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Recovery Mentorship Programs and Recovery from Addiction

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MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW
students at St. Catherine University/University of St. Thomas
School of Social Work in St. Paul, Minnesota and is conducted
within a nine-month time frame to demonstrate facility with basic
social research methods. Students must independently conceptualize
a research problem, formulate a research design that is approved by
a research committee and the university Institutional Review Board,
implement the project, and publicly present their findings. This
project is neither a Master's thesis nor a dissertation.

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Abstract

New roles in service grow from an unmet need. In the current world of addiction treatment and addiction recovery, a new role is emerging to bridge the gap between professional treatment and sustainable recovery within a client's natural environment. This role has been identified as many different titles: recovery coach, recovery mentor, peer recovery, and specialist. Peer-to-peer recovery support services are designed and delivered by peers in recovery. A review of the literature has found that recent growth in peer-based recovery support services as an addition and alternative to addiction treatment has created some uncertainty about the separation of responsibilities across three roles: 1) sponsors in 12-step programs, 2) addiction counselors, and 3) volunteer or paid peer based recovery support roles. By studying the barriers of a persons' success to maintain a program of recovery from addiction, we can identify new ways to give support to an ever growing population. Sponsors in 12-step programs, addiction counselors, recovery coaches, and person's in recovery were invited to fill out an online survey of 32 open-ended and closed-ended questions regarding the differences across these three roles and to identify barriers that may enhance a person's recovery from addiction. Results show there is a need for increased support for someone to be able to maintain a program of recovery. Implications from this study indicate a need to develop a more formal role for the recovery coach as well as informing people of what a recovery coach can do for them in supporting their recovery.

Keywords: Recovery Coaching, Addiction, Twelve Step Program

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Many people do not understand why individuals become addicted to substances or how substances change the brain to encourage substance abuse. According to The National Institute on Drug Abuse (NIDA, 2006), people mistakenly view substance abuse and addiction as strictly a social problem and may set apart those who use substances as morally weak. One very common belief is that people who abuse substances should be able to stop using substances if they are only willing to change their behavior (NIDA, 2006). What people often underestimate is the complexity of addiction; it is a disease that impacts the brain and because of that, stopping substance abuse is not simply a matter of willpower. Researchers now know much more about how exactly substances work in the brain, and how addiction can be successfully treated to help people stop abusing substances and resume their productive lives (NIDA, 2006).

Substance abuse and addiction are a major burden to society. Estimates of the total overall costs of substance abuse in the United States, including health and crime related costs as well as losses in productivity; exceed half a trillion dollars annually (National Institute on Chemical Dependency (NICD), 2006). So many people unfortunately do not get the treatment that is needed to address their substance dependency or abuse issues. The National Survey on Drug Use and Health (NSDUH) estimates 22.4 million persons aged 12 or older in 2005-2006 were classified with dependence on or abuse of any illicit drug or alcohol in the past year. Of these, 6.9 million were dependent on or had abused illicit drugs, and 18.7 million were dependent on or had abused alcohol (NICD, 2006, p.58). According to state estimates of substance use from the 2005-2006 NSDUH, it is estimated that between 338,000 – 462,000 residents of Minnesota and 338,000 – 458,000 residents of Wisconsin suffered from alcohol dependence or abuse in the past year age 12 and older (NSDUH, 2006, p.64).

Addiction is a chronic disease that causes compulsive drug seeking and use despite harmful consequences to the individual who is addicted and to those around them (NICD, 2006). Addiction qualifies as a brain disease because once the substance has been used to the extent of abuse; it changes the function and structure of the brain (NICD, 2006). Although it is true that for most people the initial decision to ingest substances is voluntary, over time the changes in the brain caused by repeated substance abuse can affect a person's self control and ability to make sound decisions, and at the same time send intense impulses to use substances (NICD, 2006).

The growing popularity of the recovery coach (RC) is evident in both public and private mental health and addiction treatment organizations. Peer-based service models are growing in the mental health service area, specifically for clients with co-occurring psychiatric and substance use disorders (Solomon, 2004).

People with substance use disorders are often deeply enmeshed in a culture of addiction that they require sustained help separating from this culture and entering an alternative culture of recovery (White & Kurtz, 2005). There continues to be a need for sustained pre-treatment, in-treatment, and post-treatment recovery support services (Wilbourne & Miller, 2003). Wilbourne and Miller (2003) assert that the role of recovery coach may become the central means through which such services are delivered.

Considerable effort is happening to answer key questions related to the recovery coaching functions; e.g., should these functions be integrated into an existing role or within a new service role? (White & Kurtz, 2005). Who is to determine where these functions can be best placed organizationally; e.g., are recovery support services best integrated within existing addiction treatment programs or within stand alone peer-based recovery advocacy and support organizations? (White & Kurtz, 2005). From the research I have done it appears the RC role

around the country is generating questions and leaving people wondering what the need is for a RC. I began to wonder myself about what the importance of a RC is if the consumer has access to 12-step programs? Along those same lines I can see how someone could justify RC's are not needed because most of these functions are already being performed by addiction counselors.

The recovery coach role incorporates and refines some dimensions of existing roles and is in between two recovery support roles: the 12-step sponsor and the addiction counselor. The purpose of this paper is to differentiate the recovery coach, sponsor, and addiction counselor roles. This is important in the field of social work as a way to better understand ways to enhance long term recovery from addiction. Further research is needed to gain an understanding of new recovery support roles by comparing and contrasting these three service roles.

Literature Review

Research on Treatment Alternatives for Substance Dependency or Abuse

Fortunately, there are treatments that help people to counteract addiction's powerful disruptive effects and regain control. Research shows that combining addiction treatment, if available or necessary, with 12-step meeting attendance is the best way to ensure success for most patients (NICD, 2006). Treatment approaches that are tailored to each patient's substance abuse pattern and any co-occurring medical, psychiatric, and social problems can lead to sustained recovery and a life without substance abuse (NICD, 2006).

The 12-step model of Narcotics Anonymous (NA) offers group meetings and many other types of assistance for individuals recovering from substance use problems. Research indicates that individuals who have substance use disorders, who attend 12-step meetings on a regular basis, such as Narcotics Anonymous or Alcoholics Anonymous (AA), have a higher level of functioning in society and longer periods of sobriety than individuals who do not attend 12-step

meetings on a regular basis, or at all (Kelly & Moos, 2003). According to Toumbourou, Hamilton, U'Ren, Stevens-Jones, and Storey (2002), an important underlying factor hindering the individual's ability to attend these 12-step meetings is the lack of knowledge and information about NA at treatment facilities and aftercare programs. Twelve-step groups need to be integrated into formal treatment facilities in order to increase the likelihood of attendance after the treatment program has ended. (Toumbourou et al, 2002).

