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Career Motivation and Professional Experiences of Addiction Peer Recovery Coaches Working in Rural Community Mental Health Centers

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Abstract

Objective: This phenomenological study investigated the experiences leading to working as a Substance Use Disorder Peer Recovery Coach (PRC) and the experiences of study participants while working in the role in rural community health centers.

Method: Phenomenological interviews were conducted with a purposeful sample of participants (n = 6) who are currently or have previously worked as a substance use disorder PRC in rural community mental health centers in Virginia.

Results: Study findings include themes describing what contributed to the pursuit of professional employment and the experience of working as a PRC in the professional environment. Implications for PRCs include boundary management, role definition and workplace power differential. Implications for employers include treatment team inclusion, standardization, addressing dual identity, supervision, relapse planning.

Conclusions: The findings showed that working within the PRC role has both personal and professional ramifications leading to sustained long-term recovery. However, there remains dissonance in navigating the duality of the role and identity as both a person in recovery and a part of the professional treatment landscape. Moreover, there are professional challenges that must be navigated to maximize the PRC service for clients addressing substance use disorders.

Public Significance Statement

This study adds to the understanding of the experiences of Peer Recovery Coaches (PRCs) by characterizing their lived experiences while working in this role. This study also highlights the environmental factors that facilitate the efforts of PRCs working in rural community mental health centers and discusses implications for rural mental health center employers.

The Career Motivation and Professional Experiences of Addiction Peer Recovery Coaches.

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Introduction

SAMHSA (2012) articulated the need for ongoing assessment of peer support/recovery coaching to learn about this groups' experiences. Historically, research on peer services has focused on service effectiveness and found that peer participation in recovery support interventions produces positive outcomes [1-5]. Moreover, research has focused on defining the differences in functions of peer recovery services in comparison to addiction counselors and Twelve-step sponsors [6-9]. Yet, a gap remains in describing the experience of why peer providers seek PRC positions.

The persistence of chronic substance use and lack of successful outcomes despite the availability of services signal a need to review the Peer Recovery Coach (PRC) experiences in a community-based approach to treat substance use disorders [10-12]. Federal investment in community-based approaches through SAMHSA grants [13] expanded a harm reduction model and supported more peer-recovery focused positions. In fact, [11] estimated an increase in PRC integration within the recovery workforce and as evidenced by PRCs working in paid and volunteer roles within community organizations, private practices, with child welfare and criminal justice initiatives, substance use disorder treatment centers, recovery community organizations, collegiate recovery programs, recovery high schools, and emergency departments [14].

Peer-Based Recovery Support Services (P-BRSS) have developed into an affordable model of care accessible by those in need of treatment to support transition into stable long-term recovery. Further supporting continued integration is that fact that managed care companies currently reimburse PRC services in 45 states (Copeland Center, n.d.). Additionally**,** forty-six states have either successfully created or are in the process of creating a certification process for peer service-providers to help standardize the service. Moreover, the International Certification and Reciprocity Consortium [IC/RC] created a national Peer Recovery credential to support the standardization movement, resulting in the long-term future of peer-delivered services.

The role of the PRC is that of a non-clinical capacity within substance use treatment [11,9]. The focus of PRCs is to maintain a recovery-focused perspective in working with clients and to promote recovery, remove barriers to recovery, connect those seeking recovery from substance use disorders with recovery support services and to promote hope, optimism, and healthier lifestyles [6]. The experiential knowledge possessed because of lived experience [15] positions PRCs to work with clients to manage the stages of recovery rather than focus on mere symptom reduction.

[11]stated the need for ongoing research and evaluation of peer support/recovery coaching in an effort to learn about their experiences and best prepare and support peer service integration. This study sought to describe the experiences of substance use disorder PRCs working in rural community mental health centers in Virginia related to their career motivation through an interpretive phenomenological viewpoint. Specifically, this study explored what led participants to seek substance use disorder PRC employment and their professional experiences while working in the role. Furthering our understanding of the experiences of persons serving in non-clinical peer roles can inform strategies to effectively recruit, integrate and support PRCs working within addictions treatment programs in rural areas. This study is practical for rural communities where peer-delivered services are part of the substance use disorder network of support due to transportation and service access challenges common in rural areas [16].

