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The Role of the Recovery Coach

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Abstract

The researchers obtain perspectives on the current drug and alcohol treatment recovery continuum from aftercare planners, alumni sponsors, and a subject matter expert. Trends and themes are identified and discussed to understand the meaning and interpretation of recovery, gaps in services, and strategies to sustain sobriety. Recommendations are discussed to improve the current recovery system to reduce recidivism and enhance sobriety rates. Addiction and the consequences have a significant impact on health and society today. The potential use of a recovery coach is assessed and discussed in analyzing research findings regarding addiction. Areas for future study are identified that comprehend the nature of addiction and recovery.

Keywords: recovery, addiction, 12-step, continuum of care, recovery coach

Introduction

Addiction is recognized and generally associated with impairments in various functionalaspects of behavioral issues. The ongoing cycle of addiction is sometimes seen as a chronic disorder. It is generally treated utilizing an acute care inpatient treatment model (Laudet & White, 2010, 51-59). The inpatient treatment model consists of screening, assessment, treatment, and discharge. Standard inpatient treatment is predominantly medical detoxification (Stinchfield & Owen, 1998). Chutuape, Katz and Stitzer, (2001) suggest that only 35% of those discharged from inpatient facilities and referred to aftercare actually comply (p. 137). It continues to produce disappointing outcomes. Often patient/clients are referred to an aftercare program for a specified time and additionally 12-step groups are recommended. Aftercare programs vary and can be private, family-based, or in group settings, and last six to 12 months. Additionally, certain communities and treatment facilities offer ongoing aftercare groups. Ahles, Schlundt, Prue, and Rychtarik (1993) suggest that those who attend and continue with aftercare display significantly higher abstinence rates at six and 12-month substance-free intervals. With relapse rates remaining high through the inclusion of inpatient, aftercare, and 12-step meetings, this author recognizes a gap in design and a potential opportunity for a holistic approach and a better-defined continuum in supporting the client.

Recovery Coaching (as defined by Wikipedia, 2012) refers to a strength-based support for persons with addictions or in recovery. This research explores the ways in which a "recovery coaching" model could reduce the degree of recidivism among recovering addicts. My working definition of "recovery coaching" includes a strong foundational structure that promotes wellness, recovery, sobriety, a thorough inclusion of consciousness (over time), spirituality, individual goals, and understanding of meaning and purpose. Prochaska and Norcross (2001) recognize a gap regarding the stages of change in recovery. They refer to these stages as "pre-contemplation", "contemplation", "preparation", "action", "maintenance", and "termination". The authors concur with Prochaska and Norcoss (2001), sthat a belief ystem regarding readiness to change could be enhanced with a coaching model that supports individual goals. If this is done in conjunction with aftercare and/or 12-step, it could potentially enhance sobriety rates.

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It may help individuals stay connected, maintain focus, and continue to achieve goals, while remaining accountable, therefore reinforcing positive behavior. The Baldwin Research Institute reported that there is a 5% sobriety retention rate for those involved in 12-step programs after one year. Although there is no consistent research, this author suggests that because there is no one way to measure the results, or methodology, statistics remain abstract and subjective. According to Baldwin, conventional treatment methods result in a 3% success rate after 5 years. Stinchfield and Owen (1998) reported a true success rate of abstinence, close to 40% after one year in a study of over 3,000 subjects treated through a traditional Minnesota Model 12-step rooted inpatient treatment facility. This common model includes detoxification and inpatient treatment. This study has no mention of aftercare or ongoing care throughout the continuum. From a social constructionist worldview, the author believes individuals recently discharged from inpatient facilities need additional support to cope, and modify behaviors due to the societal structure that may have caused addictive patterns. The research aim for this study attempts to determine whether a "recovery coach" can fulfill a gap in services by compressing and solidifying a perceived realistic and achievable action plan.

