Beginner's Guide to Addiction Peer Recovery for Justice Involved Individuals

Edited by Anna Verbraak, CASAC, Peer Recovery Coach Supervisor

PARfessionals
P.O. Box 163, DeBerry TX 75639
www.parfessionals.com

TABLE OF CONTENTS

KNOWLEDGE

RECOVERY TALK

What is recovery?

recovery [ri-**kuhv**-*uh*-ree]
noun, plural **re·cov·er·ies.**

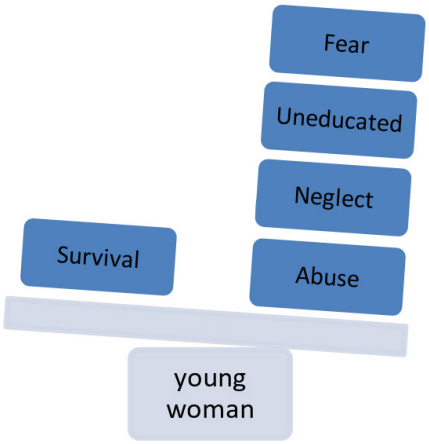
an act of recovering
the regaining of or possibility of regaining something lost or taken away
restoration or return to health from sickness
restoration or return to any former and better state or condition
time required for recovering

While the dictionary definition of recovery refers simply to a process of restoration, those who have gone through recovery from substance abuse and mental illness will tell you it was anything but simple. Not only are the complexities of biology, behavior, and environment a challenge, but the stigma attached to both conditions can be overwhelming. Those in recovery are often viewed as if there is something fundamentally wrong with them which creates a barrier in recovery much harder to overcome than the physical healing.

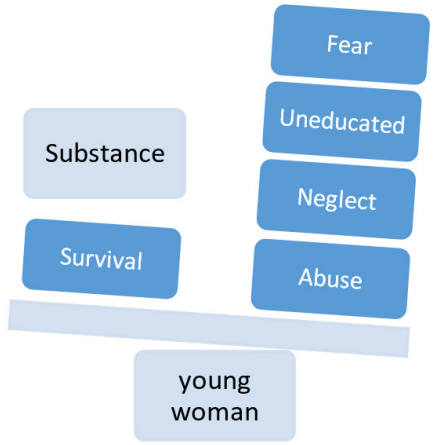
There's a biological term that refers to systems regulating for stability and constancy and research shows that humans, animals, the environment and even technology thrive in a state of homeostasis. Our bodies, for example, have delicate systems of temperature and pH that when disturbed, cause disease and malfunction. The medical establishment treats these diseases and malfunctions by bringing the body back into homeostasis. Psychologically, when we are stressed or experiencing strong emotion, the

mind and body attempt to regulate itself such as through the release of hormones or emotional expression such as crying.

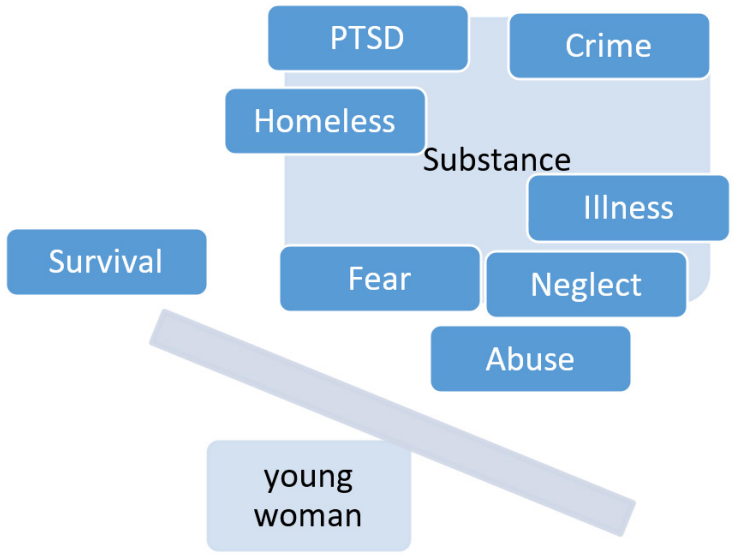
Perhaps thinking of recovery from substance use as a process of achieving homeostasis can detach the damaging barriers of self-deprecation from healing. Granted, most substance use problems are caused by one's decision to ingest those substances, but most often, those substances are being used to achieve homeostasis. For example, a young woman grows up in an abusive household. By the time she reaches adolescence, her body has been battered and broken, she has not formed secure attachments and doesn't feel loved, she has struggled in school because of her focus on surviving and her state of being is a constant state of fear. It is obvious to most that her body, mind and spirit are not in a state of homeostasis, so when she discovers a substance that numbs the pain and calms her fears, she feels closer to it. The problem is, eventually the substance wreaks havoc on her body, mind and spirit, taking her further from homeostasis but in a different way.



Prior to using a substance



Introduction of substance in an attempt to achieve homeostasis



The substance begins as a source of balance,
but ends up creating more problems.

Historically, addiction treatment addressed the substance use. As you can see from the visual representation of our example young woman, if you take away the substance, the abuse, neglect, fear and lack of education remain. With the addition of the substance and time, more problems likely arise including homelessness, crime, PTSD, physical illness as well as more fear, neglect and abuse. Without proper treatment, this woman could return to using substances. Although it may seem that it is effective in forgetting all the things that unbalance her, it can cause negative long-term effects.

If the goal of recovery is to return to a state of homeostasis, how can we only focus on the substance and not on all of the other things that cause imbalance? The good news is that research has emerged to support the idea of whole person recovery and treatment communities are finally, albeit slowly, making the transition to whole person recovery.

Your own journey through recovery, whether through the old system or the new, is a testament to what works. Everyone is different. Everyone coming into recovery has a different story and different dimensions of imbalance.

If we, as a recovery and treatment community, can provide clients with tools to understand the imbalances in their lives and show them the way to the balance they crave, perhaps we can dispel the myths surrounding substance use and mental illness. There is nothing fundamentally wrong with people in recovery and it's our job to help them understand that they can heal. They ***can*** achieve balance.

Because recovery is so different for everyone, those helping them through the journey must be prepared to meet their needs. This means helpers working on problems at different levels. Treatment for substance use and mental illness sometimes requires the medical expertise of a psychiatrist, the professional training of licensed counselors or social workers, or the lived experience and understanding of a peer supporter. Some in recovery require one, some require all, but the goal of all levels of treatment providers needs to be the well-being of clients who are working hard to achieve their definition of recovery.

Understanding your own definition of recovery will help you talk about it in ways that can help your clients discover their definition of recovery. Sharing your journey, your struggles, and your triumphs serves not only a tangible model of success, but a source of hope that is different from trained professionals who may not have recovery experience. You have lived it, you have been there, and you can walk alongside someone else and inspire them to a place of hope.

Throughout this study guide, many descriptions and modes of recovery will be explained; however, keep in mind the most valuable tool a peer supporter brings to the working relationship is experience in recovery. It is not surprising that most people have negative opinions about the treatment community and many clients will come to you with a combination of ambivalence and hope. The way you talk about and live your recovery will be a model for clients.

Why is lived experience important?

Lived experience, or experiential knowledge serves as an integral component of peer supporters (eg. addiction peer recovery coaches, peer recovery support specialists, peer mentors) both personally and professionally. It is gained by having a particular set of experiences that your client can identify with, and is a powerful way to understand, feel accepted and connect with on similar and equitable terms.

Understanding each client's situation or lived experience evolves from sincere communication through engagement. Our use of competent and relevant language and expressions are more likely to engage the client in a dialogue that brings forth an open, honest and trusting display of feelings and emotions. It is a valuable way to communicate and gain a more accurate understanding and interpretation of a client's beliefs, values, and situations of their lived experience and authentic self. Communication and understanding of the client's world or lived experience becomes a vital element to effectively carry out the role and responsibilities of a peer supporter.

For those of us who have succeeded in our own recovery, we see this work as an extension of ourselves and a way to pay it forward. Our once shameful pasts are now part of our own inspiring history that instills hope in those finding their way that invite us along. The role we have is more than keeping people sober, encompassing issues, both cognitive and behavioral. How we connect with clients not only is our privilege, but involves implications for the field of addiction recovery coaching and peer recovery support as a whole.

Working with clients that battle addiction, as we ourselves have, offers a distinctive perspective that allows us to be more relatable. It is through our own process that we possess a strong sense of empathy, an element that includes a deeper understanding and connection. Compassion is

established and felt early on in the relationship by truly recognizing the challenges and strengths of our clients. This awareness facilitates a conducive environment of cooperation and collaboration and involves a partnership. Empathy is our greatest asset and we have more than most because we have been there ourselves. We share a collective past, and now share a common goal that now seems more attainable, the possibility of recovery.

We strive to help clients achieve their recovery goals. It requires a person-centered perspective to promote change. By offering a first hand account and being a role model you are living proof that sustained and sober lifestyle changes are possible. Also, establishing a safe and open environment allows your client to work to align their actions with their desired behaviors.

As someone that has successfully battled addiction or has struggled with addictive behaviors, your experience allows for the establishment of trust. This association leads to more openness and willingness to achieve their personal best. It is within this collaborative partnership you each bring important expertise. It is our privilege to be allowed such a coveted role in a client's life, and this relationship is more advantageous for both the peer supporter and client when it is within the context of a personal account.

As we all are innately social beings, it is an inherent component to strive for connection and to be understood. How we are in our earliest interactions with our clients sets the stage as we begin to create a relationship that allows for a deeper appreciation of the trials and tribulations our clients face. It is within our own histories that serve as examples of our empathetic understanding. Since we have been there ourselves, our own experiences are what lends credibility.

Those who are striving for long-term recovery are looking for someone that can provide hope, that really "gets it," and we do. What is important is that the clients feel that we are not only supportive but knowledgeable as well.

It is through our pasts that we can facilitate change for our clients both in the present and future. Our experiential contributions are lessons that cannot be found in any manual or textbook.

We must remain aware that our clients are inviting us into their lives at their most vulnerable moments, sharing themselves during their deepest depths of despair and deserve to know that not only are we not judging them, but, "Recovery is possible, I know because I was there too." We serve many roles as peer supporters, but one of the most important is the alliance that forms with the clients we serve. Our life experiences provide credibility and offer hope and support throughout the recovery process.

While the alliance you establish is based on the mutual connection of shared experiences, it is important not to over identify with your client. It may compromise the integrity of the professional and purposeful intent for which you serve. Another consideration to keep in mind is to be aware of the amount of self disclosure you offer. Sharing insights about your past should be for the sole purpose to help your client through their own examination and engagement. So, when you see an opportunity that would benefit your client, do so in a way that enhances their process, not your own. We share a similar familiarity and feelings which can be comforting for clients and that can help us establish credibility. As peer supporters, we must be mindful that everyone is a distinctive individual and so too, is their journey. We explore the commonalities to create a safe and nurturing environment, but remain cognizant that everyone's history and perspectives are unique and should be treated as such.

As we support our clients in their exploration of authenticity, we can agree that the expertise in the area of recovery is not ours alone, but a facet of many that forms our recovery community. We humbly acknowledge our part as well as our client's and offer guidance where we can. This is what makes our roles so special, as they are reflected in our client's and in ourselves.

ADDICTION SCIENCE BASICS

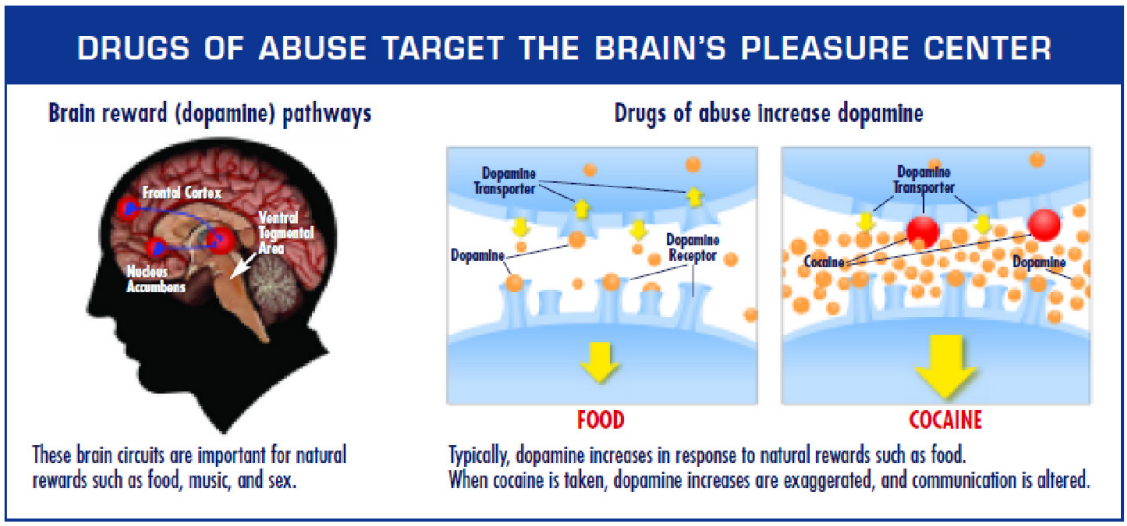
We have all heard the clichés about people who suffer from addiction.

- They could stop if they wanted to, it just takes willpower.
- Once an addict, always an addict.
- An addict never changes.
- It's all in their heads.

The list could go on. In the past decade, there has been more research focusing on the physical aspects of addiction. For some people, traditional treatment works great and they never relapse. Others are challenged and seem to have no control over addictive behaviors and continue to use

despite negative consequences. Scientists wanted to know why and whether there was a biological factor in addiction.

The good news is that researchers found good evidence that substance use changes the brain's pleasure centers and often restructures the brain so it becomes less and less effective without the substance that provided pleasure in the first place. They have also found that susceptibility to addiction can be inherited and those with the "addiction gene" will have a more difficult time controlling cravings and changing behavior.



National Institute on Drug Abuse (2010). Drugs, Brains, and Behavior: The Science of Addiction.

Examples of substances and their effects on the brain

Cocaine: As the above diagram shows, substances like cocaine exponentially increase the brain's levels of dopamine, which disrupts the brain's natural ability to feel pleasure without the substance and eventually disrupts the brain's ability to produce dopamine naturally.

Cannabinoids: The action of THC in the hippocampus interferes with memory and sense of balance; increases the production of dopamine; high doses can cause panic attacks as well as psychosis; when marijuana use starts

in adolescence, research suggests the chemical changes to the brain will cause permanent impairment in cognitive functioning; can exacerbate the symptoms of co-occurring disorders

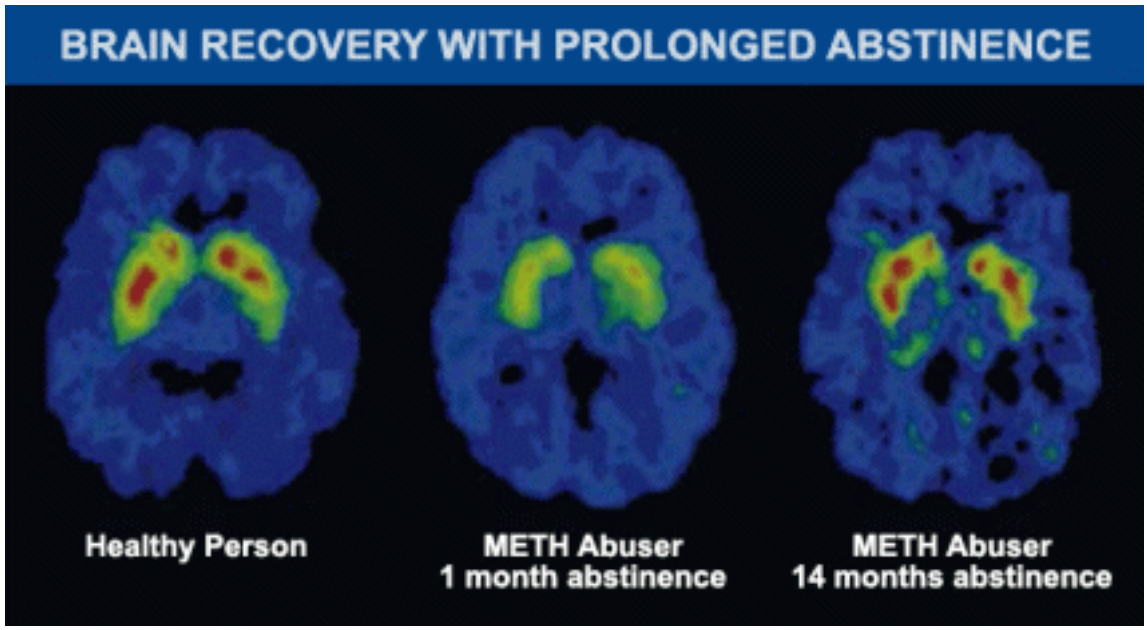
Opiates: Scientists have identified 3 different types of opiate receptors in the brain which are responsible for different functions acting on the limbic system (emotional center), the brainstem (automatic functions), and the spinal cord (sensations). As more and more artificial opiates are used, the receptors become conditioned to them and have a hard time adjusting when they are taken away (withdrawal) and can distort the body's pain centers in a way where the body gets to the point of magnifying pain, thereby increasing the dependency on artificial opiates.

Methamphetamine: A stimulant drug, methamphetamine not only blocks the reabsorption of dopamine like cocaine, but it also increases the production of dopamine, leading to much higher concentrations of dopamine in the synapses which can be toxic to nerve terminals. Once the dopamine is no longer artificially produced, the user experiences the "crash" and then requires larger doses of the drug to achieve previous dopamine levels. Chronic users end up with an inability to feel pleasure often resulting in anxiety, depression, severe mood changes, intense cravings, insomnia, violent behavior and even psychotic symptoms (paranoia, auditory and visual hallucinations). Brain scans of long term methamphetamine users also show structural and functional changes in areas of the brain associated with emotion and memory, some of which cannot be repaired. Because of the damage caused to the brain, recovery from methamphetamine can take a long time while the brain heals, sometimes longer than 14 months.

Alcohol Use: Alcohol is a depressant substance, meaning it has a significant impact on the brain and central nervous system. Alcohol enhances the activity of gamma-aminobutyric acid (GABA), an inhibitory neurotransmitter, which leads to the calming and sedative effects commonly associated with drinking. This is why alcohol can make people

feel relaxed and less anxious. Alcohol also increases dopamine levels in the brain's reward system, which creates the feeling of pleasure and reinforces the behavior of drinking, contributing to its addictive potential. As alcohol consumption increases, it impairs judgment, coordination, and reaction times. While moderate alcohol consumption may not lead to significant harm in most adults, heavy and chronic use can cause serious, sometimes irreversible damage.

Recovery of Brain Dopamine Transporters in Chronic Methamphetamine (METH) Abusers *Methamphetamine abuse greatly reduces the binding of dopamine to dopamine transporters (highlighted in red and green) in the striatum, a brain area important in memory and movement. With prolonged abstinence, dopamine transporters in this area can be restored.*



National Institute on Drug Abuse (2013). Research report series: Methamphetamine..

Implications for peer recovery

Categorizing addiction as simply a physical problem is not complete enough for true recovery and it can often leave clients with a sense of helplessness.

Simplifying addiction as a "brain disease" carries its own stigma and leads people suffering from addiction with the idea that they are powerless.

- Understanding that a biological component to recovery exists can help peer supporters guide clients to medical treatment to complement their recovery efforts.
- Help clients make appointments with medical providers who can then determine if Suboxone, Vivitrol, or other medications could be helpful for their recovery.
- Medication should not be the sole tool in recovery and providers of medication should be included in a client's treatment team with the goal of eventually ceasing use.
- Helping clients understand the brain takes time to heal. Recovery is not a short process and clients may think and feel consequences of using well over a year after abstaining from substances. Validate and normalize their experiences.
- Guide clients to making lifestyle changes that can help boost their natural ability to feel pleasure such as exercise, helping others, healthy diet, laughter, and finding different kinds of fun leisure activities.

HISTORY OF RECOVERY MOVEMENT

The concept of recovery can be traced back to the 1830's when John Perceval wrote of his personal recovery from psychosis in his book *Perceval's Experience* (Recovery within Reach, 2013). Despite the absence of formal peer recovery support resources in the 1870's, religious organizations such as the Women's Christian Temperance Union, the White, Red or Blue Ribbon Reform Clubs and the non-secular Keeley Institute and Keeley Leagues developed and embraced the peer recovery philosophy (Killeen, 2013). In the 1930's the recovery movement came into full swing in the substance abuse field with the development of Alcoholics Anonymous (AA), founded as a fellowship for people that were focused on sobriety from alcohol. This group was founded by Bill W. and is known as the largest peer recovery support group in the world. The mutual support group model goes back to the 1700's where groups of like-minded people would join together and make a pledge with each other to be sober. Even before this time, there was a "long and rich history of recovery within Native American tribes. In Recovery Circles, Native Americans shared their stories, joined together for the mutual support of the group, and elder members of the group reached out to aid newcomers." The model of an elder providing support for a newcomer has been around for hundreds of years and is the basic model that today's recovery coaching is founded upon. Recovery coaching is best described as an ongoing processional relationship between those seeking recovery and those that have successfully found the path to sobriety; often an intermediary between the client and treatment systems.

The process of recovery in the U.S., however, came to a standstill in the 1940's and 1950's when the primary model of treatment was institutionalization. Individuals were confined to state run hospitals, imprisoning them rather than rehabilitating them (Recovery within Reach, 2013). In the 1970's, the process of deinstitutionalization reduced the focus on hospitalization, and paved the way for a more community based approach. During the 1980's and 1990's, the Recovery Management model was brought to the forefront of addiction treatment and inspired change. In 2002, the President's New Freedom Commission on Mental Health led to a system wide shift in setting the goals of mental health and substance abuse services toward recovery in a way that makes treatment accessible and tailored to the needs of the people served.

The Minnesota Model

The Minnesota Model was developed by Pioneer House, Hazelden, and Willmar State Hospital (White, 1998) and is heavily influenced by the 12-Step model, based on many of the same 12-Step principles. It is sometimes referred to as the 12-Step Model or the Disease Model. Below is an overview of the Minnesota Model:

1. Substance abuse is an involuntary, primary disease that is describable and diagnosable.
2. Substance abuse is a chronic and progressive disease, that without intervention, the signs and symptoms accelerate.
3. Substance abuse is not curable, but the disease may be arrested.
4. The nature of the substance user's initial motivation for treatment is not a predictor of outcome.
5. The treatment of substance abuse includes physical, psychological, social and spiritual dimensions.
6. The successful treatment of substance abuse requires an environment in which the user is treated with dignity and respect.

7. Alcoholics and addicts are vulnerable to abuse of a wide spectrum of mood altering drugs. This cluster of mood altering substances can be addressed through treatment that defines the problem as a substance use disorder.
8. Substance use disorders are best treated by a multi-disciplinary team whose members develop close, less formal relationships with their clients and whose activities are integrated within individualized treatment plans developed for each client. The recovery coach is a member of this team.
9. The focal point for implementing a treatment plan is assigning a primary counselor, usually a recovered person of the same sex and age group as the client, who promotes an atmosphere that enhances emotional self-disclosure, mutual identification and mutual support.
10. The most effective treatment for alcoholism includes orientation to a 12-Step mutual aid group like Alcoholics Anonymous (AA), with the expectation that the addict should work the 12-Steps, attend meetings that combine confrontation and support, attend recovery lectures, and employ one to one counseling to support the creation of a dynamic "learning environment".

A well known ongoing sobriety-based support structure for clients following treatment is Alcoholics Anonymous. There are other mutual aid support groups such as Dharma Recovery, SMART Recovery, Celebrate Recovery.

When this model is used in practice common, interventions include group therapy, lectures, recovering persons as counselors, multi-disciplinary staff, therapeutic work assignments, family counseling, daily readings, presentation of a client's personal narrative, attendance at 12 step mutual aid groups and the opportunity for physical activity (Guthmann, 1999). These activities are highly structured and 12-Step mutual aid groups are viewed as an important component of aftercare.

A client participating in a recovery program based on the Minnesota Model focuses on chemical dependency as the primary problem and a first step in treatment is admitting that they are powerless over their addiction (Guthmann, 1999). Total abstinence from all substances is also required. This type of program provides an option for recovery when individuals physically dependent on substances will benefit from the support of a self-help group, and embrace a spiritual orientation.

Recovery Management Model (RM)`

The Recovery Management Model (RM) is a newer model founded in 2006 by William White, and based on the concept that drug and alcohol addiction is a chronic and progressive disease similar to diabetes, allergies, high blood pressure and autoimmune diseases. Chronic diseases (including addiction) have the following features:

- Influenced by genetic heritability and other personal, family, and environmental risk factors
- Can be identified and diagnosed using well validated screening questionnaires and diagnostic checklists
- Are influenced by behaviors that begin as voluntary choices but evolve into deeply ingrained behaviors
- Patterns of behavior that, in the case of addiction, are further exacerbated by neurobiological changes in the brain that weaken volitional control over these contributing behaviors
- Are marked by patterns of onset that may be sudden or gradual
- Have a prolonged or permanent course that varies from person to person in intensity (mild to severe) and pattern (from constant to recurrent)
- Are accompanied by risks of profound pathophysiology (defined as an abnormal or undesired condition) disability, and premature death;

- Have effective treatments, self-management protocols, peer support frameworks, and similar remission rates, but no known definitive cure
- Often generate psychological responses that include hopelessness, low self-esteem, anxiety, and depression; and
- Generate excessive demands for adaptation by families and intimate social networks.

Treating addiction like a chronic disease, shifts treatment from the typical "admit, treat and discharge" mentality to a long term approach (Killeen, 2013). Using the RM model practitioners "would not view prior treatment as a predictor of poor prognosis or the grounds for denial of treatment admission. They would not convey the expectation that all clients should achieve absolute sobriety following a single, brief episode of treatment. They should not punitively discharge clients for becoming symptomatic, which means services would not be terminated due to a relapse."

The Harm Reduction (ATA) Model

One of the more controversial models of recovery is known as The Harm Reduction Model. It is sometimes difficult for health care providers to grasp because of the underlying philosophy that focuses on reducing the physical, social, and economic consequences despite continued substance use (Killeen, 2013). For example, the clean needle exchange programs and providing free condoms designed to decrease the spread of HIV are hallmarks of the Harm Reduction Model. Out of the Harm Reduction Model, Addiction Treatment Alternatives (ATA) was developed in 2000, specifically tailoring harm reduction to the substance abuse rehabilitation field.

