MISSION BOUNDARIES TOOLKIT

FOR PEER SUPPORT SPECIALISTS AND RECOVERY COACHES

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The views expressed in the following document do not necessarily reflect the official policies of the Massachusetts Executive Office of the Trial Court, the University of Massachusetts Medical School, or Substance Abuse and Mental Health Services Administration (SAMHSA) nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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The MISSION materials mentioned within the document in addition to all versions of the MISSION treatment manual and their corresponding workbooks are available for download on the MISSION website at www.missionmodel.org. You may also contact the MISSION team through the website or Dr. David Smelson directly (see contact information below) regarding any questions about the MISSION Model and/or the materials.

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FORWARD

Peer Support and Recovery Coach work has gained momentum in the United States and is now viewed as an important treatment component of interventions designed to help people along the path to substance use and mental health recovery. As the unique contribution offered by individuals with lived experience is increasingly recognized, considerable and varied employment opportunities have opened up. Positions are now available in numerous settings, including hospitals, outpatient clinics, and criminal justice organizations. Here in Massachusetts we have two workforces with lived experience employed in behavioral health. These include Peer Support Specialists out of the mental health field and Recovery Coaches out of the addictions field. With regard to co-occurring disorders, either of these may be selected by a given agency. It is important to note that other states might not have these distinctions, and might even call people with lived experience in the workforce by other titles.

While it is essential that Peer Support Specialists and Recovery Coaches maintain the principle of being "in but not of the system," they are also increasingly faced with the reality that they do not function in a vacuum, spending much of their work life collaborating with other health service providers, outside social service personnel, and representatives of the courts. People from a variety of different disciplines and fields worked together on this toolkit to reflect the collaborative nature of recovery work. It is composed of sections authored or reviewed by Peer Support Specialists, Recovery Coaches, Behavioral Health Professionals, Researchers, and an Attorney. Because people from different disciplines authored this toolkit, some sections will refer to persons working in the field with lived experience as Peer Support Specialists, and other sections will reference Recovery Coaches. However, all sections are relevant for both Peer Support Specialists and Recovery Coaches. Additionally, please note that our contributors refer to the people that they serve by different names. Thus, the people who are being supported are referred to a participants, clients, or recoverees within this document.

While we recognize that there are important differences between Peers and Recovery Coaches, the focus of this toolkit is on boundaries issues that frequently crop up in the work of both. We have found that boundaries are a critical area in all of Behavioral Healthcare, but little has been written for Peer Support Specialists and Recovery Coaches. The boundary issues selected for this toolkit represent issues that have come up during the course of our work, and the information in this toolkit is from our collective experience and wisdom in the field. It is not meant to be exhaustive, but rather to help open up a dialogue for the field. We hope that you find the perspectives and suggestions offered here helpful as you conduct the important work of supporting others in their recovery journey.

While a lawyer was part of the team that developed this toolkit, we would like to emphasize that nothing in this document is to be considered legal advice. Never rely on your own interpretation of the law if you are worried about something. Get advice from a lawyer who knows your situation.

INTRODUCTION

Boundaries exist in all human interactions including those in personal, social, and work realms, and often feel automatic and intuitive. The relationship between Peer Support Specialists (PSS) and the individuals they support in our program, Maintaining Independence and Sobriety Through Systems Integration, Outreach and Networking (MISSION) can be complex and multi-layered, and these waters can, at times, seem murky and difficult to navigate. MISSION PSSs have constant contact with program participants in a variety of settings: participant's homes, personal vehicles, 12-step meetings, and in the community. There can also be ongoing interaction with participants' families, outside community healthcare providers, and court probation departments. As a result, the process of MISSION PSSs establishing and maintaining boundaries in relationships with the people they support can present unique challenges and requires very thoughtful consideration.

This toolkit was developed to enhance Peer Support Specialists' and Recovery Coaches' understanding of boundaries and the need for them in order to maximize the effectiveness of support services and prevent boundary violations that could harm both the person served and the PSS or Recovery Coach. While the focus of this toolkit is upon PSSs and Recovery Coaches, it is equally relevant for Case Managers with lived experience using Peer Support principles. Since the relationship between PSSs and the people they serve can differ along several dimensions from that of other service providers in traditional behavioral healthcare settings, information will also be included for supervisors, administrators, and outside stakeholders to enhance their understanding of Peer work.

In MISSION service delivery, developing and maintaining boundaries in the work we do with participants is crucial to overall success. The Peer Support and Recovery Coach field must follow an ethical code like any other profession.