In their research, Day, Lopez, Furlong, Murali, and Copello (2005) found that the 12-step model is the most widely used treatment philosophy for substance use disorders around the world. Individuals attending NA or AA are estimated at 3.5 million worldwide (Day et. al, 2005). Narcotics Anonymous provides a recovery process and support network intrinsically linked together (Narcotics Anonymous World Services, 2005). Narcotics Anonymous believes that one of the keys to its success is the therapeutic value of addicts working with other addicts. Members share their successes and challenges in overcoming active substance dependence and living substance-free productive lives through individual sharing of personal experiences with others and through the application of the 12-steps. The primary service provided by NA is the group meeting. Each group runs itself on the basis of the 12-steps and the 12 traditions. The 12 traditions of NA define the appropriate relationships between NA groups and its members, and NA as a whole. Narcotics Anonymous encourages its members to observe complete abstinence from all substances including alcohol. It has been the experience of NA members that complete and continuous abstinence provides the best foundation for recovery and personal growth (Narcotics Anonymous World Services, 2005).

According to Toumbourou, Hamilton, U'Ren, Stevens-Jones, and Storey (2002), an important underlying factor hindering the individual's ability to attend these 12-step meetings is

the lack of knowledge and information about NA at treatment facilities, aftercare programs, and in the community. Toumbourou et al, (2002) assert that twelve-step groups need to be integrated into formal treatment facilities in order to increase the likelihood of attendance after the treatment program has ended. According to Toumbourou et al. (2002), increased 12-step meeting attendance for individuals with substance use disorders increases the length of sobriety they attain and have better social support networks. The researchers also found the participants of the study who increased their 12-step meeting attendance were more likely to get a sponsor, work more steps, and provide help to others in similar situations.

According to Day et al. (2005), much of the research on substance dependence has been focused on relapse prevention in a group therapy setting and individual counseling sessions conducted with therapists. Since healthcare costs have dramatically increased over the years, more attention may need to be focused on cost-effective methods for individuals seeking help from substance use disorders (Willenbring, Kivlahan, Kenny, Grillo, Hagedorn, & Postier, 2004). Narcotics Anonymous membership is free. There are no fees or dues; the only requirement to become a member of Narcotics Anonymous is to have the "desire to stop using" (Narcotics Anonymous Basic Text, 1988, p. 62).

Effectiveness of Narcotics Anonymous (NA)

Since addiction does cost society a significant amount of money, self-help groups can complement and extend the effects of professional treatment. The most prominent self-help groups are those affiliated with Alcoholics Anonymous and Narcotics Anonymous, both of which are based on the 12-step model. Most drug addiction treatment programs encourage patients to participate in self-help group therapy during and after formal treatment (National Institute on Drug Abuse, 2005). These groups can be particularly helpful during recovery,

offering an added layer of community-level social support to help people achieve and maintain abstinence and other healthy lifestyle behaviors over the course of a lifetime.

The 12-step model of NA offers group meetings and many other types of assistance for individuals recovering from substance use problems. "Narcotics Anonymous is an international, community-based association of recovering drug addicts with more than 50,000 weekly meetings in 130 countries worldwide" (Narcotics Anonymous World Services, 2005).

Membership in Narcotics Anonymous is voluntary; no attendance records are kept either for NA's own purposes or for others. Because of this, it is sometimes difficult to provide comprehensive information about NA membership. There is, however, some objective measures that can be shared based on data obtained primarily from members attending world conventions. The following demographic information was gathered from a survey completed by approximately 13,500 NA members in 2006. The survey was made available at the 2007 World Convention of NA in San Antonio, Texas (Narcotics Anonymous World Services, 2008).

Narcotics Anonymous members had a mean average of 9.1 years clean (Narcotics Anonymous World Services, 2008). The 2007 Membership Survey "marks the first time that members were asked to assess areas of their lives that have improved with NA attendance" (Narcotics Anonymous World Services, 2008). The two areas that received overwhelming improvement were: family relationships where "90% of NA members stated enrichment, and social connectedness was realized by 83% of the respondents" (Narcotics Anonymous World Services, 2008).

How Recovery Coaching is Different than Sponsorship

It is something of a challenge to compare the roles of recovery coach (RC) and sponsor. The RC is now emerging in different forms across the country and has yet to be uniformly

defined. Sponsorship, while existing for more than 60 years, has been governed more by oral tradition than written procedures (Alcoholics Anonymous World Service, 1993).

Where the sponsor-sponsee relationship is based on a reciprocity of need (the sponsor is there in part to support his or her own sobriety) (Alcoholics Anonymous World Service, Inc., 1983, p. 7).The recovery coach has a relationship with those he or she serves; a relationship governed by ethical/legal duties and obligations. Where there is minimal power differential in the sponsor-sponsee relationship (Kelly & Moos, 2003). However, there is at least the potential for a power differential in the recovery coach service relationship. The long-term sponsorship relationship often evolves into an enduring friendship and a form of mutual sponsorship (AAWS, Inc, 1983, p. 25), but such sustained reciprocity is less appropriate in the RC service relationship. The vulnerability of persons served within the RC relationship is protected through the use of safeguards that are not present in the sponsor-sponsee relationship (e.g., informed consent, legally governed confidentiality, professional supervision, and grievance procedures). At an organizational level, agencies delivering recovery support services via a volunteer model should have responsibilities to carefully screen, orient, train and supervise RC candidates, as well as discipline or discharge RC volunteers who are not able to competently and ethically deliver services (White, 2004; White & Kurtz, 2005).

John Kelly and Rudolf Moos (2003) examined the incidence of dropout risk among individuals who are participating in a 12-step program such as Narcotics Anonymous or Alcoholics Anonymous. Kelly and Moos (2003) also investigated predictors that affect the dropout risk and treatment related factors that contribute to the high occurrence of dropout from 12-step programs.

Research indicates individuals suffering from substance disorders who become involved in Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) have a higher level of functioning in society and longer periods of sobriety than individuals who do not become involved in NA or AA (Kelly & Moos, 2003). However, a considerable portion of individuals who have been recommended to attend these 12-step meetings do not attend at all and many dropout before benefits from attending the meetings may be realized (Kelly & Moos, 2003).

Previous research done by Copeland and Hall (1992), Roffman and Klepsch (1993) has shown that specific demographic variables such as younger age, not being married, and ethnicity might affect reasons why individuals dropout from 12-step programs. Research done by Mertens and Weisner (2000) indicated that dropout rates in 12-step programs could be due to the severity of the individual's addiction and the problematic consequences that came from the addiction. Kelly and Moos (2003) looked at different predictors for reasons why dropout risk is so high. Possible risk factors they examined were counselor recommendations to attend 12-step groups, the degree of consistency in the treatment environment, and the degree of support the individual receives in the treatment program. The researchers also examined the time period at which individuals began the 12-step involvement during their treatment.

Kelly and Moos (2003) aim to observe a correlation of these specific risk factors that might affect an individuals dropout form 12-step programs at 3 levels. The first is to estimate different risk factors affecting the prevalence of dropout from 12-step programs for current attendees (Kelly & Moos 2003). The second level is to examine the individual predictors such as age, ethnicity, and religious background of dropout risks (Kelly & Moos 2003). The third level is to examine how treatment related characteristics such as the treatment environment, clinician

referral and behavior changes initiated during treatment such as getting a sponsor or reading the 12-step literature may lower the risk of dropout at the 1-year follow-up.

