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# Ethical Guidelines for the Delivery of Peer-based Recovery Support Services

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## INTRODUCTION

There is a long history of peer-based recovery support services within the alcohol and other drug problems arena, and the opening of the twenty-first century is witnessing a rebirth of such services (White, 2004a). These services are embedded in new social institutions such as

recovery advocacy organizations and recovery support centers and in new paid and volunteer service roles. These peer-based recovery support roles go by various titles: recovery coaches, recovery mentors, personal recovery assistants, recovery support specialists, and peer specialists. Complex ethical and legal issues are arising within the performance of these roles, issues for which little guidance can be found within the existing literature.

The twin purposes of this article are 1) to draw upon the collective experience of organizations that are providing peer-based recovery support services to identify ethical issues arising within this service arena, and 2) to offer guidance on how these issues can best be handled. Toward that end, we will:

- define the core responsibility of the peer recovery support specialist (here referred to generically as *recovery coach*);
- provide an opening discussion of key ethical concepts;
- outline a model of ethical decision making that can be used by recovery coaches and those who supervise them;
- discuss vignettes of ethical situations that can arise for recovery coaches related to personal conduct, conduct in service relationships, conduct in relationships with local service professionals and agencies, and conduct in service relationships with the larger community; and
- provide a sample statement of ethical principles and guidelines for recovery coaches.

An appended paper also identifies the extent to which current laws governing roles in addiction treatment (e.g., confidentiality, duty to warn, personal/organizational liability) are applicable to recovery coaches and their organizations.

We have two intended audiences for these discussions: individuals who are in positions of responsibility for the planning, implementation, and supervision of peer-based recovery support services and individuals who are working in either paid or volunteer roles as recovery coaches. This paper is designed to be adapted for use in the training of recovery coaches and their supervisors. The paper will remain in the public domain and may be adapted as a training aid or used without request by other recovery support organizations as a reading resource. We encourage the use of the decision-making model and the ethical case studies in the paper in the orientation and training of recovery coaches.

## PEER-BASED RECOVERY SUPPORT ROLES AND FUNCTIONS<sup>1</sup>

*Recovery support services*, as the term is used here, refers to non-clinical services that are designed to help initiate and sustain individual/family recovery from severe alcohol and other drug problems and to enhance the quality of individual/family recovery. The Center for Substance Abuse Treatment's Recovery Community Support Program identified four types of recovery support services:

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<sup>1</sup> This section excerpts material from White, W. (2004). Recovery coaching: A lost function of addiction counseling? *Counselor*, 5(6), 20-22.

- **Emotional support**—demonstrations of empathy, love, caring, and concern in such activities as peer mentoring and recovery coaching, as well as in recovery support groups
- **Informational support**—provision of health and wellness information; educational assistance; and help in acquiring new skills, ranging from life skills to skills in employment readiness and citizenship restoration
- **Instrumental support**—concrete assistance in task accomplishment, especially with stressful or unpleasant tasks such as filling out applications and obtaining entitlements, providing child care, or providing transportation to support-group meetings and clothing assistance outlets (clothing closets).
- **Companionship**—helping people in early recovery feel connected and enjoy being with others, especially in recreational activities in alcohol- and drug-free environments. This assistance is particularly crucial in early recovery, when little about abstaining from alcohol or drugs is reinforcing.

(Source: <http://rcsp.samhsa.gov/about/framework.htm>)

Some of the service activities now provided within the rubric of recovery support services include activities performed in earlier decades by people working as outreach workers, case managers, counselor assistants, and volunteers. Recovery support services may be provided by clinically trained professionals as an adjunct to their clinical (assessment and counseling) activities, or they may be delivered by people in recovery who are not clinically trained but who are trained and supervised to provide such support services. They are being provided as adjuncts to other service roles or within specialty roles. Recovery support services are being provided by people working in full- and part-time paid roles and by people who provide these services as volunteers.

Peer-based recovery support roles are growing rapidly in the mental health and addiction service arenas. While there are specific issues related to peer-based services that are distinct within these two fields, the fields have much they can learn from each other.<sup>2</sup>

Part of what makes the ethical delivery of recovery support services so challenging in the addictions context is that the recovery coach performs so many roles. In service organizations piloting this role, the recovery coach is being described as a(n):

- Outreach worker (identifies and engages hard-to-reach individuals, offers living proof of transformative power of recovery, makes recovery attractive)
- Motivator and cheerleader (exhibits faith in capacity for change, encourages and celebrates recovery achievements, mobilizes internal and external recovery resources, encourages self-advocacy and economic self-sufficiency)
- Ally and confidant (genuinely cares and listens, can be trusted with confidences)
- Truth-teller (provides feedback on recovery progress)

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<sup>2</sup> Particularly recommended are the following three resources from the mental health field: 1) Mowbray, C.T., Moxley, D.P., Jasper, C.A., & Howell, L.A. (Eds.) (1997). *Consumers as providers in psychiatric rehabilitation*. Columbia, MD: International Association of Rehabilitation Services; 2) Davidson, L., Harding, C., & Spaniol, L. (Eds.) (2005). *Recovery from severe mental illness: Research evidence and implications for practice*. Boston: Center for Psychiatric Rehabilitation; and 3) Spaniol, L., Gagne, C., & Koehler, M. (Eds.) (1997). *Psychological and social aspects of psychiatric rehabilitation*. Boston: Center for Psychiatric Rehabilitation.

- Role model and mentor (offers his/her life as living proof of the transformative power of recovery, provides stage-appropriate recovery education)
- Planner (facilitates the transition from a professionally directed treatment plan to a consumer-developed and consumer-directed personal recovery plan)
- Problem solver (helps resolve personal and environmental obstacles to recovery)
- Resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support; matches individuals to particular support groups/meetings)
- Monitor (processes each client's response to professional services and mutual-aid exposure, to enhance service/support engagement, reduce attrition, resolve problems in the service/support relationship, and facilitate development of a long-term, sobriety-based support network; provides periodic face-to-face, telephonic, or email-based monitoring of recovery stability and, when needed, provides early re-intervention and recovery re-initiation services)
- Tour guide (introduces newcomers into the local culture of recovery; provides an orientation to recovery roles, rules, rituals, language, and etiquette; opens opportunities for broader community participation)
- Advocate (helps individuals and families navigate complex service systems)
- Educator (provides each client with normative information about the stages of recovery; informs professional helpers, the community, and potential service consumers about the prevalence, pathways, and styles of long-term recovery)
- Community organizer (helps develop and expand available recovery support resources, enhances cooperative relationships between professional service organizations and indigenous recovery support groups, cultivates opportunities for people in recovery to participate in volunteerism and other acts of service to the community)
- Lifestyle consultant/guide (assists individuals/families in developing sobriety-based rituals of daily living, encourages activities (across religious, spiritual, and secular) frameworks that enhance life meaning and purpose)
- Friend (provides sober companionship, a social bridge from the culture of addiction to the culture of recovery) (White, 2004a)

The fact that these functions overlap with other helping roles, including that of the addictions counselor, raises the potential for role ambiguity and conflict. Agencies experimenting with these new roles insist that the recovery coach is NOT a:

- sponsor,
- therapist/counselor,
- nurse/physician, or
- priest/clergy (does not respond to questions of religious doctrine nor proselytize a particular religion/church) (See White, 2006a,c).

<b>Role Boundary Integrity: The RC is NOT a:</b>	<b>You are moving beyond the boundaries of the recovery coach role if you:</b>
Sponsor (or equivalent)	<ul style="list-style-type: none"> <li>• Perform AA/NA or other mutual-aid group service work in your RC role</li> <li>• Guide someone through the steps or principles of a particular recovery program</li> </ul>
Therapist/counselor	<ul style="list-style-type: none"> <li>• Diagnose</li> <li>• Provide counseling or refer to your support activities as “counseling” or “therapy”</li> <li>• Focus on problems/“issues”/trauma as opposed to recovery solutions</li> </ul>
Nurse/Physician	<ul style="list-style-type: none"> <li>• Suggest or express disagreement with medical diagnoses (including psychiatric diagnoses)</li> <li>• Offer medical advice</li> <li>• Make statements about prescribed drugs beyond the boundaries of your training and experience</li> </ul>
Priest/Clergy	<ul style="list-style-type: none"> <li>• Promote a particular religion/church</li> <li>• Interpret religious doctrine</li> <li>• Offer absolution or forgiveness (other than forgiveness for harm done specifically to you)</li> <li>• Provide pastoral counseling</li> </ul>

People serving as recovery coaches, rather than being legitimized through traditionally acquired education credentials, draw their legitimacy from *experiential knowledge* and *experiential expertise* (Borkman, 1976). Experiential knowledge is information acquired about addiction recovery through the process of one’s own recovery or being with others through the recovery process. Experiential expertise requires the ability to transform this knowledge into the skill of helping others achieve and sustain recovery. Many people have acquired experiential knowledge about recovery, but only those who have the added dimension of experiential expertise are ideal candidates for the role of recovery coach. The dual credentials of experiential knowledge and experiential expertise are bestowed by local communities of recovery to those who have offered sustained living proof of their expertise as recovery guides (White & Sanders, 2006). The recovery coach works within a long tradition of wounded healers—individuals who have suffered and survived an illness or experience who use their own vulnerability and the lessons drawn from that process to minister to others seeking to heal from the same condition (White, 2000a,b; Jackson, 2001).

Recovery coaching at its best offers dimensions of recovery support not available from other service roles. We asked individuals from three states (Pennsylvania, Connecticut, and Texas) who had experienced recovery coaches what these recovery coaches contributed to their early recovery experiences. Here are some of their responses.

*My recovery coach builds me up and makes me feel like I am someone and I can accomplish anything I set my mind to. He provides his experience in recovery and his strength and hope.*

*Support. It's comfortable to have someone behind me—I don't think I could do it on my own. They always help me to look at things differently.*

*My recovery coach is 100% real. She has been there and done that. She understands me and knows where I'm at in this point in my life. She knows exactly what to say and do for me to build me up and keep me strong. It's like we are on the same level and she is here to help me move on and get to the next step in my recovery and in my life.*

*He gave me a little self-esteem. He asked me, was I ready? I was able to share my past. He helped place me in the Mentor Plus program. He walked me through. He told me it would not be easy.*

*Recovery coaching has helped me set goals in my life. It has also taught me to be accountable for my actions. The coach didn't really give advice, more like guidance to make better decisions on my own.*

*She helped me paint a picture that I am not alone, and that there are a lot of recovering addicts out there and they actually have a lot of clean time. I didn't know that before.*

*I wanted to become a responsible daughter and mother and a respected and productive member of the community. I started doing anything and everything for my recovery. One of the most important things was that I got mentors for the Mentor Plus program. They came to see me every week, eventually twice a week. They gave me direction and were there to support me.*

*His demeanor of recovery showed me I could get what he has.*

Recovery coaches, particularly those serving in this capacity as volunteers, are also quite explicit in what they get out of this service process.

*I like working with people and being able to offer encouragement and support. It's very rewarding to see people start getting their lives back. Sometimes I see people who don't make the right choices, and that can be frustrating, because I remember what that was like and I feel for them. It helps me to remain grateful for how much better my life is now that I'm in recovery, and I try to pass that message on to them. I am a part of a wonderful process, and helping others helps me more than I can say.*

*In helping individuals build and rebuild recovery capital, I have learned, not only a lot about these people, but a lot about myself.*

*Today I know that I don't know. In letting someone in on that secret, it reassures them that it is okay not to be all knowing and all powerful.*

*In being a recovery coach, I am able to make a small dent in the world around me and a huge change in my own life.*

*Personally, I love what I do. I have been helping people in recovery since the beginning of my recovery in 1989. I have been blessed to have such a great appreciation for helping others that it has become a part of me. There is no greater feeling than to help someone out of the gutter where I came from and see them grow.*

*I feel I am giving back by helping assist others in their recovery process. By practicing what I preach, I am able to build and nurture areas of spiritual growth in my life. I am*

*able to maintain a sense of integrity and character. Working as a recovery coach has helped me evaluate strengths and weaknesses and improve my listening skills. I feel trusted and valued as a mentor when people allow me to help them reach their goals. I feel special.*

*When that 'light' comes on, it is so exciting to witness. I do recovery coaching for selfish reasons...I'm looking for more 'light.'*

Recovery coaching is in its frontier stage. The role is being defined differently around the country based on the unique needs of particular communities and particular client populations. That variability is both a source of strength (responsiveness to the particular needs of individuals, families, and communities) and a source of vulnerability (the lack of consistent role definition and prerequisites). Orientation, training, and supervision protocols for recovery coaches are in an early stage of development.

