

Sponsorship Facilitation

Supporting Therapeutic Peer Mentorship Relationships
Intensives Library · Clinical Practice & Treatment

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Part 1 · Overview

Sponsorship Facilitation

Sponsorship is the one recovery relationship a treatment centre cannot provide, cannot supervise and cannot replace - and it often carries a patient long after discharge. This intensive develops the competencies a centre actually controls: role clarity, practical access, patient preparation, community relationships, and the boundary discipline that keeps the relationship a patient's own.

Learning Slides

Role clarity, tradition respect, access and timing, unhealthy dynamics, and staff competency.

Implementation Map

A four-phase, 24-week sequence starting with boundaries and ending with measurement.

Self-Assessment

57 items across eight domains, scored out of 285.

Worksheet

28 reflection questions on your current facilitation practice and where it fails.

Part 2 · Slides

Introduction

Sponsorship Facilitation Excellence

Supporting Therapeutic Peer Mentorship Relationships

Sponsorship is the one recovery relationship a treatment centre cannot provide, cannot supervise, and cannot replace - and it is frequently the relationship that carries a patient long after discharge. Facilitation excellence means building the conditions for sponsorship to take hold without co-opting it.

Sponsorship belongs to the recovery community, not the treatment plan

Centres control access, timing, education and coordination - not the relationship

Facilitation failures are usually role failures, not effort failures

The measure of success is a sponsorship that survives discharge

Progress 7%

Definition

What Sponsorship Is, and What It Is Not

Precision Before Programming

Sponsorship is a voluntary, mutual, peer relationship in which someone with established recovery guides another through a program of recovery. It is not therapy, not case management, not monitoring, and not a service the centre delivers.

Voluntary on both sides, and revocable by either at any time

Peer-to-peer, not credentialed and not supervised

Program-focused rather than clinically directed

Free, and never billed, incentivised or contracted

Mutual - the sponsor's own recovery is served by the relationship

Progress 13%

Role Clarity

Clinician, Case Manager, Sponsor

Three Roles That Must Not Collapse Into One

Most sponsorship facilitation failures begin as role confusion. Each role carries different authority, different confidentiality, and different consequences when it is exceeded.

The clinician holds diagnosis, treatment planning and clinical risk

The case manager holds logistics, referrals and continuity

The sponsor holds the program, and holds no clinical authority at all

A patient who cannot distinguish the three will use one to avoid another

Staff naming their own roles out loud is a teachable clinical intervention

Progress20%

Tradition Respect

Why Staff Cannot Sponsor Patients

The Boundary That Protects Both Parties

A staff member sponsoring a current patient creates a dual relationship that compromises clinical judgment, patient autonomy, and the sponsorship itself. This holds even when the staff member is in recovery and the patient asks.

Dual relationships distort consent - the patient cannot freely decline

Clinical authority contaminates a relationship built on equality

Discharge ends the clinical relationship but not the power imbalance

Staff in recovery need clear guidance, not silence, on this boundary

Declining well is itself modelling - explain the reason, don't just refuse

Progress27%

Access

Making Sponsorship Reachable

The Facilitation Tasks a Centre Actually Controls

Patients rarely fail to get a sponsor because they refuse one. They fail because nobody made it practically possible during the window when they were willing.

Meeting access with transport, timing and schedule protection

Outside-meeting attendance rather than in-house facsimiles only

Phone access and a way to store numbers before discharge

Introductions to community members who visit the facility

Explicit permission and time to make the ask

Progress33%

Timing

When to Introduce Sponsorship

Too Early Is Noise, Too Late Is Nothing

Sponsorship raised in the first days competes with withdrawal, crisis and disorientation. Raised in the final days it becomes a discharge checkbox. The centre's job is to identify and use the window in between.

Stabilise first - sponsorship is not a detox intervention

Introduce the concept before asking for the action

Separate education, exposure, and the ask into distinct steps

Revisit rather than ask once and record a refusal

Protect enough time before discharge for a relationship to begin

Progress40%

Temporary Sponsorship

The Bridge From Treatment to Community

Lowering the Threshold of the First Ask

A temporary sponsor is a deliberately low-commitment, time-limited arrangement that lets a patient practise the relationship without the weight of a permanent choice. It converts an intimidating decision into a reversible one.

