RECOVERY COACH GUIDELINES

Suggestions for Clinical Integration of Recovery Coaches

Richard Zombeck, CARC

Six months after engagement with a recovery coach, compared to the six months prior to the engagement with a recovery coach, patients have a 44% increase in attendance at outpatient primary care and behavioral health visits, a 25% decrease in inpatient admissions, and a 13% decrease in emergency department visits.

- MGH Recovery Coach Efficacy 2018 Report

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PREAMBLE

A federally funded report released in march, 2019 came to a striking conclusion: more than 80 percent of the roughly two million people struggling with opioid addiction in the united states are not being treated with the medications most likely to nudge them into remission or prevent them from overdosing. This denial of care is so pervasive and egregious, the report's authors found, that it amounts to a serious ethical breach on the part of both health care providers and the criminal justice system.

New York Times: "Want to Reduce Opioid Deaths? Get People the Medications They Need"

PREAMBLE

This document has been adapted from a previous version. The original document was written to address existing issues that caused a previously successful and effective recovery coach program to approach imminent failure. The name of the hospital, its affiliation, and details that would only pertain to that particular program have been removed to make this document available to a larger audience. The spirit of the document remains, as it is crucial that the necessary foundation be put in place for any recovery coach program to be successful.

I currently work as a program manager for a large healthcare organization on the east coast. Our recovery coach program was introduced at the end of 2017 with one recovery coach covering 16 primary care offices. Within the first quarter we had received nearly 100 referrals from those primary care offices. As the need grew, so did our team. With the help of a grant we had secured, we grew and expanded the program in the subsequent four years, embedding coaches not only in primary care offices, but in the emergency department, medical floors, psychiatric units, ICU, and into the community. By 2019 we employed five full time coaches who reached an average of approximately 1200 patients per year.

From its inception, the recovery coach program was nested under the department of Social Work. This arrangement benefited both the recovery coaches and the social work team, as many of the patient's non-medical needs were addressed, supplementing and complementing their current medical treatment. Social workers became a natural ally to the recovery coaches. As a result of their close collaboration and an understanding of each others roles the program thrived. Many of those patients are not only in recovery today thanks to this program, but living healthy and productive lives.

Five years later, at the tail end of 2022 and into 2023, while the country was experiencing record overdose deaths, the organization restructured their departments. The recovery coaches were moved under the department of psychiatry and overseen by people who were unfamiliar with the recovery coach role, and had no apparent interest in addressing that shortcoming. They redefined the roles to suit their views, rewrote job descriptions, exiled anyone who opposed them, and began to discredit and disband the team. The results were nearly immediate. In 2023, the number of patients seen in the hospital dropped by 40 percent and some of our more capable and successful recovery coaches resigned.

This document was created at the end of a nearly two year campaign within the organization to draw attention to issues that had put the recovery coach team in peril and to stipulate that without the intervention of more influential people within that organization the program could very well fail. At the time of this writing, there has yet to be a resolution.

If you are reading this document because you are either creating a new recovery coach program or looking to improve upon what you already have, it can certainly be read as a potential guide, but read it also as a cautionary tale of the consequences of hubris and willful ignorance. Hopefully, it is also a reminder that the people hired to work as recovery coaches are experts in their field. Their lived experience, the training they have had, the credentials they have received, and their dedication to the role have prepared them for what to many of them is more than just a job —they are your best resource.

PREAMBLE

In addition to this document, there are excellent resources available, written by experts to whom I would defer and have cited in this document to corroborate my arguments. I suggest you click on and follow those links.

As a starting point, I would suggest the following:

- Anything written by William White, who is quoted in this document, as well as being cited in nearly any worthwhile document about substance use and recovery.
- The Peer Support toolkit, written by the Philadelphia Department of Behavioral Health and Intellectual Disability Services.
- Any of the links in the reference section of this document and those at RecoveryBinder.com
- Talk to recovery coaches, interview and interrogate them to get as much information as you can.
- Attend certification and supervision trainings. Learn, not only about the recovery coach role, but how they see and understand their role.
- Listen to the BudsWithSUDS podcast. If you don't have a recovery coach on hand, you can listen to nearly 25 interviews and discussions, and counting, with recovery coaches and SUD professionals.

Above all, I implore you to make every effort to fully understand, respect, and appreciate the role of recovery coaches and allow them to do their job in the way that it was envisioned and has been defined.

We are the evidence in evidence based studies and practice.

INTRODUCTION

For culture change to occur, a … prerequisite is for someone in a position of significant authority and leadership in the agency to announce that a recovery-focused transformation process is an agency-wide priority.

- Joe Schultz, Clinical Director, NorthEast Treatment Centers

INTRODUCTION

There is an implied agreement when one comes to work in a clinical practice or medical facility that they will be part of a team that strives for excellence. These organizations should strive to set the standard and serve as an example to other organizations by effectively designing and implementing best practices, policy, and procedures. To that end, it is imperative that these organizations exemplify the implementation and integration of recovery coaches into clinical practice across the organization. Policy, procedure, and guidelines must be implemented to guarantee an adherence to the fidelity of the recovery coach model, thereby insuring the success of these programs.

Recovery coaches, who are peers with a history of SUD, are increasingly being utilized to offer outreach, navigation, and support for patients with SUD. While the literature on the use of recovery coaches is limited, a 2016 systematic review suggested a positive impact. The systematic review, which included nine studies, examined the effectiveness of peer-delivered recovery support services and found that most studies showed significant improvements in abstinence and other recovery outcomes. While the range of peer-delivered services included recovery coaching, most looked at different types of peer support. The one study which looked specifically at the impact of recovery coaches in community-based recovery centers found that patients connected to a recovery coach had more primary care visits; fewer hospital, ED, and inpatient detoxification admissions; and significant improvements in recovery capital (Wakeman, et al., 2019).

The paper concludes:

In a non-randomized retrospective cohort study, integrated addiction pharmacotherapy and recovery coaching in primary care resulted in fewer hospital days and ED visits for patients with SUD compared to similarly matched patients receiving care in practices without these services (Wakeman, et al., 2019).