Kelly and Moos (2003) used a correlational non-experimental research design. The sample included 3,698 male participants at 15 Veterans Administration (VA) residential treatment programs. The residential treatment program was designed to last 21 to 28 days. The treatment program used individual and group therapy to assist the participants in meeting their treatment goals and was multidisciplinary in staffing. Of the 3,698 participants at intake, 3,330 completed a discharge assessment from residential treatment and 93 participants died during the first year follow-up. Of the 3,698 participants, 2,778 had a complete intake, discharge and 1-year follow-up, which was the data used for the analyses. Participants were asked to complete an inventory at intake, discharge and again at 1 year. Most patients (92%) completed the inventory forms as a self-administered survey that was returned thorough the mail. The remainder of the participants completed the survey either by phone or in person.

Measures on substance use were reported in 2 categories; abstinence and consequences from use. Participants who reported no alcohol or other drug use in the last 3 months were considered abstinent. A subgroup of participants received an alcohol and/or drug test during nonrandom visits to VA facilities in the first year after treatment. Self reports of abstinence were highly correlated with the drug screens (Kelly & Moos 2003). Participants completed the Problems from Substance use scale to asses the negative consequences from alcohol and/or drugs including domains such as health, legal, monetary, occupational, intrapersonal and interpersonal, and residential problems.

Participants' beliefs about addiction were measured on a scale that consisted of 10 items taken from the Understanding of Alcoholism scale. Five items were selected from the disease

model and 5 items from the psychosocial model. The beliefs about the disease of addiction were characterized by elements such as loss of control and need for total abstinence. The psychosocial scale consisted of beliefs relating to the influence of psychosocial factors such as whether alcohol or drugs could be used in "moderation". The addiction "identity" was measured by asking whether participants considered themselves to be "addicts" or "alcoholics". The participant's self-identification had shown to be predictive of a more positive treatment outcome (Kelly & Moos, 2003).

Treatment factors were measured by asking whether the case manager or counselor included in the participant's discharge plans recommendations to attend a 12-step group. When an individual is proactively linked with a 12-step program by their counselor or case manager, rather than simply being encouraged to attend a 12-step program, the likelihood of 12-step involvement was significantly improved (Kelly & Moos 2003).

To measure 12-step meeting attendance the researchers asked about the frequency of meeting attendance in the 3 months prior, and were coded on a scale ranging from "none" to "30 or more meetings". The dropout was operationally defined as someone who had attended one or more 12-step meetings during treatment or in the 3 months prior to entry into treatment, but who had not attended a single 12-step meeting in the 3 months prior to the 1 year follow up.

The prevalence of 12-step dropout rate overall at the 1 year follow up was found to be at 60% (n=1,512/2,518). However, the initial 12-step attendees had attended at least one 12-step meeting in the 3 month period prior to the 1 year follow up. Therefore, the dropout rate was 40%. To examine whether participants who dropped out had worse substance use outcomes, logistic regression analysis revealed those who had dropped out of 12-step groups, the odds of having used substances were three times that of the participants who had continued attendance at

the 1 year follow up (OR =2.72, $p<.0001$, 95%CI=2.9-3.23). For substance related consequences those who dropped out from 12-step groups were one-third more likely to report substance related consequences compared to those still attending meetings (OR=1.35, $p < .0001$, 95% CI=1.14-1.60).

Individual predictors for dropout included demographic variables (age, ethnicity, marital status), substance related variables (addict/alcoholic identity, disease model beliefs about addiction, psychosocial model beliefs about addiction and level or degree of prior 12-step group involvement). This 12-step dropout criterion was regressed on each predictor, in separate logistic regression analyses. Results from the logistic regression revealed that participants were significantly less likely to be dropouts from 12-step groups at 1 year follow up if they were of African American ethnicity, reported a formal religious background, believed more strongly in the disease model of addiction and had more prior 12-step group involvement.

Treatment related influences for reducing the likelihood of dropout were tested with a reduced likelihood of 12-step group dropout. The factors included in these analyses were a counselor referral, the degree of cohesion, the support and spirituality present in the treatment environment. The researchers also examined whether during-treatment changes in 12-step attendance was associated with a lower rate of dropout from the 12-step groups. Kelly and Moos (2003) specifically tested if acquiring a sponsor (OR =.73, p =.004), having 12-step friends (OR =.64, p <.0001), and beginning to work the steps (OR =.92, p =.47) was associated with dropout status at 1 year.

Counselors recommended participants to attend 12-step groups 79% of the time (Kelly & Moos, 2003). There was no significant relationship to be found between counselor referral and the dropout rate (OR= 0.83, $p = .05$). However, the researchers found that a more supportive (OR

=93, *p* = .0001), cohesive (*OR* = 95, *p* =.006), and spiritual-oriented (*OR* = 94, *p* =.0001) treatment environment were all associated with a lower odds of dropout at 1 year follow up.

Some limitations from this study advocate the need for further research. This study was only conducted on men so the findings of this study should not be used with regard to women. The researcher's operational definition of "dropout" was too simple. It stated that an individual who had previously attended at least one 12-step meeting in the prior 90 days was considered not to be a dropout.

Sponsors are volunteers who help others work the 12 steps in order to stay clean and sober. Recovery Coaches are paid and trained professionals. Sponsors stick to the steps, fellowship, and traditions and tell the sponsee what to do in order to recover. Recovery Coaches ask their clients how they want to pursue recovery. Recovery Coaches support sponsorship and 12-step recovery but realize that some people may prefer alternatives to 12 step programs or just want stop on their own.

How Recovery Coaches are Different than Addiction Counselors

The RC role is distinguished from the addiction counselor role by important key factors: education and training, the use of self-disclosure, and service relationship (White & Kurtz, 2005). Most addiction counselors today are formally educated and credentialed via certification or licensure, the legitimacy and credibility of the RC springs from experiential knowledge and experiential expertise (White & Kurtz, 2005). The RC involves direct experience with personal/family addiction and recovery, and the addictions counselor requires demonstrated ability to use this knowledge to affect change in others (White, 1996).

While the use of self-disclosure has become increasingly discouraged in the addictions counselor role, it is an important dimension of the RC role. The use of one's own personal

experiences to enhance the quality of service is an inherent part of both the RC and addictions counselor roles, but the use of self by the addictions counselor has changed dramatically over the past four decades (White, 1996; White, 2004; White & Kurtz, 2005). In the past, disclosing one's status as a recovering person and using selected details of one's personal addiction/recovery history as a teaching intervention were among the most prominent counselor interventions. Over time, with the professionalization of addiction counselors such disclosure came to be seen as unprofessional (Cunningham & Breslin, 2004; White, 1996).

