P U L S E F O R G O O D

Substance Use Disorder

Program Feedback Toolkit

Honest Feedback Without Jeopardizing Recovery

A specialized toolkit for capturing meaningful, shame-free feedback from people in substance use recovery. Contains 10 ready-to-use documents covering recovery-stage question design, shame-reduction language, MAT-specific considerations, peer support integration, relapse-sensitive protocols, anonymous safeguards, program improvement mapping, staff alignment, recovery signal tracking, and ethical storytelling — built for the unique vulnerabilities of people navigating recovery.

10 SUD-Specific Documents

Recovery-Stage Design • Shame Reduction • MAT Sensitivity • Ethical Storytelling

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Toolkit Contents

Substance use disorder is inseparable from shame. Every interaction a person in recovery has with an institution either reinforces or reduces that shame. A feedback system that asks about relapse in the language of failure, treats medication-assisted treatment as second-class recovery, or uses collected stories to perform inspiration will do harm — even with the best intentions. This toolkit ensures your feedback system honors the complexity of recovery.

DOCUMENT 1

Recovery-Stage–Appropriate Question Sets

Different questions for different phases of the recovery journey

📋 **INSTRUCTIONS:** *A person in their first 72 hours of detox has fundamentally different needs, capacities, and vulnerabilities than someone six months into outpatient treatment. Asking both of them the same feedback questions is not just unhelpful — it can be harmful. These question sets are calibrated to the client's stage of recovery, asking only what is appropriate for where they are.*

Stage Definitions

STAGE	TYPICAL SETTING	CLIENT STATE	FEEDBACK CAPACITY
Stage 1: Stabilization (Days 1–14)	Detox, crisis stabilization, withdrawal management	Acute physical and psychological distress. Cognitive function may be impaired. High vulnerability.	Minimal. Only the most essential, low-burden questions. Client may not be able to engage meaningfully.
Stage 2: Early Treatment (Weeks 2–8)	Residential, intensive outpatient, early PHP	Stabilizing but fragile. Beginning to engage with treatment. Emotions are raw.	Moderate. Can answer short, concrete questions about immediate experience. Avoid abstract or reflective questions.
Stage 3: Active Treatment (Months 2–6)	Outpatient, residential, sober living, IOP	Engaged in treatment. Building skills and insight. More cognitively available.	Full. Can engage with the complete survey. Can reflect on their experience and articulate needs.
Stage 4: Continuing Care (6+ Months)	Outpatient, alumni programs, recovery support services	Managing recovery in the community. May face different challenges (employment, housing, relationships).	Full + reflective. Can provide nuanced feedback on what worked and what the program should change.

Stage 1: Stabilization (Days 1–14)

Stage 1 Guidance

Many organizations should NOT collect feedback during Stage 1. Clients in acute withdrawal or crisis are not in a position to provide meaningful feedback, and asking them to do so may feel extractive.

If you do collect during Stage 1, limit to 3 questions maximum, and NEVER prompt — kiosk should be passively available only.

#	QUESTION	RESPONSE	RATIONALE
D 1	Are the staff here treating you with kindness?	👎 / 👍 / Prefer not to answer	Most basic dignity check. One concept. Binary.
D 2	Do you feel physically safe here?	👎 / 👍 / Prefer not to answer	Physical safety during withdrawal is paramount.
D 3	Is there anything you need that you're not getting?	Open text (optional)	Low-pressure, needs-focused. Not evaluative.

Stage 2: Early Treatment (Weeks 2–8)

#	QUESTION	RESPONSE	RATIONALE
E 1	How has your experience been at this program so far?	😣 😟 😐 🙂 😄	Broad, low-stakes opener.
E 2	Do the staff here treat you with respect?	👎 / 👍	Dignity and respect check.
E 3	Do you feel supported in your recovery here?	😣 – 😄 (5-point)	Recovery-specific support assessment.
E 4	Do you feel comfortable asking for help when you need it?	👎 / 👍 / Prefer not to answer	Psychological safety for help-seeking.
E 5	Is there anything you want us to know?	Open text (optional)	Client-controlled closure.