The excitement about the recovery coach's role is tempered by concerns about potential conflicts with other service roles, and concerns about harm that might come to recipients of recovery support services due to incompetence or personal impairment on the part of the recovery coach—concerns that apply to all health and human service roles. There are several characteristics of recovery support services that influence the vulnerability of consumers and providers of peer-based recovery support services.

First, recovery support needs span the periods of pre-recovery engagement, recovery initiation, recovery stabilization, and recovery maintenance. As such, these service relationships last far longer than the counseling relationships that are the core of addiction treatment, are far more likely to be delivered in the client's natural environment, and often involve a larger cluster of family and community relationships.

Second, recovery support relationships are less hierarchical (less differential in terms of power and vulnerability) than the counselor-client relationship, involve different core functions, and are governed by different accountabilities. Given these factors, the ethical guidelines that govern the addiction counselor are often not applicable to the recovery coach. Efforts to impose ethical standards from traditional helping professions might inadvertently lead to the over-professionalization and commercialization of the role of recovery coach and recreate the very conditions that created the need for peer-based recovery support services. Ethical guidelines for recovery coaches must flow directly from the needs of those seeking recovery and from the values of local communities of recovery.

Third, individual consumers of peer-based recovery support services differ in the kind of non-clinical support services they need, and it is not uncommon for the same person to need different types of support services at different stages of his or her addiction and recovery careers. This requires considerable care in evaluating support service needs, delivering those services within the boundaries of one's knowledge and experience, and knowing how and when to involve people in other service roles.

Fourth, peer-based recovery support services can constitute an adjunct to addiction treatment (for those with high problem severity and low recovery capital) or an alternative to addiction treatment (for those with low or moderate problem severity and moderate or high recovery capital). This requires considerable vigilance in determining service needs and providing services only within the boundaries of one's competence, and skill in making necessary referrals in a timely manner.

All of these conditions underscore the need for a clear set of ethical values and standards to guide the delivery of peer-based recovery support services.

## ETHICS: A BRIEF PRIMER

The topic of ethics may be a relatively new one for recovery coaches who have never worked within or received services from an addiction-related service agency. Before proceeding to a discussion of how best to make decisions in the face of ethical dilemmas, we must further enhance our understanding of what we mean when we say that an action of a recovery coach is ethical or unethical. At its most primitive level, aspiring to be ethical involves sustained vigilance in preventing harm and injury to those to whom we have pledged our loyalty. This meaning is revealed through four terms: *Iatrogenic*, *Fiduciary*, *Boundary Management*, and *Multi-party Vulnerability*.

Iatrogenic means unintended, treatment-caused harm or injury. It means that an action taken to help someone, possibly with the best of intentions, actually resulted in injury or death. Can you think of an example of such an action? There is a long history of such insults in the history of addiction treatment, e.g., mandatory sterilizations, withdrawal using chemo- and electroconvulsive shock therapies, psychosurgery (e.g., *lobotomies*), and all manner of drug insults (e.g., treating morphine addiction with cocaine). It is easy today to look back on such “treatments” and wonder “What were they thinking?!” And yet history tells us that it is hard to see such potential injuries close-up. Given the new frontier of recovery coaching, we must be vigilant to quickly weed out well intended actions that harm one or more parties. This potential for harm also underscores the importance of seeking guidance from other recovery coaches and from supervisors.

Fiduciary—a word whose roots are linked to those of the word “faith”—describes relationships in which one person has assumed a special duty and obligation for the care of another. This word is a reminder that the relationship between the recovery coach and those to whom he or she provides services is not a relationship of equal power: It is not solely a supportive friendship. “Fiduciary” implies that one person in this relationship enters with increased vulnerability requiring the objectivity, support, and protection of the other—like a relationship we would have with our own physician or attorney. While the power differential between the recovery coach and those whom he or she coaches is less than that between a surgeon and his or her patient, the recovery coach can still do injury through what he or she does or fails to do. And so these relationships are held to a higher level of obligation and duty than would be friendships that are reciprocal in nature.

Boundary Management encompasses the decisions that increase or decrease intimacy within a relationship. This is an area of potentially considerable conflict between recovery support specialists and traditional service professionals. Where traditional helping professions (physicians, nurses, psychologists, social workers, addiction counselors) emphasize hierarchical boundaries and maintaining detachment and distance in the service relationship, peer-based services rely on reciprocity and minimizing social distance between the helper and those being helped (Mowbray, 1997). While addiction professionals and peer-based recovery support specialists both affirm boundaries of inappropriateness, they may differ considerably in where such boundaries should be drawn.



We might view the relationship between recovery coaches and those they serve upon an intimacy continuum, with a zone of safety in which actions are always okay, a zone of vulnerability in which actions are sometimes okay and sometimes not okay, and a zone of abuse in which actions are never okay. The zone of abuse involves behaviors that mark too little or too great a degree of involvement with those we serve. Examples of behaviors across these zones are listed in the chart below. Place a checkmark for each behavior based on whether you think this action as a recovery coach would be always okay, sometimes okay but sometimes not okay, or never okay.

**Table 1: Recovery Coaching: An Intimacy Continuum**

Behavior of Recovery Coach in Recovery Support Relationship	Zone of Safety (Always Okay)	Zone of Vulnerability (Sometimes okay; Sometimes not okay)	Zone of Abuse (Never Okay)
Giving a gift			
Accepting a gift			
Lending money			
Borrowing or accepting money			
Giving a hug			
“You’re a very special person”			
“You’re a very special person to me.”			
Invitation to a holiday dinner			
Sexual relationship			
Sexual relationship with a mentee’s family member			
Giving your cell phone number			
Using profanity			
Using drug culture slang			
“I’m going through a rough divorce myself right now.”			
“You’re very attractive.”			
Addressing the person by his/her first name			
Attending a recovery support meeting together			
Hiring the person to do work at your home.			

Ethical issues that can arise in situations like those listed above will be explored later in this paper.

Multi-party Vulnerability is a phrase that conveys how multiple parties can be injured by what a recovery coach does or fails to do. These parties include the person receiving recovery support services, that person’s family and intimate social network, the recovery coach, the organization for which the recovery coach is working, the recovery support services field, the larger community of recovering people, and the community at large.

It is easy for organizations providing recovery support services to make assumptions about ethical behavior and misbehavior that turn out to be disastrously wrong. Let's consider five such assumptions to open our discussion.

Assumption 1: *People who have a long and, by all appearances, high-quality sobriety can be counted on to act ethically as recovery coaches.*

Fact: Recovery, no matter how long and how strong, is not perfection. We are all vulnerable to isolated errors in judgment, particularly when we find ourselves isolated in situations unlike any we have faced before.

Assumption 2: *People hired as recovery coaches will have common sense.*

Fact: "Common sense" means that people share a body of historically shared experience that would allow a reasonable prediction of what they would do in a particular situation. The diversity of cultural backgrounds and life experiences of people working as recovery coaches provides no such common foundation, and behavior that is common sense in one cultural context might constitute an ethical breach in another.

Assumption 3: *Breaches in ethical conduct are made by bad people. If we hire good people, we should be okay.*

Fact: Most breaches in ethical conduct within the health and human service arena are made by good people who often didn't even know they were in territory that required ethical decision making. Protecting recipients of recovery support services requires far more than excluding and extruding "bad people." It requires heightening the ethical sensitivities and ethical decision-making abilities of good people.

Assumption 4: *Adhering to existing laws and regulations will ensure a high level of ethical conduct.*

Fact: The problem with this assumption is that what is legal and what is ethical do not always coincide. There are many breaches of ethical conduct about which the law is silent, and there might even be extreme situations in which to do what is legally mandated would constitute a breach of ethical conduct resulting in harm or injury to the service recipient. It is important to look at issues of law, but we must avoid reducing the question, "Is it ethical?" to the question, "Is it legal?"

Assumption 5: *Ethical standards governing clinical roles (e.g., psychiatrists, psychologists, social workers, nurses, addiction counselors) can be indiscriminately applied to the role of recovery coach.*

Fact: There are considerable areas of overlap between ethical guidelines for various helping roles, but ethical standards governing clinical work do not uniformly apply to the RC role. This potential incongruence is due primarily to the nature of the RC service relationship (e.g., less hierarchical, more sustained, broader in its focus on non-clinical recovery support service needs) and to its delivery in a broader range of service delivery sites.

Assumption 6: *Formal ethical guidelines are needed for recovery coaches in full-time paid roles but are not needed for recovery coaches who work as volunteers for only a few hours each week.*

Fact: Potential breaches in ethical conduct in the RC role span both paid and voluntary roles. The question recovery support organizations are now wrestling with is whether volunteer and paid RCs should be covered by the same or different ethical guidelines.

Assumption 7: *If a recovery coach gets into vulnerable ethical territory, he or she will let us know. If the supervisor isn't hearing anything about ethical issues, everything must be okay.*

Fact: Silence is not golden within the ethics arena. There are many things that might contribute to such silence, and all of them are potential problems. The two seen most frequently are the inability of recovery coaches to recognize ethical issues that are arising and their failure to bring those issues up for fear it will reflect negatively on their performance. The latter is a particular problem where supervision is minimal or of a punitive nature. The best recovery coaches regularly bring up ethical issues for consultation and guidance.

## CORE RECOVERY VALUES AND ETHICAL CONDUCT

Traditional professional codes of conduct for the helping professions have been heavily influenced by law and have also drawn heavily from medical ethics. In setting forth a model of ethical decision making and ethical guidelines for recovery support specialists, we sought to look, not beyond the recovery community, but within the history of American communities of recovery, from traditional Twelve-Step communities to religious and secular recovery communities. We drew two conclusions from that exercise. First, we noted the importance of group conscience within the history of particular communities of recovery and the likelihood that judgments of behavior would differ across these recovery communities. That suggested to us the importance of establishing a local council of people in recovery representing diverse recovery experiences that could offer collective guidance on ethical issues as they arise. Second, we looked across recovery traditions (religious, spiritual, and secular) and within the collective experience of organizations providing recovery support services and found a set of core values shared across these organizations. We felt that these values could provide a helpful filter for ethical decision making, and that it was important to evaluate actions of the recovery coach by these shared values rather than by the values of any one recovery community. These core values and the obligations we felt they imposed on those providing recovery support services are listed below.

- Gratitude & Service  
—Carry hope to individuals, families, and communities.
- Recovery  
—All service hinges on personal recovery.
- Use of Self  
—Know thyself; Be the face of recovery; Tell your story; Know when to use your story.
- Capability  
—Improve yourself; Give your best.
- Honesty  
—Tell the truth; Separate fact from opinion; When wrong, admit it.
- Authenticity of Voice  
—Accurately represent your recovery experience and the role from which you are speaking.
- Credibility  
—Walk what you talk.
- Fidelity

- Keep your promises.
- Humility
  - Work within the limitations of your experience and role.
- Loyalty
  - Don't give up; Offer multiple chances.
- Hope
  - Offer self and others as living proof; Focus on the positive—strengths, assets, and possibilities, rather than problems and pathology.
- Dignity and Respect
  - Express compassion; Accept imperfection; Honor each person's potential.
- Tolerance
  - “The roads to recovery are many” (Wilson, 1944); Learn about diverse pathways and styles of recovery.
- Autonomy & Choice
  - Recovery is voluntary: It must be chosen; Enhance choices and choice-making.
- Discretion
  - Respect privacy; Don't gossip.
- Protection
  - Do no harm; Do not exploit; Protect yourself; Protect others; Avoid conflicts of interest.
- Advocacy
  - Challenge injustice; Be a voice for the voiceless; Empower others to speak.
- Stewardship
  - Use resources wisely.

