

CASE STUDY OF LIVED EXPERIENCES

CASE STUDY OF LIVED EXPERIENCES: THREE MALE PEER RECOVERY COACHES
AT A COMMUNITY-BASED, SPIRITUAL, RESIDENTIAL SUBSTANCE ABUSE
RECOVERY PROGRAM

by

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Liberty University

A Dissertation Presented in Partial Fulfillment of the Requirements for the Degree

Doctor of Philosophy

Liberty University, December 2021

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Doctor of Philosophy Liberty University, Lynchburg, VA

2021

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ABSTRACT

Substance use disorder is one of the most universal clinical and public health concerns in the United States. A shift in the behavioral health field from short-term cures to long-term recovery found peer-based recovery services to be a notable asset. The peer recovery coach (PRC), experientially equipped through personal substance use disorder history and recovery, is the fastest growing role in peer services. Very limited research exists into the lived experience of PRCs and the impact of the PRC role on personal recovery. This investigation aimed to fill gaps in the literature related to PRCs' lived experience and personal recovery. The theoretical orientation of the re-entry experience of an ex-offender into home, community, and work life supplied a framework for research into the re-entry experience of a PRC. The first research question was "What are the home, community, and work life re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse recovery program?" The second research question explored how the home, community, and work life experiences influence PRCs' present recovery. This qualitative case study collected data through semi-structured interviews. Data analysis themes demonstrated that the PRCs' home, community, and work life experiences were residential stability, restored relationships, togetherness, recovery support, role, feelings, benefits, and challenges. Experiences that influenced personal recovery categorized as relationships, accountability, triggers, and recovery tools. PRCs, on a journey of personal recovery themselves, need clinical support; the findings of this study could strengthen clinical support systems.

Keywords: substance use disorder, recovery-oriented systems of care, recovery management, peer-based recovery services, peer recovery coach, addiction recovery, peer support

Dedication

This dissertation is dedicated to my husband, Gifford, who has been a constant source of support and encouragement during the challenges of graduate school and life. You have listened to me, believed in me, sacrificed sleep to stay up with me, cooked meals for me, and managed our household. You have loved me well. I am so blessed to have you in my life. This work is also dedicated to my children, Paul, and Hannah, who have loved, cheered, and encouraged me when the finished project seemed far off. You expressed your love and care through many hugs, conversations, and text messages. You point people to the Lord, and I am grateful to be one of those people.

Acknowledgments

I would like to acknowledge that Almighty God opened doors for me to meet and work with PRCs at a community-based, spiritual, residential recovery program. My work grew to a divine calling which resulted in this study. Thank you, Lord, for your love, grace, mercy, and faithfulness to me.

Throughout the writing of this dissertation, I have received support and guidance from many people. I would like to thank Dr. Lisa S. Sosin, my Liberty University dissertation committee chair and faculty advisor, for believing in the project and in me. From the beginning, as I sought a school to complete my dissertation, you warmly welcomed me and advocated for me. You helped me to focus, continue, and push in times of trial and discouragement. Your prayers sustained me and pointed me to the Lord. You have taught me, by example, what it is to live in “the unforced rhythms of His grace.”

I would like to thank Dr. Mary M. Deacon, who served on my dissertation committee, for welcoming me to a new university and allowing me new opportunities for professional growth. I will always remember our supervision “treadmill talks.” Thank you for your expertise and suggestions in the dissertation writing process. I would like to thank Dr. Aubrey L. Statti, who also served on my dissertation committee, for the time, care, and competence that you added to the work.

I would like to acknowledge my colleagues from the recovery facility for their friendship, encouragement, and collaboration. I would like to especially thank Dr. Masica Jordan-Alston, Tom Bond, Dr. Darryl Arrington, Dr. Denis Antoine, Lisa S. Hanks, and Pamela Wilkerson.

I would also like to thank Dr. John Duggan, my colleague and fellow cohort, for your brevity and wisdom.

I would like to acknowledge the time, effort, patience, and diligence of my professional editor Laura Whelan. You have been a source of support and strength in the final stages.

I would like to thank my co-researchers and participants in this study. Your time, honesty, and transparency allowed for a rich dimension of data and themes. It is my hope and prayer that this study continues and advances the discussion for needed role training and clinical support for PRCs.

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List of Abbreviations

ACA - American Counseling Association

AOD – Alcohol and Other Drug problems

APA – American Psychological Association

CAPRSS – Council on Accreditation of Peer Recovery Support Services

PRC – Peer Recovery Coach

PRSS – Peer Recovery Support Services

PSS – Peer Support Services

PSW – Peer Support Worker

RM – Recovery Management

ROSC – Recovery Oriented Systems of Care

RSS – Recovery Support Services

SAMHSA – Substance Abuse and Mental Health Services Administration

SUD – Substance Use Disorder

CHAPTER ONE: INTRODUCTION

Substance use disorder (SUD) is one of the most universal clinical and public health issues challenging the United States (Office of the Surgeon General, 2016). Millions of people with SUD require a combination of long-term recovery management and recovery support services (McLellan et al., 2000). The Institute of Medicine (2005) altered the paradigm of drug and alcohol addiction services from short-term cures to long-term recovery, and this shift transported the behavioral health field to recovery-oriented systems of care (ROSC; Bradstreet, 2006). Alberta et al. (2012) pointed to peer-based recovery services as a notable strength in ROSC. The use of peer recovery support services (PRSS) with people who have SUD and co-occurring psychological disorders is on the rise in clinical environments (Eddie et al., 2019). In the SUD field, PRSS are frequently peer-driven mentoring, education, and support resources provided by people who are experientially equipped through their own history with SUD and SUD recovery to support peers with SUD and co-occurring mental disorders (Eddie et al., 2019).

The fast growth of PRSS in the United States and in the United Kingdom is ahead of the research on the subject (White & Evans, 2014). Beginning in 2009, the greatest aspect of SUD peer-service growth has been in the increase of peer recovery coaches (PRCs; Eddie et al., 2019). There is an absence of research into the lived experience of PRCs (Hymes, 2015), the relationship between helping and substance abuse recovery (Zemore et al., 2004), and the effects of the role of PRC on their own personal recovery (Bailie & Tickle, 2015). This case study, which examined the home, community, and work life of three male PRCs working at a community-based, spiritual, residential substance abuse recovery program, purposed to fill gaps in the literature relating to the lived experience of PRCs and the impacts of the PRC role on personal recovery. Eddie et al. (2019) stated a need for additional studies toward solidification of

PRSS role definitions, identification of best practice training for PRCs, and exploration of effective conditions of PRSS. Research into PRCs' lived experiences could reveal themes toward more effective treatment for SUD clients, more suitable training and supervision for PRCs, and increased awareness for healthcare institutions, community-based recovery programs, management, clinical colleagues, employers, policymakers, and funders (Eddie et al., 2019). This investigation aimed to identify role definitions, lived experiences, and personal recovery experiences by discovering the home, community, and work life experiences of a PRC and the role influences on personal recovery.

Summary of the Problem and Problem Statement

A shift has occurred in the behavioral health field, specifically in addiction treatment, from short-term stabilization to long-term recovery (Baird, 2012; Bradstreet, 2006). ROSC have highlighted peer-based recovery support services in the care and treatment of those with mental and substance use disorders (Bassuk et al., 2016). Bassuk et al. (2016) reported that drug and alcohol addiction treatment was historically delivered through concentrated professional services during critical incidences. Though this method helped reduce substance abuse, relapse rates remained high (Bassuk et al., 2016). Subscribing to the evidence-based view of addiction that there is a cure and people do get better, the Institute of Medicine (2005) and researchers called for more attention to long-term recovery and less focus on short-term cure in addiction treatment.

The new framework, called recovery management (RM), shifted the behavioral health field to a ROSC (Bradstreet, 2006) with the support of the Substance Abuse and Mental Health Services Administration (SAMHSA). Some of the contributing factors in RM are pre-recovery identification and engagement, recovery initiation and stabilization, long-term recovery

maintenance, and quality of life enhancement (Baird, 2012). The principles that guide the ROSC address recovery as reachable by different roads, self-directed, empowering, and holistically healing. Support for this process comes from peers and allies who offer advocacy, hope, and engagement in the community of recovery (Baird, 2012). Peer-based recovery support serves people with a variety of psychiatric disorders, including addictive disorders and mental illness (Alberta et al., 2012; Mahlke et al., 2014).

Bassuk et al. (2016) defined peer-based recovery support services as the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from SUD. This support is provided by peer leaders, also called recovery coaches, who have lived experience and experiential knowledge (Borkman, 1999). The concepts of mentoring or coaching refer to a one-on-one relationship where a peer leader who is in stable recovery and holds more recovery experience than the peer seeking recovery helps, encourages, motivates, and supports a peer's recovery (SAMHSA, 2009). PRSS are social support services that fill the social needs of people in or seeking recovery (SAMHSA, 2009). Types of social supports include emotional, informational, instrumental, and affiliational support. Research studies found that in a variety of SUD treatment settings, PRSS show reduced substance use and SUD relapse rates, better relationships with treatment providers and social supports, increased treatment retention, and higher treatment satisfaction (Eddie et al., 2019). PRCs serve in a variety of settings and delivery methods which will be discussed in more detail in Chapter Two. The PRC role involves tasks such as advocacy, resource connections, experiential sharing, community, relationship strengthening, mentoring, goal setting, socialization, and self-esteem shaping (Jacobson et al., 2012; SAMHSA, 2009).

The peer relationship has shown positive findings for the peer; however, the rapid growth of PRSS is a vast distance ahead of the literature (White & Evans, 2014). There is an absence of studies into the lived experience of PRCs (Hymes, 2015), the relationship between helping and substance abuse recovery (Zemore et al., 2004), and the effects of the PRC role on a PRC's personal recovery (Bailie & Tickle, 2015). Bassuk et al. (2016) stated the need for future exploration into the PRC's role and its impact on the peer workers themselves. Eddie et al. (2019) recommended additional studies pertaining to PRSS role definitions, PRC best practice training, and PRSS effective conditions.

This study explored the lived experience of three male PRCs who re-entered home, community, and work life after a year-long community-based, spiritual, residential substance abuse recovery program. The theoretical context built on the concept of ex-offenders' re-entry back into society (Listwan et al., 2006; Lynch & Sabol, 2001). The three main areas of concern for the re-entry of a recently released ex-offender are home, community, and work life. The idea of the re-entry of an ex-offender paralleled the re-entry of a PRC and supplied a framework for the research questions exploring the lived experience of a PRC re-entering home, community, and work life.

Nature of the Study

This qualitative study used the case study approach because the definition of a case study fit with the purpose of this specific research. A case study is as an exploration of a real-life contemporary bounded system through detailed in-depth data collection, involving multiple sources of information and a reporting of case description and case themes (Creswell & Poth, 2018). This single case study of Helping Up Mission involved three participants who are PRCs,

and it represented a revelatory case. A revelatory case is when an investigator has the opportunity and access to analyze a phenomenon previously inaccessible to social science inquiry. The descriptive information by itself is revelatory and validates the case investigation (Yin, 2018). A more detailed discussion of the nature of the study is included in Chapter Three.

Research Questions

The first research question was “What are the home, community, and work life re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse recovery program?” The second research question was “How do past and present home, community, and work life re-entry experiences of male PRCs influence their present recovery?” These two questions probed the lived experiences of home, community, work, and personal recovery.

Purpose of the Study

This case study explored the lived experience of three male PRCs who re-entered home, community, and work life after completing a community-based, spiritual, residential substance abuse recovery program. The purpose of this study was to learn about the PRC role, lived experience, and personal recovery impacts. This lived experience study could open discussions for necessary advocacy, targeted training, and effective supervision. Professional and personal development could positively contribute to the effective treatment of SUD clients; personal recovery of PRCs; and improved staffing, managing, and funding of stakeholders. Advocacy, training, and supervision are significant concerns because PRCs are working with SUD clients, are recovering from SUD themselves, and are re-entering the workforce. Health-care institutions, community-based recovery programs, management, employers, clinical colleagues,

policymakers, and funders need to be informed about the lived experience of PRCs as they navigate re-entering home, community, and work life. This case study aimed to fill a gap in the literature for those who counsel, manage, employ, supervise, support, and fund peer-based recovery support to consider the PRC role, lived experience, and personal recovery impacts.

Theoretical Framework

The theoretical framework for this investigation built on the re-entry concept, referring to ex-offenders' reintegration into society (Listwan et al., 2006; Lynch & Sabol, 2001). The re-entry experience of the PRC was examined in comparison to the main tenets of the recently released ex-offender. The three major areas of concern for the re-entry or reintegration of the ex-offender are home, community, and work life. Some of the ex-offender's challenges involve educational levels, employment skills, work experience, alcohol and substance abuse histories, ex-offender stigma, community and society exclusion, limited work history, and age at release (Blessett & Pryor, 2013; Lattimore et al., 2010; Seiter & Kadela, 2003).

Most ex-offenders end up living with family and friends until they find a job, save some money, and find a residence. Finding a good job, a process made difficult by low educational levels, minimal employment skills, and interrupted work experience, is usually the most serious issue (Andrews & Bonta, 1994; Seiter & Kadela, 2003). Ex-offenders looking toward being a productive member of society face stigma-related obstacles in re-entering the job market (Blessett & Pryor, 2013). Histories of alcohol and substance abuse (Mumola, 1999), along with higher chances of chronic and infectious diseases, like Hepatitis B and C, HIV, AIDS, and tuberculosis (Hammett et al., 2001), and rates of mental ill health two to four times higher than seen in the general population (Lurigio, 2001), form part of the stigma associated with challenges

transitioning into both employment and the community (Lattimore et al., 2010). The ex-offender's barriers to re-entering home, community, and work life parallel that of a PRC re-entering home, community, and work life. These similarities allow the re-entry experience of an ex-offender to provide a theoretical framework for a study on the re-entry experience of a PRC.

Key Terms

The following definitions clarify the meaning of the key terms for the purposes of this study:

Council on Accreditation of Peer Recovery Support Services (CAPRSS): A private organization that provides asset-based accreditation of addiction peer recovery support services provided by recovery community organizations and qualifying programs. CAPRSS accredits programs, rather than credentialing individual practitioners, with a purpose of supporting development of programs and a commitment to quality assurance and integrity of peer services (Faces & Voices of Recovery, 2015).

Peer: An individual who seeks help from a peer recovery support services program in establishing or maintaining his or her recovery (Faces & Voices of Recovery, 2015).

Peer-based recovery support: Peer-based recovery support is the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery, and adding to the quality of personal and family life in long-term recovery (White, 2009).

Peer-based recovery support services: Peer-based recovery support services make up the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term

recovery from substance use disorders. This support is provided by peers, also known as recovery coaches, who have lived experience and experiential understanding (Bassuk et al., 2016; Borkman, 1999; White, 2009).

Peer leader: A person in stable recovery who provides social support on a peer-to-peer basis. Peer leaders can be staff or volunteers. A peer leader is also called a peer worker (Faces & Voices of Recovery, 2015).

Peer recovery coach (PRC): A peer recovery coach balances three service roles: personal guide and mentor for those seeking long-term recovery from addiction; connector to recovery-supportive services; and liaison to community supports, resources, and activities (Faces & Voices of Recovery, 2010).

Peer recovery support services (PRSS): Peer recovery support services are strengths-based, recovery-oriented systems that offer hope and are provided by those who are experientially qualified to help others in beginning recovery, developing recovery, and enlarging the quality of life in recovery (White, 2009).

Peer support: Peer support is a system of giving and receiving help based on key concepts of respect, shared responsibility, and mutual agreement of what is beneficial (Mead et al., 2001).

Peer support worker: Peer support workers directly support clients through advocacy, resource connecting, experiential sharing, community building, relationship building, group work, mentoring, and socialization (Jacobson et al., 2012).

Peer worker: A person in stable recovery who provides social support on a peer-to-peer basis. Peer workers can be staff or volunteers. A peer worker is also called a peer leader (Faces & Voices of Recovery, 2015).

Recovery: “Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life” (White, 2007, p. 236).

Recovery coach: A person who has more recovery experience than the peer being served and who encourages, motivates, and supports a peer who is seeking, initiating, and/or sustaining recovery from addiction (Faces & Voices of Recovery, 2015). Recovery coaches are peers trained to supply informational, emotional, social, and practical support services to people with substance use disorder (Eddie et al., 2019).

Recovery management (RM): A model that looks at addiction treatment as recovery-oriented systems of care, sees recovery as bridging addiction and mental health services, and purports recovery as the organizing hub of national behavioral health policy recommendations (Department of Health and Human Services, 2003; Institute of Medicine, 2006; White, 2007).

Recovery-oriented systems of care (ROSC): An organizing framework for recovery support services (Laudet & Humphreys, 2013).

Recovery support services (RSS): RSS involves the whole spectrum of services that support addiction recovery. RSS are usually nonclinical services outside the realm of clinical assessment, diagnosis, and treatment (White & Evans, 2014).

Substance Abuse and Mental Health Services Administration (SAMHSA): An agency that funds grant projects across the United States to advance the ROSC model and to develop and deliver peer recovery support services (SAMHSA, 2009; Laudet & Humphreys, 2013).

Substance Use Disorder (SUD): A neutral term used to describe the wide range of the disorder, from a mild to a severe state of chronically relapsing and compulsive drug-taking. The word *addiction* is omitted from the DSM-5 substance use disorder diagnostic terminology because of its uncertain definition and potentially negative tone (American Psychological Association [APA], 2013).

Assumptions and Limitations

In conducting a qualitative study, I made philosophical assumptions that are applied within interpretative perspectives (Creswell & Poth, 2018). These assumptions, or beliefs, included ontology (the nature of reality), epistemology (the constitution of knowledge and the process of justification of knowledge claims), axiology (the role of values in studies), and methodology (the process of research). Philosophical assumptions exhibited in this study as grasping the concept of multiple realities, subjectively obtaining participants' views in the field where they live and work, admitting and reporting values and biases by identifying my positionality relative to the context and setting of the study, and utilizing inductive logic and an evolving design to better understand the research questions. An interpretative framework of social constructivism, seeking an understanding of the world of life and work, moved me to seek multiple views by interacting with participants, using open-ended questions, focusing on contexts of life and work, recognizing shaping of personal, cultural, and historical experiences, and interpreting the meanings that the participants have of the world.

My positionality involved my own work experience, training, ethical values, licensures, and certifications. Experience included 5 years of working with, counseling, and advocating for PRCs at a community-based, spiritual, residential substance abuse recovery program. As a licensed clinical professional counselor who upholds ethical values of promoting social justice and supporting the worth, dignity, and potential of people in their social and cultural contexts (American Counseling Association [ACA], 2014), I recognized the need for exploration into PRC role clarification, lived experience, and personal recovery. I am also trained and certified by the state of Maryland as a peer recovery support specialist supervisor who signs off on the hours that the state of Maryland requires of PRCs for PRSS certification. This positionality provided the context and impetus for this study.

Researcher bias, including information bias, interviewer bias, and selection bias, was a potential limitation of the investigation (Patton, 2002). Information bias, or classification of errors during data collection; interviewer bias, related to researcher's familiarity of the issue; and selection bias, or partiality during identification of study population, were potential threats to the data and interpretations with participants or member checking, gathering data from multiple sources through multiple methods or triangulation, and discussing evolving findings with credibility of the study. Because the researcher is the instrument in qualitative inquiry and researcher bias needs to be considered, there are components that provide evidence of researcher credibility and of trustworthiness to data interpretation (Marshall & Rossman, 2016). Lincoln and Guba (1985) suggested procedures to meet standards of trustworthiness, such as sharing strategic colleagues to make sure that results are established in the data or peer debriefing. Additional structure for trustworthiness included rich data (Maxwell, 2012), researcher's

reflective journaling (Creswell & Miller, 2000), persistent engagement or dealing with discrepancies (Patton, 2002), and an audit trail (Patton, 2002). This study demonstrated credibility and trustworthiness through member checking, triangulation, peer debriefing, rich data, reflective journaling, persistent engagement, and an audit trail. Both theoretical orientation and researchers' interpretations were evident to readers; therefore, transparency of literature use and of the researcher's background and intentions added to the soundness, or validity, of the study (Marshall & Rossman, 2016).

In addition to philosophical assumptions, positionality, and researcher bias, other limitations of the study related to case study and participant selection. PRCs, male or female, work in either volunteer or employee positions at different types of facilities located in rural, suburban, or inner-city areas within and outside of the United States. There are PRCs working in hospitals, clinics, halfway houses, prisons, community-based recovery centers, spiritual recovery facilities, intensive outpatient programs, residential programs, and detoxification units. These facilities are in different countries; geographic regions; and rural, suburban, and urban areas. Programs and administrations each have specific emphases; the foci can be medical, psychiatric, behavioral health, substance abuse, recovery-oriented, correctional, and/or spiritual. The case study selection of a community-based, spiritual, residential substance abuse recovery program in a northeastern U.S. inner city and the participant selection of male employees who have completed this specific spiritual recovery program comprised the bounds of the study and impacted the collected data.

Significance of the Study

This exploration into the home, community, and work life re-entry experiences of three male PRCs working at a community-based, spiritual, residential substance abuse recovery program aimed to learn about the PRC role, lived experiences, and personal recovery. Exploration of the home, community, and work re-entry experience offered a lens into the life of a PRC. In SUD recovery themselves, the three male PRCs completed a year-long program at a community-based, spiritual, residential substance abuse recovery program. The three PRCs moved into new careers as PRCs at the same program.