> *Ethics in the mental health field can be further explained. To practice ethically requires awareness, sensitivity, and empathy for the participant as an individual, including his or her cultural values and beliefs. Ethics often shape these boundaries.*

There are many areas in our work where boundaries must be considered. The boundary considerations in this toolkit were identified by our team as most pressing and include; working with families, using social media, collaborating with probation, supporting challenging participants and those with trauma histories, and addressing allegations of Peer sexual misconduct and substance use relapse. Some areas involving boundaries are cut and dry, while others fall into the gray zone. When you are faced with boundary issues, especially those that are in a gray area, we hope that you will find this toolkit a helpful source of information and guidance. We also encourage you to discuss boundary issues with your supervisors, colleagues,

and sponsors as appropriate. Boundary violations can harm participants and also lead to serious consequences for you, such as adverse employment actions (suspension or termination) or even criminal consequences depending on the circumstances. Therefore, being knowledgeable about boundaries is essential.

BOUNDARIES RELATED TO WORKING WITH CLIENTS' FAMILIES

Working as Peer Support Specialists or Recovery Coaches, we must be aware of boundaries even before we meet with the client, and then in every interaction that follows. It should be something that we are always thinking of, as we need remain mindful that we are working with a population in early recovery. This portion of the toolkit concerns itself with **family boundaries**. Whether interacting with husbands, wives, children, or other family members, questions involving boundaries arise.

Where does our job begin and end?

What should the boundaries look like?

The following is a discussion of our experiences supporting clients in the family setting along with suggestions for you.

Children of Clients

Many of the MISSION clients we work with have children ranging from newborns to adults. Having children involved may mean that other agencies such as the Massachusetts Department of Children and Families (DCF) are part of the picture. Figuring out your role as a Peer Support Specialist or Recovery Coach when dealing with a client's family is tricky! What's important to remember is that your client is simply that, your client. Children, although an important part of the clients' life, are not your priority. Keeping the emphasis on providing services to your client specifically can help to define the gray area where these boundaries should exist. The confidentiality piece is also important. For example, when dealing with adult children of clients, it is important to respect client's privacy. Information told in confidence isn't appropriate to divulge to children, unless the sharing of the information is discussed with the client first and he or she gives consent. Ultimately, you must abide by the client's wishes. By working with your clients and getting to know them, it will become clearer what kinds of information they will or will not agree to have shared. This applies not only children but to all other family members as well.

The issue of liability also comes up when dealing with children, especially those under the age of 18. Having a separate relationship with any child of a client is inappropriate. This would include exchanging phone numbers, giving rides, or meeting with them outside of meetings with their parents. It may be challenging to refrain from engaging with the children when it seems it could help the client. However, these boundaries are the foundation of your relationship with the client. With them in place, confidentiality is respected, and the children are ultimately kept safe. In some environments, engaging with children at all is unethical. Especially in dealing with

minors, it is best to avoid any situations where conflicts may arise. Boundaries serve not only to protect the children but to protect ourselves. Our role is to support and treat the client and the client alone. Without these boundaries, time and resources could not be allocated sufficiently to the client and care could be compromised.

A CASE EXAMPLE – TREATING BOTH SPOUSES IN MISSION

In one recent instance, we concurrently served two clients in our MISSION Program who were married to each other, but then separated. Together they had 3 children ranging in age from 2 to 8. They co-parented together, but had separate MISSION treatment teams and separate treatment plans. In such a case, MISSION teams should not share information from assessments or treatment plans with other MISSION teams without the expressed written consent of the client. Protecting the confidentiality of each individual client is top priority. Once again, a client is simply a client. They are an autonomous unit with their own goals and priorities.

DURING THE COURSE OF THE ABOVE CLIENTS' PARTICIPATION IN MISSION, DCF BECAME INVOLVED WITH THE FAMILY. DCF HAS LEGAL AUTHORITY TO PROTECT CHILDREN AND MAY TAKE ACTION THAT THE CLIENT OPPOSES. IN SUCH CASES, CLIENTS SHOULD BE REFERRED TO LEGAL HELP WHEN NECESSARY. IT CAN BE HELPFUL TO ADVISE CLIENTS THAT SOMETIMES OPENING UP A DIALOGUE WITH DCF CAN HELP THE FAMILY TO ACCESS RESOURCES AND SERVICES THEY OTHERWISE COULD NOT ACCESS.