The effectiveness and value of recovery coaches is not, nor should it be, a matter of debate. However, the integration, appropriate and proper use of recovery coaches, in addition to how they are treated, has been, and continues to be a source of frustration and hardship, resulting in dysfunction and unmet potential.

The content of this document was derived from various sources, including personal and professional experience; documented cases; third-party studies; white papers; BSAS; CCAR; and North Shore Community College, to name a few. It is little more than a proposed starting point to a larger and necessary discussion. It has been reviewed by Recovery Coaches, Recovery Coach Supervisors, RCA and CCAR Instructors, and SUD professionals from several organizations employing recovery coaches.

It is crucial to Substance Use Disorder programs, patient well-being, and to the professional and personal well-being of the Recovery Coaches that the guidelines created by organizations are comprehensive, understood, and adhered to.

RECOVERY COACHES

Regardless of their specific role, we have found that peer support staff can also vastly enhance organizational culture, adding a crucial element that complements but in no circumstances replaces clinical care: the element of hope. Through their lived experience, peer staff are a constant reminder that recovery is real and possible, regardless of one's circumstances and the limitations imposed by one's behavioral health condition.

-Dr. Arthur C. Evans, Jr., PhD, Philadelphia Dept. of Behavioral Health and Intellectual Disabilities Services and Achara Consulting Inc. (2017). Peer Support Toolkit. Philadelphia, PA: DBHIDS.

RECOVERY COACHES

In the interest of consistency and fidelity to the recovery coach model, it is imperative that the role of the Recovery Coach (RC), the parameters of their role, and how they are utilized be clearly defined and understood across the organization. Guidelines and safeguards must be put into place and adhered to if the goal is to fully integrate RCs into clinical practice. In order to avoid misunderstandings and settle disagreements these guidelines should be understood not only by the RCs, but more importantly by leadership.

Providers need to ensure that Peer Recovery Coaches (PRCs) are trained, adhere to the Code of Ethics, are certified in accordance with requirements and receive quality supervision from supervisors trained in the peer recovery coach supervision model. The majority of providers, most of whom are clinical or medical, need the training, infrastructure, and required resources to support and ensure a quality, non-clinical/recovery support staff. In order to support this new workforce, PRCs need to have opportunities for professional growth that preserve the non-clinical, non-case management nature of the RC role, and are integrated into the agency structure. State agencies, providers, insurers, and peer support workers, banning together to build this new workforce, provides a great opportunity to deliver peer driven services as part of the response to the opioid epidemic. It addresses the Substance Use Continuum of Care that focuses on the maintenance and sustainability of Recovery. (MA Department of Public Health Bureau of Substance Addiction Services, 2018)

The same document stresses not only the importance of fidelity to the role, but signals potential consequences of not maintaining that fidelity:

Provider readiness is imperative to ensuring quality PRC services, fidelity to the role, and worker satisfaction. Inadequate training and education, misuse of the role, and inadequate supervision can result in worker dissatisfaction, high turnover, and compromised recovery status..."

The document then reiterates the importance of supporting the RCs in their role within the organization, providing specific examples of inappropriate uses of the RCs:

To successfully incorporate Peer Recovery Coaches into an agency, a provider agency needs to support the PRC by not asking them to perform inappropriate tasks or roles, such as clinician (counseling), driver (to & from appointments/meetings) or babysitter (ensuring medication compliance).

Many organizations have created proprietary presentations that specifically delineate what RCs cannot do, citing examples such as, Assist patients in crisis or respond to safety concerns; Provide medication advice or monitoring; Physically transport patients to appointments and meetings; Conduct or assess behavioral health screenings, such as PHQ-9 or GAD; Convince ambivalent patients to participate in service; Be available 24/7; and Provide case management.

RECOVERY COACHES

JEVS Human Services, quoted in the "Peer Support toolkit," alludes to the potential pitfalls of not properly preparing an organization for the integration of Recovery Coaches, write:

In hindsight, we did not do enough upfront preparation work. This was our earliest and biggest struggle. [A lack of preparation] resulted in complaints from counselors and misunderstandings and [mis]perceptions. Counselors objected to and resented the integration of peer support staff. We now see upfront preparation as a critical process and realize that you always have to keep in mind new staff; therefore, preparation is a continuous process. Since that time, our Peer Support Specialists have proven their net worth to both the clinicians as well as those we serve and are viewed as an adjunctive and necessary component for promoting meaningful recovery.

Several studies have been conducted on the efficacy of recovery coaches and have specifically identified areas that make success more likely. In an executive summary, "Peer-based Addiction Recovery Support - History, Theory, Practice, and Scientific Evaluation," William White assesses 12 criteria as quality indicators, based on input from 28 grant recipients.

- Peer recovery support services are clearly defined in ways that differentiate them from professional treatment services and from sponsorship in 12-Step or other mutual-aid groups.
- The programs and peer recovery support services are authentically peer based (participatory, peer led, and peer driven) in design and operation.
- The peer recovery support program has well delineated processes for engaging and retaining a pool of peer leaders who reflect the diversity of the community and of people seeking recovery support.
- The peer recovery support program has an intentional focus on leadership development.
- The peer recovery support program operates within an ethical framework that reflects peer and recovery values.
- The peer recovery support program incorporates principles of self-care, which are modeled by staff and peer leaders, and has a well considered process for handling relapse.
- The peer program and peer recovery support services are non-stigmatizing, inclusive, and strengths-based.
- The peer recovery support program honors the cultural practices of all participants and incorporates cultural strengths into the recovery process.
- The peer recovery support program connects peers with other community resources irrespective of types of services offered.
- The peer recovery support program has well established, mutually supportive relationships with key stakeholders.
- The peer recovery support program has a plan to sustain itself.
- The peer recovery support program has well documented governance, fiscal, and risk management practices to support its efforts.

RECOVERY COACHES

Despite exhaustive descriptions, studies, and analyses by the likes of William White; BSAS; the Montgomery County, PA, Office of Mental Health; SAMHSA; and the City of Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS), to name a few, misunderstandings and disputes will continue to arise due to the lack of education and understanding surrounding the role of the Recovery Coach.

