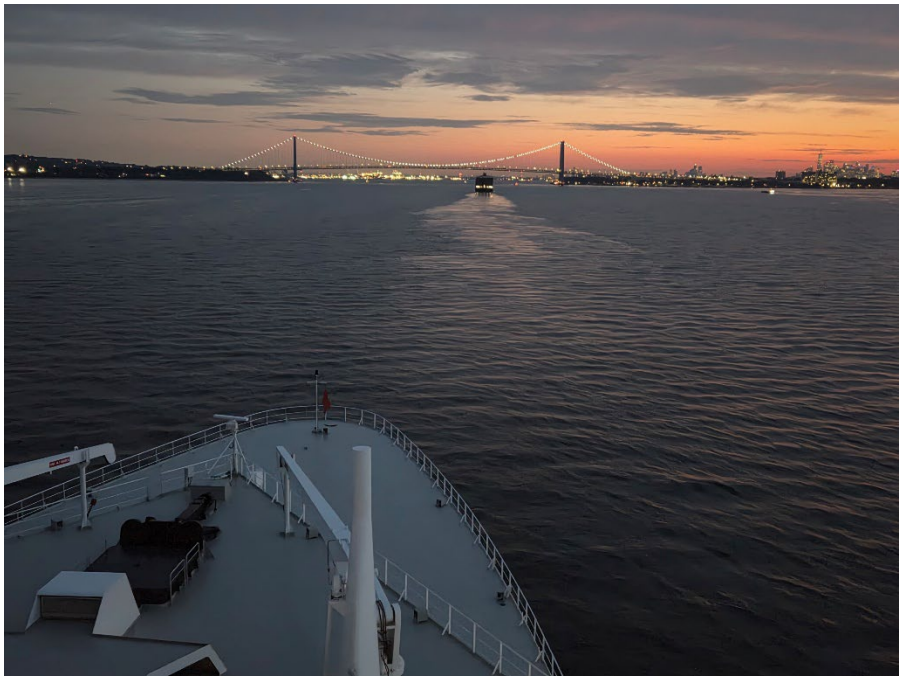
Revisiting William White - Sponsor, Recovery Coach, Addiction Counselor:
The Importance of Role Clarity and Role Integrity – Bill Stauffer & Mark Sanders

"The fate of the recovery coach role will be influenced by the forces that shaped those roles that came before it: the future evolution of professional treatment organizations and recovery mutual aid societies, evolutions in the design of addiction treatment (e.g., from acute care models to models of sustained recovery management), trends in service reimbursement policies, and what may be the inevitable professionalization of the RC role. It will be hard to retain the role's recovery focus, but history tells us that if this focus is lost, new roles will eventually emerge to recapture this focus. At the moment, the role of RC holds promise in elevating long-term recovery outcomes through the provision of pre-recovery, recovery initiation/stabilization and recovery maintenance support services and by expanding the quantity and variety of recovery support services in local communities." – Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity William White (page 18)



In 2006, William White completed an extensive paper comparing the emerging role of Recovery Coaches also known as peer supports which had risen up to bridge the gap between brief professional treatment and the long-term process of recovery. As the leading historian and thought leader of our time, he along with others who have seen our field unfold are deeply concerned about the evolution of the discipline. He had witnessed firsthand how the experiential role of the addiction counselor at the inception of the field in the early 1970s had devolved to the point that twenty-five years later the field had largely lost the capacity to connect people to indigenous communities of recovery.