The hallmark of this approach is that it aims to meet client's "where they are" in terms of their goals and personal needs (Killeen, 2013). While abstinence is a great goal, it is not viewed as the only goal in treatment with

the ATA model. Practitioners working from the ATA framework believe in developing a strong relationship with the client. Focusing on strengths the client brings to the table engaging the client in a collaborative process of recovery.

- "Do No Harm" focuses not on the drug, the harm and hazardous behaviors as a result of substance use.
- Exploration of the possible causes of the substance abuse in a person's background is important
- Using either the adaptive model, cognitive-behavioral or other models of recovery to meet the client "where they are"
- Focus on needs, affect, thought and behavior, not the substance addiction
- Any reduction in drug related harm or risky behavior.
- Work on techniques to reducing ambivalence and increasing motivation

12-step and other Mutual Aid Groups Model

The 12-step based approach is organized around the philosophy of Alcoholics Anonymous (AA). AA was founded by Bill W and Dr. Bob with the goal of developing a fellowship to stop drinking, but now consists of over 73,000 mutual aid groups' worldwide (Center for Substance Abuse Treatment, 1999). While AA does not view itself as a treatment modality, this approach has been the most prevalent model used in the U.S. over the last three decades and is often incorporated into other treatment methods. The foundation of this approach is to learn and practice the 12 Steps published in *The Big Book* (Alcoholics Anonymous, 2002):

1. We admitted we were powerless over alcohol that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.

3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take a personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

The application of these steps are personalized, incorporated into the client's daily life, and viewed as a model for change. A practitioner using this approach encourages their client to apply the 12-Step philosophies into daily living, share their experiences with others, ask for help when needed, and attend AA meetings on a regular basis. AA meetings are seen as a safe place away from the addiction and members are encouraged to find a group they can commit to attending.

AA relies heavily on sponsorship, another member with a foundation of sobriety providing newer members with guidance throughout the treatment process. In general, a sponsor is of the same gender as the client and will have more years of sobriety and recovery than the client. This

allows them to have enough perspective on recovery and the implementation of the 12 steps.

The success of AA has spawned other mutual aid groups with different philosophies where members gather together and share their experiences. Leaders often do not have formal training, but rather speak from personal experience and members support each other within the common philosophical framework of the group. Mutual aid groups other than Alcoholics Anonymous include Narcotics Anonymous (NA), Overeaters Anonymous (OA) Gamblers Anonymous (GA), Al-Anon, Women for Sobriety, Save Our Selves, Life Ring Secular Recovery, Moderation Management and Alcoholics Victorious, SMART Recovery and faith based groups such as The Buddhist Recovery Network and Celebrate Recovery (Christian).

HISTORY OF ADDICTION TREATMENT

In order for peer supporters to understand their value to the recovery community and current treatment models, it's important to know where substance abuse treatment has been, where it's going, how it's been effective, what's not been effective, and what is being done to make it more effective.

Where substance abuse treatment has been

Recovery and substance abuse treatment has come a long way in the last hundred years, but it all began with peer support. Alcoholics Anonymous (AA) was born in the 1930's and while institutionalization was the primary mode of treatment in the 1940's and 50's, AA offered an alternative that worked for a lot of people.

During the de-institutionalization movement of the 1970's, a door was opened for communities to provide treatment for those suffering from addiction. Organizations began offering programs that worked, and as they gained legitimacy the demand for treatment grew. With an increased demand for treatment, came the need to legitimize and fund services, so addiction treatment looked to the nearest equivalent: medicine. As treatment providers molded services to look like the medical model in order to get reimbursed by insurance companies and social services organizations, the acute care model was born.

The acute care model legitimized substance abuse treatment and secured funding for treatment. In order for that funding to continue, treatment needed to be in an understandable format for service delivery. As a result, substance abuse treatment began to specialize by problem areas; providers became more professional which required formal training, credentialing and licensing; services grew into a business orientation where money needed to be made in order to continue operating; levels of care (inpatient, outpatient, etc.) were created to differentiate between types of treatment, to show recovery progress, and define the amount of time a funding source would pay for each level of care. Because of all these changes, substance abuse treatment became more and more disconnected from communities and a chasm grew between medicalized substance abuse treatment and community based/mutual aid groups. In the acute care model, the goal of treatment is "graduating" from a program, and success is measured by abstinence and lack of relapse.

As research continues to provide evidence that addiction is more like a chronic disease (think diabetes, high blood pressure, etc.), the acute care model becomes more outdated. Keep in mind that without the acute care model doing what it did and showing that formalized treatment works, there would not be the recovery models we have now. For some people, the acute care model works great, but current research is showing that recovery is long-term, includes more than just abstinence from substances, and that

by providing more comprehensive services, relapse rates will continue to decrease.

Acute Care Model	
Benefits	**Challenges**
Legitimized addiction treatment with third party payers; increased access to treatment	Distanced from community recovery supports
Segregation of treatment (detox, inpatient, outpatient), specialization of addiction only treatment	Neglect of the whole person in recovery
Professionalization of addiction counseling began requiring proper training and licensing	Third party payers did not recognize community supports as legitimate treatment to be paid for
Business orientation; goals and client direction dictated by professionals	Became institution-focused, not client-focused; diminished client advocacy
Outcome-driven – improved and increased addiction research; more researchers were able to determine effectiveness of various treatment interventions	Focus on short-term and crisis recovery with little consideration for long-term recovery
	Definitions of substance "abuse" and "dependence" as dictated by the Diagnostic and Statistical Manual (IV-TR) was the main qualification for moving through levels of care. Not all addiction fits into these categories. The new

	DSM 5 uses a continuum of severity for substance issues which is much more accessible.

White, W. L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices.*

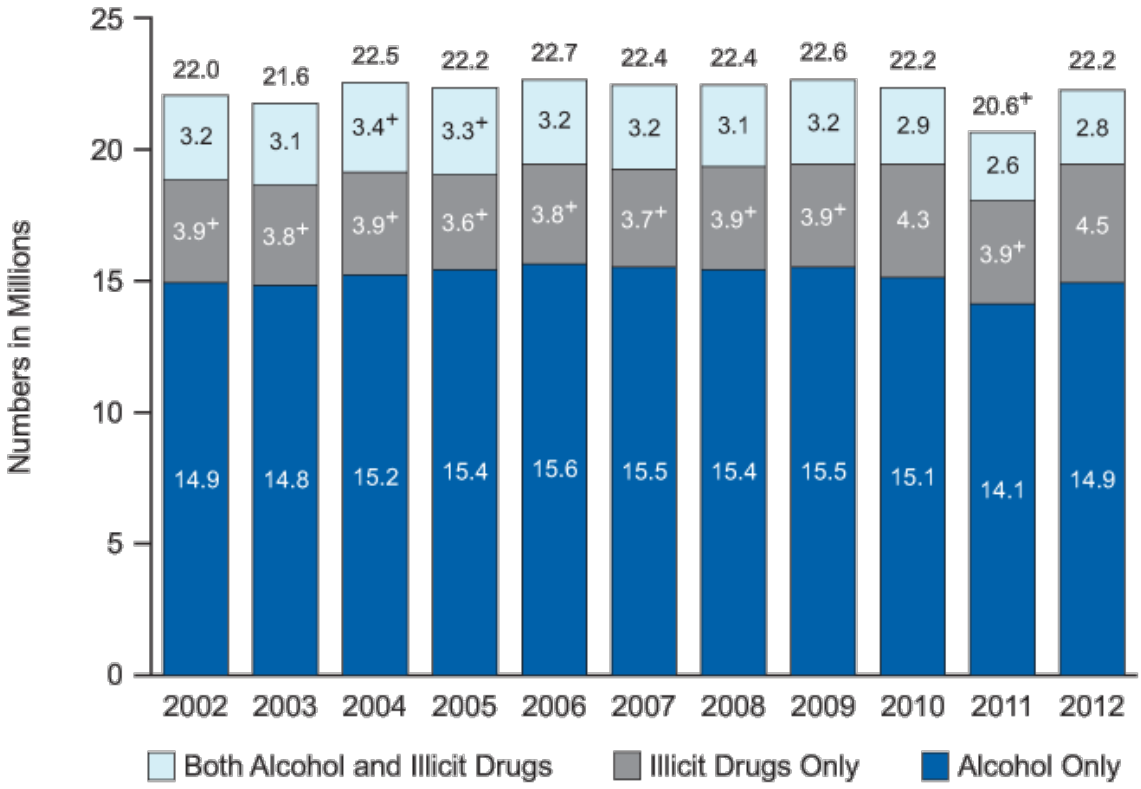
What do we know about who is seeking treatment and its effectiveness?

Here are some facts pulled from William White's and SAMHSA's research:

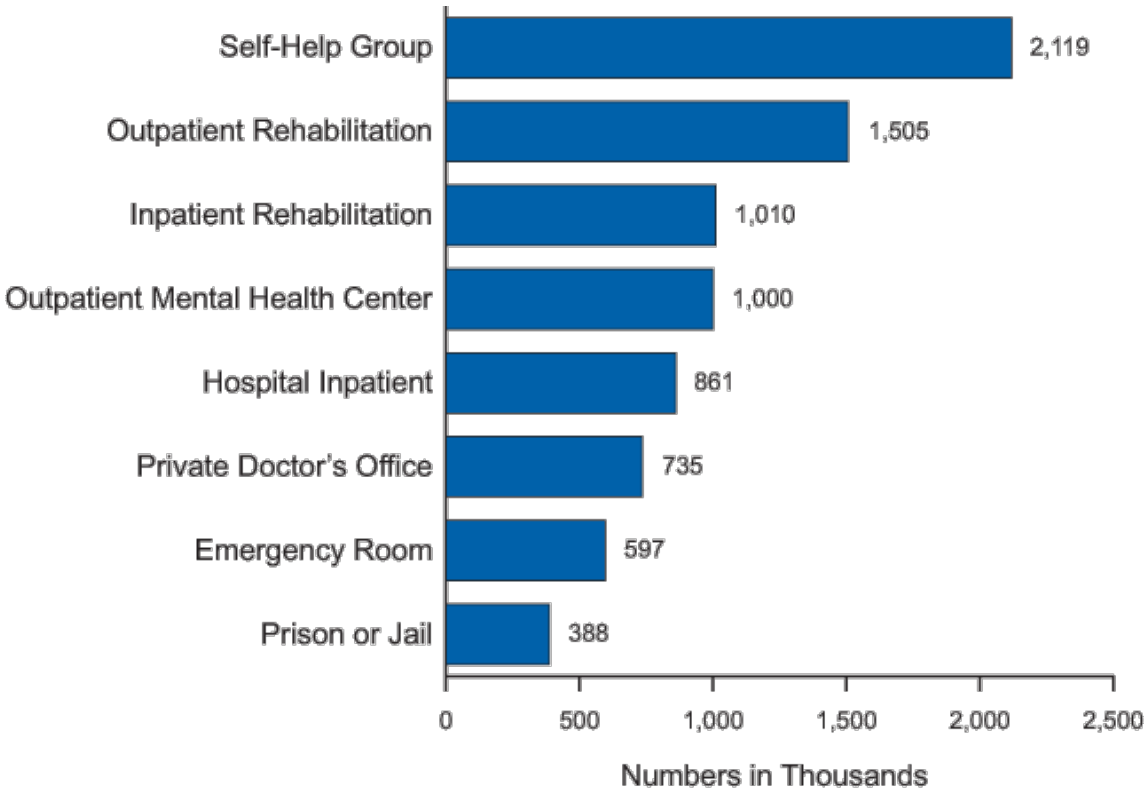
- A grand majority of people with substance use issues resolve problems on their own, a process known as natural recovery. Those in natural recovery may also include people who do not meet the diagnostic criteria for substance use disorder.
- There is another large portion of the population who experience substance problems which are resolved as a result of brief community interventions or out of natural consequences. These people may use peer supporters, mutual aid groups, family, friends, churches, etc.
- People who enter formal addiction treatment are distinguished from the above by:
    - Greater personal vulnerability (family history of use, early onset of use, etc)
    - Greater severity and intensity (longer use, dependent upon multiple substances, etc.)
    - Substance use related consequences and legal problems
    - Higher rates of trauma, PTSD
    - Greater environmental barriers
    - Lower levels of recovery capital
- Very few people who need addiction treatment actually receive it. According to the National Survey on Drug Use and Health (2012), 22.2 million people were classified as having a substance abuse or

dependence problem (graph on the left) and only 4 million received treatment. Of the 4 million who received treatment, the graph on the right shows where treatment was received. The conclusion? There are a LOT of people with substance use problems who never receive treatment.

Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2012



Locations Where Past Year Substance Use Treatment Was Received among Persons Aged 12 or Older: 2012



Substance Abuse and Mental Health Services Administration (2013). *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings.*

Why aren't more people getting treatment?

- There are many people who don't think their problems require treatment or don't want to admit they need help.
- Stigma attached to seeking treatment and being labeled an "addict."
- Some people don't want to give up using or think they can quit on their own at any time.
- Lack of knowledge about treatment or not believing it would be helpful.
- Inability to afford treatment or take time off work to get treatment.
- Barriers such as lack of transportation, day care, scheduling difficulties.

- Lack of support from family and friends; people in the community knowing.
- African American and Hispanic populations are less likely than White Americans to seek treatment.
- Individuals are more likely to seek treatment in primary health care settings and often are misdiagnosed.
- Lack of geographically accessible and affordable services.
- Long waiting lists to be admitted.
- Family not being included in treatment.

What does the research tell us about treatment outcomes?

There is a LOT of research available on addiction treatment outcomes and the following list is by no means comprehensive. The purpose of the information shared here is to help demonstrate where improvements are shown to be needed in our treatment communities.

- Those who enter treatment in the first decade of use shorten their addiction career by as much as 50%.
- The earlier treatment starts, the greater the level of recovery capital available to aid in recovery.
- The greater the social stigma attached to addiction problems, the later people will seek treatment.
- Allowing family and friends in the treatment process, the more likely someone is to utilize them for help and speed long term recovery.
- Culturally competent and accessible services are more inviting, thereby increasing the likelihood of someone approaching treatment earlier.
- Prevention and treatment education can minimize stigma and potential labeling.
- Offering services in a way that minimizes environmental and financial barriers.

- Meeting clients "where they are at," giving clients control over their recovery, and tailoring services to their needs improves long-term recovery outcomes.

We all know that addiction is never the same for everyone. Some people will succeed in the acute care model, but others who struggle with chronic addiction problems need a more comprehensive approach.

In response to the research and through the work of William White, new models of recovery and treatment have emerged.

Recovery-oriented systems of care refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes.

Recovery management is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.

SAMHSA's Working Definition of Recovery

With the prevalence of co-occurring disorders and the variety of treatments available, the Substance Abuse and Mental Health Services Administration (SAMSHA) has served as a clearinghouse for research and treatment for patients and providers of behavioral health and recovery. In 2010, they gathered leaders in the fields of behavioral health and recovery to formulate a working definition of recovery and a set of unified principles for recovery. This effort, the Recovery Support Strategic Initiative, will serve to promote comprehensive treatment of mental health and substance use disorders.

Definition: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Four Dimensions of Recovery:

- **Health**-abstinence from substances, managing other mental or physical ailments, nutrition, exercise
- **Home**-stable place to live
- **Purpose**-meaningful activities including education, employment, volunteerism, etc.
- **Community**-supportive relationships and social networks that promote healthy living

10 Guiding Principles of Recovery

- **Hope**-Belief that recovery is possible.
- **Person-driven**-Self-determination and self-efficacy are the foundation for success.
- **Many pathways**-Recovery is an individual, non-linear process.
- **Holistic**-Recovery needs to address the whole person as do services assisting with recovery.
- **Peer Support**-Social support through professionals, recovery coaches, mutual aid groups, families, churches, and communities are vital in supporting those in recovery.
- **Relational**-Increasing social resources and facilitating a sense of belonging promotes recovery.
- **Culture**-Values, traditions and beliefs are keys to sustaining the lifestyle change necessary for recovery
- **Addresses Trauma**-Healing unresolved trauma increases success in recovery.
- **Strengths/Responsibility**-Individuals have strengths to aid in their recovery and have a responsibility to cultivate them to support themselves and their communities in recovery.

- **Respect**-Many people have been affected by substance abuse and fostering an atmosphere of self-respect and respect for others in recovery requires great courage but also provides the kind of encouragement necessary for recovery.

PEER SUPPORT DEFINED

What is Peer Support?

The concept of recovery coaching started out of William White's Recovery Management model and the12 step/mutual support group model of recovery. Research supports the idea that recovery is facilitated by social support, which can be further broken down into emotional, informational, instrumental, and affiliational support (McLellan et al., 1998). Traditional mental health and substance abuse treatment facilities are limited in time, personnel and resources, leaving gaps in the aforementioned support services. Heavily influenced by funding, those providers concentrate on providing the services that will have the most impact in the shortest amount of time which often results in clients participating in groups and intensive therapy. These programs are also usually limited in the amount of time they can provide services, again, something dictated by those paying the bills. Successful recovery achieved in 28 days is unusual, so the dilemma for providers is how to structure treatment to ensure the best possible outcomes. Peer support and recovery coaches have become a cost effective way for providers to give clients a more comprehensive recovery experience as well as a connection to aftercare resources upon completion of formal treatment. SAMHSA (2009) further describes peer support as a "new kind of social support service designed to fill the needs of people in or seeking recovery." In addition to filling the gap during formal treatment it helps people stay engaged in the recovery process afterwards, decreasing the likelihood of a relapse. "Since they are designed and delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of

experiential knowledge. They can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery" (SAMSHA, 2009).

Research also suggests that those who manage their addiction as a chronic disease have success in a real recovery experience (Killeen, 2013) and we know support groups aid in chronic disease management. It may be this ability to extend services into the everyday life of the client that makes recovery coaching unique and successful.

Recovery coaches do not promote or endorse any particular way of achieving or maintaining sobriety, any particular 12-step program, or spiritual component of recovery. They focus on where the client "is at," allowing the client to create their vision of recovery in order to sustain recovery and live a meaningful life (Recovery Coaches International, 2013). The relationship between a client and recovery coach is dynamic and diverse. A coach may work with a client 24/7 for a month or have daily phone calls with the client. There is no set standard or "one size fits all" approach and the recovery coach has the ability to be flexible and use whatever methods will help the client in recovery.

There are also no prerequisites for becoming a recovery coach, except a passion to help those who are recovering from addiction (Killeen, 2013). Recovery coaches work in settings such as hospital emergency rooms, psychiatric hospitals, jails, prisons, homeless shelters, and nursing homes. They also work in community recovery centers, drop-in centers, clubhouses, the clients' home, and vocational placement agencies (Recovery to Practice, 2011).

Types of Peer Recovery Support and Service Examples

Type of Support	Description	Peer Support Service Examples
Emotional	Demonstrate empathy, caring, or concern to bolster person's self-esteem and confidence.	Peer mentoring Peer-led support groups
Informational	Share knowledge and information and/or provide life or vocational skills training.	Parenting class Job readiness training Wellness seminar
Instrumental	Provide concrete assistance to help others accomplish tasks.	Child care Transportation Help accessing community health and social services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	Recovery centers Sports league participation Alcohol- and drug-free socialization opportunities

(SAMHA 2009)

Types of Recovery Coaches

Recovery coaches are as diverse as client needs dictate. This gives an aspiring coach flexibility to define their services, but the roles described below will provide an understanding of the types of recovery coaches that you will encounter.

Peer Recovery Support Specialist

The term peer recovery support specialist is often used interchangeably in the field with the terms recovery coach, peer mentor, recovery support practitioner, care manager or recovery support specialist. A peer recovery support specialist's primary goal is to help people achieve and maintain sustained recovery (Killeen, 2013). While there are both paid and unpaid positions, in most instances, peer recovery support specialists are paid for their time. This change occurred with the Affordable Health Care Act, which required hospitals, treatment centers and social service organizations

to hire peer recovery support specialists, transforming it into a paid position.

The duties of a peer recovery support specialist vary. They will share their experiences of addiction and recovery, building an environment of trust and emotional support, helping the client develop goals and the terms of the client's recovery plan while providing social support to the client.

Travel or Sober Escort

Since transportation can be a significant challenge for a recovering addict, a travel escort or sober escort is a version of a recovery coach that may be required to transport a person in recovery (Killeen, 2013). Transportation may vary and it could be to bring the client to an appointment in town, take them to a court appointment or flying them across the country.

Long Term Recovery Coach or Sober Companion

The main difference between a recovery coach and the role of a long term recovery coach or sober companion is the time commitment. These individuals work full time with the client which might be for full 12 hour days, nights, weekends, or period of time where the coach is with the client for 24 hours of every day for an extended period of time (Killeen, 2013). This long term option might begin with a treatment discharge, supporting the client on their first day home, introducing the client to meetings, and guiding the client past triggers. This assignment might develop into a coaching relationship that continues further. With a long term recovery coach or sober companion nearby the client can be directed to make lifestyle changes that are supportive to a life in recovery.

Family Recovery Coach

"The family plays such an important role for a person in recovery, yet is so often neglected by traditional models of recovery" (Killeen, 2013). Beverly

Buncher (2012), describes a family coach's role as helping "others deal with the challenges of living and working productively and happily, while 'being there' for an addicted loved one." A family recovery coaches' duties include helping the family to:

1. Experience inner peace and serenity whether the addict is still using or not
2. Help their loved one navigate the treatment world
3. Model centered living for the addict
4. Get their own life back
5. Accept their loved one, but not accept unacceptable behavior
6. Become an effective mirror for the addict
7. Function effectively at work and home, regardless of the addict's decisions

Telephone or Virtual Recovery Coach

This type of relationship can help a recovering client beyond face to face meetings. Many treatment centers are embracing virtual recovery coaching and these centers are providing a link to a recovery coach prior to discharge when the coach and client can connect face to face at the treatment center and then by telephone or internet after discharge. The type frequency and mode of contact depends on the client and recovery coach, but could be anything from a weekly web chat to a daily phone check in.

Intervention Coach

An intervention is a planned event in which those that care for an addict confront the addict and offer treatment. An intervention coach differs a bit from the other coaching roles since it is considered to be a health care profession and thus requires certification. A resource for those interested in certification is the National Association of Drugs and Alcohol Interventionist at http://www.nadai.us/ethics.php.

Legal Support Specialist

At times a lawyer may request a specific type of recovery coach to ensure that a client remains sober prior to or during a legal proceeding. These coaches are more likely to be licensed as Licensed Clinical Social Workers or Certified Alcohol and Drug Counselors (Killeen, 2013) as they usually require certifications to establish credibility as well as legal knowledge. Coaches with knowledge of the drug court system are particularly good for these positions. A legal support specialist may perform a client assessment defining the extent of the addiction, draft a letter to the court, offer treatment suggestions, and appear with the client in court.

A Coach to Detox a Home or Room

The role of this individual is as the name implies. It is a coach who is called in to search the room, home or apartment for substances. Additional training may be required to ensure proper collection and documentation procedures especially if it will be used in legal proceedings.

Core Competencies

State and national boards have created standardized peer recovery training programs. There are guidelines put forth by reputable organizations to standardize the knowledge, skills and abilities required for successful coaching. Organizations that offer credentialing provide the public with an assurance that people credentialed have been trained according to the organization's standards and that members agree to abide by the ethical principles set forth by the organization. In addition to establishing professional credibility with future clients, professional organizations also give coaches networking and educational opportunities for professional growth.

Other core competencies for recovery coaches:

- Basic psychology
- Understanding of family and organizational systems
- Basic understanding of substance abuse, addiction and mental health
- History of coaching, current models and how coaching fits into current recovery models
- Understanding of current recovery models and the treatment systems in the area you wish to work
- Ethical principles of coaching and recovery coaching
- Phases and processes in coaching
- Self-awareness and knowledge of one's own recovery process
- Ability to create positive, supportive coaching relationships with proper boundaries
- Using communication skills, interviewing techniques and assessments to benefit the client
- Contracting, goal setting and recovery planning
- Advocacy, support, and the ability to connect clients to other services when needed

Most recovery coaches have gone through recovery themselves and know what steps made recovery successful for them. In order to use that experience for the benefit of clients; however, they will need to blend their life skills with an understanding of the theory and practice of clinical addiction models and self-awareness (Killeen, 2013). The recovery coach must be able to guide a client through the recovery treatment process both emotionally and instrumentally. While the position of a recovery coach is non-clinical, familiarization with psychological language will help when working with therapists and other treatment providers.

Recovery coaches end up taking on many roles:

Outreach worker: Identifies and engages hard-to-reach individuals; offers living proof of the transformative power of recovery and what makes recovery attractive.

Motivator: Exhibits faith in client's capacity for change; encourages and celebrates their recovery achievements; mobilizes internal and external recovery.

Resources: Encourages the client's self-advocacy and economic self-sufficiency.

Ally and Confidant: The recovery coach genuinely cares and listens to the client; coaches can be trusted with confidences and can identify areas for potential growth.

Truth-Teller: Provides honest feedback on the client's recovery progress, identifying areas which have presented or may present roadblocks to continued abstinence.

Role Model and Mentor: The recovery coach offers their life as living proof of the transformative power of recovery and provides stage-appropriate recovery education.

Planner: Facilitates the transition from a professionally directed treatment plan to a client-developed and directed recovery plan, assisting in structuring daily activities around this plan.

Problem Solver: Helps resolve personal and environmental obstacles to recovery.

Resource Broker: Knowledgeable of resources for individuals and/or their families, is aware of sources of sober housing, can suggest employment that would be suitable for a person in recovery, can refer to health and social

services, and offer additional recovery support that matches the client to particular support groups or 12-step meetings.

Monitor or Sober Companion: Sometimes a client will be best served with around the clock monitoring or companionship for a set number of hours per day, morphing the recovery coach's role into that of a sober companion. A sober companion can be available for travel in and out of the country

Tour Guide: Introduces newcomers into the local culture of recovery; provides an orientation to recovery; provides an orientation to recovery roles, rules, rituals, language, etiquette, and opens doors to the client for engagement in the recovery community. The recovery coach discusses a client's response to their therapeutic services or their mutual aid (12 steps) groups to enhance the client's engagement in recovery and reduce the possibility of attrition.