It stands to reason that if specific guidelines and definitions are used in training RCs and during the certification process, that this will be the means by which RCs define themselves, their role, and how they do their jobs. However, if these same guidelines are not understood and accepted by clinical staff, leadership, and Human Resources, and they are simply guided by their assumptions, conflicts and disputes will inevitably occur. Therefore, every effort should be made to ensure that this role is defined, understood, and respected across the entire organization.

My recovery from drug addiction is the single greatest accomplishment of my life… but it takes work — hard, painful work — but the help is there, in every town and career, drug / drink freed members of society, from every single walk and talk of life to help and guide.

– Jamie Lee Curtis

SUPERVISORS AND SUPERVISION

Trying to get people to understand the difference between a traditional administrative supervisor and a Recovery Coach Supervisor has been like trying to explain gravity to a chicken.

SUPERVISORS & SUPERVISION

The Recovery Coach Supervisor (RCS) plays a crucial role in an organization that employs recovery coaches.

SAMHSA describes peer supervision as:

...a professional and collaborative activity between a supervisor and a worker in which the supervisor provides guidance and support to the worker to promote competent and ethical delivery of services and supports through the continuing development of the worker's application of accepted professional peer work knowledge, skills, and values."

RCSs are in recovery themselves and have been trained and certified as both RC and RCS. They understand the challenges of the role, as well as the challenges of being a person in recovery. Because of this, RCs and RCSs share common lived experiences and can communicate in a short-hand familiar to the recovery community. Were a non-peer supervisor to use the same vernacular, terms, or jargon, for example, it could be perceived as condescending and patronizing.

Moreover, Recovery Coach Supervisors understand the variety of peer roles; have a deep understanding of the core competencies of peer workers and understand the specific peer support job of the person they supervise. They endorse and enact recovery-oriented practices and values; support the development of individualized professional goals; support the integration of peer workers and recovery values; and they believe in the capacity of peer workers to grow and develop professionally.

In terms of specific supervision as it relates to RCs, SAMSHA describes why they recommend against using traditional or non-peer supervisors, as they may lack experience and working knowledge of peer practice and that they may "have a clinical approach to service provisions."

Peer workers fill a relatively new and unique roles in the behavioral health care system and [non-peer]supervisors may not understand peer support well enough to provide high quality supervision and the organization may not be aligned with recovery–oriented values.

Similar to the relationship of a RC and their recovoree, RCSs are often described as a "coach for the coaches." As such, they should have no administrative duties or oversight that would insinuate "power over." RCSs should not write schedules, approve vacation or time off, and should not have the ability to terminate, discipline, or take punitive action. It's admittedly a thin line to walk and the two definitions get muddled, but there has to be a fundamental understanding by the RCS, the RC, and the organization's leadership of what the role is, why it's necessary, how it is defined, and more specifically how it differs from a traditional non-peer supervisor.

Simply put, a traditional administrative supervisor makes sure that people are doing their jobs well, and a Recovery Coach Supervisor makes sure that people are well doing their jobs.

In their presentation, "Supervision of Peer Workers," addressing how to bring recovery supports to scale, SAMSHA provides a list of benefits that a Recovery Coach Supervisors (RCS) provide to recovery coaches and to the organization that engages them.

On one slide in the presentation, "Benefits of Supervision for Peer Workers," they list:

Provides opportunities to reflect on peer support practice; Delivers better outcomes through learning that comes from exploring and discussing work issues; Enhances problem solving skills; Focus on knowledge, skills and attitudes; Improves clarity and objectivity in decision making; Provide individualized training and support; Provide venue for supporting the peer worker's professional development; Supervision empowers, motivates and increases worker satisfaction; Give feedback on work and Discusses personal reactions to the work; Validate and provide encouragement; Promote self-care practices and; Advocate for peer support roles.

On a subsequent slide, "Benefits of Supervision for the Organization," they list:

Supervision is a tool that can be used to achieve the agency's mission and objectives; Supervision improves performance and helps to manage resources; Good supervision can increase morale and improve retention; The supervisor serves as the mediator and liaison between the agency and the worker.

In reference to the final point, about RCSs serving "as the mediator and liaison between the agency and the worker." This point is often reiterated during supervision training, events, RC collaboratives, conversations, and forums, as if it were a mandate. The RCs and RCSs are told to advocate, push back, stand their ground, and be the fly in the ointment, but this ignores the very real power dynamic that exists in most workplaces - especially in healthcare. Expecting the Recovery Coach Supervisor to be the last line of defense between clinical staff and a RC is dangerously naive. Unless the organization has a champion in a position of leadership, who understands the fundamental definition of the role of RCs and who is willing to intervene in the event of disagreements, it puts both the RCS the RC in a precarious and untenable position. Without the role being clearly understood, accepted, and respected by leadership, the RCS will meet with resistance and nearly always with defeat.

I got sober. I stopped killing myself with alcohol. I began to think: 'Wait a minute – if I can stop doing this, what are the possibilities?' And slowly it dawned on me that it was maybe worth the risk.

- Craig Ferguson

PROGRESS NOTES

After having read my notes, his new therapist asked about our conversation and how meditation was working out. The patient wouldn't communicate with me for nearly two years after that, feeling that I had broken his trust.

PROGRESS NOTES

There is and has been a disturbing trend towards RCs writing clinical notes – at least in appearance.

In some cases, this is simply the RCs mimicking clinical notes they have seen, by adopting writing styles that include terms such as, “this writer,” including private and personal details, and offering opinion or diagnosis. More often than not, it’s providers who are driving this trend by insisting that certain information be included in the progress note, such as goals, assessments in meeting those goals, evaluations, substances used, planned visits, last visits, to name a few. Overlooking that much of this information can be captured in other areas of the medical record and is therefore redundant, with few exceptions, under most circumstances, there is little information the RCs should be capturing in progress notes.

