We could view the relationship between the Peer Recovery Supporter and those they serve as 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 Peer Recovery Supporter would be always okay, sometimes okay but sometimes not okay, or never okay.

Table 1: Peer Supporting: An Intimacy Continuum

Behavior of Peer Recovery Supporter in Recovery Support Relationship	Zone of Safety (Always Okay)	Zone of Vulnerability (Sometimes okay; Sometimes not okay)	Zone of Abuse (Never Okay)
Giving gift			
Accepting 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 holiday dinner			
Sexual relationship			
Sexual relationship with a mentee’s family member			
Giving cell phone number			
Using profanity			
Using drug culture slang			

“I’m going through a rough divorce myself right now.”			
“You’re very attractive.”			
Addressing person by			

their first name			
Attending recovery support meeting together			
Hiring person to do work at your home.			

Ethical issues that can arise in situations like the 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 Peer Recovery Supporter does or fails to do. These parties include the person receiving recovery support services, that person's family and intimate social network, the Peer Recovery Supporter, the organization for which the Peer Recovery Supporter 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, quality, sobriety can be counted on to act ethically as Peer Recovery Supporter's.*
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 Peer Recovery Supporter's 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 Peer Recovery Supporter's 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 assure 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 could 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 Peer Recovery Supporter.*

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 in its delivery in a broader range of service delivery sites.

Assumption 6: *Formal ethical guidelines are needed for Peer Recovery Supporter's in full- time paid roles, but are not needed for Peer Recovery Supporters 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 Peer Recovery Supporter 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 could contribute to such silence, and all of them are a potential problem. The two most frequent are the inability of a Peer Recovery Supporter to recognize ethical issues that are arising or his or her 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 Peer Recovery Supporter's regularly bring ethical issues up 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. Two conclusions were drawn from that exercise. First, we noted the importance of group conscience within the history of particular communities of recovery and that judgments of behavior would likely differ across these recovery communities. That suggested to us the importance of establishing a local council of persons 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 these values could provide a helpful filter for ethical decision-making and that it was important to evaluate actions of the Peer Recovery Supporter by these shared values rather than 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.

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 could take in that situation. We propose that those providing recovery support services ask three questions to guide their decision-making.

Question One: Who has the potential of being harmed in this situation and how great is the risk for harm? This question is answered by assessing the vulnerability of the parties listed in the table below and determining the potential and 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			
Peer Recovery Supporter			
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?

X	**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	

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 four arenas: 1) service context, 2) personal conduct of the Peer Recovery Supporter**,** 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 their reputation is being hurt by key practice decisions.

____ ABC hires people as Peer Recovery Supporters who have minimal sobriety time.

The legitimacy of each RC is derived from experiential knowledge and experiential expertise. Where there is no or little experience, there is no legitimacy. Peer Recovery Supporter's should be hired who have established a personal program of recovery marked by duration and quality. Minimum recovery requirements for Peer Recovery Supporters are currently ranging from one to two years,

with many Peer Recovery Supporter's possessing more than five years of continuous recovery. This minimum requirement is for the protection of those receiving and for the persons and organizations providing recovery support services.

____ ABC does little to orient, train, or supervise their Peer Recovery Supporter's.

Failure to provide the RC with the needed orientation, training, and supervision affects their capabilities, their credibility, and the safety of 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, 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 assure that the delivery of RC services will be covered within the sponsoring organization's liability/malpractice insurance.

____ ABC pays Peer Recovery Supporter's 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. Adequate support for volunteers, adequate salaries, advancement opportunities for RCs in paid roles, and setting limits on hours worked for both volunteers and paid support specialists are crucial in sustaining the quality of peer-based recovery support services.

____ ABC assigns volunteer Peer Recovery Supporter's to perform counselor functions and 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 Peer Recovery Supporter's via recruitment, screening, selection, orientation, ongoing training, ongoing supervision and events celebrating the service work of RC volunteers.

____ ABC assigns Peer Recovery Supporter's 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 to meeting in high risk neighborhoods, etc.