Historically, the relationship between peers and PRCs has demonstrated positive findings for the peer; however, the rapid growth of PRSS exceeds the literature (White & Evans, 2014). There is an absence of studies into the lived experience of PRCs (Hymes, 2015), the relationship between helping and substance abuse recovery (Zemore et al., 2004), and the effects of the PRC role on a PRC's personal recovery (Bailie & Tickle, 2015). Bassuk et al. (2016) stated the need for future research to explore the impact of providing peer support on the peer workers themselves. Eddie et al. (2019) pointed to a need for additional studies in PRSS role definitions, PRC best practice training, and PRSS effective conditions.

A study into PRCs' lived home, community, work, and personal recovery experiences allowed for conversation related to role definition, best practice training and supervision, and personal recovery impacts. Healthcare institutions, community-based recovery programs, management, employers, clinical colleagues, policymakers, and funders need to be informed about the lived experience of PRCs who navigate re-entering home, community, and work life. For those who manage, employ, supervise, counsel, support, and fund peer-based recovery

support, this case study filled a gap in the literature to learn about the PRC role, lived experience, and personal recovery. This study has the potential to explicate PRC re-entry experience, clarify PRC role definitions and conditions, suggest best practices for PRC training and supervision, and to educate on PRC personal recovery. Applications and implementations of this knowledge could positively impact PRCs' personal and professional development, personal recovery, work conditions, and peer-based recovery support services policies and funding.

Summary

This chapter introduced SUD and provided a background to long-term RM and RSS that benefit those with SUD (Alberta et al., 2012; McLellan et al., 2000). The greatest facet of SUD peer-service growth has been the rise of PRCs (Eddie et al., 2019). PRCs, who are in stable recovery and have more recovery experience than the peers they work with, supply nonprofessional, nonclinical encouragement, motivation, and support (SAMHSA, 2009). Due to the absence of literature into the lived experience of PRCs and into the effects of the PRC role on personal recovery, there is a need for studies into the lived experience of PRCs. The first research question was "What are the home, community, and work life re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse recovery program?" The second research question was "How do past and present home, community, and work life re-entry experiences of male PRCs influence their present recovery?" The concept of re-entry or re-integration of an ex-offender, upon release, into home, community, and work life paralleled the re-entry of a PRC and provided a theoretical framework for the research questions investigating the re-entry experience of a PRC.

The purpose of this study was to learn about the PRC role, lived experience, and personal recovery impacts. This study has the potential to explicate the PRC re-entry experience, clarify PRC role definitions and conditions, supply best practices for training and supervision, and to educate on PRC personal recovery. Funders, policy makers, employers, managers, supervisors, clinical colleagues, and clinical supporters can utilize this information to provide vocational and personal support, effective training and supervision, personal recovery awareness, and improved work conditions. This introductory chapter, addressing this study's problem statement, research questions, nature and purpose, theoretical framework, key terms, assumptions, limitations, and significance, prepared the reader for a review of related literature.

The next chapter of this dissertation, reviewing the broader base of literature, relates literature to the research questions, compares different points of view, summarizes literature that defines important aspects and establishes rationale for the conceptual framework, explains potential themes and perceptions, reviews literature related to both the selected research method and differing methods, and supplies an organization of major themes. Major theme organization outlines the contextual shift in addiction treatment, an overview of PRSS, a conceptualization of PRCs, and a theoretical framework of ex-offenders' re-entry into home, community, and work life (Listwan et al., 2006; Lynch & Sabol, 2001). The literature review comprises a critical synthesis of the most relevant and current published knowledge on PRCs.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

The largest portion of PRSS rapid growth has been the expansion of the PRC field (Eddie et al., 2019). There is limited research, with partially answered or completely unanswered questions, relating to how peer support workers personal recovery may be impacted by their role and what connection might exist between a PRC's position and their personal recovery (Bailie & Tickle, 2015). Hymes (2015) emphasized an absence of research into the lived experience of PRCs. The expressed need for future research created a context where this study on the lived experience of PRCs could add to the literature.

A review of the literature on PRSS with a focus on PRCs drew from evidence-based qualitative, quantitative, and mixed-methods studies, systematic reviews, and theoretical articles. The content of this chapter considers a contextual shift in addiction treatment, an overview of PRSS, a conceptualization of PRCs, and a theoretical framework of ex-offenders' re-entry into society. A contextual shift in addiction treatment consists of the acute model to the continuum of care model, short-term versus long-term treatment for chronic illness, the RM approach and definition of recovery, RM's transformative change at city and state levels, and the implementation and support of RM. An overview of PRSS involves examining background and definitions, settings, support types, recovery continuum, roles, benefits, and challenges. A conceptualization of PRCs entails definitions and activities, roles, settings, qualifications, training, benefits, challenges, professional and personal lived experience, and future research. A theoretical framework includes an overview; ex-offenders' experience of re-entry into employment; ex-offenders' experience, needs, and challenges; and parallels to re-entry

experience of PRCs. The theoretical framework sets a structure for exploration of the lived experiences of PRCs back into home, community, and work after completing a community-based, spiritual, residential substance abuse treatment program. This re-entry parallel with ex-offenders directly relates to the research questions investigating the lived re-entry experience of a PRC.

Search strategies in research utilized key words such as peer support worker, personal recovery, peer recovery support services, addiction, recovery coaching, addiction recovery, recovery management, addiction recovery management, ROSC, peer support, and peer recovery coach. Databases, such as EBSCO, ProQuest Central, and PsycINFO, provided evidence-based scholar-reviewed articles, and the reference sections from those articles supplied additional relevant literature. The literature search sought studies related to the background, roles, settings, delivery methods, benefits, challenges, and experiences of PRCs. The reviewed literature reflects a shift in addiction treatment, an overview of PRSS, conceptualization of PRCs, and a theoretical framework of ex-offenders' re-entry into home, community, and work life (Listwan et al., 2006; Lynch & Sabol, 2001).

Context of Shift in Addiction Treatment

SUD, (one of the most widespread clinical and public health issues that exists in the United States (APA, 2013; Office of the Surgeon General, 2016), is “viewed as the number one public health problem in the U.S.A.” (Kelly & White, 2011, p. 305). The behavioral health field is moving toward recovery-oriented approaches to treat and care for clients with mental health issues and SUD (Bassuk et al., 2016). The contextual shift in addiction treatment refers to the movement from the acute model to the continuum of care model, short-term versus long-term

treatment for chronic illness, the RM approach and definition of recovery, RM's transformative change at city and state levels, and implementation and support of recovery management.

From Acute Model to Continuum of Care Model

Drug and alcohol addiction, historically treated during acute episodes, has been addressed in the form of acute biopsychosocial stabilization, and dispensed in distinct, individualized methods where the service relationship ended soon after discharge (Bassuk et al., 2016; Kelly & White, 2011). Some individuals who meet criteria for SUD attain remission without formal treatment (Kelly et al., 2017); however, many millions of people with SUD require combinations of acute care, stabilization services, long-term RM, and recovery support services to sustain remission, similar to the treatment of other chronic health illnesses like diabetes and hypertension (McLellan et al., 2000). Evidence exists to support the utilization of such combinations in long-term care services for individuals with SUD (McLellan et al., 2000). The Institute of Medicine (2005) and leading addiction researchers (McLellan et al., 2000) called for a shift in addiction treatment from an acute care model to a continuum of care model paralleling that used in other chronic health conditions.

SAMHSA (2011) promoted the ROSC model as an organizing structure for recovery support services. The ROSC model aims for early intervention with those with SUDs, support of ongoing recovery from SUD, and improvement of health and wellness of SUD patients and their families. The ROSC model suggests a layered system with individual-centered continuity of care where a thorough list of coordinated services and supports are specific to a person's recovery stage, needs, and selected recovery path (Clark, 2007, 2008; Laudet & Humphreys, 2013). Clients may receive support in areas like education and job training, housing, childcare,

transportation, case management, spiritual help, and SUD-related services. These services might include relapse prevention, recovery support, SUD family education, peer-to-peer services, recovery coaching, and support groups (Kaplan, 2008; Sheedy & Whitter, 2009). These approaches, based on a holistic definition of recovery, view recovery as a self-directed process of change where people improve their health and well-being and work to see their full potential (SAMHSA, 2011).

Short-term versus Long-term Treatment for Chronic Illness

O'Brien and McLellan (1996) recognized that physicians, as well as the public, view addictions as acute conditions similar to a broken leg or pneumonia. McLellan et al. (2000) compared drug dependence with other chronic illnesses and found that the results of drug dependence treatment were optimized when patients received continuing care and unlimited monitoring. Appropriate treatment in the acute care context was detoxification, and relapse was viewed as failure. However, when the drug was taken out of the body and the patient experienced withdrawal, the addiction did not go away. After a detoxification, the addictive disorder continued and tended to lead to relapse/return to drug use. Detoxification did not address the fundamental disorder; therefore, it was not suitable treatment. McLellan et al. (2000) concluded that drug dependence needs to be insured, treated, and evaluated like other chronic illnesses.

Addictions have similarities with other chronic disorders like arthritis, hypertension, diabetes, and asthma. Physical brain pathway changes and medical, social, and employment difficulties that occur during addiction do not dissolve after detoxification. Even after detoxification treatment, these issues and challenges become a context for potential and likely relapse. O'Brien and McLellan (1996) found that addiction treatment should be viewed as long-

term and that a single treatment will probably not cure the addiction illness. Dennis et al. (2005) published data from a longitudinal study sample of a U.S. public treatment program showing an average of 27 years from the beginning of substance use to stable recovery. Kelly and White (2011) described acute, biopsychosocial stabilizations as self-contained programs where the provider relationship ended just after discharge with minimal provision of resources for continuing care or recovery support. These authors reported that the acute treatment model was insufficient to meet the needs of the chronic illness of SUD.

The acute care model, often administered in abbreviated programs with the service relationship ending near discharge, does not typically devote time or sensitivity to connecting the patient with support for future triggers and risks (Kelly & White, 2011). Following a treatment episode, an estimated 50%–70% of people will pick up alcohol or drug use in the first year, and most do so within 90 days (Hser et al., 1998). Additionally, 25%–35% of patients treated in addiction programs will return within 2 to 5 years (Brown & Romo, 2006; Simpson et al., 1999, 2002). This scientific data supported the views of recovery advocacy groups and the experiences of patients and their families. Kelly and White (2011) suggested that RM and ROSC efforts provide hope by matching services with the chronic and complex issue of addiction. These investigators informed that the future of addiction treatment as a social entity may rely on successful alignment with a model of continuous recovery management.

Recovery Management Approach and Definition of Recovery

RM and ROSC are new models for addiction treatment and recovery from severe AOD problems (Kelly & White, 2011). The basis of the RM approach is the concept of recovery; it is necessary to define addiction recovery to understand its role as an organizing paradigm in RM.

The most common terms used to explain improvement after AOD problems are *sobriety*, *remission*, and *recovery*. SAMHSA (2006) published a report stating that sobriety or remission may signify the elimination of AOD problems (e.g., patients do not continue to meet DSM-5 criteria for abuse) and the meaning of recovery expands from remission to a wider grasp of global well-being. Sobriety and remission highlight what has been taken away, and recovery emphasizes what has been added to an individual's life (White, 2007).

Recovery involves components of abstinence that include current abstinence, a desire for continuing abstinence, and an awareness of the need for activities that support and encourage abstinence (Kelly & White, 2011). Abstinence is both foundational and a central goal to making progress and moving away from SUD (Koob & Le Moal, 2006). RM approaches that have a sole focus on abstinence have shown notable long-term recovery rates (Skipper & DuPont, 2011). Recovery capital, or connections with supportive and fulfilling activities, provides engagement of time and attention along with encouragement of abstinence (Cloud & Granfield, 2001; Granfield & Cloud, 2001). While acute models of addiction treatment center on weaknesses and pathology, the RM and ROSC approaches evaluate and focus on strengths, assets, and recovery capital. White (2007) referred to recovery as the experience of healing from addiction while growing in awareness of relapse-vulnerability and creating a "healthy, productive, and meaningful life" (p. 236).

Recovery Management's Transformative Change at City and State Levels

Kelly and White (2011) reported that RM and ROSC best fit with treatment of those who are diagnosed with severe chronic AOD problems and who have limited recovery strengths and supports. The existence of specialized treatment for severe AOD problems as a social entity

relies on the progress of movement toward RM and ROSC. The shift toward a recovery paradigm which includes RM and ROSC shows up in the growth and development of recovery mutual aid groups, new recovery support initiatives, and a new recovery advocacy movement. Engagement with free, peer-led community resources, such as Alcoholics Anonymous, with 12-step facilitation approaches can strengthen and lengthen the effects of formal care. This type of RM intervention, however, is an additive change and not the needed transformative change in which the total philosophical and practice structure of the system experiences radical change. Transformative-level change is necessary for lasting change, large impacts, provider and service-user clarity, and overall integrated services (Achara-Abrahams et al., 2011).

Documented benefits of the implementation of RM and ROSC show transformation at treatment-system and city and state levels (Kelly & White, 2011). Specific examples of transformative change include evidence-based studies of a treatment system in Oxford House (Kelly & White, 2011), the city of Philadelphia (Achara-Abrahams et al., 2011), and the state of Connecticut (Kirk, 2011). The 2-year follow-up of a study on the community-based, peer-led, residential resources of Oxford House yielded an approximate \$613,000 in savings of productivity and incarceration benefits. The city of Philadelphia executed large-scale transformative-level change in its behavioral health care system with results of improved quality of life, increased levels of community participation, and decreased use of emergency care. Agencies with peer-led and professionally led programs realized retention rates of 50%–75%. Connecticut redesigned its total public and private behavioral health care system, a transformative state-level initiative treating about 100,000 people annually, resulting in a 62% decrease in acute inpatient service usage, a 40% increase in first-time admission access, and a

24% decrease in average annual per-client costs. The impact on receipt of continuing care for those leaving treatment by community-based peer recovery support services resulted in 15,000 hours of volunteer service, 37,000 outgoing telephone support recovery contacts to 1,420 recovering individuals, and \$400,000 of provided services.

Implementation and Support of Recovery Management

A groundbreaking five-step procedure for managing addiction as a chronic condition involves tracking, assessing, linking, engaging, and retaining, (TALER; Scott & Dennis, 2011). These researchers found that individuals receiving TALER recovery management check-ups were significantly more likely to enter treatment earlier, receive treatment longer, increase abstinence time, and decrease time in need of treatment while in the community. A national-level study of RM implementation examined physicians suffering from SUD (Skipper & DuPont, 2011). This research pointed to early discovery and treatment of physicians with SUD along with substantive treatment, wide-range monitoring, and proactive connection to continuing abstinence-focused recovery support as factors that produced remarkable 5-year abstinence rates of 79% and back-to-work rates of 96%. This RM approach builds on eight components: finding a motivational reason, supplying thorough beginning assessment and continued treatment; providing care support for many years; having high hopes for abstinence-based recovery; connecting individuals to recovery support groups; monitoring, supporting, and intervening; increasing support in potential relapse situations; and blending these facets within a cohesive program. Kelly and White (2011) cited this eight-point physicians health program as an example of a practical synopsis of the RM approach. According to Kelly and White (2011), this 8-point

program provided the best evidence to date that high-quality, sustained RM initiatives can attain exceptional long-term rates of addiction remission and recovery.

Policymakers and healthcare leaders in the United States and abroad are embracing recovery as an organizing construct for the chronic illness of addiction, where people can recover and access evidence-based treatments and long-term support services (Best & Lubman, 2012; Office of the Surgeon General, 2016; White, 2007). Two key initial federal policies that translated recovery concepts into practice were the 1999 Surgeon General's Report, which recommended that all mental health systems have a recovery focus (Sacher, 1999), and the president's New Freedom Commission on Mental Health, which stated that recovery was the aim of a transformed system (Bradstreet, 2006). The Affordable Care Act of 2010 and the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 also addressed the needs of those with chronic physical and behavioral health conditions (Laudet & Humphreys, 2013). The Affordable Care Act supported an expansion in care and number of services, including recovery support services. Changes in the U.S. healthcare system have happened simultaneously with the promotion of recovery-oriented concepts by SAMHSA and endorsements of the recovery model by mental health organizations such as the American Psychiatric Association and the American Psychological Association (Ahmed et al., 2015; Laudet & Humphreys, 2013).

Recovery-oriented methods allow many systems to address ongoing care with a complete outline of services and supports and a focus on an individual's specific recovery journey. Clark (2007, 2008) explained the goal of recovery as encouraging abstinence and a fuller quality of life. A major tenet of RM and ROSC programs involves including nonclinical, often peer-based

recovery support services throughout the long-term recovery stages. White and Evans (2014) referred to PRSS as a visible aspect of community responses to SUD issues.

Overview of Peer Recovery Support Services

The movement of the recovery model in the behavioral health field and the resulting recovery-based transformation of the field has included a multiplication of peer-led interventions (Ahmed et al., 2015). These interventions can be categorized as mutual support/self-help programs, consumer-oriented services, and peer support (Ahmed et al., 2015; Davidson et al., 2006). The first two services occur outside traditional care environments, while peer support services occur in traditional care settings (Ahmed et al., 2015). Peer support happens when people with mental distress history support each other as equals and utilize their lived experience as a tool in that support (Beales & Wilson, 2015). An overview of peer-based recovery support encompasses background and definitions, settings, support types, recovery continuum, roles, benefits, and challenges.

Background and Definitions

Peer support, described by Moll et al. (2009), acknowledges a history of mental illness and experience with the mental health system as an advantage rather than a disadvantage. Employing consumers of mental health in the role of mental health service providers began in the early 1990s. The consumer-provider model is grounded in a philosophy of self-help and mutual aid. The hiring of consumers as service providers acknowledges that not all people with mental illness have needs that can be supplied by professionals and promotes that peer support providers have unique and valuable qualifications. Moll et al. (2009) explained that peer support providers, also labeled peer specialists or peer providers, have experienced significant progress

in their mental health issues, enabling them to provide services to those who have not experienced such growth in their recovery process.

Eddie et al. (2019) referred to SAMHSA's (2009) definition of PRSS as "a peer-helping-peer service alliance in which a peer leader in stable recovery provides social support services to a peer who is seeking help in establishing or maintaining their recovery" (p. 2). SAMHSA (2009) explained that PRSS is a new type of social support services that facilitates recovery (McLellan et al., 1998) with the purpose of meeting the needs of those in recovery or seeking recovery. The word *peer* in PRSS indicates that delivery of services is provided by those who have a personal history of SUD and recovery. PRSS, as reported by SAMHSA (2009), help people with engagement in the recovery process and contribute to reduction of potential relapse. The success and stability of peer service providers' recovery creates a powerful, hope-filled message and a vast amount of experiential understanding. PRSS allow the treatment setting to move out of the clinical realm and into the daily lives of those who choose recovery.

Mead et al. (2001) defined peer support as a process of providing and receiving help based on key tenets of respect, shared responsibility, and mutual consensus of what is beneficial. Peer support is not based on mental illness models and diagnostic criteria. It is about the empathic understanding of another's circumstance through the shared ground of emotional and mental pain. This shared ground builds an alliance with a deep, holistic cognizance based on mutual histories, where individuals can be with each other without the restrictions of traditional professional-patient affiliation.

Peer support can provide a health and ability culture in contrast to an illness and disability one (Curtis, 1999). Mead et al. (2001) stated that the primary goal of peer support is to

validate the personhood and story of the individual while not accepting the premise of mental illness. Creative thinking and nonjudgmental attitudes regarding a person's process of making meaning in life are necessary in peer support. Peer support, a natural continuation and development of community, moves toward the growth of self-sufficiency and relationship-building (Mead et al., 2001).

Formal peer support, according to Bradstreet (2006), involves specific roles within current mental health environments which are established specifically for those who have significant mental health histories. White (2009) defined peer-based recovery support as the process of giving and receiving nonprofessional, nonclinical help to accomplish long-term recovery from extreme SUD. This type of support, provided by experientially credentialed people, helps in initial and continuing recovery and adds a quality to personal and family life through the recovery process. Faces and Voices of Recovery (2010), a White House Recovery Management Health Reform Roundtable which was instrumental in more focused peer service and in accreditation of organizations delivering PRSS, viewed PRSS as building recovery-oriented systems and offering hope on a foundation of strength. SAMHSA detailed peer recovery support for SUD as a set of nonclinical peer-based activities that involve, teach, and uphold people toward life changes necessary for recovery (Reif et al., 2014).

Settings, Support Types, and Recovery Continuum

The adaptability of PRSS to various service settings, stages, and styles of recovery and program contexts demonstrates its robust nature (SAMHSA, 2009). This versatility has established PRSS as an effective means of taking recovery from the treatment venue to the communities and living spaces of those in recovery. RSS are provided in both paid and volunteer

organizational models within community-based settings (White & Evans, 2014), such as recovery community centers, faith-based institutions, jails and prisons, health and social service centers, and addiction and mental health intervention agencies (Faces and Voices of Recovery, 2010). SAMHSA (2009) informed stakeholders that PRSS exist in urban and rural communities with varied types of populations that may be defined by age (e.g., young people, elderly people), race or ethnicity (e.g., Asian American, Latino American, Native American, Caucasian), gender (e.g., women), or by more than one circumstance (e.g., HIV/AIDS and other diseases, mental health diagnoses, vagrancy, or prison records). Peer support services (PSS) fit best in prevention-based services (Biss & Curtis 1993) compared to traditional services which generally react to crises. RSS are delivered in both face-to-face and technology-operated vehicles, such as the internet and smart phones (White & Evans, 2014). The contexts for RSS are sequential models (professional care followed by RSS), parallel models (professional care and RSS at the same time), and integrated models (treatment intervention and RSS in a coordinated care environment).