Possible exceptions might include the following scenarios: (1.) A recoveree who, for whatever reason, has given express permission for this information to be added to their record. (2.) If the recoveree has expressed a desire to have their goals tracked. (3.) Cases of immediate crisis, such as suicidal or homicidal ideation, or any threat of harm to themselves, the coach, or another person. (4.) With the express permission of the recoveree, information about a medical or behavioral health need that would require another provider.

Care and respect must be given to the relationship between a RC and the recoveree, as it is one of trust and mutual respect. Anything that demonstrates “power over” should be avoided. Notes in a medical record, seen as a “permanent record” by some, demonstrates, or at the very least insinuates, “power over.”

Conversations between the RC and a patient occur with an expectation of privacy. In most cases, it’s the single most useful tool a coach has at their disposal. Private conversations with “recoverees,” goals, opinion, medical compliance, judgments, evaluation of status, diagnoses, and anything else that falls squarely within the area of clinical assessments or case management should not be recorded by a RC in the medical record.

The medical community historically does not have a laudable track record when it comes to the treatment of substance use disorders and there still, understandably, exists a degree of apprehension and mistrust on the part of alcoholics and addicts. In many cases the relationship developed by the RC with the patient might be the one thing that salvages and repairs that relationship and potentially convinces people to agree to treatment. For this reason, anything that attempts to make the role more clinical or give the appearance of such, does a disservice to the role, the patient, and the organization.

The Recovery Coach role is by nature and by definition non-clinical. That is by design.

PROGRESS NOTES

Guidelines for Clinicians:

Due to the delicate nature of the relationship between a RC and the recoveree, providers and clinicians should try to respect and understand that relationship and avoid opining or siding with patients in their notes. For example, a note by a clinician that includes, “patient doesn’t feel that the RC is a good match, doesn’t call enough, and feels the RC doesn’t like them,” presents a multitude of problems.

Opinions by doctors, written in a medical note, are generally accepted as fact by other providers and particularly by patients. Opinions and musings by a provider in medical notes undermines the work of the RC, gives the appearance of siding with the patient, splits staff, and signals a judgment of the RC to other providers, and to the patient.

Providers should work with the RCs in a collaborative effort to meet the needs of the patient. Rather than transcribing what the patient said, the provider could suggest that the patient discuss their concerns with the coach or provide the patient with the RC’s phone number to reach out themselves during working hours, for example.

RCs should be seen as colleagues and team members working towards the same goals of collaborative patient care, rather than a prescriptive service.

Note: I worked with a particularly challenging patient for several years. The patient had been incarcerated and hadn’t seen a day of sobriety in nearly three decades. He had a significant history of violence, trauma, and abuse. We had discussed meditation, which he was willing to explore, but had experienced some difficulties with it in the past due to trauma. I made the mistake of mentioning the topic of meditation in the note – nothing more than that.

Around the two-year mark of our working together and sober now for those two years, he was introduced to a new therapist due to his former therapist having resigned. After having read my notes, his new therapist asked about our conversation and how meditation was working out for him. The patient wouldn’t communicate with me for nearly two years after that, feeling that I had broken his trust.

PEER ADVISORY BOARD AND EXECUTIVE CHAMPION

The leadership of any agency creates the vision, sets the tone, and ensures accountability at all levels of the agency. To those ends, an executive champion is needed to ignite and fan the flame of peer support integration. Also, for staff who may be slower to embrace the idea of peer support or may even be skeptical, executive champion involvement will signal the agency's commitment to peer support to all staff.

Arthur Evans Jr., Ph.D.

PEER ADVISORY BOARD & EXECUTIVE CHAMPION

Some thought should be given to a strategy of centralizing the recovery coach team as a service provided to PCP offices, outpatient, the emergency departments, and medical floors across the system. At the very least a Peer Advisory Board or committee should be formed to provide some ongoing guidance, training, and oversight.

Organizations have a responsibility, not only to educate the clinical staff about the role and its parameters, but to also hold people accountable when they venture beyond those parameters. It's one thing to suggest a list of best practices, it's another thing entirely to set clear expectations that these practices be implemented, respected, and adhered to.

When RCs are pulled out of their roles, not utilized correctly, or the role is simply misunderstood, they need to have some assurances that they are protected, will be defended, and that they have recourse. A centralized board or committee could provide the necessary resources, oversight, and training to clinical staff and act as a resource broker, mediator, and watchdog for the RC team.

Significant challenges have occurred with departments or offices within organizations not fully understanding or supporting the role of RCs and the RCS in terms of responsibilities, the appropriateness of referrals, and the way coaches do their jobs. Due in part to a fundamental misunderstanding or misinterpretation of the role, what should have ended with simple and straightforward discussions, have escalated into harassment, retaliation, denigration, and in some cases, resignations and terminations.

Organizational leadership has to recognize and admit to there being a very real power dynamic in healthcare and that non-clinical roles working within healthcare are seldom offered the same degree of respect or consideration as someone with clinical credentials.

For example, an Advisory Board, comprised of RCs, RCSs, and potentially an Executive Champion would potentially be responsible for:

- Provide training and presentations to clinical departments, HR, and offices.
- Determine hiring requirements for RCs, such as CARC compliance, length of recovery, dress codes, criminal backgrounds, etc.
- Serve as a mediator in the event of disputes or disagreements and provide an educated and informed resolution.
- Advise HR and leadership about the role of RCs and RCSs including job descriptions, duties, and boundaries.
- Create policy and procedure as a living document.
- Assist in the integration of RCs into clinical settings.
- Provide oversight in terms of the RC role.
- Create training documentation and distribute information related to recovery and recovery coaching.
- Creating, maintaining, and overseeing adherence to a written memorandum of understanding.

PEER ADVISORY BOARD & EXECUTIVE CHAMPION

The aforementioned "Executive Champion" is by no means an original concept. The City of Philadelphia implemented this approach as a necessary measure to address the potential difficulties that RCs could face.