#### A PEER-BASED MODEL OF ETHICAL DECISION MAKING

A model of ethical decision making is simply a guide to sorting through the complexity of a situation and an aid in determining the best course of action that one might take in that situation. We propose that those providing recovery support services ask three questions to guide their decision making (Note: A worksheet on these questions is provided after the article, on Page 31).

Question One: Who has the potential to be harmed in this situation, and how great is the risk for harm? One answers this question by assessing the vulnerability of the parties listed in the table below and determining the potential for, and possible severity of, injury to each. Where multiple parties are at risk of moderate or significant harm, it is best not to make the decision alone, but to seek consultation with others, given the potential repercussions of the situation.

Vulnerable Party	Significant Risk of Harm ( √ )	Moderate Risk of Harm ( √ )	Minimal Risk of Harm ( √ )
Individual/Family Being Served			
Recovery Coach			
Service Organization			
Recovery Support Services Field			
Image of Recovery Community			
Community at Large			

**Question Two:** Are there any core recovery values that apply to this situation, and what course of action would these values suggest be taken?

- Gratitude & Service (Carry hope to individuals, families, and communities).
- Recovery (All service hinges on personal recovery).
- Use of Self (Know thyself; Be the face of recovery; Tell your story).
- Capability (Improve yourself; Give your best).
- Honesty (Tell the truth; Separate fact from opinion; When wrong, admit it).
- Authenticity of Voice (Accurately represent your recovery experience and role).
- Credibility (Walk what you talk).
- Fidelity (Keep your promises).
- Humility (Work within the limitations of your experience and role).
- Loyalty (Don't give up; Offer multiple chances).
- Hope (Offer living proof; Focus on the positive).
- Dignity and Respect (Express compassion; Accept imperfection; Honor potential).
- Tolerance ("The roads to recovery are many.") (Wilson, 1944)
- Autonomy & Choice (Recovery is voluntary; it must be chosen).
- Discretion (Respect privacy; don't gossip).
- Protection (Do no harm to and protect self and others; Avoid conflicts of interest).
- Advocacy (Challenge injustice; be a voice for the voiceless; empower others).
- Stewardship (Use resources wisely).

**Question Three:** What laws, organizational policies or ethical standards apply to this situation, and what actions would they suggest or dictate?

In the next section, we will explore a wide variety of ethical dilemmas that can arise in the context of delivering recovery support services and illustrate how this three-question model can be used to enhance decision making.

## ETHICAL ARENAS

Ethical issues can crop up in a number of arenas related to the delivery of peer-based recovery support services. In this section, we will present and discuss case vignettes to highlight such issues within five arenas: 1) service context, 2) personal conduct of the recovery coach, 3) conduct in service relationships, 4) conduct in relationships with other service providers, and 5) conduct in relationships with local recovery communities. The vignettes and discussion were developed in consultation with the PRO-ACT Ethics Workgroup and other organizations delivering recovery support services. The responses to the vignettes are not intended to generate rules for behavior; they are intended to convey the evolving sensitivities on key ethical issues within the growing recovery support services movement.

### SERVICE CONTEXT

Exploitation of Service Ethic: Agency ABC visibly promotes itself as providing peer-based recovery support services, but the agency's reputation is being hurt by key practice decisions.

- ABC hires people as recovery coaches who have minimal sobriety time.

*The legitimacy of each RC is derived from experiential knowledge and experiential expertise. Where there is little or no experience, there is no legitimacy. Recovery coaches should be hired only if they have established personal programs of recovery marked by duration and quality. Minimum recovery requirements for recovery coaches are currently ranging from one to two years, with many recovery coaches possessing more than five years of continuous recovery. This minimum requirement is for the protection of those receiving, and for the people and organizations providing, recovery support services.*

- ABC does little to orient, train, or supervise their recovery coaches.

*Failure to provide RCs with the needed orientation, training, and supervision affects their capabilities, their credibility, and the safety of both the RC and the person receiving recovery support services. The quality of screening, training, intense initial supervision, and ongoing supervision constitute the foundation for the delivery of effective and ethical recovery support services. The delivery of RC services, particularly volunteer-based RC services, requires more supervision than clinical services provided within an addiction treatment context, because non-clinical recovery support services often lack some of the mechanisms of protection built into the delivery of treatment services, e.g., prolonged training and credentialing, a formal informed consent process, and office-based service delivery. Developing clear policies governing the delivery of recovery support services, and establishing monitoring procedures to oversee the delivery of those services, also can help ensure that the delivery of RC services will be covered within the sponsoring organization's liability/malpractice insurance.*

- ABC pays recovery coaches a pittance while asking them to work excessive hours that often interfere with their own recovery support activities.

*This practice constitutes a form of financial exploitation of recovering people that contributes to RC burnout, high RC turnover, and erosion in the quality of recovery support services. Providing adequate support for volunteers, paying adequate salaries, offering advancement opportunities for RCs in paid roles, and setting limits on hours worked for both volunteers and paid support specialists are crucial steps in sustaining the quality of peer-based recovery support services.*

- ABC assigns volunteer recovery coaches to perform counselor functions, then bills for these services.

*This practice is a breach of ethical principles (honesty & fidelity), a breach of law, and a practice that violates the integrity of both the counselor role and the RC role. RCs are not cost-free labor; substantial expense should be incurred in the infrastructure to support volunteer recovery coaches via recruitment, screening, selection, orientation, ongoing training, ongoing supervision, and events celebrating the service work of RC volunteers.*

- ABC assigns recovery coaches to work in isolation, delivering home-based services in drug- and crime-saturated neighborhoods.

*RCs assigned to home-based services, particularly those delivering pre-treatment engagement and support (outreach) services, need elevated supports to counter the particular stressors inherent in this role. Such supports include special training related to safety management, team-based service delivery (co-coaching), technical supports (cell phones, two-way radios), neutral sites for meetings in high-risk neighborhoods, etc.*

- ABC uses recovery coaches almost exclusively to recruit clients into treatment.

*This practice, when it involves using the RC role to “fill beds” or outpatient “slots,” constitutes an exploitation of the RC role for the financial benefit of the organization. It reflects poor stewardship of the RC resource by displacing the recovery support needs of clients for the financial interests of the organization.*

**Screening Practices:** DEF is a grassroots recovery advocacy organization that provides recovery coaching services through a cadre of volunteers from the recovery community. Today, a man notorious for his predatory targeting of young women entering NA arrives at DEF announcing that he would like to volunteer as a recovery coach. How should DEF respond to this request?

*The screening of volunteers and staff for recovery support roles is designed in part to protect the hiring agency and its service constituents. This protection function must be ensured, and at the same time the agency must practice standards of fairness in its selection procedures, e.g., not excluding someone based only on second-hand gossip. Selection for RC roles is unique in that a past addiction-related felony conviction (followed by a long and stable recovery career) might be viewed as more a credential than grounds for disqualification. On the other hand, a history of and reputation for exploitive behavior within the recovery community might be grounds for disqualification. The purpose of such disqualification would be the protection of service recipients and the protection of the reputation of the recovery support organization, e.g., ensuring that people feel safe and comfortable seeking services at the organization. White and Sanders (2006) describe how the credential of experiential expertise is established:*

*Experiential expertise is granted through the community “wire” or “grapevine” (community story-telling) and bestows credibility that no university can grant. It is bestowed only on those who offer sustained living proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes not from their preparation but from their character, relationships, and performance within the community (White & Sanders, 2006, p. 69).*

*The community wire can withhold as well as bestow the credential of experiential expertise, and it can grant such expertise with conditions, e.g., using the individual in the above role as a closely supervised RC, but only with men.*

## PERSONAL/SERVICE CONDUCT

Self-Care: Jerome brings great passion to his role as an RC, but models very poor self-care. He is overweight, smokes excessively, and has chronic health conditions that he does not manage well. To what extent are these ethical issues related to his performance as a recovery coach? What is the nexus between such private behaviors and Jerome’s performance as an RC?

*Private behavior of the RC is just that—private, UNTIL there is an inextricable nexus (link) between private behavior and one’s performance as a RC. In this case, Jerome’s poor self-care does potentially impact his effectiveness as a RC. The expectation here is not one of perfection, but one of reasonable congruence between one’s espoused values and the life one is living. In this case, Jerome is modeling potentially lethal behaviors that those he coaches may well integrate into their own lifestyles, e.g., “It is okay for me to smoke because Jerome smokes.” Part of the job of the RC is to make recovery attractive—to make recovery as contagious as addiction in the local community. To become a recovery coach requires being, not only a face and voice of recovery, but also a person whose character and lifestyle others would choose to emulate. Our ability to achieve that is enhanced by self-care training that is built into the overall RC orientation and training program.*

Personal Impairment: Mary has functioned as an exceptional RC for the past two years, but she is currently going through a very difficult divorce. The strain of the divorce has resulted in sleep difficulties, a significant loss of weight, and concern by Mary about the stability of her sobriety and sanity. When do such events in our personal lives become professional practice issues? What should Mary and her supervisor do in response to these circumstances?

*Again, events in our personal lives are of concern when, and only when, they ripple into our performance in the service arena. All of us undergo developmental windows of vulnerability that require focused self-care and temporarily diminish our capacities for service to others. Mary and her supervisor need to consider what would be best for her, for those she coaches, and for the agency. One option is for Mary to decrease her hours or number of people served and to have increased supervisory or peer support (e.g., team coaching) for a period of time. Another option would be for Mary to take a sabbatical to focus on getting her own health back in order. For Mary to raise this issue in supervision is not something to be ashamed of, but the mark of service excellence—*



*making sure that our own periodic difficulties do not spill into the lives of those we are committed to helping.*

**Lapse:** Ricardo, who has worked as an RC for more than a year, experienced a short lapse while attending an out-of-town wedding. Because the lapse was of such short duration, Ricardo plans not to disclose the relapse to the organization through which he provides RC services. What ethical issues does this situation raise? What should Ricardo do? What should be the organization's/supervisor's response if this situation is brought to his or her attention? What organizational policies must be established to address the issue of lapse/relapse?

*There are several core values that apply to this situation, e.g., honesty, credibility, primacy of recovery. All of these values suggest a course of action that would begin with Ricardo's disclosure of the lapse to his supervisor and focusing on re-establishing the stability and quality of his personal recovery program. The organization should rigorously follow the guidelines/protocols it has established to respond to such an event. Options might include Ricardo's taking a break from his RC responsibilities, performing activities that do not involve direct coaching responsibilities, and later phasing back into RC responsibilities via co-coaching and more intensive supervision.*

**Personal Bias:** Zia has many assets that would qualify her as an excellent RC, but in interviewing her for an RC position, you are concerned about one potential problem. Zia passionately believes that AA's Twelve Step program is the ONLY viable framework of long-term addiction recovery, and she expresses considerable disdain for alternatives to AA. What ethical issues could arise if Zia brought her biases in this area into her functioning as an RC?

*The core value of tolerance asserts the legitimacy of and respect for diverse pathways and styles of long-term recovery. Bill Wilson (1944) was one of the first advocates of such diversity. If Zia cannot develop such tolerance, she may be better suited to the service role of sponsor within a Twelve Step program than to the role of an RC who works with multiple programs of recovery. The same principle would apply to those using recovery programs other than the Twelve Steps who believe there is only one true way to recovery, or who have antipathy toward one particular program. What we know from research on recovery is that ALL programs of recovery have optimal responders, partial responders, and non-responders (Morgenstern, Kahler, Frey, & Labouvie, 1996). Training and exposure to people in long-term recovery representing diverse recovery pathways can be used to promote tolerance for multiple pathways of recovery.*

**Pre-existing Relationships:** Barry's supervisor has assigned a new contact for Barry to visit in his RC role. Barry recognizes the name as a person to whom Barry once sold drugs in his earlier addicted life. Who might be harmed in this situation? What should Barry do? Does Barry have a responsibility to report this pre-existing relationship to the supervisor?