Stage 3: Active Treatment (Months 2–6)

#	QUESTION	RESPONSE	RATIONALE
A 1	How has your experience been at this program?	😣 – 😄 (5-point)	Broad opener.
A 2	Do the staff treat you with respect?	👎 / 👍	Dignity check.
A 3	Do you feel your treatment plan reflects what YOU want to work on?	👎 / 👍 / Not sure	Person-centered care. Critical in SUD where client agency is often diminished.
A 4	Do you feel supported in your recovery here?	😣 – 😄 (5-point)	Core recovery environment metric.
A	Have you felt pressured to do	👎 No / 👍 Yes /	Coercion screen. Critical in SUD

5	things you weren't comfortable with?	Prefer not to answer	programs with mandated clients.
A6	Do you feel safe here — physically and emotionally?	👎 / 👍 / Prefer not to answer	Combined safety check.
A7	Is there anything you want us to know about your experience?	Open text	Client-controlled final question.

Stage 4: Continuing Care (6+ Months)

#	QUESTION	RESPONSE	RATIONALE
C1	Overall, how was your experience at [Program Name]?	☹ – 😄 (5-point)	Retrospective satisfaction.
C2	Did this program help you build skills you use in your daily life?	👎 / 👍 / Not sure	Transfer of treatment gains to real life.
C3	Did you feel like the staff believed in your ability to recover?	👎 / 👍	Hope and confidence from providers.
C4	What did this program do well that other programs should learn from?	Open text	Strength-based reflection. Produces powerful improvement data.
C5	What is one thing you wish had been different?	Open text	Constructive criticism from a place of stability.
C6	Would you encourage someone in a similar situation to try this program?	👎 / 👍 / It depends	Net promoter proxy. Meaningful from people in recovery.

DOCUMENT 2

Shame-Reduction Language Guide

Words that heal vs. words that wound in SUD feedback collection

📋 **INSTRUCTIONS:** *Shame is the primary emotional barrier in substance use recovery. It is the reason people avoid treatment, leave treatment, and lie in treatment. Every word in your feedback system either amplifies or reduces shame. This guide trains your eye to see the shame embedded in language that the field has normalized — and to replace it.*

The Shame Principle

If a Question Could Make Someone Feel Broken, Weak, or Judged for Having SUD, It Fails

Shame does not motivate recovery. It prevents it. Every interaction with your feedback system should communicate: your substance use is something that happened to you, not something that defines you. Your recovery is yours. We are here to support it, not evaluate it.

Language Replacement Table

NEVER USE (Shame-Loaded)	ALWAYS USE (Person-First / Recovery-Affirming)
Addict, junkie, alcoholic (as labels)	Person in recovery, person with substance use disorder, participant
Clean / dirty (referring to drug tests)	Positive / negative test result, or avoid referencing tests entirely in feedback
Abuse (as in “drug abuse”)	Use, substance use, substance use disorder
Habit	Substance use disorder, pattern of use
Getting clean / staying clean	Recovery, being in recovery, maintaining recovery
Relapse / relapsed	Return to use, setback in recovery
Failed (a drug test, treatment, etc.)	Had a positive test result, experienced a challenge, returned to use
Non-compliant	Chose differently, was not able to follow, faced barriers
Enabler	Support person, family member
Opioid replacement / substitution therapy	Medication-assisted treatment (MAT),

	medications for opioid use disorder (MOUD)

Shame-Reduction Checklist for Survey Questions

☐	The question uses person-first language throughout (“person in recovery,” not “addict” or “alcoholic”)
☐	The question does not reference drug test results, compliance, or abstinence as measures of value
☐	The question does not assume a single path to recovery (abstinence-only language is exclusionary of MAT clients)
☐	The question does not frame recovery as a moral achievement or relapse as a moral failure
☐	The question does not ask the client to confess, disclose, or justify their substance use history
☐	The question does not compare the client to other clients (“Compared to others in your program...”)
☐	The question would feel equally safe to a person on MAT, a person in abstinence-based recovery, and a person who has returned to use
☐	The question was reviewed by someone with lived experience of substance use disorder