____ ABC uses Peer Recovery Supporter's 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.

<u>Screening Practices</u>: DEF is a grassroots recovery advocacy organization that provides Peer Recovery Supporting 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 Peer Recovery Supporter. 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 assured at the same time the agency practices standards of fairness in their 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 could 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., assuring that people will 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. (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 Peer Recovery Supporter? 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 and RC. In this case, Jerome's poor self-care does potentially impact his effectiveness as an 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 Peer Recovery Supporter 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 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 they ripple, and only when they ripple, into how we perform 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 get 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 are raised by this situation? What should

Ricardo do? What should be the organization's/supervisor's response if this situation is brought to their attention? What organizational policies need to 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 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 the role of RC that 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. 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). *Tolerance for multiple pathways of recovery can be achieved by training and exposure to people in long-term recovery representing diverse recovery pathways.*

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 could 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 are potentially 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 alternative is Barry or no service (e.g., a situation where Barry might be the only Peer Recovery Supporter in a community), Barry and his supervisor should explore additional options or explore how these RC services could be provided while minimizing harm to all parties. The most critical factor here is maximizing the comfort and safety of the individual/family receiving*

services. It is best if RCs are expected to immediately declare the existence of any pre-existing relationship 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 that 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 could 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 Peer Recovery Supporters who are also very 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 they 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 Peer Recovery Supporter 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 referring people to the recovery home that he owns? How could 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 could injure Raphael's reputation as an RC and the reputation of the organization for which Raphael 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 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 and works as a volunteer Peer Recovery Supporter and also works full time as a certified addictions counselor. What problems could be posed by Marcella bringing the clinical orientation from her counselor role into her volunteer role as a Peer Recovery Supporter? How can the organization/ supervisor help "counselors as peers" relinquish their clinical orientation?

The potential problems in this situation are numerous. First, if Marcella drifted into her counseling role as a volunteer, 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 importantly: during the time Marcella is doing counseling, the client is not receiving needed recovery support services.

Compassion Fatigue: Elizabeth has volunteered as an RC for the past 2 ½ 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 Peer Recovery Support?

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 need to be acknowledged and addressed in supervision. Elizabeth may need a break in her coaching activities, might consider reducing hours or an altered level of problem severity of those with whom she works, 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 Peer Recovery

Supporters 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. Not disengaging when they need to and precipitous disengagement both present potentials of harm to those receiving recovery support services.

Conduct in Service Relationships

Choice/Autonomy: Charise works as a Peer Recovery Supporter 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 question is: "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 resolving this tension is working with people who by definition (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 the person through the early stages of recovery until they can make choices that support their own best interests. At a practical level, that 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 freedom to choose different pathways of recovery but also the freedom to choose not to recover.

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

Mismatches in the assignment of Peer Recovery Supporter are inevitable, just as mismatches occur in the assignment of counselors. A match between a Peer Recovery Supporter and those with whom they serve may be even more important because of the increased time spent together and the potential duration of the relationship. Occasional mismatches are best acknowledged early and either resolved via

alterations in coaching style or reassignment of a new Peer Recovery Supporter. The alterations in coaching style or reassignment of a new Peer Recovery Supporter. The affects of Peer Recovery Supports 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 get to ultimately define who qualifies as a "peer." Evaluating and resolving potential mismatches is an integral part of good supervision. It is 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 capacities 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 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 development of a larger and more sustainable sobriety-based support network.

Friendship: Raymond volunteers as a Peer Recovery Supporter 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 Peer Recovery Supporter. 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 Peer Recovery Supporter. Are there any ethical issues raised by this friendship?

Friendships may develop within the context of Peer Recovery Supports, but there is one thing that distinguishes the Peer Recovery Supporter relationship from other social relationships, and that is the service dimension of that relationship. This means that Peer Recovery Supporters 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 was 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 prevents 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; it's 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 to potentially 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 with a dual relationship.

Sexual Exploitation: You supervise Peer Recovery Supporter's 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 was not with the primary "client" but with a family member or friend who was involved in the service process? Could the Peer Recovery Supporter 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 where an RC could exploit service relationships for his or her personal, emotional, sexual, or financial gain. It is that power discrepancy that makes an intimate relationship between an RC and those 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 intimate relationships between an RC and service recipient extends to the family and intimate social network of the person being coached who are involved in the service process. As for relationships with persons 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 could be involved with an individual he or she met within the recovery community who they discover 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 their 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 Peer Recovery Support 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, this 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 be not only ethical but essential in maintaining the service relationship in another. 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 could 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 their 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 was a physician volunteer, their 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 to discuss these issues, e.g. a physician trained in addiction medicine.