The Peer Support Toolkit States:

"While engaging recovery champions and influential staff will be crucial to your agency's implementation efforts, identifying an executive-level champion is of great importance. The leadership of any agency creates the vision, sets the tone, and ensures accountability at all levels of the agency. To those ends, an executive champion is needed to ignite and fan the flame of peer support integration. Also, for staff who may be slower to embrace the idea of peer support or may even be skeptical, executive champion involvement will signal the agency's commitment to peer support to all staff. Lastly, having an executive champion can be instrumental in securing staff access to the resources needed to remove barriers and overcome obstacles. Many providers find that some of their organizational policies and procedures hinder rather than facilitate the delivery of peer support services. For example, policies that prohibit staff from providing services outside of the office building, [or providing other non-traditional services], can significantly impede the ability of peer staff to succeed at their jobs. Although supervisors can remove some of the barriers that peer staff face, in many instances, only executives have the authority to make the necessary policy and other organizational changes."

They add:

Ideally the executive champion would serve as the executive sponsor for the peer staff. Concretely, this would mean:

- Peer staff have direct access to the executive champion. They have open communication directly with their executive sponsor and are not forced to communicate up the chain of command.
- The executive champion understands and values the role of peer support services and is willing to advocate peer services at the executive level and in the broader system of care.
- The executive sponsor regularly meets with peer staff individually or as a group to identify organizational barriers and potential solutions for successful implementation. Regular meetings also to ensure that the peer staff members feel supported and have multiple venues for assertively addressing concerns.
- The executive sponsor is directly involved with tracking the impact of peer support services and leading the integration of any needed adjustments over time. This might involve reviewing evaluation data or participating in focus groups a few times a year with people receiving services. (Peer Toolkit)

While this level of involvement may seem extreme, without senior leadership involved in the integration and implementation of these services, the full potential of these programs will not be realized.

HUMAN RESOURCES AND EAP

The measure of a society is how it treats its weakest & most vulnerable members.

HUMAN RESOURCES AND EAP

Human Resources and EAP should be equipped to deal with employees in recovery and with the possible consequences of hiring a workforce for this particular kind of work.

Within the recommendations of the 2019 Massachusetts Recovery Coach Commission, created by former Massachusetts Governor, Charlie Baker and led by the then HHS Secretary, Marylou Sudders, one of the items listed in the Commission's eleven recommendations was, "Due to the potential for relapse, there should be support and resources available to RCS from the board of registration as well as their employers, as appropriate to the individual circumstance."

While checking the proverbial box addressing possible relapse when it comes to RCs is helpful, it is neither the only thing to be considered, nor should it be regarded as inevitable. There are a myriad of areas that need to be considered by HR departments and EAP when it comes to people in recovery. Particularly people in recovery who have exposed and made themselves vulnerable as a requirement to being hired for the role. Moreover, one would hope that HR and EAP in any organization would have measures in place to address employee substance use.

In October, 2024, the CDC released the findings of a study in which they found that, 85% of health workers who experienced harassment reported feeling anxiety, compared with 53% of those who did not. Sixty percent of harassment victims reported experiencing depression, nearly double the number of health workers who had not suffered harassment. Meanwhile, the number of healthcare workers experiencing harassment by patients and coworkers — including violent threats, bullying and verbal abuse — doubled during the time of the study, particularly in the areas of behavioral health. The study also found that about 44% of health care workers wanted to look for a new job the previous year, while interest declined among workers outside of health care. (CDC, 2023)

This is particularly concerning when it comes to people in recovery, many of whom suffer from behavioral health issue, have experienced trauma, and are at a higher-than-normal risk of suffering from secondary traumatic stress due to the nature of their role.

The RC team should be assigned a designated representative or Business Partner (BP) within Human Resources (HR). Due to the nature of the work, the confusion around the role, and because RCs interact with nearly every department within the organization, including, but not limited to, ED, ICU, Medical Floors, Psychiatry (both in-patient and out-patient), Social Work, Security, Pastoral Services, and the community at large, they interact with a number of different people from different disciplines, all with a variety of views and interpretations of what RCs do. In the event of disagreements, disputes, or complaints, HR, at the very least, should be able to react knowledgeably and act as arbitrators. Some states and various agencies have made specifics recommendations in terms of defining the role, and those should be the criteria by which organizations define the role as well. The BP assigned to the RCs should ideally not be the same individual assigned to the department under which the RCs are designated in the organizational hierarchy to avoid that department defining the role to HR as they see fit.

See Note on page 22, below.

Job Descriptions and Implied Expectations

If the expectation of the roles of the RC and the RCS is to advocate, push back, stand their ground, address stigma, and be agents of change, the roles of the RCs and the RCS should be clearly defined and within the oversight of HR. In addition to the organization's written job description of these roles, there should be an understanding of both the expressed and implied expectations, and the parameters of the role to insure that RCs and RCSs are not punished for doing the job they were asked to do.

Americans With Disabilities Act (ADA)

According to the ADA website:

The Americans with Disabilities Act (ADA) addresses addiction to alcohol, illegal drugs, and the unlawful use of legal drugs in each stage of employment.

The ADA generally considers addiction a disability within certain parameters, and since most of those parameters are met by RCs, they may be regarded as having a disability and afforded protection under the law.

The website states:

The ADA applies to addiction to alcohol and to the illegal use of drugs differently. Addiction to alcohol is generally considered a disability whether use of alcohol is in the present or in the past. For people with an addiction to opioids and other drugs, the ADA protects a person in recovery who is no longer engaging in the current illegal use of drugs.

More information can be found at the U.S. Commission on Civil Rights.

Relapse Policy

Specific, clear, and well understood policies in the event of relapse should be put in place. While relapse is not inevitable, in the event that it occurs, organizations employing RCs should have a policy in place to address this, both humanely and professionally. RCs are hired specifically because they are in recovery and while they are not legally required to provide evidence of recovery, nor is an employer legally allowed to ask, many agencies do specify a required, albeit arbitrary, length of sustained recovery in job postings and applications.

As a result, in the event of relapse, organizations are faced with a professional and ethical dilemma. If an organization is going to present itself as a compassionate and SUD friendly healthcare provider, does it do so for both its patients and employees; or does it hold its employees to a higher standard and insist that they maintain the length of sobriety they claimed in order to be employed and remain employed? Does the organization apply the same criteria to maintaining recovery as they do certification and licensure?