The addiction counselor role implies specialty knowledge and skills, governed by legal and ethical mandates. In the addiction counselor role there is an inequality of power in the service relationship that can be misused for emotional, financial, or sexual exploitation (Day et al., 2005). In examining the different relationships that clients experience with RC's and counselors, the differences are not in power equality versus inequality but in degrees of power inequities. For example, such behaviors as accepting a gift from a client, maintaining phone or email contact with a client following his or her discharge from treatment, having dinner with a client, and giving a client a ride to a recovery support meeting would be deemed unacceptable in the counselor-client relationship, but may be accepted and crucial to the delivery of long-term recovery support services.

Day, Lopez, Furlong, Murali, and Copello (2005) conducted a study to examine the potential benefits counseling professionals can bring to facilitating their clients' involvement in 12-step groups such as Narcotics Anonymous (NA). A range of factors may influence the number of substance users attending NA meetings within a particular society, including the level and type of substance abuse; the structure, extent and beliefs of the professional treatment system (Day et. al, 2005).

Previous research done by Wells (2005) suggests that attitudes toward NA were more cynical within both the substance using culture and professional cultures. Day et al. (2005) propose that a key variable may be a recommendation to attend NA by a treatment worker in the field. The likelihood of treatment staff suggesting NA attendance depends on factors such as the chosen treatment goal but may, in turn, depend on their level of knowledge about and their attitude toward NA (Day et al, 2005). Research done by Tonigan et al. (2003) found that if therapists want their clients to be involved in NA, then they should see to it that NA attendance begins during treatment and encourage their clients to attend 3 or more meetings per week.

It has been shown that interest in incorporating 12-step meetings into treatment plans has grown in the United States because of managed care and shorter durations in inpatient treatment programs (Day et al, 2005). Because managed care has reduced the amount of time spent in a treatment facility, treatment professionals are increasingly interested in facilitating patient involvement in 12-step groups as a way of achieving and maintaining treatment goals (Day et al, 2005).

Day et al. (2005) intend to answer a number of questions using a cross-sectional survey design. First, the researchers wanted to quantify how much substance use treatment staff felt they knew about NA and to explore their attitudes and beliefs about 12-step groups. Second, the researchers wanted to investigate the individual factors that are associated with an increased likelihood of referral to NA meetings, including the perceived level of knowledge about the 12-steps and the NA program.

The study included the 61 treatment agencies in the West Midlands of England, which has a population of over 5 million people. These treatment facilities were contacted by phone and asked for the names of all non-medical treatment staff currently working from them. The

researchers sent 487 questionnaires, one to each staff identified from the 61 treatment centers, of which 346 replied. Each Staff was sent a questionnaire by mail along with a stamped return envelope. The questionnaires did not require the staff to reveal their names. Each questionnaire did have a unique code to facilitate the sending of a second mailing to non-responders, and the code list was not made available to the researchers analyzing the data to maintain confidentiality.

The researchers developed a questionnaire that was comprised of 5 sections. The first section asked the participants general questions about the service in which they worked, how long they had worked there, and the type of problems that their clients had. The second section was composed of questions surrounding knowledge and attitudes toward NA. The participants were asked a series of fixed-response questions to rate their overall attitude toward NA treatment, how suitable they felt it was for their clients, and how likely they were to recommend that their clients attend NA meetings. The researchers also asked the treatment workers to estimate the percentage of their client group who attended NA regularly.

To assess the knowledge and experience with NA in the sample, the researchers used a logistic regression analyses. A Majority of the respondents (305) rated their level of knowledge about NA as average or above average with a 133 respondents rating their knowledge as high or very high. Treatment center staffs, with the exception of counselors or case managers, were least likely to report an average or above average knowledge base. Nurses reported that they had a high or very high level of knowledge and nearly a third (114) of the respondents reported they had attended an NA meeting at some point. When the respondents were asked to estimate the percentage of their clients who currently attends NA, the participants indicated that approximately 10% attended NA meetings (Day et al, 2005). This percentage was the lowest for workers who only treated substance users (Day et al, 2005).

The researchers found that when the participants were asked about their overall attitude toward NA, most respondents were unsure. A total of 134 treatment workers said that their attitude was positive or very positive toward NA, and most of the respondents reported that they were neutral in their overall attitude toward NA. A third of the participants felt that their clients were suitable or very suitable for NA, and only 55 reported that they felt their clients were unsuitable for NA. When the participants were asked how likely they were to recommend their client to attend NA, only 45% stated that they would likely or very likely recommend NA meeting attendance. When the participants were asked about their conceptual beliefs about addiction, only 225 responded to the question. Of them, 78% felt that addiction was a bad habit and only 22% felt that addiction was a disease. The factors associated with referral to NA show that significantly more of the participants working in agencies that treat clients with both alcohol and drug problems reported a more positive attitude toward NA than those who treated either alcohol or drug problems alone, and the recommendation to attend NA meetings was also higher.

The survey conducted shows that although staff working in substance treatment centers feel satisfied with their levels of knowledge about the NA program, yet they rarely recommend their clients to attend NA meetings (Day et al, 2005). An important variable that was missing from this survey was the number of treatment workers who were in recovery themselves.

Conceptual Framework

Systems theory, when applied to an individuals' system as a whole, requires a shift in focus from the symptoms or problems of the individual; to the overall system of which the individual is a part of. This approach recognizes that the individuals (or parts in the system) have a consistent relationship to each other. These parts of the system interact in particular ways which sometimes produce symptoms (e.g. not having support system in place to address issues

that surround recovery). Looking at the relationship between the various supports in an addicts life (e.g. addictions counselor, recovery coach, sponsor, 12-step meetings, ways to access support services); it is best to look at the whole system to better identify the interactions and relationships these have on each other. Systems theory affords the ability to look at the picture as whole of a person's life and how to better enhance the whole system.

Methodology

Research Design

This is a qualitative study using a semi structured online interview format. The goal of the researchernwas to identify the importance of recovery coaches in aiding addictions counselors and 12 step programs in the long term recovery from addiction. The researcher hoped to compare and contrast the role of the addictions counselor, a 12 step sponsor, and a recovery coach to highlight the importance of each role, as well as identify the barriers that exist to better enhance a person's recovery from addiction. The researcher wanted to gather data in a way that would preserve the language of the participant. To achieve this goal, the researcher selected a mixed method research design, an online survey of open-ended and closed-ended questions.

Sample

The population for this study was recovery coaches, persons who have participated in a recovery coaching program, addictions counselors, members of 12 step programs, and 12 step sponsors. To be eligible for this study, participants had to be at least 18 years of age and have a role as a recovering addict, recovery coach, received services from a recovery coaching program, addictions counselor, a member of a 12 step program, and is or have been a 12 step sponsor. Fifteen individuals participated in the study including recovery coaches (n=1), addiction

counselors (n=5), 12-step sponsors (n=12), and persons in recovery themselves (n=13). The total responses were higher than the number of participants in the study because all respondents were asked to mark each category that applied to them.