As a Peer Support Specialist, you need your client's consent before speaking with any agency or any person on their behalf unless it is a situation in which you are mandated by law to make a report. Initiating such collaboration is important because without it, treatment can become fragmented and needs can go unmet. When this happens, both the client and the family unit can suffer and achieving treatment goals is more difficult. Therefore, MISSION teams should utilize as many community resources as possible, including DCF, as their potential to help clients is vast. Team work between MISSION team members as well as outside agencies really does make the dream work.

BOUNDARIES AND SOCIAL MEDIA

In being a part of a MISSION team in this day and age, the issue of social media is likely to surface. This issue brings up many questions involving boundaries. What is appropriate when it comes to client care? At first glance, social media may seem like an immediate “Don’t Do,” but we have found that it may be an appropriate and effective communication tool. It is important to understand, however, that everything we post publicly can be seen by clients, colleagues, employers, and other stakeholders, so good judgment should always be exercised. Social media exists in many forms including Facebook, LinkedIn, Snapchat, Instagram, and more.

Is it appropriate to connect with clients on social media platforms?

- The MISSION team should proceed as it seems fit. There is no clear answer to this question.
- Setting your account settings to private is good practice to avoid any possible invasion of privacy or unwanted contact.
- Adding your entire client list to every form of social media is discouraged.
- Remember any content that you post, personal information, or pictures can be visible to clients as they may search for you or stumble upon your profile.
- Use your discretion when posting on social media.
- Always consider potential safety risk prior to interacting with any client on social media.

Connecting with Clients via Social Media

Although connecting with clients on social media is controversial, and may even be frowned upon, it can also be a valuable tool when it comes to client care. Often, clients struggle to get and maintain cell phones. They may not have the funds to secure their own phone. In our experience, clients who don’t have phones often make it a point to make contact via social media. We have conversed with several clients this way and sometimes it’s the only way a client will respond to the MISSION team. Keeping this in mind, social media can absolutely serve as an essential tool when it comes to maintaining client engagement. Whereas there would be no available line of communication before, people seem to have a knack for accessing social media regularly.

In addition to this, connecting on social media is a good way to interface with clients. People who frequently check in on Facebook, for example, make it easy to observe their lives. Being friends on Facebook allows a Peer Support Specialist to remain updated on a client’s whereabouts and activities. On more than one occasion, information posted on social media has led to violations

of probation. For example, a client “checked-in” on social media in another state and alluded to the fact that he was planning on having a drink. Naturally, this alarmed the MISSION team. In a pre-session, this information was brought to the judge and probation, as the Facebook post was available to the public. The client was subsequently reprimanded when he appeared at court. In this situation, MISSION didn’t warn the client that this information would be presented to the Judge and probation. The client felt like trust had been violated. What we can learn from this experience is to keep an open line of communication when this happens and to, when possible, approach the client first to let them know that the information will be shared by the MISSION team. Having this type of discussion with the client first can help to further develop and maintain the client’s trust in the team.

BOUNDARIES AND WORKING WITH PROBATION

Being part of a MISSION team involves participation and interaction with the Probation Department. It's important to remember that probation is there to carry out orders of supervision. There are laws which govern what they have to do.

Our concern is the welfare of the client and their recovery. And sometimes we don't agree on what each other should be doing, but we have to remember that we see things differently and respect that. Remember that one of the things that we want to show to our clients is that they have to be accountable and responsible. Though we understand relapse is part of the disease and recovery, the use of substances is a violation that needs to be reported. That doesn't mean that the Peer Support Specialist or Recovery Coach can't advocate for treatment placement.

IN MASSACHUSETTS, THE PROBATION DEPARTMENT SERVICE IS PART OF THE TRIAL COURT. THEIR RESPONSIBILITY IS TO FOLLOW THE LAW AND COURT ORDERS AND PROTECT THE PUBLIC SAFETY.

Where Does MISSION Fit In?

MISSION is a program that is separate from the Probation Department and has its own system of operation. However, the MISSION team does work closely with both probation and the presiding Judge. There is literature on the MISSION Criminal Justice model (accessible at www.missionmodel.org) that addresses this relationship. Part of our role is to coordinate services between parole/probation for our clients. MISSION work involves a series of assessments, and structured and unstructured sessions with clients. This work isn't necessarily aligned with the probation relationship. For example, what is revealed to us during an unstructured session is not necessarily material to share with probation. The general rule has been that unless the client has used substances or otherwise violated their probation, the information shared stays within MISSION. Of course, if a client has thoughts of harming themselves or others, this information must immediately be shared.