These are admittedly difficult questions to answer, but there must be a policy in place that makes sense.

Note: Statistically, according to multiple studies, individuals in recovery for five or more years have on average a 46-80 percent Recovery/Remission rate, as opposed to rates below 15 percent for individuals with less than five years of sustained recovery. Several researchers have determined the set-point for stability to be in the range of five years of continuous recovery.

Workplace harassment and hostile work environment

HealthStream videos, shown to healthcare employees and generally mandated by employers, defines harassment as:

"Gratuitous sabotage and undermining of work performance."

The General Laws of Massachusetts, for example, describe it as:

"Whoever willfully and maliciously engages in a knowing pattern of conduct or series of acts over a period of time directed at a specific person, which seriously alarms that person and would cause a reasonable person to suffer substantial emotional distress."

Through certification, training, and on-boarding, RCs are well advised of their role, the ethical boundaries of the role, guiding principles, and its parameters. HR and leadership must, at the very least, have some awareness or basic knowledge of these precepts. Without this understanding by the organization or the people within that organization who wield power over the RCs, disagreements over misguided directives will inevitably occur. If these disagreements escalate to the level of maligning work performance, retaliation, and threats of job loss, it could very easily be construed as harassment.

In extreme cases, since the conventional wisdom within the medical community is that addicts and alcoholics are more susceptible to stress and anxiety and thereby prone to relapse, one could argue that these actions and behaviors were carried out with malice to intentionally cause harm.

Discrimination

Discrimination is real and it's pervasive. At times it's overt, but mostly involves subtle acts of preconception or prejudice. People in recovery have been discriminated against by the Health Care community for centuries.

If an organization, particularly a healthcare organization, is going to expect people in recovery to work in an environment with the potential for toxic and hostile behaviors directed at them or at the people they serve, safeguards need to be in place to ensure that these claims are taken seriously and addressed quickly. Launching campaigns once a year in September, circulating videos that most people play in the background while sifting through email, and hosting the occasional event or presentation is moderately commendable, but if HR doesn't take complaints about discrimination seriously, act on them, much less respond to or acknowledge them, it not only signals to the recovery community that the organization is not serious or determined to do what is necessary to effect real change, but that it tacitly encourages the behavior.

The same sense of urgency should apply to official Bias Reports and internal Safety Events.

Note: Personal feelings and personalities aside, it is a mistake to put Recovery Coaches under the control and authority of Psychiatry. While it may make sense to those who consider addiction and alcoholism a behavioral or a Behavioral Health issue, many people in recovery would strongly disagree. In fact, psychiatry has often historically been seen as the culprit in substandard care of people with Substance Use Disorders. As suggested by Arthur C. Evans, Jr., PhD, "Given the dissimilar philosophical underpinnings of these two approaches, deliberate attention must be given to organizational culture to avoid the confusion and tension that can quickly surface and impede progress."

Additionally, the conventional medical model is far removed from a recovery-oriented approach. Historically, practitioners using medical models have focused on biopsychosocial stabilization and symptom management. In recovery-oriented approaches, providers seek to understand people with behavioral health disorders in the larger context of their historical, political, and socioeconomic circumstances. Assessment and service planning strategies in recovery-oriented approaches are much broader in scope than in medical models and address multiple life domains to identify and maximize all potential levers for change. (White, 2008).

In recovery-oriented approaches, the power shifts from the provider to the person receiving services, and decision making is collaborative rather than hierarchical.

Recovery - real and sustainable recovery - can be better achieved from a holistic approach that addresses multiple social and medical needs. While Psychiatry can play a substantial supportive role in someone's recovery, Social Work, with its patient centered approach would be better suited as an ally and provide a more sustainable mutually beneficial relationship.

HUMAN RESOURCES AND EAP

There is a compelling argument to be made for Recovery Coaches being part of Pastoral Services, as the nature of the work is similar and, in many cases, closely aligned.

AA Speaker, Sandy B., in several of his speaking engagements paraphrases a concept from a post by Eliot Dacher, M.D., "Addiction, Meditation, and Contemplative Practice," saying, "All Addiction is an erroneous path to spiritual awakening." In another post, Dacher talks about the beginnings of Alcoholics Anonymous and its precursor, The Oxford Group. In the piece, he points to the 19th Century Swiss Psychiatrist, Carl Jung and his early interaction with Rowland Hazzard, saying, "Jung understood that the driving force and root cause of addictive behavior was the addicts unrecognized and unmet spiritual need. In order to heal addiction at its source this natural and unmet spiritual need must be responded to and satisfied in an appropriate and authentic manner."

A large percentage of people in long term recovery claim to have achieved and maintained it through spiritually aligned programs like AA, and/or some other form of spiritual practice including, but not limited to, meditation, yoga, exercise, communing with nature, social activities, groups, and traditional religion.

It is not to be expected that you give your alcoholic employee a disproportionate amount of time and attention. They are not to be made a favorite. The right kind of person, the kind who recovers, will not want this sort of thing. They will not impose upon you. Far from it. They will work like the devil, and thank you to their dying day.

- Chapter 10: To the Employer, The Big Book of Alcoholics Anonymous

NOTHING ABOUT US, WITHOUT US

Nihil de nobis, sine nobis.

NOTHING ABOUT US WITHOUT US

"Nothing About Us without Us" embodies the idea that the development and implementation of policy should not be decided by any representative or representative organization without the full and direct participation of members of the group or groups effected by that policy.

Nearly every document, article, white paper, study, or guide that addresses integrating RCs into their organization, insists that people in recovery and with lived experience be part of setting policy in addition to the process, planning, and implementation of services. Commissions and listening sessions have been created by state governments across the country in order to hear the concerns of people in the recovery community before creating policies that would affect them.