In a peer-helping-peer service relationship, a peer leader with established recovery gives social support services to a peer who seeks aid in beginning or continuing their recovery (SAMHSA, 2009). The four types of social support that peer leaders provide were listed in the literature (Salzer, 2002; SAMHSA, 2009) as emotional, informational, instrumental, and affiliational. Emotional support shows empathy, caring, or concern to build up a person's self-esteem and self-assurance. Informational support demonstrates sharing knowledge and life skills. Instrumental support involves helping another to accomplish a task. Affiliational support

manifests as connecting with others to learn social skills, build community, and achieve a sense of belonging.

Recovery occurs in stages, and peer leaders give social support to people at all stages on the recovery change continuum (SAMHSA, 2009). Various pathways to recovery can be religious, spiritual, secular, medical, and/or cultural. The Prochaska et al. (1995) stages of change model categorized the stages of precontemplation, contemplation, determination/preparation, action, maintenance, and relapse. PRSS are offered across the stages of pre-recovery engagement, recovery initiation and stabilization, recovery maintenance, and greater quality of personal and family life in long-term recovery (White, 2009). RSS, distinctive from traditional addiction treatment, addresses the person, family, and social and larger community.

Roles

Although the many definitions of PRSS provide a starting place for practice and study, a broad range of peer roles exist, along with a variety of involvement aspects to the roles (Eddie et al., 2019). Roles include ad hoc, lay, or peer volunteers or full-time, trained, paid positions. In a lot of clinical environments, noncompensated lay peers have been asked to give support to SUD clients in various recovery stages. The SUD field has usually exhibited roles of mentoring, education, and support where peer leaders respected many roads to and styles of recovery (Eddie et al., 2019). These roles emphasized long-term continuity of care by involving the client, the family, and the community (Valentine, 2010; White, 2010). Research into the utilization of new peer worker roles showed the need for clarity to minimize negative impact of role benefits (Gillard et al., 2013; Moran et al., 2013).

Jacobson et al. (2012) described the peer support worker's role in either direct or indirect work with clients as nonclinical, collaborative, advocacy-based, relational, and informational. These investigators found that peer workers spent 56% of their time directly working with clients and 44% of their time supporting their work with clients. The types of direct client work included advocacy, resource connection, experiential sharing, community building, relationship building, group facilitation, skill building, mentoring, socializing, and self-esteem building. Tangible portrayal that demonstrated the work philosophy of PRSS involved experience, approach, presence, role modeling, collaboration, challenge, and compromise.

Benefits

Peer support work is beneficial for clients, the mental health field, and the workers themselves (Davidson et al., 2012; Repper & Carter, 2010). In a 2012 study, Miyamoto and Sono found that clients, or peers receiving help, received clinical, personal, and emotional benefits in a better quality of life, reduced hospitalization, and improved feelings of understanding or trust. The mental health service team became more patient-centered or recovery-oriented through peer support providers being on the team. Peer providers, seen as role models, helped clients and staff to be hopeful and supportive of the recovery process. Peer workers generated understanding between staff and patients, moved the mental health service culture and practice toward a recovery and relationship focus, and dissipated stigmas around abilities of people with mental illness (Miyamoto & Sono, 2012).

Limited studies exist regarding peer support workers; however, the existing evidence supported PRSS to be as effective, and maybe even more effective, than nonpeer services (Bradstreet, 2006). Benefits for peer support workers encompassed training and employment

opportunities, contributions of “giving back,” mental health history disclosure as attributes, and validation of lived experience. People with long-term mental health “disability” were more frequently unemployed than other disability groups (Social Exclusion Unit, 2004). The chance to give back to others in recovery was viewed as helpful to one’s own recovery. In peer support work, sharing a history of mental health issues became a qualification and positive trait. The placement of value on the lived experience of the peer worker and the utilization of person-centered planning and recovery techniques were positive benefits to the peer worker.

Miyamoto and Sono (2012), in a comprehensive review of both systematic reviews and qualitative studies, found peer support providers benefited in self-efficacy, increased self-knowledge, and in skill development. These researchers also noted that benefits included personal growth, initiative, perseverance, improved communication, more confidence, positive feedback from peers, identity, and status as a wage-earner. Bailie and Tickle (2015), in reviewing and synthesizing 10 qualitative studies, found four constructs which described peer support workers’ views on the effects that their role had on their personal recovery. These constructs were greater comprehension of personal mental health, sense of identity, position within a profession, and result of employment. One specific organization’s 10-year outcome of peer support, reported by Beales and Wilson (2015), identified personal provider benefits as finding empowerment and a voice; growing confidence, self-esteem, respect, and acceptance; experiencing belonging; building relationships; and reintegrating into communities. Many peer workers enjoyed being able to give something back, seeing how far they had come in their own recovery, furthering employment opportunities, and challenging stigmas and discrimination (Beales & Wilson, 2015). Findings in Eddie et al.’s (2019) systematic review of 12 studies

demonstrated the advantages of peer support in various SUD treatment environments to be reduced substance use and SUD relapse rates, better relationships with treatment teams and social networks, more treatment retention, and higher treatment satisfaction. Nine studies systematically reviewed by Bassuk et al. (2016) suggested that peer support in recovery had a healthy effect and made a positive addition to substance use outcomes.

Moll et al.'s (2009) qualitative collective case study recognized the literature's support for effectiveness of peer support in mental health treatment with the benefits of financial gain, personal development, vocational and interpersonal skill advancement, positive feelings about helping others, enhanced personal recovery, and better quality of life. A case study of 11 peer support specialists (Mowbray et al., 1998) presented evidence that their positions created personal and professional growth shown in competencies of personal value and worth, normalization through work routine, better quality of life, access to money and an improved standard of living, vocational development, core work skills, safe beginning for future employment, and growth of helping skills. Another case study conducted by Salzer and Shear (2002) focused on the benefits to consumer-providers as helpers and reported seven meta-theme benefits: facilitation of others' recovery, growth in one's own recovery, social approval, professional development, career experiences, position and recovery advantages, and mutual support. When reviewing the data with interview participants, the PSS clarified that all other benefits were secondary to helping others in their recovery. Though helping others aids all of those in human service professions, it held significant meaning in a 12-step program context because of Step 12's emphasis on carrying the message of the steps to other alcoholics. Step 12 points to helping others as a pivotal part of an individual's recovery process. A phenomenology

study with seven participants by Dyble et al. (2014) derived three main themes of vacillating identities, peer support workers' roles, and system culture, where interviewees saw themselves changing socially, growing personally, clarifying the role, and advocating for a person-centered approach. Bracke et al. (2008) conducted an empirical study of 628 peer users and found that providing peer support was more beneficial than receiving it.

Challenges

Bailie and Tickle (2015) pointed out that although being employed as a peer support worker has the potential for a positive personal recovery experience, the role could also impede recovery. Evidence from the studies reviewed by these researchers showed that impediments to recovery would lessen with attention to training, pay scales, and supervision. Alberta et al.'s (2012) quantitative research spelled out the external challenges (the integration of PSS staff into professional culture) and the individual challenges (the need for training, supervision, and support) of peer-based recovery support services. There was a question as to the ideal level and type of training for PSS (Alberta et al., 2012). Bradstreet (2006) stated that these specific changes would be necessary before peer workforce development in Scotland would be possible: conception of professional boundaries, content of training, identification of best locations, and advocacy for value as team members. Jacobson et al. (2012) referred to literature on how poorly defined job roles hinder the success of the PSS. An ignorance about peer support workers, the current mental health environment, an overemphasis on clinical aspects, and the requirement of certification and documentation can hinder the power of peer support work (Beales & Wilson, 2015). The lack of buy-in from professional staff can lead to barriers like fear of job security, lack of role clarity, and stigma of mental health background (Conchar & Repper, 2014).

A grounded theory study organized by Moran et al. (2013) identified three challenge domains as work setting, occupational journey, and personal recovery. Gillard et al. (2014), in their comparative case study, noted that the lack of a clear change model, explaining what peer workers do, was a limitation. Moll et al.'s (2009) case study included the main challenges as definition of roles, negotiation of the learning curve, balance of tension of peer and staff roles, navigation of role model challenges, transition from consumer to provider, and acceptance in work setting. In their case study, Mowbray et al. (1998) described problems related to attitudes toward peers, costs to their recovery, program operations (structure, supervision, and training), and overall mental health field criticisms. Difficulties identified by Dyble et al.'s (2014) phenomenological analysis consisted of managing multiple identities, role vagueness, staff attitudes, and limited understanding. Bracke et al.'s (2008) quantitative analysis showed a lack of balance in peer support and demonstrated the need to manage the concepts of caregiver load, care distress, or cost of caring.

A comprehensive review of systematic reviews and qualitative studies done by Miyamoto and Sono (2012) found challenges of peer support workers to be role conflict, boundaries, peer status disclosure, role questioning, low compensation, and work hour limitations. Eddie et al. (2019), in a systematic review of 12 studies, found many ethical and practical barriers for PRSS interventions in SUD work. Bassuk et al. (2016) investigated nine studies and found challenges of PRSS to be inconsistencies in the definitions of peer workers' roles and responsibilities. Two obstacles to building a research base to guide RSS, outlined by Laudet and Humphreys (2013), were the lack of a valid multidimensional measure of recovery outcomes and the inability of RSS

to match professional treatment research. Each of these obstacles contributed to the weak research funding setting for PRSS.

Conceptualization of Peer Recovery Coaches

In the field of SUD peer services, the largest area of growth has been the involvement of PRCs (Eddie et al., 2019). This fast growth created a need for clarification of the role of a PRC (Bailie & Tickle, 2015; Bassuk et al., 2016; Conchar & Repper, 2014; Dyble et al., 2014; Eddie et al., 2019; Gillard et al., 2013, 2014; Jacobson et al., 2012; Miyamoto & Sono, 2012; Moll et al., 2009; Moran et al., 2013). A conceptualization of PRCs entailed definitions and activities, roles, settings, qualifications and training, benefits and challenges, professional and personal lived experience, and future research.

Definitions and Activities

PRCs, peers who share the lived experience of addiction recovery, continue to be integrated into primary care agencies to aid in reaching and treating patients with SUD (Jack et al., 2018). PRCs are peers trained to supply informational, emotional, social, and practical support services to those with SUD through organizations like recovery community centers, hospitals, and outpatient clinical settings (White, 2009). Usually, PRCs are paid employees working part-time or full-time with a minimum education of high school diploma or GED. SAMHSA (2009) defined PRC as having a one-on-one relationship where a peer leader with more time in recovery than the peer served encourages, motivates, and supports a peer who is initiating or growing in recovery. PRCs, as noted by Valentine (2011), exist along a continuum between case manager at one end and 12-step sponsor at the other end.

Core PRC activities, identified by Jack et al. (2018) in their qualitative case study, entail system navigation, behavior change support, harm reduction, and relationship building. The Surgeon General's Report (Office of the Surgeon General, 2016) listed a PRC's responsibilities as provision of strategies to maintain abstinence, connection of people to recovery housing and social resources, and help for people to develop personal skills that stabilize recovery. Though the nature of coaching can vary from one agency to another, general activities encompass setting recovery goals, outlining recovery treatment plans, linking to recovery-related needs, and helping with collateral concerns like criminal records, physical challenges, job skills, and new hobbies (SAMHSA, 2009). White (2006) compared PRCs to motivators or cheerleaders, allies or confidants, truth-tellers, role models and mentors, problem solvers, resource brokers, advocates, community organizers, lifestyle consultants, and friends. Some labels that do not confer to PRCs, according to White (2006), were sponsor, therapist, nurse/physician, and priest/clergy.

Role Settings, Qualifications, and Training

Faces and Voices of Recovery (2010) viewed PRC roles as personal guides and mentors for people desiring to accomplish long-term recovery from SUD, resources for instrumental recovery, and liaisons to formal and informal community activities and supports. Specific service roles provide emotional and social support, goal setting, support in life and coping skills, community networking, role modeling, connections to health and human services, liaisons to probation officers and/or social workers, and advocacy for individual needs. Verbs that describe PRC roles are identify, advocate, consult, praise, support, enhance, identify, share, monitor, transport, engage, organize, encourage, enlist, link, express, help, orient, and motivate (White, 2006). SAMHSA (2009) pointed out that the role of PRC is highly supportive, as opposed to

being directive. Both SAMHSA (2009) and White (2006) highlighted the need to distinguish the role of the PRC from the treatment counselor or other professional role and the 12-step sponsor. White (2006) remarked that the PRC role being defined differently across agencies is less significant than clarity of the role within an agency. Key support for the developing role would look like refinement of role definitions and standards, modeling of criteria for hiring PRCs, compensation and benefit plans, orientation, training and supervision models, ethical codes, and evidence-based protocol.

The ideal service settings for PRC tasks, outlined by Faces and Voices of Recovery (2010), are inviting nonprofessional and nonclinical spaces and community settings (e.g., recovery community centers, libraries, coffee shops, etc.) and phone and other electronic modalities. Service settings need to be suitable to building trust and minimizing power differentials between the PRC and the peer user and building community support. To avoid the chance of eroding the peer relationship and experiencing issues with treatment and professional providers, the service setting should not be physically centered in a clinical environment. If PRCs are linked to professional or clinical environments, the peer meetings should take place in community-based spaces that are conducive to nurturing the peer relationship.

Due to the PRC role being peer-specific, the service role is open to qualified people who are in recovery from addiction. Faces and Voices of Recovery (2010) listed the basic requirements for a PRC as abstinence time, education, orientation, and training. Effective practice requires a PRC to meet the following qualifications: minimum of 1 year in recovery, literacy, orientation and training, continuing training, weekly supervision, and background checks per specific agencies. PRCs must fulfill core competencies that qualify them to execute

work responsibilities with confidence. Specific understanding and skills can allow PRCs to serve peers ethically with a foundation and authenticity in the recovery path. Knowledge areas include the science of addiction and recovery, recovery process and supports, practice of recovery values, ethical practice in nonclinical settings, cultural sensitivity and practice, trauma and its impact on recovery, community resources, and organizational delivery of peer recovery coaching. Skills for ethical practice of the PRC role include engagement, motivation, active listening, conflict resolution, crisis intervention, recovery support, written abilities, and community liaison and advocacy.

Although no national standardized system for the training of PRCs exists, some community-based recovery organizations do offer training for recovery coaches (Office of the Surgeon General, 2016). The Connecticut Community for Addiction Recovery, an example of a lead recovery community organization, developed and runs a 5-day experiential training at their Recovery Coach Academy, where future PRCs learn about being role models, advocates, mentors, problem solvers, and friends (Valentine, 2011). Additionally, the Academy educates learners about behavioral health disorders, crisis response, cultural practice, ethical responsibility, communication skills, and wellness planning. Future PRCs learn about core values of recovery, relationship skills, medication-assisted therapy, the stages of change, and wellness planning.

Benefits and Challenges

Faces and Voices of Recovery (2010) found that highlighting a PRC's personal and lived experience of recovery, a component that is missing from other service settings, was the key to the effectiveness, popularity, and success of peer services. The minimization of the power

differential between the coach and the peer created an environment of trust and encouragement. Jack et al. (2018) found that both patients and coaches looked at PRCs as an appreciated role that promotes recovery through visible system guidance and intangible social bolstering. PRCs, by the nature of their role, interacted with patients outside of the clinical setting, which allowed for the filling of critical care voids and explained why these peer leaders were a critical piece of recovery management (Eddie et al., 2019; White, 2009). Other benefits of the PRC role, as noted by Jack et al. (2018), consist of shared histories, behavior change encouragement, availability, and resource connections. When sharing a story of personal transformation, the face and voice of recovery was a compelling influence (Valentine, 2011). A case study by Jack et al. (2018) noted these challenges: uneasiness of the patient when asking for help, absence of clarity in the PRC role, and strain within the service team. These researchers suggested better communication between PRCs and agency leadership regarding definition of the role to help ambiguity and related tensions between PRCs and other staff members.

Professional and Personal Lived Experience

Consumer-delivered services are provided by people who have personal experience with issues closely related to mental health and substance abuse participants (Salzer & Shear, 2002). While consumer-delivered services allow opportunities for professional benefits, like skill building, experience, and knowledge, PSS can give back to others the same help that they received. Hymes (2015) reported the professional experiences of the PRC as service as a gap-bridger, adjustment to the PRC role, duality of role and identity, work setting, and growth in career. Peer support workers offered training and job opportunities, a chance to give back, and a supportive work environment (Bradstreet, 2006).

Addressing the challenges as well as the benefits supplied a balanced look at the PRC role and the potential for guidance, support, and specific training for the role (Bailie & Tickle, 2015). Some of the challenges involved the complexity of dual roles (Silver, 2004), non-peer staff paternalism, social out-casting, ignorance of professional boundaries, and stigma of the PRC's background (Walker & Bryant, 2013). The possibility of psychosocial factors contributing to ill mental health existed in instances of job stress, a lack of social connectedness, an abundance of mental overload, and work-benefit disparity (Stansfeld & Candy, 2006).

PSS explained that helping others was a fulfilling contribution to their own recovery. The Salzer and Shear (2002) study indicated that the peer workers viewed personal benefits, including their personal recovery, as secondary to the mission of helping others. Moran et al.'s (2012) qualitative study of 31 peer workers found positive effects on role recovery, work-setting factors, and sharing personal experiences. The quantitative analyses of a mixed-method study by Ahmed et al. (2015) supplied evidence that PRC employment may add to hope, empowerment, social involvement, and ability. Personal experiences consisted of personal growth, progress in recovery, confirmation of change, and certainty of acceptance (Hymes, 2015). Conchar and Repper (2014) recorded personal benefits of the peer support worker role as increased confidence, individual development, fewer hospitalizations, improved finances, and healthy relationships.

Future Research

Amidst the growth of peer-based recovery support services, it is imperative, according to Mead et al. (2001), that these services remain involved in ongoing research and evaluation. Some suggested research categories consisted of action, narrative, ethnography, life story models,

empowerment, recovery assessments, and quantitative studies. Unanswered or partially answered questions related to the personal long-term recovery results of PRSS (White & Evans, 2014), effects of employment on a peer support worker's personal recovery (Bailie & Tickle, 2015), and the relationship between mental health stigmas from professionals and the recovery of peer support workers (Bailie & Tickle, 2015). Hymes (2015) pointed to an absence of research into the lived experience of PRCs. Zembre et al. (2004) stated that even though helping others moves recovery forward, there is a gap in empirical research regarding the relationship between helping, 12-step affiliation, and substance abuse recovery. Bailie and Tickle (2015) recommended careful attention to the ethics of research participation in studies on how the role of peer support workers may affect personal recovery.

The Surgeon General's Report (Office of the Surgeon General, 2016) recommended future research into understanding the effectiveness of PRSS and PRCs. Reif et al. (2014) pointed to the need for additional research into the examination of the evidence base for PRCs. Furthermore, a systematic review of the literature by Bassuk et al. (2016) found only limited research focusing on the effectiveness of peer-based recovery support services. These investigators reported the strong necessity for research describing the nature and the role of peer support, the training and credentialing of PRCs, a clear, detailed explanation of the PRC role, and the impact of the PRC role on the workers themselves. Bailie and Tickle (2015) concluded the need for further research into how peer support workers' personal recovery may be impacted by their role and called for both quantitative and qualitative studies to investigate the connection between their position and personal recovery.

A Theoretical Framework

This study investigated the lived experience of three male PRCs who re-entered home, community, and work life after completing a year-long community-based, spiritual, residential substance abuse recovery program. The theoretical context built on the conceptualization of an ex-offender's re-integration into society (Listwan et al., 2006; Lynch & Sabol, 2001). The re-entry experience of the PRC was examined by comparison with the main tenets of the recently released ex-offender. The three major areas of concern for the re-entry or re-integration of the ex-offender were home, community, and work life. Some of the challenges involved educational levels, employment skills, work experience, alcohol and substance abuse histories, the stigma of being an ex-offender, community and society exclusion, lack of work history, and age at release (Blessett & Pryor, 2013; Lattimore & Steffey, 2010; Seiter & Kadela, 2003).

Ex-Offenders' Experience of Re-entry into Employment

Most ex-offenders end up living with family and friends until they get a job, save some money, and find a residence. Finding a good job, made difficult by low educational levels, minimum employment skills, and both little and gapped work experience, was often the most serious issue they faced (Andrews & Bonta, 1994; Seiter & Kadela, 2003). Histories of alcohol and substance abuse (Mumola, 1999), along with higher chances of chronic and infectious diseases, like Hepatitis B and C, HIV, AIDS, and tuberculosis (Hammett et al., 2001), and rates of mental ill health two to four times higher than seen in the general population (Lurigio, 2001) formed part of the stigma associated with challenges transitioning into both employment and the community (Lattimore & Steffey, 2010). The stigma of being an ex-offender was an obstacle to

both successful re-entry and employment opportunities to ex-offenders looking toward being a productive member of society (Blessett & Pryor, 2013).

Ex-offenders' Experience, Needs, and Challenges

For most of the 20th century, once the decision was made to release prisoners, in-depth efforts ensured their preparation for re-entry (Seiter & Kadela, 2003). It was a continual struggle to develop programs that succeed or make a significant impact on the lives of ex-offenders (Wright et al., 2014). The challenges that former inmates faced upon re-entering noninstitutionalized society were enormous (Raphael, 2011). Prison time diminished social relationships with families and friends.