*Multiple parties may be at risk here: Barry, his contact, the contact's family, and Barry's agency. Barry should disclose the relationship and request another assignment. If the only alternatives are Barry or no services (e.g., a situation in which Barry might be the only recovery coach in the community), Barry and his supervisor should explore additional options or explore how they might ensure that these RC services are provided and still minimize harm to all parties. The most critical factor here is the need to maximize the comfort and safety of the individual/family receiving services. It is best if RCs are expected to declare immediately any pre-existing relationships with those to whom they have been assigned.*

Use of Information Across Roles: Rebecca is a natural listener. Everyone talks to her—in her RC role and outside her RC role. Rebecca is also very active in the local Twelve-Step community. Today, a person Rebecca is coaching mentions the name of a new boyfriend whom Rebecca recognizes as a man with whom one of her sponsees is involved. The relationship between the sponsee and this man has been a major source of sabotage to the sponsee's recovery, and the sponsee also contracted an STD from this man. Can Rebecca use information gained from roles in her personal life in her role as an RC? How should she handle this situation?

*This vignette generated considerable disagreement among the recovery support agency representatives who reviewed it. Opinions split into two camps. The first group suggested that Rebecca could, and had a duty to, disclose this information as long as it was judged to be reliable and as long as no anonymity was violated related to the disclosure. The other camp took the position that disclosing this information would violate AA etiquette ("What's said here, stays here"), that it was not Rebecca's role to disclose this information, and that Rebecca needed to stay supportive through whatever unfolded within this relationship. A good general guideline is: moving information from one role into another role (e.g., using information gained at a Twelve-Step meeting into one's RC activities) is fraught with potential harm and should be brought into supervisory discussion before such information is used in this manner.*

Advocacy: Many RCs are also involved in recovery advocacy activities in their local communities. Are there any situations that might arise in one's advocacy role that could conflict with one's role as an RC? Could any of these situations involve potential harm to others?

*This would depend on the nature of the recovery advocacy activities. There are many recovery coaches who are also very much involved in the new recovery advocacy movement who experience minimal conflict in these roles. Conflicts could arise if the recovery advocate/coach:*

- *used the RC context to zealously recruit those whom he or she coached into advocacy activities;*
- *used the RC role to push particular ideological propositions; or*
- *took such extreme, controversial positions that individuals and families were not comfortable having the individual serve as their RC.*

*Such potential conflicts are best processed with one's supervisor.*

Conflict of Interests: Raphael works as a recovery coach and also owns a recovery home. In his RC role, Raphael frequently encounters people who need sober housing. What ethical issues could arise from Raphael's referral of people to the recovery home that he owns? How might Raphael best handle any real or perceived conflicts of interest? What organizational policies address the issue of conflicts of interest?

*Referring clients to his own recovery home raises potential conflicts between the client's best interests and Raphael's own financial interests. Even the PERCEPTION of bias relating to this linkage process might injure Raphael's reputation as an RC and the reputation of the organization for which he is working. Raphael would be better advised to refer his clients to other recovery homes or to offer a list of all available resources*

*without any accompanying interventions that would direct individuals to his own facility. In addition, Raphael may want to assign a “manager” to do all screening for potential residents to his home, so that he not only doesn’t refer his own clients, but also doesn’t make decisions related to their entrance. At a minimum, Raphael will want to make sure that those he serves always have a choice of resource options and that he does nothing to steer people toward institutions in which he has a financial interest.*

**Role Integrity:** Marcella is in long-term recovery, works as a volunteer recovery coach, and also works full time as a certified addictions counselor. What problems might be posed by Marcella’s bringing the clinical orientation from her counselor role into her volunteer role as a recovery coach? How can the organization/supervisor help “counselors as peers” suspend their clinical orientation while they are functioning in their RC roles?

*The potential problems in this situation are numerous. First, if Marcella drifted into her counseling role while performing volunteer service, she would be providing counseling without the client protections and supports built into traditional treatment agencies, e.g., informed consent, legal confidentiality, clinical documentation, clinical supervision, and agency liability insurance. Assuming Marcella’s client is still in treatment, the therapy Marcella provides may be counterproductive to the therapy the client is already receiving. And perhaps most important: during the time in which Marcella is doing counseling, the client is not receiving needed recovery support services.*

**Compassion Fatigue:** Elizabeth has volunteered as an RC for the past 2½ years, supporting the recovery processes of individuals with very severe, complex, and long-term substance use disorders. In recent months, she has noticed that she is bringing less energy and enthusiasm to her volunteer work and is dreading seeing some of those with the greatest needs. How should Elizabeth respond to this diminished motivation for recovery coaching?

*The danger here is a process of emotional and physical disengagement that could do a great disservice to those in need of recovery support services. Elizabeth is exhibiting signs of burnout, which must be acknowledged and addressed in supervision. Elizabeth may need a break in her coaching activities, might consider reducing her hours, might need to work with people who have lower levels of problem severity for a while, or might want to consider co-coaching for a period of time. It might also be a good time for Elizabeth to refresh her stress-management skills via training or her own personal coaching. Those volunteering as recovery coaches need the option of taking sabbaticals from this service work, but they also have a responsibility to recognize this need early enough to plan an orderly transition or termination process for those with whom they are working. Both precipitous disengagement and a failure to disengage when disengagement is indicated present potentials for harm to those receiving recovery support services.*

## CONDUCT IN SERVICE RELATIONSHIPS

**Choice/Autonomy:** Charise works as a recovery coach in a women’s program that is known for its assertive—some would say aggressive—style of outreach to women referred from the child welfare system. The women Charise attempts to engage in treatment and recovery support services are very ambivalent in the early stages of engagement—not wanting to see her one day, thrilled to see her the next. The questions are: “When does ‘NO’ really mean ‘No’?” What

is the line between assertive outreach and stalking? How do we reconcile a person's right to choose with the knowledge that volitional will is compromised, if not destroyed, through the process of addiction?

*The ethical tension here is between the values of autonomy and choice versus paternalism and outright domination. What complicates any resolution of this tension is the fact that we are working with people who by the definition of their illness (addiction) have compromised capacities for free choice, leaving the RC questioning whose free choice they should listen to—Dr. Jekyll's or Mr Hyde's. In short, what do we do with someone who one moment wants recovery and the next minute wants to get high? The answer is that we recognize that addiction is a disease of the will and that recovery involves a progressive rehabilitation of the will. The RC's job—particularly in the outreach function—is to jumpstart motivation for recovery where little exists, and to guide people through the early stages of recovery until they can make choices that support their own best interests. At a practical level, this means that “no” (“I don't want you to contact me anymore”) has to be said several times to different people on different days before we give up on someone (for the time being). If after a reasonable period of time, the answer is still “no,” then we disengage with the assurance that we will be available in the future if the person should CHOOSE to call us. The proposition that recovery is voluntary means, not only the freedom to choose different pathways of recovery, but also the freedom to choose not to recover.*

Choice/Autonomy: Roberto has been assigned as a recovery coach for Oscar, but four weeks into this process, Oscar requests a change in recovery coaches on the grounds that he is having difficulty relating to Roberto. Do those receiving RC services have the right to select their own recovery coach?

*Mismatches in the assignment of recovery coaches are inevitable, just as mismatches occur in the assignment of counselors. A match between a recovery coach and someone whom he or she serves may be even more important because of the increased time spent together and the potential duration of the relationship. The occasional mismatch is best acknowledged early and resolved either through alterations in coaching style or through reassignment to a new recovery coach. The affects of recovery coaching result from personal influence, not from any power or authority ascribed to the role. An essential principle of peer-based recovery support services is that those receiving the service ultimately get to define who qualifies as a “peer.” Evaluating and resolving potential mismatches is an integral part of good supervision. It is also important that RCs be supported through these situations.*

Emotional Exploitation: John is a highly sought-out RC. He is charismatic and unrelenting in his support activities. As his supervisor, you have one area of concern about John: he is emotionally possessive of those he works with, hypercritical of other service providers who don't live up to his standards, and competitive with the sponsors of those he coaches. Many of those John serves do very well in their recovery, but they seem to see the source of their recovery as John more than a program of recovery. You are troubled that those John works with seem to have developed an excessive emotional dependency in their relationship with him. What ethical issues are raised by this situation?

*There are several core values that apply to this situation, e.g., humility, respect, tolerance, autonomy, capability. The style described above, by cultivating dependence and emotionally rewarding crises, actually weakens people's future capacity for self-*

*sustained recovery. Those served end up feeling progressively better about John, but worse about themselves. Such a style may meet John's needs, but it ill serves those he coaches. Such styles harm clients, overshadow other RCs who may be doing much more effective service work, and often end up harming the community agency's credibility in the long run. A degree of dependence is normal early in the RC relationship, but such dependence is best transferred to the development of a larger and more sustainable sobriety-based support network.*

**Friendship:** Raymond volunteers as a recovery coach for a recovery community organization (a freestanding organization, unaffiliated with any treatment organization, that provides recovery support services). Raymond shares a lot in common with Barry, a person to whom Raymond has been assigned to serve as a recovery coach. Over a period of months, Raymond and Barry have developed quite a friendship and now share some social activities (e.g., fishing) beyond the hours in which Raymond serves as Barry's recovery coach. Are there any ethical issues raised by this friendship?

*Friendships may develop within the context of recovery coaching, but there is one thing that distinguishes the recovery coach relationship from other social relationships, and that is the service dimension of that relationship. This means that recovery coaching relationships are not fully reciprocal, whereas friendships are. The RC has pledged that the focus of the RC relationship is on the needs of the person being coached. In that light, ethical problems could arise if: 1) the friendship were initiated by Raymond to meet his needs and not Barry's needs, 2) problems in the friendship interfered with Raymond's ability to provide effective coaching services, or 3) the friendship with Raymond prevented Barry from developing other sobriety-supportive relationships within the recovery community and the larger community. RC relationships will, by definition, be less hierarchical and more reciprocal than will relationships between an addiction counselor and his or her client. It's not that one boundary demarcation is right and the other is wrong; what is important is that boundaries are maintained that are role-appropriate. In other arenas of peer-based services, their effectiveness has been attributed in great part to the lack of professional detachment and distance (Fox & Hilton, 1994). Where a developing friendship is getting in the way of effective RC services, it is the responsibility of the RC to raise this concern with his or her supervisor, and possibly to review this situation with the RC, the supervisor, and the client. One potential option is to assign and transition the client to another RC, to avoid potential problems stemming from the dual relationship.*

**Sexual Exploitation:** You supervise recovery coaches for a local recovery advocacy and support organization. It comes to your attention that Joshua, one of your RCs, is sexually involved with a person to whom he is delivering recovery support services. What are the ethical issues involved in this situation? How would these issues differ depending on: 1) age or degree of impairment of the person receiving services? 2) whether this was a person currently receiving or a person who had previously received recovery support services? 3) the time that had passed since the service relationship was terminated? Would you view this situation differently if the relationship were not with the primary "client" but with a family member or friend who was involved in the service process? Could the recovery coach or the agency face any regulatory or legal liabilities related to this relationship?

*The RC service relationship is not a relationship of equal power. The vulnerability of those seeking RC services and the power of the RC role offer situations in which an RC might exploit service relationships for his or her personal, emotional, sexual, or financial*

gain. It is that power discrepancy that makes intimate relationships between RCs and those with whom they work with ethically inappropriate. The harm that can come from such relationships spans injury to the person/family being served (emotional trauma, severance of services, resistance to seeking future services), injury to the reputation of the RC, and damage to the reputation and financial solvency of the service organization (via litigation against the organization for improper hiring, training, supervision, etc.). The prohibition against an intimate relationship between an RC and service recipient also extends to members of the service recipient's family and intimate social network who are involved in the service process. As for relationships with people who previously received RC services, agencies are defining a period of time (mostly in the two-year range) in which such relationships would still be improper. The key here is to evaluate situations that might arise based on the issue of exploitive intent. For example, an RC might be involved with an individual he or she met within the recovery community who he or she discovers once received RC services from the RC's organization. The RC did not work at the organization at the time, never served as the person's RC, had no knowledge of the person's status as a service recipient, and did not use the influence of his or her RC role and organizational affiliation to initiate the intimate relationship. In short, there was no exploitive intent.