Advocate: Helps an individual and/or their families navigate the complex social service and legal systems.

Educator: A recovery coach provides a client with information about the stages of recovery, informing the client of professional helpers within the community, and instruct the client about the many pathways and life-styles of long-term recovery and after a relapse, the recovery coach provides recovery re-initiation education services.

In their position as a role model for successful recovery, the following values serve a coach well and become the basis for ethical decision-making in the recovery community (White, 2007).

SAMSHA Core Competencies for Peer Workers in Behavioral Health Services

Category I: Engages peers in collaborative and caring relationships

This category of competencies emphasized peer workers' ability to initiate and develop on-going relationships with people who have behavioral health condition and/or family members. These competencies include interpersonal skills, knowledge about recovery from behavioral health conditions and attitudes consistent with a recovery orientation.

1. Initiates contact with peers
2. Listens to peers with careful attention to the content and emotion being communicated
3. Reaches out to engage peers across the whole continuum of the recovery process
4. Demonstrates genuine acceptance and respect
5. Demonstrates understanding of peers' experiences and feelings

Category II: Provides support

The competencies in this category are critical for the peer worker to be able to provide the mutual support people living with behavioral health conditions may want.

1. Validates peers' experiences and feelings
2. Encourages the exploration and pursuit of community roles
3. Conveys hope to peers about their own recovery
4. Celebrates peers' efforts and accomplishments
5. Provides concrete assistance to help peers accomplish tasks and goals

Category III: Shares lived experiences of recovery

These competencies are unique to peer support, as most roles in behavioral health services do not emphasize or even prohibit the sharing of lived experiences. Peer workers need to be skillful in telling their recovery stories and using their lived experiences as a way of inspiring and supporting a

person living with behavioral health conditions. Family peer support worker likewise share their personal experiences of self-care and supporting a family-member who is living with behavioral health conditions.

1. Relates their own recovery stories, and with permission, the recovery stories of others' to inspire hope
2. Discusses ongoing personal efforts to enhance health, wellness, and recovery
3. Recognizes when to share experiences and when to listen
4. Describes personal recovery practices and helps peers discover recovery practices that work for them

Category IV: Personalizes peer support

These competencies help peer workers to tailor or individualize the support services provided to and with a peer. By personalizing peer support, the peer worker operationalizes the notion that there are multiple pathways to recovery.

1. Understands his/her own personal values and culture and how these may contribute to biases, judgments and beliefs
2. Appreciates and respects the cultural and spiritual beliefs and practices of peers and their families
3. Recognizes and responds to the complexities and uniqueness of each peer's process of recovery
4. Tailors services and support to meet the preferences and unique needs of peers and their families

Category V: Supports recovery planning

These competencies enable peer workers to support other peers to take charge of their lives. Recovery often leads people to want to make changes in their lives. Recovery planning assists people to set and accomplish goals related to home, work, community and health.

1. Assists and supports peers to set goals and to dream of future possibilities
2. Proposes strategies to help a peer accomplish tasks or goals
3. Supports peers to use decision-making strategies when choosing services and supports
4. Helps peers to function as a member of their treatment/recovery support team
5. Researches and identifies credible information and options from various resources

Category VI: Links to resources, services, and supports

These competencies assist peer workers to help other peers acquire the resources, services, and supports they need to enhance their recovery. Peer workers apply these competencies to assist other peers to link to resources or services both within behavioral health settings and in the community. It is critical that peer workers have knowledge of resources within their communities as well as on-line resources.

1. Develops and maintains up-to-date information about community resources and services
2. Assists peers to investigate, select, and use needed and desired resources and services 3. Helps peers to find and use health services and supports
4. Accompanies peers to community activities and appointments when requested
5. Participates in community activities with peers when requested

Category VII: Provides information about skills related to health, wellness, and recovery

These competencies describe how peer workers coach, model or provide information about skills that enhance recovery. These competencies

recognize that peer workers have knowledge, skills and experiences to offer others in recovery and that the recovery process often involves learning and growth.

1. Educates peers about health, wellness, recovery and recovery supports
2. Participates with peers in discovery or co-learning to enhance recovery experiences
3. Coaches peers about how to access treatment and services and navigate systems of care
4. Coaches peers in desired skills and strategies
5. Educates family members and other supportive individuals about recovery and recovery supports
6. Uses approaches that match the preferences and needs of peers

Category VIII: Helps peers to manage crises

These competencies assist peer workers to identify potential risks and to use procedures that reduce risks to peers and others. Peer workers may have to manage situations, in which there is intense distress and work to ensure the safety and well-being of themselves and other peers.

1. Recognizes signs of distress and threats to safety among peers and in their environments
2. Provides reassurance to peers in distress
3. Strives to create safe spaces when meeting with peers
4. Takes action to address distress or a crisis by using knowledge of local resources, treatment, services and support preferences of peers
5. Assists peers in developing advance directives and other crisis prevention tools

Category IX: Values communication

These competencies provide guidance on how peer workers interact verbally and in writing with colleagues and others. These competencies suggest language and processes used to communicate and reflect the value of respect.

1. Uses respectful, person-centered, recovery-oriented language in written and verbal interactions with peers, family members, community members, and others
2. Uses active listening skills
3. Clarifies their understanding of information when in doubt of the meaning
4. Conveys their point of view when working with colleagues
5. Documents information as required by program policies and procedures
6. Follows laws and rules concerning confidentiality and respects others' rights for privacy

Category X: Supports collaboration and teamwork

These competencies provide direction on how peer workers can develop and maintain effective relationships with colleagues and others to enhance the peer support provided. These competencies involve not only interpersonal skills but also organizational skills.

1. Works together with other colleagues to enhance the provision of services and supports
2. Assertively engages providers from mental health services, addiction services, and physical medicine to meet the needs of peers
3. Coordinates efforts with health care providers to enhance the health and wellness of peers
4. Coordinates efforts with peers' family members and other natural supports

5. Partners with community members and organizations to strengthen opportunities for peers
6. Strives to resolve conflicts in relationships with peers and others in their support network

Category XI: Promotes leadership and advocacy

These competencies describe actions that peer workers use to provide leadership within behavioral health programs to advance a recovery-oriented mission of the services. They also guide peer workers on how to advocate for the legal and human rights of other peers.

1. Uses knowledge of relevant rights and laws (ADA, HIPAA, Olmstead, etc.) to ensure that peer's rights are respected
2. Advocates for the needs and desires of peers in treatment team meetings, community services, living situations, and with family
3. Uses knowledge of legal resources and advocacy organization to build an advocacy plan
4. Participates in efforts to eliminate prejudice and discrimination of people who have behavioral health conditions and their families
5. Educates colleagues about the process of recovery and the use of recovery support services
6. Actively participates in efforts to improve the organization
7. Maintains a positive reputation in peer/professional communities

Category XII: Promotes growth and development

These competencies describe how peer workers become more reflective and competent in their practice. The competencies recommend specific actions that may serve to increase peer workers' success and satisfaction in their current roles and contribute to career advancement.

1. Recognizes the limits of their knowledge and seeks assistance from others when needed

2. Uses supervision (mentoring, reflection) effectively by monitoring self and relationships, preparing for meetings and engaging in problem-solving strategies with the supervisor (mentor, peer)
3. Reflects and examines own personal motivations, judgments, and feelings that may be activated by the peer work, recognizing signs of distress, and knowing when to seek support
4. Seeks opportunities to increase knowledge and skills of peer support

https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf

Documentation

Good documentation is essential: "if it isn't documented, it didn't happen." Documentation is important not only to protect you as a peer provider, but it is required by insurance companies, Medicaid and Medicare to monitor the client's progress and justify expenses. In addition, other professionals on the treatment team may rely on your notes. Clients involved with other

mental health services, physicians, probation/parole officers, drug court, Child Protection Services, or the Intoxicated Driver programs may rely on your notes to show program compliance, progress, etc.

What you put into a note is just as important as what you leave out. Keep in mind who will be reading the notes and will likely follow the client in their permanent health or legal record. Keep notes fact based, related to the client's stated goals, and progress toward those goals.

A simple note format to use is called D.A.P. The letters of D.A.P. are an easy way to remember what needs to be included in a well-developed progress note. D stands for data, A for assessment and P for plan. Below is an outline to follow when using the D.A.P. method.

Data- Subjective and objective data about the client

- Subjective - what client can said or said they felt (always use direct quotes)
- Objective – observable behavior
- Content discussed and progress towards goals
- Was homework completed and reviewed?

Assessment – What is going on?

- Working hypotheses on client status in recovery
- Results of any tests, screening tools or assessments
- Response to treatment (example "more involved…")

Plan - Response or revision

- What you are going to do next, based on client's response to treatment
- Goals and objectives addressed / accomplished during this session
- Next session date

- Any topics to be covered in next session(s), and homework given

The following checklist can be used to ensure that you are developing well written documents.

- Think about what you are going to write and formulate before you begin
- Be sure you have the right file!
- Date and sign every entry
- Proofread
- Record as "late entry" anytime it doesn't fall in chronological order; be timely
- Think about how the client comes through on paper
- Watch abbreviations-use only those approved
- Write neatly and legibly; print if handwriting is difficult to read
- Use proper spelling, grammar and sentence structure
- Don't leave blank spaces between entries; can imply vital information left out
- Put client name/case number on each page
- Avoid slang and curse words
- Write so another provider can continue quality care from these notes
- Use descriptive terms
- Describe what you observed, not your opinion of what you observed
- Use power quotes: For example: "Client remains at risk for _____ as evidenced by _____" "The current symptoms include _____" "The client has shown limited progress in _____"

CREATING PARTNERSHIP

PHASES OF PEER SUPPORT & BASIC SKILLS

A coaching or peer recovery support relationship is unique in that it is closer and more intensive than a therapeutic relationship, but professional detachment is still required. Research by Castonguay, Constantino and Holtforth (2006), showed how significant the relationship is for clients in counseling, which can be generalized to all those in helping roles. More importantly, however, is that it is the client's perception of the relationship that is the best predictor of outcome for recovery success.

What does a successful therapeutic relationship look like?

- The client feels like a priority. Meetings are about them, conversation is about them, plans are about them. The helper listens, validates, and normalizes.
- The client is able to trust the person helping. The helper is a living example of being honest, up front about expectations, firm with boundaries, and doing what they say they are going to do and holds the client to the same behaviors.
- The client is valued for who they are. The helper distinguishes the character and personality of the client from behavior the client engaged in while using.
- The client begins to see themselves positively through the helper. The helper is an encourager, a cheerleader, pointing out strengths and positive progress.

- Recovery is client-driven. The helper does not lead the client, the helper is on the journey side by side with the client with the client feeling empowered to call the shots. The helper should not work harder than the client.

There are several skills a recovery coach can use to solidify a trusting relationship with a client. The primary skill is active listening. Armstrong (2006), explains that active listening is more than just what is being said, but it is also how it is being said that is important. It allows the client to note you are interested, keeps them focused on the topic and encourages them to talk more (Egan, 2010). It also strengthens the professional relationship while building rapport. A client will know when you are actively listening by your posture, body position, head nods, facial expressions, gestures, and verbal encouragement. A recovery coach should focus attention on the client, be nonjudgmental, resist distractions, and reflect back to the client what is heard in order to validate the client's feelings and desires (Kottler & Brown, 2000).

The value of peer support and recovery coaching goes beyond guiding a client through recovery and supporting them through obstacles. The power of peer support is in the living example of successful recovery through everyday living. When a coach keeps commitments, interacts with others nonjudgmentally, maintains healthy boundaries with others, advocates for a client, encourages a client, and continues to stay away from substances themselves the client begins to see the possibility of living that way themselves.

Phases of Coaching

There are many sources that identify phases in the coaching process, but the general themes are the same. For the purposes of this training, the phases listed below are solution-focused. This means that our job is to help clients see their recovery future clearly and assist them in the journey to that

future. People who have struggled with addiction and/or mental health are very good at identifying and owning the problems in their lives. As a peer supporter, your job is to reframe all those problems into recovery capital and encourage clients that they already have the tools they need to get to where they want to go.

1. Establish relationship
2. Identify where the client wants to go (goals) and problem areas that are interfering
3. Write goals and create objectives to meet goals
4. Take action to meet objectives; promote self-advocacy
5. Celebrate achievement of objectives and goals
6. Evaluate and readjust if necessary

First meeting

Initial contact with the client can cause stress or anxiety for both the client and the recovery coach. Many times clients do not know what to expect. You will want to be sure to set the proper tone for them even before the first meeting. It is suggested that the recovery coach provide the client with a definition of coaching and the time frame for which coaching will take place (Killeen, 2013). This information can be distributed through a brochure, information on the coach's website, or written directly into a coaching contract. Before the initial meeting, a recovery coach may also request information from the client in the form of a questionnaire. This questionnaire can help determine what the client expects to receive from the coaching relationship and should be completed prior to the initial session.

The first meeting is a critical step in the process. At this stage there is a logical development that a recovery coach and a client must go through in order to solve any problem (Egan, 2010). The first stage, is called the "current picture" in which the recovery coach learns about the client's

current situation, key issues, motivation for change, and resources needed. It is also at this point that a trusting relationship is developed which will be the foundation of the recovery coach/client relationship (Egan, 2010).

One way to get a current picture is to have the client create a personal narrative. Mitchell (2002), writes that "we are our stories, our accounts of what happened to us," thus "no stories, no self." This concept is the epitome of personal narrative therapy which is a form of psychotherapy based upon the belief that we all have a unique story to tell. With personal narrative therapy clients are highly encouraged to narrate their personal life story which is often referred to as their 'autobiographical self' (Pawelczyk, 2011). Through the use of storytelling techniques, this exercise is a way to give meaning to the past. Using this approach, a coach can see how a client's life is highly influenced by their family, culture and social circles. (Center for Substance Abuse Treatment, 1999).

This technique was originally developed by Michael White and his colleague David Epston for clients in therapy to recall events of their life and it has an important application in recovery as well (Killeen, 2013). In regard to the recovery field, personal narratives play dual purpose in the journey towards recovery and are a way that clients can see how they organized their lives around specific events. It allows clients to 1) take ownership of past behavior and 2) to develop self-insight. Both are important general goals for those in recovery. This technique also has a dual purpose of allowing a recovery coach to gain deep insight into the client as a whole. By learning what a client is willing to reveal about their life events, the recovery coach is able to truly learn their story.

This technique is often used in treatment centers and in traditional talk therapy. By allowing client's to author their life story, their life becomes meaningful and allows the client to take ownership by breaking old patterns and developing new solutions (Center for Substance Abuse Treatment, 1999). It is by no means an easy task. Often this is the first time that clients

have sat down and documented their early childhood experiences and it may bring up a storm of emotions. Killeen (2013) suggests that if the narrative takes more than two weeks to write, a client is showing resistance which should be noted and discussed further.

To further apply the narrative approach in the recovery field you might ask your client, "How has substance abuse influenced your life?" or "Have there been times when you did not allow addiction to take over?" Such questions can help recognize positive aspects and potential resources that can be enhanced, as well as deficits that must be conquered (Center for Substance Abuse Treatment, 1999).

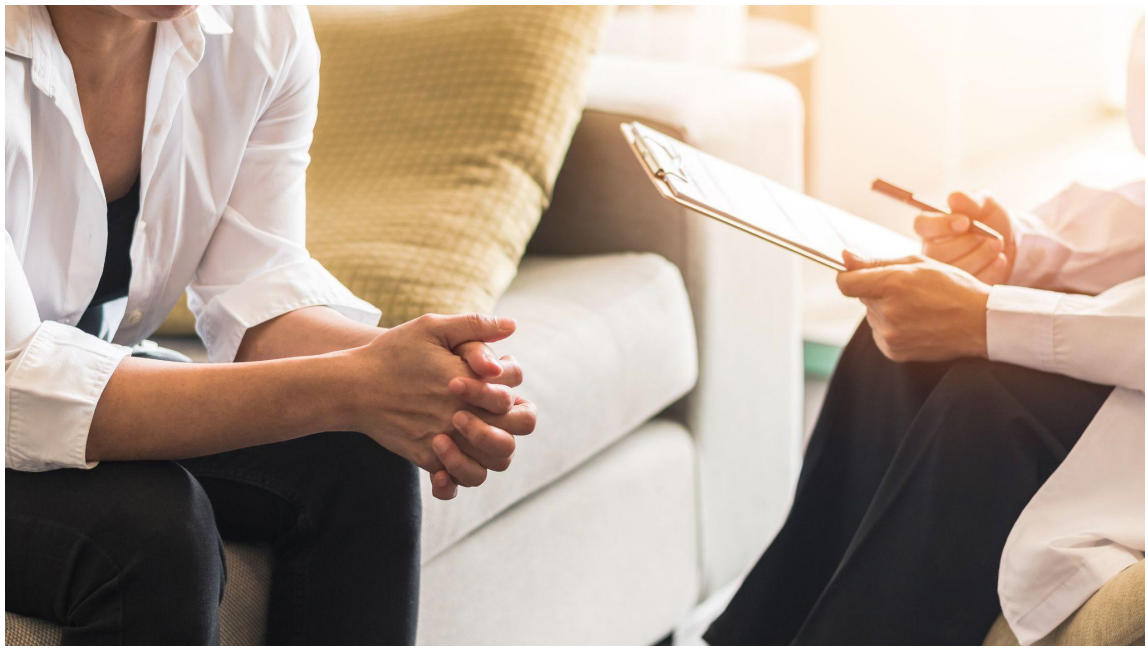
According to *Brief Interventions and Brief Therapies for Substance Abuse* by the Center for Substance Abuse Treatment, narrative therapy helps clients resolve their problems by:

- Helping them become aware of how events in their lives have assumed significance
- Allowing them to distance themselves from impoverishing stories by giving new meaning to their past
- Helping them to see the problem of substance abuse as a separate, influential entity rather than an inseparable part of who they are (note there is a discrepancy between this theory and the use of the introductions by AA member's ; "My name is Jane, and I am an alcoholic")
- Collaboratively identifying exceptions to self-defeating patterns
- Encouraging them to challenge destructive cultural influences they have internalized
- Challenging clients to rewrite their own lives using an alternative and/or a preferred script

If a client is able to write the personal narrative prior to the first meeting, it will give the coach a better idea of how to proceed with further assessments. If it is a difficult process for the client, it may be better for

them to write the personal narrative after securing coaching and counseling support. It's important to remember that many people who struggle with substance abuse have trauma histories which can trigger strong feelings and lead to relapse. Trust your instincts with clients. If they are hesitant to do a personal narrative, there may be a good reason and may be a sign to connect them with a counselor.

ASSESSMENT



Assessment Basics

Assessment is a broad term used in social sciences to describe an "ongoing and cyclical process of observation, inference, and hypothesis testing with the goal of building an accurate, but tentative and fluid client model (Spengler et al, 1995)." This process involves interviewing clients, talking with other providers, observing client behavior, and administering tests. All of these things are important to create a picture of your client but they are meant to be used together; no one piece of information can be the sole source of information.

You may be the first point of contact with a client, you may come into contact with a client while they are in treatment, or shortly after. If you are

the first point of contact, the thoroughness with which you assess a client and share information with other providers will not only benefit the client by getting them what they need quicker, but it will also be helpful in establishing your credibility as a recovery coach. If you are in contact with a client further into the treatment process, check with providers for assessments and request access to the information. Then, you can make decisions whether to duplicate any instruments and what other instruments could be helpful to the client.

Assessments are also used in the treatment community to determine levels of care and justify the continued expense of treating a client. For example, providers who are paid by insurance or other third party payers, identify what level of care could best serve the patient, such as inpatient, intensive outpatient, outpatient, or aftercare. Definitions of these levels of care differ and are influenced by state law and payer policies. Payment for each level of care is often authorized for a length of time determined by the payer and justification is needed for treatment continuation or transition to the next level. Each treatment provider will have its own protocol, but there are generally "level of care placement criteria" which are determined through the use of standardized assessment instruments. By using similar assessment models in recovery coaching, you will be able to facilitate relationships with other providers and provide a continuity of care to clients. Recovery coaching is included in third party payer systems, which will require you to justify the need for your services.

Before diving into assessment; however, it's important to have a good foundation. Understanding why and how you are going to evaluate clients will not only help you provide quality services to your client, but it will also help the client understand themselves in an empowering way.

Purposes of assessment

- To gather information, learn about client, establish a relationship

- To determine goals and objectives that can be measured
- To measure client functioning against norms
- To determine symptoms and/or symptom severity to support further treatment recommendations
- To measure client progress throughout recovery

Assessment ethics

- ***Know yourself.*** You will be teaching clients about self-awareness and it is imperative that you lead by example. Knowledge of your own biases will protect you from boundary violations and will prevent you from extending yourself outside of your level of experience.
- ***Know the instruments you are using and be prepared to explain them.*** Take the assessments yourself, look into the research that supports their findings, and understand why they are important to the recovery process. Learn them well enough so you can explain them to clients in plain language.
- ***Are the instruments you want to use valid*** (measure what they say they measure) ***and reliable*** (can the instrument be repeated with the same results)? The checklists in magazines are not credible instruments of assessment. To be taken seriously by professionals in the recovery field, use instruments that can be used in other aspects of the client's treatment.
- ***What qualifications and training are necessary to administer the instrument?*** There are differences between instruments that require specialized training and instruments available free online. Both are beneficial as long as it is clear to the client that the results are suggestions. What will be important to the client is the level of discovery, knowledge, and empowerment gained from taking the instruments. For example, the Myers-Briggs Type Inventory (MBTI) is a terrific instrument for enhancing a client's understanding of themselves, but to get excellent results, it is best administered and interpreted by a qualified professional. This costs

money, which clients may not be interested in spending. There is, however, a free version available online called the Jung Typology Test, which is the foundational theory for the MBTI. Is it exact? No, but it will get the client started in self-exploration.

- *Present results to clients in a nonbiased, multicultural context.* The way results are interpreted will influence how a client receives the information. Clients may interpret results as "bad" or "negative" but you have an opportunity to reframe them in a more positive, nonbiased, nonjudgmental way. It's also important to understand that not all assessments are culturally appropriate. Some personality instruments may convey judgment, favoring characteristics or traits which may not make sense for your clients. Good assessment instruments will be nonbiased and they will take culture into account.
- *Are you duplicating assessments already done? Will they complement other providers?* If you are part of a client's treatment team, talk to the other providers about assessments that have been done and what your ideas are for assessing a client. You may choose to repeat an assessment to determine progress, to clarify, or to verify previous information, but nothing is more exasperating to a client than repeating assessments when meeting another provider.
- *How will the assessment be used?* Be able to explain to a client the purpose for using the information gathered from the assessment process. Some are good for exploration, some are good for building recovery capital and measuring progress, while others are good for screening for other problems. The client needs to know that all this collected information will be used for their benefit.
- *Documentation* of assessments is important. As stated in the documentation module, if it isn't documented, it didn't happen.

Characteristics of good assessors

- Patient
- Good communication
- Awareness of bias
- Good listening skills
- Skeptical
- Pays attention to nonverbal data
- Curious
- Open-minded
- Persistent
- Develops rapport
- Delays judgment

Suggested assessments

There are many types of formal assessments available and as a coach gains more experience, assessment will become a more fluid, informal, integrated part of getting to know a client. Assessments that are more formalized are helpful for a number of reasons, mostly for establishing a starting point from which to measure progress.

History of substance use and current use

Obtaining a history of substance use in the initial meeting is most important if you are the first point of contact. If you are not, save time and frustration by getting historical information from the client's treatment provider so you can focus on the client's current situation.

Information to gather in a substance use history includes:

- Each substance used
- First use & amount used for each substance

- Last use & amount used for each substance
- Typical pattern of use for each substance
- Evaluate tolerance for each substance. Has the client used more and for a longer period than intended?
- Has the client had persistent desire and unsuccessful attempts to quit and cut down?
- Has the client spent excessive amounts of time using, obtaining, and recovering from the effects of the substance?
- Has the client continued use despite social problems caused or exacerbated by use
- What stage of change is the client in for each substance?

Mental health history-check for co-occurring disorders and suicidality

Due to the prevalence of co-occurring disorders, it's important to screen substance use clients for mental health and suicidal ideation. This can be done in an informal interview, or in a more formal manner by having a client fill out a questionnaire themselves. The Modified Mini Screen (MMS) (Hazelden Foundation, 2013) in the appendix has basic questions to alert you if a client should be evaluated further. This screen can be used to address safety in the case of suicidal ideation, to discover potential mental health causes for substance use, and to refer a client to a mental health professional. The MMS has a question for suicidal ideation, but it's important to assess risk yourself. Clients with a history of substance use are likely to have a history of trauma, all of which are risk factors for self-harm. A brief suicide risk assessment form is included in the appendix.

MBTI – Self-discovery

The official Myers-Briggs Type Indicator is a continuum based personality inventory that measures preferences as opposed to traits, abilities, and character. Only qualified trainers can administer and interpret the full MBTI, but those interested in a shorter, self-help version can go to

www.humanmetrics.com to take the Jung Typology Test which is the basis of the MBTI. Here, a client can get their 4 letter type to gain insight on their preferences.

How could this be helpful to a recovery coach and the client?

- Increases self-awareness
- Affirms things clients may already know about themselves ("So that's why I don't like crowds!")
- Gives the client permission to explore their identity and potential strengths.
- A recovery coach can suggest healthy lifestyle changes in congruence with the client's preferences. For example, an extreme introvert who doesn't like sharing feelings will have a hard time sharing at a 12-step meeting and a coach can provide other options.

The General Self Efficacy Scale – Empowerment

According to Social Cognitive Theory the prime factor that influences behavior is self-efficacy, which is defined as a person's belief in their ability to achieve an intended goal (Killeen, 2013). It also is defined as having the ability to cope with a broad range of stressful or challenging demands, both of which are common during the recovery process.

The General Self-Efficacy Scale gets a client thinking about their own self-efficacy, gives the coach insight, and provides ideas for areas of improvement. Taken at the beginning of recovery and after a time in recovery can show a client how they are changing and building self-efficacy.