Explicitly time-limited, which reduces the fear of asking

Gives an immediate contact for the first days after discharge

Lets a patient learn what fit feels like before committing

Normalises changing sponsors rather than abandoning sponsorship

Works particularly well for patients with prior treatment experience

Progress47%

Common Failures

How Centres Get This Wrong

Patterns Worth Auditing For

Sponsorship facilitation degrades in predictable ways. Naming the patterns makes them auditable rather than anecdotal.

In-house groups substituted for real community meetings

Sponsorship assigned by staff rather than chosen by the patient

The ask recorded as a discharge task and never followed up

Staff sponsoring patients informally and unrecorded

Sponsors treated as an information source about the patient

No distinction drawn between a sponsor and a recovery coach

Progress53%

Communication

Information Flow, Releases and Limits

Coordination Without Surveillance

A sponsor is not a member of the treatment team and does not hold clinical information by default. Where coordination genuinely serves the patient, it happens with explicit consent and narrow scope.

No clinical information moves without a specific, informed release

Scope the release to what coordination actually requires

A sponsor is never asked to report on, monitor or verify a patient

The patient decides what they share with their sponsor, always

Document the boundary conversation, not the sponsor's disclosures

Progress60%

Step Work

Coordinating Clinical and Step Progress

Two Tracks That Should Not Be Merged

Step work and treatment planning run in parallel and answer to different authorities. Clinical staff can support step work without directing it, and should recognise where the two genuinely interact.

Step progress is not a clinical outcome and is not charted as one

Recognise where step work surfaces material needing clinical support

Do not assign, grade or require step work as a treatment condition

Understand the steps well enough to hold a competent conversation

Refer trauma content surfaced in step work back into clinical care

Progress67%

Difficult Dynamics

When a Sponsorship Relationship Is Unhealthy

Recognising Harm Without Overreaching

Most sponsorship relationships are beneficial. A minority are not, and clinical staff need a way to respond that respects autonomy while taking real harm seriously.

Watch for control, financial entanglement, isolation or exploitation

Distinguish discomfort and challenge from genuine harm

Educate patients on what they may reasonably expect and refuse

Support a change of sponsor as normal rather than as failure

Escalate exploitation and abuse as safeguarding, not as program business

Progress73%

Populations

Sponsorship Across Diverse Needs

One Practice Does Not Fit Everyone

Fit matters, and access to a suitable sponsor is unevenly distributed. Facilitation excellence means noticing who the default pathway does not serve.

Patients whose identity is under-represented in local meetings

Patients on medication for opioid use disorder facing stigma

Patients with significant co-occurring mental health needs

Adolescents and young adults needing age-appropriate matching

Patients for whom faith language is a barrier, and the alternatives

Progress80%

Community Pipeline

Alumni and Peer Structures

Building the Supply Side

Facilitation is limited by how many suitable sponsors exist and how reachable they are. Centres that invest in community relationships create the conditions their patients depend on.

Sustained relationships with local groups and service structures

Alumni pathways into service without turning alumni into staff

Hosting outside meetings on terms the community sets

Clarity that alumni volunteers are not an arm of the programme

Long-term community trust as an organisational asset

Progress87%

Staff Competency

Training for Sponsorship Facilitation

A Teachable, Assessable Skill Set

Sponsorship facilitation is usually assumed rather than taught, which is why it varies so widely between staff members in the same building.

Working literacy in 12-step structure, language and traditions

Explicit boundary training for staff who are themselves in recovery

Practised language for introducing, timing and revisiting the ask

Competence in recognising unhealthy relationship dynamics

Supervision that treats facilitation as clinical skill, not admin

Progress93%

Call to Action

From Referral to Facilitation

Assessment, Implementation, Excellence

Move the organisation from handing out a meeting list to systematically building the conditions in which sponsorship relationships form and survive discharge.