**Financial Exploitation:** Alisha is providing RC services to a very socially prominent and wealthy individual and his family. She has repeatedly turned down the family's offers of money for her services and communicated that her services are provided through a federal grant and are available to all local citizens without charge. It has casually come up in conversations that Alisha is saving money to begin taking courses at the local community college. When Alisha arrives for her visit today, the family announces that they have discussed it among themselves and that they want to pay Alisha's tuition to return to college. What should Alisha consider in her response to this offer?

*Money changes relationships. Accepting this gracious offer would threaten the integrity of the coaching relationship. Alisha should express her appreciation for the family's offer, but explain that she must decline because acceptance of this gift while the recovery coaching is in process could affect that relationship. The family's feelings can be further protected if Alisha can inform them that there is an agency policy that prevents any RC from accepting any gifts of substantial value. The situation might be viewed differently if some time after the service relationship was ended, the same family wanted to donate money to Alisha's education or to the service organization. The key here is that the vulnerability or gratitude of the family is not used in an exploitive manner. All offers of gifts to an RC during or following a service relationship should be discussed with the supervisor.*

**Gifts:** Marie works as an RC in an addiction treatment unit within a local community hospital. Her job is to provide recovery support services to those discharged from addiction treatment. She serves a predominately Native American population and conducts most of her work via home visits on two reservations. When she arrives for one of her visits today, the family she is visiting presents her with an elaborate, culturally appropriate gift as a token of their appreciation for her support. The problem is that Marie works in a hospital whose personnel code prohibits any staff member from accepting a personal gift. Marie is concerned about the consequences of accepting the gift, but is also concerned that refusal of the gift could harm her relationship with the family and the tribe. What are the ethical issues here? What should Marie do?

*Ethical decision-making must be culturally grounded. What this means is that the pros and cons of any action must be evaluated in the cultural context in which it occurs. What might be unethical in one cultural context (e.g., accepting a gift) might in another be, not only ethical, but also essential in maintaining the service relationship. In this case, Mary could accept the gift in the name of the hospital, protecting herself from the hospital policy and leaving the RC relationship intact. Mary could report the gift to her supervisor and display the gift in a common area of the hospital for all to enjoy. What would be equally appropriate would be for Mary to raise the broader issue of the need for more flexible interpretations of this particular policy when working in this tribal context. Ironically, a policy designed to protect patients might actually result in injury to patients, severance of the service relationship, and damage to the reputation of the service institution. RCs working across cultural contexts need policy flexibility and good supervision to protect the service relationship.*

**Boundaries of Competence:** During a visit today with Camella, a person you are coaching, she asks you what you think about the effects of anti-depressant medications on recovery from alcoholism. She is clearly ambivalent about the medication she is being prescribed, and your first inclination is to tell her to forget the medication and get to more meetings. What are the ethical issues in this situation? How would you respond?

*It is quite appropriate for the RC to listen to Camella's concerns about her medication, encourage her to talk to her physician about these concerns, and link her to resources to get additional information about recovery and anti-depressant medications. It is not appropriate for the RC to offer his or her opinion or advice about any prescribed medication. To do so would be to move beyond the boundaries of the RC's education, training, and experience. Even if the RC were a physician volunteer, his or her responsibility in the RC role would be to link Camella to medical resources she could consult about this question, rather than to provide that information directly. Under no circumstance should an RC ever advise anyone to stop taking a prescribed medication. If the RC has concerns about the effects of particular medications on Camella's recovery (e.g., prescribed sedatives or narcotic analgesics), the RC's role is to link Camella to someone with expertise, e.g., a physician trained in addiction medicine, to discuss these issues.*

**When to Refer:** Martha has attempted to engage Rita in the recovery coaching process for the past five weeks, but the chemistry between the two of them seems to have gone from bad to worse. All efforts to work through these difficulties in supervision have failed to improve the situation. At what point should Martha acknowledge this situation to her supervisor and Rita and seek to have another recovery coach assigned to Rita?

*The value of honesty dictates that Martha acknowledge to Rita and to Martha's supervisor her concerns about the relationship difficulties, and that she raise the question of whether or not Rita would be better served with a new RC. She should raise this question with the supervisor, and if efforts to improve the relationship fail, then a meeting between Martha, Rita, and the supervisor may be in order. The agenda is to avoid harm to Rita from a relationship mismatch, to establish an effective coaching relationship, but to also avoid any feelings of abandonment that Rita might experience by the suggestion of a new RC.*

**Discretion:** Maria serves as an RC for women and their families who are participating in a local women's treatment program. Maria frequently hears from those she coaches, "I want to tell you

something, but you can't tell my family" or "I want to tell you something important about Jennifer, but I don't want you to tell her I told you." What ethical issues are raised when the RC is placed in the middle of these types of communications? How should Maria handle such communications?

*It is essential to establish communication ground-rules at the beginning of the RC relationship. The values of discretion, respect, and fidelity demand that the RC not disclose information beyond the established ground-rules. Those ground-rules include review of circumstances in which disclosures will be made, e.g., supervision, medical emergencies, or imminent threat of harm to self or others. Before deciding whether or not to agree to the requested promises described above, Maria should again review those communication ground-rules and the disclosure exceptions.*

**Discretion versus Duty to Report:** A person for whom you are serving as recovery coach discloses to you that he has been using during the past week with another person who lives with him in a local recovery home. The disclosure makes it clear that the other person provides the drugs used and may be dealing in the home and in the larger community. Further complicating the situation is the fact that the owner of the recovery home is a member of your board of directors. Do you have an ethical responsibility to protect this disclosure or to report the content of the disclosure to the house manager or the owner of the recovery home? Would a recovery coach have a similar obligation to report the presence of a "script doctor" who was pumping massive quantities of prescription opiates into the community—when the source of that information was one of those he or she was coaching?

*Such information could not be ethically reported without permission for such disclosure. In both cases, the RC could discuss with the disclosing individual whether or not that individual thought the information should be conveyed to responsible authorities, if the individual was comfortable making such a report, or if he or she would want the RC to make such a report without disclosing his or her identity as the source. Using this process would address the threat to the recovery home environment or the community without violating the promise of confidentiality.*

**Threat to Community:** When you arrive for a home visit with Joe Martin, a person you are coaching, you find him intoxicated. Joe says he can't talk to you right now because he has to return to the bar he just left to pay off a debt. Joe has his car keys in his hand. What do you do?

*Use all of your persuasion skills to keep Joe out of the car. Ask Joe to give you the car keys, and let him know that, if he gets in the car, you will have no recourse but to call the police. If he gets in his car and drives away, call the police, informing them that you observed an intoxicated man by the name of Joe Martin getting into a car, and provide the vehicle description and location. Do not identify yourself in your service role, and do not identify Joe as a service recipient of the organization. The challenge here is to address the threat to public safety without disclosing Joe's status as a service recipient.*

**Personal Bias:** Fred has worked hard to educate himself about medication-assisted recovery since he was first hired as an RC, but he still has very negative feelings about methadone in spite of the research literature he has read about it. It's not a "head thing"; it's a "gut thing." Marcy, another RC, has similarly negative feelings about explicitly religious pathways of recovery because of the number of people she has known in AA for whom religion alone did not work as a framework for recovery. Describe how the personal biases of the RC might result in



harm or injury to multiple parties, and how that harm might be avoided. For example, how might Fred separate the scientific facts about methadone from his feelings (opinions) about methadone?

*As individuals, we may have all manner of biases about different addiction treatments, but in the RC role, we have a responsibility to outline the choices available to those we serve as objectively as possible and support each person's choice of the option that seems best for him or her at this moment. Discouragement of a particular method of treatment may prevent a client from getting the "one" treatment method that might be most successful. Fred and Mary should continue to acknowledge and discuss their biases with their supervisor. Fred and Mary may not need more information and training on alternative treatments and pathways to recovery as much as they need direct contact with people who have successfully used these methods to achieve long-term recovery. As experiential learners, many RCs won't credit the research findings until they experience this evidence face-to-face.*

## CONDUCT IN RELATIONSHIPS WITH OTHER SERVICE PROVIDERS

Responding to Unethical Conduct: Susan, a person for whom you have been serving as an RC for the past month, discloses to you today that she is in a sexual relationship with the counselor she is seeing at a local addiction treatment agency. The counselor is a very prominent person in the local recovery community and is very active in the state addiction counseling association. What ethical issues does this situation present? How would you respond?

*This situation raises several needs. The first is to acknowledge to Susan that such a relationship is a breach of the counselor's professional ethics, and to ask if she wants a referral to a different treatment agency, and if she wants to file a formal complaint with the state counselor certification board or seek other legal redress. Linking Susan to such resources would be a natural RC function, as would supporting Susan through this process. Depending on the policies of your agency, you may also let Susan know that you will need to report this disclosure to your supervisor, who may also be bound to report it to the state certification board, either with Susan's name or without it. All reports of ethical breaches by other service professionals in the community that come to the RC's attention should be communicated to the RC's supervisor.*

Representation of Credentials (Example 1): Samuel works as a recovery coach, doing post-treatment telephone monitoring. In his interactions with the larger community, Samuel has represented that he is working as a "counselor." He also makes periodic mention of his plans to "get back" to graduate school," but Samuel has only completed two years of college and has not been in school for more than ten years. What ethical issues does this situation raise?

*The values of honesty and credibility call upon the RC to accurately represent his or her education, training, and experience. The supervisor should acknowledge that he or she has heard the above reports and emphasize why it is important that, if the reports are true, these communications stop and be replaced with an accurate description of Samuel's role and educational credentials. This might well be accompanied by a broader discussion of how RCs establish credibility and legitimacy within the larger service community.*

**Representation of Credentials (Example 2):** Would you view Samuel's situation any differently if he accurately represented his role and education, but misrepresented the length of his own recovery and his degree of current involvement in AA, NA, or another recovery mutual aid group?

*No, both would undermine his capability and credibility as an RC. The value of authenticity of voice is paramount here. The following guideline is recommended: "Filter decisions related to disclosure of your ATOD use history, your recovery status, and your pathway(s) of recovery initiation and maintenance through the values of honesty (tell the truth); discretion (protect your privacy); and, for those in Twelve Step recovery, the tradition of anonymity at the level of press" (White, 2006b).*

**Role Clarity/Integrity:** George has worked as Larry's RC for the past two months. Today, Larry asks George if George would be his NA sponsor. George has a long history in NA and a long history of sponsorship activities, but agreeing to this arrangement would mean that he would be both Larry's RC and his sponsor. What harm and injury (if any) might result from such a dual relationship, and who might be harmed?

*Failure to maintain boundary separation between the roles of RC and sponsor might harm Larry, George, others receiving RC services, the relationship between George's organization and the local recovery community, and the larger community. The effect of dual relationships is often to "water down" both relationships. Here are some suggested operating principles (Excerpted from White, 2006c).*

- 1. Performing sponsorship functions (e.g., making a Twelve Step call as an AA member, meeting with sponsees) on time in which one is working as an RC is a violation of Twelve-Step Traditions and professionally inappropriate (beyond the scope of most agencies' RC job descriptions and explicitly prohibited in many).*
- 2. Performing sponsorship functions through the RC role could weaken local sponsorship practices and diminish community recovery support resources, by replacing such natural support with the formal support of local treatment agencies.*
- 3. Seeking reimbursement for sponsorship functions performed by a recovery coach is, at best, a poor stewardship of community resources and, at worst, fraud.*
- 4. Role ambiguity and conflict resulting from the mixing of sponsorship and RC functions might inflict injury on clients/families, service workers, service agencies, and the community.*
- 5. The RC role represents a form of connective tissue between professional systems of care and indigenous communities of recovery, and between professional helpers and sponsors. When those filling this role abandon this middle ground and move too far in one direction or the other, that connecting function is lost.*

## CONDUCT IN RELATIONSHIPS WITH LOCAL COMMUNITIES OF RECOVERY

**Role Clarity/Integrity:** George, who is a salaried RC, has a practice of linking those he coaches to recovery communities by taking them to, and participating with them in, particular recovery support meetings. A complaint has come to the agency about George's "getting paid" for the time he is in meetings, with the charge that this constitutes accepting money for Twelve-Step work. What are the ethical issues here? How might George more clearly delineate his paid activity from his NA service work?