Strengths, Grit, and Optimism – Tapping client resources

The Authentic Happiness Center at the University of Pennsylvania is the culmination of the work of positive psychologist Martin E.P. Seligman. His theories of happiness and resilience is based upon the belief that people have

the ability to make change in their lives and flourish if they pay attention to and use the strengths and resources they already possess. The Center's website has a number of questionnaires clients can use to learn about the positive aspects of themselves. Three that can be helpful in recovery coaching is the Brief Strengths Test, The Grit Survey, and the Optimism Test. The strengths test can help you guide a client towards internal resources they may not be aware they possess, the measure of grit complements the self-efficacy scale by measuring how the client may respond to future adversities (i.e. relapse), and the optimism test can tell you how the client views the upcoming recovery journey. Again, using these assessments later in recovery can show the client measurable progress.

Coping Assessment – Identification of coping skills

A final assessment that can be helpful for clients and coaches is an evaluation of current coping skills a client uses when stressed. Often, a substance has been the client's coping mechanism and when that is taken away in recovery, the safety and security of that coping mechanism is also gone. The goal is to help the client find healthier coping mechanisms to replace unhealthy ones. The Brief COPE questionnaire categorizes skills into emotion-focused, problem-focused, and dysfunctional skills. The list of skills not only provides identification of current skills, but it also helps drive conversation about the types of skills the client would like to develop. From here, goals for learning new skills can be written for the recovery plan and retaking the questionnaire further in recovery will show measurable results of progress.

Basic Skills

Active Listening

In active listening, the basic assumption is that it is not about the listener, it's about the client. As humans, we accumulate loads of bad

communication habits that can be difficult to break, but practicing some of the active listening techniques listed below will help you convey your interest and empathy in the client and what they have to say.

Reference the following table for active listening techniques.

TABLE 3.1

10 SKILLS FOR ACTIVE LISTENING			
Skill	**Behavior**	**Do**	**Avoid**
Attending, acknowledging	Provide verbal or nonverbal awareness of the other person.	Face the speaker and maintain eye contact, nod, etc.	Looking around the room or fidgeting.
Restating	Respond to the person's basic verbal message.	Repeat the phrase you would like clarified.	Changing the subject.
Reflecting	Reflect perceptions of content that are heard or perceived through cues.	Listen for what is not said. Respond with phrases such as, "So you feel that..."	Discounting or downplaying the speaker's feelings.
Interpreting	Offer a tentative interpretation about the person's feelings, desires, or meaning.	Keep an open mind about what you are hearing; try to picture what the speaker is saying.	Assuming you know what the speaker is trying to communicate without listening.
Summarizing, synthesizing	Bring together feelings and experiences to provide a focus.	Repeat back what you heard briefly but accurately; paraphrase.	Elaborating on what the speaker is saying.
Probing	Question the speaker in a supportive way to request more information or clear up any confusion.	Wait for the speaker to pause to ask clarifying questions; try "dangling" or open-ended questions.	Interrogating or challenging the speaker.
Giving feedback	Share perceptions of the person's ideas or feelings, disclosing relevant personal information.	Wait three seconds, and then respond with phrases such as: "So you feel that...", or "I felt that way when...".	Interrupting or offering solutions; preaching or teaching.
Supporting	Show warmth and caring in one's own individual way.	Pay attention to what isn't said—to feelings, facial expressions, gestures, posture, and other nonverbal cues.	Judging the speaker or rehearsing your response in your head while they are speaking.
Checking perceptions	Find out if interpretations and perceptions are valid and accurate.	Check the accuracy of your perceptions with phrases such as, "I think that you are saying..."	Making assumptions or jumping to conclusions.
Being quiet	Give the person time to think as well as to talk.	Try to understand what the speaker is feeling and have empathy for the speaker.	Filling pauses; instead, let the speaker set the pace.

Quesenbery, W. & Brooks, K. (2010). *10 Skills for Active Listening from* Storytelling for User Experience.

Direct Communication

- Use clear language that is appropriate and respectful to the client.
- Clearly articulate expectations, rules, and boundaries and communicate clearly when reinforcing them.
- Provide clear, honest, compassionate feedback.
- Be able to call out problems or problem behavior in an honest, compassionate way.

Self-Management

- Managing one's own biases, vulnerability, reactions in a way that is detached from the client's process.
- Recognition of self-care needs and the ability to get those needs met outside of client time.
- Avoiding becoming personally involved with a client either mentally, emotionally, or physically; knowing the warning signs of becoming overinvolved.

Stages of Change – Client centered inspiration for change

Recovery, like any major life change, is a difficult journey that is not always successful the first time around. The stages of change model of recovery is a spiral, taking relapse into account, and allowing for success despite setbacks (Connors, Donovan & DiClemente, 2001). This model stresses meeting a client where they are in their process of change and using motivational interviewing will help a client to come to their own decisions about change through stage appropriate interventions.

TABLE 1.1. Stages of Change and Associated Features

Stage of change	Main characteristics of individuals in this stage	Intervention match	To move to next stage
Precontemplation	• No intent to change • Problem behavior seen as having more pros than cons	• Do *not* focus on behavioral change • Use motivational strategies	• Acknowledge problem • Increase awareness of negatives of problem • Evaluate self-regulatory activities
Contemplation	• Thinking about changing • Seeking information about problem • Evaluating pros and cons of change • Not prepared to change yet	• Consciousness raising • Self-reevaluation • Environmental reevaluation	• Make decision to act • Engage in preliminary action
Preparation	• Ready to change in attitude and behavior • May have begun to increase self-regulation and to change	• Same as contemplation • Increase commitment or self-liberation	• Set goals and priorities to achieve change • Develop change plan
Action	• Modifying the problem behavior • Learning skills to prevent reversal to full return to problem behavior	• Methods of overt behavior change • Behavioral change processes	• Apply behavior change methods for average of 6 months • Increase self-efficacy to perform the behavior change
Maintenance	• Sustaining changes that have been accomplished	• Methods of overt behavior change continued	

Note. Data from Prochaska and DiClemente (1983, 1992).

Many substance abuse treatment facilities and mental health facilities use stages of change to drive level of care placement criteria, treatment planning and evaluation. Understanding what stages your client is in will help you coordinate treatment and guide your client through recovery at their pace.

Keep in mind that a client will have more than one stage of change. For example, your client has been using alcohol and methamphetamine for 5 years and wants to quit drinking because of a recent liver disorder diagnosis. The client works full time and loves his job. He talks about getting and using meth with his coworkers who happen to be his best friends and says meth makes him a better worker. His manager, however, has given him a warning about aggressive behavior displays at work. He has no other friends outside of work and often drinks when he's alone so he doesn't have to think. Although it's been difficult for him, he has changed his drinking habits from every night after work to one night on the weekend. He has also started eating healthy and exercising upon the recommendation of his doctor.

Once you have the stages of change for each problem, it becomes easier to prioritize a recovery plan. In this example, the client has already demonstrated that his health is important to him by the actions he's taken since his liver diagnosis. Interventions stressing the physical effects of methamphetamines and educating the client about health dangers taps into the client's values, increasing the probability of moving the client out of the precontemplation stage. As problem areas are targeted and the client moves through each stage, progress is also easily demonstrated.

Motivational Interviewing

According to Miller and Rollnick (1991), the overall goal of the first session is to identify the client's stage of change. Motivational Interviewing (MI) focuses on exploring a client's intrinsic motivations for change and resolving ambivalence in a way that is congruent with the client's values and concerns. It's more of a collaborative conversation about change designed to strengthen a client's motivation and commitment to change. MI research suggests that those clients who create their own meaning for change are more likely to succeed in lasting change.

Principles and techniques of MI

- Collaboration (not confrontation)
  - Expressing empathy
- Evocation (drawing out, rather than imposing ideas)
  - Rolling with resistance and developing discrepancy
- Autonomy (not authority)
  - Supporting self-efficacy

MI is less of an assessment technique than it is a style of talking with a client throughout a coaching relationship. During the assessment phases, the helper listens for "change talk" to determine a client's stage of change and then guides the client through change talk. When a client talks about

change, they may say things like "I want to change," "I should change, but I don't know what to do," "If I don't change, bad things will continue to happen." A helper would then use techniques such as asking open ended questions, exploring goals and values, asking for elaboration or coming alongside a client. The more a client talks about change in a positive way, the more likely positive change will occur.

MI Principles to use with clients

As previously mentioned, MI is a style of interacting with clients, not something you do one time (Mid-Atlantic Addiction Technology Transfer Center, 2013). The following four principles guide the practice of MI throughout treatment:

Expressing empathy relies on the client perceiving the coach as able to see the world as the client sees it. The important point with empathy is that the ***client*** believes the coach is able to understand and feel the way the client does. It does not mean that the coach has gone through exactly what the client has, only that the client feels able to be heard and understood. Empathy serves as the foundation of trust in the relationship and the client is more likely to be honest with the coach.

Supporting self-efficacy is the way the coach encourages the client to build on their strengths and resources in order to believe that change is possible.

Rolling with ambivalence is usually the most difficult principle to get used to, but the goal is to eliminate confrontation with the client and guide them to come to terms with their own desire to change. It includes de-escalation of conflict, not challenging a client's ambivalence and "dancing" rather than "wrestling" with a client's desire to change.

Developing discrepancy is showing clients the mismatches between where they are and where they say they want to be. The goal is to guide the clients to the recognition that their current situation is interfering with their goals.

Clients eventually become aware that their current behaviors are leading them away from what they want.

MI Skills

The next question becomes, "How is this done?" The goal is to guide clients to positive change talk and generating their own commitment to change. OARS is a set of skills used to elicit change talk using the principle listed above.

Open-ended questions are those questions which require more than a "yes/no" or short, specific answer. Open-ended questions invite elaboration and deep thinking creating the momentum needed for clients to explore the possibility of change. An example would be, "Tell me about the time you were successful quitting for a short time."

Affirmations are the key to supporting self-efficacy and helps clients see themselves in a positive light. Often, clients are blind to their strengths in early recovery and may not view certain behaviors as positive. Continuing with the open-ended question above, the client may say they got a new job that was intellectually challenging and only went back to using because the company downsized and they got bored. You could respond to the client by telling them that taking on a difficult job like that took a lot of tenacity and determination and perhaps that intellectual curiosity is the key to staying clean.

Reflections or reflective listening is a crucial helping skill that helps a client feel understood and builds empathy. It involves understanding what a client is saying and then offering it back to the client to confirm that understanding. An example of a reflection, using the example above, could be: "You must have been devastated when the company down-sized."

Summaries are a type of reflection that recaps what the clients concerns are and can highlight both sides of a client's ambivalence as well as promote

the development of discrepancy by strategically selecting what is included and not included in the summary. For example, "You have been able to quit on your own, cold turkey, without treatment when you were in an environment that supported your natural intellectual curiosity, but when something out of your control took that away, you felt helpless and lapsed."

Keep in mind that this is a basic overview of Motivational Interviewing and that training is available to develop these skills to proficiency. If you are able to integrate MI into every aspect of your client relationships, you will find clients will trust you quicker, will generate their own change talk faster, and recovery outcomes will be more positive.

Cognitive Distortions

There are numerous challenges encountered in every stage of working with a recovering client. A well prepared recovery coach can anticipate reluctance in discussing the topic of addiction or exploring the reasons for certain feelings with their client. Common psychological defenses such as denial, minimizing, sidetracking, and avoidance will appear in their discussions. An example of sidetracking during a conversation with the client is when the topic changes immediately to the client's child and their problem with a math homework assignment as the client is sharing some deep intimate feelings about their history. An example of minimizing is when the client has been arrested for shoplifting and the client defends themselves by saying it should be dismissed because her offense was stealing a hat that *only cost $15* (Killeen, 2013).

15 Common Cognitive Distortions by John Grohol (2009), lists and defines common distortions. Below are the top 10 taken in whole from this source.

1. Filtering.

We take the negative details and magnify them, while filtering out all positive aspects of a situation. For instance, a person may pick out a single,

unpleasant detail and dwell on it exclusively, so that their vision of reality becomes darkened or distorted.

2. Polarized Thinking (or "Black and White" Thinking).

In polarized thinking, things are either black-or-white, and never gray. We have to be perfect or we're a failure — there is no middle ground. You place people or situations in "either/or" categories, with no shades of gray or allowing for the complexity of life. If your performance falls short of perfect, you see yourself as a total failure.

3. Overgeneralization.

In this cognitive distortion, we come to a general conclusion based on a single incident or a single piece of evidence. If something bad happens only once, we expect it to happen over and over again. A person may see a single, unpleasant event as part of a never-ending pattern of defeat.

4. Jumping to Conclusions.

Without individuals saying so, we know what they are feeling and why they act the way they do. In particular, we are able to determine how people are feeling toward us. For example, a person may conclude that someone is reacting negatively toward them but doesn't actually bother to find out if they are correct. Another example is a person may anticipate that things will turn out badly, and will be convinced that their prediction is already an established fact.

5. Catastrophizing.

We expect disaster to strike, no matter what. This is also referred to as "magnifying or minimizing." We hear about a problem and use *what if* questions (e.g., "What if tragedy strikes?" "What if it happens to me?"). For example, a person might exaggerate the importance of insignificant events

(such as their mistake, or someone else's achievement). Or they may inappropriately shrink the magnitude of significant events until they appear tiny (for example, a person's own desirable qualities or someone else's imperfections).

6. Personalization.

Personalization is a distortion where a person believes that everything others do or say is some kind of direct, personal reaction to the person. We also compare ourselves to others, trying to determine who is smarter, better looking, etc. A person engaging in personalization may also see themselves as the cause of some unhealthy external event that they were not responsible for. For example, "We were late to the dinner party and that *caused* the hostess to overcook the meal. If I had only pushed my husband to leave on time, this wouldn't have happened."

7. Control Fallacies.

If we feel *externally controlled*, we see ourselves as helpless a victim of fate. For example, "I can't help it if the quality of the work is poor; my boss demanded I work overtime on it." The fallacy of *internal control* has us assuming responsibility for the pain and happiness of everyone around us. For example, "Why aren't you happy? Is it because of something I did?"

8. Fallacy of Fairness.

We feel resentful because we think we know what is fair, but other people won't agree with us. As our parents tell us when we're growing up and something doesn't go our way, "Life isn't always fair." People who go through life applying a measuring ruler against every situation judging its "fairness" will often feel badly and negative because of it. Because life isn't "fair", things will not always work out in your favor, even when you think they should.

9. Blaming.

We hold other people responsible for our pain, or take the other track and blame ourselves for every problem. For example, "Stop making me feel bad about myself!" Nobody can "make" us feel any particular way, only we have control over our own emotions and emotional reactions.

10. Should.

We have a list of ironclad rules about how others and we *should* behave. People who break the rules make us angry, and we feel guilty when we violate these rules. A person may often believe they are trying to motivate themselves with *shoulds* and *shouldn'ts*, as if they have to be punished before they can do anything. For example, "I really should exercise. I shouldn't be so lazy." *Musts* and *oughts* are also offenders. The emotional consequence is guilt. When a person directs *should statements* toward others, they often feel anger, frustration and resentment.

It should be noted that it takes effort and a lot of practice to help the client reframe deeply ingrained thinking patterns. The goal is to refute the negative thinking over and over slowly diminishing over time, replaced by more rational and balanced thinking. Grohol (2009) continues in *Fixing Cognitive Distortions* by listing several steps to help correct cognitive distortions.

1. Identify Cognitive Distortion.

Create a list of troublesome thoughts and examine them later for matches with a list of cognitive distortions.

2. Examine the Evidence.

A thorough examination of an experience allows us to identify the basis for our distorted thoughts. If we are quite self-critical, then, we should identify a number of experiences and situations where we had success.

3. Double Standard Method.

An alternative to "self-talk" that is harsh and demeaning is to talk to ourselves in the same compassionate and caring way that we would talk with a friend in a similar situation.

4. Thinking in Shades of Gray.

Instead of thinking about our problem or predicament in an either-or polarity, evaluate things on a scale of 0-100. When a plan or goal is not fully realized, think about and evaluate the experience as a partial success, again, on a scale of 0-100.

5. Survey Method.

We need to seek the opinions of others regarding whether our thoughts and attitudes are realistic. If we believe that our anxiety about an upcoming event is unwarranted, check with a few trusted friends or relatives.

6. Definitions.

What does it mean to define ourselves as "inferior," "a loser," "a fool," or "abnormal." An examination of these and other global labels likely will reveal that they more closely represent specific behaviors, or an identifiable behavior pattern instead of the total person.

7. Re-attribution.

Often, we automatically blame ourselves for the problems and predicaments we experience. Identify external factors and other individuals that contributed to the problem. Regardless of the degree of responsibility we assume, our energy is best utilized in the pursuit of resolutions to problems or identifying ways to cope with predicaments.

8. Cost-Benefit Analysis.

It is helpful to list the advantages and disadvantages of feelings, thoughts, or behaviors. A cost-benefit analysis will help us to ascertain what we are gaining from feeling bad, distorted thinking, and inappropriate behavior.

GROUP FACILITATION BASICS

Leading a group can be an intimidating experience. It is important to understand that groups operate differently depending upon the type of group it is and the facilitator's role depends upon the type of group.

Peer providers can be instrumental in the following group types:

- **Psychoeducational** – These types of groups have limited interaction between group members and often involve a facilitator instructing or presenting material to members. Peer supporters may be asked to lead the facilitation if they are knowledgeable of the subject matter, or they may be asked to co-facilitate and lend

knowledge and support to the facilitator. Interaction between group members is minimal.

- **Support group** – The main purpose of this group is for the members to support each other and the group facilitator's purpose is to make sure each member has opportunities to share and support each other, enforce group rules, mediate conflicts, and keep the group focused. Interaction between group members is integral to the success of the group.
- **Therapy group** – The focus of a therapy group is on the process and interaction between group members. Usually there is a topic associated with the group and the facilitator is trained in group therapy. As a co-facilitator, peer supporters can be instrumental in therapy groups as a voice of success, encouragement, and mediation.

Facilitation challenges

Every group faces challenges and dynamics between members that can disrupt the group. These are to be expected, but a good facilitator will use the skills at their disposal to help the group through these challenges:

- Silence or side conversations
- Small talk as avoidance
- Group members who monopolize discussion
- Acting out or hostile behavior between members or directed at the facilitator
- Resistance
- Absences
- Manipulators
- Do-gooders
- Hidden agendas

Groups serve many functions, but one of the most poignant is the process. In a group setting, members can experience relationship repair by working

through some of the challenges listed above. For example, someone who comes into group and monopolizes the discussion with incessant small talk may feel like people don't listen and the incessant talking forces people to listen. A corrective group experience could be one where the facilitator asks the member if they notice how much they talk and invite them to share what that does for them. The group can be instrumental in demonstrating active listening skills and positive feedback so the talkative member can learn what it really feels like when someone is listening.

Skills necessary for group facilitation

- Self-awareness and constant checking in with yourself to figure out if reactions are only yours or if they are shared with the group.
- Modeling behavior expected of group members as well as recovery success
- The ability to share experiences in a helping way
- Focus on the needs of members

- Maintaining agreed upon group rules
- Expressing empathy and encouraging participation
- Confronting and challenging members in a helpful way
- Linking members to each other by inviting interaction and connection between members
- Utilization of open-ended questions and asking "what" or "how" questions instead of "why"
- Bring participant awareness back to the process by describing behaviors and guiding them through fixing problems as a group

If you are or will be expected to facilitate a support or an education group, it is highly recommended that you get training and proper supervision. Group facilitation is an art whether you are a leader or a co-facilitator. Group members will respond and thrive in well-run groups and groups that are well run are dependent upon the skills of the facilitator.

CO-OCCURRING DISORDERS

Co-occurring disorders

According to the 2009 National Survey on Drug Use and Health (SAMSHA, 2009), 8.9 million adults with any mental illness also have a substance use disorder. Only 7.4 percent of them are receiving treatment for both conditions while 55.8 percent are not receiving any treatment at all. While more attention is being paid to providing appropriate treatment for co-occurring disorders, there are still far too many recovery and treatment centers that have not adopted services to meet the needs of both.

In addition to mental illness, a client's trauma history will also affect their recovery success. In 1998, SAMSHA commissioned the Women, Co-occurring Disorders and Violence Study, which was a comprehensive study on treatment utilization and effectiveness of women who presented for substance abuse treatment. They found that women who participated in this study presented for treatment an average of 14 times before their history of trauma was even factored into their recovery. These women had experienced interpersonal violence in some form since middle childhood and their substance use and mental health issues began in adolescence. When provided with trauma-informed interventions, the outcomes for recovery were much better and longer lasting. While this study focused on service delivery for women, it brought attention to the need for trauma-informed services and further changed the perspective of co-occurring disorders treatment. As a recovery coach, you may be the bridge between the client and finding the right recovery resources.

The assessments you do with a client will be important in connecting them with the right resources. Because of the high prevalence of mental illness and trauma, assume that your client will likely have one or both. How they answer your questions about the beginning of their substance use problems will indicate whether further comprehensive evaluation is necessary. For example, when assessing for stages of change, the client may express a desire to quit, but say that they are afraid to because the substance fulfills a need for them. Typical needs substances meet include helping with focus or calming down, numbing strong emotions, self-destruction, escape, increasing energy, or accomplishing tasks. They may also have a long history of recovery and relapse and low scores on the self-efficacy scale. You may ask them if they've experienced or witnessed events which scared them or caused them to fear for their life. If the answer is yes, it is highly likely that unresolved trauma will complicate recovery efforts.

An additional assessment that can be used is the Modified Mini Screen (Hazelden Foundation, 2013), which can either be self-administered or asked of a client in an interview format. This instrument screens for depression, suicidality, bipolar disorder, anxiety, social anxiety, obsessive and compulsive tendencies, PTSD, paranoia, hallucinations and delusions. If a client answers affirmatively to any of the questions, it is important to have them fully evaluated by a licensed mental health professional who specializes in co-occurring disorders. If your client has a history of trauma, it is especially important to have them evaluated and treated by someone with expertise in trauma-informed co-occurring disorder treatment.

Licensed mental health providers who specialize in trauma-informed co-occurring disorder treatment are trained to treat the mental illness, trauma and substance abuse at the same time. The treatment and recovery plan should be all inclusive, meaning the client's work with the recovery coach will complement their work with a counselor and, if appropriate, the psychiatrist prescribing medications.

According to Dual Recovery Anonymous (2009), a 12-step mutual aid group for people with co-occurring disorders, states a variety of problems are possible as a result of a co-occurring disorder.

- Psychiatric symptoms may be covered up or masked by alcohol or drug use.
- Alcohol or drug use or the withdrawal from alcohol or other drugs can mimic or give the appearance of some psychiatric illness.
- Untreated chemical dependency can contribute to a reoccurrence of psychiatric symptoms.
- Untreated psychiatric illness can contribute to an alcohol or drug relapse.

Other problems and consequences that are associated with co-occurring disorders include:

- Family problems or problems in intimate relationships.
- Isolation and social withdrawal.
- Financial problems.
- Employment or school problems.
- High risk behavior while driving.
- Multiple admission for chemical dependency services due to relapse.
- Multiple admissions for psychiatric care.
- Increased emergency room admissions.
- Increased need for health care services.
- Legal problems and possible incarceration.
- Homelessness

It is tempting to figure out which came first, the substance use disorder or the mental health problems. There are many different philosophies and it's important for a recovery coach to understand how a counselor will approach co-occurring recovery with your client. As mentioned previously,

the relationships a client has with the recovery support team is essential to success and that includes how you work with mental health professionals to whom you refer your clients. Individuals living with mental illness may be more sensitive to the effects of alcohol and other drugs (National Alliance on Mental Illness, 2013), and those substances can exacerbate the symptoms of their mental health disorder. In some cases the person may have turned to substances as a way to control and self-medicate their mental health symptoms. Regardless of the order, the use of substances with a mental health disorder can create a perpetuating negative feedback loop which is difficult to disrupt. The focus should be present-focused on treatment and recovery and as a recovery coach, you will have more opportunities to observe and recognize behaviors in your client that can be brought to the attention of their mental health provider.

TRAUMA-INFORMED CARE

Why trauma-informed care?

The Women, Co-Occurring Disorders and Violence Study (WCDVS) conducted in 1998-2003 with over 2,000 women presenting for substance abuse treatment, taught us many things about women who seek treatment and their experiences.

- Victimization of women is rampant in the United States and research shows that 70-80% of women who were abused either physically or sexually as children are victims of violence in adulthood.
- Fifty five to 99% of women with substance abuse problems reported being victimized at some point in their lives; the average age of onset for the violence was age 7.
- Women who are victimized are more likely to have more complex mental health issues which are often compounded by physical health issues.
- Most women who suffer from any and all of the above are more likely to view service providers as not safe, trustworthy, or understanding.
- Most women are likely to present to general practitioners for health difficulties rather than mental health or substance abuse providers.
- Women are terrified of what will happen to their children if they present for treatment.

While these statistics are from an older study involving only women, there is plenty of research supporting the fact that men with substance abuse problems have endured long histories of violence as well. The findings of

this research has generated many studies about the impact of trauma and how a history of trauma can affect the development of mental health issues, substance abuse, and even physical health issues.

The significant impact of trauma on recovery has led SAMHSA and other leading recovery organizations to integrate treatment interventions that take violent histories into consideration. Training treatment providers with the tools necessary to provide trauma-informed care has become a national priority.

Trauma informed care is more than recognizing and treating clients with trauma histories. These models of care consider that clients need to feel in control of their recovery. Many people with trauma histories have had their voice, power and control taken away from them and providers need to create empowering environments and include the client in every step, allowing them to make decisions about their care.

Changing the belief system of providers also includes reframing the question "What's wrong with you? What's your problem?" to "What's happened to you?" and "How can we help you heal?" This includes the need to provide collaborative services and to invite support persons and families into the recovery process with clients.

What peer supporters need to know:

- Substance use and abuse may be a sign or symptom of something else.
- A substance is fulfilling a need for the client. Removing what that fills that need before learning a new way to fulfill it will likely make things worse for the client.
- Clients with traumatic histories will need therapy. It is important to guide clients to a therapist who is not only trained in trauma counseling, but who has experience treating co-occurring disorders and is willing to work with the client's treatment team.