Method

The purpose of this qualitative study was to characterize the experiences of working as a substance use disorder PRC. Incorporating a qualitative approach to this study presented rich descriptions of the lived experiences of participants to accurately define the phenomena. This philosophical foundation corresponds with the research question "What are the lived experiences of individuals working as Substance Abuse Peer Recovery Coaches?" A phenomenological design was befitting the development of a deep understanding of the participants' perspectives on the phenomenon of working as a substance abuse PRC.

The phenomenological design does not develop theory; rather, it provides insight into the lived experiences and living world of the participants. Specifically, phenomenology seeks to understand the individual and collective internal experiences of the phenomenon and how participant's think about their experiences [17,18]. As [19] noted, phenomenology emphasizes the human experience [19] and elicits this universal description or essence consisting of *what* the participant experienced and *how* the participant experienced it [20].

Procedure

This study was granted approval from the Institutional Review Board for research with human subjects and adhered to the ethical principles of human science research. The Community Services Board (CSB) system in the state of Virginia constitutes a total of 41 CSB locations (VACSB, 2014). Given the focus of the study on the experiences of those providing recovery coach services, identifying a single site to capture a large enough sample proved difficult. To narrow the potential CSB sites offering PRC Services within substance use disorder treatment programs, the Peer Support Manager with the Virginia DBHDS was contacted via telephone. As such, the number of appropriate sites was reduced to a total of 14 CSB locations.

Addiction treatment clinical directors of the 14 CSBs in the state of Virginia were contacted to participate in this study (if they employed PRCs) and e-mailed the organization participation letter to be completed by the clinical director prior to the site being included. Upon receiving the signed letter of participation from sites the recruitment email was sent to the substance use disorder clinical directors and they were asked to forward the recruitment email to those working in PRC positions to invite them to participate in the study. Those previously employed as PRCs were recruited using snowball sampling [21]. Snowball sampling was completed through addiction treatment services clinical directors forwarding the recruitment email to those who previously worked at their CSB site in the PRC role. This resulted in the inclusion of two additional participants. PRCs meeting the inclusion criteria contacted the researcher via email and time scheduled to speak with them via telephone to verify eligibility verbally to participate in the study, discuss participation, and schedule the interview. The researcher addressed any questions regarding the study.

The primary researcher conducted interviews with six participants who met the following criteria: 1) identified as a person in recovery from substance abuse, 2) having no less than one year of abstinence from mood-altering substances, and 3) as a person who is currently working or formerly worked as a PRC,

and the ability to schedule a 60-90 minute interview.

Seven participants qualified for study inclusion, however, one subject declined participate in the study, resulting in the inclusion of six study participants (n = 6). Each participant received an emailed packet detailing the purpose of the study and informed consent documentation. Before any interview began, informed consent was discussed with each participant, participants were asked to read and sign the consent form via DocuSign computer application, participants confirmed that they met eligibility guidelines for the study, and demographic information was collected. The Docusign computer application was utilized due to the proximity of the participants in comparison to the researcher. Once informed consent was obtained, the interview was conducted. Each participant was given a pseudonym to protect his or her confidentiality.

Interviews were conducted either in-person or via telephone as a result of the participants' location in proximity to the researcher. Interviews were audio-recorded for review and transcription and lasted from 60-90 minutes in duration. Semi-structured face-to-face interviews were conducted with two participants in a private office at their worksite. The remaining four interviews were conducted with participants via telephone due their location being in excess of 100 miles from the researcher. The interview format allowed for direct, verbal interaction with participants designed to evoke detailed narratives of their experiences thus creating this cooperative dialogue. Research questions focused on "What are your experiences related to working as a Peer Recovery Coach?" and "What events led you to working as a Peer Recovery Coach?" These two questions provided the basis for textural and structural descriptions. Additional exploratory questions included: "What went into your decision to work as a Peer Recovery Coach?", "What has been challenging in working as a Peer Recovery Coach?", "What has been rewarding in working as a Peer Recovery Coach?", and "In what ways has working as a Peer Recovery Coach contributed to a career trajectory?

