2008; Miller, 2000).

RC education should provide a foundational knowledge base on substance use and recovery processes, as well as guidance on how RC

specific activities should be approached. State certification requirements can form a good starting point for content, as can the aforementioned training resources in both their content and references. Organizations can enrich training content, build their own training programs, or purchase RC training courses from one of the many organizations offering these. These differ in both breadth and depth of content coverage, as well as in delivery formats. Management can test-drive training options to determine the best fit for their organizational needs and culture.

The following are some areas typically included in basic 40-hour RC training:

- Substance use disorder and recovery processes/definitions
- Recovery-oriented systems of care concept
- Person-centered, strength-based, and collaborative relationships
- Ethical practices
- Wellness domains assessment and recovery plan development
- Motivational interviewing
- Advocacy and mentoring
- Stages of change
- Recovery capital
- CBT model of relapse prevention, functional analysis, and problem solving
- Involving family and close others
- Interpersonal and communication skills
- Multicultural awareness and special population considerations

Educational requirements related to the specific environment and identified roles for the RC must also be identified and satisfied.

Supervision is an important ongoing training component to ensure competence and well-rounded client care. A group supervision model can be particularly beneficial as individual experiences and questions can be shared and resolved. As the boundaries of a RC can sometimes appear cloudy, supervision can help clarify responsibilities and situations that would call for referrals or assistance from others in the organizations. Ethical questions, such as boundaries of client confidentiality for

the RC, often arise (CSAT, 2009; Eddie et al, 2019; ICB, 2020; Loveland & Boyle, 2005).

Defining Specific Functions of the Recovery Coach

As discussed above, the specific role of the RC will vary to be responsive to specific organizational and client needs. In general, the following functions are considered basic to the RC role:

- Establish and maintain a trusting, supportive, collaborative, and personal client relationship.
- Utilize a participant-centered Recovery Wellness Plan model to help clients develop effective recovery and general life goals.
- Conduct recovery coaching services, including mentoring or coaching, resource connecting and advocacy, leading recovery support groups, and building community.
- Provide indirect services to maintain collaborative and supporting relationships within the organization and within the community.

Education that encourages a person-centered, strength-based, and collaborative approach is critical to the overall effectiveness of the RC.

Detailed guidelines and expectations for performance of RC basic functions are needed. For example, how often, when, and where will the RC meet with clients? Will their role include various types of skills training or group meetings? What resource connections for clients are available? What access will they have to client records? Will they provide clients with transportation? The quality of the RC role performance will depend on articulation of specific role requirements (SAMHSA, 2015).

Research findings to date provide some support for the potential RC services in SUD and other treatment settings related to reduced usage and relapse rates, enhanced satisfaction with and retention in treatment, and enhanced social supports (Eddie et al., 2019; Myrick & del Vecchio, 2016). Expanded research is needed to understand the relative impact of RC services as compared to other support services, and to consider variations in education, role definitions, and service settings utilizing RC services.