The authors have chosen a multiple paradigm approach to a qualitative study that embraces several worldviews. The study will include a post-modern and integral construct approach to include culture and history in its design. A phenomenological and potentially emergent-grounded theory in its interpretive research will assess the gap in treatment in relation to outcomes of abstinence, sobriety, and recovery. The strategy and focus will strive to study how "a recovery coaching model" could add value to the interpretation, foundation, and future definition of what we call recovery (Creswell, 2007, 2009). There is a collective and growing focus on the ecology of addiction recovery regarding relationships between individuals and their physical, spiritual, social, and cultural environment that may promote or inhibit long-term outcomes (White, 2009). From a social constructionist standpoint, one could ask what causes addiction, and what fosters a habit. There is also a need to understand the global problem of addiction. Research within the addiction recovery industry supports that active participation in an aftercare program in conjunction with 12-step meetings can enhance and improve inpatient treatment outcomes (Lash, Petersen, O'Connor & Lehmann, 2001). The researchers experiences in 12-steps programs has taught that addiction is a spiritual disconnect that at some level was instilled from birth. It might be based on achieving the American dream of a nice house, family, car, etc…, that focuses patterns of behavior on the need for external or material gatherings or searching for something outside of ourselves.

The role of a recovery coach based on solid foundation does not diagnose or address the past. The International Coach Foundation (ICF) regards coaching as supportive in addressing life's goals, improving present life experience through compassionate listening, and providing accountability, enhancing structure, and fostering clarity and focus. This is done by solidifying and supporting successful and mindful change in advancing personal growth to become transparent, present, and joyful. The researchers see an emergent design and holistic vision shared through the combination of wellness, quality of life, and recovery as an educational and insightful aspect of personal growth and lifestyle transition. The utilization of self-determination, integral theory, self-discovery, and organic transformational change are the tenets of coaching. Wolever, et al (2011) explains that Integrative Health Coaching is an ongoing definition of coaching, and still is being formulated. The coaching model often utilizes a wheel of life that integrates all of the components of the lived experience in learning holism. The authors believe that if recovery could understand and embrace holism, the ability to link goals with values and sense of purpose would increase recovery rates and provide a heightened awareness and different perspective on change by redefining the definition of recovery. The positivity induced through coaching can generate an open-mindedness to change, foster creative problem solving through reflection with a qualified coach, and provide hope rooted in purposeful action and a positive ongoing result (Curtis & Kelly, 2011).

McKay, et al., (2009) explained coaching, case management, community coordination, and attention to reoccurring problems have seen positive research support in the literature, although actualization has been limited in enhancing the field. The exemplary work of the Betty Ford Institute (2007) continues to evolve a working definition of "recovery". Within the current drug and alcohol inpatient/outpatient recovery paradigm, there is recognition of a need for stronger recovery rates, a better understanding of the nature of the problem and less relapse and recidivism. The addiction treatment industry is determined to reconcile and evolve a working holistic definition that reconciles/balances science and spirit, qualitative and quantitative in understanding addiction and recovery (Betty Ford Institute Consensus Panel, 2007). The industry, with little research, and somewhat limited success ponders the question: Is addiction a choice or a disease?

In continuing to define the meaning and root cause of addiction, the industry continues to explore a model that could offer improved outcomes regarding long-term percentages of recovery. The industry reflects two vantage points as it moves toward a potentially holistic approach to addiction. The working definition of "recovery" continues to evolve, potentially to include root and symptom, science and spirit, and the impact on society regarding whole system thinking. The Betty Ford Panel (2007), by stating they want more than "symptom remission" has loosely defined recovery as "a voluntarily maintained lifestyle characterized by sobriety; personal health, and citizenship"(page 222). The authors envision a whole system definition continuing to emerge in combining science and spirit through 12-step, neurobiology, psychopathology, psychology, mind-body medicine, coaching, and nutrition in potentially grounding an integral transcend and include model of change to addiction. A study known as Project MATCH (Stinchfield & Owen, 1998), reported the results of a three month post treatment program utilizing the posits of cognitive behavioral therapy, motivational enhancement therapy, and 12-step facilitation, delivered individually to over 1,500 combined outpatient and aftercare subjects randomly assigned to one of three groups. This rigorous study showed that the outpatient group maintained 19% abstinence, the aftercare group had 35% abstinence and those in the 12-step group versus cognitive behavioral therapy and motivational enhancement therapy had 10% better outcomes. Kimberly and McClellan (2006) state the continuum of ongoing care offers the realization that addiction is best treated as a chronic illness rather than acute care. The recovery industry has realized they are in transition regarding definition, best practices, and inquiry toward an evidence-based approach, elegant research, and better outcomes.