Data saturation was reached at six participants as no new data, new coding or new themes emerged from participant transcripts. The primary researcher carried out the transcription of each interview upon completion. Each completed transcription was sent to the participant for content verification and feedback. Per participant verifications, no statements or context was removed from the original interviews. After the participants verified the transcription reflected what they intended to share during the interview, the digital file was erased. Upon the participants' transcript confirmation, all identifiable information from the transcripts was removed. In addition, another set of data containing pseudonyms and redacted information was created and used for data analysis.

Data Analysis

Data analysis was guided by [22] approach to analyze phenomenological data. The primary researcher organized, read in entirety, and filed all transcripts in the order they were conducted. Each transcript was then re-read to get a general sense of the entire transcript and a password protected transcript was emailed to participants for member checking. Member checking was used to validate if the analysis captured the lived experience of the participant. All six participants verified the context of their interviews with only one participant adding to the original interview statement. Any modifications made to the data during member checking were incorporated into the final product.

Significant statements that directly pertained to the investigated topic were extracted and recorded on a separate sheet noting their pages and line numbers. The significant statements extracted were the basis for themes. Meanings were formulated as they emerged from the data through using creative insight, while remaining faithful to the original data. A second coder completed the same task independently. The independent second coder was familiar with phenomenological research but did not have PRC specific knowledge and was not a member of the research team. Given the interaction between participants and the researcher, bracketing was used to add rigor. Bracketing in phenomenological research is used to maintain objectivity and allows the researcher to leave his or her world behind and to fully enter into the experiences of the participant through written description [23,24,25]. To support promoting reflexivity, the primary researcher engaged in journaling throughout the duration of this study. Journaling supplements reflexivity as it serves to locate the self in the research process [26]. The researcher employed a three-step process of reflexive journaling as proposed by [27].

Once completed, the primary researcher and independent secondary coder met to compare themes emerging from the transcript. This process took place following the completion of each individual interview transcription. Consensus between the primary researcher and the independent second coder was reached in order for the theme to be included in the results section of the study. Extracted statements were then organized into categories, clusters of themes, and themes that were integrated to form exhaustive descriptions of the investigated topic meant to describe how the participants experienced the phenomenon. The above process was repeated for each individual transcript.

Results

Completion of the analysis identified two prominent themes representative of the shared experiences of the participants: career motivation of addictions PRCs and professional experiences of working as an addictions PRC.

Career Motivation of Addiction Peer Recovery Coaches

Three themes emerged as contributing to career motivation that led to seeking PRC positions: (a) giving hope; (b) encouragement, and (c) job stability. The participants' narratives clearly indicated the importance of using their personal recovery experiences to support others seeking recovery from substance use disorders. Additionally, working as a PRC offered the opportunity to stabilize and support one's own needs and the needs of his/her family. Equally as important was the recognition participants received from fellow members of the recovery community that served as validation of personal change, thereby, inspiring participants to seek PRC positions.

Giving hope. A desire to give back and instill hope was predominant within the participant's' narratives. Viewing the descriptions of giving back and instilling hope through hermeneutic reduction [19] resulted in the concept arising in two separate levels of recovery. Internally, a strong sense of personal acceptance of past indiscretions supported a higher level of personal recovery through meaning making and finding purpose within those past experiences. Externally, a multidimensional sense of obligation in helping others transition to a life in recovery strongly underlies the participant's narratives.

The decision to come and be a part of this came from working the twelve-steps and giving back…that helps me remember the pain and misery of where I was and where I don't want to go back to and that was a big part of the decision.

Another participant shared it was her experience in recovery that contributed to realizing her desire to give back to others, "…after being in recovery I realized I could use my recovery to help other people".

Encouragement. Receiving encouragement from someone within the recovery community emerged as an essential element of seeking PRC positions. Messages of encouragement represented positive affirmations to the participants of the change process that participants made through engagement in personal recovery. On a deeper level, the narratives of receiving encouragement conveyed a sense of being accepted as a valued and productive member of society and, more importantly, conveyed a level of trust and confidence by members of the recovery community in the participant's ability to guide others seeking recovery.