Promoting peer culture and peer leadership is more than simply hiring peer support staff to shift organizational culture. Real and effective peer culture is seen when the voices and experiences of people in recovery drive practice and service delivery and inform policy. A robust and effective peer culture is present when people receiving services are advising on policies and procedures. When services in the ED, the medical floors, PCP offices, behavioral health, Bridge Clinics, etc., are being planned and implemented, people in recovery should have a seat at the table. Specifically, people known to be in recovery.

Creating this strong peer culture, according to Dr. Arthur C. Evans, Jr., PhD, Philadelphia DBHIDS, is possible when:

- People receiving services are advising on policies and procedures.
- Celebrating hope and recovery is regular practice.
- People in recovery and their family members have active leadership roles in all aspects of service delivery.
- People receiving services are the authors and owners of their individualized recovery plans.
- Individuals with lived experiences are hired as peer support staff and are valued team members who have active roles from initial engagement through continuing support services.

Importantly, peer support staff also address two key issues that have long hounded the behavioral health community: (1) the need to attract individuals to treatment and services well before their behavioral health conditions exact painful tolls on individuals, families, and communities, and (2) the need to move beyond treatment settings and support individuals in the communities in which they live, work, and play. The past decade has also taught us that peer staff must be more than merely present in an organization; in order to maximize their impact, they must become a fully integrated part of the service team and play an integral role in service planning and delivery as well as in organizational leadership.(Evans, 2017)

NOTHING ABOUT US WITHOUT US

Note: During the planning of some services in our organization, I pointed out that no one in recovery was represented at the planning and implementation meetings and tried to stress the importance that people in recovery have a voice and a seat at the table during this process. The person responded to me, saying, "You don't know that there's no one in recovery at these meetings. Not everyone is so open about their condition."

I'm going to assume that I don't have to explain the irony and contempt in that statement or how tone deaf it is.

Having people openly in recovery is precisely the point of having people in recovery as part of the care team. They provide meaningful involvement, and it should be considered an ethical imperative as it can help prevent patronizing and exclusionary policies and actions. Additionally, we should welcome the considerable expertise offered by people with lived experience, who have previously navigated these systems.

Oppression occurs when individuals are systematically subjected to political, economic, cultural, or social degradation because they belong to a social group. Oppression of people results from structures of domination and subordination and, correspondingly, ideologies of superiority and inferiority.

- James I. Charlton, Nothing About Us Without Us: Disability Oppression and Empowerment, 2000

FINAL THOUGHTS

People like you hired people like us, because people like you didn't know how to deal with people like us.

Now, people like you want to tell people like us how to deal with people like us.

FINAL THOUGHTS

I have struggled with this section because of what I feel needs to be said and how it will be perceived. I have agonized over the lede in this section, questioned the content of this entire document, and have doubted my ability to convey the concepts within these pages in a way that might cause any meaningful change. I have struggled mostly with an attempt to not appear as if I'm taking this personally.

But it is personal - very personal.

In 2007, I was taken by ambulance to my local hospital. I was experiencing renal failure due to the amount of alcohol I had been drinking, and about an hour after I was admitted, my esophagus ruptured. I was told later that I had been dangerously close to death. As it turns out, the stars had aligned that night, and several very capable and dedicated doctors and nurses were on hand. They worked to save my life — a life I had, for a long time, very much felt wasn't worth saving. I spent the next several days in the ICU, while concerned family and friends awaited my fate. I was later sent to the medical floors while I recovered. I had been fired for having missed work, and social workers and case managers worked with my employer to reinstate my employment status and, more importantly, my health insurance. One of the hospital NPs came to see me one evening. She checked the things that NPs check, looked me up and down, and commented about how lucky I was to have survived. She then, in no uncertain terms, but very kindly told me to get my shit together. It was a simple case of being told just the right thing, at the right time, by the right person, in the right tone.

The social workers and case managers arranged transport to a facility later that week where I would spend the next several days before coming home. During the early years in sobriety, I attended AA, found a PCP, saw a therapist, paid my mortgage, bought a car, found work in a tech firm, went to D.C. to lobby for financial reform, wrote nationally published articles, and became what most people would call - and some would debate - a productive member of society. I made some really good friends, some of whom I buried too soon and too young. I was reunited with family and just shy of 10 years later, buried my dad. I experienced some real joy and some real heartache over those years. I did what one does in recovery; stayed sober and I lived life.

In 2017, I was hired by the same medical facility and I was given the opportunity to work within the very organization, and alongside some of the people who had saved my life nearly a decade earlier. It was a significant pay cut, but an opportunity to maybe do good things and be a part of something meaningful. For one of the few times I can remember, I was proud of what I was doing. We grew quickly from having one RC covering 16 primary care offices, to bringing on more coaches as the number of referrals grew. We applied for and were awarded a grant, allowing us to expand into the hospital and the medical floors.

In March of 2020, as a result of COVID, many of the systems that had been in place broke down. In April of that year, we realized that no one from the Addictions Consult Team (ACT) was responding to referrals, so we did. For months, we contacted hundreds of ACT referrals, provided ED outreach, and managed the referrals we continued to receive from primary care. We used our contacts in the community to get people the help they needed. The RC Team logged 5,869 encounters with 1,522 unique patients that year.

During that year, working with department heads in the ED, medical floors, security, pastoral services, and social work, we took the opportunity to develop procedures to better respond to referrals and patient needs. We created numerous documents concerning appropriate referrals, placing orders, paging recovery coaches, contacting recovery coaches, referring to outside agencies, and handing off patients who had been discharged with "bridge scripts," just to name a few.

FINAL THOUGHTS

In 2021, we reentered the hospital and shortly thereafter were integrated with hospital staff, and thanks to the grant funding we had procured, a newly hired NP and a psychiatrist who would be dedicated to the SUD teams. The idea, at least to us, was that we would be accepted as collaborating partners and part of a multidisciplinary team. Instead, despite the work we had done and what we had accomplished during the previous four years, we were quickly made to understand that we were little more than "the help," and eventually the problem.

The cruel irony of us being at odds with the people whose salary we had assured through the grant we procured, has not been lost on any of us.