The proposed research question "Can a recovery coach bridge the gap in services in the continuum of ongoing care upon discharge from a traditional inpatient drug and alcohol treatment center to improve sobriety from the perspectives of aftercare planners and sponsors?" To answer this question, qualitative analysis can be done to determine the role that a discharge/aftercare planner and alumni sponsor can have in coordinating resources to help the patient maintain abstinence.

Materials and Methods

Two sets of interviews were conducted. The first group included 5 aftercare/discharge planners. The inclusion criteria had each of the 5 participants in the first group currently working in inpatient addiction treatment centers for at least one year and be located in Pennsylvania. The second group included 5 alumni sponsors. A sponsor generally serves as a mentor, guide for individuals striving for sustained recovery, and encourages positive behaviors, compliance to 12-step models, structure, and enhanced accountability to one's recovery. This immediately occurs upon inpatient discharge. The inclusion criteria for the 5 participants in the second group, was at least 2 years sobriety, being a client in a traditional inpatient ATC, served the role of a permanent sponsor for at least 1 person, and be located in Pennsylvania.

Participants from each group were recruited by the researcher through phone contact. Upon Institutional Review Board (IRB) approval, the researchers contactedfive ATCs to recruit the 5 aftercare/discharge planner interviews. The sponsor interview recruitments occurred by asking individuals in Alcoholic Anonymous meetings in Scranton, Pennsylvania, and Clarks Summit, Pennsylvania to participate. A convenience sample was used for purposes of the study by contacting ATCs and 12-step program sponsors that the researchers currently had contact. The perspectives from the interviewees are of adult patients only discharged from an ATC. Adult patients are considered eighteen years of age and older. In addition, 1 subject matter expert interview was conducted.

Each of the 10 participants engaged up to 75-minutes per interview. The participation was voluntary. Individual perspectives dealing with the care plan for persons re-integrating back into society were gathered. A few broad, open-ended, and scripted questions were used to learn the challenges, barriers, relapse triggers and other vulnerable situations during the patient's reintegration into society. The interviews were tape-recorded to ensure exact words were transcribed. Participants had the right to request the tape recorder be turned off at any point and stop the interview. Additionally, the lead investigator used a co-researcher to serve as note taker to cross validate the summarized interview reports. The interviews for group one took place on-site at the ATCs as did the subject matter expert interview. The interviews for group two took place at a site identified by the interviewee to help ensure participant privacy and confidentiality.

The interviews were completed for the study in the months of June and July 2012. Participants were not compensated by the researcherThe subject matter expert interview was also conducted on-site at a local facility. Upon completion and transcription of the interviews, the researchers sent the transcribed report to each of the participants to validate accuracy of information. The researchers organized data sets horizontally to identify common themes. A summarized report of the findings was completed and prepared for possible manuscript publication.

The researchers followed protocols identified in both the American Psychological Association and IRB. Before beginning the interviews with each of the 5 aftercare/discharge planners, the 1 subject matter expert and with each of the 5 alumni sponsors, the researchers used the Consent to Participate in Research material, explaining safeguards and right to privacy. Completion of the survey constituted informed consent to participate in the study. Signed consent forms were obtained for the study. Participants were assured that no identifying information would be collected, audio-recordings would not contain identifying information, and tape recordings/computer recordings would be destroyed by the researcher.

Results

The results support the social constructivism perspective found in the phenomenological study. Aftercare and sponsors agree that recovery requires a change in lifestyle and behavior that includes an engaged 12-step program based in spiritual practice (See figure 1). At the same time, the recovery system does not adequately provide consistent transitional support that re-enforces positive skills and coping techniques, and holding early recovery clients accountable for sustained practice (See figure 2).