One of the ladies that already worked for the company I work for attends my home group. So, after a meeting one Saturday she came up to me and said 'I've seen how much you grown and how serious you are about your recovery'. She said 'one of my coworkers mentioned they are hiring for a recovery coach and I think you would be wonderful for the position'.

Similarly, another participant was also unable to recall the name of the specific person providing the message of encouragement. However, she was able to recall the person being a member of the professional treatment system. She stated, "…I had given my testimony at a [recovery community] picnic one year. So, when the job came open in [county of residence] county…somebody approached me and asked me if I was interested".

Job stability. The participants narratives described the opportunity to achieve personal and family stability through receiving stable pay and a benefits package (i.e. health insurance, sick pay, vacation, holiday pay). The inclusion of a benefits package emerged as a determinant leading to working as a PRC and presented an opportunity to address the participant's personal and family needs and support increased stability in major life categories. One participant illustrated the importance of stability, "it was good to think well I will have a 9-5 job for the most part you know I will get 40-hours a week, I will get benefits, I'm sold on that". Moreover, another participant depicted the impact of stability on multiple levels through the inclusion of a benefits package.

The fact that I would have insurance and paid holidays, and vacation, and sick days, cause you know, it hurts when you have holidays you have to miss and you don't get paid and its Christmas and you need the money. So yeah, that was part of the appeal too.

Stability is an important component of recovery and often those seeking recovery sense little stability in major areas of life, especially early in the process. For the participants, stability included job stability, personal stability, and increased stability in being able to provide care to the needs of family members. PRC positions were viewed as an avenue toward feeling like and being viewed as a valuable member of the workforce and community. Moreover, the participant's narratives illuminated the unique internal and external impressions of value an improved career outlook held. In this sense, PRC positions offered the opportunity for participants to experience stable and meaningful work while simultaneously altering their internally held perceptions of professional careers being unattainable. One participant clearly expressed this experience; "…I just never thought I would be in this position or this type of field…it has just opened up the idea of other options as far as where you can go career wise". As the participants in this study tell us, the idea of stability serves as a vital motivating factor for career potential and trajectory.

Professional Experiences of Working as an Addiction Peer Recovery Coach

Five themes emerged from the analysis illustrating the professional experiences of working as a PRC. Professional experiences included (a) bridging the gap, (b) adjusting to the PRC role, (c) duality of role and identity, (d) the workplace environment, and (e) pursing a professional career opportunity.

Bridging the gap. Participant's narratives embodied the importance of serving to bridge the gap that often exists between clients and professional treatment providers. The experiences offered by participants able to navigate the language barriers that exist between professional staff and clients.

Sometimes I feel like an interpreter too because of clients not understanding the big words coming out of the therapists' mouth and they are just looking like 'what are they talking about'…or they [professional staff] are not understanding what the client is saying so I have to put it into technical terms for them and I'm like this is harder than translating Spanish.

Furthermore, being identified by clients as a recovery ally through helping bridging the preconceived notion by clients that professional staff will not understand the challenges inherent to seeking recovery was a salient subject.

You can almost see the relief on their [the client] face when you go meet with them the first time and they are considering recovery…you say 'I totally know what you're going through, I've been there'. And they are like 'what do you mean?' And you say, 'well I'm actually in recovery myself' and you can see the relief of like 'oh my gosh, they get it'.

Adjusting to the peer recovery coach role. Participant's narratives clearly indicated a series of challenges intrinsic to the adjustment of working in the PRC role. The absence of a clearly defined job description affected participants' feelings of confidence and overall competency in providing PRC services. A shared sentiment of confusion was present in deciphering the boundaries that are vital to maintain in both personal recovery and the PRC role.