Shame in Context: Common Mistakes

SCENARIO	SHAME-LOADED VERSION	SHAME-REDUCED VERSION
Asking about program helpfulness	“How well is this program helping you stay clean?”	“Do you feel supported in your recovery here?”
Asking about treatment engagement	“Are you compliant with your treatment plan?”	“Do you feel your treatment plan reflects what YOU want to work on?”
Asking about peer environment	“Are other clients here negatively influencing your sobriety?”	“Do you feel the environment here supports your recovery?”
Asking about medication	“Are you still on medication-assisted treatment?”	Do NOT ask this in a feedback survey. MAT status is clinical, not feedback.
Asking about challenges	“What caused your last relapse?”	NEVER ask this. This is a clinical question, not a feedback question.

DOCUMENT 3

MAT-Specific Feedback Considerations

Respecting medication-assisted treatment in survey design, data analysis, and program reporting

📋 **INSTRUCTIONS:** *Medication-assisted treatment (MAT) — including methadone, buprenorphine (Suboxone), and naltrexone (Vivitrol) — is an evidence-based, life-saving treatment for opioid use disorder. Despite this, MAT clients frequently experience stigma within treatment settings, from peers, staff, and institutional culture. Your feedback system must not perpetuate this stigma, either in its questions, its analysis, or its reporting.*

MAT Stigma in Feedback Systems

The Problem

Some SUD programs, intentionally or not, treat MAT as "less than" abstinence-based recovery. This shows up in feedback systems when:

- Questions frame abstinence as the only valid outcome ("are you drug-free?")
- Surveys ask about MAT status, creating a tracked subgroup that feels singled out
- Data is disaggregated by MAT status and used to argue MAT clients have worse outcomes
- "Success stories" only feature people who are no longer on medication
- Staff interpret low satisfaction from MAT clients as non-compliance rather than a service gap

Design Rules for MAT-Inclusive Feedback

☐	The survey does NOT ask whether a client is receiving MAT (this is clinical data, not feedback data)
☐	No survey question equates recovery with abstinence from all substances (MAT clients are in recovery)
☐	The word "clean" or "drug-free" does not appear anywhere in the survey
☐	Questions about "medication management" ask about safety and respect, not compliance
☐	If your program serves both MAT and abstinence-based clients, questions are designed so both groups can answer honestly
☐	No survey question could make a client on methadone, buprenorphine, or naltrexone feel excluded from "recovery"
☐	The survey was reviewed by a person currently or formerly receiving MAT

MAT-Specific Questions (Optional Supplement)

Add these only if your program specifically provides MAT services and wants to assess the MAT experience:

#	QUESTION	RESPONSE	NOTES
M 1	Do you feel respected by staff regardless of how you manage your recovery?	👎 / 👍 / Prefer not to answer	Does not specify MAT. Covers all recovery pathways.
M 2	Do you feel your medications are managed safely and explained to you?	👎 / 👍 / Not applicable	Covers medication safety without singling out MAT clients.
M 3	Have you felt judged by anyone here — staff or other clients — for the type of treatment you receive?	👎 No / 👍 Yes / Prefer not to answer	Captures MAT stigma without naming it.
M 4	Do you feel your treatment goals are respected even if they're different from what others are working toward?	👎 / 👍 / Not sure	Validates individual recovery pathways.

MAT Considerations in Data Analysis

⚠ Do NOT Disaggregate Feedback by MAT Status Unless:

- Your organization explicitly provides MAT services and wants to assess the MAT-specific experience
- The disaggregation is done to IMPROVE the experience for MAT clients, not to compare them unfavorably
- Sample sizes meet the minimum threshold (N≥10) for any subgroup analysis
- Findings are framed as program performance questions ("How can we serve MAT clients better?"), never as client performance questions ("Why are MAT clients less satisfied?")
- MAT-specific findings are reviewed by a clinician with MAT expertise before dissemination

DOCUMENT 4

Peer-Support–Friendly Survey Formats

Leveraging the credibility and safety of people with lived experience

📋 **INSTRUCTIONS:** *Peer support specialists — people with lived experience of SUD who work in treatment settings — are uniquely positioned to promote the feedback system because they carry credibility that clinical staff do not. This document shows how to involve peers appropriately without turning them into data collectors or compromising the anonymity of the system.*

Why Peers Matter for Feedback

The Trust Gap

When a clinician or case manager mentions the feedback kiosk, a client in SUD treatment may hear: “The people who control my treatment want me to evaluate them.” Power dynamics make this feel unsafe.