The overarching goal is to prevent clients from recidivating. This involves the ability to work hand in hand with probation. It's important to be on the same page when it comes to conditions of probation, coordinating services, and helping clients to stay on the right path.

Navigating Relapses and Violations of Probation

Conflicts can easily arise between MISSION workers and the Probation Department. One example is when a client has a relapse. This is seen as a direct violation of probation in which the Probation Officer should be notified. However, the first thought of a MISSION Case Manager or Peer Support Specialist may be to get the client into treatment. One instance occurred in which a client had secured a bed in treatment but probation asked the individual to check in at the courthouse before going. Getting to treatment was time-sensitive. Going to the courthouse would surely mean the bed would become unavailable. In this situation, the MISSION team decided to bring the client to treatment, skipping the crucial step of abiding by the wishes of probation. Immediately a warrant was issued for the client. The Judge was notified of the situation and explained to the MISSION team the protocol and liability that comes along with a relapse. Although the client secured the treatment bed, probation was not happy. *The lesson learned from this experience is that it is necessary and safer to collaborate with probation, especially when dealing with a relapse or a direct violation of probation.*

When any violation of probation happens, it is a priority to make the court aware of what is happening. At the same time, the MISSION team is encouraged to protect their relationship with a client. For example, if a client leaves the state or relapses, it may be hurtful to go behind their back and tell probation without having a conversation with the client first. If the client didn't personally disclose this information to the MISSION team and it was stumbled upon via social media or another source, opening a line of communication is beneficial to maintaining a good relationship with a client.

Building and developing trust with clients is an invaluable tool and a situation like this can really make it or break it. Here's a strategy:

1. First, present the client with the information
2. After having done so, what has worked in the past is nudging a client in the direction of talking directly to probation themselves.

Also, MISSION may let the client know that if they are unable or unwilling to speak with probation, it becomes the responsibility of the MISSION team. Clients should never feel like they are being punished, but that they can pick up the pieces and get back on the right track by doing the next right thing.

Dealing with clients on warrant status may be cumbersome but is a huge part of the job. Regardless of how or why they were issued a warrant, the consensus is to get them to report in to probation or court. This way, the MISSION team as well as probation and the Judge can come up with a solution. Working as a team to address this issue is powerful. Sometimes, the court

prefers if communication and services stop upon the issue of the warrant. However, ethically, the MISSION team should continue to support the client within reason and not necessarily enable the client to stay in warrant status. A client may opt to go to treatment before clearing a warrant. If that is their choice, you may communicate with probation where the client may be otherwise unwilling to do so. This keeps everyone in the loop and is the best option to ensure client safety. Ultimately, the client needs to go in and clear the warrant.

SUPPORTING CHALLENGING CLIENTS

People enrolled in MISSION often have different backgrounds, needs, preferences, strengths, and challenges. A challenge common to most MSSION clients is the need to address mental health issues.

> THE MISSION TEAM, AND ESPECIALLY PEER SUPPORT SPECIALISTS, DO NOT CONCEPTUALIZE OR LABEL THE CLIENTS WITH WHOM THEY WORK WITH PSYCHIATRIC DIAGNOSES. RATHER, THEY MAINTAIN A HUMANISTIC AND PERSON-CENTERED APPROACH, AVOIDING DIAGNOSTIC LABELS AND CLINICAL LANGUAGE.

The value of Peer Support Specialists in promoting client care is being increasingly recognized, and PSSs are now working in a range of traditional and non-traditional settings. In more traditional clinical settings, diagnostic labels may be used by service providers from other health care disciplines (e.g., psychiatrists, psychologists, and social workers) for the following reasons:

1. It is important for peers to understand the meaning of diagnostic terms is that it may help them to better understand the communications of these providers and allow them to participate more fully in case discussions.
2. Clients may share that they have received a diagnosis from another provider and have questions or concerns about it that they want to explore with their PSS.

We are not suggesting that PSSs use clinical, diagnostic language themselves. But rather, that they understand the communications of those with whom they are collaborating, which includes both other clinicians and their clients, while at the same time contributing their own person-centered, nonclinical perspective.

Studies have shown that individuals with criminal justice involvement and co-occurring mental health and substance use disorder (COD) have higher rates of being diagnosed with a DSM-5 Cluster B Personality Disorder (PD). Since MISSION programs are designed to support people with criminal justice involvement and/or COD, it is likely that MISSION teams will have a number of clients on their caseloads who have been diagnosed with a PD. Therefore, we thought it was important to include information about PD and boundaries in this toolkit.