Central in making this adjustment was locating the boundaries of the PRC role in comparison to those of a twelve-step sponsor or those of a clinical service provider. A participant elaborated on this challenge in saying, "as a clinician you have absolute boundaries. As a recovery coach, having to figure out that you can't be someone's sponsor as a recovery coach but you still want…them [the client] to know that you are on their side". Additionally, conflict arose in advocating for clients while also being viewed as an authority figure rather than a peer by those same clients. Similarly, the presence of a power differential emerged to further complicate adjusting to this new role by making the boundaries of serving as a client advocate as well as a member of professional treatment more confusing.

…I am a peer in the sense that I am not a counselor…but I am not a peer at the same time. Many of them [clients] see me as something above them. Or if they tell me something they will get in trouble…it's hard sometimes. I know they are lying and you have to walk around it and sometimes it's difficult.

Duality of role and identity. A number of shared experiences were discussed describing the intersection of working in the PRC role and engagement in personal recovery within the community. Akin to adjusting to this new role, duality of role and identity represented a new challenge for participant's as their former identities as persons-in-recovery were now linked to working as a part of the professional treatment system.

…I had a couple people…get kind of weird on me thinking, I guess, if I was going to act like I was better than them now or how it was because I wasn't just a member of the twelve-step group or whatever. I was caught in the middle. I felt like I didn't fit in anywhere…because now I am one of them, like, one of the people that try to fix us.

The complexities presented by this dual role and identity placed participants in precarious situations regarding engagement in personal recovery, protecting client confidentiality and managing a fixed identity in recovery within a workplace environment where often felt forgotten or overlooked. Moreover, this shared identity was clearly an evolution the participants did not feel prepared for.

…I think sometimes because of my role and because of changes I have made sometimes I think maybe they [the staff] forget I am a recovering addict and sometimes they speak out… they don't associate me with as like well she is in recovery because it is not the typical person they are used to dealing with because I have made changes.

Although participants shared varying ways of managing this duality there was a common sense of apprehension in how they were perceived by their peers within the recovery community, by the professional treatment staff of their workplace, and by the clients they worked with as a PRC.

The workplace environment. The workplace environment emerged as a critical element to providing Peer Recovery Coaching services. Workplace environments were described as exhibiting either acceptance of PRCs or not showing acceptance of PRCs.

An accepting environment included feeling embraced as a peer provider by staff and program leadership, promoted engagement and inclusion in client decision-making as a part of the professional treatment team, and both supported and promoted the continued recovery needs of PRCs.

I think the number one thing that they [the staff] did was to treat me like I was one of them…they didn't treat me different. They didn't treat me like I was a client… they didn't treat me any different than another person who was an actual counselor or a case manager.

Conversely, non-accepting work environments included a staff hierarchy, excluded participants and left them feeling absent of voice and showed unaddressed bias in coworker attitudes. Participants' felt unheard as a consequence of differing levels of education, credentials, and being viewed by professional staff as essentially little more than someone in recovery. Moreover, they described feeling as though the PRC role holds more value than simply placating the shift to Recovery Oriented Systems of Care (ROSC) [28,29,30] through hiring workers with lived experience in recovery.

…I didn't feel like I was being heard cause my position wasn't taken as serious as the other ones. I think that is mainly because of the schooling or that you can't bill for my position…that I am just another, you know, one of the addicts they let in the door to make themselves look good.

Professional career opportunity. Pursuing a professional career opportunity emerged as seeking a stable and respectable professional career by obtaining training and professional credentials. Interwoven into this experience for many participants was recognition of PRC services transitioning into a Virginia Medicaid billable service. Notably, becoming a billable service was viewed as a legitimatization of the PRC service and supported career stability.

Within the next two months I will be certified and that opens the door for us to be billable through Medicaid when they [the state of Virginia] do finally approve all of it because that is what they are working towards…with the certification…will make our positions more secure.

Although participants described contrasting views in terms of their desired career trajectory there was clear consistency in progressing toward an improved work opportunity in the future in either an increasingly clinical role or continuing as a PRC.

Discussion

Previous literature focused on conceptualizing and defining the role of PRC services in comparison to the differing levels of service providers working in the addictions field, yet did not describe the motivation behind seeking PRC positions or the experiences of working within the role. The findings of this study illuminate the themes that motivate seeking these positions and the experience of working in the PRC role within addictions treatment.