While all 5 sponsors indicated that the current traditional recovery model could not be improved, they each indicated sponsees are often not motivated to stay engaged in their recovery and find the external environment from which they came from as a trigger point. These societal norms or trigger points are often referred to as "people, places, and things", reflecting old behavior. However, a sponsor did recommend that follow-up upon inpatient discharge by the facility can help create accountability. It was also suggested that better role models in society could assist in preventing drug and alcohol abuse. The aftercare coordinators also identified this need but recognized that reduced insurance payments and reduced covered inpatient and outpatient services limit their capacity to follow clients' post- discharge. The aftercare coordinators identified the need for improved transitional services upon inpatient discharge for proper re-integration to society. It was identified by both study groups that individuals often relapse as a result of non-engagement in 12-steps programs, lack of consistency, following direction, and limited communication with the recovery community (see figure 3).

It seems that a fully integrated post-discharge communication system is required to help establish new habits, maintain a support system and ongoing relationship to the system, and allow more opportunities to maintain accountability for behavior. In fact, to ensure new positive behaviors are sustained, professionals and clients themselves need to make sure that the underlying cause of addiction is being addressed (see figure 4). They need to discern the ongoing differences between root causes of addiction and symptoms (see figure 5). These varying perspectives between sponsors and aftercare planners may impede the direction given to clients upon discharge that are not consistent. Change is mandatory.

You can see that both groups identify filling a void as well as the contribution genetic disposition and family dysfunction in early childhood leads to addiction. However, the aftercare group includes other factors such as societal norms, external environment, learned behaviors, and personal choice that were not recognized by the sponsors. It is apparent in the results that society does play a role in contributing toward addiction. The respondents indicated that in addition to genetics and personal childhood trauma, sustained negative behaviors, such as drinking alcohol, can lead to bad habits that may eventually lead to addiction. Our society endorses the use of alcohol at sports events, family celebrations, television programming, and other social venues. There is a presence of alcohol and cigarette advertisement in society that promotes usage and can contribute to learned behaviors leading to addiction (see figure 9). Many children are raised in an environment that integrates alcohol as a normal adult activity.

The sponsors and aftercare planners identified key strategies to sustain sobriety (see table 6) and perceived gaps in care that inhibit long-term sobriety (table 7). The most common strategy recommended by the participants was the need for individuals to engage in a 12-step program and to maintain honest, open communication with sponsors, peers, and aftercare workers in an outpatient setting or halfway house.

However, the common response by both groups regarding gaps in care is the weak post-discharge re-integration process that has limited structure and cohesiveness. People often get lost in the system and relapse during this period. The strategies recommended by groups strongly emphasized 12-step engagement, motivation, in addition, consistency by incorporating new habits into the daily routine. Rigorous honesty, being surrounded by positive people and groups, and positive contribution to society were also identified. The aftercare group emphasized the importance of identifying emotional trigger points, developing a plan when the trigger points are present, and then execute the plan. This requires a skill set gained through alumni reunions, sense of ongoing community, and recovery workshops. The sponsors also suggested journaling, self-help books, prayer, and meditation.

It is interesting to note that the aftercare participants identified the need for step-down services such as halfway houses or sober living and engagement with alumni and recovery workshops. Sponsors did not seem to point this out as a key strategy to sustaining sobriety. Gainful employment was also mentioned, but the challenge becomes whether an individual recently discharged should go back to the same place of employment. The system is costly, with varying degrees of aftercare programming for each client anddiffering insurance coverage for those services. The participants felt that government, insurance, and clients should play a role in resource allocation. Ultimately society receives both the positive and negative consequences of how this is addressed (see figure 8).

The challenges remain for clients in their efforts to sustain sobriety (see figure 9). Although some stages or phases of recovery are perceived (see figure 10), there is a common understanding that clients need to "work the 12-steps". The challenges that are both personal such as learning and applying new habits, and external environment such as social norms on the acceptance of alcohol use and corporate marketing of alcohol needs to be addressed. When asked after detoxification what people are recovering, the common themes were around internal issues such as self-worth and self-awareness along with enhanced outside relationships (see figure 11) being achieved through ongoing 12-step engagement and guidance by a trusted other. This is where the role of the sponsor is instrumental in one's sustained sobriety or the potential use of a recovery coach (see figure 12 and figure 13) to facilitate, guide, and lead by example through a customized recovery plan.