The participants in the Serious and Violent Offender Reentry Initiative assessment (United States Department of Justice, 2002) had long criminal and substance use histories, limited years of education and job skills, and families and peers who were substance and prison-system partakers (Lattimore et al., 2009). Assessment findings confirmed previous research that ex-offenders re-entering communities had elevated levels of felt needs (Lattimore et al., 2010). Most of the participants reported the need for at least one of 10 transition services, including legal assistance, financial assistance, public financial help, healthcare insurance, coaching, work documents, a residence, transportation, a driver's license, clothes, and food bank access. Nearly all respondents demonstrated a need for one or more services such as job training, a position, continued education, financial management, life skills, healthy relationship skills, and criminal mindset change. Over 90% needed more schooling and over 80% requested job training. There is much work to be done toward developing re-entry programs that will help ex-offenders leaving a time of confinement and desiring to lead improved, successful lives (Lattimore et al., 2010).

Parallels to Re-entry Experience of Peer Recovery Coach

The concept of re-entry or reintegration of an ex-offender upon release into home, community, and work life paralleled the re-entry of a PRC and provided a theoretical framework for the research questions investigating the re-entry experience of a PRC. The three major areas of concern of the ex-offender—home, community, and work life—directly related to the re-entry experience of the PRC. The PRC may have weakened relationships with family and friends, lack of housing, community and society exclusion, and barriers to employment such as stigma of substance abuse background, low levels of education, gaps in employment, the need for job training, and/or missing identification. Some of the expressed needs are similar to those of ex-offenders: the need for a job, further education, financial management, life skills, healthy relationship skills, and inclusion into community and society. PRCs who have completed this community-based, spiritual, residential substance abuse recovery program are leaving a time of residential institutionalism and re-entering home, community, and work with a desire to lead better, more productive lives.

Summary

The rapidly expanding field of PRCs and the absence of studies on the lived experience of PRCs created a context for needed research into the lived experience of PRCs. A review of the PRC literature considered a contextual shift in addiction treatment, an overview of PRSS, a conceptualization of PRCs, and a theoretical framework of ex-offenders' re-entries into society. The re-entry of ex-offenders into home, community, and work life provided a theoretical framework for this study. This re-entry paralleled that of PRCs returning to home, community, and work life after completing a community-based, spiritual, residential substance abuse

recovery program. The research questions, addressing the home, community, and work life re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse recovery program, emanated from the theoretical framework of ex-offender re-entry.

The next chapter of this dissertation, establishing the research method, ties the research method to the problem statement and the two research questions. The chosen research method is the qualitative tradition in which the research design was a case study. This revelatory single case study, where the site is a community-based, spiritual, residential substance abuse recovery program, explores three participants' experiences. Chapter Three justifies the research design, states the research questions, describes the context for the study, explains ethical steps, reports the role of the researcher, specifies criteria for participants, details data collection procedures, projects analysis of data, and addresses validity of the study.

CHAPTER THREE: RESEARCH METHOD

Introduction

PRCs represent the largest portion of the rapidly growing PRSS field (Eddie et al., 2019; White & Evans, 2014). With the growth of peer-based recovery support services, it is imperative that these services remain continually researched and evaluated (Mead et al., 2001). Limited research exists on how peer support workers' personal recovery may be impacted by or linked to their role (Bailie & Tickle, 2015). These researchers suggested a need for both quantitative and qualitative studies regarding peer support workers and their personal recovery.

Zemore et al. (2004) reported that even though helping others moves recovery forward, there was a gap in empirical studies regarding the relationship between helping, 12-step affiliation, and substance abuse recovery. Based on their systematic review, Bassuk et al. (2016) reported the strong need for studies describing the nature and the role of peer support, the training and credentialing of PRCs, a clear, detailed explanation of the PRC role, and the impact of the PRC role on the workers themselves. Hymes (2015) emphasized an absence of research into the lived experience of PRCs. The rapid advancement of PRCs, the obvious gaps in the literature, and the need for future research created a context for research studies on the lived experience of PRCs.

The necessity for investigation into the lived experience of PRCs led to a qualitative research approach. Qualitative research methodology, which highlights learning about a phenomenon of interest through context, emphasizes the process where people build and appoint meanings to their relationships and their lives (Heppner et al., 2016). Qualitative research aims to acquire a detailed understanding of underlying reasons, beliefs, and motivations, purposing to

understand reasons, processes, influences, and contexts by utilizing words as data, studying a purposefully selected small number of participants, holding in-depth interviews, interpreting findings, and developing a beginning knowledge to identify and explain behavior, beliefs, or actions (Hennink et al., 2011).

Qualitative design allows for the researcher to recognize issues from the participants' perspectives and learn of the meanings and interpretations that they give to events, objects, or behaviors (Hennink et al., 2011). The qualitative investigator, who needs to be open-minded, curious, empathic, flexible, and active in listening to individuals telling their stories, studies people in their natural settings to discover how their experiences and actions are shaped by their social, economic, cultural, and physical context. The focus of understanding perceptions and experiences from that of the participants' perspectives, a concept labeled *Verstehen*, involves studying peoples' lived experiences in their own context with descriptions from their own words and ideas (Hennink et al., 2011). This explanation of the qualitative research approach demonstrates the ways that this proposed study into the lived experience of PRCs logically fit the qualitative method.

Qualitative Research Design Choice

The research questions of this study drove the research design toward a qualitative case study. A case study is an exploration of a real-life contemporary bounded system through detailed in-depth data collection, multiple sources of information, and a reporting of case description and case themes (Creswell & Poth, 2018). Yin (2018) defined a case study's scope as studying a contemporary phenomenon (the case) in detail within its real-life context, specifically when the boundaries between the phenomenon and the context may not be clearly visible. The

case features or characteristics, when navigating the situation where there are more interest variables than data points, benefit from theoretical framework that guides design, data collection, and data analysis, and case features require multiple sources of informational data for analysis. After defining the specific real-world case, it is important to clarify, or bound, the case (Yin, 2018) by distinguishing who will be included and what timeframe will be covered. One of the five rationales for single case studies (Yin, 2018), the revelatory case, occurs when an inquirer has an opportunity to observe and analyze a phenomenon that was not previously accessible to social science investigation. An embedded case study design involves an analysis of systematic data from embedded subunits which can be selected through sampling approaches (Yin, 2018). Though a focus exists at the subunit level, it is important to keep the original case, or phenomenon of interest, as central and not contextual to the investigation.

This single case study of the lived experience of three male PRCs who completed a year-long community-based, spiritual, residential substance abuse recovery program and are now employed at that facility gathered multiple data from different sources, described the responses, and reported themes. The case, the lived re-entry experience of PRCs at the substance abuse recovery facility, included the bounds of three male PRCs working at the same facility and the specific timeframe from the beginning of their employment as a PRC to the present. I had the opportunity and access to study the lived re-entry experience of male PRCs in a community-based, spiritual, residential substance abuse recovery program. This was a phenomenon that had not been previously studied, making this a revelatory case study (Yin, 2018). The proposed case study with an embedded case study design utilized sampling techniques to select PRCs for systematic data and for case study focus (Yin, 2018). It was important to keep the original case

as the focus and to recognize if the data or analyses from the embedded subunits moved from context to focus.

The five qualitative methods, explained below (Creswell & Poth, 2018), categorize separately into the five groups of ethnography, narrative, phenomenology, grounded theory, and case study. Although the five methods utilize similar data collection approaches (observation, interviews, text reviews), the differentiation is in the purpose of each research method (Creswell, 2015). Ethnography requires the researcher to be immersed, sometimes as a participant observer, in the participants' environment to learn about goals, cultures, struggles, ambitions, and themes. The narrative method involves in-depth interviews with one or two participants over weeks, months, or years to see how an individual's story demonstrates the bigger influences that form the person's story. Phenomenology, utilizing potentially 5–25 interviews, videos, and/or visits, builds enough data to describe an event, activity, or phenomenon. Grounded theory employs interviews and existing notes, with sample sizes ranging from 20 to 60, to supply a theory or an explanation behind an event. Case studies, which can be explanatory, exploratory, or descriptive, use several data sources toward an explanation of an organization, entity, company, or event.

The purpose of this study—to explore the role, lived experience, and personal recovery impacts of PRCs employed at a community-based, spiritual, residential substance abuse recovery program—aligned best with a qualitative case study design (Creswell & Poth, 2018). The aim of case study contrasts with observing a culture (ethnography), viewing the bigger influences that build a person's story (narrative), describing an event, activity, or phenomenon (phenomenology), or providing a grounded theory or explanation preceding an event. The goal

of a case study is to develop ideas for future research by exploring a real-life contemporary bounded system through detailed data collection from multiple information sources (Yin, 2018).

Research Questions

This study, purposing to learn about the PRC role, lived experience, and personal recovery impacts, investigated the lived experience of three male PRCs who re-entered home, community, and work life after completing a community-based, spiritual, residential substance abuse recovery program. The first research question was “What are the home, community, and work life re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse recovery program?” The second research question was “How do past and present home, community, and work life re-entry experiences of male PRCs influence their present recovery?” These two questions probed the lived experiences of home, community, work, and personal recovery. The research questions relied on related literature, a theoretical orientation of re-entry experience, and the research problem of the need for exploration into the lived experience of PRCs.

Study Context

The quickly growing field of PRCs and the absence of studies on the lived experience of PRCs generated a context for needed research into their lived experience (Bailie & Tickle, 2015; Bassuk et al., 2016; Eddie et al., 2019; Hymes, 2015). Evidence-based studies and articles related to PRCs informed of a contextual shift in addiction treatment, the resulting recovery-based interventions of PRSS, the role of PRCs, and a theoretical framework of re-entry experience. The Institute of Medicine (2005) and leading addiction researchers (McLellan et al., 2000) called for a shift in addiction treatment from an acute model to a continuum of care model much like the

model used in other chronic illnesses. The ROSC model, promoted by SAMHSA (2009), highlighted early treatment for those with SUDs, support of continual recovery from SUDs, and improvement of health and wellbeing of SUD clients and their families. Peer support for SUD, not based on mental illness models but on empathic understanding of another's situation through a shared base of emotional and mental pain, is an alliance with a deep, holistic cognizance that involves, teaches, and supports people toward life changes necessary for recovery (Mead et al., 2001; Reif et al., 2014).

PRSS has experienced rapid development (White & Evans, 2014) and the largest portion of that growth has been the expansion of PRCs (Eddie et al., 2019). PRCs are peers trained to provide informational, emotional, social, and practical support services to those with SUD through organizations like recovery community centers, hospitals, and outpatient clinical settings (White, 2009). Though the nature of coaching can differ from one agency to another, core activities entail setting recovery goals, outlining recovery treatment plans, linking to recovery-related needs, and helping with collateral concerns like criminal records, physical challenges, job skills, and new hobbies (SAMHSA, 2009). There is an absence of research into the lived experience of PRCs (Hymes, 2015); a need to study the challenges and the benefits of the PRC role for the purposes of guidance, support, and training for PRCs; and a call for both quantitative and qualitative investigations into PRCs and their personal recovery (Bailie & Tickle, 2015; Bassuk et al., 2016; White & Evans, 2014; Zemore et al., 2004). The need for this investigation is justified through evidence-based literature regarding the shift in addiction treatment to long-term recovery support services, the nature of the PRC role within the resource of PRSS, and the suggestions for future research from many studies.

The theoretical framework for research into the re-entry experience of a man with SUD history, residential treatment, and a current role of PRC was built on the re-entry concept of ex-offenders' returning to society (Listwan et al., 2006; Lynch & Sabol, 2001). The three central areas of an ex-offender's re-entry—home, community, and work life—directly related to the re-entry experience of the PRC (Blessett & Pryor, 2013; Lattimore & Steffey, 2010; Seiter & Kadela, 2003). PRCs from this community-based, spiritual, residential substance abuse recovery program completed a time of residential institutionalization and re-entered home, community, and work with a desire to lead more productive lives. This re-entry parallel with ex-offenders, provided a basis for exploring the lived re-entry experience of three PRCs working at a community-based, spiritual, residential substance abuse recovery program.

Participant Access and Ethical Protection

Ethical issues can arise during several phases of a study and develop in scope as investigators become more aware of the needs of participants, research sites, stakeholders, and research publishers (Creswell & Poth, 2018). Ethical concerns in qualitative research, as listed in Creswell and Poth (2018), can occur prior to the study, at the start of the study, during collection and analysis of data, in reporting of data, and in publishing the study. Before the investigation began, I sought institutional review board approval, viewed professional association ethical standards, acquired local access permissions, chose a site without an interest in the study outcome, arranged authorship for publication, and gained permission for use of unpublished items from other researchers. At the beginning of the study, ethical standards required the investigator to reveal the purpose of the study to participants; to inform participants that study participation was voluntary; to respect cultural, religious, gender, and other differences; and to

secure appropriate consent. While collecting data, I built trust and communicated anticipated disruption in accessing population, disclosed the purpose and the use of the data, respected possible power differences, supplied rewards for participation, and stored data and information securely. Ethical data analysis directed the investigator to report different perspectives and negative responses and to respect the participants' confidentiality in recording information. Ethical data reporting instructed the research worker to document findings honestly, de-identify individuals for protection, utilize language appropriate for the research audience, and to carefully address reprinting or adapting others' works. During study publication, the inquirer supplied copies of reports to participants and stakeholders, communicated results with diverse audiences, limited same findings to one publication, and accounted for ethical compliance and conflict of interest.

Procedures for gaining access to participants, as described by Creswell and Poth (2018), entailed obtaining approval from the Liberty University Institutional Review Board (LU-IRB) and including evidence of LU-IRB approval in research report. I provided examples of forms to be used in the study such as an IRB stamped consent form (see Appendix A). The consent form communicated the participants' right to voluntarily withdraw from the investigation at any time, the study's purpose and data collection procedures, the confidentiality protection statement, the risks of study participation, the participants' benefits, and the participants' and investigator's signatures (Creswell & Poth, 2018; Marshall and Rossman, 2016). The stamped consent form, indicating IRB approval on April 2, 2020, was used to gain the consent of the research participants.

Clear recruitment goals helped with understanding appropriate techniques for access and strategies to recruit participants (Hennink et al., 2011). For this study, the overall purpose of participant recruitment was to recruit for homogeneity which translates to one shared characteristic. Of the five most used strategies, which include formal and informal gatekeepers, formal and informal networks, snowball sampling, advertisements, and research-based recruitment, this study utilized informal gatekeeper and informal networks. I employed informal gatekeeping by seeking and obtaining approval of the facility's board-level medical committee and the chief executive officer. Informal networks are suitable for recruiting participants with specific characteristics, such as the position of a PRC. A signed permission letter, approved by the LU-IRB, can be found in Appendix B.

Marshall & Rossman (2016) reported that the energy of the investigator can spread and positively affect access. Both positive and negative aspects existed for doing research in an investigator's work setting. Positive aspects encompassed ease of access to participants, decreased time in data collection, a workable location for research, potential for trust-building, and the desire to study the inquirer's people (Marshall & Rossman, 2016). Yeh and Inman (2007) pointed to the advantage of more accurate interpretations due to the interconnectedness and mutual understanding between researcher and participant. Disadvantages consisted of researcher bias, subjectivity, and a researcher's struggle to separate herself from the research. Toma (2000) reported that a connection with the participants and the phenomenon supply subjective understanding which can largely increase the quality of the qualitative data. Marshall and Rossman (2016) identified a realistic site as one where there is possible entry; there is a great chance for a rich mix of processes, people, programs, and interactions; there is likelihood that the

investigator can build trusting relationships with the study participants; the study can be administered and described ethically; and the quality of the data and the credibility of the study can be reasonably confirmed.

Researcher's Role

Reflection and transparency about a researcher's identity, positionality, and voice are important to avoid predetermining the findings or influencing the study (Marshall & Rossman, 2016). I needed to position myself by stating my positionality relative to the context and the setting of the study (Creswell & Poth, 2018). This necessitated an explanation of my background of work experiences, cultural experiences, and educational and personal history that could impact the preparation, data collection, and interpretation of the study (Creswell & Poth, 2018; Hennink et al., 2011; Marshall & Rossman, 2016;). Positionality, where the writer becomes transparent and self-aware of biases, values, and experiences that they bring to the research, involved discussing past experiences and addressing the way that these experiences shape the writer's interpretation of the explored phenomenon (Creswell & Poth, 2018).

I previously served as the clinical director of the men's community-based, spiritual, residential substance abuse recovery program and supervised the staff PRCs at the men's residential facility. After 3 years, I changed positions to become the clinical program director of the women's community-based, spiritual, residential substance abuse recovery program at the same facility. This professional work experience sparked an interest to find out more about the role of a PRC, experiences, and personal recovery. I observed many different situations in both the personal recovery and work experiences of PRCs. My training and certification as a licensed

clinical professional counselor in the state of Maryland added context and concern for PRCs' lived experiences of home, community, work, and personal recovery.

Another notable fact is that I am a certified Maryland peer recovery support specialist supervisor who signs off on the internship hours of PRCs seeking certification. One of the participants of this study was certified in 2018 and the other two plan to be certified in 2022. I previously supervised one of the participants and hired the other two before I moved on to direct the women's recovery program at the site. My supervisory role and hiring history enhanced the ease of the data collection through professional rapport and mutual respect with the PRCs.

Marshall and Rossman (2016) argued that the success of qualitative research depends on the researcher's interpersonal skills of building trust, managing good relations, respecting standards of reciprocity, and considering ethical concerns. The qualitative approach was appropriate for me because of experience in conversing easily, listening actively, showing sincerity, expressing authenticity, empathically understanding, and respecting others' perspectives (Marshall & Rossman, 2016). Specific interactions helpful to building rapport included keeping eye contact, talking in an amiable tone, and refraining from expressing judgment or disapproval. I tend to develop a closeness, engagement, and involvement with others while also maintaining professional boundaries, which added to the richness of the research. The position of the role of the researcher creates a power differential softened through sensitivity to small talk, drinking coffee or tea, seating arrangements, researcher dress, and vocabulary choices (Hennink et al., 2011).

Researcher bias, which includes interviewer bias, is a potential limitation of the investigation (Patton, 2002). Awareness of experiences or biases related to the topic aided me in

understanding the ways that these experiences or biases impact the interpretation of the phenomenon (Creswell & Poth, 2018). After 5 years of working with or supervising PRCs, I developed an interest in PRCs' personal recovery experiences, role definitions, supplemental training, and needed support. I was moved by the fact that, in addition to working to help those in recovery, PRCs are on their own path of recovery. The combination of past work with PRCs and research on PRCs fostered a need for exploration into the lived experience of PRCs. This investigation could add to stakeholders' knowledge base and pave the way for clear role definitions, targeted training, improved supervision practices, and more effective personal recovery support.

Participant Selection

A solid investigation entails an explanation for participant selection, or sampling strategy, and a justification of participant numbers, or sample size. Selection, a conceptually or theoretically driven process, occurs when a researcher becomes interested in a specific issue, phenomenon, or group of people and establishes a set of criteria for defining or bounding the issue (Schensul et al., 1999). In qualitative studies, purposeful sampling occurs when the investigator chooses participants and sites for research because they can specifically provide knowledge of the research problem and the main phenomenon of the investigation (Creswell & Poth, 2018). A successful plan for a qualitative research study identifies one or more levels of sampling, such as the site, process, and/or participant levels. Investigators may use one or more sampling strategies in a study and can choose from a list of 15 or more sampling types, including maximum variation, homogeneous sampling, and convenience sampling (Creswell & Poth, 2018). Maximum variation decides some criteria that differentiate the site or participants prior to

the study and then selects sites or participants based on the different criteria; homogeneous sampling identifies individuals with one similar characteristic; and convenience sampling utilizes sites or participants where the inquirer can access and gather data (Creswell & Poth, 2018; Hennink et al., 2011). This study selected participants that are PRCs (homogeneous sampling), with a variety of ages, races, and recovery timeframes from a community-based, spiritual, residential substance abuse recovery facility (maximum variation sampling) where the investigator has access to this population (convenience sampling). A letter of interest and a screening survey were emailed to potential participants (see Appendices C and D).

A common guideline regarding sample size in qualitative investigations is to study a few sites or participants and to collect considerable details for each site or person in the study (Creswell & Poth, 2018). The number of individuals in a qualitative inquiry is usually small due to the purpose of gathering a depth of information and experiences and the practical constraints of time to collect information from the participants (Hennink et al., 2011). Yin (2014) and Creswell and Poth (2018) did not recommend more than four or five case studies in a single investigation because this number of participants supplies a large enough database to identify themes and to analyze cross-case themes. Hennink et al. (2011) explained that after the third interview, most of what has been shared has been repeated several times and not much will be added by continuing. The evidence-based studies of Yin (2014), Creswell and Poth (2018), and Hennink et al. (2011) justified this investigation exploring the lived re-entry experiences of three PRCs at their residential recovery program.

Data Collection Procedures

This investigation utilized interviews, case notes, and artifacts in data collection (Creswell & Poth, 2018). According to Yin, an in-depth picture of the case can be built through interviews, documents, and physical artifacts, and none of these sources has a total advantage over the others. A solid case study draws from many sources. Principles of data collection compiled by Yin (2018) included using multiple sources of evidence, designing a case study database, and following a chain of evidence.

Benefits of interviewing entailed quick accumulation of data, access to immediate clarification, and the researcher's understanding of the meanings of specific situations (Marshall & Rossman, 2016). Case study interviews, which look like guided conversations, worked on the level of following the line of questioning and on the level of asking relevant questions in a friendly, nonthreatening manner (Yin, 2018). Audio recordings, which provide accuracy of the interview content, required permission from the participant, a specific plan for transcription, a signed nondisclosure agreement from the transcription vendor that was submitted to IRB, systematic listening to the recordings, familiarity with recording devices, and commitment to listen closely during the interview (Yin, 2018). I conducted case study one-on-one interviews and shorter case study check-ins to corroborate findings (Yin, 2018).