Implications for Peer Recovery Coaches

The results of this study align with previous research areas of concern on PRC development and implementation. Specifically, the recognition of boundaries [31]and the effect of boundary management in adjusting to and managing dual relationships with clients [32,33] and dual roles and identities within the recovery community [32,4,7,33]. Additionally, the importance of a clearly defined role and job description [1,34,11,31] was a an important concern despite the standardization of peer roles through certification processes.

Finally, the presence of a power differential with professional staff [11,7]. Each of these has been recognized in past literature as areas requiring attention. However, the findings of this study identified a power differential existing between PRCs and the recipients of peer support service. This appears directly linked to the dual roles and identities PRCs share with clients through being members of the recovery community and further confounded by their identities as members of the professional treatment system. The boundaries of a clinical provider are more readily defined and recognizable in comparison to those of non-clinical roles like PRCs. Inconsistent job description throughout the state of Virginia, however, complicated the provision of PRC services by perpetuating these boundary issues. The creation of the CPRS [35] and credential through IC/RC help bridge this gap by outlining the minimum requirements to become certified as a Peer Support Specialist, including a code of

ethics specific to working as a Peer Support Specialist and offers a list of approved trainings to meet the defined requirements.

Implications for Peer Recovery Coach Employers

Retention of PRCs requires employers to assess multiple aspects of peer support service programs. Although financial security and benefits serve as incentive for those working within the role, the prevalence of low pay, little job security due to positions being grant-funded, and a plateau of advancement comprised participant's narratives of vulnerability. There are five areas of intervention suggested for PRC coaches: (a) inclusion, (b) standardization, (c) addressing dual identity, (d) supervision, and (e) identifying or creating a relapse plan.

Employers and programs need to address the inclusion of PRC voices into treatment team meetings and client decision-making. Participants discussed experiences of exclusion from treatment teams, and felt their voices were not being heard pertaining to client decision-making. According to [36] the amount and kind of training received by paraprofessionals was an urgent question requiring an answer if professionals and paraprofessionals were to coexist. Because the services provided by PRCs span a longer time frame [7]and are on a more personal level than that of professional treatment staff, PRCs can offer valuable perspectives, information, and voice as a part of the treatment team.

Despite the creation of standardization for peer–delivered services, there remains little standardization of the definition of peer-service providers [1]. Clearly defining the role serves programs in multiple ways: it gives direction to PRC service providers, it helps professional staff to understand and utilize PRC positions, it gives clear definition to how job performance is measured by the organization, and it helps clients to understand the boundaries of the PRC in comparison to professional providers. The creation of a clearly defined role is suggested to help PRCs and professional providers to clearly understand the framework of PRC services to maximize its strengths.

Additionally, the dual identity as a member of recovery and the treatment system poses a challenge to acceptance within the recovery community, especially when accompanying clients to recovery community meetings. Accompanying clients to recovery community meetings not only affected personal recovery engagement but also placed PRCs in a position of discerning whether to share pertinent information with treatment staff to client needs or withholding information in order to hold true to the stated traditions of Twelve-step recovery meetings. Participants varied in the degree in which they engaged in community support groups while working as a PRC. This is important to note as those reporting longer sustained time in recovery might have been at a different emotional level due to their personal recovery work, thus requiring less focus on maintaining personal recovery within this setting.

Limitations

The current study had several limitations. The study's small sample size and its lack of gender and geographic diversity limit the generalizability of study findings. Only one male participant was included in this sample and all participants were from a single state. Four of the six interviews were conducted via telephone and two were conducted in-person. It is possible that these different assessment methodologies yielded different responses to study questions and influenced interviewer-interviewee rapport.

Conclusion

This study identified themes associated with pursuing employment as a PRC and the experiences of working as a PRC through the perspectives of individuals with lived experience. The findings extend existing knowledge by offering insights into the experiences of seeking employment and working as a PRC. To recruit and retain PRC workers it is recommended that focus is placed on treatment system and workplace inclusion, standardization of roles and processes, and supervisory styles and processes that support the unique needs of PRC workers.

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