There were numerous challenges identified post-discharge. Both groups stressed that clients must change "people, places, and things". However, the respondents recognized it is hard for clients to change families, employment, and physical address. This is where new habits, skill sets, group meetings, and commitment to a 12-step program can offer a consistent, positive daily routine in one's life. This is particularly true for those in early recovery with limited time in sobriety and short duration of engaging in a new routine.

Another finding from this study was the lack of level or stages of sobriety identified and defined in one's recovery process. The researchers continue to experience a distilling of the continued 12-step philosophy over time. Different generations of people appear to have a varying comprehension and appreciation of recovery traditions. This could be the experience of reading the steps or attending meetings versus becoming or embodying the lived experience, actually unifying with the ideology underlying the 12 steps. Historically, there have been no measures of discernment or benchmarks regarding stages of recovery. Different from the ten interviewees, the subject matter expert defined three various stages of recovery. The first stage is detoxification, stabilization, and physiologically improved health. This leads to the second stage of emotional recovery and refined state of well-being and receptiveness to sustained change. Stage 3 allows a maturity to appear along with meaning, purpose, and spiritual values.

Over time the definition and treatment model continues to reflect a varied clinical protocol in understanding the true nature of the problem. The subject matter expert from this study identified the industry shifting from a once abstinence-based model, or Minnesota model, to a hybrid/comfort model that often includes pharmaceuticals as part of the treatment protocol and plush environments. The subject matter expert suggests that the original model has been diluted which can skew recovery rate data reporting of the effectiveness of the various treatment models. In summary, it appears that stage 1 would be the immediate detoxification and stabilization of the client to include an estimated 28-day inpatient stay or intensive outpatient treatment. This stage would include time in early recovery, from 1-2 years, focusing primarily on the physiological aspects and safety needs of recovery.

This includes physical health, gainful employment, and social integration with a daily routine schedule to include 12-step meetings, and intense contact with a sponsor and home group. The focus is on self, stability, sense of safety, and awareness of a higher power greater than the self.

Stage 2 would appear to occur after at least two years in sobriety, sometimes longer, where an individual can begin to deeply engage emotionally with others, and access a profound meaning and responsibility resulting from creating new behaviors and a richer life. This newfound awareness encouraged through healthy ego development, can enhance coping skills and self-motivation. Individuals are more emotionally stable and less reactive. There is a refined sense of self.

This phase of development can lead to stage 3 which is a self-actualization through spiritual practice. This newfound meaning or sense of self-discovery allows one to cultivate a relationship with a power greater than themselves. It is here where one could fully engage in life as a human being. (See figure 11) As mentioned earlier, the subject matter expert identified emotional healing and post-detoxification spiritual healing as essential components of sobriety. Although the sponsors or aftercare planners did not specifically identify stages of recovery, it is interesting to note that both groups recognized self-worth, self-esteem, relationships, Higher Power or God, and other emotional and spiritual aspects of the recovery process. The responses from both groups emerged common themes in how this was being achieved through connecting with positive people, groups, prayer, meditation, Higher Power, 12-step programs/Alcoholic Anonymous, and community engagement (See figure 12).

The prospect of a recovery coach into the recovery process is still to be discussed. It is a relatively new concept with several of the sponsors and aftercare planners unaware of this type of professional. Both groups referred to the sponsor as a type of recovery coach. The subject matter expert identified the recovery coach as a sponsor who is compensated and can provide additional guidance. The aftercare planners did suggest that the recovery coach have additional training, knowledge, and holistic perspective than a sponsor, who may not include collective goal setting. A common characteristic between a sponsor and a recovery coach is that each serve as a trusted guide as perceived by the interviewees. The following table lists the possible role a recovery coach can play in the continuum. However, it is still unclear as to whether a recovery coach is a designated professional in the continuum, with simply additional training, or certification as a recovery coach for specific professionals that are already in the field such as counselors or aftercare planners. The level of coaching needed remains questionable (see figure 13).

It appears a recovery coach can be useful playing the role of a navigator in the post-discharge recovery system. They may hold the client accountable for behavior, provide customized guidance to sustain 12-step engagement, motivate, and help facilitate growth at the pace appropriate for that person at the right time. Both groups also suggested that the recovery coach should lead by example and have significant time in recovery themselves. The value of a good listener who is trustworthy was also a common trait recommended by both groups.