As background, the need for a broader focus on long term recovery, that included the innovation of peer support within the larger New Recovery Advocacy Movement was in no small part the outcome of a field that had lost its focus on recovery. It had become dominated by market forces and not community needs. Ethics in the field eroded, as summarized it in a review of his 1994 essay, a commitment to ethical action. He listed six bullet points to highlight what he and many of us saw unfold in our field in that era:

1. An abundancy of private pay units with open beds and a lack of access to publicly funded programs.
2. As private sector programming rapidly expanded, there were many mergers and reorganizations impacting the field.
3. Staff morale in the field had eroded, which contributed to excessively high turnover rates for direct service workers.
4. Seasoned workers left the field because the spirit of the work had been lost.
5. Harm in the name of help / exploitation for financial gain led to a crisis in public confidence in the field.
6. A growing sense that the identify and character of the field was no longer in the control of those in the trenches who best understood the challenges and opportunities.

It was out of this soil that the New Recovery Movement and the innovation peer support / recovery coaches emerged. Given the history of the field, White warned us that role confusion and over-professionalization can erode both the peer support role and the existing community recovery capital. He could see presciently that the vitality of peer services is connected bidirectionally with both the vitality of the broader movement and the ecology of the recovery community. He concludes the essay asserting that that clearly defined roles, strong ethical standards, and sustained recovery support are essential to improving long-term recovery outcomes.

We wanted to revisit this important paper to see how the role has evolved. To consider the substantive progress we have made strengthening the role and to revisit the challenges he was concerned about twenty years ago. The role differed

from existing ones in our field but was evolving and not fully defined. In the essay written twenty years ago he distinguishes the scope of functions for sponsors, recovery coaches, and addiction counselors, emphasizing that each serves a unique and complementary purpose rather than competing with one another. He framed services and supports as an ecological onion at the center of which is self and close familial or recovery family structures. The second layer is community. Formal support and treatment services are one level further out at the third layer where tentacles emanate out to medical and social service institutions. He envisioned the recovery coach as the vital connective tissue bringing the fragmented elements of the ecosystem and the pathology-oriented institutions into a more cohesive process reoriented to strengths and resiliency factors. This places the recovery coach as a change agent not just for the person served but also our broader institutions. This was integral to shift our focus away from acute treatment and grounds it in long-term recovery. He was deeply concerned of recovery coaches / peer supports becoming an adjunct to our care system and if this unfolded, the transformation of our service system would ultimately fail.

Role Viability in the Context of the Broader New Recovery Advocacy Movement

The foundation of the peer role was in essence to be a recovery carrier that help persons develop a sense of belonging within indigenous recovery communities. Conceptually, it was understood that the role would require a focus on building community across multiple pathways of recovery, not just an individualized service role. It was recognized that the fate of the recovery coach / peer support function was dependent on the health of the broader movement and the viability of recovery community, both which require intentional tending and nurturing to remain healthy. This includes a focus on strengthening the sinew of indigenous recovery community. The vision for recovery coaches / peer supports was to serve as a fulcrum to shift our collective efforts from a billable hour model to a community strengthening model. White was able to see that a peer service orientation posed a very real risk of attrition to the underlying movement as the service facet would become detached from the underlying communities of recovery. It is the outcome that repeats over the course of our history that William White has documented time and time again and a deep concern he had in this essay.

One of the greatest long-term challenges in our field is that what the industry focuses efforts on is not the same as what we need to heal and flourish over the long term. Twenty years on, we continue to fund acute care strategies but fail to properly support the processes of sustained recovery that found within our communities. We serve people in ways that ultimately support the system but not the community needs. Peer support sprouted from a movement a generation ago aimed to radically transform our care system. To bridge the gap from acute service-oriented care to sustained community grounded processes of resolution. Not just to establish a new adjunct role within our acute care structured system.

The writings of John McKnight were quite influential in White's 2006 essay. McKnight saw that when institutions do things for people and communities that they can and should do for themselves as paid services, those same institutions rob those served of agency for the benefit of the institution. It fosters dependency, not resiliency.