Assess current facilitation practice across all five domains

Close the role-clarity and boundary gaps first - they are cheapest

Build community relationships before demand outstrips supply

Measure sponsorship that persists past discharge, not asks recorded

Progress100%

Part 3 · Map

Strategic Implementation Map

Sponsorship Facilitation Excellence: 24-Week Timeline

Phase 1: Boundary and Role Foundation (Weeks 1-6)

Weeks 1-2: Current-State Audit

- Complete the Sponsorship Facilitation assessment with the leadership team
- Establish how many patients currently leave with a sponsor rather than a list
- Review every existing policy that touches staff, patients and outside recovery
- Identify undocumented practice - what staff actually do, not what policy says

Weeks 3-4: Write the Boundary Policy

- State plainly that staff do not sponsor current patients, and why
- Extend the policy explicitly to the post-discharge period
- Define the reporting route for boundary concerns and breaches
- Write the guidance staff in recovery need, rather than leaving it to judgment

Weeks 5-6: Role Clarity Training

- Train all clinical staff on clinician, case manager, coach and sponsor roles
- Practise declining a sponsorship request in a way that explains the reason
- Build role clarity into induction rather than one-off training
- Add facilitation practice to the clinical supervision agenda

Phase 2: Access and Patient Preparation (Weeks 7-14)

Weeks 7-9: Remove the Practical Barriers

- Map every barrier between a willing patient and an outside meeting
- Fix transport, staffing and scheduling before addressing motivation
- Solve phone access and contact-number retention before discharge
- Distinguish in-house groups from community meetings in the programme

Weeks 10-12: Build the Education Sequence

- Separate the concept, the exposure and the ask into distinct steps
- Teach what a sponsor does, does not do, and what a patient may decline
- Give patients practised language for making the ask
- Introduce temporary sponsorship as a legitimate first step

Weeks 13-14: Fix the Timing

- Define the window after stabilisation when sponsorship is introduced
- Replace the single ask with a revisit schedule across the episode
- Protect enough pre-discharge time for a relationship to begin

- Stop recording a first refusal as a closed item

Phase 3: Community Relationships and Equity (Weeks 15-20)

Weeks 15-16: Build the Supply Side

- Name an owner for each local group and service-structure relationship
- Host outside meetings on the community's terms, not the centre's
- Create a welcoming, predictable process for community members visiting
- State plainly to the community that volunteers are not an arm of the programme

Weeks 17-18: Consent and Information Discipline

- Rebuild the release process so sponsor-related scope is narrow and specific
- End any practice of asking sponsors to monitor, report or verify
- Document boundary conversations rather than sponsor disclosures
- Remove step work from anything functioning as a treatment condition

Weeks 19-20: Equity of Access

- Identify which patient groups the default pathway does not serve
- Map which local meetings are genuinely welcoming to which populations
- Prepare patients on medication for opioid use disorder for stigma they may meet
- Build the concern route for unhealthy sponsorship dynamics and train it

Phase 4: Measurement and Sustainability (Weeks 21-24)

Weeks 21-22: Measure the Right Thing

- Replace "sponsorship discussed" with sponsorship that persists after discharge
- Separate patients who have a sponsor from patients who have a phone number
- Break the measure down by population to expose unequal outcomes
- Set the follow-up interval at which the measure is actually taken

Weeks 23-24: Embed and Review

- Feed facilitation data into programme change, not only into reporting
- Re-run the assessment and compare against the Phase 1 baseline
- Fix variation between staff members before adding new practice
- Set the annual review point and name who owns it

Implementation Success Factors

Boundaries before outreach. Community goodwill spent on a practice you will have to change is goodwill spent twice.

Access before motivation. Most patients who do not get a sponsor were willing and unable, not unwilling.

The community sets its own terms. A centre that hosts meetings on its own terms is running a programme, not a meeting.

Facilitation is a clinical skill. Treated as an administrative task, it will vary by staff member and never improve.

Measure survival, not intent. A sponsorship that ends at discharge was a conversation, not a relationship.