Discussion

The authors recognize that the aftercare coordinators have a broad spectrum on the interpretation of what they regard as recovery. The sponsors interviewed have a tighter, perhaps an experiential, lived definition that appears to be focused on the individual in defining the term recovery. The two definitions reflect an I/WE, or personal versus collective nature regarding the common response to the question of "What is Recovery?" It seems this sense of separation arisesin the differences on perception. The author recognizes this as associated with lived separation regarding the potential root of the problem. The industry does not have a unified answer to this question. The researchers believe this is a societal issue, and solely not a drug and alcohol industry related problem. It is clear that no unified voice or belief system has succinctly defined why we become addicted. The authors reflect through the sponsor interviews, that there was less need for understanding of why we become addicted and a keener sense of action steps to move beyond the addiction. The authors believe this understanding by the sponsors is a direct result of the 12-step design that suggests moving toward action beyond the symptoms of addiction. The various perception of the belief systems ofthe underpinnings of the nature of addiction, lead to the various reasons why the participants felt people relapse. The aftercare coordinators and 12-step sponsors both agree that full participation in a 12-step program offers the keys to successful sobriety and enhanced appreciation for life.

The researchers see an enhanced global perspective from the professionals, in terms of strategies and recommendations to recovery whereas the sponsors saw a narrow and unified approach focused on individuals using the 12 steps.

The aftercare professionals concur; they additionally infuse other worldly issues such as relationships, career, environments, family support, extended care, and 12-step consistency. Both groups recognize the uniqueness of the individual along the 12-step journey. The researchers distinguish this as components of human consciousness that allow us to differ and suggest further research in this area be conducted. The researchers recognize the individual nature of each person's experience with spirituality by mirroring their flight of recovery and understanding of the journey.

The 12-step sponsors felt that the program is exemplary, and the resulting sobriety reflects the individual's grasp and commitment to the program. The aftercare planners suggest various societal issues, such as a potential integrated post-treatment step down models, longer length of inpatient stay, stronger insurance support, and stronger individual structure in guiding individuals upon discharge toward integration. Both groups suggest that sobriety rests in the hands of the individual; however, additionally recommending 12-step, the traditional model could experience stronger outcomes if we had a robust and heightened congruence, more structure, and sense of accountability with post-treatmentindividuals. The researchers suggest that upon discharge, a personal connection, either professional or 12-step based, could help bridge the person between discharge, 12-step, and life immersion. The aftercare providers also recognize additional staff training, stronger internal programming for patient/clients, and more flexibility in designing a holistic care plan related to the uniqueness of individuals. Finally, connecting individual to community whereas they are out of region or network also remains an issue.

The vast array of interpretation regarding root cause versus symptoms of addiction among participants reflects a gap of human consciousness and the current problem. Prior research suggests low recovery rates in our society. The authors regard this as a problem of consciousness, and/or our relationship or separation to self and other, whereas our unique, individual, mind discerns an illusory worldview of non-fulfillment that 12-step is referred to as "a spiritual disconnect". The authors' experience through practice of the steps recognizes the egoist, selfish and self-centered nature of the illness as the root to be treated. This form of separation can be witnessed, surrendered to, and reabsorbed as self, through the engagement of meditation and prayer. We can understand our unified and separate sense of self that lives through the symptoms of addiction. The inherent rational nature of ordinary consciousness perceives and experiences this internal life-long debate, yet recognizes that society can unify our beliefs and experience of divine perfection subconsciously. However, society has never offered a map or avenue toward unified experience of a "spiritual unity". People in addiction have been seeking oneness and transparency through altered consciousness by possibly seeking unity consciousness. The researchers, through this study recognize this as the most powerful finding.