After consent from each participant, these interviews were conducted using sound interview procedures (Creswell & Poth, 2018) and an interview protocol/guide (see Appendix E) in a distraction-free room, recorded with more than one device at different locations in the room, and transcribed by a voice-to-text application called Go Transcript (<https://www.gotranscript.com>). The participants brought the completed demographic

information sheet with them to the interview (see Appendix G). When I closed the interview, I thanked the interviewee and gave him a gift card as a token of appreciation. Additionally, I backed up data such as transcripts, journal writings, and notes; organized the information; and stored it with participants' names de-identified.

Typically, documents and audiovisual information supplement interviews. Data gathering involved the participants selecting excerpts from daily case notes (Marshall & Rossman, 2016). These documents were created in the daily life of the participant and selected specifically for the study. Creswell and Poth (2018) referred to journaling as a popular data collection method in case studies. I asked participants to select excerpts of daily case notes from client meetings. The analysis of these documents provided richness in illustrating the values and beliefs of the participants (Marshall & Rossman, 2016).

Creswell and Poth (2018) stated that a physical or cultural artifact adds to the rich context of the data by supplementing interviews. I asked the participants to bring in an artifact—something that had meaning related to their personal recovery or professional position—and share the significance of this item. Each participant had a personal connection with the artifact, and the items were either placed in their offices or carried with them daily. The artifacts and the daily case notes (see Appendix F), combined with the interview transcriptions and the interviewer's notes, added depth to the case study and provided data triangulation to strengthen construct validity and reliability (Yin, 2018).

Management, Analysis, and Interpretation of Data

The next steps, which included management, analysis, and interpretation of data, required strategies for analysis and interpretation. In addition to proper data recording and efficient data

retrieval, I managed the transcription and translation process, the data analysis, analysis strategies, and analytic procedures (Marshall & Rossman, 2016). Transcribing and translating, critical when utilizing interviews, involved technical aspects, as well as judgment and interpretation (Marshall & Rossman, 2016). Data analysis entailed generating categories, seeing patterns, trying out linkages, and recognizing and gathering more data to understand outliers. Crabtree and Miller (1992), informing of a continuum of analysis strategies, referred to template and editing analysis strategies where the research worker begins with a set of codes to apply to the data and revises the codes with contextual detail from the data. Analytic procedures encompassed organization of the data, immersion in the data, generation of case summaries and possible categories, coding of the data, interpretations through analytic memos, searches for alternate understandings, and writing the report (Marshall & Rossman, 2016).

Yin (2018) advised that case study investigators utilize rigorous thinking, adequate presentation of evidence, and thoughtful deliberation of other interpretations. Computer-assisted tools, an analytic strategy, and analytic techniques contributed to a sound study (Yin, 2018). Analytic strategies, which entailed searching for patterns, insights, or concepts, connected the case study data to ideas of interest and then connected those ideas to a path for analysis. Four strategies suggested by Yin (2018) included reliance on theoretical propositions, utilization of data from the ground up, development of case descriptions, and examination of plausible rival explanations. Analytic techniques, consisting of pattern matching, locating repetitions, finding similarities and differences, cutting and sorting, and asking questions, helped to develop internal and external validity in case study investigations (Bernard et al., 2017; van Manen, 2015; Yin, 2018).

Matching predicted patterns with empirical patterns strengthened the internal validity of the study (Yin, 2018). This case study posited the re-entry experience of three PRCs with the proposition that the re-entry experience of PRCs included barriers similar to those of ex-offenders. The differences between ex-offenders and PRCs' re-entry experiences held the proposed outcomes of restored relationships, community involvement, a stable position of employment, continual recovery work, and spiritual grounding. These differences provided a context for and a lived experience of overcoming the typical re-entry barriers in home, community, and work life. The lived experience of overcoming barriers demonstrated: a PRC's home life is satisfying and stable; a PRC's community life is fulfilling, and his connections are growing; a PRC's work is a calling with benefits and challenges; a PRC actively manages his continued vulnerability to AOD problems and develops a healthy, productive, and meaningful life; and a PRC values spirituality (White, 2007, p. 236). The PRCs' lived experiences of finding a stable job, the most serious re-entry issue in the case of ex-offenders, had the potential to break through employment barriers such as educational levels, employment skills, employment gaps, alcohol and substance abuse histories, residency needs, community exclusion, and work experience (Blessett & Pryor, 2013; Lattimore & Steffey, 2010; Seiter & Kadela, 2003;).

In summarizing and interpreting gathered data, case study researchers follow several guidelines closely (Hancock & Algozzine, 2017). One instruction recommended refining the main research questions after investigation of early data. A second guideline suggested continual focus on the research questions. The third guideline stated that the researcher must gather and analyze only data that is pertinent to the study. A fourth guideline involved developing a method for labeling, storing, and accessing information.

The synthesis of multiple sources of information in case study research required strategies to identify and report meaningful findings (Hancock & Algozzine, 2017). There was a basic process that included repetitive, constant review of gathered information to discover frequent patterns or themes. Each concept was examined to determine if it answered research questions, and these answers were grouped into themes. Information sources were fully reviewed, and themes were written down as findings.

Lincoln and Guba (1985) and Yin (2018) focused on four foundational principles for sound social science investigation. First, an analysis needs to address and cover the evidence including rival explanations and the key research questions. Second, an analysis should explore all plausible rival alternatives and list any unaddressed rivals as potential for future research. Third, an analysis must explain the most important tenet of the case study, which in this case study was the lived home, community, and work experience of a PRC working at a community-based, spiritual, residential substance abuse recovery program. Lastly, this investigation demonstrated a knowledge of the current literature and ideas on the topic of PRCs.

Trustworthiness

Marshall and Rossman (2016) informed that because the researcher is the instrument in qualitative study and researcher bias needs to be considered, there are components that provide credibility to the researcher and trustworthiness to the interpretation of data. Procedures to meet standards of trustworthiness included sharing data and interpretations with participants or member checking, gathering data from multiple sources, and discussing evolving findings with strategic colleagues, also known as peer debriefing, to make sure that results were established in the data (Lincoln & Guba, 1985). Rich data (Maxwell, 2012), researchers' reflective journaling

(Creswell & Miller, 2000), and audit trails (Marshall & Rossman, 2016) added to the list of components for trustworthiness. I demonstrated credibility and trustworthiness by member checking, triangulation, peer debriefing, rich data, reflective journaling, and audit trails. Both theoretical orientation and my interpretations were evident to readers; therefore, transparency of both literature use and the researcher's background and intentions added to the soundness, or validity, of the study (Marshall & Rossman, 2016).

A discussion on trustworthiness within a qualitative study entailed consideration of the fit within the setting and the participants' needs (Marshall & Rossman, 2016). At the proposal stage, trustworthiness was not only evaluated by a competent research approach but also by my ethical engagement. An emphasis on the protection of human subjects, in addition to thinking through procedures and documentation, received attention when gaining access and encouraging interviewees to participate. A respect for people, beneficence, and justice remained ongoing in my everyday practice.

Summary

This chapter outlined the research design; research questions; study context; participant access and ethical protection; researcher's role; participant selection; data collection procedures; management, analysis, and interpretation of data; and trustworthiness. The first research question, exploring the lived home, community, and work re-entry experience of three PRCs working in a community-based, spiritual, residential substance abuse recovery program, drove the research design toward a qualitative case study. The second research question investigated how the past and present home, community, and work life re-entry experiences of male PRCs influenced their present recovery. A study context resulted from the quickly growing field of

PRCs and the absence of studies on the lived experience of PRCs. Ethical attention in qualitative research occurred before the study, at the beginning of the study, during the collection and analysis of data, in the reporting of data, and in the publishing of the study. Procedures for gaining access to participants included clear recruitment goals, IRB approval, informed consent, and informal gatekeeping and network recruitment strategies.

Reflection and transparency about a researcher's identity, positionality, and voice are significant to avoid predetermining the findings or influencing the study. This study selected participants that were PRCs (homogeneous sampling) with a variety of ages, races, and recovery timeframes from a community-based, spiritual, residential substance abuse recovery facility (maximum variation sampling) where the investigator had access to the population (convenience sampling). The evidence-based studies of Yin (2014), Creswell and Poth (2018), and Hennink et al. (2011) justified this investigation exploring the lived re-entry experiences of three male PRCs at a community-based, spiritual, residential substance abuse recovery program. I built an in-depth picture of the case by gathering multiple sources of evidence (interviews, case notes, and physical artifacts), designing a case study database, and following the chain of evidence.

Analytic procedures encompassed organization of the data, immersion in the data, generation of case summaries and possible categories, coding of the data, interpretations through analytic memos, searches for alternate understandings, and writing the report (Marshall & Rossman, 2016). Of the four suggested analytic case study strategies (Yin, 2018), I followed the theoretical framework of the re-entry experience of an ex-offender re-integrating into society (Listwan et al., 2006; Lynch & Sabol, 2001). This investigation examined the plausible rival

explanations and demonstrated credibility and trustworthiness by member checking, triangulation, peer debriefing, rich data, reflective journaling, and audit trails (Yin, 2018).

The next chapter explains the data collection, data analysis, and findings. Data collection consists of the generation, gathering, and recording of information. An in-depth picture of the case involves collection of data through interviews, case notes, and physical artifacts. Data analysis entails transcription processes, analysis strategies, and analysis techniques. The analysis process covers management, analysis, and interpretation of data. The findings section includes the components of the study and the researcher, the participants' information, and the themes. The themes organize around the two research questions and within the theoretical framework.

CHAPTER FOUR: FINDINGS

Introduction

This chapter explains the data collection, data analysis, and findings of this case study. Data collection included generation, gathering, and recording of data from lived experience questions, case notes, and physical artifact questions. Systems of data analysis involved transcription and translation processes, data analyses, analysis strategies, and analytic techniques (Marshall & Rossman, 2016). Findings, both confirming and nonconfirming, addressed the purpose of the research, answered the research questions, analyzed the complete data set, and identified separate categorical themes (Hancock & Algozzine, 2017). Strategies that directly link the findings to the data encompassed looking through the theoretical framework lens, using data from the ground up, developing case descriptions, and examining plausible rival explanations (Yin, 2018).

This findings discussion is organized around research question one, research question two, and the case notes and physical artifacts analysis (Hancock & Algozzine, 2017). The first research question was “What were the home, community, and work life re-entry experiences of a male PRC working at a community-based, residential, spiritual substance abuse recovery program?” PRCs expressed lived home experiences as residential stability and restored relationships, lived community experiences as togetherness and recovery support, and lived work experiences as the PRC role, feelings, benefits, and challenges. The second research question was “How did past and present home, community, and work life re-entry experiences of a male PRC influence present recovery?” Home, community, and work life re-entry experiences that influenced present recovery were relationships, accountability, triggers, and recovery tools.

Analysis of case notes and physical artifacts found themes that corresponded with the themes from the lived experience questions.

Data Collection

Yin (2018) described an in-depth picture of the case as collecting data through interviews, documents, and physical artifacts. Data collection principles consisted of using multiple sources of evidence, designing a case study database, and following a chain of evidence (Yin, 2018). Interviewing allowed for quick accrual of data, immediate access to clarification, and the researcher's understandings of specific meanings (Marshall & Rossman, 2016). Participants selected excerpts from daily case notes and shared relevance to their PRC roles (Creswell & Poth, 2018; Marshall & Rossman, 2016). PRCs also brought a physical artifact, relating to either their PRC role or personal recovery, and explained its meaning (Creswell & Poth, 2018; Yin, 2018).

The data collection process included the generation, gathering, and the recording of data. Initial steps entailed gaining approval from both the LU-IRB and from the facility. Once obtained, recruitment letters with screening surveys were emailed to potential participants. Screening surveys demonstrated age, gender, position, and type and location of facilities. I contacted three PRCs via email to explain that they were eligible for the study and included an informed consent form and a demographic information sheet. The three PRCs responded to the email and brought consent forms and demographic information sheets to the scheduled interviews. I reviewed the informed consent form and the demographic information sheets with the interviewees. The initial interviews, which lasted about an hour, consisted of dialogue based

on the Semi-Structured Interview Guide (see Appendix E) and the Journal and Artifact Sharing Interview Guide (see Appendix F).

The multiple sources of evidence, which included interviews, client notes, and artifacts, created a multifaceted picture of the case (Yin, 2018). The interviews, or guided conversations, asked questions directly related to the research question in a friendly, nonthreatening manner (Yin, 2018). Audio recordings from two devices at different locations in the room provided data for transcription by a voice to text application called Go Transcript (<https://www.gotranscript.com>; Creswell & Poth, 2018). Detailed notes and observations were made during the interview for analysis context. Transcription processes entailed de-identifying participants' names, backing up data to a laptop, and storing for analysis (Creswell & Poth, 2018).

Data collection involved the participants' selection of excerpts from daily case notes and physical artifacts relating to their PRC role or their personal recovery (Marshall & Rossman, 2016). The participants chose daily notes from meeting with clients and answered questions from the Journal and Artifact Sharing Interview Guide. They also selected and brought a physical artifact and explained its significance in their personal recovery or their PRC role. The PRCs shared specifics as to the reason for their choice and the origin and meaning of the physical artifact. Analysis of the case notes and the physical artifacts demonstrated the values and beliefs of the participants and added richness to the study (Marshall & Rossman, 2016).

Two remaining principles of the data collection process consisted of the development of a case study database and the maintenance of a chain of evidence (Yin, 2018). A case study database required organizing and documenting the collected data. This database, which included

electronic interview transcriptions and researcher's notes, aligned with the participants and their answers to the questions from the three sources of evidence. The reader can easily retrieve the raw data if there is a need to view the data sources (Yin, 2018).

Lastly, a chain of evidence allowed for readers to trace the steps from findings back to the two research questions and from the two research questions forward to the findings (Yin, 2018). This chain verified that the findings were based on the same evidence collected from the case study site during the collection of data (Yin, 2018). The findings contained tabular and narrative information extracted from the transcriptions referring to interviews, case notes, and physical artifacts. These specific sources comprised actual evidence with key phrases and words highlighted with a different color for each of the lived experiences of home, community, work, and personal recovery. Data collection recorded interview times and places which showed compliance with specified procedures and questions in study protocol. A review of the case study protocol confirmed the linkage between the interview questions and the two research questions. A solid chain of evidence strengthened construct validity and increased the case study's quality, which merited further analysis (Yin, 2018).

Data Analysis

The analysis process of this study covered management, analysis, and interpretation of data (Marshall & Rossman, 2016). Hancock and Algozzine (2017) recommended focusing on the research questions, gathering and analyzing only pertinent data, and establishing a method for labeling, storing, and accessing information. Repetitive, constant review of data was necessary to discover frequent patterns and themes (Hancock & Algozzine, 2017). Themes emerged from both deductive and inductive analyses (Hennink et al., 2011). Deductive analysis allowed for a

review of evidence-based literature, the theoretical framework, the two research questions, and the interview questions (Bernard et al., 2017; Hennink et al., 2011). Observational and manipulative techniques, through the physical handling of the recordings and of the transcription texts, involved proofreading, marking, underlining, and color-coding key words and phrases (Bernard et al., 2017).

Analysis and interpretation of data consisted of both inductive and deductive techniques (Hennink et al., 2011). The inductive conceptual process utilized deductive concepts from the research literature, theoretical orientation, researcher's values, and personal experiences (Bernard et al., 2017; Hennink et al., 2011). The first steps in understanding this case study included looking at literature themes, interview protocols, and research questions (Bernard et al., 2017). Inductive conceptualization comprised observational and manipulative techniques of looking for repetition, similarities, and differences, and cutting and sorting transcription texts (Bernard et al., 2017; Hennink et al., 2011). Analytic strategies and techniques also required methods for labeling, storing, and accessing information (Hancock & Algozzine, 2017).

Labeling, storing, and accessing information necessitated a system for tracking data and themes (Hancock & Algozzine, 2017). This system included forming potential theme lists; highlighting transcription texts; color-coding index cards; cutting, pasting, and pile-sorting coded transcription texts to index cards; and tracking ongoing themes (Bernard et al., 2017; Hennink et al., 2011). Potential theme lists covered key concepts from the literature review, theoretical framework, researcher questions, and researcher experience (Bernard et al., 2017; Hennink et al., 2011). Transcripts, color-coded according to home, community, work, and personal recovery, reflected repetitions, similarities, and differences. Written index cards, color-coded with four

facets, noted key words and concepts. Cutting and sorting entailed cutting transcription quotes; pasting on index cards; color-coding by home, community, work, and personal recovery; and sorting quotes into piles of similar concepts (Bernard et al., 2017). After the list of themes emerged, I confirmed that the themes answered both research questions.

This case study relied on the theoretical framework of the re-entry experience of an ex-offender. This framework, specifically the home, community, and work lived experience of PRCs, led to the structuring of the two research questions and the lived experience questions (Appendix E; Yin, 2018). Throughout the analysis process, the two research questions remained a continual focus (Hancock & Algozzine, 2017). A set of themes and subthemes answer each of the two research questions (Hancock & Algozzine, 2017). Thematic statements describe the PRCs lived experience of home, community, and work life and the influence of this life experience on their personal recovery (van Manen, 2015).

Findings

The fastest area of SUD peer-service growth has been the PRC position (Eddie et al., 2019). There is an absence of studies into the lived experience of PRCs (Hymes, 2015) and the impact of the PRC role on their own personal recovery (Bailie & Tickle, 2015). These gaps in the literature provided the need for an exploratory case study into the lived experience of three male PRCs at a community-based, spiritual, residential substance abuse recovery program (Creswell & Poth, 2018). This section on findings organizes the components of the study and the researcher, participants' information, research questions one and two, and the case notes and physical artifacts.

The Study and the Researcher

The purpose of this study was to fill gaps in the literature relating to the lived experience of PRCs and the impacts of the PRC role on personal recovery (Bailie & Tickle, 2015; Hymes, 2015). The aspect of re-entry of an ex-offender into home, community, and work life paralleled the re-entry of a PRC and provided a theoretical framework for the two research questions (Listwan et al., 2006; Lynch & Sabol, 2001): What are the home, community, and work life re-entry experiences of a male PRC working at a community-based, residential, spiritual substance abuse recovery program? How do past and present home, community, and work life re-entry experiences of male PRCs influence their present recovery?

This investigation aimed to explore role definitions, lived experiences, and personal recovery experiences of PRCs. Discussions for necessary advocacy, targeted training, and effective supervision of PRCs could result from this case study. Advocacy, training, and supervision were significant factors in a context where PRCs work with SUD clients while recovering from SUD themselves and re-entering the work force (Eddie et al., 2019).

My background as a researcher consists of work experience, training, ethical values, licensures, and certifications. My experience included a 6-year timeframe with PRCs as co-workers, trainees, and supervisees. As a Maryland licensed clinical professional counselor who supports ethical values of promoting social justice and upholding the worth, dignity, and potential of people in their social and cultural contexts (ACA, 2014), I recognized the need for exploration into PRC role definition, lived experience, and personal recovery. In addition, I am certified by the state of Maryland as a peer recovery support specialist supervisor, and I signed off on PRCs' supervised hours as required by the Maryland Addiction and Behavioral Health

Professionals Certification Board for PRSS certification. Interest in this topic and the impetus for this study emanated from my experience, training, and values.

Participants' Information

The use of pseudonyms, identifying participants as Scott, Mark, and Tony, provided anonymity. Participants represented different demographic backgrounds and history (see Table 1). The three participants identified their PRC experience, racial categories, marital status, faith tradition, formal education, substance abuse history, prison history, homelessness timeframes, and current residential situation. Experiences as a PRC ranged from 14 months to 8 years. Racial categories and marital statuses included African American, Caucasian, divorced, and married. Faith traditions consisted of Baptist, nondenominational Christian, and Catholic. All participants attended some years of college with one participant earning a bachelor's degree.

Participants experienced histories of substance abuse from 15 to over 40 years. Primary drugs of choice included alcohol, heroin, opiates, and cocaine. Recovery time ranged from 4 to 14 years with the longest period of sobriety being from 4 to 10 years. All participants served prison time lasting from 20 days to 1 month. Charges for incarceration consisted of theft over \$1,000, theft scheme, DWI, and domestic violence. Experienced homelessness involved 1 month, 2 months, and 2 years. Two participants currently live at the residential facility in private graduate housing and the other participant lives with his wife in their home.

This investigation followed the interview protocol detailed in Chapter Three. The case study entailed two in-person interviews and one Zoom interview due to the participant being quarantined for health protection during the COVID-19 pandemic. The in-person interviews

were held at different times and dates in the same private office within the facility. I conducted the interview asking questions as they were written in the interview protocol.

Table 1*Demographic Information of the Peer Recovery Coaches*

Demographics	Scott	Mark	Tony
PRC experience	14 months	14 months	8 years
Racial category	African American	Caucasian	Caucasian
Marital status	Divorced	Married	Divorced
Faith tradition	Baptist	Nondenominational Christian	Catholic
Formal education	3 years college	Bachelor's degree	2 years college
Substance abuse	40+ years	20+ years	15+ years
Primary drugs	Heroin, cocaine, alcohol	Alcohol, opiates	Alcohol, heroin
Time in recovery	4 years	5 years	14 years
Prison time/offense	45 days/domestic violence	20 days/DWI	1 month/theft over \$100/theft scheme
Homelessness	Yes/2 years	Yes/1 month	Yes/2 months
Current residence	Residential facility	Homeowner w/spouse	Residential facility

Research Question One

The first research question was “What are the home, community, and work life re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse recovery program?” Participants’ responses to the interview questions provided themes and subthemes that answered research question one (see Table 2). Data analysis showed the lived home experiences as residential stability and restored relationships, lived community experiences as togetherness and recovery support, and the lived work experiences as the PRC role, feelings, benefits, and challenges. For each of the lived work experience themes, subthemes developed as relationship building and guidance for the PRC role; a spectrum of emotions for feelings; spiritual grounding, growth, and purpose for benefits; and burden bearing, time sacrifice, and training gaps for challenges.