Signs and things to look for if clients do not disclose trauma

Trauma is subjective, but has the same effect on the body and mind. It is essentially any event during which the client was fearful or frozen. When asked about traumatic events in their past, a client may say there weren't any, but while getting to know them, you may hear about many of the following:

- Witnessing violence as a young child, including parents fighting
- Being bullied at school or in the neighborhood
- Early childhood surgeries or hospitalizations
- Stating they didn't feel loved as a child or felt like they couldn't please caregivers
- Moving a lot, lack of stability
- Absent parent(s)
- Accidents or injuries
- Bad things happened to friends or family members
- Death of significant people in their lives

Many people who grow up with parents who had a tumultuous or combative relationship will likely not view witnessing that as traumatic because it was "normal" for them. Depending upon the age of the client at the time they experienced any of the above, the client may be feeling the effects without being cognitively aware that it was a traumatic experience. Many symptoms of anxiety and depression are a direct result of these experiences. A client may feel the symptoms "came out of nowhere" and felt like something was wrong with them thereby opting to self-medicate in hopes the symptoms would go away. Sometimes explaining to a client that the symptoms of anxiety and depression they felt may have been a natural reaction to the things they witnessed or experienced can relieve that feeling of being damaged enough to offer hope for recovery.

Many clients with trauma histories have been through some form of treatment before. The participants in the WCDVS averaged 14 attempts

to get help before they were connected with trauma-informed services. Your client will have stories of what didn't work and why they don't want therapy. Forcing someone into therapy is counterproductive, but you may be the bridge to what your client needs. If you have relationships with quality therapists, invite clients to meet the therapist with you, leaving the decision to pursue therapy in the clients' hands. Trust is primary, and if your client trusts you, make sure you connect them with a therapist who can be an extension of that trust.

Tips for working with clients

- Become educated about the biological and emotional effects of trauma in a way that you can explain it to clients to help validate and normalize what they are experiencing.
- Understand that a client who has a history of trauma is highly likely to have a history of damaged relationships. Many of those relationships may include abuse, neglect, or situations where the client was powerless and not valued for who they were. Those relationship patterns will be projected onto treatment providers and gives helpers an opportunity to offer a healthy, corrective relationship experience by demonstrating unconditional positive regard, empathy, and use of boundaries.
- Learn to recognize dissociation and flashbacks as well as grounding techniques to bring clients to the present.
- Allow clients their feelings. Validate feelings but offer healthy options for expressing feelings, if necessary.
- Be prepared to help the client focus on positive progress and offer encouragement.
- Help client with self-advocacy and point out victories often to help build client's self-esteem.
- Assist client in identifying triggers of trauma and creating ways to manage strong feelings when triggered through grounding, mindfulness and other self-care exercises.

- Encourage clients to create safety plans which include physical, mental and emotional safety.
- As clients learn healthy coping skills, work with them to integrate those skills into daily life by checking in with how the client is using them and offering suggestions for using them more often.
- Be aware of your own trauma history and your own triggers. Secondary trauma is a huge risk when working with clients and often you may be triggered in unexpected ways. Have plans in place to deal with things as they come up for you either through supervision, consultation, therapy, or increased self-care.

Peer supporters are an invaluable resource for clients who have experienced trauma, but peer supporters do not have the training and experience required to provide therapeutic interventions with clients. Despite the number of self-help books and workbooks available to the general public, it is not advisable, nor is it ethical, for a peer supporter to guide a client through trauma without a qualified, licensed treatment professional involved.

MEDICATION ASSISTED TREATMENT (MAT)

There are several opportunities and challenges for clients in recovery and the use of medication is attractive for managing mental health issues as well as substance use issues. There are many providers who will prescribe medication for mental health disorders, but fewer are qualified to prescribe for co-occurring disorders. The American Society of Addiction Medicine (2013) is a professional society that offers training and credentials to physicians specializing in addiction medicine, and their mission is to promote comprehensive recovery for clients with the understanding of the roles counselors and recovery coaches play. ASAM credentialed physicians understand the nature of addiction as a chronic disease, the interactivity of psychotropic medication and substance specific medication, and the psychological factors related to using medication in recovery.

Medications for alcohol dependence (SAMHSA, 2013)

- Naltrexone (ReVia®, Vivitrol®, Depade®): In pill form or monthly injectable, Naltrexone blocks the "high" of drinking thereby diminishing cravings and assists in resisting the urge to drink. Provider must be licensed to prescribe.
- Disulfiram (Antabuse®): Interferes with the body's ability to metabolize alcohol, causing unpleasant side effects when alcohol is ingested. Client must take pill daily in order for it to work and compliance can be an issue.
- Acamprosate Calcium (Campral®): Assists with physical and emotional discomfort of withdrawal.

Medications for opioid dependence

- Methadone: Blocks the effects of opiates and when tapered, can ease withdrawal symptoms and cravings. Administered by licensed providers and length of treatment is at least one year.
- Buprenorphine (Suboxone® and Subutex®): In pill form or sublingual tablet, it blocks the effects of opiates and eases withdrawal symptoms. Progression through all three treatment phases can take a year or more and there are more risks for interactions with psychotropic drugs as well as addiction to buprenorphine itself. Providers are licensed, regulated, and limited in the number of of clients per provider.
- Naltrexone: pill form or monthly injectable blocks the "high" of using opiates which diminishes craving and assists in resisting the urge to use. Provider must be licensed to prescribe.

Benefits of MAT

- Improve survival
- Increase retention in treatment
- Decrease illicit opiate use

- Decrease hepatitis and HIV seroconversion
- Decrease criminal activities
- Increase employment
- Improve birth outcomes with perinatal addicts

Barriers and challenges of using MAT

- Accessibility: ASAM qualified medical providers trained to treat clients with co-occurring disorders are difficult to find.
- Availability: Prescribers are monitored and regulated by government agencies who limit the number of clients per provider which limits availability of medications such as buprenorphine and naltrexone.
- Cost: Psychotropic medications and addiction specific medications are expensive, and most will require long-term use to ensure positive outcomes. Not all insurances will cover substance related medications and those that do have strict guidelines that must be followed by the client and the provider. If medications are covered, there may also be limitations in the length of time a client can use them which may be in conflict with actual time needed for recovery.
- Compliance: There is stigma attached to using medication and clients may have to deal with the implication of substituting one drug for another. Some treatment models and recovery communities who are abstinence based may not welcome clients utilizing MAT. Clients may also have difficulty adjusting behaviorally to new daily habits that may be in conflict with addiction habits.
- Comprehensiveness: The importance of a comprehensive treatment team for clients in MAT cannot be stressed enough. The treatment/recovery plan should be shared between all providers and all providers should be in regular communication with each other and with the client. None of these interventions work alone, rather, they complement each other.

Recovery coaches can be integral in connecting a client to quality providers. Look for providers who have the best credentials and who will work within a treatment team that has the client's goals for recovery in mind. Establish relationships in advance so you can educate your clients and be an advocate for the client. When guiding clients through MAT, the added dimensions of accessing the right providers, navigating the policies involved with paying for and securing the medication, as well as keeping the client from becoming complacent or fully reliant upon medication can affect recovery in positive and negative ways. A good recovery coach can help relieve some of that stress.

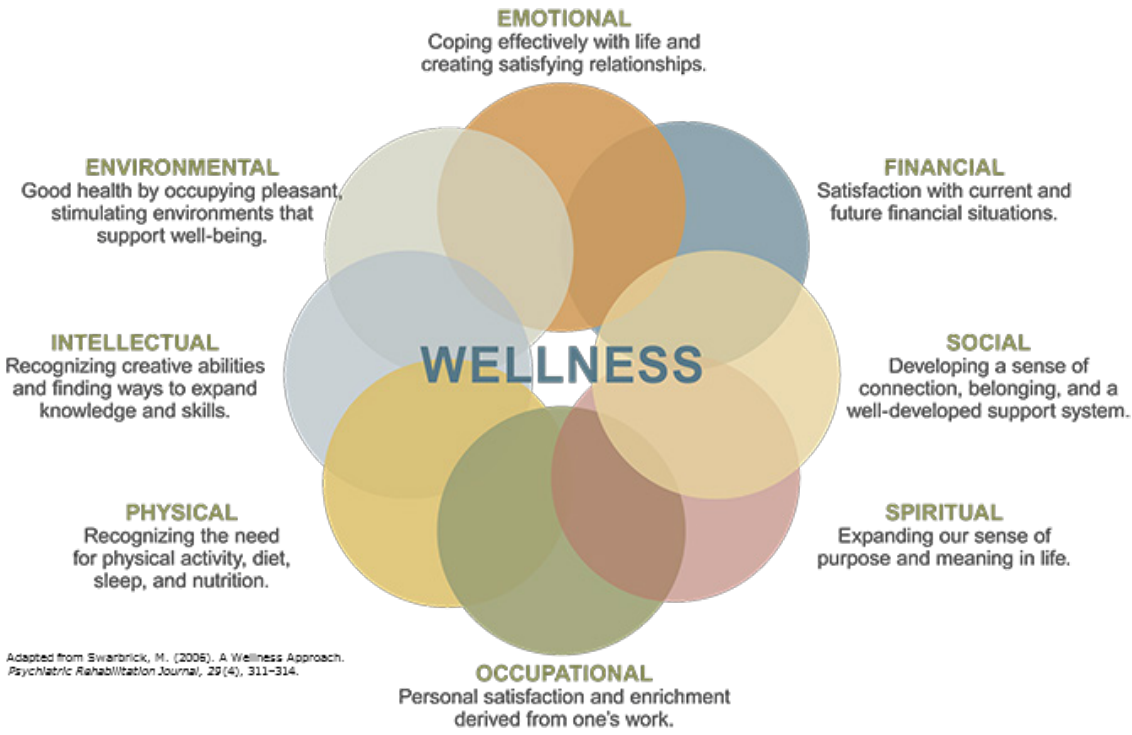
WHOLE HEALTH RECOVERY

Substance use does not occur in a vacuum, nor does the recovery process. Humans are complex creatures and human behavior is even more complex. What works for one person in recovery may not work for another, and for some, only focusing on the substance use problem will only create a set-up for relapse. While discovery of the underlying issues may take time or another professional, as a peer recovery specialist, you can help clients understand that recovery is a lifestyle change. Guiding them through planning for whole-person recovery from a wellness perspective can help them with the lifestyle changes needed for recovery success.

Eight Dimensions of Wellness: A Holistic Guide to Whole-Person Wellness

For people with mental health and substance use conditions, wellness is not the ***absence*** of disease, illness or stress, but the ***presence*** of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness.[1]

Wellness means overall well-being. It incorporates the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life. Each aspect of wellness can affect overall quality of life, so it is important to consider all aspects of health. This is especially important for people with mental health and substance use conditions because wellness directly relates to the quality and longevity of your life.



Adapted from Swarbrick, M. (2006). A Wellness Approach. Psychiatric Rehabilitation Journal, *29(4), 311–314.*

Whole person recovery means taking into account all aspects of one's life and creating plans to address those areas. For example, a client with an opiate addiction may have started using because of chronic pain. They may have lost their job and health insurance along the way which caused them to sink into depression resulting in isolation from friends, family and activities they used to enjoy. With this short example, 5 of the 8 domains of wellness have been adversely affected. When working with this client, a peer recovery specialist can help the client tap into social services and resources to help address each domain.

Integrated Care

One of the ways medical systems have begun to address the issue of whole health care is through integrated care. Integrated care is the systematic coordination of general and behavioral healthcare. Integrating mental

health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.

Most people with mental illness or substance use issues present to their primary care physicians for physical complications resulting from these issues or for medication to deal with them. Integrated care asks physicians to screen patients for substance use issues and basic mental health problems and either have a mental health professional available or strong referral sources. Patients are more likely to follow up with recommendations made by a physician and some medical practices are beginning to have peer specialists on hand to help patients navigate the referrals and next steps toward managing their whole health.

Not only are mental health and substance issues co-occurring, but there are strong correlations with physical illnesses as well. The goal of integrated care is to help people live longer, healthier lives and reduce health care costs at the same time.

Implications for Peer Support

As a peer supporter, you can help a client through whole-health recovery and integrated care systems by:

- Introducing the whole-person wellness approach to recovery
- Conduct basic assessments with clients to identify needs
- Add whole-person elements to clients' WRAP plans
- Reducing barriers to integrated health by maintaining relationships with health care providers, therapists, social services and other programs for referrals
- Guide and empower client self-advocacy by teaching client to be in charge of their whole recovery and not relying solely on others
- Assist in coordination with client and the treatment team
- Help client identify progress in each area of whole health

Families and important others

Much of treatment is focused on the client in recovery, and until recently the people around the client were rarely included in treatment. Substance use and mental illness affect more than just the client, but families, friends, significant others and communities can be affected. Not only can they experience the consequences of use, but they may have been part of the cause.

Earlier in this section, it was said that recovery does not occur in a vacuum. Ignoring the people around a client does a disservice to the client. Significant relationships in that person's life will serve to make or break success in recovery and while some relationships will be permanently severed or changed, that isn't always possible.

Just as a client needs to learn new coping skills and behaviors, the people around the client need to learn how to adjust and support the client through the changes. Family members may also be candidates for therapy individually, but where the relational damage is severe, it may be wise to refer for family therapy. For example, in a family of 5, the husband has struggled with methamphetamine abuse on and off for 20 years. His wife has stuck with him and supported him through many bouts of recovery, as have his 3 adolescent children. When the husband goes into recovery, the family lives in a state of fear "waiting for the shoe to drop." The children suffer from depression and behavioral issues; the wife suffers from anxiety, depression and views her husband as her "fourth child." The family has become isolated from extended family, their church and community as a result of the husband's repeated relapses. As the husband moves further into recovery, feeling good about himself and his choices, he can't understand why his family can't see the changes or offer him encouragement. In this case, no matter how well the husband is doing, if he feels his family is "dragging him down," what are his chances of sustained recovery? If the husband doesn't sustain recovery, what further damage will the rest of the

family experience? If the relationships between family members are not addressed and repaired in family therapy, it is highly likely that the husband will continue to relapse and the other family members will drift further away from him and into their own issues.

RECOVERY PLANNING

RECOVERY CAPITAL

Recovery capital (RC) is defined as the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery (White & Cloud, 2008) as well as the quality of the client's life, their home or family life, the status of their work life, their financial security and their physical or mental health (Killeen, 2013).

William White & Dr. William Cloud (2008) identify three types of recovery capital; personal, family/social and community recovery capital which are to be the focus of every recovery coach.

Personal recovery capital can be divided into physical and human capital. A client's physical recovery capital includes physical health, financial assets, health insurance, shelter, clothing, food, and access to transportation. Within this group is a sub group of *Human recovery capital*, which includes a client's values, knowledge, educational/vocational skills and/or credentials. It also includes their problem solving capacities, self-awareness, self-esteem, and self-efficacy (which is defined as the self-confidence in managing high risk situations). Personal recovery capital also includes hopefulness, optimism, the perception of one's past/present/future, a sense of meaning or purpose in life, and the client's interpersonal skills.

Family and social recovery capital is indicated by the willingness of friends, intimate partners and family members to participate in understanding treatment and recovery. It includes the presence of others in recovery, both within the family and the client's social network. It assures access to sober outlets for sobriety-based fellowship, leisure activities, and relational

connections to conventional institutions (school, workplace, church, and other mainstream community organizations).

Community recovery capital encompasses community attitudes/policies/resources related to addiction and recovery that promote the resolution of alcohol and other drug abuse problems. Does your client's community include these signs of Community Recovery Capital? Are active efforts made to reduce addiction/recovery-related stigmas in the community? Is there a visible and diverse local presence of a variety of recovery role models, and a full continuum of addiction treatment resources in the client's neighborhood? Are resources of 12 step or mutual aid meetings that are accessible within a local recovery community, and which can include recovery support centers or other social services? Are the accessible services that provide resources of sustained recovery support, early intervention and social services, for example health care, welfare and food stamps?

Developing recovery capital is part of a long term, approach to recovery from substance abuse and is aimed at preventing relapse. Recovery capital should be assessed both at the time of assessment and frequently during the coaching relationship. Many times clients will enter a treatment center with great recovery capital (good finances, strong family support, steady job, etc.) but when leaving treatment these resources will be depleted. An addict leaving treatment may not have a home or job to return to (Killeen, 2013). If it is determined that a client has poor recovery capital upon discharge this can be an additional stress on the client. This added stress could result in a relapse. This is important to note since research has demonstrated that relapse is highest during the earliest stages of recovery, a recovery coach would want to ensure that developing recovery capital is a high priority (Laudet & William, 2008).

A tool to measure recovery capital is the Recovery Capital Scale (White & Cloud, 1998). It is designed as a self-assessment tool and can be completed by the client and then discussed together at the initial interview. The Recovery Capital Scale uses the Likert scale in which a client will assign a 1-5 numerical score to each question that ranges from strongly agree to strongly disagree.

After assessing recovery capital the recovery coach will be able to determine the client's recovery capital strengths and weaknesses. The coach can help identify the gaps of what might be missing. This is a very individualized method and there is no "one size fits all" approach. Each client will be different and should be treated as a unique individual.

A client may have very little or zero recovery capital at discharge from a treatment center. This will need to be rebuilt and may begin with basic skills, like hygiene, or wellness skills as well as educational, and/or career coaching. Rebuilding the client's recovery capital is a vital step in recovery and can be done by locating resources for housing, coordinating transportation, and job assistance (Killeen, 2013). This course of coaching would vary since "every person's recovery capital is different because each of us has different resources available to use in our lives" (Torbay & Southern Devon Health & Care, 2013). Granfield and Cloud (1999) go further to state that recovery capital differs within the same individual at multiple points in their life.

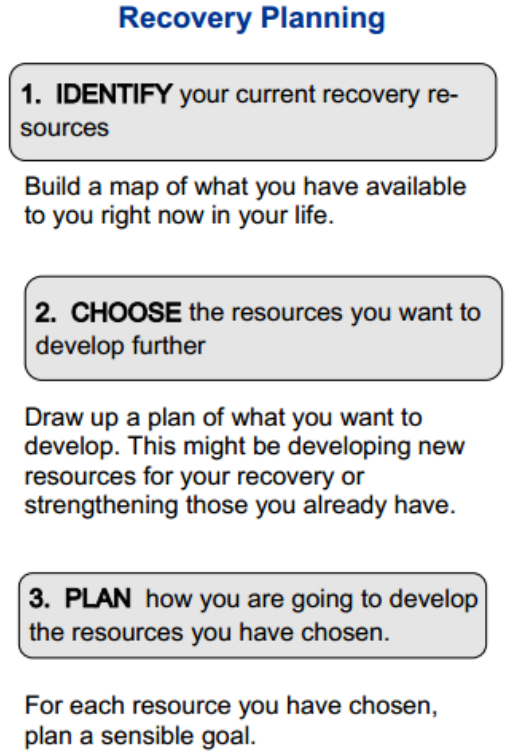
In addition a client's level of severity should be taken into consideration. A client with a severe problem but very high recovery capital may require fewer resources to initiate and sustain recovery than an individual with a less severe problem but very low recovery capital (Granfield & Cloud, 1999). For example, a client with high recovery capital might do well in outpatient counseling, link to recovery support groups and need a moderate level of ongoing monitoring, while a client with a low level of recovery capital may require a higher intensity of treatment, greater enmeshment in

a culture of recovery (e.g., placement in a long term recovery home or ½ way house, greater intensity of support group or outpatient treatment involvement, involvement in recovery-based social activities), and a more demanding level of supervision by the recovery coach.

TYPES OF RECOVERY PLANS & HOW TO GET THERE

Recovery Plans

Once assessments are completed and goals formulated, the recovery plan is developed. If assessments give a client's current picture and goals are where the client wants to go, the recovery plan is the map to get there. Not only will the plan guide the client towards their goals, but it will also help the client identify and cultivate internal and external resources they will need for successful recovery.



(Torbay & Southern Devon Health & Care, 2013)

SMART Goals

Goals provide clients with a way to plan for what they want in recovery and give them benchmarks to celebrate progress. Research suggests that those who write and formulate specific, measurable, achievable, realistic and time-bound (SMART) goals are more likely to achieve them (Meyer, 2003).

SMART goals are specific and strategic. For example, it is not enough to state "I want a job." A coach would guide a client through questions (Who? What? Where? When?) to further define what this means to them. A more specific goal would be: "I want a job as a nurse's aid at a major metropolitan hospital."

Secondly, SMART goals are measurable. This ensures that there is a way to measure progress towards the goal. Not only does this help the client stay on track towards their goals, but agencies, treatment centers and payers like Medicare or health insurance companies will require that goals are documented with a concrete criterion in place. Without a goal being measureable, there is no way to determine if a client has achieved their goal. Returning to the job example, it could be made measurable by adding "by applying for 2 positions per week."

The goal must also be attainable and achievable. We want to be sure that we are setting the client up for success, so a goal should be within reach. Does the client have the skills, knowledge and resources to obtain the goal? If a client has no training to become a nurse's aid, the goal might be rewritten to include the pursuit of training. "Take a one year training course at the community college."

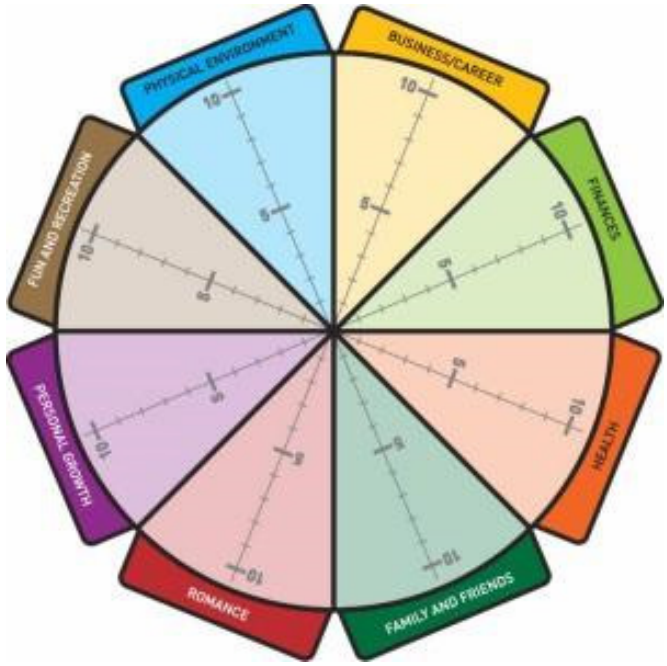
Goals also need to be realistic. For example, some professions that require licensing or certification, such as those in healthcare, may have restrictions related to legal history and certain forms of substance use. If your client has a felony possession of opiates charge on their record, it may be extremely difficult for them to be considered for licensure. It may be appropriate, however, to add researching certification requirements to the goal to determine whether the goal is realistic.

Finally, goals must be time bound. Again agencies, treatment centers and payers, like state funders, Medicaid, Medicare or health insurance companies, will also require a time frame for goals and often these goals will be established around a voucher, a waiver and/or review period. For example, a common review period is 90 days. A sample goal with a time frame might be "apply for nurse's aid training program within 30 days and start classes within 60 days." Giving a goal a time frame allows you to reflect back on progress and determine if your client has reached the goal.

Wheel of Life

The Wheel of Life, also referred to as the Life Balance Circle, can help clients formulate goals by giving them a visual representation of their current life situation and determine if there is a balance within their life (MindTools, 2013). By examining each area, the client and coach can identify what areas are off balance and which areas might need more of the client's time and attention. There are eight main aspects of life that are identified on the wheel.

- Finances
- Friends and Family
- Fun and Recreation
- Career or Business
- Romance
- Personal Growth
- Physical Environment
- Health and Wellness



A peer supporter can guide a client through each component of the wheel. The center of the wheel is marked as 0 representing the lowest satisfaction level. The edge of each component is marked as 10, representing the highest level of satisfaction.

The scoring is as follows:

0-4 means they are not satisfied

5-7 means they are more or less satisfied, but further attention should be sought

8-10 means there is a high level of satisfaction

Once a client has marked each of the components, a line will be drawn to connect the marks around the wheel. This will give the client and the coach a visual representation of how balanced their life is, and shows the client what areas need improvement. The areas that received low scores are those that may need more attention. To further process the Wheel of Life tool results, the recovery coach can help the client identify the lowest satisfaction level areas (those with the lowest numerical score) and prepare an action plan with SMART goals on how to achieve balance. For example you might ask the client "What would make you more satisfied with this area of your life?" Then to build on their response you could ask "What are the specific steps that you could take to ensure satisfaction in this area?" Having the client write these steps down is a powerful tool. It is suggested that the client write these steps down directly on their Wheel of Life and keep it. Then at a later date the client can complete the same process to see if their life is more or less balanced by comparing the results.

Another technique for using this tool is through the use of a blank Wheel of Life which allows the client to personalize their own components.

1. Start by brainstorming with the client to select the eight outside dimensions of the circles. These dimensions are the aspects of the client's life that are important for them. Different suggestions for these dimensions are:

- The roles played in life for example: husband/wife, father/mother, manager, colleague, team member, sports player, community leader, or friend
- Areas of life that are important for example: recovery, artistic expression, positive attitude, career, education, family, friends, spirituality, financial freedom, physical challenge, pleasure, or public service

2. Any combination of these (or different) things reflect the things that are your client's priorities in life. (e.g. family, friends, work, health, fun and

recreation). Describe this approach assuming what will help the coaching client be happy and fulfilled if they could find the right balance of attention for each of these aspects of their lives. Also understand that different areas of the client's life will need different levels of attention at different times. Write down these dimensions on the Blank Wheel of Life diagram, in the area on the outer ring of each spoke of the life wheel in the boxes provided

3. Begin by asking the client questions linked to the **current** dimension of their life to complete this portion. An example question may be: "Are your priorities in life focused around your family?" Considering each **current** dimension or area in turn, the low scale would be 1, meaning totally avoiding that aspect of life; the high scale is 5 representing giving that dimension of their life a lot of attention, receiving satisfaction and a sense of achievement. Have the client place a dot on the spoke of the wheel to designate the numerical amount that they have achieved in that area of their life. An example could be in the area of finances, a statement saying "I am gaining control of my finances". This statement could produce a 3 or 4 on the Wheel. On the Blank Wheel of Life mark a dot between 3 and 4 on the spoke for the dimension of finances. Follow this same procedure around the wheel. Then, connect the dot-marks around the circle. Have the client look at the Life Wheel and see if the Life Wheel confirms how much attention they are giving to certain areas of their life, currently.