When to Refer: Martha has attempted to engage Rita in the Peer Support 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 not improved the situation. At what point should Martha acknowledge this situation to her supervisor and Rita and seek to get another Peer Recovery Supporter 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 raise the question of whether Rita would be better served with a new RC. This question should first be raised 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 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 by the RC being in the middle of such communications? How should Maria handle such communications?

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

<u>Discretion versus Duty to Report</u>: A person for whom you are serving as Peer Recovery Supporter discloses to you that he has been using 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 owner of the recovery home? Would a Peer Recovery Supporter 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 from 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 they thought that information should be conveyed to responsible authorities, if the individual was comfortable making such a report, or if they would want you 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.*

<u>Threat to Community</u>: 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 forfeit 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 get in 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.*

<u>Personal Bias:</u> 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 could result in harm or injury to multiple parties. How could Fred separate what he knows about methadone (the facts) 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 them at this moment. Discouragement of a particular method of treatment could 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

<u>Responding to Unethical Conduct</u>: 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 are the ethical issues presented by this situation? How would you respond?

> *There are several needs raised in this situation. The first is to acknowledge to Susan that such a relationship is a breach of professional ethics, to request whether she would want a referral to a different treatment agency, and whether 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: Samuel works as a Peer Recovery Supporter doing post- treatment telephone monitoring. Samuel has represented in his interactions with the larger community 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 are raised by this situation?

The values of honesty and credibility call upon the RC to accurately represent their 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 true, these communications stop and be replaced with an accurate description of Samuel's role and educational credentials. This might well be accompanied with a broader discussion of how RCs establish credibility and legitimacy within the larger service community.

Representation of Credentials: Would you view the situation above with Samuel 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 sponsor. What harm and injury (if any) and to whom could result from such a dual relationship?

Failure to maintain boundary separation between the roles of RC and sponsor could 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 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 Peer Recovery Supporter is, at best, a poor stewardship of community resources and, at worst, fraud.*
4. *Role ambiguity and conflict resulting from a mixing of sponsorship and RC functions could inflict injury on clients/families, service workers, service agencies, and the community.*
5. *The RC role represents a form of connecting 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 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 "getting paid" for the time he is in meetings and that this constitutes accepting money for Twelve Step work. What are the ethical issues here? How could George more clearly delineate his paid activity from his NA service work?

The values of stewardship require that the RC carefully allocate their 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 12 stepping.

Discretion: You are working as a Peer Recovery Supporter attached to a treatment agency. You take an assigned client, Troy, to a local recovery support meeting and also 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 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 could encourage Troy to go 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: Claude has been in and out of treatment and NA multiple times and has an off and on again relationship with you as a Peer Recovery Supporter. 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 to Rudy's question) extend to the Peer Recovery Supporter relationship?

If you are in an organization (e.g., treatment agency) covered by federal confidentiality regulations, you may not respond to that question or even acknowledge that Claude is a client at your organization unless you had a signed release to talk to Rudy about Claude. If you are in an organization not covered by federal confidentiality regulations (e.g. a freestanding recovery support organization, a recovery ministry within a church, etc.), your response should be guided by your policies on confidentiality and discretion and the agreement about permitted disclosures of communications 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 Peer Recovery Supporter. 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 Peer Support 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 to AA. This would violate AA's anonymity tradition as well as be potentially 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 was 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 Peer Recovery Supporter for women who are just entering intensive outpatient treatment and who are 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 via 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 client in finding meetings with a "climate" that is safe and supportive.*

Potential Iatrogenic Effects of Peer Recovery Support: Ellen, a highly respected elder in the local AA community, is expressing criticism of Peer Recovery Supporter's 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 Peer Recovery Support and shown the statistics and local experience related to the role of Peer Recovery Supporters in successful long-term recovery. Ideas should also be solicited from Ellen about how the Peer Recovery Supporter role could be designed and supervised to assure 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 Peer Recovery Supporter. 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 Peer Recovery Supporter 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, etc.) 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 role confusion between the RC and sponsor roles.*

Summary

This essay has described a model of ethical decision-making for Peer Recovery Supporter 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 Peer Recovery Supporters and their sponsoring organizations grows. This growing foundation of experience will spawn formal ethical guidelines for Peer Recovery Supporters 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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- 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.