When a peer support specialist mentions the kiosk, a client may hear: “Someone who has been through this thinks it’s worth doing.” Lived experience reduces the power differential.

This does NOT mean peers should be assigned to promote the kiosk. It means peers can be equipped to mention it naturally if they choose to.

Peer Roles in the Feedback System

APPROPRIATE PEER ROLE	INAPPROPRIATE PEER ROLE
Mention the kiosk casually to clients when it comes up naturally	Be assigned to “get people to use the kiosk” as a job responsibility
Explain what the kiosk is and that it’s anonymous if asked	Stand near the kiosk to encourage or assist clients
Share their own positive experience using the kiosk (“I used it and it felt good to be heard”)	Disclose what they wrote or encourage specific types of feedback
Provide input on survey question design and language review	Read, analyze, or access raw feedback data
Participate in the annual trauma-informed audit (Document 10, Trauma Toolkit)	Be held responsible for response rates or participation numbers
Serve on a client advisory group that	Conduct one-on-one feedback interviews or

reviews feedback results in aggregate	focus groups

Peer-Informed Survey Design Checklist

☐	At least one person with lived SUD experience has reviewed all survey questions before deployment
☐	Peer reviewers were asked specifically: “Is there any question that would have felt unsafe to you during your treatment?”
☐	Peer reviewers were compensated for their time (stipend, gift card, or equivalent)
☐	Peer input resulted in at least one concrete change to the survey
☐	Peer reviewers will be invited to review annually when questions are updated
☐	If your organization employs peer support specialists, they received the same feedback training as all other staff (Trauma Toolkit, Document 5)

Peer Verbal Introduction Script

SITUATION: A peer support specialist casually mentions the kiosk to a client

PEER: “Hey, I don’t know if you’ve seen this, but that’s a feedback kiosk. It’s anonymous — you just tap a few answers about how things are going here. Nobody knows what you wrote.”

“I’ve used it. It’s actually kind of nice to have a way to say what you think without anyone looking at you. But it’s totally up to you.”

IF CLIENT ASKS “Does it actually matter?”

PEER: “Yeah, they actually read this stuff and change things. I’ve seen it happen. But even if nothing changes, sometimes it just feels good to say it out loud.”

DOCUMENT 5

Relapse-Sensitive Response Protocols

When feedback reveals return to use — responding without punishing honesty

📋 **INSTRUCTIONS:** *If your feedback system is working, some clients will tell you that they have returned to use, are struggling, or are considering using. This is a sign that the system is trustworthy, not a sign that the system has failed. How your organization responds to these disclosures determines whether the system stays trustworthy.*

The Core Principle

A Client Who Tells You They Are Struggling Is Showing Trust, Not Failure

Return to use is a common part of recovery. It is not a moral failing, a treatment failure, or a violation of an unwritten contract. When a client discloses return to use through the feedback system, they are giving you information they did not have to give. If that disclosure leads to punishment, loss of privileges, or discharge, you have destroyed the most valuable thing in their recovery: their willingness to be honest.

Decision Framework: When Feedback Reveals Return to Use

FEEDBACK CONTENT	CLASSIFICATION	RESPONSE
“I’ve been using again” or “I used last weekend”	Level 2 — Serious Concern	Clinical review same day. Assess safety. Adjust treatment plan collaboratively. Do NOT discharge or punish.
“I’m thinking about using”	Level 2–3 — Pre-lapse warning	High-value clinical signal. Environmental response: increase support, check in with clinical staff.
“Someone gave me drugs here”	Level 2 — Environmental Safety	Immediate environmental investigation. Protect reporter’s anonymity. Review security/access.
“I don’t think this program is working for me”	Level 3 — Engagement Signal	Clinical team review. May indicate treatment mismatch, not treatment failure. Ask: does the treatment plan need revision?
“I had a drink but I’m okay”	Level 3 — Self-reported minor	Do not escalate disproportionately. Clinical awareness is sufficient. Consider: is the client’s treatment plan realistic?

	setback	
“I overdosed last week”	Level 1 — Safety	Immediate clinical assessment. Safety planning. MAT assessment. Naloxone availability check.