CLUSTER B PERSONALITY DISORDERS

Cluster B Personality disorders are characterized by dramatic, emotional, or erratic behavior, and include the following:

CLUSTER B PERSONALITY DISORDER	FREQUENTLY EXHIBITED BEHAVIOR
Antisocial Personality Disorder (ASPD)	Deceitfulness and lying
Borderline Personality Disorder (BPD)	Extreme idealization or devaluing of others as well as stress-related paranoia
Histrionic Personality Disorder (HPD)	Inappropriate sexually seductive or provocative behavior
Narcissistic Personality Disorder (NPD)	Feelings of entitlement and ensuing lack of empathy for others

(DSM-5, 2013)

These disorders have associated behavioral features of that can affect the creation and maintenance of healthy interpersonal boundaries. Being knowledgeable about these and other features of PDs can help the MISSION team to identify problematic dynamics around boundaries early on and to tailor inventions to minimize potentially harmful situations to the client and/or themselves.

Recommendations to Address Problems Related to PDs

Documentation

- The MISSION team should address problems related to PD on treatment plans as they are developed and updated with clients.
- Symptoms of PD should be documented in terms of the associated behaviors that the client is demonstrating and is interested in addressing. This can help MISSION staff and outside providers more effectively coordinate their efforts to support clients and foster cohesion among providers and between providers and the client.

Meeting Coordination

- Team members are encouraged to: stick firmly to the boundaries of their profession; be direct, clear, and straightforward in their communications; persistently identify and address reality; make only those promises they can keep; and clarify that they are not omnipotent or omniscient (Hendrickson et al., 2004).

Supervision

- While supporting people with PDs, it is especially important to monitor one's own feelings and to have supervision on a regular basis. A Peer Navigator or a Senior Peer is well suited to provide supervision in these complex cases (for more information on the role of Peer Navigators in MISSION, please access the Peer Navigator Toolkit at www.missionmodel.org).

It is important to note that some of the behaviors that can result from substance use or from a trauma history can mimic symptoms of a PD, and this should be carefully teased apart. Specific issues related to boundaries that may arise when working with people who have a trauma history will be discussed in the next section of this toolkit.

SUPPORTING CLIENTS WITH TRAUMA HISTORIES

Traumatic experiences are external threats that overwhelm a person's available coping resources. These experiences can shatter trust and leave people feeling unsafe and powerless. MISSION is not a trauma-specific or PTSD intervention, and acutely symptomatic clients are referred to specialized clinical care. However, because high trauma rates are well documented among all populations served by MISSION, including individuals with substance use and mental health problems, those with criminal justice involvement, and Veterans, Trauma-Informed Care (TIC) considerations have been incorporated into the overall MISSION treatment model. This section of the toolkit will focus specifically on how clients' past traumatic experiences can influence boundaries and the level of connection between clients and PSSs. Additionally, it will offer suggestions for PSSs on how to relate to their clients who have trauma histories in ways that foster mutual and healthy connections. For more general information on TIC in MISSION please go to: www.missionmodel.org.

PEOPLE WITH TRAUMA ALL EXPRESS THEIR PAIN DIFFERENTLY, WHICH MAY MAKE IT DIFFICULT FOR THE SERVICE DELIVERY TEAM TO RECOGNIZE THAT VARIOUS CLIENT BEHAVIORS ARE RELATED TO PAST TRAUMATIC EVENTS, ESPECIALLY IF THE CLIENT HAS CHOSEN NOT TO DISCLOSE HIS OR HER PAST TRAUMA(S). THEREFORE, IT IS A CORNERSTONE OF TIC PROGRAMS TO APPROACH ALL CLIENTS AS IF THEY HAVE A TRAUMA BACKGROUND.

The Potential Impact of Trauma on Relationships

People who are attempting to cope with past trauma(s) may unknowingly re-enact their trauma in different ways. Violent experiences are often compounded by betrayal, silence, blame, or shame, which can have lasting effects on one's ability to trust others and to form appropriate and/or close interpersonal relationships. If left unrecognized, this dynamic can impede the development of a productive relationship between clients and PSSs.