Table 2*Themes Answering Research Question One*

What are the home, community, and work life re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse recovery program?

Experiences	Themes	Subthemes
Home experiences	Residential stability	
	Restored relationship	
Community experiences	Togetherness	
	Recovery support	
Work experiences	PRC role	Relationship building
		Guidance
	Feelings	Spectrum of emotions
	Benefits	Spiritual grounding
		Growth
		Purpose
	Challenges	Burden bearing
		Time sacrifice
		Training gaps

Lived Home Experiences

Participants were asked to describe their home re-entry experiences while working as a PRC. The two themes that emerged were residential stability and restored relationships (see Table 2). The co-researchers opened a lens into their home lives as they shared their living situations.

Residential Stability. Scott, with over 40 years of SUD and 2 years of homelessness, explained that he now lives in a private single dormitory on campus and has lived on the campus for 4 years. Previously an addict in an unhealthy relationship, Scott cheated on his wife. He stated that in his present home setting, he needs to be accountable, reliable, and honest.

With 20 years of substance abuse history beginning at age 14, Mark presently experiences residential stability. Mark's living situation evolved from being homeless to living at the program campus to renting a room from a friend to owning his own home. He explained that living with his wife, getting married, and purchasing a home has been "a big part of my recovery process."

Tony's 15-year history of substance abuse, which began when he was married and his sons were in elementary school, involved theft, prison time, and homelessness. He now lives in a residential aftercare house with a private room on the facility campus. He pays rent, along with seven other men living at the house, and most of the men have been program alumni for 5 years or more. Tony recognized that he is looked up to and "in a role of just being basically a leader."

Restored Relationships. Scott now "spends a lot of time with my 11 grandkids" going to sporting events and outings and "just hanging out and getting to know them." He currently has a "genuine friendship and a relationship" with his first wife, who "gets a chance to see the person

that she married from the start.” His first wife “applauds” and “respects” what he’s doing and his family “trusts me again.” Scott pointed to a picture of himself on an old program identification badge, taken when he was battling recovery, and said, “You could just see the hurt and the struggle in my face and in my eyes and all the pain.”

Mark viewed it as a blessing “to be in a healthy relationship and to be in a position where I was ready to make a commitment to marriage.” He also referred to negative experiences, bad decisions, and unhealthy relationships in the past and explained, “I’ve restored the relationships with my father, and my mother, and my brother, and my sister.”

Tony maintains contact with his ex-wife, and they discuss their sons’ lives and their futures. His sons both work and attend college, and he is very proud of them. His lived home experience where “everyone gets along really well down here” and his interactions with his mother, brother, ex-wife, and sons represented restored relationships.

Lived Community Experiences

The co-researchers were asked to describe their community re-entry experiences while working as a PRC. The two themes that emerged were togetherness and recovery support (see Table 2). It is evident from their own words that being together and recovery help defined their lived community experiences.

Togetherness. Participants defined the word *community* and expressed their specific community interaction. Scott, “just looking for acceptance,” hung out with people who accepted him, began drinking at 13 years old, and moved on to marijuana, heroin, cocaine, and pills. Scott defined community as “togetherness” and “a tight-knit group of people who have one purpose and one goal.” Mark correlated community as a “support group” and “something that is essential

to recovery.” He continued to say community is family and “any group of people with a common bond or a common goal and with common values working together towards the same path.”

Tony characterized community as “everybody getting along together and helping each other.”

This participant, who has worked at the mission for 8 years, indicated that his community involvement is with the guys in the program.

Recovery Support. Scott saw community as accountability and shared that while he was in the program, his treatment coordinator held him accountable by being “caring, understanding, and loving.” Outside of work, Scott’s community involvement looked like volunteering at a coworker’s church, coaching his grandson’s youth football team, and acting in a recovery-themed stage play sponsored by a local church. The play is entitled *Who is your neighbor?* and Scott said it “reminds me of my life.” Mark equated his community involvement as active membership in Alcoholics Anonymous and Celebrate Recovery, mentorship of a boys’ soccer team, and fellowship with his coworker community. He added that “to coach and mentor boys . . . at the age group where I started to make poor decisions . . . has been really special for me in recovery.” Tony viewed the guys as his community and enjoyed walking to meetings or hanging out with one of them. He recounted that “sharing my personal life and things that happened to me helps guys recover, but it helps me recover as well.”

Lived Work Experiences

PRCs expressed lived work experience themes of the PRC role, feelings, benefits, and challenges (see Table 2). The PRC role divided into subthemes of relationship building and guidance. Feelings exhibited as a spectrum of emotions. Benefits organized into spiritual

grounding, growth, and purpose. Challenges categorized as burden bearing, time sacrifice, and training gaps.

PRC Role. The PRC role, one of four key themes of the lived work experiences of PRCs, constituted the subthemes of relationship building and guidance (see Table 2). Scott, who was in and out of the program for 19 years, looked at this spiritual recovery program as welcoming the “homeless, downtrodden, hard times, addicted” and as being a place of “safe haven.” He expounded, “I could pretty much relate to the guys because I’ve been through what they’re going through.” Scott portrayed his role as sitting down with the guys, talking with them, and sharing experiences. Mark chronicled his role as being consistent, following up, keeping detailed notes, and showing them “you’re in their corner” to help build relationships. Tony, who has worked in this role and maintained sobriety for the longest timeframe, detailed a normal day as beginning with walking down the street with a guy to get a cup of coffee, meeting one-on-one with guys, walking around the building to catch up with guys, and “being a friend, basically.” Each of the participants considered building relationships as a major aspect of the role.

Participants specified guidance, a second subtheme of the PRC role, as part of their lived work experiences. Scott, depicting the PRC role as being an advocate and holding clients accountable, reported the importance of “giving them all the tools that they need to sustain a healthy recovery” and helping to “navigate them through the program.” Mark explained that guys look to “people in our role” for “support and guidance,” especially in uncertain times like “navigating through the current situation with COVID-19.” Tony expressed, “You want to allow them to come up with the answer, but you want to help them along a little bit where you can.”

Feelings. The second of the four key themes in the lived work experience of PRCs is feelings. Mark summarized that “it’s a whole spectrum of emotions,” and Tony indicated that feelings “run the gamut.” Scott and Mark presented some of their feelings as “being overwhelmed,” and “I feel a bit overwhelmed.” Mark, who is currently enrolled in a master’s level counseling program, remembered “joy and satisfaction in seeing guys grow” and explained that listening to the trauma men have experienced, “you naturally feel saddened.” Tony, recalling times both of ecstatic happiness and of tears, shared, “Sometimes a guy will share something, and it touches me in a way that a guy would be willing to share that type of emotion or incident or feeling.” Feelings, in the role of PRC, comprised a wide spectrum of emotions.

Benefits. The third key theme in the PRC lived work experience is benefits. This theme can be broken down into subthemes of spiritual grounding, growth, and purpose (see Table 2). When asked about the impact of the spiritual aspect of this recovery program, the participants’ responses reflected on both their personal spiritual walks and their PRC roles. Scott, who identifies with the Baptist tradition, lived at 15 or 16 other programs without a spiritual component. He exclaimed, “It’s just mind-boggling how you could take all of your worries and your suffering, your pain to the altar, and let God handle it.” He added that “the foundation for me right now is Christ.” Mark, who attends a nondenominational church, asserted the spiritual aspect is “at the heart of what we do here,” and “it’s at the heart of my recovery and transformation.” He continued to say, “Without that spiritual connection, I wouldn’t be able to do this job with my own willpower.” Tony, who has a Catholic background and a desire to learn more about religion, God, and the Bible, communicated that spirituality is a “needed aspect” and it makes everything more human, loving, caring, and family oriented.

The next subtheme under the benefits theme of lived work experience is growth. The PRCs spoke about both current growth and future aspirations. Scott commented that, in the past, he met opportunity with sabotage, but now he “takes on all challenges” because he has higher expectations of himself. He sees his career path as remaining at the mission and “increasing.” Mark recounted that he came to the mission, “got clean,” and began working in peer roles. He looks to “become a leader here” at the program facility and to use the equipping that he has received from his master’s level training. Tony expressed excitement and appreciation for the structure and the autonomy in his role. This PRC wants to learn more and be “a role model for guys.”

Purpose is the last subtheme of the benefits facet of PRCs’ lived work experiences. Scott, who had undiagnosed dyslexia and low self-esteem in early childhood, affirmed that the role of PRC “gives me purpose” and “I’m looked up to.” Mark highlighted benefits as being able “to make a living doing something that I love gives me purpose.” Tony, a divorcee living in different areas of the facility campus for over 10 years, related that the PRC role “brings more joy to my life” and makes him appreciate and enjoy “people, places, and things.” Each PRC experienced purpose as a benefit of their work roles.

Challenges. The last major theme of the PRC lived work experience is challenges, which is separated into subthemes of burden bearing, time sacrifice, and training gaps (see Table 2). Mark clarified that the PRC role could be “draining” at times because “we carry a lot of burdens in this role.” Scott noted the need to take breaks and get off campus due to feeling like he has “a guy’s life and recovery in my hands at times.” Both Scott and Mark had served in this role less than 15 months, and Scott reported the need to “be cautious about taking on another person’s

issues and problems and recovery,” while Mark pointed to the “grind” in doing this type of work. These participants connected feeling overwhelmed with bearing another’s burdens. Tony, with 8 years of PRC experience, did not mention the weight of carrying others’ burdens.

Challenges in the lived work experience of a PRC also entailed time sacrifices. Scott did not look at this role as a job, but as a career, and he could not think of any way that the job took away from his life. Mark expressed that the need to cut back from daily recovery meetings to one to two meetings a week had been a challenge in his personal life. The need for Mark to scale back was due to talking “about recovery all day long” potentially leading to burn out. Tony, the most experienced PRC, acknowledged that the PRC position had taken time away from his life and that he now attends two recovery meetings a month. He disclosed that his recovery changed from daily meetings to client conversations. Of the two participants who now attend considerably fewer recovery meetings, one viewed it as a challenge and the other considered it an adjustment.

Training gaps, the last subtheme of the challenges category, covered needed office skills and professional development. All three participants shared a desire to improve office skills such as computer use and typing. Scott would like to learn to speak in large gatherings, grow his vocabulary, and to complete his PRC certification. Mark stated that “the job and the type of work does require . . . more mental health training” and “training around trauma.” He would like to be “better equipped to identify those issues and be able to support the men that I serve.” Tony explained that it is a key need to learn more about the mental health side because “sometimes I’m unable to answer or understand the guys.” Tony would also like to learn more about the Bible and how “to better talk about God.” Each of the participants depicted gaps in training as challenges in their PRC role.

Research Question Two

The second research question was “How do past and present home, community, and work life re-entry experiences of a male PRC influence present recovery?” Participants’ responses to the interview questions provided themes and subthemes that answered research question two (see Table 3). Data analysis categorized the lived experiences that influenced the PRCs’ personal recovery as relationships, accountability, triggers, and recovery tools. For each theme, subthemes emerged as God, others, and self for relationships; recovery support for accountability; reminders and burden bearing for triggers; and healthy reminders and boundary setting for recovery tools.

Table 3

Themes Answering Research Question Two

How do past and present home, community, and work life re-entry experiences of a male PRC influence present recovery?

THEMES	SUBTHEMES
Relationships	God
	Others
	Self
Accountability	Recovery support
Triggers	Reminders
	Burden bearing
Recovery tools	Healthy reminders
	Boundary setting

Lived Experiences Influencing Personal Recovery

Home, community, and work life experiences that influenced PRCs' present recovery were relationships, accountability, triggers, and recovery tools (see Table 3). The subthemes for relationships encompassed God, others, and self. Accountability exhibited as recovery support. Triggers categorized with subthemes of reminders and burden bearing. Recovery tool subthemes consisted of healthy reminders and boundary setting.

Relationships. Scott declared that the spiritual aspect of this program over the past 5 years taught him that "God comes first" and then "my recovery" and "my family." He stated, "My Lord and Savior is going to make sure that everything will be okay." Mark shared that the spiritual aspect is "at the heart of my recovery and transformation." He articulated that to maintain his personal recovery, he stays in God's Word and practices a daily routine of prayer. Tony wished to learn more about the Bible and about God, and he regarded the spiritual facet as "a needed aspect."

Others and self, the remaining subthemes of relationships, also conceptually influenced personal recovery. Tony communicated that interaction with guys "makes my recovery stronger." Scott viewed his "genuine friendship and a relationship" with his first wife as a key relationship in his personal recovery. Mark listed his wife, family, friends in recovery, and his sponsor as key to his personal recovery. Scott recapped, "It all starts with loving yourself," and he proclaimed, "I love myself and I trust God." Mark utilized fitness, marathon competitions, and hiking as sources of balance and selfcare. He recognized that eating healthy, getting proper sleep, and staying physically fit "have a positive effect on my overall health and wellness and

recovery.” Tony reiterated that “sharing my personal life and things that happened to me helps guys recover, but it helps me recover as well.”

Accountability. The second theme influencing personal recovery was accountability with a subtheme of recovery support. These PRCs looked to the recovery community for accountability and support. Mark explained, “I have friends that are in recovery, and we all hold each other accountable” by going to a meeting together or by checking in on each other. Scott sought advice from the man who was his PRC when he was in the spiritual recovery program, and this man “holds you accountable.” Tony remarked that sharing with friends in the recovery community has “helped me in my recovery.” Recovery support consists of “giving back” and “one addict helping another” (Scott), “working together towards the same path” (Mark), and “helping each other” (Tony).

Triggers. Triggers, the third theme influencing personal recovery, contained the subthemes of reminders and burden bearing (see Table 3). Scott conveyed that listening to guys telling their “war stories” takes him back and “reminds me of those times in my addiction.” Mark portrayed that the humanity factor in the role affected him, and he indicated the drain of being reminded of his past challenges and traumatic experiences. Tony referred to the years that he was new to peer recovery when the sight of a guy’s veins “would drive me nuts” because they reminded him of drug use. When interacting with guys, these participants experienced reminders of past addiction that acted as triggers.

The other triggers subtheme which influenced recovery was the bearing of another’s burdens. The role of a PRC involved navigating another person’s problems and struggles. Scott described necessary caution in “taking on another person’s issues and problems and recovery.”

Mark touched on the need to cope with overwhelming feelings when hearing and seeing the effects of trauma in a man's life. The two participants with less experience expressed the need for help when other men are struggling and in crisis. Scott depicted burden bearing as "having a guy's life and recovery in my hands at times." This participant quoted the phrase, "Heavy is the head that wears the crown" and interpreted it to mean taking on others' issues and problems and "still dealing with my sobriety as well."

Recovery Tools. The last theme that influenced a PRC's personal recovery was recovery tools. The subthemes of recovery tools were healthy reminders and boundary setting (see Table 3). Scott considered his past time of struggle in comparison to where he is now as proof of hope and blessing. Mark framed reminders of the past through a gratitude perspective—"for not having been through some of the things" and "that I am no longer in that situation." Tony asserted that when guys talk about certain things, he says, "I'm not going to do that." Scott understood that "it's all about choices and decisions" because "I'm six dollars away from a pill or dope." Mark aimed "to stay vigilant in my own recovery because one bad decision and I could be back to square one."

Boundary setting, a recovery tool, was the second subtheme that impacted personal recovery. Setting up and practicing boundaries "to protect myself" were important tools in Scott's personal recovery. This participant pointed out the need to remember that "it's not my job to do a guy's recovery." Mark emphasized "not trying to take on too much of other people's problems and just setting healthy boundaries for myself." He added that if he doesn't set healthy boundaries, "it has a negative effect on my recovery." Tony expressed that there is a line that he won't cross over in his thoughts when guys share their stories.

Case Notes and Physical Artifacts

In addition to the lived experience questions (see Appendix E), this investigation drew from a specific set of interview questions related to case notes and physical artifacts (see Appendix F; Creswell & Poth, 2018). Each participant was asked to bring excerpts from client case notes and a physical artifact representing either the PRC role or personal recovery. Analysis of case notes and physical artifacts added richness by showing the values and beliefs of the participants (Creswell & Poth, 2018; Marshall & Rossman, 2016). Transcripts from case notes and physical artifact discussions demonstrated home, community, and work life experience themes congruent with residential stability, restored relationships, togetherness, recovery support, the PRC role, feelings, benefits, and challenges (see Table 2). The home, community, and work experiences that influenced personal recovery corresponded with relationships, accountability, triggers, and recovery tools (see Table 3).

Scott's Case Notes

Case notes selected by Scott represented excerpts of daily update notes on a specific client. When the client began meeting with Scott, he was restless, anxious, exhausted, and discouraged. This client, aloof and down and out, received time, encouragement, and care from Scott. The depiction of this client conjured up “really personal” feelings because, Scott said, “I was that guy,” and “I didn’t have anywhere else to go just like this gentleman.” Scott chose this client because “he’s still early in recovery,” “still not out of the woods,” and “you can see the progress and the potential.” Scott’s reflections on both himself and the client evidenced the home, community, and work life experience themes of stability, recovery support, PRC roles of relationship building and guidance, feelings, benefits, and challenges. His personal recovery has

been influenced by relationships, accountability, potential triggers of reminders and burden bearing, and recovery tools of healthy reminders and boundary setting.

Scott's Physical Artifact

Each participant selected a physical artifact representing something about personal recovery or the PRC role. Scott stated that his artifact signified “all of the above.” The artifact was a pictorial diagram of a tree with a copy of each one of his identification badges from an applicant badge at the base of the tree trunk to the current employment PRC badge at the top. It showed his progression, “growth,” and “transformation” from first-time graduate to intern to second-time graduate to alumni to a staff position. Scott said this artifact is “a daily reminder of where I came from and how much further I could go.” It hangs on his office wall, and he uses it to encourage guys to “stick and stay” and to “imagine your picture on the badge.” This physical artifact illustrated the themes and subthemes of stability, recovery support, the PRC role of relationship building and guidance, feelings, benefits of growth and purpose, and challenges. Themes of relationships, accountability, potential triggers, and recovery tools influenced personal recovery.

Mark's Case Notes

Mark selected excerpts from three clients that addressed different aspects of mental health and addiction recovery. One client, dealing with shame and guilt from giving his brother the drugs that killed him, needed help with trauma, codependency, medical issues, and mental health. A second client completed the 12 steps with an Alcoholics Anonymous sponsor, put inherited money in an escrow account, and enrolled in PRC training. Mark also helped a third client, a pastor's son suffering from the shame and guilt of being in addiction, to begin to think

through writing a letter to his family to let them know that he is okay. Talking about these clients “stirred up some emotions” and served as a reminder to follow up with these men. The selection and the review of these case notes reflected the home, community, and work life experience themes of stability, recovery support, the PRC role of relationship-building and guidance, feelings, benefits of growth and purpose, and challenges of burden bearing. Case notes excerpts also transmitted the personal recovery influences of relationships, accountability, potential triggers, and recovery tools of healthy reminders and boundary setting.

Mark’s Physical Artifact

Mark asked if his wedding ring would work as a representation of his recovery and his PRC role. He added, “Without my own personal journey of recovery and where I’m at, I wasn’t marriage material.” The wedding ring “represents my faith, my recovery journey . . . it represents the greatest gift that God has given me through this journey.” Mark thought back on how unhealthy his relationships were when he began the spiritual recovery program. His reflection on his recovery journey included the time “from where I was to where I’m at now.” He described parts of the journey as “my relationship with God, my wife, our faith, and our walk together.” The conversation around Mark’s physical artifact echoed the home, community, and work experience themes of residential stability, restored relationships, recovery support, the PRC role, feelings, benefits, and challenges. The factors that influenced personal recovery coincided with themes of relationships, accountability, potential triggers, and recovery tools of healthy reminders.

Tony's Case Notes

Tony picked excerpts from his case notes about a client who struggled through math classes in pursuit of a trade school certification and considered putting school on hold to work at Amazon. Tony felt like the client “was settling” and wanted the easy money. After talking through possible reasons for this switch, the client realized he felt “less than, because he didn’t have money in his pocket.” This client re-enrolled in school and now attends meetings; however, Tony asked him to consider “getting a sponsor” to understand “why he’s going to the meeting and everything that’s involved with it.” Tony reflected on his time in the spiritual recovery program and wished “I had somebody sit and work for me that way.” The selection and review process of Tony’s case notes corresponded with the home, community, and work experience themes of PRC role of relationship building and guidance, benefits of purpose, and challenges. The influences on personal recovery constituted relationships, accountability, potential triggers, and recovery tools.

Tony's Physical Artifacts

Tony remarked that two physical artifacts—a circular, smooth flat rock, and a folded paper star—signify both his personal recovery and his PRC role. The rock, which one of his two sons gave him, was from a walk they took where he tried to explain why he was at the spiritual recovery program and how “it wasn’t going to take away from them.” The folded star, which still has candy in it from years ago, came from the other son, and Tony explained, “It reminds me of one of the reasons why I did this in the first place, and that I’m still doing this.” Tony related that it’s a “father-son thing” and that he looks at his relationship with the guys in the program as a “father-son” relationship too. The rock sits in his office at work and the paper star sits on his

bureau at home in front of both of his boys' pictures. These physical artifacts illustrated home, community, and work life themes of stability, restored relationships, recovery support, the PRC role, benefits, and challenges. Influential themes of personal recovery reverberated as relationships, accountability, potential triggers, and recovery tools.