Participants were recruited by advertising at local treatment clinics, hospitals within southeast Minnesota and southwestern Wisconsin, and 12-step meetings within southeast Minnesota and southwestern Wisconsin. Advertisements noted that persons who do not fall into the criteria are not eligible to participate. Individuals informed of the study were also encouraged to inform other persons who fit the criteria to participate in the online survey. Other than the stated roles identified for this study, no other exclusions were made with regards to participants, as long as they met those qualifications.

Data Collection

The semi-structured online survey consisted of 32 questions regarding experience with recovery and recovery coaching programs (see Appendix B). The survey was administered using an online survey. The research study was approved by the Institutional Review Board of St. Catherine University prior to data collection. Ethical measures were used to protect the study participants. To protect the anonymity of the participants, the researcher chose to create a survey that was posted on the internet for participants to complete. Their participation was completely anonymous and they were able to answer as completely as they chose to. Participants could also decide not to participate in the survey altogether. This online survey included consent to the survey; the participant was informed the consent was given by taking the survey (see Appendix A). On the consent form presented to the participant in the online survey was the purpose and procedures involved in the study (see Appendix A).

Participation in the study was explained to be voluntary and the participants would be given the option to skip any questions that he/she did not want to answer in addition to stopping the interview at anytime. The researcher explained in the consent form that data from the online survey would be later presented as part of a clinical research presentation, but that the participants' identities would remain confidential and no identifying information would be present

Additionally, participants were informed that their participation in the study would have no bearing on their relationship with St. Catherine/St. Thomas University, the Minnesota Recovery Connection, the treatment setting they may or may not participate in, as well as the recovering community they live in. St. Catherine/St. Thomas University, treatment centers, 12 step meetings, and recovery coaching programs were not informed as to who participated in this study. The research records and online interviews were kept in a locked file once printed from the internet in the home of the researcher. The online interview data is protected online by a username and password that only the researcher will have access to. Participants are not being offered any monetary payment for their participation in this study.

A consent form, attached as Appendix A, was listed on the website for the participant prior to the online interview to ensure subject privacy and protection. This consent form was approved by the St. Catherine University Institutional Review Board (IRB) and contains the appropriate information on the participants' privacy and anonymity. In addition, this consent form maintains compliance with the Protection of Human Subjects requirements as well as qualified for exempt level review by the Institutional Review Board.

This researcher contacted the local outpatient treatment clinics in the Houston county of MN and La Crosse county of WI in order to utilize their help in informing people in the target

population study. All facilities contacted agreed to post a flyer in waiting areas to inform eligible

people of how to become involved. These flyers include information briefly explaining the study

and calling for eligible participants interested in participating to go to the website listed to take

the survey. This flyer also includes contact information if they have any questions about the

survey or the study itself.

Data Analysis

In order to analyze the data obtained from the interview, the research methodology of

grounded theory was utilized. Grounded theory, an interpretative approach to analysis of the

qualitative data, was used to analyze the responses from the online survey (Monette et al, 2011).

Once three or more codes, or patterns found in the data, a theme was created consisting of a

minimum of three literal quotes from the participants. Codes and themes were carefully

identified throughout the online survey data.

The research began by printing off all of the responses. Using the printed surveys, the

researcher coded the data to look for themes in the material. These themes were considered

common if the response was found in three or more surveys. The researcher used open coding to

look for patterns in the data and to verify what themes were most common throughout the data

(Monette et al, 2011). Codes were generated from the data, rather than predetermined. The

researcher then used a deductive approach to match these themes back to the original words used

within the online survey. The data was then re-analyzed inductively through a second review of

the data to check for any applicable codes seen in the data.

Findings

Participant Demographics

The results of the survey reflected the experiences and views of the participants surveyed. Each participant voiced their opinions by answering the open-ended online survey questions. Of the 15 respondents who took the survey, five were addictions counselors, 13 are in recovery themselves, 12 respondents have been a 12-step sponsor in a program such as Narcotics Anonymous, and one had participated in a recovery coaching program. All respondents were asked to mark each one that applied to them. Participant's who took the survey had the opportunity to choose more than one category that was relevant to their status as a participant in the survey.

The mean age in years is 43 years old. Of the respondents' who took the survey, three were male and 12 were female. The survey began with questions about the respondents' attendance at 12-step meetings. Participants' attendance ranged from 0-18 meetings in the last 7 days and 0-126 in the last 30 days. The questions begin by gaining an understanding of the respondent's experience in working with people with addiction, then gain complexity by addressing gaps in service to those affected by addiction. The questions were intentionally formed this way in order to gain a better understanding of the relationship between how perception of people affected by addiction could benefit from a peer based recovery support program.

Treatment Alternatives

The first theme that was found related to treatment alternatives and how the community has identified the need for support and the difficulties they are having getting it started. The researcher noticed the theme of treatment alternatives during the reliability check and developed several different references throughout the survey's that were made in regards of identifying alternatives for support and how to connect consumers to that support. The respondent's statements in regard to this question are as follows:

I know that there is some other places that there are some recent movements in looking at training individuals who are in recovery from mental health with some substance abuse. There's people looking into the validity of that and how to put that in play. I am not quite sure how far they are with all of that.

Most people think, "That's (Narcotics Anonymous) not for me", and its hard for most of us to feel like we fit in.

It's really hard in this community there's very little (support)although I know aurora mental health recently put together a peer specialist and Western Wisconsin Cares contracts with them for a couple of people. When they identify someone with some chronic substance abuse they try to put one of those workers in the home. I am not sure how well it's gonna be integrated into mainstream.

I have had 3 (sponsors) in my recovery life. My first one was there for me for about 2 years but relapsed, so then i got a 2nd one and she picked me up every Saturday and took me to a meeting and then breakfast and we talked about life issues. She got her Professional license back and I did not hear from her after about a year. My present Sponsor has been there to guide me through my Step work however, she hasn't been there for me in over a year and has not returned my phone calls, her life has changed with a boyfriend and new baby. So, i feel I need a new Sponsor

Effectiveness of Narcotics Anonymous (NA)

The next theme that was discovered related to the effectiveness of 12-step programs at engaging consumers to stay in their programs to gain long term sobriety. The following quotes from the respondents' support this theme:

I would have loved to provide them (sponsors) with some training because I think that some sponsors can be marvelous but I think sponsors can also inadvertently turn some people away who might have been candidates for getting some support as they go down that road.
We are asking people in a pretty vulnerable state to make pretty huge leap. (to attend 12 step meetings) I like to tell people to imagine for moment, you have been diagnosed with something and you are ashamed and now you are told to go into a meeting and if you want to get well you gotta walk in there and say you are so and so and that you are an addict. Now how many times do you think you need to do that before you start to feel comfortable? And how often do you think you might leave that first meeting you might leave that first meeting going hmmm. I don't like those people, they don't like me. How often do you think people want to repeat going through that emotional stress there.

Human frailty. Egos. Addicts who think they are "working the program" but are truly not invested and "act out" routinely. They may not, (probably don't), even realize the dangers they present to others when they misrepresent the program (NA).