Emotional reactions to trauma and problems connecting to others secondary to it can be varied among clients. For some individuals, trauma experiences may have resulted in feelings of inferiority and powerlessness, and as a result, these individuals may have a dependent style in which they to look to the PSS to make their decisions. For others, the trauma may have led to

feelings of mistrust and despair, and as a consequence, they are pessimistic about what the Peer has to offer and are guarded or avoidant. Still, others may have developed patterns of relating that further isolates them from others as a means of self-protection, and they may engage with the PSS in an overly aggressive or antagonistic manner.

PSSs should remain mindful of how past trauma may be impacting how their clients interact them. Peers can talk about trauma and its impact with clients, if clients are willing to, in ways that acknowledge and honor people's own individual experience of the event(s). They can help clients to articulate their own strengths and assist them to identify past, current, and new coping strategies. The figure below provides recommendations for Peers to enhance the development of trusting relationships with the clients they serve who have trauma histories.

Recommendations for Peers to Facilitate the Development of a Trusting Relationship with Clients with Trauma Histories

Adapted from Blanch, A., Filson, B., Penney, D. (2012)

Developing Trusting Relationships with Clients with Trauma Histories	
	Ensure that the environment is safe and non-traumatizing.
	Listen to the language a client uses regarding his/her trauma and/or ask directly what language is preferred, for example does the client self-identify as a trauma survivor or victim, and demonstrate respect for his/her experience by using that language too.
	Understand the central role that trauma may have played in a client's life and refrain from asking questions like "What is wrong with you?" Instead ask "What happened to you?" (Sandra Bloom).
	Be aware that both violence and healing occur in a cultural context, be knowledgeable about culturally specific considerations and healing methods.
	Be cognizant that there may be gender-specific differences associated with the experience of trauma as well as gender-specific needs. For instance, women are more likely to experience violence at the hands of people they know and trust, while men are more likely to experience violence from strangers. Understand that these differences have a profound effect on how women and men understand their trauma experiences.
	Emphasize that *healing is possible*.
	Reinforce to the client that he/she her has faced great challenges and survived, and underscore individual's strengths, resilience, and courage that got them to where they are today.
	Emphasize choice, trustworthiness, collaboration, and empowerment in the relationship.
	Be honest - trauma survivors are often adept at detecting inauthenticity, and have good reason to be attuned to issues of power and authority.
	Recognize any areas that create a sense of powerlessness in you, whether they are related to trauma or to discrimination.

When PSSs create a safe atmosphere with healthy boundaries for clients, it allows clients to feel cared for and valued, and affords them with a template for healthy ways of engaging and connecting on a more meaningful level. It also increases the likely of the development of a strong mutual, collaboration between the client and Peer in addressing the client's current needs, whether mental health, substance use, housing, vocation/education or trauma-related.

BOUNDARY ISSUES RELATED TO SEXUAL MISCONDUCT

This section will discuss **boundary issues and sexual misconduct** by Peer Support Specialists with clients. It is important that for PSSs to model healthy behavior, especially with relationships, and to separate their work and professional life from their personal life.

The relationship between the PSS and clients can be a close one because inherent to the PSS role is the sharing of their own personal lived experience as well as possibly even seeing people in recovery circles around town (e.g., AA or NA meetings). For PSSs, feelings of closeness can lead to confusing feelings of attraction and sexual interest in clients if left unchecked. The higher level of involvement by PSSs than other traditional community health service providers can also confuse a client as well as other stakeholders, who may misinterpret the behavior of the PSS, leading to unwarranted concerns that boundaries are being crossed. For example, a PSS having a scheduled meeting in a local coffee shop or even on a bench in a park with a client may be viewed as inappropriate by those unfamiliar with the PSS role, but is well within the scope of acceptable work behavior by PSSs.

For these reasons, it is important to educate PSSs, clients, and community stakeholders about the higher level of engagement between the PSS and clients; (1) helping PSSs to understand that the close nature of the relationship may at times lead to feelings that should be promptly addressed and **never** acted upon, and (2) to avoid arising unwarranted suspicions resulting in baseless allegations being made by the client or others.

It cannot be stressed enough that any form of intimate sexual relationship between PSSs and clients is unethical, and in some situations illegal. In order to understand sexual misconduct, it is important to start with a definition. Sexual misconduct is defined here as any physical contact of a sexual nature with clients, as well as an activity directed toward establishing a sexual relationship with them, such as sending intimate letters, engaging in sexualized face-to-face dialogue or through an email, text, or electronic communication, or dating. This applies to all current MISSION clients or any person who has received services and been discharged from the program within at least the last three years.