As White wrote:

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

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

Contrast of Peer Support / Recovery Coach to Sponsor and Counselor

White distinguished three complementary roles: the sponsor, counselor, and emerging recovery coach / peer support. As he articulated, the mutual aid sponsor offers mutual support within a particular recovery fellowship, while the counselor provides clinically focused treatment based on professional training. The recovery coach was envisioned as the bridge

between these worlds and the person's individualized recovery processes and pathways of recovery. Unlike the counselor, the coach or peer focuses less on treatment and more on building recovery capital, relationships, community, and a sustainable life in recovery. Unlike the sponsor, the coach/ peer is not tied to one pathway or recovery fellowship and can support multiple pathways of recovery. The greatest potential of the role is connecting people to existing recovery community and related resources rather than becoming the resource themselves.

Twenty years later, these distinctions remain fundamentally sound, even as the roles have increasingly overlapped. Recovery coaching has become more professionalized, while counselors have become more recovery-oriented and sponsors remain essential natural support. The inherent danger that White was able to see twenty years ago is that recovery coaches / peer supports become simply another form of counselor or case manager within the behavioral health system. The enduring challenge is to preserve the lived experience, community connection, and non-possessiveness that made recovery coaching different in the first place.

The Philosophical Grounding for Recovery Coaches / Peer Supports is Experiential in Nature
In considering the section of White's paper on the philosophical farmwork of recovery coaching / peer support, it is clear that experiential learning is at the cornerstone of the role, not traditional classroom training. As he writes *(page 11): Experiential learning at the core of viable peer recovery support. The practical implications of this orientation are that the RC (recovery coach):*

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

Based on his work to understand the evolution of recovery supportive processes across many generations, White described what he termed a recovery carrier. A recovery carrier is, in essence, a person who nurtures the culture of recovery into relationships and communities. Recovery carriers are people, typically in recovery, who make recovery infectious to those around them by their openness about their experiences, their quality of life and character, and the compassion for and service to people still suffering from alcohol and other drug problems. They don't tell someone *how* to recover; their presence communicates that recovery is possible, meaningful, and readily available. This is vital to how we develop effective recovery coaches. There are key facets here across five points: **1) Experiential knowledge matters.** A person who has not just survived but flourished through addiction into recovery possesses a form of knowledge that cannot be acquired entirely through formal education. **2) Recovery is transmitted relationally**. Hope, values, language, behaviors, and identity are learned through relationships with people who embody recovery as they walk along side recovery initiates. **3) The recovery coach / peer support embodies the proof of recovery**. Their life demonstrates that recovery is not merely a clinical outcome but a way of living. **4) Recovery carriers connect people to indigenous recovery community.** White repeatedly emphasized that healing occurs through connection with families, peers, recovery communities, and other sources of recovery capital. **5) They don't need to be professionals**. In fact, White was deeply concerned based on his command of our history that professionalizing these relationships at the expense of the experientially grounded knowledge could diminish the natural recovery capital already present in communities.

We are seeing efforts to expand credentialing requirements based on traditional classroom learning processes and to create advanced peer credentials that should be of deep concern here. These processes lead to what White articulated in many of his writings but perhaps most directly in his 2013 essay State of the New Recovery Advocacy Movement where he stated that if the recovery movement becomes primarily focused on developing the recovery coach / peer support role the movement would fail. A future generation would need to start over again with a new movement and arise anew from the ashes of our efforts. Advanced peer support roles or complex and exclusive training routines developed to justify credentialing is an echo of the over professionalization dynamics that diminished the experiential facets and unfolded in the early 1990s. It led to the loss of recovery orientation that had been carried experientially within the paraprofessionals who founded our field in the 1970s.

Funding is now primarily compartmentalized in Medicaid
White articulated a model that was transformative of the service relationship. One that transcended overly professionalized relationships and hierarchical care structures. The vision was to develop more "natural reciprocal, enduring and non-commercialized relationships" (page 8). As our field historian he warned us that the professionalized

service model bends towards the needs of the provider and away from the needs of those served. The peer role was intended to be disruptive of these dynamics not to become an adjunct to it.