I think we really missed the boat there. I think that 12 step groups have a lot of value but it that orientation phase that the ball can really get dropped. What if they happen to pick the one group to go to that rigid or not accepting of people on medication and also remember that people in recovery groups have stigmas and stereotypes of people with MI issues, not only do they not feel welcome they probably weren't. It's one of those areas where we say it doesn't work but we haven't made sure they can get past that initial phase.

The respondents' were asked how many 12 step meetings they attended in 30 days. The average for all meetings attended in 30 days was 20. The ratio variable in this study measures respondents' meeting attendance. This variable is operationalized with the question "During the past 30 days how many recovery related support groups did you attend". The response ranged from 0-126 meetings attended. The nominal variable in this study measures if the respondents' have ever relapsed. This relapsed variable is operationalized with the question "have you ever relapsed?" The response options are yes or no.

The research question for the study is: What is the relationship between the respondents' meeting attendance and if they have relapsed? The research hypothesis for the study is: There is a relationship between respondents' meeting attendance and if they have relapsed. The null hypothesis is: There is no relationship between the respondents' meeting attendance and if they have relapsed.

Table 2 shows the correlations of the relationship between the two variables, Meeting Attendance and Relapse. The calculated correlation ($r=-.393$, $p > .0001$) indicates a negative

moderate correlation; a negative correlation indicates the variables are inversely related. As one variable goes up, the other variable goes down. In Table 2 the p value is .147; however this is greater than .05, it indicates this is not a statistically significant relationship between meeting attendance and relapse; therefore we fail to reject the null hypothesis.

Table 1. *Descriptive Statistics for the Relationship Between Meeting Attendance and Relapse*

Descriptive Statistics

	Mean	Std. Deviation	N
Meeting Attendance	19.47	31.566	15
Ever Relapsed	1.53	.516	15

Table 2. *Relationship Between Meeting Attendance and Relapse*

Correlations

		Meeting Attendance	Ever Relapsed
Meeting Attendance	Pearson Correlation	1	-.393
	Sig. (2-tailed)		.147
	N	15	15
Ever Relapsed	Pearson Correlation	-.393	1
	Sig. (2-tailed)	.147	
	N	15	15

**. Correlation is significant at the 0.01 level (2-tailed)

The ratio variable in this study measures respondents' meeting attendance. This variable is operationalized with the question "During the past 30 days how many recovery related support groups did you attend". The response ranged from 0-126 meetings attended. The ordinal variable in this study measures the respondents' success in detaching from unhealthy relationships. This

detachment variable is operationalized with the question "I would rate my success in detaching myself from prior alcohol and drug focused relationships as" The response options are poor, making progress, good and excellent.

The research question for the study is: What is the relationship between the respondents' meeting attendance and success in detaching from unhealthy relationships? The research hypothesis for the study is: There is a relationship between respondents' meeting attendance and ability to successfully detach from unhealthy relationships. The null hypothesis is: There is no relationship between the respondents' meeting attendance and success in detaching from unhealthy relationships.

Table 4 shows the correlations of the relationship between the two variables, Meeting Attendance and Detachment. The calculated correlation (r=-..250, p > .0001) indicates a negative weak correlation; a negative correlation indicates the variables are inversely related. As one variable goes up, the other variable goes down. In Table 4 the p value is.368. This is greater than .05, it indicates this is not a statistically significant relationship between meeting attendance and relapse; therefore we fail to reject the null hypothesis.

Table 3. *Descriptive Statistics for the Relationship Between Meeting Attendance and Detachment from Unhealthy Relationships*

Descriptive Statistics

	Mean	Std. Deviation	N
Meeting Attendance	19.47	31.566	15
Detachment	3.13	.352	15

Table 4. *Relationship Between Meeting Attendance and Detachment from Unhealthy Relationships*

Correlations

		Meeting Attendance	Detachment
Meeting Attendance	Pearson Correlation	1	-.250
	Sig. (2-tailed)		.368
	N	15	15
Detachment	Pearson Correlation	-.250	1
	Sig. (2-tailed)	.368	
	N	15	15

**. Correlation is significant at the 0.01 level (2-tailed)

Differences of Recovery Coaches and Sponsors

The next theme relates to the differences between sponsors and recovery coaches. Most respondents' (n=13) did not have any knowledge of what a recovery coach is. The researcher identified this theme throughout the interview. The importance of having someone that can participate in the process with the consumer that is willing to commit to supporting him or her all the way. The importance of supporting the consumer through the range of emotions and not having as much rigidity as a sponsor might have. Twelve step sponsors are not supposed to focus on many areas of the addict's life. Twelve step sponsors have their own lives, jobs, families to take care of; unfortunately this can and will affect the sponsor's ability to be there for the addict. The following quotes from the respondents support this theme:

Someone to guide me through my moment in time. Someone I trust, someone who I can be honest with.

A recovery mentor would be someone who understands the recovery process, to also have some basic skill set in communication, problem solving skills, and that they would literally make an agreement just like in a recovery mentor program. Often you schedule a particular time that you meet perhaps the 2 people would set the goals and agenda together and then reevaluate it to make sure that people were actually fulfilling the bargain that would be a typical piece but I really see that it would be someone who could say oh yeah that's an interesting point you bring up here's how I understand it.

But I would also want them to engage in some training around boundaries, they would need to know how to put themselves in a position of help and support rather than mix up and confuse. Communication can get so out of whack.

Differences of Recovery Coaches and Addiction Counselors

The last theme has to do with the differences between recovery coaches and addiction counselors. Again many respondents' (n=14) did not have any experience with recovery coaches, but were able to articulate they could see a difference between an addictions counselor and a recovery coach. The following quotes from the respondents' support this theme:

I would probably want them to have 2-5 years of recovery, if they are to be a recovery mentor I lean toward they have to have that (addiction) experience. While I don't believe the same thing is true for therapists, I would really want the recovery coach to have the experience of recovery.

I think the trickiest thing always has been to be able to get the community to get together and work together and everyone is so afraid they are going to lose what they have they tend not to be willing to share or someone wants to take all the toys.

Addiction counselors cannot attend meetings with you, I wish they could. I trust my counselor and I wish she could be my sponsor. But she cant because I guess it is against her code of ethics or something.

Only through doing through research was a I able to identify the breakdown of support from addiction counselors to addicts. Ethics do play a role in supporting the counselor-client relationship and there are certain things that counselors are bound by where a RC would not have to necessarily be bound by. They could pick up the client and take them to meetings. They would not be excluded from attendance because they themselves are in recovery. Many of the barriers that impede an addict from attending 12 step meetings would be eliminated with the role of a recovery coach.

Discussion

What participant's stated in the research appears to be consistent with the research that is out there. Only through doing through research was I able to identify the breakdown of support from addiction counselors to addicts. Ethics do play a role in supporting the counselor-client relationship and there are certain things that counselors are bound by where a RC would not have to necessarily be bound by. They could pick up the client and take them to meetings. They would not be excluded from attendance because they themselves are in recovery. Many of the barriers that impede an addict from attending 12 step meetings would be eliminated with the role of a recovery coach. It was interesting to hear the respondents' who had some knowledge see the real gap that lies within the system of continuing care.