What NEVER Happens When Feedback Reveals Return to Use

⚠ These Responses Will Destroy Trust and the Feedback System

✘ Client is discharged or threatened with discharge based on anonymous feedback content

✘ Client’s privileges are revoked because of a disclosure in feedback

✘ Staff confront the client: “We know you’ve been using” (breaches anonymity AND is punitive)

✘ Feedback content is shared with probation, parole, or the court system

✘ The disclosure is entered into the client’s clinical record as “admitted relapse”

✘ Staff treat the disclosure as evidence to justify a more restrictive treatment level

✘ The disclosure is discussed in a group setting or community meeting

The non-punitive principle is absolute. If clients learn that honest feedback leads to consequences, the system dies — not just for that client, but for everyone who hears about it.

Communicating the Non-Punitive Principle

Ensure all clients AND staff understand this principle. Post it near the kiosk and include in staff training:

What You Share Here Will NEVER Be Used Against You

This feedback is anonymous. Nothing you say on this kiosk will be used to change your treatment, take away privileges, or share with anyone outside this program.

If you’re struggling, we want to know — not so we can punish you, but so we can do better. Recovery is not a straight line. There is no wrong answer here.

DOCUMENT 6

Anonymous Disclosure Safeguards

42 CFR Part 2 and beyond: protecting SUD feedback data at the highest standard

📋 **INSTRUCTIONS:** *SUD treatment records are protected by 42 CFR Part 2, the most stringent federal privacy regulation in healthcare. While anonymous feedback may not technically constitute a "treatment record," your organization should treat feedback data with the SAME level of protection. Any disclosure that a person is in SUD treatment — even indirectly through feedback data — can have devastating consequences: loss of employment, housing, custody, and social standing.*

The Elevated Standard

SUD Feedback Data Requires the Highest Level of Protection

HIPAA protects health information. 42 CFR Part 2 protects the fact that someone is receiving substance use treatment at all. The mere knowledge that a person is in SUD treatment is itself a protected disclosure.

Your feedback system must be designed so that no one outside the program could ever determine — from the data, reports, or stories — that a specific person participated in SUD treatment.

Data Protection Checklist

☐	Feedback data is stored in an encrypted system separate from clinical records
☐	Feedback data is NEVER linked to client identifiers (name, client ID, date of birth, SSN)
☐	Feedback reports shared with funders do not include any individual-level data that could identify a participant
☐	Data suppression rules are applied: no subgroup data published if N<10
☐	Open-ended responses shared externally are reviewed for identifying details before publication
☐	No feedback data is shared with law enforcement, probation/parole, courts, or child welfare agencies unless a specific mandatory reporting obligation is triggered
☐	The feedback platform vendor's data handling practices have been reviewed for 42 CFR Part 2 alignment
☐	Staff who access feedback data have signed confidentiality agreements specifically covering SUD information
☐	Feedback data is not stored on personal devices, personal email, or unencrypted

	shared drives
☐	Printed feedback reports are shredded after use — never left on desks or in common areas

Specific Risks in SUD Settings

RISK	SCENARIO	SAFEGUARD
Court-ordered clients	A probation officer asks the program if a specific client completed a survey or what they wrote	Response: “We do not collect identifying information with feedback. We cannot link any response to a specific individual.”
Drug court reporting	A drug court requests feedback data as evidence of engagement or compliance	Response: feedback data is anonymous and cannot be used as evidence of individual participation or engagement.
Child welfare involvement	CPS/DCFS asks whether a parent in SUD treatment gave positive or negative feedback	Response: feedback is anonymous and aggregate. Individual responses are not attributable.
Employer inquiries	An employer verification includes questions about program engagement	Response: we do not disclose whether any individual is or was in our program, per 42 CFR Part 2.
Funder site visits	A funder asks to see “some raw responses” during a site visit	Response: we share aggregate data and curated quotes. Raw data is not available for review per our data protection policy.