Part 4 · Assessment

Role Clarity and Boundary Integrity

Our staff can clearly articulate the difference between a clinician, a case manager, a recovery coach and a sponsor

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We have an explicit, written policy that staff do not sponsor current patients

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Staff members who are themselves in recovery receive specific guidance on this boundary rather than being left to judge it alone

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Staff decline sponsorship requests from patients in a way that explains the reason rather than simply refusing

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Our policy addresses the period after discharge, not only the active treatment episode

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Patients are told plainly which of their relationships are clinical and which are not

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Boundary breaches involving sponsorship are treated as reportable events rather than handled informally

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Progress: 13%

Access, Timing and the Practical Ask

Patients attend outside community meetings rather than only in-house facsimiles

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Transport, scheduling and staffing genuinely permit meeting attendance rather than nominally allowing it

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Patients have practical phone access and a way to retain contact numbers before discharge

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We introduce the concept of sponsorship separately from, and before, asking a patient to act on it

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Sponsorship is raised after stabilisation rather than during acute withdrawal or crisis

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We revisit sponsorship over the course of the episode rather than asking once and recording a refusal

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Enough time is protected before discharge for a sponsorship relationship to actually begin

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Progress: 25%

Patient Education and Preparation

Patients receive concrete education on what a sponsor does and does not do

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We teach patients how to ask someone to sponsor them, including practised language

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Patients are taught that temporary sponsorship exists and is a legitimate starting point

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We normalise changing sponsors as a healthy option rather than a failure

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Patients learn what they may reasonably expect from a sponsor and what they may decline

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Education addresses the difference between sponsorship and friendship

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Patients with previous treatment experience receive education pitched beyond the introductory level

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Progress: 38%

Community Relationships and Sponsor Supply

We maintain sustained working relationships with local recovery groups and service structures

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Outside meetings are hosted on terms the recovery community sets rather than terms we set

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Community members are able to meet patients inside the facility through a clear, welcoming process

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We have alumni pathways into service that do not convert alumni into unpaid staff

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We are explicit with the community that volunteers are not an arm of our programme

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We monitor whether the supply of available sponsors actually meets our patients' demand

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Community trust is treated as a long-term organisational asset with a named owner

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Progress: 50%

Coordination, Consent and Information Boundaries

No clinical information reaches a sponsor without a specific, informed release from the patient

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Releases involving sponsors are scoped narrowly to what coordination genuinely requires

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Sponsors are never asked to monitor, report on, or verify a patient's behaviour

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Staff understand that a sponsor is not a member of the treatment team

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

The patient decides what they disclose to their sponsor, without staff direction

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We document the boundary conversation rather than documenting what a sponsor disclosed

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Step work is not assigned, graded or required as a condition of treatment

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Progress: 63%

Recognising and Responding to Unhealthy Dynamics

Staff can recognise controlling, isolating or financially entangled sponsorship dynamics

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We distinguish an appropriately challenging sponsorship from a genuinely harmful one

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Patients are told how to raise a concern about a sponsor and to whom

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Supporting a change of sponsor is treated as routine rather than as a clinical setback

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Exploitation or abuse within a sponsorship is escalated as safeguarding, not as programme business

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We respond to unhealthy dynamics without overriding the patient's autonomy

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Staff know the limits of their authority over a relationship outside the treatment episode

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Progress: 75%

Equity of Access Across Populations

We actively address sponsor access for patients whose identity is under-represented in local meetings

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Patients on medication for opioid use disorder are prepared for, and supported through, stigma in some groups

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We know which local meetings are and are not welcoming to our specific patient populations

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Adolescents and young adults receive age-appropriate matching rather than the general pathway

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Patients for whom faith-based language is a barrier are offered genuine alternatives

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Patients with significant co-occurring mental health needs receive tailored facilitation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We measure whether sponsorship outcomes differ across patient groups rather than assuming they do not

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Progress: 88%

Staff Competency, Supervision and Measurement

Staff have working literacy in 12-step structure, language and traditions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Sponsorship facilitation is explicitly taught rather than assumed

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Facilitation practice is addressed in clinical supervision, not treated as an administrative task

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Facilitation quality is consistent between staff members rather than varying by individual

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We measure sponsorship that persists after discharge, not merely asks recorded before it

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Our data distinguishes patients who have a sponsor from patients who have a phone number

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Facilitation outcomes inform programme change rather than only being reported