The confirmation of identifying treatment alternatives has already been established in the recovery literature. Until recent years, since the economic downturn people have begun to identify more creative ways to approaching the disease of addiction. When the treatment boom happened in the 1970's money and resources were plentiful (White, 2004). After the process of professionalizing the addiction counseling field and the old adage of being in recovery was the best qualifier to be an addiction counselor went out the window (White, 2004). Yet, in this research several themes are present that shed light on the significant reasons for the need of RC's.

Day et al. (2005) found that the 12-step model is the most widely used treatment philosophy for substance use disorders around the world. So many treatment centers do the best they can to connect their clients with a recovery support program but cannot fully see the effects of the outcomes of the clients' attendance due to the fact of anonymity. Few studies have actually been able to fully measure the effects of 12-step meeting attendance for this very reason. This in turn identifies a gap needed in services where someone would have a look into how that clients recovery supports are going. Participant's identified that it would have helped them or they might have been more successful in attaining 12 step meeting attendance if they would have someone to attend the meetings with them in the first stages of the recovery process.

Another similarity between the literature and the findings in this study is in regards to the effectiveness of NA. The respondents' (n=15) agreed that 12-step programs are one of the biggest supports for people who suffer from addiction, but somewhere along the line a breakdown in communication happens.

One study that was conducted called The 2007 Membership Survey "marks the first time that members were asked to assess areas of their lives that have improved with NA attendance" (Narcotics Anonymous World Services, 2008). The study finding (n=15) that 12-step programs are one of the biggest supports of people in recovery is consistent with the literature reporting enriched family relationships and social connections resulting from NA attendance (Narcotics Anonymous World Services, 2008)

The respondents' (n=11) identified a sponsor versus recovery coach as an area that needed attention in relationship to connecting newly clean people to 12 step programs. Where the sponsor-sponsee relationship is based on a reciprocity of need (the sponsor is there in part to support his or her own sobriety) (Alcoholics Anonymous World Service, Inc., 1983, p. 7).The recovery coach has a relationship with those he or she serves; a relationship governed by ethical/legal duties and obligations (Kelly & Moos, 2003). Sponsors have no formal training; it is more passed down from tradition of whatever their sponsor taught them. This way of passing down tradition does not work for everyone. Each individual is addicted yes, but at the same time they cope in different ways. Their interpretation of the 12 steps is supposed to be a individual, spiritual experience; yet they have someone with 5 years clean who is telling them they are working recovery wrong. A RC role would not be to work the 12 steps with an addict, the role would focus more on the emotional pieces that sponsors are not paying attention to.

The respondents' noted some differences that play an important role for the recovery of the client. Respondent's reported addiction counselors cannot give the client a ride to meetings, give them gas money, or provide daycare for their children while they attended the meeting. The respondents' also identified the lack of funding available for the addictions counselor to take the time to process meetings attended in a supportive setting. Treatment for addictions is time

limited these days and counselors have many items essential to cover when it comes to the welfare of the client and giving them what they need. This literature states there are certain ethics addiction professionals need to adhere to, whereas the developing role of an RC would not need to adhere to as strict ethics or boundaries.

Implications for Social Work Practice

The findings of this research indicate that many factors contribute to identifying the need for more formal development of a recovery mentor or coach. Funding continues to get cut from the addiction field; the literature found for this research supports these themes as well. Social work practice should work on finding ways for people who suffer from addiction to access needed resources. Often this disease is overlooked; people blame people with addiction as if they chose to become addicted. Social work practice should focus on how to decrease the stigma of addiction and develop alternative ways to support an addict other than suggesting they go to 12 step meetings in a room full of strangers and be honest about their own feelings. Research has shown that it takes 4-5 years of sobriety to truly decrease the effects of addiction (Troumbou et al.2002). Treatment for addiction has never lasted that long. Funding for addiction of payment from insurance companies will not pay to treat someone for that duration, nor should they. The real gap lies in between the ending of a treatment program and connecting someone to lasting support.

The importance of early and sustained recovery support is further indicated by treatment-related studies confirming that: most people with alcohol- and other drug-related problems do not seek help through mutual aid or professional treatment (Cunningham, 1999; Cunningham & Breslin, 2004), less than half of those admitted to publicly funded addiction treatment

successfully complete treatment (SAMHSA, 2008; Stark, 1992), more than 50% of individuals discharged from addiction treatment resume alcohol and/or other drug use within the following twelve months (Wilbourne & Miller, 2003), recovery from addiction problems are not fully stabilized until between four to five years of sustained remission (Wilbourne & Miller, 2003), the transition from initial recovery to lifelong recovery maintenance is mediated by the process of social support (Humphreys et al.,1999), and approaches to post-treatment continuing care can elevate long-term recovery outcomes in adults (Prochaska & DiClimente, 1999). Based on the respondents' responses to the longevity of sobriety, there is a clear indication for a need to find ways to develop long term support for people who suffer from addiction.

Strengths and Limitations

A major strength of this study is the nature of the information to be collected through a mixed methods approach. Since recovery coaching is a newer area of research, online survey's will allow the researcher to really look in depth at individual experiences, providing rich data that has not been fully studied in the current review of the research.

For data collection, an online approach was chosen as it would have several important advantages: The flexibility of the online format would make it possible to include and directly compare different groups (i.e. recovery coaches, persons in recovery, 12 step sponsors, and persons who have participated in a recovery coaching program). Also, the online format would support anonymity. Finally, the flexibility of an online format will enable participants to add freely further information and/or answer possibilities to most questions. Thus, despite its strong quantitative nature, this online survey can remain largely exploratory and open to the overall Grounded Theory approach.

One of the debates surrounding Internet-based research involves informed consent (Monette et al, 2011). The use of Internet methods precludes the ability to obtain a signed informed consent document. In most instances individual university review boards must determine acceptability of the procedures. One way I intend to obtain informed consent in an online context participants will be directed to a website that provides a full description of the study (Monette et al, 2011), after which participants are directed to select an option to decline participation or to enter the online survey.

External validity speaks to the ability to which the research findings can be generalized. It is difficult to generalize findings to the general population when the sample used is unrepresentative and not randomly selected. Therefore, the results of this study apply specifically to the sample researched, rather than generalizing to the wider population. In regards to external validity this research will be based on self report of the participants. Therefore it is possible to that information collected may not actually be representative of their experience, rather how they choose to report on their symptoms and experiences. If the setting in which they took the online survey such as their home or a library affected the participants, then a reactive setting could be a threat to external validity. Another limitation would be having the ability to access a computer or the internet.

The findings of this study helped to answer my research question by identifying the gap in service to individuals who struggle with addiction. All respondents' (n=12) who identified themselves as an addict indicated they relapsed once treatment stopped if they did not start participating in some sort of 12-step support group while in treatment or once treatment ended. The respondents who identified themselves as an addict also stated it was very difficult for them

to participate in a 12-step program because they had to initiate the support all on their own. The findings of this study implicate a need to find better ways to enhance a persons' long term recovery from addiction.