*The values of stewardship require that the RC carefully allocate his or her time. George should be careful to separate RC hours from hours spent in recovery support meetings so as not to receive payment for meeting time. The RC function stops at the doorway of recovery support meetings: George should introduce his client to other recovery support group members and “hand him off” for Twelve Stepping.*

**Discretion (Example 1):** You are working as a recovery coach attached to a treatment agency. You take an assigned client, Troy, to a local recovery support meeting, and you stay for the meeting. At the meeting, Troy discloses information that he has not told his counselor at the treatment program. Is this information you have heard considered confidential, or do you have an obligation to report it to the counselor?

*The information disclosed at the meeting may not be revealed outside the meeting. To do so would violate recovery mutual-aid values and place the RC in the role of “undercover agent” at such meetings. You can encourage Troy to take the information to his counselor. This is another example of the strong need for ongoing supervision and support to help the RC deal with complex issues regarding his or her role.*

**Discretion (Example 2):** Claude has been in and out of treatment and NA multiple times and has an off-and-on-again relationship with you as a recovery coach. Today you run into Rudy, one of Claude’s former NA sponsors with whom you collaborated, in the mall. Rudy’s first comment to you is, “How’s our boy doing?” How do you respond? Would this be an appropriate disclosure or simply gossip? Do the confidentiality guidelines that cover treatment relationships (and which would prohibit any disclosure in answer to Rudy’s question) extend to the recovery coach relationship?

*If you are in an organization covered by federal confidentiality regulations (e.g., a treatment agency), you may not respond to that question, or even acknowledge that Claude is a client at your organization, unless you have a release signed by Claude specifying that you may speak to Rudy about him. If you are in an organization not covered by federal confidentiality regulations (e.g., a free-standing recovery support organization, a recovery ministry within a church), your response should be guided both by your organization’s policies on confidentiality and discretion and by the agreement about permitted disclosures of communications that you negotiated with Claude at the beginning of the RC relationship. The key thing here is the value of fidelity: to keep our promises.*

**Anonymity:** Ernest is a long-time AA member, recovery advocate, and recently hired recovery coach. In his earlier recovery advocacy work, Ernest has always been very careful in identifying himself publicly as a “person in long-term recovery,” without noting his AA affiliation. Today, Ernest is on a panel at a local social service conference to talk about the pilot recovery coaching project in which he works. The conference is being covered by local media, who ask to interview Ernest after the panel. One of the reporters follows up Ernest’s report of his recovery status and its duration with the question, “Are you a member of AA?” What are the ethical issues involved in this situation? How should Ernest respond? How would this be different if Ernest was in an alternative recovery support group that did not have a tradition of anonymity?

*Ernest should NOT disclose his membership in AA. This would violate AA's anonymity tradition and might be viewed as a personal endorsement of a particular mutual-aid group. Such a disclosure and the potential controversy spawned by it could interfere with Ernest's service relationships, isolate Ernest from the local AA community, and harm the relationship between Ernest's organization and the local AA community. If Ernest were not in AA or another Twelve Step program, there would be no explicit anonymity guideline, but Ernest would still need to be cautious in any disclosures at the level of press.*

**Predatory Behavior:** Felicia works as a recovery coach for women who are just entering intensive outpatient treatment and living in a women's recovery home. One of Felicia's responsibilities includes linking these women to local recovery mutual-aid meetings. Many of the women Felicia works with have histories of sexual victimization as well as long histories of toxic intimate relationships. Felicia is aware that predatory behavior ("Thirteenth Stepping") is common in some local recovery meetings. To what extent is Felicia responsible for preparing the women she refers for such behavior or protecting them by linking them to meetings with a strong group conscience?

*Felicia needs to honor the potential of her clients to be harmed in groups with little "group conscience." She should assist her clients in finding meetings with a "climate" that is safe and supportive.*

**Potential Iatrogenic Effects of Recovery Coaching:** Ellen, a highly respected elder in the local AA community, is expressing criticism of recovery coaches and the broader recovery support services offered by a local recovery advocacy agency. It is Ellen's position that such roles and services will undermine the importance of sponsorship and weaken the service ethic within the local recovery community. How do you respond?

*Ellen should be invited to discuss her views on recovery coaching and shown the statistics and local experience related to the role of recovery coaching in successful long-term recovery. You should also solicit ideas from Ellen about how the recovery coach's role might be designed and supervised to ensure that it enhances rather than undermines the service ethic within the local AA community.*

**Role Integrity:** Mel is an elder statesman in AA who offers to volunteer as a recovery coach. Mel's orientation to coaching is to do what he does as a sponsor: help people work the steps and develop a life of sobriety and serenity. What harm, if any, could come from this merger of the sponsor and recovery coach roles?

*The primary harm in this merger of RC and sponsor roles would come from the broader recovery-support needs (e.g., sober housing, medical needs, transportation, day care) that would be addressed in the fully developed RC role but not addressed in the RC-as-sponsor role. Harm to the client could also result from the confusion between the RC and sponsor roles.*

## SUMMARY

This essay has described a model of ethical decision making for recovery coaches and their supervisors and identified some of the emerging ethical issues in the delivery of peer-based

recovery support services. Ethical sensitivities and approaches to ethical decision making will continue to evolve as recovery support services become more formalized and the collective experience of recovery coaches and their sponsoring organizations grows. This growing foundation of experience will spawn formal ethical guidelines for recovery coaches and more formal approaches to ethical decision-making. PRO-ACT has created a peer services ethics advisory panel and a set of ethical guidelines for its peer specialists that we expect will become more refined in the coming years. We have included a description of the advisory panel and these guidelines as appendices to this paper.

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## APPENDICES

- A. Ethical Decision-making Worksheet
- B. PRO-ACT Peer Specialist Code of Ethics
- C. "The Law and Peer-Based Recovery Support Services," Prepared by Renée Popovits and Elizabeth Donohue

ETHICAL DECISION-MAKING WORKSHEET

**Step One:** Who is vulnerable to harm in this situation, and what is the potential degree of such harm?

Vulnerable Party	Significant Risk of Harm ( ✓ )	Moderate Risk of Harm ( ✓ )	Minimal Risk of Harm ( ✓ )
Individual/Family Being Served			
Recovery Coach			
Service Organization			
Recovery Support Services Field			
Image of Recovery Community			
Community at Large			

**Step Two:** What core recovery values apply to this situation, and what action would they suggest be taken?

✓	Core Recovery Value	Suggested Course of Action
	Gratitude & Service	
	Recovery	
	Use of Self	
	Capability	
	Honesty	
	Authenticity of Voice	
	Credibility	
	Fidelity	
	Humility	
	Loyalty	
	Hope	
	Dignity and Respect	
	Tolerance	
	Autonomy & Choice	
	Discretion	
	Protection	
	Advocacy	
	Stewardship	

**Step Three:** What laws, standards or historical practices might guide your conduct in this situation?

**Step Four:** Where risk of injury is great to multiple parties, document:

- What you considered:
- Who you consulted:
- What you decided and did:
- The outcome of the decisions you made and actions you took:



## **Preamble**

PRO-ACT acknowledges its duty and obligation to those individuals, families, and communities it serves to assure the delivery of peer support according to recovery-focused guidelines, principles and values. Toward that end, we have: **1)** defined a code of conduct within a value-driven decision-making process that will guide delivery of our services and our service relationships; **2)** developed a Peer Specialist Review Panel; **3)** established ethical guidelines for the delivery of peer-based recovery support services provided through PRO-ACT; and **4)** outlined the process for recruiting and screening of potential peer specialists, training requirements both initial and ongoing, ongoing support, and supervision.

## **Value Oriented Decision-making Process**

All PRO-ACT staff and volunteers shall follow the recovery guidelines and principles when making decisions involving complex choices, choices in which one or more parties could be injured by what we do or fail to do. They will develop the ability to recognize an ethical dilemma using the PRO-ACT decision-making questions to clarify their choices.

- 1.) Recognize when a situation arises that is a value-related issue.
- 2.) Use the PRO-ACT value-driven decision-making questions to clarify your choices.
- 3.) Seek consultation from supervisor and consider guidance from the Peer Specialist Panel to make the best possible decision.
- 4.) Communicate what you did, your rationale for what you did, and the outcome of the decision to your supervisor for purposes of review and documentation.
- 5.) Debrief the experience with others at PRO-ACT to enhance the sensitivities and ethical decision-making abilities of others.

## **Principle Decision-making Questions**

All PRO-ACT staff and volunteers shall answer three questions as part of their process of ethical decision-making:

- 1) Who has the potential of being harmed in this situation and how great is the risk for harm?
- 2) Are there any core recovery values that apply to this situation and what course of action would these values suggest be taken?

\*In this document the titles Recovery Mentor, Peer Specialist, and Recovery Coach are interchangeable. For brevity, the Peer Specialist terminology will be utilized.

- 3) What laws, organizational policies, or ethical standards apply to this situation, and what actions would they suggest or dictate?

### **Peer Specialist Panel**

The Peer Specialist Panel consists of three to five individuals who volunteer their talents and time to assist PRO-ACT in analyzing and responding to complex value-related questions or dilemmas. This committee/panel will be made up of individuals in long-term recovery (with more than four years continuous recovery) who are widely known in the recovery community for their personal integrity, who can analyze and respond to complex principle dilemmas, and offer guidance in a timely and consistent manner when complex value issues arise.

Each panel member serves a yearly term that may be extended by mutual agreement between each panel member and PRO-ACT. The Panel must meet on a routine basis to set up their operational guidelines and to also be available in a timely fashion to respond to Peer Specialist complex principle or guideline dilemmas.

The Peer Specialist Review Panel will have input into the continuing education and training requirements of peer specialists based in part on the principle and guideline dilemmas that are presented to assure a continuous learning process is available for all parties.

All proceedings of the Peer Specialist Panel shall be recorded by the chair of the panel, and records of these meetings shall be kept for at least five years in confidential locked files.

### **Process for Recruiting, Screening, Training, and Supervision needs of Peer Specialists**

PRO-ACT will use non discriminatory practices to recruit members of the Recovery Community representing a broad spectrum of recovery pathways. PRO-ACT will screen all applicants in order to assure the safety of all involved. All Peer Specialists and their supervisors are required to attend initial and ongoing trainings to enhance their job performance. PRO-ACT will develop trainings to enhance the various skills required, and will also focus on creating trainings to enhance Peer Specialists' cultural sensitivity and other issues of importance to the Recovery Community. PRO-ACT will provide opportunities to share and discuss complex principle or guideline dilemmas.

### **PRO-ACT Principles and Guidelines for Peer Specialists**

As a Peer Specialist, I understand that my sole mission is to help individuals and families recover from addiction and its related problems. To that end, I will help remove or overcome all obstacles to recovery and help each individual and family find resources within and beyond themselves to both initiate and sustain the recovery process. My actions will be guided by the following core recovery values and service guidelines.

#### **Gratitude & Service**

I understand that my service to others is a sacred trust and that my actions flow from myself, from PRO-ACT, and from the larger recovery community. I offer my experience, strength, and hope to assist others in recovery out of gratitude to those who assisted me in my recovery.

**Personal Recovery**

I will work on my recovery so that I may be beneficial to those who depend on me for recovery support.

**Face and Voice of Recovery**

I will be a good example of recovery for those I serve.

**Self-Improvement**

I will foster self-improvement.

**Honesty**

I will tell the truth and when wrong, I will promptly admit it.

**Authenticity**

I will carry the recovery message in word and in deed.