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

We can evidence our sponsorship facilitation practice to an external reviewer

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Never · Always

Progress: 100%

Scoring guide

Sponsorship Facilitation Excellence Assessment

Therapeutic Peer Mentorship Support Quality Evaluation

Role Clarity and Boundary Integrity

Our staff can clearly articulate the difference between a clinician, a case manager, a recovery coach and a sponsor

We have an explicit, written policy that staff do not sponsor current patients

Staff members who are themselves in recovery receive specific guidance on this boundary rather than being left to judge it alone

Staff decline sponsorship requests from patients in a way that explains the reason rather than simply refusing

Our policy addresses the period after discharge, not only the active treatment episode

Patients are told plainly which of their relationships are clinical and which are not

Boundary breaches involving sponsorship are treated as reportable events rather than handled informally

Access, Timing and the Practical Ask

Patients attend outside community meetings rather than only in-house facsimiles

Transport, scheduling and staffing genuinely permit meeting attendance rather than nominally allowing it

Patients have practical phone access and a way to retain contact numbers before discharge

We introduce the concept of sponsorship separately from, and before, asking a patient to act on it

Sponsorship is raised after stabilisation rather than during acute withdrawal or crisis

We revisit sponsorship over the course of the episode rather than asking once and recording a refusal

Enough time is protected before discharge for a sponsorship relationship to actually begin

Patient Education and Preparation

Patients receive concrete education on what a sponsor does and does not do

We teach patients how to ask someone to sponsor them, including practised language

Patients are taught that temporary sponsorship exists and is a legitimate starting point

We normalise changing sponsors as a healthy option rather than a failure

Patients learn what they may reasonably expect from a sponsor and what they may decline

Education addresses the difference between sponsorship and friendship

Patients with previous treatment experience receive education pitched beyond the introductory level

Community Relationships and Sponsor Supply

We maintain sustained working relationships with local recovery groups and service structures

Outside meetings are hosted on terms the recovery community sets rather than terms we set

Community members are able to meet patients inside the facility through a clear, welcoming process

We have alumni pathways into service that do not convert alumni into unpaid staff

We are explicit with the community that volunteers are not an arm of our programme

We monitor whether the supply of available sponsors actually meets our patients' demand

Community trust is treated as a long-term organisational asset with a named owner

Coordination, Consent and Information Boundaries

No clinical information reaches a sponsor without a specific, informed release from the patient

Releases involving sponsors are scoped narrowly to what coordination genuinely requires

Sponsors are never asked to monitor, report on, or verify a patient's behaviour

Staff understand that a sponsor is not a member of the treatment team

The patient decides what they disclose to their sponsor, without staff direction

We document the boundary conversation rather than documenting what a sponsor disclosed

Step work is not assigned, graded or required as a condition of treatment

Recognising and Responding to Unhealthy Dynamics

Staff can recognise controlling, isolating or financially entangled sponsorship dynamics

We distinguish an appropriately challenging sponsorship from a genuinely harmful one

Patients are told how to raise a concern about a sponsor and to whom

Supporting a change of sponsor is treated as routine rather than as a clinical setback

Exploitation or abuse within a sponsorship is escalated as safeguarding, not as programme business

We respond to unhealthy dynamics without overriding the patient's autonomy

Staff know the limits of their authority over a relationship outside the treatment episode

Equity of Access Across Populations

We actively address sponsor access for patients whose identity is under-represented in local meetings

Patients on medication for opioid use disorder are prepared for, and supported through, stigma in some groups

We know which local meetings are and are not welcoming to our specific patient populations

Adolescents and young adults receive age-appropriate matching rather than the general pathway

Patients for whom faith-based language is a barrier are offered genuine alternatives

Patients with significant co-occurring mental health needs receive tailored facilitation

We measure whether sponsorship outcomes differ across patient groups rather than assuming they do not

Staff Competency, Supervision and Measurement

Staff have working literacy in 12-step structure, language and traditions

Sponsorship facilitation is explicitly taught rather than assumed

Facilitation practice is addressed in clinical supervision, not treated as an administrative task

Facilitation quality is consistent between staff members rather than varying by individual

We measure sponsorship that persists after discharge, not merely asks recorded before it

Our data distinguishes patients who have a sponsor from patients who have a phone number

Facilitation outcomes inform programme change rather than only being reported

We can evidence our sponsorship facilitation practice to an external reviewer

Excellent Sponsorship Facilitation

Score: 240 and above

Role boundaries, access, community relationships and measurement are all working together.