If you develop personal feelings for a client, you should talk to a supervisor and you should ask for a different Peer Support Specialist to be assigned. Always remember that the client's recovery is paramount, and that people in early recovery have lots of confusing feelings. The client is in a vulnerable state and may be confused about his or her feelings.

Why are sexual relationship with clients and their significant others unethical?

- Sexual relationships with clients are unethical. This is a professional relationship.
- Although strived for, the PSS/client relationship can never truly be one of equal power. The vulnerability of the client and the power of the PSS role can lead to situations where the PSS could exploit the service relationship for his or her own personal, emotional, sexual, or financial gain. The harm that can result from such a relationship can be damaging to the client and his or her family members, leading to emotional distress (such as feelings of exploitation and difficulty trusting others), discontinuation of needed services, and resistance to seeking similar services in the future.
- In addition, inappropriate sexual relationships, can be damaging to other clients in the program who may hear rumors about the relationship as it can cause them to lose trust in their mutual MISSION providers and in the MISSION Program generally.
- Finally, it can also damage the reputation of the MISSION program in the eyes of community stakeholders and affiliates whom may be reluctant to refer people in need of services to the program.
- Any complaint regarding inappropriate behavior or contact between a PSS and a client should be investigated by the employer. There are legal requirements that employers need to follow which may impact the Peer Support Specialist's ability to work in the field moving forward.

HOW PROGRAMS CAN HELP PREVENT SEXUALLY INTIMATE RELATIONSHIPS WITH CLIENTS

It is essential for programs to proactively take steps to help prevent situations involving sexual misconduct from happening in the first place.

- An important first step is to provide instruction and information on boundaries, including the prohibition of any form of sexual contact or intimacy during orientation and continuing education as needed.
- The PSS's obligations and responsibilities toward clients in maintaining healthy boundaries, including acting as role models of appropriate behavior, setting and maintaining appropriate boundaries with clients should be explicitly stated, and examples of inappropriate behavior (such as romantic relationships of any kind with clients, or providing drugs or alcohol to clients, etc.) should be discussed.
- PSSs should be instructed on who to talk to if the employee observes the behavior of another employee that violates these obligations, and on how the agency responds to situations including possible disciplinary action.
- A safe atmosphere should be created in supervision for PSSs to address any issues that may arise around boundaries such as sexual and other feelings toward clients and how to appropriately manage clients who may be sexually provocative. As previously noted

above, staff should be educated that it is not uncommon for helping professionals and paraprofessionals who work closely with clients to occasionally develop feelings of attraction. Supervisors can normalize these feelings, while reinforcing that acting upon them is unethical. Supervisors can also assign clients to an alternate staff member if warranted, and let the PSSs know that seeking their own outside individual therapy to help them to manage these feelings is often beneficial.

SUD REOCCURRENCE AND THE IMPACT ON A TEAM

In Recovery Coaching, we have a saying: you are in recovery when YOU say you are. Recovery Coaches are people in recovery from Substance Use Disorders who help mentor, guide, and advocate for those dealing with their own SUD who may be at different stages in their journey of recovery. Many of us have called ourselves "Wounded Healers" because we have come out on the other side of active addiction and our lives have gotten better. The work we do is both rewarding and challenging. Like any other occupation, Recovery Coaching comes with its own set of challenges; many of them are not obviously visible to the people around them. For this reason, we need someone in and out of the workplace who can support, guide, and mentor us.

The Substance Abuse and Mental Health Administration (SAMHSA) defines recovery from mental disorders and/or a substance use disorder as "**A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential**" (https://www.samhsa.gov/sites/default/files/samhsa-recov).

The definition of recovery is a topic for debate because recovery is a personal journey of change, discovery, and growth, and people have strong personal opinions about what it should look like.

There are multiple pathways towards recovery and some people choose complete abstinence though twelve step fellowships, alternative pathways such as Reiki or Acupuncture, while others embrace harm reduction. Whatever pathway people choose, it is their journey and this is the philosophy of Recovery Coaching. That said, it must be highlighted that some recovery approach philosophies, such as harm reduction, may be more concerning in certain settings. For example, criminal justice agencies and courts usually see harm reduction as inconsistent with their obligation to enforce the law since harm reduction may involve the use of illegal substances.