**Keeping Promises**

I promise to keep my promises.

**Humility**

I will work within my limitations, handle disagreements respectfully, and seek help when I need it.

**Loyalty**

I will serve others as others served me and promote the recovery mission of PRO-ACT.

**Hope**

I will help others focus on their assets, strengths, and recovery possibilities.

**Respect**

I will honor the imperfections of others and myself and treat those seeking recovery with dignity.

**Acceptance**

I accept all pathways to recovery however diverse, even those opposite my own.

## **Recovery Integrity**

I can carry the message, but I cannot carry the person. I help others by empowering the recovery of others.

## **Protection**

I do no harm by respecting privacy and refraining from gossip. I avoid all forms of exploitation or harassment of those I serve. Our relationship is a sanctuary of safety.

## **Advocacy**

I confront injustice when necessary on behalf of those who have not been empowered but never do for others what they can do for themselves.

## **Stewardship**

I use or create resources in the wisest way possible to provide benefits others need to achieve recovery.

*Prepared by Renée Popovits and Elizabeth Donohue*

## **Overview**

While the peer-based recovery support services trend within the addiction treatment community is not new, these services have rapidly expanded in recent years under various names, such as recovery coaches, recovery mentors, and peer specialists. Furthermore, these roles do not fit neatly within the “traditional” addiction treatment field, and little guidance can be found concerning the complex ethical and legal issues that arise when providing peer recovery support services.

Since this is uncharted territory, we have created this Addendum with the goal of providing a brief analysis of some common legal issues that addiction treatment providers address daily, and how these issues may or may not affect those providing peer recovery support services. Specifically, this article addresses the following issues:

- The application of 42 C.F.R. Part 2
- The application of the Health Insurance Portability and Accountability Act (HIPAA)
- Mandatory Child Abuse Reporting
- Informed Consent
- Organizational Liability

## **Federal Confidentiality Considerations**

Confidentiality protections exist to encourage people to seek treatment for addiction to alcohol or other drugs or a mental illness. Mental health confidentiality is generally governed by state law as well as the federal HIPAA Privacy Standards. On the other hand, addiction treatment programs meeting certain criteria are governed by very stringent federal regulations (42 C.F.R. Part 2), which, in most cases, are far more protective of patient confidentiality than the HIPAA Privacy Standards.

Several providers furnishing recovery support services have questioned whether 42 C.F.R. Part 2 (“Part 2”) applies to such services. To assist in determining the applicability of Part 2 to recovery support services, this article includes a decision-making diagram, contained in Exhibit A. The key questions a recovery support provider needs to consider are:

- Is the service a federally assisted “program” or part of a program within the meaning of Part 2?
- Is the service rendered by an employee or a volunteer of a “program”?
- Has a “program” contracted with a Recovery Support Specialist to render services as part of its continuing care?
- Is the person to whom you are providing recovery support services a “patient” within the meaning of Part 2?

- What are the services furnished by the Recovery Support Specialist, and are these services covered by Part 2?
- Do you receive or have access to “patient identifying information” protected by Part 2?

These questions are explored more fully below.

### **Are You a Federally Assisted Program?**

The first legal consideration is the obligation to comply with the confidentiality restrictions imposed under federal law and regulations (42 U.S.C 290dd and 42 C.F.R. Part 2, respectively). The federal regulations prohibit “federally assisted substance abuse treatment programs” from communicating patient identifying information unless the regulations expressly authorize such disclosures for the purpose of treating substance use disorders, making a diagnosis for that treatment, or making a referral. A “federally assisted substance abuse program” is defined as an addiction treatment program that is:

1. Conducted in whole or in part by any department or agency of the United States;
2. Carried out under a license, certification, or registration or other authorization including certification under the Medicare program; authorization to conduct methadone maintenance treatment; or registration to dispense a substance under the Controlled Substances Act, to the extent that the controlled substance is used in the treatment of addiction;
3. Supported by funds provided by any department or agency of the United States, including receipt of Federal financial assistance in any form, including assistance from the State or a local government unit which in turn receives Federal funds that could be used for addiction treatment; or
4. An IRS tax-exempt entity.

Federally assisted programs, as used in Part 2, include programs funded by the federal government, as well as programs conducted under a license, certification, registration, or other authorization granted by any federal department or agency, including Medicare certification or authorization to conduct methadone maintenance treatment. Federal assistance also includes tax exemption granted by the IRS. Even if the program does not meet the definition of a federally assisted program, state law or state licensure regulations may require adherence to Part 2. This is because states can impose the same or more stringent requirements than Part 2. For instance, in Illinois, recovery homes have to comply with Part 2 via the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse licensure regulations. If this State licensure mandate did not exist, recovery homes would not be subject to Part 2 because they do not provide treatment services within the meaning of Part 2.

## **Are You An Employee of a Federally Assisted Program?**

If the program meets the definition of a “federally assisted substance abuse program,” then individuals who are providing peer recovery support services through the covered program must also decide whether they would be considered employees of the program for the purposes of Part 2, and would therefore need to comply with these regulations. Generally, if a Recovery Support Specialist is employed directly by a program and is receiving reimbursement by the program for the services he or she provides, the Recovery Support Specialist would be considered an employee. This applies even though the Recovery Support Specialist is not providing direct addiction treatment services to clients. If the Recovery Support Specialist is an employee, and has access to protected information through work (in whatever capacity) with the program, then the Specialist must comply with Part 2 (see 42 C.F.R. 2.12).

## **Do You Have a Contractual Relationship With a Program?**

However, if the Specialist is not directly employed or affiliated with the program, but provides services to the program as part of a “continuum of care,” most often through a contractual arrangement, then the Specialist would be considered a “Qualified Service Organization” (QSO) of the program. A QSO provides contractual services to the program that include access to information protected by Part 2. A QSO Agreement would be executed between the program and the Specialist and would contain provisions requiring the Specialist to protect the information received in the course of the work the Specialist is doing with the program.

## **Are You a Volunteer of a Program?**

If the Recovery Support Specialist is providing services on a strictly volunteer basis, and is receiving no reimbursement for the services provided, then the Recovery Support Specialist must determine whether he or she would have access to protected information, and if he or she is providing services to a covered program. If the answer to these questions is yes, then the Recovery Support Specialist must comply with Part 2.

## **Is the Person You Are Providing Support To a Patient?**

Part 2 strictly governs the disclosure of any information, whether recorded or not, that would either directly or indirectly identify a client as a person with an alcohol or other drug problem. Protection is afforded to each “patient” in a program, meaning any individual who has applied for or been given diagnosis or treatment for alcohol- or other drug-related problems at a federally assisted program. This includes any individual who, after arrest on a criminal charge, is identified as having an alcohol- or drug-related problem in order to determine that individual’s eligibility to participate in a program.

Under Part 2, the confidentiality protections extend to “patients” in a program. Once an individual becomes a patient, all individually identifiable information about that patient is protected. Applicants for addiction treatment services are patients even if they are not admitted to the program. However, a person who does not show up for an appointment for an assessment to determine whether a substance-related problem exists is not a patient. Former patients and deceased patients remain protected as well.

## Are You Providing Services To the Patient?

In some cases, Recovery Support Specialists will be employed by, or work with, Recovery Community Organizations (RCOs) that provide non-clinical recovery support services through paid and volunteer staff and act as “drop-in centers,” service hubs, and places of fellowship. Remember, Part 2 applies only to programs and to those individuals who are employed by, or affiliated with, those programs. If the RCO does not meet the definition of a covered program, then Part 2 will not apply, unless there are more stringent State licensing or funding regulations. In addition, however, the RCO and/or the Recovery Support Specialists will need to make a determination whether the support they provide meets the definition of a “covered service” under Part 2. Some questions to be asked include:

1. Does the RCO provide “diagnosis” for clients? A diagnosis is defined as “any reference to an individual’s alcohol or drug abuse, or a condition which is identified as having been caused by that abuse, which is made for the purpose of treatment or referral for treatment.” However, this is not limited to assessments by medical professionals. An evaluation or assessment carried out by a counselor would be considered a “diagnosis” covered by the regulations. However, a “screen” or “prescreen” to identify individuals who may need to be referred to a specialist for a diagnosis would not be covered by Part 2.
2. Are targeted prevention services provided that are aimed at individuals who have been identified as having substance-related problems? If so, these services are covered by Part 2.
3. Is the referral of an individual to addiction treatment made after an assessment or diagnosis has been made? A referral for services alone is not enough to be covered by Part 2, but if the referral is made after a “diagnosis” has identified the person as suffering from a substance use disorder, then Part 2 applies. A referral for housing, medical care, or other similar services would not trigger Part 2.

For an in-depth discussion of each type of service rendered by a Recovery Support Specialist, consult the Legal Action Center’s analysis in its newsletter *Of Substance*, entitled “Recovery Support Services – Are They Covered by the Confidentiality Regulations? Part I” (Vol. 26, No.3 May/June 2005).

## Do You Have Access To Protected Information?

The drug and alcohol confidentiality regulations restrict both the disclosure and the use of information about individuals in federally assisted addiction treatment programs. 42 C.F.R. 2.3(a). Records of the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with the performance of any program or activity relating to alcohol dependence or alcohol abuse, or in connection with the performance of any drug abuse prevention function, which is conducted, regulated or directly or indirectly assisted by any department or agency of the United States, must be kept confidential. 42 C.F.R. 2.12(a) and (b).

Patient identifying information is defined broadly to include any information whereby the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information. The Privacy Standards also protect information that identifies or could reasonably be used to identify an individual. The Privacy



Standards contain many of the same “identifiers” as Part 2, as well as numerous additional identifiers which are afforded protection (i.e., client ID numbers). See the glossary for definitions of Protected Health Information (PHI) under HIPAA and patient identifying information under Part 2. It is also worthy to note that Part 2 covers any information (written or oral) relating to a patient that is received or acquired by a federally assisted addiction treatment program. The Privacy Standards cover PHI about an individual (oral, written, etc.) only when maintained, collected, used, or disseminated by or for a covered entity.

Records are broadly defined to include “verbal” (spoken) communications as well as what is typically thought of as written medical records. Therefore, patient records include any information relating to the patient, written or oral. In addition to disclosing any of the patient identifying information above, there are other ways of disclosing patient information (for example, giving written records with a patient’s name on it or answering a telephone and informing the caller that the person to whom the caller wishes to speak is present).

### **the Health Insurance Portability and Accountability Act of 1996 (Hippaa)**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to provide better access to health insurance and to toughen the law concerning health care fraud. In addition, it created national standards to facilitate the electronic exchange of health information and protect the privacy of any patient-identifying health information.

An addiction treatment “program” required to comply with Part 2 is not automatically a covered entity under the Privacy Standards of HIPAA. A covered entity is a health plan, health care clearinghouse, or health care provider who transmits any health information in electronic forms in connection with a covered transaction.

The Privacy Standards establish a federal floor of safeguards to protect the confidentiality of medical information by limiting the disclosure of PHI. PHI is any individually identifiable health information in **any** form: electronic, written, oral, or any other form. Protected health information may not be used or disclosed except as authorized by the patient or as permitted by the regulations. In other words, if the provider does not transmit any health information electronically, the provider is not a covered entity under the Privacy Standards. If the provider transmits health information in connection with covered transactions (see glossary) electronically via the Internet; an extranet; private networks; e-mail; or transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk, etc. then the privacy standards apply, even if all other information is kept in paper form.

Therefore, assuming the treatment agency is both a “Program” under Part 2 and a “covered entity” under the HIPAA Privacy Standards, PHI becomes protected upon its creation or receipt by the provider of treatment for substance use disorders (SUDs)<sup>3</sup>. The person does not have to be admitted as a patient. If a person calls and makes an inquiry and the addiction treatment abuse agency documents identifying information about the individual, the information would be considered PHI. This protection applies to any PHI in any form and remains protected for as long as the covered entity transmits or maintains it.