Focus on sustaining community trust and on sharing this practice with the field.

Good Facilitation with Enhancement Opportunities

Score: 200 and above

A strong foundation with specific gaps. Identify the lowest-scoring sections below; boundary and role-clarity gaps are usually the cheapest to close first.

Moderate Facilitation Requiring Systematic Enhancement

Score: 160 and above

Sponsorship is encouraged but not systematically facilitated. Patients are likely leaving with a meeting list rather than a relationship.

Low Facilitation Quality Requiring Intensive Development

Score: 120 and above

Major gaps in access, education or boundaries. Sponsorship is probably being recorded as a discharge task rather than built during the episode.

Crisis-Level Facilitation Deficits

Score: below the band above

Sponsorship is effectively unsupported, and role boundaries may be actively unsafe. Begin with the boundary policy and staff guidance before anything else.

Sponsorship Facilitation Assessment Results

Priority Areas for Development

Part 5 · Worksheet

Sponsorship Facilitation Excellence

Reflection Worksheet

Role Clarity and Boundaries

If asked today, could every member of your staff explain the difference between a clinician, a case manager, a recovery coach and a sponsor? How do you know?

Your response...

What is your written policy on staff sponsoring current or former patients, and where does it fall silent?

Your response...

What specific guidance do staff who are themselves in recovery receive about this boundary?

Your response...

The last time a sponsorship boundary was crossed, how was it handled - and was it recorded anywhere?

Your response...

Access and Timing

What proportion of your patients attend genuine outside community meetings during their episode, rather than in-house groups?

Your response...

Which practical barriers - transport, staffing, scheduling, phone access - most often stop a willing patient from getting to a meeting?

Your response...

When in the episode is sponsorship actually raised, and who decides that timing?

Your response...

When a patient declines, what happens next? Is the topic revisited, or is the refusal recorded and closed?

Your response...

Patient Education and Preparation

What do your patients actually learn about what a sponsor does and does not do, and where is that taught?

Your response...

Do patients get to practise asking someone to sponsor them before they have to do it for real?

Your response...

How is temporary sponsorship introduced, and is it presented as a legitimate step or as second best?

Your response...

How do you teach patients that changing sponsors is normal rather than a failure?

Your response...

Community Relationships and Supply

Name the local recovery groups you have a real working relationship with. Who in your organisation owns those relationships?

Your response...

When outside meetings are hosted in your facility, whose terms govern them - yours or the community's?

Your response...

How do alumni move into service without becoming unpaid staff, and where is that line drawn?

Your response...

Do you know whether the supply of available sponsors meets your patients' demand? What would tell you?

Your response...

Consent, Coordination and Information

What information reaches a sponsor, under what release, and how narrowly is that release scoped?

Your response...

Has a sponsor ever been asked - formally or informally - to report on, monitor or verify a patient? What made that happen?

Your response...

What gets documented about sponsorship: the boundary conversation, or what the sponsor disclosed?

Your response...

Is step work ever assigned, graded or required as a condition of treatment? Where does that creep in?

Your response...

Equity and Difficult Dynamics

Which of your patient groups are least well served by the default sponsorship pathway, and what have you done about it?

Your response...

How are patients on medication for opioid use disorder prepared for stigma they may meet in some groups?

Your response...

How would a patient raise a concern about a sponsor, to whom, and what would happen next?

Your response...

Where is your line between an appropriately challenging sponsorship and a harmful one, and who decides?

Your response...

Strategic Action Planning

What are your immediate action priorities for sponsorship facilitation? Boundary and role-clarity gaps are usually the cheapest to close first.

Your response...

What will you start measuring - sponsorship that survives discharge, rather than asks recorded before it?

Your response...

What are your staff competency and supervision goals for facilitation as a clinical skill?

Your response...

What is your two-year vision for the community relationships this work depends on?

Your response...

Email worksheet to...

Scoring guide

Sponsorship Facilitation Worksheet