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Appendix A

Recovery Mentorship Programs
RESEARCH INFORMATION AND CONSENT FORM

Introduction:
You are invited to participate in a research study investigating Recovery Mentorship Programs. This study is being conducted by Carmen Berzinski, student in the MSW Program at St. Catherine University. Valandra, the faculty advisor will be overseeing the research conducted in this study. You were selected as a possible participant in this research because you fit into one of the following criteria: (a) you are an addictions counselor (b)you are in recovery yourself (c) you are or have been a 12-step program sponsor(such as Alcoholics Anonymous or Narcotics Anonymous) (d) you are a recovery coach (e) you have participated in a recovery coaching program. Please read this form and ask questions before you decide whether to participate in the study. In order to participate in this research study, you must be 18 years of age or older.

Background Information:
The purpose of this study is to identify sources of support for people who struggle with substance abuse issues in the community and to find ways to better support those individuals. Approximately 15 people are expected to participate in this research.

Procedures:
If you decide to participate in this survey, you will be asked 32 questions related to your experience with 12 step meetings, recovery coaches, addictions counselors, recovery coaches, your past treatment experience, and barriers that might affect your ability to access support. This on-line survey should take you approximately 50 minutes to complete.

Risks and Benefits:
The study has minimal risks.   First, you will have to have the ability to access the Internet. No personal identifying information will be asked of you. Second, if you feel uncomfortable in any way at anytime, you have the right to stop the survey at anytime you so choose.

There are no direct benefits to you for participating in this research.

Confidentiality:
Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results in a password protected computer and/or a locked file cabinet in my home and only myself and my advisor will have access to the records while I work on this project. I will finish analyzing the data by 01/31/2013. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:
Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with Minnesota Recovery Connection, any outpatient clinic where you attend treatment, and 12 step programs that you participate in, or St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

Contacts and questions:
If you have any questions, please feel free to contact me, Carmen Berzinski at1-608-406-4490. You may ask questions now, or if you have any additional questions later, the faculty advisor,Valandra, at 1-612-963-3767, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher,you may also contact the Saint Catherine University Institutional Review Board by talking to Lynne Linder, administrative assistant, at lelinder@stkate.edu, 651-690-6951.

Statement of Consent:
You are making a decision whether or not to participate. Your decision to fill out this survey indicates that you have read this information and your questions have been answered. Even after starting this survey, please know that you may withdraw from the study at any time and no further data will be collected.

Appendix B

Questionnaire about Recovery Coaching and your Experience with Recovery

This researcher is trying to understand how the roles of a recovery coach, sponsor, and addictions counselor can help enhance long term recovery from addictions. I am also trying to assess reasons why it might be difficult to access supports in your community. This is important in the field social work research to better understand ways to enhance long term recovery from addiction. All that is required of you is to fill out this survey. This questionnaire should only take about 50 minutes to complete. If you decide to participate in this study, remember that participation is voluntary. You can choose at any time not to complete this questionnaire. Responses to this questionnaire are anonymous—there is no way that you will be identified in any way with the responses on this questionnaire. If you have never attempted any period of abstinence or experienced a treatment program, please do not answer questions that pertain to sobriety or participation in a treatment program.

1. During the past 7 days, how many recovery related support groups did you attend? _____

2. For how many of these meetings did you stay for the *whole* meeting? _____

3. During the past 30 days, how many recovery related support groups did you attend? _____

4. For how many of these meetings did you stay for the *whole* meeting? _____

5. On average, how often do you attend recovery related support groups in a week? _____

6. I am very interested in learning in your own words when you don't really want to go to a recovery related support group, what gets you there?

7. Have you ever relapsed? _____yes _____ no (please go to question # 9)

8. How many times? _____

9. What is the longest length of sobriety you have accomplished? _____ (in years and months)

10. How long have you currently been sober? _____ (in years and months)

11. What is your age? _____

12. What is your gender? _____woman   _____man

13. Do you currently have a sponsor? _____yes   _____no (please go to question # 15)

⬇

14. Would you like to have a sponsor? _____yes   _____no

15. The number of phone numbers I have of people who support my recovery is (please circle your answer).

    1-5 people

    5-9 people

    10+ people

16. I would rate my success in detaching myself from prior alcohol- and drug-focused relationships and places as
    Poor
    Making progress but needs improvement
    Good
    Excellent

17. What would help you attend more meetings? Please list you top 4 choices, by placing the

numbers one, two, three, and four in the spaces provided. 1= most important 4= least important

    _____ I don't need any help

    _____ Childcare

    _____ Transportation

    _____ Money for gas

    _____ Meeting times that are different from the current schedule

    _____ An program that could help with meeting attendance

    _____ More convenient meeting locations

    _____ A list of places and times where meetings are located

_____ Someone to go with

18. I am interested in learning in your own words how you were first introduced to recovery related meetings?

19. Would you have found it helpful to have had someone such as another person in recovery attend your first few meetings with you? Please explain.

20. If you have been in a treatment program, did the program require that you attend recovery related meetings?

   (Check one answer)

   _____ I have never been in treatment

   _____I have been in treatment, but the program did NOT require that I attend recovery related meetings

   _____I have been in treatment, and the program DID require that I attend recovery related meetings

21. Have you ever been required by a court or judge to attend recovery related meetings?

   ____No ___Yes

22. If you are a recovering addict or have been in recovery in the past please answer the following question. If this does not apply to you please move on to question 23.

In the past 30 days how often did you…	About once a day	Several times a week	About once a week	Rarely	Never
Think about using chemcials?	1	2	3	4	5
Want to use chemcials?	1	2	3	4	5
Feel a strong	1	2	3	4	5

use to use chemcials?					
Wish you could use chemicals to feel better?	1	2	3	4	5
Struggle to keep from using chemcials?	1	2	3	4	5

23 .When you hear the words "recovery coach" what does that mean to you?

24. Tell me about what you feel are the issues that prevent someone from attending recovery related meetings.

25. What do you feel could be done to connect people in recovery to support groups in the community?
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26. When thinking about people with addictions, what defines success in your opinion for those individuals?

27. Tell me about your perception of people in recovery and what makes them successful?

28. Tell me about your experience with Addictions counselors.

29. Tell me about your experience with 12 step sponsors

30. Tell me about your experience with Recovery coaches.

31. What are other barriers do you see in the recovering community?

32. What do you see are positive aspects of a recovering community?

Here are some resources available to you if you feel there are any issues that you would like to talk to someone about as a result of taking this survey:

http://www.greatrivers211.org/ or Dial 2-1-1 or toll free in WI, MN, IA, (800) 362-8255

TTY - (866) 884-3620.

Minnesota Regional Helpline (877) 767-7676 TOLL FREE

http://naminnesota.org/

http://www.bigriversna.org/resources.htm