We made several attempts to challenge ill-conceived assumptions by providing resources, documents, and offering to educate and inform staff and leadership on the role of RCs. All of these attempts were rebuffed. One such response came from a physician claiming that they were "well aware of what recovery coaches do," after having insisted the week before that recovery coaches provide transportation for patients.

Because there was no one in leadership or HR who intimately understood our roles, we were left at the mercy of people purporting to outrank us. They deemed us incompetent and insubordinate to their superiors, and that sentiment continued up the chain and was repeated in leadership meetings.

Listed below are just a few of the challenges we've experienced that illustrate what a lack of oversight and unwillingness to collaborate has produced. These selected claims are accurate, albeit condensed in the interest of brevity, and only represent an overview of events. They have been documented, can all be corroborated, and cannot be easily dismissed as melodrama, hyperbole, or the rantings of a lunatic.

- During a meeting of the Addictions Consult Team, one of the psychiatrists referred to addicts as "retards and losers." We brought the matter to leadership and when the behavior wasn't addressed and continued, we filed a Bias Report. The department's leadership investigated themselves, found no wrong-doing on their part, put the blame squarely on us, and removed us from the team.

- After having received several inappropriate referrals, we brought our concerns to leadership, we offered to help train staff, created documents with guidelines and instructions, and watched as they continued to refer patients who suffered acute SI, HI, were actively psychotic, aggressive, and in mental distress. When we pushed back, we were accused of refusing to see patients and called incompetent.

- We brought our concerns to HR, adding that some members of our team were in emotional distress due to the continued antagonizing behaviors and that thoughts of relapse and self-harm were prevalent. We received no response. The same applies to a feckless EAP.

- Attempts at diplomacy, mediation, and education in an effort to correct and address the misunderstandings and animosity were refused and declined.

- Earlier this year, I filed two safety events regarding referrals to the RCs: a patient who had been sexually assaulted the night before, and another who was openly threatening physical violence to doctors and nurses in the ED. We were told, "Your job is to see the patients we send you." Shortly thereafter, we were removed from the hospital and the RC team was split up. I was no longer allowed to supervise or communicate with RCs in the hospital.

- During a meeting with a member of the leadership team about the restructuring of departments the conversation about past actions that were taken against the RC team was brought up. In particular the smears and accusations against my team and me. I was blithely informed that I had "not been here long enough to be protected."

- Rather than try to understand and accept the roles of the RC and the Supervisor, job descriptions were rewritten and we were made to reapply for our newly defined positions in order to remain employed.
- During a departmental meeting, the lead psychiatrist of the substance use program asserted that he had, "never seen an adult alcoholic or addict stay sober," nor did he believe that they could.
- RCs have been excluded from planning committees and roll-outs of SUD services; including, of all things, Recovery Month celebrations.

Whether any of this would have been avoided had some of the safeguards suggested in this document been in place is not clear, but had they existed, and had there been a consensus by willing parties surrounding the RC role, they might have given HR and leadership the opportunity to react with an informed approach, rather than appearing to tacitly encourage retaliatory and adversarial behavior.

Healthcare organizations made a decision to hire people from the recovery community because they needed our help and because what they were doing wasn't working. Despite the miracle drugs, studies, and psychiatric theories, people were dying by the thousands — they still are. These institutions asked for our help and when they did, they required us to out ourselves and to expose who we are to a society in which most people in recovery keep their stories and history hidden because of how that very society has viewed, judged, and treated them.

We were told to advocate, for our patients, for ourselves, and for recovery. We were told to address stigma, inequities, and unfair treatment. They talked about patient centered and trauma informed care. They told us to stand our ground, to not back down, and that we would be heard — that we would be given a voice.

Precisely because of how we've been treated and how others like us have been treated, we accepted. We personally and professionally outed ourselves to the world. A world that still discriminates, stigmatizes, and mistrusts us. We did so, in some cases, because it was noble and altruistic and we thought that maybe, just maybe, from the inside, with a seat at the table, and despite the skepticism, we could help make things better.

Perhaps we were naive to assume that we would have the support we needed when we were inevitably met with resistance. It was after all, at the very least, implied that the organizations asking us to stick our necks out had some idea of the potential consequences of this strategy, given the history of their institutions.

There is seemingly an unwillingness on the part of the medical community to address behaviors at a certain level and an apparent aversion to holding their peers accountable. The behavior is rationalized as a "cultural issue" or "internal politics." In the meantime, and as a direct result of this dysfunction, we have lost extremely capable, dedicated, and wonderful people who chose their own mental health over a job they loved.

There also exists an undercurrent of perception that we, the recovery coaches, were found at a bus stop and given our first real job. Many of us come from having had professional careers. We know how to navigate the workplace, we come with a variety of useful skills and talents, and we know how to act and dress in polite society. At the very least, many of us have worked in customer service, which when at its best, healthcare employs a similar approach — patient centered, patient informed, multidisciplinary team based, and collaborative care.

FINAL THOUGHTS

In recovery, we are taught that in order to survive and eventually thrive, we must challenge old concepts and ideas. Meditative or mindfulness practices suggest that we remain curious. Science, in order to advance and make new discoveries, questions and scrutinizes existing theories. Both recovery coaches and the medical community could benefit from this advice and remain curious, lest they become entrenched in concepts and ideas that have no benefit to the people we serve. Yes, curiosity killed the cat, but it also cured polio.

My fear is that without the full support of the organization, the recovery coaches will flounder, and these programs will fail. The ensuing postmortem will most likely not be the medical community reflecting on its own failures, but on that of the recovery coaches and people in recovery. The blame will fall squarely on a population that historically, and by their own admission, have been difficult to deal with; and that would be a travesty.

Cause sometimes you just feel tired. Feel weak, and when you feel weak, you feel like you wanna just give up. But you gotta search within you.You gotta find that inner strength. And just pull it out of you, and get that motivation to not give up, and not be a quitter, no matter how bad you wanna just fall flat on your face.

– Eminem

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Ethical Guidelines for the Delivery of Peer-based Recovery Support Services
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Peer Support Worker Comparison Chart
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