4. Next it's time to consider the **ideal** level in each area of their life. A balanced life does not mean getting a 5 in each life dimension/area: Naturally, some areas may need more attention and focus than others at any time (e.g. children need more focus than house maintenance). Inevitably, the client will need to make choices and compromises, as their time and energy are not in unlimited supply! So the question is what would the ideal level of attention be for them in each life area? Plot the "ideal" scores around the Life Wheel, using a different colored pen or marker to indicate the client's **ideal** goals in which to work towards for a more balanced life.

5. Now connect the dots-marks, using the same colored pen that was used for the **ideal** areas. Now the coaching client has a visual representation of their current life balance and ideal life balance. This is an opportunity to examine the gaps. Gaps are the areas of the client's life that need attention. Remember that gaps can go both ways. Gaps are indicated on the wheel by open spaces between the two different colored plot lines around the circle. There are certain areas that are not getting as much attention as the coach or the client would like.

However, there may also be areas where the client is putting in more effort than they should. These areas are sapping the client's energy and enthusiasm that may better be directed elsewhere.

6. Once the client has identified the areas that need attention, it's time to plan the actions needed to work on regaining balance. Starting with the neglected areas, the areas of 1's and 2's, what does the client need to start doing to regain balance? In the areas that currently sap their energy and time, what can they stop doing, reprioritize or delegate to someone else? Allow the client to make a commitment to these actions by writing them in a daily journal.

ACCESSING PROGRAMS

During the assessment process, clients will go through the Wheel of Life exercise. That wheel has several dimensions in it that are outside the scope of what a peer supporter can provide. As a supporter, you are expected to guide the client through building resources, acting as a hub of sorts to help clients build self-efficacy and make connections. Clients in recovery are often intimidated by the perceived difficulty in making drastic lifestyle changes. One of the most effective ways a peer supporter can help is through modeling and introducing clients to recovery-oriented services.

For example, a peer supporter may have a relationship with the local workforce development agency where clients can be introduced to case workers with whom the supporter has a relationship. Those relationships benefit the client in several ways including reducing anxiety related to the unknown entity. If all parties are educated about the process of recovery, the stigma of a substance using history can be less of a barrier and conversation about the type of work or work environment for which the client is best suited becomes easier. Should problems arise during the process, the coach can also help with proactive solutions designed to help the client maintain recovery.

Healthy and social life are two other areas on the wheel of life for which a peer supporter may be helpful. Perhaps the coach has a relationship with a doctor's office that provides general health care, but has knowledge and empathy about the physical consequences of substance use. For some clients, it can be difficult to re-establish relationships with physicians, especially if the client was known as a "med-seeker." The peer supporter

can act as a bridge and a support to both the client and the physician. For example, if the physician notices a client's behavior changing or reverting to old behaviors, the peer supporter can be invited to participate and support the client.

For many clients, using was their social life and transitioning to "sober life" can be a daunting task. A coach can serve as a source of information about recovery-oriented events, groups or organizations that promote healthy living. These groups do not need to be recovery-specific, but may emphasize outdoor activities, physical fitness or other healthy lifestyle activities that can be used to replace unhealthy activities.

A client may also need to access local, state or county social services such as signing up for disability, accessing health insurance, securing an attorney, navigating through family services or the judicial process. Part of the role of the peer supporter is to identify the need for services and help the client locate and access them. If a coach has knowledge about the services available, the peer supporter can guide the client to help when and if it is needed. It is recommended that a coach has access to those services and knows about the basic eligibility requirements for them. As with the other aspects of recovery mentioned above, it is best if the peer supporter has relationships established with social service agencies and organizations to facilitate introductions.

GROW Recovery Plans

There are several frameworks to help structure your recovery plan, but one that works well for structuring a coaching discussion is the GROW model (Killeen, 2013). It was originally developed by a performance coach with the coach acting as a facilitator; helping the client select the best options rather than offering advice or direction.

1. **G**oals, establishing goals through the use of various instruments (can be used with SMART goals)
2. **R**eality, compare the reality of the situation
3. **O**ptions, explore the client's options
4. **W**rap up or Write the Recovery Plan

The first step is the formulation of goals and can be combined with the SMART goals and the Wheel of Life exercises.

Secondly, the coach will compare the reality of the client's situation in relation to their goal, reality represents the "R" in GROW. The purpose here is for there to be an accurate assessment of where the client currently is, in relation to their goals and where they want to be. If the goals are not realistic, the recovery coach can help shape the client goals to ensure that they are realistic and reachable.

The "O" in GROW represents the clients current options. The goal is not to find a solution immediately, but to generate several possible alternatives by brainstorming potential courses of action. Once several options have been identified, the recovery coach and client can work to select one option to put into action.

The final step is often referred to as "wrap up" and also "way forward," but it is also the point where the recovery coach begins "writing" the recovery plan. This is where the discussion is put into action and the client begins to take the actions needed to move forward towards their goals.

Strengths Based Recovery Plans

The strengths based approach focuses on the client's strengths and makes them the focus of building resources. Clients are asked to identify their personal strengths, abilities, achievements and personal qualities. This allows clients to have a voice in their treatment while developing independence and empowerment. Hammond (2010) states that this

strength-based approach offers a different language to describe difficulties and struggles since the starting point is "what's right with person." It allows one to see opportunities, avoids labeling, and casts the coach as a partner rather than as an expert. A defining feature of this approach is that it believes that everyone has the potential to learn, grow and change. Considering a client's strengths can be a coach's overall philosophy in addition to a model for developing recovery plans.

The 5 principles of the strength based approach include:

1. The focus is on individual strengths rather than the addiction (pathology).
2. The community is viewed as an oasis of resources.
3. Interventions are based on the needs and desires of the client (self-determination).
4. Aggressive, recovery community outreach is the preferred model of intervention.
5. People suffering from addiction can continue to learn, grow and change.

"Assessing strengths requires a focus on capacities to move forward in the face of adversity, using positive learning experiences and rewarding success" (Killeen, 2013). While clients may struggle to focus on their strengths, the role of the peer supporter is to help the client identify their past successes and current strengths. This approach is used throughout the treatment relationship with the client's strengths being used to help them reach their goals.

RELAPSE PREVENTION

WRAP®

Mary Ellen Copeland, an internationally acclaimed author, educator, and mental health advocate, initially developed the Wellness Recovery Action Plan®, or WRAP® to help with her own struggles with mental health challenges (Copeland, 2012) Research supports that people with mental health and substance abuse disorders have been able to self-manage their conditions with positive outcomes using this approach. Currently WRAP® is being utilized in formal and informal recovery programs in all 50 U.S. States and in countries around the world. WRAP® has been recognized as an Evidence Based Practice in the field of mental health recovery.

Even though relapse could be a part of recovery (but not always), a good recovery coach can identify when their client is coming close to the "slippery slope" by using the WRAP® method. This information can be developed with the client after they create their recovery plan and sobriety has started to take hold. Relapse, even if expected, can move to crisis very quickly. As described by people in recovery, "addiction" has been doing "push-ups in the parking lot" and returns even stronger than it was before the client became sober. There are many stories of individuals thinking, "I'll try this just once," and end up on a binge that lasts a week, or worse, dead from an overdose (Killeen, 2013).

Just as emergency planning works in a natural disaster, the WRAP® method of relapse planning works for the addict/alcoholic to prevent relapse. It is

imperative that your client completes a Relapse Prevention Plan (or Action Plan as the WRAP® guidelines call it) when sober, while the client has a reasonable amount of clear headedness under their belt to formulate the plan (Killeen, 2013).

The WRAP® method involves your client listing their personal resources, called Wellness Tools, and then using the following guidelines to develop an Action Plan to use in specific situations in which they need extra support in maintaining their sobriety. WRAP® also includes a Crisis Plan or Advance Directive which is helpful in the event the addict cannot make decisions on their intervention because of a relapse, such as if the client is unconscious from an over dose, or an auto accident. The Wellness Recovery Action Plan© encourages your client to create a list for the following categories:

1. Wellness Tools-Things that keep me well
2. A Daily Maintenance Plan-What keeps me well
3. Triggers – What do I have to watch out for
4. Triggers Action Plan-What do I do when I am triggered?
5. Early Warning Signs –What are my early warning signs of relapse?
6. Early Warning Signs Action Plan- What must I do, who will I ask for help?
7. This is How I Know When Things are Breaking Down - Things are going downhill fast, what am I doing?
8. Relapse Action Plan – This is what I have to do when I relapse
9. Crisis Plan or Advance Directive – This is what I want to be done, in the event my relapse leaves me unable to speak for myself
10. Post Crisis Plan. –OK, its' over, where do I go from here? What have I learned?
11. What do I revise in the Action Plan?

CRISIS PLANNING

Define CRISIS

While there are obvious crises such as violence, relapse or suicidal ideation, like any other issue, crises are heavily influenced by client perception. During recovery planning, it's important to help clients determine what will constitute a crisis for them and develop a plan to get through it.

Some examples of crises that a peer supporter may encounter include:

- Relapse or threat of relapse
- Harm to self or others
- Self-injury
- Drastic changes in employment or financial situations
- Change in living situation or homelessness
- Impulsive behavior
- Drastic change in a client's mental state
- Sudden physical illness
- Unexpected relationship changes
- Accidents and natural disasters
- Death of a friend or family member

Why a plan?

Much of the anxiety surrounding crises is exacerbated by fear of the unknown. Not only will a plan help a client identify crises and plan for them, but the idea of one happening will become less intimidating after

outlining the resources to help minimize distress. In addition, most people do not think clearly in the midst of a crisis, so having a written plan can help set the plan in motion more quickly. Finally, it will help clients feel a sense of control and instill hope that even if a crisis occurs, they have the resources to move through it successfully. When working with a treatment team, sharing the plan with them can give the client a sense of peace with the

Plan components

There are a number of plan templates available for use, one of the best has been developed by Mary Ellen Copeland, the founder of the Copeland Center and creator of WRAP.

The Copeland Center crisis plan includes:

- When I am feeling well, I am (describe yourself when you are feeling well):
- The following signs indicate that I am no longer able to make decisions for myself, that I am no longer able to be responsible for myself or to make appropriate decisions.
- When I clearly have some of the above signs, I want the following people to make decisions for me, see that I get appropriate treatment and to give me care and support:
- I do not want the following people involved in any way in my care or treatment. List names and (optionally) why you do not want them involved:
- Preferred medications and why:
- Acceptable medications and why:
- Unacceptable medications and why:
- Acceptable treatments and why:
- Unacceptable treatments and why:
- Home/Community Care/Respite Options:

- Preferred treatment facilities and why:
- Unacceptable treatment facilities and why:
- What I want from my supporters when I am feeling this badly:
- What I don't want from my supporters when I am feeling this badly:
- What I want my supporters to do if I'm a danger to myself or others:
- Things I need others to do for me and who I want to do it:
- How I want disagreements between my supporters settled:
- Things I can do for myself:
- Indicators that supporters no longer need to use this plan:
- I developed this document myself with the help and support of:

Once the plan is completed, distribute copies to people who are involved in the plan and anyone else who should know about the plan.

Post-crisis planning

Once the immediate crisis has passed, evaluating and planning for life after the crisis can help stabilize clients and prepare them for any changes that can be made in order to prevent future crises. It is also a good time to evaluate how well the crisis plan worked and whether any changes are required.

Another tool the Copeland Center recommends is the post crisis plan. The first item in this plan is how one would like to feel when the crisis has passed and how will one know when the crisis has passed? It also addresses who needs to be notified or involved once the crisis has passes as those people may be different from those involve in the actual crisis.

One of the dangers following a crisis is things that may have left that may fall into the "neglected" category and those things can be overwhelming. The post crisis plan addresses these issues including determining what items

may be urgent versus which ones can wait; what has to be done by the person coming out of crisis and what can be delegated to others.

Other items included in the post crisis plan include:

- Things I might need to do every day while I am recovering from crisis.
- Things and people to avoid while recovering from a crisis.
- Signs that I may be beginning to feel worse.
- Wellness tools to use if I am starting to feel worse.
- What do I need to do to prevent further repercussions from the crisis and when they will be done such as thanking people, apologizing to people, making amends with people, medical, legal or financial issues to be resolved.
- Things I need to do to prevent further loss.

Advance directives

When planning for crises, it is beneficial for clients to consider what they would like to happen on their behalf if they ever become incapacitated or die? Will the people around them know what to do? Advance directives do two things:

1. Establish medical power of attorney, or someone authorized to make medical decisions on your behalf if you are unable to.
2. What your wishes are for medical treatment and/or life-sustainment options.

Each state has its own requirements and rules for advance directives. Consulting with an attorney is recommended in order to make sure your directives will be honored should you ever need to use them.

SUPPORTING ACTIVITIES

SELF-ADVOCACY

Self-advocacy is often thought of as speaking up for oneself, although it is much more than that. As a recovery coach, you will want to be sure that you are helping your client develop the ability to advocate for themselves. According to research, allowing a client to help themselves and make their own choices allows them to take charge of their life more fully and develops a greater sense of self confidence (National Alliance on Mental Illness, 2013). This develops empowerment which can be defined as self-advocacy, and can be accomplished by training the client to act on their own behalf and empowering the client to change their environment directly so that their rights and entitlements are protected (Rothman, & Sager, 1998). This approach also allows the client to take responsibility for their life, while you act as a support system. Self-advocacy would also include demanding respect from others, making your own decisions, and standing up for your rights.

As a peer supporter you want to make sure that your client is aware of these rights. These include, but are not limited to the following:

- Ask for what you want
- Say yes or no
- Change your mind
- Make mistakes
- Follow your own values, standards and spiritual beliefs throughout treatment
- Express your feelings
- Determine what is important to you

- Make your own decisions based on what you need
- Be treated with dignity, compassion and respect at all times
- Decide on services and supports that are right for you and lead you on the path to recovery
- Be listened to
- Be aware of all treatment options
- Have time to make decisions
- Be encouraged
- Communicate your concerns, symptoms and thoughts
- Involve friends and family in the treatment progress when applicable
- Be yourself
- Be safe
- Ask for a second opinion
- Express concerns and ask questions
- Be taught how to help yourself
- Receive as much information as possible about the risks and benefits of all treatment options, including anticipated outcomes
- Weigh the pros and cons of recommended treatments
- Track and evaluate your progress, symptoms and outcomes.

Clients, may shrink from this role and instead of confrontation will try to use collaboration, cooperation, and discussion tactics (Rothman, & Sager, 1998). While collaboration, cooperation and discussion can be utilized initially, if the desired resolution is not reached, the recovery coach can assist the client in the advocacy process. Research demonstrates that positive outcomes are associated with the use of communication and mediation rather than power.

The value and application of self-advocacy is illustrated as follows:

One of my clients was upset about the way a residential monitor had treated her while she was at detox. When the client arrived in my office

in the morning she told me that she should report the residential monitor and took the step of taking the monitor's name down. I encouraged her to go ahead with her request and made my office phone available. By being near her, I provided support, but not offer direct assistance. After reporting what had occurred to the director of the detox center, the client discussed with me how she felt. She felt so much better and was proud of herself. Clearly she had developed a new skill to aid in her recovery.

Your work as a recovery coach is to help the client find their voice through the recovery process. Self-advocacy is a skill that is needed throughout the recovery process, although there are often specific events that can trigger the need for advocacy services. Typically, advocacy services are needed when a client is denied social services such as food stamps or welfare, but may also occur when there is an imbalance of power and resources (Rothman, & Sager, 1998). The goal of self-advocacy would be to resolve the conflict at hand, which in this case would mean the client reporting the inappropriate behavior of a monitor. Research by Bartlett (1986), demonstrates that it is necessary for clients to develop the following advocacy competencies:

- General advocacy skills and strategies, e.g., developing effective personal relations, developing knowledge, self-confidence, and savvy listening and negotiating skills;
- Preparation skills and strategies, e.g./ gaining access to administration, setting reasonable goals, and learning the rules of the game;
- Implementation skills and strategies, e.g., being concrete in explaining patient education, establishing quality assurance policies, and persistence.

CULTURAL COMPETENCY

Culture – patterns of behavior including language, communication, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. (Resource Links pub) Also includes age, gender, sexual orientation, religious affiliation, language and literacy abilities, educational level, physical ability and social class.

Competence – the capacity to function effectively as a helper within the context of culture presented by the consumer and the community in which they reside

Cultural competence is built from two foundations:

- awareness and knowledge of one's own culture and cultural biases
- awareness and knowledge of clients and communities

Whether we care to admit it or not, aspects of our culture put us in positions of power and powerlessness. Culturally competent helpers are those who take responsibility for themselves by becoming aware of the power and privilege they possess. With this knowledge, they are able to recognize when a culturally based power imbalance exists and work towards creating more balance. Power imbalances in helping relationships tend to be distracting and destructive, often doing more harm and severely interfering with the client's recovery.

Review the example below using the "addressing" model that demonstrates differences in power in each of the cultural categories.

ADDRESSING

A model of cultural influences and their relationship to the social construct of power

Cultural characteristic	Power	Less power
Age	Adults	Children, adolescents, elders
Disability	Temporarily able-bodied	Persons with disabilities
Religion	Christians	Jews, Muslims, other non-Christian
Ethnicity	Euro-American	People of Color
Social Class	Owning & Middle Class (access to higher ed.)	Poor & Working Class
Sexual Orientation	Heterosexuals	Gay men, Lesbians, Bisexuals
Indigenous Background	Non-native	Native
National Origin	U.S.born	Immigrants & Refugees
Gender	Male	Female, Transgendered, Intersexed

Hays, P. A. (2001). *Addressing Cultural Complexities in Practice: A Framework for Clinicians and Counselors*. Washington, D. C.: American Psychological Association.

Awareness and knowledge of self

What is your self-identified culture?

A – age
D – disability (born with)
D – disability (acquired)
R – religion
E – ethnicity
S – social class/socioeconomic status
S – sexual orientation
I – indigenous origin (geographic place you come from)
N – national origin (the nation/political atmosphere you come from)
G - gender

What biases do you hold about others? If you are from the city, what stereotypes do you hold about people who live in rural areas? If you are in your 50's, what do you think about today's teenagers? If you come from the south, what assumptions do you make about people from the east coast?

Understand that these biases can affect how you approach clients and will be evident in your nonverbal communication as well as in the types of questions you ask.

Awareness and knowledge of clients and communities

The best way to teach this aspect of cultural competency is a simple directive: Do your homework!

Listen and communicate with your clients. Find out what is important to them. Which parts of their culture are important to them? Which are not?

Other culture points

- Identity is different for everyone and is developmental
- Differences in cultural identity can set up power dynamics
- Oppression (real or perceived) plays a role in identity, mental health and recovery.
- Acculturation (adapted and changed to fit into host culture) vs. enculturation (preservation of culture of origin): Conflicts between these 2 can affect recovery, including whether or not someone will reach out for help
- A client's knowledge about addiction and mental health will determine how and what they share. Also find out what it means to the client to "get better" or "recover"?
- Cultures display emotions and symptom expression differently.
- What is accepted in a culture or how treatment is approached will be different. Treatment may be accepted, it may not.

Take a look at the following statistics from SAMHSA's Results from the 2012 National

Survey on Drug Use and Health: Mental Health Findings and consider the questions posed.

- In 2012, the percentage of adults aged 18 or older with past year mental illness and substance use disorder was 1.1 percent among Asians, 3.3 percent among blacks, 3.4 percent among Hispanics, 3.8 percent among whites, 4.3 percent among persons reporting two or more races, and 14.0 percent among American Indians or Alaska Natives.
  - *Does a culture's perception and/or acceptance of mental illness and substance use affect whether it is reported? For example, a collectivist Asian culture may not report issues or disorders if it will reflect negatively upon a family or community. Does that mean people of Asian descent do not experience mental illness or substance use problems?*

- Among adults aged 18 or older in 2012, those who graduated from college were less likely to have past year mental illness and substance use disorder (2.7 percent) than their counterparts who had not completed high school (4.1 percent), those who had graduated from high school but had no further education (3.7 percent), and those who had some college education but no degree (4.1 percent).
  - ➢ *How does education play a role in mental illness or substance use disorders?*
- The percentage of adults aged 18 or older with co-occurring mental illness and substance use disorder in 2012 was higher among adults who were unemployed (8.0 percent) than among adults who were employed full time (3.4 percent) or part time (4.1 percent) (Figure 5.8).
  - ➢ *Which comes first, unemployment or mental illness/substance use problems?*

Think about the type of work you're hoping to do as a peer supporter. What cultural influences do you expect to be present in your future clients?

Successful peer supporters will be able to approach each client as a unique individual. Learn to see how a client's culture influenced their path to addiction and how culture can provide recovery capital to shape their path to wellness. Directing clients to culture-supportive services will also be beneficial. For example, directing a client to a support group that is in conflict with their religious beliefs can do more harm than good. Or directing a family-oriented client to an inpatient treatment center that does not allow visits or participation from family will likely not be successful. The key is understanding your client and tailoring their recovery to their needs.

This is an exciting time since the role of a recovery coach is becoming more widely accepted and valued. The Department of Veteran Affairs (VA) has trained and hired peer specialists in mass numbers. "In some ways, the VA's efforts have encouraged states that once considered peer support

meaningless or marginally meaningful to reconsider their positions and, ultimately, create peer specialist programs" (Harrington, 2011).

In 2001, Georgia became the first state to obtain Medicaid reimbursement for peer support services (such as a recovery coaches) and since then, 47 other states have followed suit (see https://peerrecoverynow.org/wp-content/uploads/2024-MAY-15-prcoe-prss-medicaid.pdf). With the growing demand for recovery services, the peer support specialist profession will enjoy considerable (and likely rapid) growth in the next decade. One recent study has shown that peer support can reduce re-hospitalization by as much as 72 percent (OptumHealth.com, 2011).

Some of the factors driving this increase include the following:

- The growing recognition of the reality of recovery from severe and persistent psychiatric conditions
- A political climate that expects cost-effectiveness for public funds
- Positive outcomes associated with peer support
- A ready labor force
- The establishment of formal peer training and certification of peer specialists (Harrington, 2011).

There are many associations for recovery coaches or peer support specialists including the National Association of Peer Specialists (NAPS), Recovery Coaches International (RCI), the International Coaching Federation (ICF). In addition to the national organizations, check your state for resources and continue networking through PARfessionals.

Certification still varies and each state has their own requirements. Contact your state credentialing bureau or your state's licensing department to find out the requirements for certification as a recovery coach. Some states require training only, while others require a number of supervised hours of work or volunteer coaching experience. Some states require the completion

of a comprehensive exam, request references, an interview, background investigations or a combination of all of these. One of the largest certification organizations that features a peer mentoring credential is the IC&RC (2013). This Harrisburg, PA, based organization offers certification credentials that are recognized by all fifty states.

The outlook looks great, but you still might be asking yourself what does it take to become a recovery coach running your own business? According to Killeen (2013), one must have an entrepreneurial mindset and strategic information on the business structure of recovery coaching and support. If you decide to become a recovery coach on your own rather than working for an organization, strong business skills will help you to succeed.

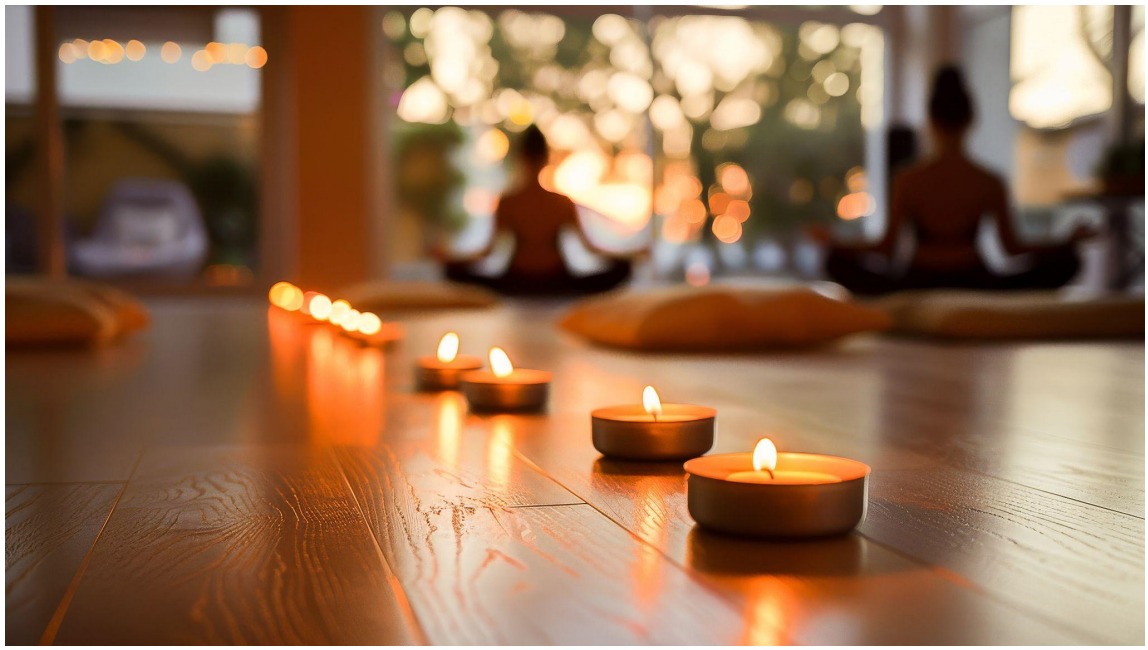
You will want to register your business with the IRS and obtain a tax identification number. Killeen (2013), also suggests employing a good accountant, a business attorney, and becoming familiar with computer programs for small businesses such as Quicken or Peachtree. Obtaining liability and malpractice insurance to protect you and your business is also essential. Marketing is an important role for the entrepreneur and this includes developing a strong business plan with financial and marketing goals A coach needs to draw in clients and your marketing efforts may take the form of word of mouth referrals, presenting your services to outreach and aftercare coordinators at treatment centers , offering free coaching sessions, networking with Employee Assistance Associations, publishing blogs, writing articles, giving free talks, and having a website (Killeen, 2013).

Starting your own business as a recovery coach is not for everyone. Another option is to seek a position with an agency or organization. As noted above, the opportunities are expanding as organizations are creating more positions. Common internet databases (such as Monster.com and HotJobs.com) are a good starting points for job openings; however, many terms are used for the title of a recovery coach including peer support

specialist, peer mentor, recovery support practitioner, care manager or recovery specialist.