Summary

This chapter covered the data collection, data analysis, and the findings of this case study. The process of data collection and the systems of data analysis incorporated clear descriptions. Data collection involved a set of interview questions related to the home, community, work, and personal recovery experiences of PRCs, along with a separate set of questions about case notes and physical artifacts. Themes emerged from the transcription analysis of the lived experience questions that answered the two research questions. The findings included the components of the study and the researcher, participants' information, research questions, and the case notes and physical artifacts analysis.

This study purposed to fill gaps in the literature related to the lived experience of PRCs and the impact of the PRC role on personal recovery (Bailie & Tickle, 2015; Hymes, 2015). My values, training, and experience led to an interest into the lived experience of PRCs. Each participant encountered substance abuse, incarceration, homelessness, and broken families and relationships, but each one reported difference in PRC experience, race, marital status, faith traditions, formal education, and current residential situations.

Participants' responses to the interview questions on lived experience provided themes and subthemes that answered the two research questions. The first research question was "What are the home, community, and work life re-entry experiences of a male PRC working at a

community-based, spiritual, residential substance abuse recovery program?” PRCs expressed lived home experiences as residential stability and restored relationships, lived community experiences as togetherness and recovery support, and lived work experiences as the PRC role, feelings, benefits, and challenges. The second research question was “How do past and present home, community, and work life re-entry experiences of a male PRC influence present recovery?” Home, community, and work life re-entry experiences that influenced present recovery were relationships, accountability, triggers, and recovery tools. Transcription analysis of the case notes and physical artifacts discussion found themes corresponding with the themes from the interview questions.

This study demonstrated that themes from home, community, work, and personal recovery experiences intertwined like a braided ribbon. As Scott explained, “I take on a lot of these guys’ issues and their problems, and I’m still dealing with my sobriety as well.” Mark identified the PRC role as “a reminder to stay vigilant in my own recovery because one bad decision and I could be right back to square one.” Observing “what [men in the program are] going through” helped Tony “not want to go through some of the stuff and be thankful for where I’m at in my recovery.” Transcription analysis revealed both benefits and challenges of the PRC role and of its influence on personal recovery.

The following chapter includes an overview of the study, an interpretation of findings, implications for social change, recommendations for action and further study, reflection on the researcher’s experience, and evidence of quality research. The study overview entails details of the study and a summary of the findings. Interpretation of findings refers to peer-reviewed literature and to the theoretical framework. Social change implications incorporate outcomes

from both Chapter One and Chapter Four. Recommendations flow from the conclusion and point to potential additional studies. Researcher bias, underlying values, and impressions comprise the researcher's reflection. Evidence of quality discussion consists of procedures and supporting documents.

CHAPTER FIVE: DISCUSSION

Introduction

This chapter presents an overview of the study, an interpretation of the findings, implications for social change, recommendations for action and further study, a reflection of my experience, and evidence of trustworthiness of the study. The overview consists of background and setting, purpose, theoretical framework, research questions, research design, data collection and analysis, and a findings summary. An interpretation of findings relates this study's findings to the larger body of literature and to the theoretical orientation. Implications for social change involve clinical practice, education, and supervision. Recommendations for action revolve around an informed clinical support system and findings dissemination. Future research suggestions include varied populations, methods, and investigations. Reflection of the research process entails researcher bias, positionality, and outcomes. This study employed standards of trustworthiness through specific methods.

Overview of the Study

One of the most universal clinical and public health concerns in the United States is SUD (Office of the Surgeon General, 2016). McLellan et al. (2000) recounted that people with SUD need both long-term recovery management and recovery support services. In 2005, the Institute of Medicine shifted the mindset of drug and alcohol addiction services from short-term cures to long-term recovery. The behavioral health field moved to ROSC (Bradstreet, 2006) with peer-based recovery support as a notable strength (Alberta et al., 2012). PRSS, reaching people with SUD and co-occurring psychological disorders in clinical environments, continued to grow

(Eddie et al., 2019). Since 2009, the greatest facet of peer-service growth has been the number of PRCs (Eddie et al., 2019).

Background and Setting

PRCs, experientially equipped through their own SUD history and recovery journey, support peers with SUD and co-occurring disorders (Eddie et al., 2019). Research about PRSS lags behind the rapid growth of PRSS in the United States and in the United Kingdom (White & Evans, 2014). Studies show an absence of research into the lived experience of PRCs (Hymes, 2015), the relationship between helping and substance abuse recovery (Zemore et al., 2004), and the impact of the PRC role on personal recovery (Bailie & Tickle, 2015). Bassuk et al. (2016) reported the importance of future exploration into the impact of the PRC role on the peer workers themselves. The rapid expansion of the PRC position and the absence of studies on the PRC experience provided a setting for research into the PRC lived experience.

Purpose

This case study aimed to fill a gap in the literature related to the PRC role, lived experience, and personal recovery. Direct work with peers, the journey of personal recovery, and re-entry into the work force formed the basis for studying the lived experience of PRCs. This investigation could continue and advance advocacy, training, supervision, and support conversations with PRCs' counselors, managers, employers, supervisors, supporters, and funders. A lens into the PRC lived experience has the potential to explicate the PRC re-entry experience, clarify the PRC role, and to inform about PRCs' personal recovery experiences.

Theoretical Framework

The theoretical framework for this exploration built on the re-entry concept that referred to ex-offenders' re-integrations into mainstream life (Listwan et al., 2006; Lynch & Sabol, 2001). The main tenets of a recently released ex-offender's re-entry—home, community, and work life—paralleled the central components of a PRC's re-entry into society. The theoretical orientation of the re-entry experience of an ex-offender into home, community, and work life provided a framework for a study on the re-entry experience of a PRC. This study investigated the lived experiences of three male PRCs who re-entered home, community, and work life after completing a year-long community-based, spiritual, residential substance abuse recovery program.

Research Questions

From the theoretical orientation, the concepts of home, community, and work life drove the research questions. The first research question was “What are the home, community, and work life re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse recovery program?” The second research question was “How do past and present home, community, and work life re-entry experiences of male PRCs influence their present recovery?” These two questions guided the investigation into the PRCs' home, community, work, and personal recovery experiences.

Research Design, Data Collection, and Data Analysis

The research questions directed the research design toward a qualitative case study. Qualitative design entailed studying peoples' lived experiences in their own context through their personal descriptive phrases and understandings (Hennink et al., 2011). This case study, which

followed Yin's (2018) definition of scope, boundary, and timeframe, explored a real-life contemporary bounded system with a theoretical framework that guided design, data collection, and data analysis. Ethical adherence throughout the process included approval from the LU-IRB, reflection of the researcher's position, and criteria for participant selection and sample size.

Multiple sources of information (Creswell & Poth, 2018) created an in-depth picture of the case and consisted of interviews, case note documents, and physical artifacts. Data collection also involved sound interview procedures, an interview protocol/guide, a case study database, and a chain of evidence (Yin, 2018). Data analysis included data organization, data immersion, category generation, data coding, memo documentation, and report generation (Marshall & Rossman, 2016). Credibility and trustworthiness developed through member-checking, multiple sources, peer debriefing, rich data, reflective journaling, audit trails, literature transparency, and researcher's intentions (Creswell & Miller, 2000; Lincoln & Guba, 1985; Marshall & Rossman, 2016; Maxwell, 2012).

Findings Summary

The two research questions remained a continual focus of the analysis process. The data developed a set of themes and subthemes. Data analysis demonstrated the PRCs' home, community, and work life experiences to be residentially stable, relationally restorative, connective, supportive, emotional, beneficial, and challenging. The home, community, and work experiences that influenced personal recovery were relationships, accountability, triggers, and recovery tools.

Research question one asked about the lived home, community, and work re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse

recovery program. PRCs described home experiences as residential stability and restored relationships. They identified lived community experiences as togetherness and recovery support. PRCs expressed lived work experiences with themes of the PRC role, feelings, benefits, and challenges. Lived work experience themes incorporated subthemes of relationship building and guidance for the PRC role; a spectrum of emotions for feelings; spiritual grounding, growth, and purpose for benefits; and burden bearing, time sacrifice, and training gaps for challenges.

Research question two asked how past and present home, community, and work life re-entry experiences of a male PRC influence their present recovery. Home, community, and work life experiences that influenced PRCs' present recovery categorized as relationships, accountability, triggers, and recovery tools. The subthemes for relationships were God, others, and self. The subtheme for accountability was recovery support, and the subthemes for triggers were reminders and burden bearing. Recovery tools incorporated the subthemes of healthy reminders and boundary setting.

Analysis of case notes, documents, and physical artifacts added richness to the study (Creswell & Poth, 2018; Marshall & Rossman, 2016). The themes that emerged from the case notes and physical artifacts mirrored the themes from the interview questions. Transcripts from the case notes and the physical artifact discussions demonstrated home, community, and work life experience themes congruent with residential stability, restored relationships, togetherness, recovery support, the PRC role, feelings, benefits, and challenges. Conversations on case note documents and physical artifacts exhibited the home, community, and work experiences that influenced personal recovery to reflect the themes of relationships, accountability, triggers, and

recovery tools. Themes from home, community, and work life experiences intertwined with the themes of the influences of lived experiences on personal recovery.

Interpretation of Findings

A return to the literature review distinguished the findings of this study from the larger body of literature on PRCs (Moustakas, 1994). An interpretation of findings covered a summary of the literature review, a position of the study, and comparisons to the literature review components. The discussion addressed both research questions and included practical applications of the findings. A summary of the literature review provided the comparison information. The study was positioned relative to the literature review and the theoretical orientation. Categories from the broader literature generated as definitions, settings, role, qualifications, support, training, benefits, challenges, future research, and theoretical framework.

Summary of Literature Review

A summary of the literature review framed the interpretation of findings. A literature review on PRSS and focusing on PRCs drew from evidence-based qualitative, quantitative, and mixed-methods studies; systematic reviews; and theoretical articles. Prior research reflected a contextual addiction treatment shift, a PRSS overview, a PRC conceptualization, and a theoretical framework. I examined the literature for studies addressing the background, roles, settings, delivery methods, benefits, challenges, and experiences of PRCs.

The section on the context of a shift in addiction treatment provided background on the models of RM and ROSC. RM and ROSC recognized nonclinical peer-based recovery support services throughout the long-term recovery process as a major component and a visible aspect of community responses to SUD issues (Clark, 2007, 2008; White & Evans, 2014). The literature

showed PRSS encompassing background and definitions, settings, support types and recovery continuum, roles, benefits, and challenges. An understanding of PRCs consisted of definitions and activities, roles, settings, qualifications and training, benefits and challenges, and professional and personal lived experiences. The theoretical framework integrated the re-entry of an ex-offender into home, community, and work life with the re-entry of a PRC into home, community, and work life.

Position of Study

An interpretation of findings required the positioning of this study and its findings in relation to the literature review. An overview of PRSS, a conceptualization of PRCs, and a theoretical framework included 59 citation reviews. These three sections of the literature base contained 10 categories: definitions, settings, role, qualifications, support, training, benefits, challenges, future research, and theoretical framework. The discussion also addressed themes that were not mentioned in the broader literature.

Comparisons to Literature Review

The 10 categories that synopsise the literature base are definitions, settings, role, qualifications, support, training, benefits, challenges, future research, and theoretical orientation. These components developed from an overview of PRSS, a conceptualization of PRCs, and a theoretical framework. The broader literature provides a foundation of comparison to determine if my findings mirror, supplement, or differentiate from the literature. The comparisons conclude by addressing themes from this study that are absent in the broader literature.

Definitions

For the first category, definitions, 14 studies established that peers with personal histories of SUD and significant recovery progress offered hope, experiential understanding, nonclinical-based activities, nonjudgmental attitudes, community, relationship building, and a health-and-ability culture to peers seeking recovery (Curtis, 1999; Faces & Voices of Recovery, 2010; Mead et al., 2001; Reif et al., 2014; SAMHSA, 2009). The definitions, specific to the PRC position, entailed existing on a continuum from case manager to 12-step sponsor; building relationships; becoming friends, truth-tellers, advocates, and role models; and recognizing nonclinical parameters (Jack et al., 2018; SAMHSA, 2009; Valentine, 2011; White, 2006; White, 2009). A qualitative study on patient and recovery-coaching perspectives on the PRC role identified core PRC descriptions as system navigator, behavior-change supporter, harm reducer, and relationship builder (Jack et al., 2018). Findings from papers, articles, book chapters, and investigations confirmed findings that a key theme of the lived work experience is the PRC role with subthemes of relationship building and guidance. This study's findings of the PRC role with components of relationship building and guidance directly aligned with the concepts of experiential understanding, friendship, nonjudgmental attitudes, community, relationship building, role models, support, and navigation.

Settings

Settings, the second category, involved community-based settings, urban and rural communities, various populations and circumstances, prevention-based services, and different contextual models (Biss & Curtis, 1993; Faces & Voices of Recovery, 2010; SAMHSA, 2009; White & Evans, 2014). Ideal service settings for PRCs comprised inviting, nonclinical

community spaces conducive to building trust, minimizing power differentials, and nurturing the peer relationship (Faces & Voices of Recovery, 2010). The findings from my study do not show key themes related to service settings; however, PRCs alluded to spaces being welcoming, safe, loving, caring, family-oriented, and spiritually transforming. Although service settings are outside of the scope of this inquiry into the lived home, community, and work experience of PRCs working at a community-based, spiritual, residential substance abuse recovery program, prior research on service settings supplied context for this study.

Role

Role, category three of the literature review, consisted of three papers and three qualitative studies that described a broad range of PRSS roles and various components of the roles. Resources emphasized long-term continuity of care; client, family, and community involvement; mentorship; education; support; collaboration; advocacy; resource connection; experiential sharing; relationship building; skill building; and group facilitation (Eddie et al., 2019; Gillard et al., 2013; Jacobson et al., 2012; Moran et al., 2013; Valentine, 2010; White, 2010). Three articles added that PRC roles need to be defined specifically, be distinguishable from a treatment counselor or professional and a 12-step sponsor, and to exist clearly within an agency (Faces & Voices of Recovery, 2010; SAMHSA, 2009; White, 2006). The researchers' findings were consistent with this study's findings that a key theme of lived work experience, the PRC role, embodied relationship building and guidance. Differences in the findings demonstrated as the broader literature portraying lists and recommendations and this study's co-researchers sharing personal experiences.

Qualifications

Qualifications, the fourth category, consisted of four studies on peer support (Mead et al., 2001; Moll et al., 2009; SAMHSA, 2009; White, 2009) and one source on the PRC role specifically (Faces & Voices of Recovery, 2010). The peer support studies highlighted a history of mental illness and experience with the mental health system, experiential understanding, shared ground based on mutual histories, and experiential credentialing as unique and valuable qualifications. Faces and Voices of Recovery (2010) listed qualifications of the PRC role as abstinence time, orientation and training, weekly supervision, and ethical skills. While the co-researchers did not directly refer to qualifications, they recognized experiential understanding, ethical skills practice, and training needs. Even though PRC role qualifications were not a focus of this research, an understanding of qualifications from the literature provided necessary dimension for this investigation.

Social Support

Category five of the literature base, social support, included five studies (Prochaska et al., 1995; Salzer, 2002; SAMHSA, 2009; White, 2009). These studies showed peer leaders offered emotional (empathy), informational (knowledge), instrumental (accomplishments), and affiliational (community connections) social support. This support entailed spiritual, secular, medical, and/or cultural pathways in recovery. These findings were consistent with this investigation's findings that the PRC role, a key theme of lived work experience, involved relationship building and guidance. Participants of this study described relating to their peers, showing them "you're in their corner," giving them tools for a healthy recovery, and helping them navigate through the program and life changes.

Training

Training, the sixth category of the research review, consisted of two investigations (Office of the Surgeon General, 2016; Valentine, 2011). Though there is no national standardized PRC training system, Connecticut Community for Addiction Recovery runs a 5-day interactive training for PRCs. This education covers behavioral health disorders, ethical practices, recovery values, relationship skills, crisis response, stages of change, and cultural awareness. This study's participants referred to training needs as challenges and desired additional training in office and computer skills, PRC certifications, mental health and trauma, public speaking, writing, and Bible knowledge. Literature findings focused on informational training facts, and this investigation's co-researchers voiced experiential training needs and frustrations. The literature base focus differed from this study's focus of lived experience.

Benefits

Previous literature reported on benefits, the seventh category, for clients, the mental health field, and the peer support workers themselves. Benefits to clients and to the mental health field, outside of the scope of this investigation of PRCs' lived experience, brought context from the literature. Twelve investigations reported benefits to peer support workers and to PRCs as opportunities for professional and personal growth, lived experience validation, wage-earner status, "giving back," personal recovery progress, relationship building, and quality of life improvement (Ahmed et al., 2015; Beales & Wilson, 2015; Bradstreet, 2006; Conchar & Repper, 2004; Dyble et al., 2014; Hymes, 2015; Jack et al., 2018; Miyamoto & Sono, 2012; Moll et al., 2009; Mowbray et al., 1998; Salzer & Shear, 2002; Social Exclusion Unit, 2004). Prior research findings were consistent with findings of the lived PRC work experience theme of benefits and

subthemes of growth and purpose. One difference in this study's findings is the inclusion of spiritual grounding as a benefit; the co-researchers viewed spiritual grounding as central in their personal and professional experience.

Challenges

Seventeen investigations found PRC challenges, the eighth category, related to professional culture, training, supervision and support needs, role clarity, clinical environment, certification requirements, role model struggles, caregiver load, boundaries and balance, and personal recovery (Alberta et al., 2012; Bailie & Tickle, 2015; Beales & Wilson, 2015; Bracke et al., 2008; Bradstreet, 2006; Conchar & Repper, 2014; Dyble et al., 2014; Gillard et al., 2014; Jack et al., 2018; Jacobson et al., 2012; Moll et al., 2009; Moran et al., 2013; Mowbray et al., 1998; Salzer & Shear, 2002; Silver, 2004; Stansfeld & Candy, 2006; Walker & Bryant, 2013). Findings from the literature confirmed the lived experiences of the co-researchers and pointed to challenges as a key theme of lived work experience, with subthemes of burden bearing, personal recovery time sacrifice, and training needs and frustrations. The broader literature found certain PRC challenges—personal recovery, caregiver load, and boundaries and balance—were also consistent with the study's findings of personal recovery influence themes (the triggers of bearing another's burdens) and recovery tools (boundary setting). Outcomes from prior research regarding challenges of professional culture, role clarity, clinical environment, certification requirements, and role model struggles were not congruent with themes from this study's findings. Possible reasons for the absence of these themes in this study could be the unique family-oriented, community-based environment, the specific questions asked, the sample size, clear role understanding, and/or a collaborative culture.

Future Research

Category nine, future research, included 12 studies that recommended investigations into the effectiveness of PRSS and PRCs; the nature and the role of peer support; the training and credentialing of PRCs; a clarification of the PRC role; the impact of the role on the PRC; the connection between PRC role and their personal recovery; orientation, training, and supervision models; ethical codes; and the lived experiences of PRCs (Bailie & Tickle, 2015; Bassuk et al., 2016; Bracke et al., 2008; Gillard et al., 2013; Hymes, 2015; Jack et al., 2018; Moran et al., 2013; Office of the Surgeon General, 2016; Reif et al., 2014; White, 2006; White & Evans, 2014; Zemore et al., 2004). The voices of the co-researchers found themes of lived home, community, and work experiences and personal recovery influences consistent with the need for research in these areas. The lived experiences of these PRCs pointed to residential stability, restored relationships, community, recovery support, the PRC role, a whole spectrum of emotions, benefits, challenges, relationships, accountability, triggers, and recovery tools. These themes of lived experience replicated the findings for suggested research topics.

Theoretical Framework

The final category from the broader literature, theoretical framework, represented 14 sources (Andrews & Bonta, 1994; Blessett & Pryor, 2013; Hammett et al., 2001; Lattimore et al., 2009, 2010; Listwan et al., 2006; Lurigio, 2001; Lynch & Sabol, 2001; Mumola, 1999; Raphael, 2011; Seiter & Kadela, 2003; United States Department of Justice, 2002; Wright et al., 2014). The re-entry of ex-offenders into home, community, and work life is like that of PRCs returning to home, community, and work life after graduating from a community-based, spiritual, residential substance abuse recovery program. The findings of prior research on ex-offenders' re-

entry experiences were consistent with the findings of this study. Evidence-based literature on ex-offenders' re-entry experience supplied a theoretical framework for the two research questions. The second research question, investigating the influences of past and present home, community, and work life re-entry experiences on a male PRC's personal recovery, emanated from the theoretical orientation; however, the research review did not include an emphasis on personal recovery.

Themes Absent from Literature Review

Some of this exploration's findings were absent from the literature review findings. Missing elements from the first research question exhibited as the lived home experiences of residential stability and restored relationships, the lived community experiences of togetherness and recovery support, the lived work experiences of a spectrum of emotions, and the lived work experience benefit of spiritual grounding. These missing components were due to gaps in the literature on lived home, community, and work experience. The themes absent from the second research question on personal recovery influences comprised relationships with God, recovery support as accountability, reminder triggers, and healthy reminders. The absent themes related to personal recovery influences seemed to be the result of limited research on PRCs' personal recovery lived experiences. These qualitative case study findings provided specific outcomes from the co-researchers' lived experiences and added to the literature.