References

- Bennett, M., & Bellack, A. (2015). *On Track NY Recovery Coaching Manual*. Retrieved from https://www.ontrackny.org/portals/1/Files/Resources/RecoveryCoach_2015.01.21.pdf
- Center for Substance Abuse Treatment (CSAT). (2009). *What are Peer Recovery Support Services?* HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Retrieved from <https://store.samhsa.gov/system/files/sma09-4454.pdf>
- Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoepfner, B., Weinstein, C., and Kelly, J.F. (2019). Lived experience in new models of care for substance use disorder: A systematic review of peer recovery support services and recovery coaching. *Frontiers in Psychology*. 10:1052. doi: 10.3389/fpsyg.2019.01052 Retrieved from <https://www.frontiersin.org/articles/10.3389/fpsyg.2019.01052/full>
- Idaho Department of Health and Welfare (IDHW). (2020). *1.0 Certified Peer Support Specialist (CPSS) Standards*. Retrieved from <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=4039&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1>
- Illinois Certification Board (ICB). (July, 2020). *Illinois Certification Board Peer Recovery Support Training Program Accreditation Standards CRSS and CPRS*. Springfield, IL: ICB.
- Kaplan, L. (2008). *The Role of Recovery Support Services in Recovery-Oriented Systems of Care*. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration. Retrieved from <http://www.pacdaa.org/SiteCollectionDocuments/SAMHSA%20White%20Paper%20on%20The%20Role%20of%20Recovery%20Support%20Services.pdf>
- Loveland, D. and Boyle, M. (2005). *Manual for Recovery Coaching and Personal Recovery Plan Development*. Springfield, IL: Illinois Department of Human Services Department of Alcoholism and Substance Abuse. Retrieved from https://bha.health.maryland.gov/CLINICAL%20SERVICES/Documents/ROSC/RC_ManualDASAedition7_22_05.pdf
- McShin Foundation. (2017). *Recovery Coaching Manual: Substance Use Disorder Recovery Program (2nd ed)*. Richmond, VA: McShin. Retrieved from https://mcshin.org/wp-content/uploads/2019/07/RCM-2020_SML.pdf
- Miller, W. R. (2000). Rediscovering fire: Small interventions, large effects. *Psychology of Addictive Behaviors*, 14(1), 6–18. <https://doi.org/10.1037/0893-164X.14.1.6>
- Myrick, K., & del Vecchio, P. (2016). Peer support services in the behavioral healthcare workforce: State of the field. *Psychiatric Rehabilitation Journal*, 39(3), 197–203. <https://doi.org/10.1037/prj000188>
- Oregon Health Authority Peer Delivered Services (OHA). (n.d.). Certified Peer Support Specialist Requirements. Retrieved January 15, 2021 from <https://www.oregon.gov/oha/HSD/AMH-PD/Documents/Certified-Peer-Support-Specialist-Requirements.pdf>
- Substance Abuse and Mental Health Services Administration's (SAMHSA). (2015). *Core Competencies for Peer Workers*. Retrieved from <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers>
- Substance Abuse and Mental Health Service Administration (SAMHSA). (2016). *Creating a Healthier Life: A Step-By-Step Guide to Wellness*. SMA-16-4958. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Retrieved from <https://store.samhsa.gov/product/Creating-a-Healthier-Life-/SMA16-4958>
- University of Massachusetts Medical School (UMASS). (2018). *Compendium of Recovery Coach Certification Requirements by State*. Retrieved from <https://rizema.org/wp-content/uploads/2019/01/UMass-RIZE-Recovery-Coach-Certification-By-State-Final-Workbook-Submitted.xlsx>

White, W. & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61. Retrieved from <http://mx1.williamwhitepapers.com/pr/2006VarietiesofRecoveryExperience.pdf>



Courtney Kibble, PsyD, LP, LPC, CADC, is an Assistant Professor at Governors State University (GSU) in the Department of Addiction Studies and Behavioral Health. She specializes in trauma and substance use concerns. She is also the Program Coordinator for the MHS in Addiction Studies program. She has been involved in many instructional opportunities including serving as site leader for a Suicide Assessment Training Team, providing trauma training for counselors, and assisting in the development and delivery of GSU's recovery coaching education program.



Mary McClure, EdD, LPC, is an Assistant Professor at Governors State University (GSU) Department of Addiction Studies and Behavioral Health. With 12 years of experience as a counselor educator, she has been working in this current position since 2015, developing and delivering Master's level courses in the department's Addiction Studies MHS programs. She currently leads GSU efforts in development and delivery of recovery coaching education and internship.

For More Information visit www.NRADAN.org

Training for Addiction Prevention, Treatment, & Recovery Professionals

National Rural Institute on Alcohol, Drugs, and Addictions

June 21-24, 2021
VIRTUAL • 36th Annual

Earn 20 hours/2.0 CEUs

\$295*

Participate Live or Watch On-Demand
*Includes On-Demand access during July 2021 to earn even more...

National Rural Alcohol and Drug Abuse Network (NRADAN, Inc.)