Networking is essential and maybe your best source of referrals, especially if you connect with other professionals to create a complete treatment team for your clients. This can be done in a formal manner with social networking sites such as LinkedIn and Facebook, or an informal manner such as attending trainings, conferences, and professional development. Each of these activities will open up your professional network. In addition to other professionals, your clients will be a strong referral source and maintaining relationships with them after their time with you can lead to many other opportunities.

SELF-CARE



MYTH: Taking care of oneself is selfish.

TRUTH: In order to provide quality support or helping services, one must have enough internal resources on which to draw. Depletion or exhaustion of internal resources results in compassion fatigue and/or burnout.

While helping others is incredibly rewarding, it is also draining. Helpers have a tendency to neglect themselves in favor of providing support to others thinking it selfish to spend time on themselves. A good self-care plan will not only help you keep yourself healthy, but it will help your clients by modeling proper self-care and by protecting them from an unhealthy peer supporter.

Awareness

The first component of good self-care is learning how you feel when you are stressed versus how you feel when you are well then learning the symptoms of compassion fatigue.

It is very easy to breeze through life focusing on what needs to be done only to wake up one day feeling overwhelmed. Checking in with yourself on a daily and weekly basis will help you to identify your signs of stress for early intervention.

- Breathing and centering is a mindfulness exercise where one concentrates attention on the breath, physically slowing it and paying attention to the body sensations affiliated with breathing. The goal is ONLY to pay attention and BE in the present moment, NOT to achieve a meditative state. Thoughts may intrude, and that is normal, just bring attention back to the breath.
- A body scan exercise is similar to the breathing exercise, but pay attention to each part of your body noticing sensations. This one takes longer, but again, the goal is to focus attention, not to achieve meditation.
- Set aside quiet time during the week to review how you feel, accomplishments, goals, tasks ahead and get rid of things that aren't urgent.
- Schedule regular vacations and mental health days. These are times to detach from the work and focus on other things.

These are only a few of the many things you can do to check in with yourself about your level of stress. It's also a good idea to surround yourself with trusted colleagues and mentors who can help you recognize symptoms of stress or draw your attention to changes in behavior they notice.

When stress becomes too intense, especially in relation to the work, compassion fatigue may begin to set in. Compassion fatigue or burnout results from unresolved stress or when client needs overshadow your own

to the point where you begin resenting clients. It can also occur if your personal life becomes so stressful that it begins to interfere with functioning.

Symptoms of compassion fatigue

- Excessive blaming
- Bottled up emotions
- Isolation from others
- Receiving an unusual amount of complaints from others
- Voicing excessive complaints about administrative functions
- Substance abuse used to mask feelings
- Compulsive behaviors such as overspending, overeating, gambling, sexual addictions
- Poor self-care (i.e., hygiene, appearance)
- Legal problems, indebtedness
- Reoccurrence of nightmares and flashbacks to traumatic event
- Chronic physical ailments such as gastrointestinal problems and recurrent colds
- Apathy, sad, no longer finds activities pleasurable
- Difficulty concentrating
- Mentally and physically tired
- Preoccupied
- In denial about problems
- Frequent absences, lateness or missing appointments

Practice self-care

Self-care means attending to and respecting all parts of yourself. Self-care activities include intentional actions you take to care for yourself, including, but not limited to setting boundaries for work, home and relationships; physical and emotional activities. Everyone requires something different for self-care, the point is that it is intentional and practiced regularly.

Tips for maintaining boundaries

- Set definitive times for work and leave work at work; don't bring it home. This includes taking phone calls, texts, emails from clients or supervisors after hours.
- Create a ritual for leaving the work at work and preparing for your personal life.
- Limit the amount of personal information you share with clients, including places you go, people you know, etc. This prevents ethically challenging situations involving potential dual relationships and confidentiality. It also gives you space to have a life outside of work.
- Limit the number of needy or energy-draining people in your personal life and/or limit the amount of time you spend with them.

Physical self-care

- Eat right, get plenty of sleep and exercise regularly.
- Get adequate medical attention including dental and vision checkups.
- Maintain personal and environmental safety.

Emotional self-care

- Participate in counseling or mutual support groups to help deal with recovery issues that may come up for you, for help in maintaining boundaries, and for checking in.
- Participate in relaxation activities. These could include mindfulness exercises, meditation or prayer, massage, sports, reading, writing, walks in nature or anything else that helps you unwind.
- Practice grounding, centering and mindful techniques that allow your brain a rest.
- Spend time with people who love you and encourage you.
- Talk to supportive friends, relatives, therapist or pastor.

Create your self-care plan and include daily, weekly, monthly, quarterly and yearly activities. Post them in a place where you will see them. The more distressed you become at a given time, the more difficult it can be to take care of yourself and the more difficult it can be to remember what to do to take care of yourself. These lists can remind you how to calm and comfort yourself. Self-care is for you and only for you. The more self-care you practice, the better example you will be for your clients and the more rewarding you will find your work.

ETHICS

The ethical delivery of services is important not only to the success of the client, but also the peer supporter. The professional organizations in the peer support and coaching field provide guidelines for professional relationships, confidentiality and ethical decision-making, all in the interest of "doing no harm" to clients and the profession.

Professional conduct in relationships includes communicating honestly and clearly with a client, setting expectations and limitations in advance, treating everyone involved with a client's recovery with dignity and respect, and maintaining professional boundaries. As a helper, it's tempting to do everything possible to help a client and it's tempting to get "sucked in." Establishing boundaries early with clients protects both parties and sets up a model of a healthy professional relationship from which the client can learn and apply to other relationships.

Boundaries

An example of a boundary may include limiting communication to certain hours of the day, consistent with the terms of the contract. If a peer supporter is providing support with weekly face-to-face meetings, it is important to explain appropriate communication in advance. Giving a client permission to contact 24/7 may not be in the best interest of the coach or the client. The coach needs personal time and the client needs to learn how to work through issues that come up and not rely on the peer supporter as a "rescuer."

Interpersonal boundaries are another important ethical consideration. Before a peer supporter assesses the client in the first session, the client will assess the peer supporter. Peer Supporters who are in recovery themselves have an added responsibility to ensure that the coaching relationship is about the client's recovery, not their own. While friendship with a client is important, be careful to maintain proper boundaries in the release of personal information. It may be helpful for a client to know that you are in recovery, but keep the information shared to that which will help the client with their recovery. Clients are perceptive and will be able to detect if the relationship will be more about the coach than the client. The best way to prevent or catch softening of boundaries is for the peer supporter to have a mentor, supervisor or other professional to help keep the peer supporter accountable.

Another example of professional conduct is setting clear terms and expectations up front and remaining consistent throughout the peer support relationship. The professional organizations stress the importance of written agreements. If something is not in writing, it is difficult to uphold or enforce it. For example, including things in your contract that explain the peer supporter's role and the limits of that role, what the client's responsibilities are, what financial obligations are expected and how they will be handled, how success will be measured, and how the peer support relationship can or will be terminated. If there are any changes during the course of the peer support relationship, those changes must also be agreed upon in writing. For example, if a client requires transportation assistance 2 months after the coaching relationship begins, a coach may offer to provide transportation until the client is able to provide their own. A written transportation agreement may include how often a peer supporter is willing and able to transport, where a peer supporter is willing to go, who is paying for expenses related to transport, how long transport will be offered, as well as client goals for transportation independence.

Professional limitations

Peer supporters are in a unique position to do a lot of good in clients' lives. However, providing help within the context of your training and expertise dictates that coaches have enough self-awareness to know their own limits and when it's appropriate to refer a client for other services.

For example:

Peer Supporters are NOT a:	**You are moving beyond the boundaries of the peer supporter role if you:**
Sponsor (or equivalent)	• Perform AA/NA or other mutual aid group service work in your RC role • Guide someone through the steps or principles of a particular recovery program
Therapist/Counselor	• Diagnose • Provide counseling or refer to your support activities and "counseling" or "therapy" • Focus on problems/"issues"/trauma as opposed to recovery solutions
Nurse/Physician	• Suggest or express disagreement with medical diagnoses • Offer medical advice • Make statements about prescribed drugs beyond the boundaries of your training and experience
Priest/Clergy	• Promote a particular religion/church • Interpret religious doctrine • Offer absolution/forgiveness • Provide pastoral counseling

(White, 2007)

Clients and other treatment providers will appreciate a coach's acknowledgement of limitations. Establish relationships with other providers with whom you can work symbiotically and have those referral sources ready.

Another professional limitation to be aware of is that of dual relationships with clients. A professional relationship is one between a client and a peer supporter for the purpose of recovery. It is prohibited for licensed professionals in helping fields to have personal, sexual and business relationships with clients. The rules for peer supporters are less strict; most stating they are discouraged if they interfere with the ability to provide good services to the client. However, consistency within the helping fields make it easier for clients and for the emotional and professional safety of the coach, these boundaries are strongly encouraged.

Confidentiality and Privacy

For providers of substance abuse services, there are multiple layers of confidentiality of which to be aware. The exact rules and policies will depend upon the system and state a recovery coach or peer specialist is

working within; however, it is wise and in accordance with ethics put forth by professional organizations for entrepreneurial coaches to follow the same rules.to keep things simple for clients and to cover the coach.

Ethical confidentiality

Confidentiality rules are outlined in ethics standards and codes of conduct for professional associations as well as written into state regulations. In general, these rules and standards state that what happens within the coaching or peer support relationship stays within that relationship and can only be released with written permission from the client. There are also rules for which confidentiality can be broken without client consent, such as if a client becomes a danger to self or others, if child abuse is reported, in an emergency situations, or with court orders. Each state has different requirements and these limits to confidentiality should be outlined in the coaching agreement and discussed at the very beginning of the coaching relationship.

When working with minors, families, or other supporters of the client, it is especially important to put your policies in writing and express them clearly. It is generally accepted by professionals working in recovery to maintain the confidentiality of the client in all situations. In other words, communicating with family members without the client's knowledge is frowned upon and has a good chance of damaging your coaching relationship with the client. For example, if something needs to be communicated to family members or supporters, it is recommended to encourage the client to communicate that information. The coach can be there for support or to facilitate communication. Not only are you maintaining your professionalism with the client, but as a facilitator, it can help the client feel empowered as they navigate through difficult communications.

Often, peer supporters are asked to facilitate support groups. Groups are effective for practicing relationship and communication skills, for building a support community, and normalizing the challenges encountered in recovery. Confidentiality is especially difficult in groups and should be addressed early in the group process. In groups, the clients hold confidentiality. The peer supporter is bound by confidentiality rules and laws, but clients are not. It is recommended that clients be made aware of this. Often, a condition of group attendance is that clients agree to respect the confidentiality of other members. This confidentiality extends to outside of the meeting location including social media sites. For example, clients should be advised not to post anything about group meetings or group meeting topics on social media. Interactions in public places should remain anonymous as well unless otherwise agreed upon by group members. For example, if members see each other in the grocery store, are they comfortable saying hello? Some people in recovery are not comfortable with others knowing, therefore, if another group members says "hello" in public, it may be awkward for the other member to explain how the members know each other.

42 CFR Part 2

In addition to HIPAA, those providing substance abuse recovery services also have to comply with Federal Rule 42 CFR Part 2. Basically, this regulation states that no information about a client's identity, diagnosis, prognosis or treatment can be disclosed without written permission. Some exceptions are allowed under the law to comply with state and federal law, but it is generally acceptable to not even identify that a client is a client under this regulation (Kunkel, 2012).

Confidentiality and privacy laws can be complicated, but a good rule is to maintain the highest level of confidentiality possible. This includes keeping paper and electronic records secure, being aware of where meetings are held and who will be there and getting the client's written permission for

anything that could be construed as a violation of any of the above including consultations with supervisors or other providers.

An Introduction to Federal Health Care, Housing and Workplace Discrimination Laws

Peer supporters should have a basic understanding of some of the many laws that can have an impact on their clients' lives. There is an enormous amount of information available on each of the topics discussed below, published by Congress, and the various agencies or organizations that are responsible for regulating or enforcing these laws. In addition to that mountain of information, there are volumes of legal opinions issued by federal courts, state courts and government agencies. Finally, there are countless private organizations that publish information regarding how to navigate your way through the various systems, file claims, or seek some type of remedy or assistance.

The amount of information available on each of these subjects is overwhelming. There are legal professionals who spend entire careers devoted any one of these issues. With that in mind, each section of this paper should be viewed as a sign you may come across, posted at the base of a long and winding trail up that mountain of information. As we move through each topic, this paper will provide you with links to additional sources of information or resources if you are interested, or have a need, to explore further and learn more about each subject.

Understanding the system

Before we can begin to tackle any of these issues, it is helpful to have a general understanding of the system that operates each of these laws. Like the subjects which follow, this topic alone fills entire sections of libraries.

Federal and State Law

At its most basic level, our legal system is divided between state and federal law. The focus of this paper is federal law, passed by the United States Congress and signed into law by the President. These laws are regulated and enforced by United States government agencies. Lawsuits concerning the validity and application of these laws are primarily decided in federal courts.

Depending on the law, it is often necessary to initiate a complaint or seek enforcement through the federal agency responsible for the regulation of a particular set of laws. For example, the U.S. Equal Employment Opportunity Commission (EEOC) is responsible for "enforcing federal laws that make it illegal to discriminate against a job applicant or an employee because of the person's race, color, religion, sex, national origin, age (40 or older), disability or genetic information." In these types of cases, a person cannot ask a federal court for relief, or damages, until after the party has first gone through the process of seeking a remedy from the government agency.

Many states pass laws that mirror federal law. Occasionally, the state law is an exact duplicate of the federal version of the law. Often times, there are significant differences between the state and federal version of the law on any particular subject. Just as there may be two sets of laws, rules or regulations, there may be two similar agencies, state and federal, that are charged with enforcing rules or regulating conduct. For example, in Texas, in addition to the EEOC, the Texas Work Force Commission (TWC) is responsible for regulating the workplace. The TWC works "in cooperation with the federal Equal Employment Opportunity Commission (EEOC) to resolve employment discrimination allegations."

Good health, a place to live and a job

It is always best to start with the basics: Health, shelter and the means to support yourself and/or your family. First, we will take a very general look at healthcare laws, including the Affordable Care Act (generally referred to as "Obamacare"). Next, we will look at federal laws and agencies that regulate housing, then finish with a brief look at federal employment discrimination laws.

Healthcare Law: Medicare vs. Medicaid

Medicare is for older adults or individuals determined to be disabled. Medicare recipients pay deductibles, copays for medical services, medications and medical devices. They pay monthly premiums. Medicare is primarily intended to serve people who are over the age of 65 regardless of their income. Medicare provides coverage for peer support specialist and community health worker services. The PEERS in Medicare Act aims to expand access to peer support services by allowing federally qualified health centers, rural health clinics, community mental health centers, and certified community behavioral health clinics to offer these services In some cases, Medicare can cover people under age 65, who are disabled.

Medicaid is a federal assistance program. Medicaid recipients do not pay premiums, although they may be required to pay subsidized copayments for certain services. This program serves low-income people regardless of their age. Although Medicaid is a federal program, it is administered by state and local governments according to certain federal guidelines. As a result of this system, the administration and regulation of Medicaid benefits vary widely from state-to-state.

Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Peer support services can be offered to beneficiaries with either mental health conditions or substance use disorders.

Medicaid and Medicare are both administered by the Centers for Medicare and Medicare Services.

The Peer Support Act

There is a recent bill in Congress called the PEER Support Act (S.2733), introduced in the Senate on September 6, 2023. This bill aims to address behavioral health workforce shortages by supporting peer support specialists. These specialists are individuals with lived experience in recovery from mental health conditions or substance use disorders, who are certified to provide peer support services.

The bill includes provisions to:

- Recognize the profession of peer support specialists.
- Establish an Office of Recovery within the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide leadership and support for recovery services.

The Affordable Care Act

The Affordable Care Act, widely referred to as "Obamacare" is a highly charged subject. Depending on who you ask, Obamacare is an innovative attempt to provide affordable health insurance. While people are passionate about this issue on all ends of the social and political spectrum, a consistent feature of this legislation is that many people simply do not understand how this law operates. For purposes of your roles as peer supporters, Obamacare does not have a significant impact on low-income clients who are at, or below the poverty level. Those clients will, on the whole, obtain benefits under their state's Medicaid program.

Obamacare is intended for those people (or families) who earn too much income to qualify for Medicaid assistance, but not enough to afford what has become increasingly expensive private healthcare insurance. A link is

provided below for a brief summary of the mechanics of Obamacare. One of the primary features of Obamacare is that it prohibits insurance companies from denying health care insurance based on a person's pre-existing medical conditions.

Much as has been written about the "Individual Mandate" feature of Obamacare. The Individual Mandate is a method for funding Obamacare by requiring individuals to "Maintain Minimum Essential Coverage." There is a monetary penalty levied on those individuals who are mandated, but do not obtain minimally required health care coverage. Importantly, there are significant exceptions to the mandate which include exceptions from this penalty for low income taxpayers.

HIPAA

HIPAA refers to the Health Care Portability Accountability Act of 1996. One of the goals of HIPAA, like Obamacare, is to limit the likelihood that a person will be denied health care insurance coverage as a result of the disclosure of a pre-existing condition. HIPAA spells out the rules and regulations that hospitals, doctors and other healthcare providers must follow regarding protecting, and limiting the disclosure of a patient's sensitive health care or personal identifying information. On the federal level, this law is administered by the U.S. Department of Health and Human Services.

With regard to privacy, the Department states that the "General Principle" of HIPAA is:

> "... to define and limit the circumstances in which an individual's protected health information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the

> individual who is the subject of the information (or the individual's personal representative) authorizes in writing."

A client must sign an authorization consenting to disclosure of any information protected under HIPAA. Importantly, a person is entitled to his or her own copy of any information disclosed under HIPAA.

HIPAA relates to a very particular class of information. Specifically, HIPAA protects the following categories of information from disclosure unless the individual consents, in writing, to such disclosure:

- Information concerning an individual's past, present or future physical or mental health or condition;
- Information concerning the past, present, or future payment for the provision of health care to the individual;
- Information which may identify an individual, such as birth dates or Social Security Numbers, all of which can be used to investigate an individual's background.

Implications for peer support and treatment providers

HIPAA is a privacy law that is enforceable and punishable with fines and prison time (Freedman & McCaughan, 2008). Not only does it cover an entity in terms of compliance, but it also legitimizes the entity and promotes professionalism and client confidence.

There is a section of HIPAA that pertains to communicating with third party payers and another that handles administrative security. This guide will focus on the two rules that are most relevant to coaches, The Privacy Rule and The Security Rule.

The Privacy Rule covers anything that can identify an individual, referred to as PHI (personal health information). First, you are not to release any PHI without the consent of your client, and second, you must keep a record

of all disclosures. You must also have privacy policies and procedures in written form and available to clients upon request.

The Security Rule covers administrative, physical, and technical privacy. The HIPAA law is very specific about these safeguards and includes policies and procedures that clearly show how you comply with the HIPAA law. Regular training should be included in the plan as should contingency plans, internal audits, and how you will handle security breaches. If you work with outside vendors that could have access to PHI, they must also be HIPAA compliant and have signed agreements to that effect. Finally, the physical safeguards used must be outlined as well. Physical safeguards include how hardware and software will be introduced, maintained and removed in a secure fashion. Methods include the double-lock rule, meaning employees have to get through 2 locks or 2 layers of security to get to PHI; keeping PHI away from any eyes not authorized to view it which includes computer screens, files, check-in lists, etc. Technical safeguards must also be in place to protect digital data including phone lines, computer systems, mobile phones, faxes, and emails.

The bad news is compliance is taken seriously and violations are strict. The good news is that the Office of Civil Rights has a lot of the materials you need on their website, including sample agreements, policies, procedures and audit plans.

The American with Disabilities Act

The American With Disabilities Act, (ADA) "[P]rohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation." The ADA is regulated by the U.S. Department of Justice. As discussed below, substance use disorders can be considered "disabilities" within the meaning of the ADA. However, those terms are carefully defined and limited.

Social Security Benefits

The Social Security Administration manages the Social Security Disability Insurance (SSDI) programs that provide benefits based on disability or blindness. The Social Security Administration defines "disability" as a "medically-determinable physical or mental impairment(s)" that prevents an individual from engaging in "any substantial gainful activity." The condition causing the disability must have lasted, or must be expected to last, for a continuous period of at least 12 months. If an individual's application for these benefits is rejected by the SSA, that individual may appeal the SSA's determination.

Housing Law

The federal laws directed toward the prevention of discrimination in both the sale and rental of housing are codified in the Fair Housing Act. The Fair Housing Act is enforced by the United States Department of Housing and Urban Development. While attempting to the read actual health care laws is, mostly, not very helpful (the text of the Affordable Health Care Act/Obamacare spans nearly 1,000 pages), a look at the language of The Fair Housing Act is fairly straight and to the point. The Fair Housing Act provides that it is a violation of federal law for a landlord, or seller of private property:

- "To refuse to sell or rent after the making of a bona fide offer, or to refuse to negotiate for the sale or rental of, or otherwise make unavailable or deny, a dwelling to any person because of race, color, religion, sex, familial status, or national origin.
- To discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection therewith, because of race, color, religion, sex, familial status, or national origin.
- To make, print, or publish, or cause to be made, printed, or published any notice, statement, or advertisement, with respect to

the sale or rental of a dwelling that indicates any preference, limitation, or discrimination based on race, color, religion, sex, handicap, familial status, or national origin, or an intention to make any such preference, limitation, or discrimination.

- To represent to any person because of race, color, religion, sex, handicap, familial status, or national origin that any dwelling is not available for inspection, sale, or rental when such dwelling is in fact so available."

Substance use are within the definition of a "disability" with regard to the Fair Housing Act. The definition of "drug addiction" under the act does not include "addiction caused by current, illegal use of a controlled substance." Also, it should be noted that that the statute uses the word "sex" and not "sexual orientation." As a result, "The Fair Housing Act does not specifically include sexual orientation and gender identity as prohibited bases. However, a lesbian, gay, bisexual, or transgender (LGBT) person's experience with sexual orientation or gender identity housing discrimination may still be covered by the Fair Housing Act." The link in the references box provides some examples of situations in which the Fair Housing Act may apply despite the fact that the Act does not specifically include sexual orientation.

Employment Discrimination

Discrimination in the workplace covers a wide variety of issues and can take many forms. As noted above, the Equal Employment Opportunity Commission is responsible for enforcing a variety of federal laws including:

- Title VII of the Civil Rights Act of 1964 (Title VII), which prohibits employment discrimination based on race, color, religion, sex, or national origin;
- Title VII also applies to claims involving sexual harassment and "hostile work environment" claims;

- The Equal Pay Act of 1963 (EPA), which protects men and women who perform substantially equal work in the same establishment from sex-based wage discrimination;
- The Age Discrimination in Employment Act of 1967 (ADEA), which protects individuals who are 40 years of age or older;
- Title I and Title V of the Americans with Disabilities Act of 1990, as amended (ADA), which prohibit employment discrimination against qualified individuals with disabilities in the private sector, and in state and local governments; and
- Sections 501 and 505 of the Rehabilitation Act of 1973, which prohibit discrimination against qualified individuals with disabilities who work in the federal government.

There is one very important feature to employment discrimination claims. In many cases, the statute provides for the award of attorney's fees by the Court. This is usually not the case in American jurisprudence. These fee shifting provisions are designed to encourage attorneys to prosecute employment discrimination claims, even if a large award of monetary damages is not at stake for the complaining party.

Substance Use

Drug addiction is recognized as a "disability" under the American with Disabilities Act. The EEOC has issued guidance on this issue which is instructive. The EEOC takes the position that, "It is important to remember that past illegal drug addiction is a covered disability under the ADA (as long as the person is not a current illegal drug user), but past casual use is not a covered disability." The link provided is also useful with regard explaining to clients what a potential employer may, or may not, ask when it comes to the issue of drug addiction.

To summarize, it is always permissible for an employer to ask questions, or request a pre-employment drug test, as it relates to the current use of a controlled substance. However, an employer may not ask questions that are

designed to determine whether an applicant may or may have been addicted to drugs or alcohol in the past. An employer may ask whether an applicant has used illegal drugs in the past. An employer may not ask “"How often did you use illegal drugs in the past?" "Have you ever been addicted to drugs?" "Have you ever been treated for drug addiction?" or "Have you ever been treated for drug abuse?"

Employment Discrimination and Sexual Orientation

The issue of LGBT rights in the workplace, much like the issue of marriage, is left to the states. The federal government prohibits discrimination based on sexual orientation with regard to employment with the federal government and its various agencies and departments. Federal anti-discrimination laws regarding sexual orientation may apply to private employers working on federally funded government contracts. However, with regard to private sector employment, in its own words, “The U.S. Equal Employment Opportunity Commission (EEOC) does not enforce laws that prohibit discrimination and harassment based on sexual orientation, status as a parent, marital status and political affiliation. However, other federal agencies and many states and municipalities do.” The American Civil Liberties Union, publishes a useful map showing which states do, and do not, include sexual orientation as part of the protected class of citizens within the meaning of their workplace discrimination laws.

Sources for more legal information

- U.S. Equal Employment Opportunity Commission www.eeoc.gov/eeoc/
- Summary of the Affordable Care Act. http://abcnews.go.com/Health/obamacare-explained-idiot/story?id=21292932&singlePage=true

- U.S. Department of Health & Human Services 2014 Poverty Guidelines http://aspe.hhs.gov/poverty/14poverty.cfm
- Obamacare Facts: 'Individual Mandate' Explained http://blogs.findlaw.com/fourth_circuit/2011/06/obamacare-facts-individual-mandate-explained.html
- U.S. Department of Labor FAQs re: HIPAA www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html
- U.S. Department of Health & Human Services Health Information Privacy www.hhs.gov/ocr/privacy/hipaa/understanding/summary/
- Americans with Disabilities Act 2010 www.ada.gov/2010_regs.htm
- Social Security Administration Overview of Disability Programs www.ssa.gov/redbook/eng/overview-disability.htm
- U.S. Department of Housing and Urban Development www.hud.gov/offices/fheo/disabilities/reasonable_modifications_mar08.pdf\
- portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/LGBT_Housing_Discrimination
- American Civil Liberties Union Non-Discrimination Laws State by State Information www.aclu.org/maps/non-discrimination-laws-state-state-information-map

REFERENCES

Abramson, T.A., Trejo L., & Lai, D.W.L. (2002). Culture and mental health: providing appropriate services for a diverse older population. *Generations*. 26*(1*):21-27.