Consent for Feedback Participation

Although the feedback survey is anonymous, your consent screen should include SUD-specific language:

SUD-Specific Consent Addition

“Your answers will never be connected to your name or to the fact that you receive services here. No one outside this program will see what you wrote. Your feedback cannot and will not be shared with courts, probation, or any other outside party.”

DOCUMENT 7

Program Improvement Mapping Worksheet

Connecting SUD-specific feedback themes to measurable, actionable program changes

📋 **INSTRUCTIONS:** *This worksheet translates common feedback themes in SUD programs into specific improvement actions. Unlike general feedback prioritization, this document addresses the unique operational, clinical, and cultural dynamics of SUD treatment settings.*

Common SUD Feedback Themes and Improvement Pathways

FEEDBACK THEME	TYPICAL FEEDBACK LANGUAGE	ROOT CAUSE TO INVESTIGATE	POTENTIAL IMPROVEMENTS
Staff treating MAT clients differently	“They act like I’m not really in recovery”	• Staff beliefs about MAT • Training gaps • Cultural bias in the program	MAT-specific staff training. Policy review. Supervision focus.
Not feeling like treatment is individualized	“Everyone does the same thing here”	• Rigid programming • Group-heavy schedule • Treatment plan not updated	Individualized treatment plan reviews. Increase one-on-one time. Client choice in programming.
Peer environment is unsafe	“People are using in the parking lot” “Someone offered me drugs”	• Physical plant security • Peer monitoring gaps • Staff presence during transitions	Environmental security audit. Staff scheduling review. Client safety committee.
Not feeling heard by counselor	“My counselor doesn’t listen to what I want”	• Caseload too high • Directive vs. collaborative style • Cultural mismatch	Motivational interviewing fidelity check. Caseload review. Client-counselor match process.
Discharge feels abrupt	“They just cut me loose”	• Inadequate continuing care planning • Insurance-driven discharge • No warm handoffs	Structured discharge planning. Alumni program. 7-day post-discharge check-in.
Feeling punished for honesty	“I told my counselor I was struggling and got more restrictions”	• Punitive culture • Policy ties disclosure to consequences • Staff using disclosure as evidence	Policy review: decouple honesty from consequences. Retrain staff. Leadership messaging.

Improvement Action Tracker

THEME	ACTION	OWNER	DEADLINE	STATUS	OUTCOME MEASURE

DOCUMENT 8

Staff Alignment Checklist for SUD Feedback Use

Ensuring clinical and support staff use feedback data appropriately in SUD settings

📋 **INSTRUCTIONS:** *SUD treatment staff occupy a unique position: they often carry strong beliefs about what recovery "should" look like, may work with mandated clients who resist feedback, and sometimes interpret client dissatisfaction as a symptom of the disorder rather than a signal about the program. This checklist ensures staff are aligned on how feedback data is used — and not used.*

Staff Belief Alignment

Before using feedback data in team meetings, verify that all participating staff agree with these statements:

☐	Client dissatisfaction is a signal about our program, not a symptom of the client's disorder
☐	Feedback from mandated clients is as valid and important as feedback from voluntary clients
☐	A client who reports return to use through feedback is showing trust, not defiance
☐	Medication-assisted treatment is a legitimate recovery pathway; MAT clients' feedback carries equal weight
☐	Low satisfaction scores do not mean clients are "resistant" or "not ready for change"
☐	Feedback data will never be used to identify, confront, or punish any individual client
☐	We can learn from negative feedback without becoming defensive
☐	Client feedback about staff behavior deserves investigation, not dismissal

Data Use Rules for SUD Staff

RULE	RATIONALE	EXAMPLE OF VIOLATION
Feedback data is discussed in aggregate, never at the individual response level	Protects anonymity and prevents witch-hunting	"That response about the cafeteria was definitely [name]"
Negative	Prevents dismissing valid	"Of course that person is unhappy —

feedback is treated as program data, not as evidence of client pathology	concerns as symptoms	they're in early recovery"
Mandated-client feedback is given equal weight in prioritization	Court-ordered clients deserve quality services too	"They're only here because the judge made them"
Feedback about staff is investigated, not dismissed	Staff accountability is essential to client trust	"Clients always blame staff when they're not doing well"
No feedback data is shared with referral sources, courts, or probation	42 CFR Part 2 alignment and non-punitive principle	"We told the PO that client feedback has been concerning"
Return-to-use disclosures are treated as clinical signals, not infractions	Honesty must be protected	"The feedback proves they're not working their program"