When considering the evolution of the recovery coach / peer support role, he noted that all facets were vital and needed to be sequenced and available when they were needed as person-initiated recovery processes through to sustained long term recovery. From a service perspective, this means funding across Private Insurance, Medicare, Medicaid and non-Medicaid public funding avenues. The primary way that peer services are funded in the USA is currently via Medicaid. This can be a set up in respect to funding that requires people to stay on Medicaid for providers to get compensated. It fosters dependency and is in conflict with core goals of helping people to develop autonomy. There is an incentive for to keep people sustained on government benefits and not find living wage employment that is baked into our funding system in this way.

In the 2006 monograph, Recovery Management, William White estimated that in the 80's and 90's, 70% of addictions professionals were in recovery and 30% were not. Stigma of addiction increased during the crack cocaine crisis and there was a growing demand to "professionalize the field" which shifted staff demographics from recovering counselors to degreed counselors. According to White recovery status among professionals working in the field shifted to 70% non-recovery to 30% in recovery. He predicted that with the emerging role of the recovery coach, recovery representation among paid staff would increase. He was correct!

In preparation for the shift, White published this article, *Sponsor, Recovery Coach, Addiction Counselor: The importance of Role Clarity and Role Integrity.* He viewed these roles as **complementary** and equally important in a recovery-oriented systems of care. Recovery coaches are now sounding the alarm believing that we need to return to White's vision. In recovery coach focus groups throughout the country, we have heard the following concerns.

- "We are grossly underpaid. While the field says are role is important, folks are leaving the field to work at Walmart to feed their families."
- They often have us doing the work of the counselor and recovery coach without training us for the counselor role."
- "While Narcan distribution is important, we have other skills that can help support recovery."
- "Too many supervisors are unaware of the recovery coach role and are supervising us as if we were counselors."
- "When organizations don't understand the recovery coach role, "they assign us rookie duty."
- "Turnover is high because we often burn out on the frontline and there is no career ladder for advancement."
- "Our agency has hired 10 new recovery coaches and no new counselors. There is tension because the counselors really do believe we are there to replace them"

A generation ago, when White wrote this important essay, the rallying cry of the recovery community was "nothing about us without us." The mantra heard around the nation was "recovery happens in community." We do not hear these things nearly enough anymore. White and many of his contemporaries of a generation ago provided us exceptionally well-articulated blueprints to engage people in recovery management strategies that were ultimately nestled within recovery-oriented systems of care grounded in community, not an emerging industry. Not a structure designed to perpetuate the existing systems but to radically transform them so that they meet the needs of all of our communities.

History also reveals that the industries and money-making schemes that evolve out of recovery movements also fail as the boom turns to a bust. The workforce who are generally motivated to support resiliency become jaded by the lack of focus on long-term recovery that is ever present in our acute oriented care industries. They then leave the field. The quality of care erodes further. This unfolds in parallel while the community sees with their own eyes that the care system fails to deliver on the promise of long-term recovery but instead focuses on their bottom line. At that point, each time in our history when the promise falls short of that outcome and the industries of care become focused on sustaining itself a call for change emerges.

Because of the life work of William White and so many others, we have never been better armed with the lessons that can be yielded by the study of our own history and the application of that knowledge. Perhaps no one said it better than one of our other statemen of the New Recovery Advocacy Movement than Don Coyhis, founder of White Bison and the Wellbriety movement: *"We must actively heal the community and its institutions at the same time an individual works on his or her own healing from alcohol or drugs or other unwell behaviors."* Don knew we must tend the soil from which our efforts grow.

One of the fundamental goals of the recovery coach / peer support role was to radically transform our systems by addressing its shortcomings while at the same time nurturing indigenous recovery communities across all of our communities. Twenty years on, it is clear that we have fallen far short of those ambitious and aspirational goals. There is no question in our minds whether we will as a community revisit these critical facets, but rather when that will occur and how much progress is lost before we do.

Sources

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