When it comes to employment as a Recovery Coach, many companies require a minimum length of time that one must be in recovery to be employed as a Recovery Coach (i.e., two years). Some people feel when a person is abstinent from all mind-altering substance (prescribed medication excluded), that is the start of their recovery. Others feel they truly don't start recovery until they begin improving their lives from the inside out. There are also recoverees

who feel they are in recovery because they have stopped using their substance of choice but they may use other substances in moderation. In a blog post, Phil Valentine (https://ccar.us/a-crock-of-clean-time-crap/), Director of CCAR (Connecticut Community of Addiction Recovery), asks the question: *is recovery measured by consecutive time or cumulative time?* People's answers may be different. Learning how to share our recovery stories is important; the message of how our lives are improving and lessons we are learning may be more important than the amount of time we have.

When Recovery Coaches Encounter Setbacks

The tools we learn along our path are not always simple to apply and setbacks will become a reality for some of us who embark on the journey of recovery. There are several questions to consider when a setback happens.

How can agencies support Recovery Coaches when they have a setback?

What steps can an agency take to protect a Coach's job?

What is the process of reintegrating a Coach back to work?

Here are two scenarios to consider about this topic: The first scenario would be if a Recovery Coach decides to disclose about their setback and plans to seek treatment. The other scenario is if a Coach does not disclose but work performance is affected by the Coach's changing behavior.

While working as a Coach, when recoverees have setbacks, they talk about the shame, embarrassment, and guilt they feel. They dread having to start the process all over again and telling others (family, friends, or their clinicians) that they had a setback. No matter how much reassurance and encouragement are given to keep moving forward, they still beat themselves up with regret. It is hard to imagine how coaches feel coming back to an environment where part of the skill set is sharing one's recovery story and that story has now changed. Looking at what we consider a setback is also another curve ball thrown in. What happens if someone uses a substance once vs. a whole weekend or longer?

A SUD reoccurrence (i.e., relapse or resumption of substance use) is not always grounds for automatic termination. Thanks to compassion, understanding, and certain state and federal laws, employees may have some protection if they have a setback. It is important for you to

know that this is a very complex legal issue because state and federal laws that apply depend on the size of the employer as well as other factors.

If you are considering disclosing a substance use reoccurrence to your employer or you are being investigated and your job is in jeopardy because of a setback, you should consult an attorney with expertise in this area of the law.

CONCLUSION

Peer Support Specialists and Recovery Coaches offer unique and invaluable support to people new to or struggling with recovery. Workers in both fields are able to serve as role models as they use their hard-earned lived experience and training to help others along their recovery paths. These fields are relatively new and continue to evolve, and as they do, more questions and the need for more information arises. In this toolkit, we started the conversation on boundary issues that can potentially occur in several different realms.

This toolkit is by peers, for peers. Yes, we got input from behavioral health specialists, researchers, and a lawyer because helping people in recovery from substance use and mental health problems is challenging work with very high stakes. Peer Support Specialists and Recovery Coaches are having a tremendous impact on the successful recovery of many people and it is important to expand this role in ways that will continue to legitimize and further the profession.

GLOSSARY OF TERMS

DSM-V is an abbreviation for the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition. This is a classification manual to quantify symptoms in order to diagnose a mental health condition.

Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking (MISSION) is a wraparound service intervention designed to meet the needs of those experiencing co-occurring mental health and substance disorders. Specialized versions of the model have been developed for veteran, homeless and criminal justice populations.

Peer Support Specialists (PSSs) are people in recovery from substance use, mental health disorders, and/or homelessness who use their shared experience(s) to promote hope, resiliency, and positive change. Peer specialists work with people to support them in a variety of ways, including assisting them in exploring their own inner wisdom.

Recovery Coaches (RCs) are people in recovery from addiction.

Sexual Misconduct is any physical contact of a sexual nature with clients, as well as an activity directed toward establishing a sexual relationship, such as sending intimate letters, engaging in sexualized face-to-face dialogue or through an email, text, or electronic communication, or dating

Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the negative impact of substance use and mental health problems on America's communities.

Trauma-Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma.

REFERENCES

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

Blanch, A., Filson, B., Penney, D. (2012). Engaging Women in Trauma-Informed Peer Support: A Guidebook. Center for Mental Health Service National Center for Trauma-Informed Care.

Bloom, S.L. & Reichert, M. (1998). Bearing Witness: Violence and Collective Responsibility. New York, NY: Haworth Press.

Hendrickson, E. L., Schmal, M. S., & Ekleberry, S. C. (2004). Treating co-occurring disorders: A handbook for mental health and substance abuse professionals. New York, NY, US: Haworth Press.