Staff Meeting Ground Rules for Feedback Review

Read These Aloud Before Every Feedback Review Meeting

1. We are reviewing feedback about OUR program, not evaluating our clients.
2. Every response is anonymous. We will not speculate about who wrote what.
3. Negative feedback is valuable data. We will respond with curiosity, not defensiveness.
4. If a feedback theme makes us uncomfortable, that's a sign we should pay closer attention to it.
5. Feedback from mandated, MAT, and early-recovery clients is as important as any other feedback.
6. No information from this meeting will be used to identify, confront, or punish any client.

DOCUMENT 9

Recovery Success Signal Tracker

Measuring what matters in recovery — beyond sobriety dates

📋 **INSTRUCTIONS:** *Traditional SUD outcome measures focus on abstinence: days clean, negative drug tests, completion rates. These metrics tell you about substances. They do not tell you about the person. Feedback data reveals recovery success signals that clinical measures miss: hope, connection, agency, belonging, and purpose. This tracker captures those signals.*

The Expanded Definition of Recovery Success

Recovery Is More Than the Absence of Substance Use

SAMHSA defines recovery 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."

This definition includes four dimensions: Health, Home, Purpose, and Community. Your feedback system can measure signals in all four dimensions — not just the first.

Success Signal Mapping

SAMHSA DIMENSION	FEEDBACK SIGNAL	WHICH QUESTION CAPTURES IT	POSITIVE INDICATOR	WATCH SIGNAL
Health	Feeling supported in recovery	Stage 2+ Q: "Do you feel supported in your recovery here?"	≥4.0 avg (5-point scale)	Declining trend or <3.0 avg
Health	Physical and emotional safety	Safety Q: "Do you feel safe here?"	>90% "Yes"	>10% "No" or increasing "Prefer not to answer"
Home	Connection to stable environment	Continuing Care Q: "Did this program help you build skills for daily life?"	>75% "Yes"	<50% or declining
Purpos	Treatment	Active Q: "Does	>80% "Yes"	High "Not sure" or declining

e	plan reflects client goals	your treatment plan reflect what YOU want?"		"Yes"
Purpose	Feeling believed in	Continuing Care Q: "Did staff believe in your ability to recover?"	>85% "Yes"	<70% or declining
Community	Willingness to recommend	Continuing Care Q: "Would you encourage someone to try this program?"	>75% "Yes"	<50% or increasing "It depends"
Community	Feeling heard and respected	Core Q: "Do staff treat you with respect?"	>90% "Yes"	Any decline below 85%

Quarterly Signal Dashboard

SIGNAL	Q1	Q2	Q3	Q4	TREND	STATUS
Feeling supported in recovery						🟢 / 🟡 / 🔴
Physical and emotional safety						
Skills for daily life						
Treatment plan reflects client goals						
Staff believe in recovery						
Would recommend program						
Treated with respect						

Qualitative Success Signals

Track these themes from open-ended responses. They indicate recovery-positive program culture:

POSITIVE SIGNAL	EXAMPLE FEEDBACK	FREQUENCY THIS QUARTER
Agency /	"For the first time I feel like my recovery is	

autonomy	mine, not someone else’s plan”	
Hope / possibility	“I’m starting to believe I can actually do this”	
Connection / belonging	“I don’t feel alone anymore”	
Staff as humans, not authority	“My counselor treats me like a person, not a case file”	
Gratitude without performance	“Thank you for not giving up on me” (expressed freely, not prompted)	
Self-efficacy	“I’m learning things that actually help outside of here”	

DOCUMENT 10

Ethical Storytelling Guardrails

Using recovery feedback for communication without exploitation

📋 **INSTRUCTIONS:** *Recovery stories are powerful. They move funders, inspire communities, and humanize statistics. They are also among the most exploitable forms of human narrative. A person's story of addiction and recovery is not content. It is their life. This document establishes guardrails for using feedback-derived narratives ethically.*

The Fundamental Question

Every Use of a Recovery Story Must Pass This Test

Does this use of the story serve the person whose story it is — or does it only serve the organization?