Cohesiveness, re-integration, human connection, and motivation, are suggested by both groups. Although not mentioned specifically, the authors concur and recognize our varied human consciousness as the gap. This gap in societal unified consciousness reflects the nature of addiction, and this research continues to reflect the spiritual tenets as espoused and offered in the 12-step program. Additionally, aftercare personnel recognize the continuum of care and societalfinancial model as paramount by offering a comprehensive, nurtured approach.It has been uncovered that aftercare coordinators recognize that society pays for the gap through the consequences of the current gap in care. From a philosophical perspective, the researchers recognize what individuals experience in society is the lived experience. This results from the duality of addiction and the separation from oneness of a deeper universal, divine, and unified approach caused by our divided belief systems. Society is paying the price and embodies the invaluable nature of the solution within each person.

Both groups unite on the concepts of self, individual culture, and personal relationship to the true sober nature, as the challenge in personal growth and recovery. The authors believe that personal conviction, belief systems, and the courage to immerse and surrender to the 12-step model remains the number one challenge for the post discharge/or ongoing recovering community. Recovery or self-discovery of self-awareness points toward a spiritual direction as perceived by both groups. Achieving a different way of life through the understanding of a universal path of spirituality offered through 12-steps, is the underlying basis for recovery. The 12-step program provides the knowledge and experience of a level of consciousness that offers a different way of life and a genuine happiness through a newfound sense of self, and living and coping skills.

The professional field of coaching continues to grow in life, as a business and career. Perhaps,a recovery coach could address the gaps between post-discharge and initial recovery rates, and the gap between short-term and long-term sobriety. They might be able to expand potential, regarding meaning, optimum health, and life purpose. The post-discharge and initial recovery rates and the gap between short-term and long-term sobriety rates might see alterations. Through the inclusion of a coaching liaison, the system and individual could potentially have access to expanded recovery regarding meaning, optimum health, and life purpose. This could also enhance continuing education for professionals on their own consciousness, and help bridge the gaps in affecting the recovery rates and societal issues regarding addiction, the relationship to addiction, worldview, and human potential.

Several limitations to the findings in the study exist. The lead researcher has 20 years in sobriety and has lived through the phenomena. Although personal perspectives and assumptions were set aside on paper prior to the study beginning to avoid bias, possible influence may exist in the presentation of findings. The lead researcher did use a co-investigator to note take and observe the lead researcher to ensure bias did not enter into the study and to retain optimal objectivity. The convenience sample limited the responses to Central and Northeastern Pennsylvania. It may be difficult to generalize the information to populations outside of the Commonwealth of Pennsylvania. It is also important to note that the concept and role of the recovery coach is in its infant stage and little is known or studied on their efficacy and effectiveness. It is also important to recognize that even if the recovery continuum of care can be improved, it does not guarantee that individuals' post-discharge would be motivated to comply with the guidance and additional services offered.

The study is significant because it can further clarify the service needed to guide people through the challenges and barriers of successful recovery. It identified relapse triggers that may arise in the process. This can serve as a platform for further research regarding identifying and filling the gap in service, and to study the role and potential impact a recovery coach has on reducing relapse rates, and ultimately improve the continuum of care recovery model or system.

As a teacher, student, and recovery individual with long-term sobriety, the lead investigator has been entrenched in the field of recovery for over 18 years. This research us intended to align future research interests in this area and study the use of recovery coaching as a potential valued service in the continuum of care. The researchers feel there is a need for individualized patient recovery care that addresses personal, spiritual, emotional, psychosocial, and physical needs. As a certified and seasoned meditation and yoga teacher, the lead researcher believes these practices can be useful tools for the recovery coach as they relate to individual consciousness and the collective consciousness of society. It is important to note that the researchers were not directly in contact with the patients upon discharge in the proposed study, but only the discharge/aftercare planners and the alumni sponsors.

The information gathered in this study can evolve the continuum of care to understand the problems, identify gaps, and develop new research questions for studying the efficacy and role of recovery coaching to improve sobriety. The research results can also assist both interview groups with information to help them understand how to approach aftercare needs of recently discharged individuals. It is apparent that individuals' perceptions on addiction and recovery vary. It is with this conclusion, that the researchers suggest that a unique, congruent, and customized care plan be established and monitored upon inpatient discharge. Further research is needed to study if a cohesive, person-specific approach, whether it is the use of a recovery coach, sponsor, or other person, can lead to stronger long term sobriety rates.

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