Implications for Social Change

This study on PRCs' lived home, community, work, and personal recovery experiences filled a gap in the literature on PRC lived experience and personal recovery influences. This study has the potential to explicate the PRC re-entry experience, clarify PRC role definitions, and

to describe PRC personal recovery impacts. Those who interact with PRCs, including professional counselors, managers, employers, clinical staff and colleagues, policy makers, and funders, need to be informed about the lived and personal PRC experiences. Outcomes of this study could positively impact PRCs' personal and professional development, personal recovery, and support networks.

The co-researchers identified (a) lived home experiences as residential stability and restored relationships; (b) lived community experiences as togetherness and recovery support; and (c) lived work experiences as PRC role, feelings, benefits, and challenges. Home, community, and work experiences influenced personal recovery through relationships, accountability, triggers, and recovery tools. These themes specifically answered each of the research questions. These findings could beneficially change and improve the understanding and practice of clinical counselors, counselor educators, and clinical supervisors.

New information and improved understanding on PRCs lived experiences and personal recovery for professional counselors, counselor educators, and clinical supervisors requires exposure, awareness, and conversation. PRCs, who are in recovery and working with those in recovery, need clinical support. This support from counselors, educators, and supervisors necessitates that these clinical professionals learn more about the lived home, community, work, and personal recovery experiences of PRCs. The findings of this study could benefit the practice of both entry-level and seasoned counselors (ACA, 2014), training materials in the specialty area of addiction counseling for counselor educators (Council for Accreditation of Counseling and Related Educational Programs, 2016), and the conversations and treatment plans of counselor trainees in clinical supervision (ACA, 2014). An informed clinical support system moves

forward the mission of the ACA: “To enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity” (2014).

Recommendations for Action

This qualitative case study presented findings for the lived home, community, work, and personal recovery experiences of PRCs. Themes from home, community, and work experiences emerged as residential stability, restored relationships, togetherness, recovery support, the PRC role, feelings, benefits, and challenges. Findings from the influences of home, community, and work on personal recovery developed as relationships, accountability, triggers, and recovery tools. Co-researchers shared challenges of burden bearing, time sacrifice, and training gaps. They also described impacts on personal recovery as triggers of reminders and burden bearing and recovery tools of healthy reminders and boundary setting.

The challenges, triggers, and recovery tools suggested the need for support in personal and professional development. Support for personal and professional development, specifically personal addiction recovery and career-related growth, could be cultivated by an informed clinical support system. An informed clinical support system involves clinical supervisors, counselor educators, and professional counselors with an understanding of PRCs’ needs for support and advocacy in personal addiction recovery and professional development.

Recommendations for dissemination of findings consist of publishing findings in counseling-related journals, offering CEUs for PRC experiences to entry-level and seasoned counselors, and

inviting clinical professionals who have experience working with PRCs to share in counselor education classes and programs.

Recommendations for Future Research

Evidence of the need for future study builds on the fact that SUD is one of the most universal clinical and public health concerns in the United States, the research that shows the PRC field is rapidly growing, and the findings of this study. Future research suggestions developed from the broader base of literature, the findings of this study, and from the voices of the co-researchers of this investigation. Themes from this investigation confirm the need for qualitative and quantitative inquiries into PRCs' role definitions and clarification, PRC training and credentialing, the effects of the PRC role on personal recovery, connection between the PRC role and personal recovery, PRC lived experiences, ethical codes, and models for orientation, training, and supervision. Observations of needed research include lived experience of PRCs, representing varied populations, locations, socioeconomic statuses, and work settings. Other suggested research topics entail longitudinal studies exploring the personal recovery outcomes of PRCs, investigations into the effects of clinical services on personal recovery support and the PRC role, and exploration of types and strengths of PRCs' personal recovery support.

Themes expressed by the co-researchers of this study that are absent from the literature are lived home experiences of residential stability and restored relationships, lived community experiences of togetherness and recovery support, lived work experiences of feelings, spiritual grounding benefits, personal recovery influences of relationships with God, recovery support accountability, triggers of reminders, and recovery tools of healthy reminders. These findings point to the need for further research into the lived experience of PRCs' home and community

lives, feelings within the PRC role, and benefits of spiritual grounding. Future investigative suggestions related to personal recovery will also fill gaps in the literature. Some study recommendations are connections between personal recovery and spirituality, personal recovery and accountability of the PRC role, personal recovery and past reminders of addiction and trauma, personal recovery and PRC role time sacrifices, personal recovery and caregiving loads, personal recovery and helpful tools, and personal recovery and boundary setting.

Researcher's Reflections

A reflection of my experience with the research process encompasses researcher's bias, positionality, and outcomes. Throughout a 5-year period of working with and supervising PRCs, I observed the personal recovery journey and professional career experience of PRCs at a community-based, spiritual, residential substance abuse recovery facility. Presence at the facility and involvement with the PRCs' work contributed to my interest in this study, access to the population, and context for interview questions. During the research process, I employed measures of member checking, peer debriefing, multiple sourcing, and reflective journaling toward researcher credibility and data interpretation trustworthiness (Marshall & Rossman, 2016; Lincoln & Guba, 1985). Researcher positionality, consisting of work experience, training, ethical values, licensures, and certifications, did not negatively affect rapport building, participant transparency, or conversation depth.

Proposed outcomes of residential stability, recovery support, benefits and challenges, managed recovery, and spiritual values aligned with the findings from the home, community, and work experiences of the co-researchers. Shifts in my thinking involved reminders of past addiction and trauma being both triggers and recovery tools, the weight of caregiving loads on

the co-researchers' hearts, and the constant intentionality of boundary setting. A specific unexpected response from each co-researcher was the pause, the "Wow, that's deep right there," and the "Can we come back to that?" when asked about personal recovery triggers that may occur in their role. Each of them did choose to answer the question and two of them reminded me to ask the question again. Their momentary steps back could indicate a desire to be private about personal recovery struggles, inexperience with being asked direct questions about their personal recovery journey, or an awareness of my leadership position as clinical program director on the women's side of the facility.

Trustworthiness

Trustworthiness in the interpretation of the data and credibility of the research must be addressed because in qualitative study the researcher is "the instrument" (Marshall & Rossman, 2016). Standards of trustworthiness adhered to Lincoln and Guba's (1985) member checking, multiple sourcing, and peer debriefing. Components of trustworthiness entailed rich data, reflective journaling, and audit trails (Creswell & Miller, 2000; Marshall & Rossman, 2016; Maxwell, 2012). Transparency of literature use and of researcher positionality added to the soundness of the study (Marshall & Rossman, 2016). Lastly, a competent research approach and ethical researcher engagement enhanced trustworthiness within this qualitative case study (Marshall & Rossman, 2016).

Conclusion

Concluding remarks consider how the findings of this study compared to the broader literature. The literature review positioned this investigation and demonstrated the need for the inquiry into PRCs' lived experience. A thorough search of the literature on PRCs and a

comparison of my findings provided clarity to see the uniqueness of the findings in this research. This study explicated the PRC re-entry experience, clarified the PRC role, and informed about PRCs' personal recovery experiences.

This exploration differs from prior research in the purpose, theoretical framework, research questions, research design, findings, and the findings comparisons. The differences in purpose, theoretical framework, research questions, research design, findings, and comparisons make a unique and significant contribution to the literature. This study's purpose was to fill a gap in the literature related to the PRC role, lived experience, and personal recovery. The chosen theoretical framework, built on the re-entry of ex-offenders into home, community, and work life, provided a direction for the research questions.

The first research question investigated the home, community, and work life re-entry experiences of a male PRC working at a community-based, spiritual, residential substance abuse recovery program. This question supplied the springboard for the second research question: "How do past and present home, community, and work life re-entry experiences of a male PRC influence present recovery?" The two research questions guided the study of lived experience toward a complete description, including home, community, work, and personal recovery of a PRC's life. The research questions also directed the research design to a qualitative case study of exploring people's lived experiences in their own context through their personal descriptions and phrases.

Some of this investigation's findings confirm those from the literature; however, this probing into the lived home, community, and work experience of PRCs allows for a larger lens into the PRC's life and integrates personal recovery within the total lived experience. New

themes emerged in relational, emotional, and spiritual aspects because of the uniqueness of the research questions on the home, community, and work life experiences. Though the literature mentioned personal recovery, caregiving loads, and boundary setting, this study found additional themes of relationship with God, accountability, reminder triggers, and healthy reminders. The similarities in the findings demonstrate the interconnectedness between the lived home, community, and work experiences and the personal recovery influences. These findings significantly add to the literature and achieve the purpose of filling literature gaps in the areas of lived experience and personal recovery.

The unique findings directed implications for social changes, recommendations for action, and recommendations for further research. The findings from this study, along with the PRC role and personal recovery journey, suggest the need for an informed clinical support system “to enhance the quality of life in society . . . to promote respect for human dignity and diversity” (ACA, 2014). Recommendations for dissemination of findings involve publishing findings in counseling-related journals, offering CEUs to entry-level and seasoned counselors for PRC involvement, and inviting clinical professionals who have experience working with PRCs to share in counselor education classes and programs. Findings different from the literature provided recommendations for future research on topics specific to the home, community, work, and personal recovery experiences of PRCs.

In personal reflection, it has been an honor and a privilege to hear these men’s stories, learn about their experiences, see the gleam in their eyes, and feel the struggles in their hearts. Unexpected findings included reminders and triggers of past addiction and trauma, the weight of caregiving on their hearts, and the constant necessity for boundary setting. I appreciated being in

a position that allowed access to this population. The desire to understand their inclusive life experiences amid their addiction recovery journeys began as an interest and developed into an ethical study of their world through their eyes. The findings suggest needed personal recovery and professional development support for PRCs.

The findings of this study fill a gap in the literature. It is my hope that these findings will inform counselors, counselor educators, and clinical supervisors about the lived home, community, work, and personal recovery experiences of PRCs. An informed clinical support system could help PRCs in their personal recovery journeys and in their professional roles. A lens into the lived experience of PRCs allows clinicians, educators, and supervisors to uphold the ethical values of promoting social justice and supporting the worth, dignity, and potential of people in their social and cultural contexts (ACA, 2014).

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APPENDIX A: Consent

Consent

Title of the Project: Case Study of Lived Experiences: Three Male Peer Recovery Coaches at a Residential, Spiritual, Substance Abuse Recovery Program

Principal Investigator: Vicki L. Moak, M.A., LCPC-MD, NCC, Doctoral Candidate, Liberty University, School of Behavioral Sciences

Faculty Sponsor: Lisa Sosin, PhD, LPC, LLP, BACS, Director, CACREP Accredited PhD in Counselor and Education Supervision Program, Liberty University, School of Behavioral Sciences

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be a male who is 18 years or older and working as a peer recovery coach at a community-based, spiritual, residential, substance abuse recovery program located in Baltimore, Maryland. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the proposed study is to improve resources and support for continued training and supervision for Peer Recovery Coaches who work in health-care institutions and community-based recovery programs. The absence of literature into the lived experience of Peer Recovery Coaches and into the effects of the Peer Recovery Coach role on personal recovery creates the need for studies into the lived experience of Peer Recovery Coaches. The central research question is: "What are the home, community, and work life re-entry experiences of a male Peer Recovery Coach working at a community-based spiritual, residential, substance abuse recovery program?"

What will happen if you take part in this study?

If you agree to be in this study, I would ask you to do the following things:

1. Fill out short demographic questionnaire (about 10 minutes).
2. Participate in audio-recorded initial interview (about 30-45 minutes).
3. Participate in audio-recorded journal page and artifact sharing interview (20-30 minutes).
4. Participate in audio-recorded member-checking interview (about 20-30 minutes).

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include increased public knowledge on the experience of Peer Recovery Coaches. Improved support, training, and supervision could allow for Peer Recovery Coaches to benefit from best practices and to succeed personally and professionally. Ultimately, because Peer Recovery Coaches serve a population of clients with substance abuse issues, this project could benefit those that are served by Peer Recovery Coaches. In helping Peer Recovery Coaches be successful in their role, the greater community is impacted. These impacts could

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look like more people in recovery maintaining sobriety, finding their purpose, holding jobs, reconnecting with family, and experiencing a better quality of life. These factors would potentially decrease the cycle of addiction and recidivism in the prison system.

What risks might you experience from being in this study?

The risks involved in this study are minimal. These risks are equal to the risks that you would encounter in everyday life. There is a minimal psychological risk that a participant may need to process answers to questions with a mental health professional. If the codebook is lost, there is a potential risk of a breach of confidentiality.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential through the use of pseudonyms. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on this researcher's password-locked computer and may be used in future studies or presentations. After three years, all electronic records will be deleted.
- Interviews will be audio recorded and transcribed. The transcription service, located in the United Kingdom, requires transcribers to sign a non-disclosure agreement. The files are encrypted when being sent over the internet. Once this researcher downloads the transcription, this researcher will delete the audio and transcription data from the transcription service data base. Additionally, the transcription service deletes both the audio and transcription files from their system. Recordings will be stored by this researcher on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

How will you be compensated for being part of the study?

Participants will be compensated for participating in this study. Participants will receive a \$20.00 gift card to Chipotle upon completion of all procedures.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Helping Up Mission or Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Vicki Moak. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [REDACTED] and/or [REDACTED]. You may also contact the researcher's faculty sponsor, Dr. Lisa Sosin, at [REDACTED].

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

Printed Subject Name

Signature & Date

APPENDIX B: Letter of Permission

January 28, 2020



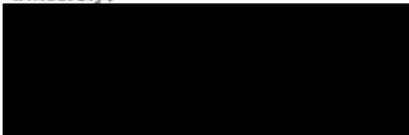
Dear Vicki:

After careful review of your research proposal entitled Case Study of Lived Experiences: Three Male Peer Recovery Coaches at a Residential Spiritual Recovery Program, I have decided to grant you permission to contact our Peer Recovery Coaches and invite them to participate in your study.

Check the following boxes, as applicable:

- ☒ The requested data will not be stripped of identifying information before it is provided to the researcher.
- ☒ I am requesting a copy of the results upon study completion and/or publication.

Sincerely,



APPENDIX C: Letter to Potential Participants

Dear Peer Recovery Coach:

As a post graduate doctoral student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a Doctor of Philosophy degree in Counselor Education and Supervision. The purpose of my research is to explore the home, community, and work life re-entry experiences of male Peer Recovery Coaches working at a community-based, spiritual, residential, substance abuse recovery program. I am writing to invite eligible participants to join my study.

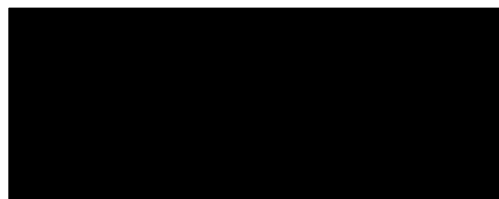
Participants must be 18 years of age or older, male, and currently employed as a Peer Recovery Coach at a community-based, spiritual, residential, substance abuse recovery program in Baltimore, Maryland. Participants, if willing, will be asked to complete a short demographic questionnaire taking about 10 minutes and participate in both a 30-45 minute audio recorded initial interview and a 20-30 minute audio recorded journal page and artifact sharing interview. The participant will bring a journal page and an artifact to this interview. A journal page is a self-selected page out of daily work notes representing reflection, interactions, and activities. An artifact is an item that has a significant meaning in either the role at work or personal recovery. Artifacts might be a picture of a family member, a quote, a book, a certificate of accomplishment, a coin, or anything with special meaning related to the role at work or to personal recovery. Additionally, the participant will participate in a 20-30 minute audio recorded member-checking interview. This interview allows the participant to review the transcripts, from the previous interviews, for accuracy.

Names and other identifying information will be requested as part of this study, but the information will remain confidential. In order to participate, please complete the attached screening survey and return it to me via email at [REDACTED]. If you are chosen to participate, I will contact you via email with a consent document for your review and additional instructions about participation. The consent document contains additional information about my research.

In order to make an informed decision about participating, you are encouraged to review the consent document prior to participation. You may either bring a signed copy of the consent form with you to the interview or sign a consent form when you arrive for the interview. I will answer any questions you have to make sure that you understand the consent document and the purpose of the research.

Participants will receive a \$20.00 gift card to Chipotle upon completion of all procedures.

Sincerely,

A large black rectangular redaction box covering the signature area.

APPENDIX D: Screening Survey

Instructions: Please provide an answer for each of the following questions. After answering, please send as an attachment to email address.

1.What is your age? _____

2.What is your gender? Female _____ Male _____

3.Does your position at work involve peer recovery coaching?

Yes _____ No _____

4.Do you work in a spiritual, residential substance abuse recovery facility?

Yes _____ No _____

5. What is the location of the facility where you work? _____

APPENDIX E: Semi-Structured Interview Guide (Hennink et al., 2011)**Introduction**

This research is being conducted to explore the home, community, and work life re-entry experiences of a male Peer Recovery Coach at a community-based, spiritual, residential substance abuse recovery program. I am conducting this study for my doctoral dissertation at Liberty University. I am interested in the experiences of men of different ages and of different backgrounds working as Peer Recovery Coaches at a spiritual residential substance abuse recovery program. The questions that I would like to ask you relate to your home, community, and work life experiences and your present personal recovery. Everything that you tell me will be only used for this research project and will not be shared outside of the research team. Your name will not be used to make sure that no one can identify any answers. You have already consented to the interview with the consent form. Before we begin, do you have any questions?

Opening Questions

1. Tell me a little about your work environment.

Probe: work life; positive and negative experiences, responsibilities

2. Who do you live with?

Probe: home life, marital status

3. What does a normal day at work look like?

Probe: work life

4. What does community mean to you?

Probe: relationships; support network; community

5. Who do you go to for advice?

Probe: mentor; role models; support network; community

6. Outside of work, what activities are you involved in?

Probe: community life; service

7. What are some skills that are necessary in your job?

Probe: work life

Key Questions

8. How is your home life similar or different from before you were a PRC?

Probe: home life experiences

9. What does your community involvement look like today?

Probe: community life experience changes

10. How is your work path the same or different from the time before you became a PRC?

Probe: work life experiences

11. What are some of the most important parts of your job?

Probe: work life experiences

12. In your role, are there situations or conversations that are triggers in your personal recovery?

Probe: work experiences; personal recovery

13. What do you do to maintain your personal recovery?

Probe: personal recovery; work life

14. How does your role as a PRC impact your personal recovery?

Probe: work life; personal recovery

15. What impact does the spiritual aspect of this program have in your work as a PRC?

Probe: work experience

16. Is there anything you would like to share about your personal recovery?

Probe: personal recovery

17. What are some feelings you experience in your work?

Probe: work life

18. Does your position as a PRC add to your life in any way? How?

Probe: work and community life; personal recovery

19. Does your position as a PRC take away from your life in any way? How?

Probe: work and community life; personal recovery

20. Are there relationships that are key to your personal recovery? If so, what are they?

Probe: personal recovery

21. Are there any skills in your work that you would like to improve? If so, what and why?

Probe: work experiences

22. Is there any aspect of your specific substance abuse recovery program that makes it different from others?

Probe: work experiences

23. Is there any part of your job as a PRC that impacts your recovery? If so, what and how?

Probe: work experiences; personal recovery

Closing Questions

24. What trainings or resources would be helpful for you in your work as a PRC?

Probe: work life

25. How do you see your career path for the future?

Probe: work

APPENDIX F: Journal and Artifact Sharing Interview Questions**Journal**

- 1. Do you have your daily journal entry with you?**
- 2. Are you comfortable reading it aloud or would you rather me read it silently?**
- 3. Based on your references to these aspects of your day, would you help me understand more about _____?**
- 4. How was the journal writing experience for you?**
- 5. What emotions did you feel while describing a day in your life as a Peer Recovery Coach?**
- 6. Were there any thoughts that came to mind that you didn't expect?**

Artifact(s)

- 1. What artifact did you bring that represents something important about your recovery or your role as a Peer Recovery Coach?**
- 2. Does this artifact relate to your recovery or your role as a Peer Recovery Coach? How so?**
- 3. Please share the significance of this artifact.**
- 4. When did you acquire it?**
- 5. Where do you keep it?**
- 6. When looking at it, what thoughts come to mind?**
- 7. Is there anything that you would like to share with me about this artifact?**

APPENDIX G: Demographic Information

Instructions: Please provide an answer for each of the following questions.

1. How long have you worked at this facility? _____

2. With which racial or ethnic category do you identify?

African American ____ Asian/Pacific Islander ____ Caucasian ____ Latino ____ Other ____

3. What is your marital status?

Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

4. With what denomination or faith tradition do you most closely identify?

5. What is your annual income (or combined if married)?

Less than \$60,000 ____ \$60,001 to \$70,000 ____ \$70,001 to \$80,000 ____

\$80,001 to \$90,000 ____ \$90,001 to \$100,000 ____ Greater than \$100,000 ____

6. What is your highest level of formal education? _____

7. Do you have a history of substance abuse? ____ **If so, how long?** _____

8. What were your primary drugs of choice? _____

9. How long have you been in recovery? ____ **Longest period of sobriety?** ____

10. Have you ever served prison time? ____ **If so, how long?** _____

11. What were the charges? _____

12. Have you ever been homeless? ____ **If so, for how long?** _____

13. Please make a check mark below to designate your current living situation.

At home with parents _____ Living alone _____

Living with spouse _____ Living with other family members _____

Living with a roommate _____ Living in a residential facility _____