If the answer is "it serves the organization" (fundraising, marketing, grant reporting, PR), you must apply every guardrail below. The story must be handled with the same care you would give a clinical disclosure, because to the person who lived it, that's what it is.

Guardrail 1: Consent and Attribution

SCENARIO	CONSENT REQUIRED	ATTRIBUTION
Using an anonymous quote from the feedback kiosk in a report	No additional consent needed — the response is anonymous by design	Always: "Anonymous participant feedback" — never attribute identity
Using a quote that could identify the person from context	DO NOT USE without redacting identifying details	Strip all identifying details. If the quote is still identifiable after redaction, do not use it.
A person volunteers to share their story publicly	Written, informed consent with specific scope and revocability	Per the person's preference. ALWAYS offer anonymity as an option.
Using feedback data to construct a composite narrative	No individual consent needed if truly composite	Clearly label: "This is a composite narrative reflecting common themes."

Guardrail 2: Narrative Framing

EXPLOITATIVE FRAMING	ETHICAL FRAMING
"Rock bottom" narratives that sensationalize the worst moments	Stories that center the person's agency, choices, and growth
Before/after structure that reduces a person to their diagnosis	Present-focused narratives that honor the whole person
"Success" defined exclusively as abstinence	Recovery defined by the person themselves (health, stability, purpose, connection)
Gratitude narratives that position the organization as savior	Narratives that position the person as the active agent and the program as a support
Dramatic details about substance use for emotional impact	Enough context to understand the journey without voyeuristic detail
Implying that this person's outcome is guaranteed for others	Honest framing: this is one person's experience; outcomes vary

Guardrail 3: What You Never Do

⚠ Absolute Prohibitions

✘ Never use a client's story without their explicit permission if they are identifiable

✘ Never share a story in a context the person did not consent to (e.g., consented for a grant report, used on social media)

✘ Never include details about specific substances, amounts, or use patterns

✘ Never include mugshots, "before" photos, or images that depict a person at their most vulnerable

✘ Never imply that a person's recovery is complete or guaranteed

✘ Never identify a person as being in SUD treatment without explicit written consent (42 CFR Part 2)

✘ Never use children's stories or images in SUD storytelling under any circumstances

✘ Never pressure a person to share their story ("It would really help other people" is pressure)

Guardrail 4: The Feedback-to-Story Pipeline

When turning anonymous feedback quotes into external communications:

☐	The quote is genuinely anonymous and cannot be traced to an individual
☐	The quote does not include program-specific details that could identify the site and thereby narrow the pool of possible respondents
☐	The quote represents a PATTERN in the data, not an outlier (Document 3, Feedback-

	to-Funders Toolkit)
☐	The quote is presented alongside data, not as a standalone emotional appeal
☐	No details have been added, embellished, or dramatized
☐	The quote has been reviewed by someone with lived SUD experience
☐	The context in which the quote will be used has been defined and is proportionate (a grant report is different from a billboard)
☐	The quote would not embarrass, endanger, or exploit the person who wrote it if they saw it in print

Guardrail 5: Ongoing Consent for Named Stories

If a person has consented to share their story publicly (with their name):

REQUIREMENT	YOUR STATUS
Consent is in writing and specifies exactly where the story will be used	☐
Consent can be revoked at any time, and the person knows this	☐
The person reviewed the final version before publication	☐
The person was not financially incentivized to share (stipend for time is okay; payment for the story is not)	☐
The person was offered the option to remain anonymous and chose to use their name	☐
The person was informed of the potential risks of public identification as a person in recovery	☐
A check-in occurs 6 months after publication: does the person still want the story public?	☐
If the person returns to use after sharing their story, the story is not withdrawn punitively but the person is contacted to ask their preference	☐

End of Toolkit

Honest feedback without jeopardizing recovery.

For implementation support, contact your Pulse For Good account manager or visit pulseforgood.com

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