Adams, W.L., Barry, K.L., & Fleming, M.F. (1996). Screening for problem drinking in older primary care patients. *Journal of the American Medical Association.* 276(24):1964-1967. doi:10.1001/jama.1996.03540240042028.

Alcoholics Anonymous (2002). *The Big Book* (4th ed.). New York, NY: Alcoholics Anonymous World Services, Inc.

American Association on Health and Disability. Policy Alert: Expanding Peer Support. Retrieved from https://aahd.us/2024/05/policy-highlight-peers-act/

American Psychological Association (2014). *Mental and Behavioral Health and Older Americans.* Retrieved from http://www.apa.org/about/gr/issues/aging/mental-health.aspx Accessed 16 March 2014.

American Society of Addiction Medicine (2013). About ASAM. *ASAM: The Voice of Addiction Medicine*. www.asam.org/about-us/about.asam

Armstrong, P. (2006). *The practice of counseling*. Melbourne: Thomson Higher Education.

Atkinson, R.M.; Ganzini, L.; & Bernstein, M.J. (1992). Alcohol and substance-use disorders in the elderly. In: Birren, J.E.; Sloane, R.B.; and Cohen, G.D., eds. *Handbook of Mental Health and Aging*, (2nd ed.) San Diego, CA: Academic Press.

Barlow, G. & Sawyer, D. (2009). *Characteristics of an effective meeting/group visit*. Princeton NJ: Robert Wood Johnson Foundation. Retrieved from http://www.diabetesinitiative.org/resources/tools/documents/41-PROV-Facilitatinggroupvisits_skills-Gerda8-05_web.pdf

Bartels, S.J., Blow, F.C., Brockmann, L.M., & Van Citters, A.D. (2005). *Substance abuse and mental health care among older Americans: The state of the knowledge and future directions*. Rockville, MD: WESTAT

Bartlett, E. (1986). Advocacy skills and strategies for patient education managers. *Patient Education and Counseling, 8,* 397-405.

Blixen, C.E., McDougall, G.J., & Suen, L. (1997). Dual diagnosis in elders discharged from a psychiatric hospital. *International Journal of Geriatric Psychiatry*. 12(*3*):307-313.

Bruce, M.L., Van Citters, A.D., & Bartels, S.J. (2005). Evidence-based mental health services for home and community. *Psychiatry Clinics of North America*, 28:1039–1060.

Buncher, B. (2009). Loving mirror family recovery coaching. *Family Recovery Resources, LLC*. Retrieved July 10, 2013 from www.familyrecoveryresources.com.

Canadian Mental Health Association (2010). *Mental Health and Addictions Issues for Older Adults: Opening the Doors to a Strategic Framework.* Retrieved from http://ontario.cmha.ca/public_policy/mental-health-and-

addictions-issues-for-older-adults-opening-the-doors-to-a-strategic-framework/ Accessed 15 March 2014.

Castonguay, L. G., Constantino, M. J., Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training, Vol 43(3),* 271-279. doi:10.1037/0033-3204.43.3.271

Centers for Medicare & Medicaid Services. Guidance to States interested in peer support services under the Medicaid program. Retrieved from

https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf

Center for Substance Abuse Treatment (1999). *Brief Interventions and Brief Therapies for Substance Abuse. Treatment Improvement Protocol (TIP) Series, No. 34*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (1998). *Substance abuse among older adults*. Treatment Improvement Protocol (TIP) Series, No. 26. Rockville (MD): Substance Abuse and Mental Health Services Administration. Retrieved from: http://www.ncbi.nlm.nih.gov/books/NBK64422/

Center for Substance Abuse Treatment (1999). *Treatment of adolescents with substance use disorders.* Treatment Improvement Protocol (TIP) Series, No 32. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (2009). *What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454.* Rockville,

MD: Substance Abuse and Mental Health Services Administration.

Compassion Fatigue Awareness Project (2013). *Recognizing Compassion Fatigue*. Retrieved from http://www.compassionfatigue.org/pages/symptoms.html.

Congress.gov Peer Support Act. Retrieved from https://www.congress.gov/bill/118th-congress/senate-bill/2733/text

Connors, G. J., Donovan, D. M., & DiClemente, C. C. (2001). Substance abuse treatment and the stages of change: Selecting and planning interventions. New York, NY: The Guilford Press.

Copeland, M.E. (2012). Crisis plan. *Copeland Center for Wellness and Recovery.* Retrieved from http://wrapandrecoverybooks.com/recovery-resources/crisis-planning.php

Copeland, M.E. (2012). Post crisis plan. *Copeland Center for Wellness and Recovery.* Retrieved from http://wrapandrecoverybooks.com/recovery-resources/crisis-planning.php

Copeland, M.E. (2012). The Wellness Recovery Action Plan (WRAP). *Copeland Center for Wellness and Recovery.* Retrieved July 17, 2013 from http://copelandcenter.com/what- wrap/history-wrap.

Dev Anand, D. P. (2002). Comorbid psychiatric disorders in late life depression. *Biological Psychiatry*, 51(3): 236-242.

Dual Recovery Anonymous (2009). Dual diagnosis or co-occurring disorders. *Dual Recovery Anonymous.* Retrieved July 29, 2013 from http://www.draonline.org/dual_diagnosis.html.

Egan, G. (2010). *The skilled helper (9th ed.).* Belmont, CA: Cengage Learning.

Florio, E.R., & Raschko, R. (1998). The Gatekeeper Model: implications for social policy... referring community-dwelling older adults who may be in need of help. *Journal of Aging & Social Policy*. 10(*1*):37-55.

Freedman, M. N. & McCaughan, A. M. (2008). HIPAA for dummies: A practitioner's guide. In G.R. Walz, J.C. Blueuer, & R. K. Yep (Eds). *Compelling counseling interventions: Celebrating VISTAS' fifth anniversary* (pp. 305-312), Ann Arbor, MI: Counseling Outfitters.

George, L.K. (1994). Social factors and depression in late life. In: Schneider LS, Reynolds CFI, Lebowitz BD, Friedhoff AJ, eds. *Diagnosis and treatment of depression in late life*. Washington, DC: American Psychiatric Press, Inc.

Granfield, R. & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment.* New York: New York University Press.

Grohol, J. (2009). 15 Common Cognitive Distortions. *Psych Central.* Retrieved July 31, 2013, from http://psychcentral.com/lib/15-common-cognitive-distortions/0002153

Grohol, J. (2009). Fixing Cognitive Distortions. *Psych Central.* Retrieved July 31, 2013, from http://psychcentral.com/lib/fixing-cognitive-distortions/0002154

Guthmann, D. (1999). *Models of alcohol and other drug treatment for consideration when working with deaf and hard of hearing individuals.* Minneapolis: Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals.

Hammond, W. (2010). Principles of strength-based practice. *Resiliency Initiatives*. Retrieved July 29, 2013 from http://www.ayscbc.org/Principles%20of%20Strength-2.pdf.

Harrington, S. (2011). National Association of Peer Specialists. *Recovery to Practice Weekly Highlights, (2)* 21. Retrieved from http://www.samhsa.gov/recoverytoPractice/Resources/2011_weekly/2011_06_09/wh_2011_06_09.html

Hays, P. A. (2001). *Addressing Cultural Complexities in Practice: A Framework for Clinicians and Counselors.* Washington, D. C.: American Psychological Association.

Hazelden Foundation (2013). Modified Mini-Screen. Retrieved from http://www.bhevolution.org/public/screening_tools.page?menuheader=4

Holder, H., Boyd, G., Howard, J., Flay, B., Voas, R., & Grossman, M. (1995). Alcohol-problem prevention research policy: The need for a phases research model. *Journal of Public Health Policy.* 16:324-346.

Holder, H.D., & Blose, J.O. (1992). The reduction of health care costs associated with alcoholism treatment: A 14 year longitudinal study. *Journal of Studies on Alcohol.* 53:293-302.

IC&RC (2013). About IC&RC. *IC&RC Leading the world in credentialing.* Retrieved from www.internationalcredentialing.org/about

International Center for Clubhouse Development (2014). SAMHSA's National Registry of Evidence-Based Programs and Practices. http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=189 Accessed 16 March 2014.

International Coach Federation. (2013). Core Competencies. *ICF: International Coach Federation*. Retrieved from http://www.coachfederation.org/credential/landing.cfm?ItemNumber=2206&navItemNumber=576

International Coach Federation. (2013). Ethics & Regulation. *ICF: International Coach Federation*. Retrieved from http://www.coachfederation.org/about/ethics.aspx?ItemNumber=850&navItemNumber=621

Jeste, D.V., Alexopoulos, G.S., & Bartels, S.J., et al. (1995). Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next 2 decades. *Archives of General Psychiatry,* 56(*9*):848-853.

Karel, M.J. (1997). Aging and depression: Vulnerability and stress across adulthood. *Clinical Psychology Review,* 17:847-879.

Killeen, M. (2013). *Recovery coaching: A guide to coaching people in recovery from addictions.* Laurel Springs, NJ: MK/RC Publishing.

Kottler, J. A. (2000). *Introduction to therapeutic counseling: Voices from the field.* (4th ed.). Belmont, CA: Wadsworth.

Kunkel, T. (2012). *Substance abuse and confidentiality: 42 CFR Part 2*. Williamsburg, VA: National Center for State Courts.

Laudet, A. & William, W. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use Misuse, 43* (1), 27-54.

Liberto, J.G., Oslin, D.W., & Ruskin, P.E. (1992). Alcoholism in older persons: A review of the literature. *Hospital and Community Psychiatry*, 43(*10*):975–984.

Mark, T.L., Coffey, R.M., Vandivort-Warren, R., Harwood, H.J., & King, E.C. (2005). *U.S. Spending For Mental Health and Substance Abuse Treatment, 1991-2001*. Health Aff (Millwood).

McKregg, K. & Oakden, J. (2009). *Characteristics of good peer support*. Wellington, New Zealand: Wellink Trust. Retrieved from http://www.wellink.org.nz/pdf/Characteristics_of_Good_Peer_Support.pdf

McLellan, A. T., Hagan, T. A., Levine, M., Gould, F., Meyers, K. & Bencivengo, M., et al. (1998). Research report: Supplemental social services improve outcomes in public addiction treatment. *Addiction, 93*(10), 1489-1499.

Mental Health Commission of Canada (2003). *Guidelines for Comprehensive Mental Health Services for Older Adults*. Retrieved from http://www.mhccseniorsguidelines.ca Accessed 16 March 2014.

Meyer, P. J. (2003). Attitude is everything: If you want to succeed above and beyond. Waco, TX: Meyer Resource Group, Inc.

Mid-Atlantic Addiction Technology Transfer Center, MI Basics, *Motivational Interviewing Website.* Retrieved from www.motivationalinterview.org.

Miller, W. & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York, NY: Guilford Press.

Mindtools, Ltd. (2013). The Wheel of Life: Finding balance in your life. *Mindtools.* Retrieved from http://www.mindtools.com/pages/article/newHTE_93.htm#

Mitchell, S. (2002). *Can love last? The fate of romance over time.* New York: Norton.

Moses, D.J., Glover Reed, B., Mazelis, R., & D'Ambrosio, B. (2003). *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study.* Substance Abuse and Mental Health Services Administration. Retrieved from http://www.prainc.com/wcdvs/pdfs/CreatingTraumaServices.pdf

Myers and Briggs Foundation (2013). MBTI basics. Myers and Briggs Foundation. Retrieved July 20, 2013 from http://www.myersbriggs.org/my-mbti-personality-type/mbti-basics/.

National Alliance on Mental Illness (2013). Becoming a self-advocate. *Strength of Us.* Retrieved July 13, 2013 from http://strengthofus.org/pages/view/156/.

National Alliance on Mental Illness (2013). Substance abuse and co-occurring disorders. *National Alliance on Mental Illness.* Retrieved August 3, 2013 from http://www.nami.org/Content/NavigationMenu/Hearts_and_Minds/Smoking_Cessation/Substance_Abuse_and_Co-occurring_Disorders.htm.

National Association of Drugs and Alcohol Interventionists. (n.d.). NADAI Certification. Retrieved from http://www.nadai.us/ethics.php.

National Institute on Drug Abuse (2010). *Drugs, Brains, and Behavior: The Science of Addiction (NIH Publication No. 10-5605).* National Institutes of Health, U.S. Department of Health and Human Services. Retrieved from http://www.drugabuse.gov/sites/default/files/sciofaddiction.pdf

National Institute on Drug Abuse (2013). *Marijuana: Facts for teens.* National Institutes of Health, U.S. Department of Health and Human Services. Retrieved from http://www.drugabuse.gov/publications/marijuana-facts-teens/letter-to-teens

National Institute on Drug Abuse (2007). *Mind Over Matter: Opiates NIH Publication No. 03-3856.* National Institutes of Health, U.S. Department of Health and Human Services. Retrieved from http://teens.drugabuse.gov/educators/curricula-and-lesson-plans/mind-over-matter/opiates

National Institute on Drug Abuse (2013). *Research report series: Methamphetamine.* National Institutes of Health, U.S. Department of Health and Human Services. Retrieved from http://www.drugabuse.gov/publications/research-reports/methamphetamine/letter-director

Northeast ATTC Resource Links Volume 7, Issue 2 *Cultural competency: Its impact on addiction treatment and recovery.*

OptumHealth (2011). [poster presentation] Association for Community Mental Health Administration Summit. New Orleans, LA.

Pawelczyk, J. (2012). "No stories, no self": Co-constructing personal narratives in the psychotherapy session. *Poznan Studies in Contemporary Linguistics, 48*, 1-21.

Purdue University (n.d.). Everything you ever wanted to know about case notes. *Student Resources.* Retrieved from http://www.purdue.edu/hhs/hdfs/engagement/documents/MFT_forms/Student/Resources/Casenote.PDF

Quesenbery, W. & Brooks, K. (2010). *10 Skills for Active Listening from* Storytelling for User Experience. New York: Rosenfeld Media. Retrieved from http://www.rosenfeldmedia.com/books/storytelling/

Recovery Coaches International (2013). Core competencies. *Recovery Coaches International: The voice of choice for recovery and beyond.* Retrieved from http://www.recoverycoaching.org/content.aspx?page_id=22&club_id=263697&module_id=142736

Recovery Coaches International (2013). What is recovery coaching. *Recovery Coaches International: The voice of choice for recovery and beyond.* Retrieved July 7, 2013 from http://www.recoverycoaching.org/content.aspx?page_id=22&club_id=263697&module_id=142729

Recovery within Reach (2013). History of the recovery movement. *Recovery Within Reach.* Retrieved July 3, 2013 from http://www.recoverywithinreach.org/Recovery/history.

Rothman, J. & Sager, S. (1998). *Case management: Integrating individual and community practice.* (2nd ed.). Upper Saddle River, NJ: Pearson.

Seeking Solutions: Canadian Community Action on Seniors and Alcohol Issues (2003). *Older Adults, Alcohol and Depression.*

Spengler, P. M., Strohmer, D. C., Dixon, D. N., & Shivy, V. A. (1995). A scientist-practitioner model of psychological assessment: Implications for training, practice and research. *The Counseling Psychologist 23:* 506-534. doi: 10.1177/0011000095233009

Substance Abuse and Mental Health Services Administration. (2007) *An action plan for behavioral health workforce development.* Retrieved from: http://www.samhsa.gov/Workforce/Annapolis/WorkforceActionPlan.pdf

Substance Abuse and Mental Health Services Administration. (2012). Building Communities of Recovery: How Community-Based Partnerships and Recovery Support Organizations Make Recovery Work. *National Recovery Month.* Webcast retrieved from http://www.recoverymonth.gov/Resources-Catalog/2012/Webcast/09-How-CommunityBased-Partnerships-and-Recovery-Support-Organizations-Make-Recovery-Work.aspx

Substance Abuse and Mental Health Services Administration (2013). Eight dimensions of wellness. Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal, 29*(4), 311–314. Retrieved from http://promoteacceptance.samhsa.gov/10by10/dimensions.aspx

Substance Abuse and Mental Health Services Administration, Division of Pharmacologic Therapies (2013). *Medication-Assisted Treatment*

for Substance Use Disorders. Retrieved from http://dpt.samhsa.gov/index.aspx

Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's Working Definition of Recovery* (Recovery Support Initiative PEP12-RECDEF). Washington, DC: U.S. Government Printing Office. Retrieved from http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF

Substance Abuse and Mental Health Services Administration & Policy Research Associates (1998). *Program Summary: Women, Co Occurring Disorders and Violence Study*. Retrieved from http://www.wcdvs.com/publications/default.asp

Substance Abuse and Mental Health Services Administration (2013). *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration (2014). *TIP 57: Trauma-informed care in behavioral health services.* HHS Publication No. (SMA) 14-4816. Rockville, MD: Substance Abuse and Mental Health Services Administration.

The Commonweatlh Fund Medicare Reforms Support Behavioral Health by Expanding Access to Peer Support Specialists and Community Health Workers. Retrieved from https://www.commonwealthfund.org/blog/2024/medicare-reforms-support-behavioral-health-expanding-access-peer-support-specialists-and

Torbay & Southern Devon Health & Care (2013). *Recovery Capital Workshops*. Retrieved July 17, 2013 from http://www/tsdhc.nhs.uk/publications/TSDHC/Recovery%20Capital%20Workshops%20Leaflet.pdf

U.S. Census Bureau (2000). *Projections of the Resident Population by Age, Sex, Race, and Hispanic Origin: 1999-2100.* Population Projections Program: Washington, DC.

Van Citters, A.D., Bartels, S.J. (2004). A systematic review of the effectiveness of community-based mental health outreach services for older adults. *Psychiatric Services*. doi: 10.1176/appi.ps.55.11.1237

White, W., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits R. & Donohue, B. (2007). *Ethical Guidelines for the Delivery of Peer-based Recovery Support Services.* Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, *9*(5), 22-27.

White, W. L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices.* Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Transfer Center, and the Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

CONTRIBUTORS

Trudi Griffin, MA, MS
Licensed Professional Counselor Intern

Trudi Griffin provides trauma-informed counseling under supervision for individuals and families recovering from substance abuse, mental health issues, and co-occurring disorders in an integrated care setting at Ten Clinic, in Waxahachie, TX.

Ms. Griffin is a graduate of Marquette University (Milwaukee, WI), and holds a Master's of Science in Clinical Mental Health Counseling: Addictions and Mental Health. As a clinic manager and counselor at The Bridge Health Clinics & Research Centers in Milwaukee, WI, she provided trauma-informed counseling to individuals utilizing evidence-based therapies including CBT, DBT, REBT, and Seeking Safety, and facilitated substance abuse groups utilizing SMART Recovery, CBT, REBT, Seeking Safety, Motivational Interviewing, and 12 Step interventions. She also counseled survivors of sexual assault and conducted groups for survivors in recovery.

In Eddy County, NM, Ms. Griffin served as an Adolescent Intensive Outpatient Therapist and provided counseling to adolescent drug court participants and their families, using Moral Reconation Therapy. While there, she also coordinated a new adolescent intensive outpatient substance abuse program based upon The Matrix for Teens and Young Adults, which included groups, individual and family therapy.

Jorea McNamee Lenard
Founder/Executive Director

PARfessionals is founded in 2011 by Jorea M. Lenard, who is a Mental Health consumer in recovery. The organization is entirely funded by members of her family. PARfessionals aims to promote mental health awareness, education, and support for individuals and families affected by mental health and addiction challenges. The organization provides a range of services, including advocacy, peer support, and training. PARfessionals is committed to breaking down the stigma surrounding mental illness and helping individuals lead fulfilling and productive lives. Through its work, PARfessionals has made a positive impact on the lives of many individuals and families, and they continue to strive towards their mission of improving mental health outcomes for all.

Jorea is an accomplished individual with a wide range of educational experiences. She earned a B.S. degree in Management in 2009 and completed most mesrequirements for a M.A. in Criminal Justice from the American (Military) Public University System the following year. She has also completed a graduate certificate in Applied Forensic Psychology Services from The Chicago School of Professional Psychology. Along with these degrees, Jorea has obtained numerous certificates, including those in mental health, home health assistant, non-profit management, applied forensic psychology services, family and business mediation, substance abuse, and emergency management.

Jorea has also received training in a vast array of important topics from various organizations and colleges. Some of these topics include rape/domestic violence crisis intervention, hospice, and health unit coordination. Her training has come from institutions such as Parkland Health & Hospital System, Lakewood College, Center for Degree Studies, Brookhaven College, Northwestern University Feinberg School of Medicine's Clinical and Translational Sciences Institute, Thomas Edison

State College, University of Texas at Arlington-Continuing Education Division, Richland College, and many more.

In summary, Jorea's diverse educational background and extensive training demonstrate her passion for learning and her commitment to personal and professional growth.

Jorea Lenard is an accomplished author, peer recovery advocate and healthcare professional with a passion for helping ex-offenders get ahead in today's society. In her self-published book "Getting Ahead: An Ex-Offenders Guide to Getting Ahead in Today's Society", she provides practical advice for ex-offenders looking to participate in clinical research trials.

Jorea has received numerous credentials from the Texas Certification Board of Addiction Professionals (TCBAP), including the Peer Recovery Specialist (PRS), Peer Mentor/Peer Recovery Coach (PM-PRC), Certified Criminal Justice Addiction Professional-Applicant (CCJP-A) and the Associate Prevention Specialist (APS) credentials but has since retired those credentials . She is also a Nationally Certified Psychiatric Technician and has worked as an Addictions Counselor Intern (CI).

Jorea is currently focused on privately funding her ideas and content development for PARfessionals, a unique Workforce Development curriculum Program designed with the help of medical doctors, clinicians and other behavioral health professionals from across the globe. If you are interested in connecting with Jorea and learning more about her work, please don't hesitate to reach out to her directly.

Shira Goldberg, BSc., RRW
Goldberg Sober Coaching & Host of The Addiction Show

Shira Goldberg is a sober coach, host of The Addiction Show and a graduate student at the University of San Francisco where she is studying

to become a psychotherapist. Shira graduated from Kaplan University in 2011 with a degree in psychology, her emphasis in Applied Behavioral Analysis. Prior to that, she attended University of Wisconsin-Milwaukee, where she was in the pre-medicine program. She was awarded the Ronald McNair Scholarship, a Postbaccalaureate Achievement Program, and a fellowship at the Medical College of Wisconsin where she did cancer research. She graduated Summa Cum Laude and is in Psi Chi, Psychology's International Honor Society.

After surviving her own battle with alcohol, she had an awakening and began focusing her efforts and dedication on the recovery community and became a sober coach. Her motivation is to encourage and celebrate recovery by promoting its message of hope. She is the host of The Addiction Show (theaddictionshow.com), an online effort that reduces the marginalization and stigma that surrounds addiction and to help those that have a need find not only resources, but community.

"By supporting and encouraging clients to achieve their life goals, within the context of long-term recovery, I get to see not only collectively, but individually, the benefits of recovery and their new lease on life. I cannot imagine doing anything more important than that."

Shira Goldberg, founder of and a Sober Coach in private practice.

Attorney Gregory Samurovich

Instructor/Course Writer, Legal Overview for Peer Supporters

Attorney Gregory Samurovich, is a senior trial attorney with the law firm Wright & O'Donnell, P.C. in Conshohocken, Pennsylvania. He has focused his practice on complex civil litigation in the medical device, manufacturing and transportation industries. Attorney Samurovich has represented national and international Fortune 500 companies. His experience includes matters involving product liability, serious injury and

wrongful death claims, catastrophic motor vehicle and industrial accident liability, chemical exposure, property damage and fire, and construction and workplace accidents, as well as complex insurance coverage litigation and strategic advice.

Attorney Gregory Samurovich was selected for inclusion in the Rising Stars of Pennsylvania Super Lawyers.

Russia Robinson

Russia Robinson is currently a freelance writer out of Atlanta, Georgia. She holds a BA in English Creative Writing and American Literature from San Francisco State University and post graduate studies at Kennesaw State University in Technical Writing. With an extensive background in social services including youth mental health, behavioral counseling, and education, she has more than 10 years' experience with helping young people achieve emotional and social well-being. As a writer, she promotes quality standards of care and evidence based, best practice approach to mental health. Creating articles, essays, and blogging, she educates others about the significance of mental health. This includes the impact mental disorders has on individuals and their families and approaches to treatment. Russia Robinson is a certified Language Arts Teacher for the state of Georgia, with professional documentation training in mental health, counseling, and management. Her research articles describing mental health and its effects on society can be viewed on her website at russiarobinson.wordpress.com.

Melissa Killeen, MSOD. MPhil

Melissa Killeen earned both a MSOD and MPhil in Organizational Dynamics from the University of Pennsylvania.

She is the CEO of Melissa Killeen Recovery Coaching MK/RC which focuses on coaching for executives that are recovering from drug and alcohol addictions. Her client list includes Allstate and Comcast and privately held health management businesses, high end retail and real estate firms.

Prior, to opening her own executive coaching business, Melissa has worked for several organizations, including the University of Pennsylvania, GMAC Mortgage, the Pew Charitable Trust and the Camden County Cultural and Heritage Commission.

Melissa Killeen is the former President of Recovery Coaches International.

She serves as a consultant for our Peer Recovery Training course.

Dr. Laura Pipoly

Laura Pipoly earned her Bachelor of Arts in Psychology from Hiram College. She then graduated summa cum laude with her master's degree from Youngstown State University in education in both school counseling and clinical mental health counseling. She is a Professional Counselor (PC) and a certified K-12 school counselor. In addition, Laura is recognized as a National Board Certified Counselor. Laura completed her doctorate degree from Nova Southeastern University with a dual concentration in instructional technology and distance education (ITDE) and special education. Her dissertation focuses on distance education counseling students and is titled *Counseling Students Perceptions towards the Efficacy of Online Counseling.*

Laura enjoys teaching courses for Grand Canyon University and University of Phoenix. Most recently, Laura authored the book foreword to an E-book titled, "*Meeting the Challenges of Bipolar Disorder: Self Help Strategies that Work!"*