However, we should note that, based on the functions and services provided by RCOs, we believe it very unlikely that HIPAA would apply to RCOs, since RCOs would not be engaging in

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<sup>3</sup> In cases where the 42 C.F.R Part 2 and the Privacy Standards apply and conflict, the more stringent of the two laws will apply.

electronic healthcare transactions. Therefore, the RCO would not meet the definition of a “covered entity” under HIPAA. In addition, based on a review of the functions and duties of Recovery Support Specialists, we have concluded that Recovery Support Specialists are not engaging in electronic healthcare transactions that would make them covered entities under the HIPAA.

### **How Do You Share Protected Information?**

There are a number of ways to share protected health information without breaching a client’s confidentiality. The most obvious is to use de-identified information or to disclose the information without identifying the person as a recipient of SUD treatment services. If you need to include patient identifying information, you may legally disclose: (1) with written patient authorization; (2) with a valid court order; (3) to staff within the program; (4) to a qualified service organization; (5) under a child abuse reporting exception; (6) to law enforcement for a crime on program premises or against program personnel; (7) to health care personnel for medical emergencies; (8) for research; and (9) for audit/evaluation activities.

Patient identifying information includes the name, address, social security number, fingerprints, voiceprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information (42 C.F.R. Section 2.11). In order to release this information, the regulations require the execution by the patient of a valid consent. Consents for disclosure are governed by the federal confidentiality regulations (42 C.F.R. Section 2.31) and must be in writing. To make a disclosure in accordance with these regulations, the following elements must be included in the written consent:

- (1) Name of patient
- (2) Name or general designation of program making the disclosure
- (3) Kind of information and amount of information to be disclosed
- (4) Name or title of person or organization to which disclosure is to be made
- (5) Purpose for disclosure
- (6) Date on which consent is signed
- (7) Signature of patient
- (8) Signature of parent or guardian, if applicable
- (9) Statement that the consent is subject to revocation (except to the extent program has relied upon it)
- (10) Statement that the consent will terminate upon a specific date, event, or condition

The federal confidentiality statutes and regulations, as discussed above, govern consent for disclosure. Prior to making a disclosure, a written consent form (containing the required elements of 42 C.F.R. 2.31) should be signed by the patient.

### **Mandatory Child Abuse Reporting**

All fifty states have provisions for mandatory reporting of physical and/or sexual abuse of children. These statutes are based on the premise that the potential harm to children from abusive acts outweighs the potential harm that could occur through the violation of client confidentiality. The ethical command is to ensure that abuse does not recommence and to ensure the safety of other potential victims. The key question will be whether Recovery Support Specialists fall within a state’s definition of a mandated reporter. If that is the case, there are three approaches the Recovery Support Specialist may follow.

The first approach takes the position that the Specialist should report only those cases of abuse that clearly fall under the definition of legally mandated reporting. This option makes compliance with the law the framework for ethical conduct. The risk here is twofold: first, that cases may arise in which there is an ethical mandate to protect which falls outside the legal requirement to report; and second, that actions taken to protect—mandatory reporting—may, in some unique circumstances, do harm to those targeted for protection.

The second approach takes the position that the Specialist should report only in those circumstances in which there is a legal obligation to report AND the action of reporting is judged by the Specialist to be the best available vehicle capable of protecting the innocent parties and supporting the long-term health and safety of all parties involved. With this option, a judgment not to report is an implicit assumption of responsibility and legal liability by the Specialist for the welfare of those involved, but one deemed justifiable under certain circumstances. In fact, in some states, a mandated reporter's failure to report child abuse or neglect is typically a misdemeanor, and grounds for disciplinary action by applicable licensing boards, if the Recovery Support Specialist possesses any such licenses. To further encourage reporting, some states also have immunity provisions for those who report abuse and neglect.

The third approach posits that the specialist should report, not only those cases that fall under the definition of legally mandated reporting, but also cases where the Specialist feels an ethical duty to protect but circumstances are not of such severity as to legally require reporting. The risk in this option is of unduly violating client confidentiality and of adding non-critical work to an already overburdened child protection system. Once again, if the specialist reports in "good faith," some state statutes provide immunity for such reporting.

For example, the Pennsylvania Consolidated Statutes, Title 23 (Domestic Relations), Chapter 63, states that any people who come into contact with children in the course of their employment, occupation, or practice of their profession shall report a reasonable suspicion of child abuse. Mandatory reporters include "social services workers," "child care workers," and "mental health professionals." In addition, child care services are defined to include "early intervention and drug and alcohol services for children."

Therefore, if the Recovery Support Specialist is also a mental health professional, the Recovery Support Specialist is a mandated reporter and must report child abuse under the statute. However, if (for example) a Recovery Support Specialist in Pennsylvania were not also engaged in a profession which is defined as that of a mandated reporter, there would not be a legal duty to report child abuse under the statute, but there might be an ethical duty to report governed by professional codes of conduct.

When in doubt, a Recovery Support Specialist should report child abuse. As stated above, most states have immunity provisions for those who report child abuse in good faith. In addition, the Recovery Support Specialist could face greater liability for not reporting. Furthermore, if the Recovery Support Specialist is not covered by Part 2, he or she will not be restricted by those regulations concerning the types of information he or she may disclose in connection with a suspicion of child abuse.

To reconcile the client's right to confidentiality with the duty to report, it is crucial that each agency clearly defines how it operationalizes both of these mandates within the span of the three positions noted above. Once that position has been determined, clients can be told of the

exceptions to confidentiality in language precise enough to allow them to make informed choices regarding likely responses to their disclosures.

There are numerous variations on abuse situations that make it more difficult to sort out one's legal and ethical duties. The agency/specialist response to each situation can be discussed using the following questions:

- Does the situation, as presented, warrant suspension of confidentiality and reporting to an outside authority? If yes, which outside authority?
- What actions in addition to, or as an alternative to, external reporting would enhance the protection of safety in the situation?
- Who will benefit, and who may be harmed by the proposed action?
- Which ethical values should guide our response to the situation?

### **Personal Or Organizational Liability**

In general, courts have required that the patient be told: (1) the nature and purpose of the procedure; (2) the risks and consequences; (3) the alternatives; and (4) the risks of no treatment. Failure to disclose risk is the most common source of liability. This concept is known as informed consent. Because of the nature of Recovery Support Services, this concept of informed consent does not appear to apply. Nevertheless, people providing such services have questioned under what circumstances personal or organizational liability might accrue.

To determine whether a professional practice standard was breached, courts would look to the standards of what a reasonably prudent Recovery Support Specialist in the community would do in exercising reasonable care, as well as any statutory or regulatory requirements to determine the "appropriate standard of care." Liability in these cases is typically imposed on the individual as well as the agency under negligence theories. Thus, the plaintiff would be required to prove that the peer specialist had a duty and breached the duty, and that the client suffered injury as a result of the breach (meaning the peer specialist caused the client's injury) and damages were sustained. The key question in these cases is often whether the patient can prove that, had the risk been disclosed, he or she would not have consented to the procedure or treatment. In addition, liability could be imposed on the agency for failure to meet certain standards of care with respect to negligent hiring, training, supervision, or retention of staff. Some of the licensure, business, legal, and employment considerations that could impact these decisions and standards of care are:

- Will licensure regulations be modified to address this new role and the minimum standards for the state's seal of approval?
- Will funding agencies impose requirements on agencies employing this new role?
- Will these peer support roles be perceived as members of the "treatment team"? Are they volunteers? Are they interventionists? Are they case managers/outreach workers? Where do these roles fit in the continuum of care and supervision of the clinical team?

- Will reimbursement mechanisms for these new services drive the standards of care and associated breaches of those duties?
- Will certification agencies establish the standards of care and associated breaches of those duties?
- Will credentialing and other regulatory bodies establish the minimum credentials of those qualified to render services, thus imposing the corollary obligation to engage in appropriate recruitment, orientation, training, and supervision of the peer support specialists?
- What responsibilities will be imposed on Recovery Support Specialists to document their services?
- Will the existence of documentation change the role, expectations, and assumed liability of these peer support specialists?
- Will agency approaches to minimum sobriety “guidelines” impact the success of recruiting qualified peer support recovery specialists?
- Will agency codes of ethics relating to peer relationships with fellow clients affect “bright line prohibitions” of professional behaviors in the employment context?
- What similarities exist between Recovery Support Specialists and consumer employees in the mental health field? What challenges have been encountered and lessons learned from that field that can be replicated for these positions?
- Will restrictions need to be imposed to “wall off” Recovery Support Specialists from information in a client record (including but not limited to joint clinical staffing to discuss client issues, the written medical record, the electronic information in clinical and billing systems), to preserve clients’ right to confidentiality from fellow employee/fellow clients?
- With the Recovery Support Specialists presumably being involved with the clients for longer terms to support lifelong recovery, how does that impact the definitions of “clients” for purposes of determining whether a relationship can occur between a peer support recovery specialist and a “former client”?

At the present time, Recovery Support Services are deemed neither clinical nor medical procedures for which informed consent is required, and therefore there is a minor risk of liability. However, even as we speak, several states are modifying their licensure regulations to address Recovery Support Specialist services. Funding agencies will not be far behind. This public policy shift will have a huge impact on the nature of the services Recovery Support Specialists provide. As Recovery Support Specialists become an integral part of the treatment team and/or the continuum of care, we will witness licensing and funding authorities creating standards to govern these services, to justify reimbursement for them, and to create minimum levels of expectations. Once these standards are imposed, patients will have a greater ability to prove a breach of these standards and successfully sue Recovery Support Specialists for various types of liability.

Although standards professionalize the service, establish minimum public safety thresholds, and hold recipients of government funding accountable, mandated standards have contributed to survival strategies driving the addiction treatment field to focus on documentation, certifications, credentials, and reimbursement rather than the peer-based recovery concepts necessary for sustaining life-long recovery. This reality resulted in the peer-based recovery movement. Once federal, state, and local governmental authorities impose standards on these innovative recovery support services, they may very well destroy the effectiveness of the interventions that they choose to govern.

Based on a review of the functions and duties of 'PSRS', we have concluded that 'PSRS' are not engaging in electronic healthcare transactions that would make the PSRS a covered entity under the Health Insurance Portability and Accountability Act (HIPAA). Therefore, no discussion of HIPAA has been included in this chart.

Does the Peer Support Recovery Specialist (PSRS) work for a federally funded program as defined in 42 C.F.R. 2.12?\*

YES

NO

Is the PSRS an employee of the program?

Are there state confidentiality or privacy laws that pertain to the PSRS and the work he/she does?

- YES – Must comply with 42 C.F.R. Part 2 and determine when information needs to be shared:
1. Within the program – consent not needed
  2. With client – consent not needed
  3. With other programs/agencies – need consent
  4. With family members or attorney – need consent
  5. With Court/State's Attorney/Probation Services – need consent

NO – Is the PSRS performing services on behalf of the facility as part of a continuum of care?

YES – PSRS must execute a Qualified Service Organization (QSO) Agreement and comply with 42 C.F.R. Part 2

NO – Is PSRS providing services on a voluntary basis to the program (i.e. no payment for services)

YES - PSRS would need to comply with 42 C.F.R. Part 2 even if an unpaid volunteer because the PSRS has access to protected information

NO – PSRS does not need to comply with 42 C.F.R. Part 2

NO – PSRS is not bound by federal or state confidentiality requirements but may still be bound by ethical or professional association requirements

YES – use criminal justice consent

\*The restrictions on release of drug treatment information found in 42 C.F.R. 2.12 only apply to information obtained by a federally assisted substance abuse program for the purpose of treating substance abuse, making a diagnosis for that treatment, or making a referral. A Federally assisted program is defined as a program (1) conducted in whole or in part by any department or agency of the United States, (2) being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States, including Medicare certification, authorization to conduct methadone maintenance, or registration to dispense under the Controlled Substance Act if the substance is used to treat substance abuse, (3) receiving Federal financial assistance in any form, including assistance from the State or a local government unit who in turn receives Federal funds that could be used for substance abuse treatment, or (4) if the program is an IRS tax-exempt entity. Programs and PSRS within those programs must determine whether their programs would be considered federally funded.