Peer Specialist Facilitator Curriculum Guide

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Peer Specialists Igniting Recovery

ACCESS TO INDEPENDENCE INC.

Wisconsin Department of Health Services

Preparing to Facilitate Peer Specialist Training

Congratulations on your commitment to Peer Specialist training. Experience is the best training when it comes to offering suggestions to others. As you teach the course, keep in mind what has worked well for you in your own life. Facilitating is a very personal skill and it is helpful to continually experiment to find the style that works best for you and those you serve.

Participants often bring special needs that have to be planned for and accommodated if the session is to run smoothly. They may feel apprehensive about participating in a group or meeting new people. The role of the facilitator is to help everyone be a part of the group and participate in the process.

GENERAL GUIDELINES

- Use a strengths perspective recognizing that all of us have innate skills, gifts and talents. Learn to recognize those strengths in yourself and others. Encourage participants to do the same so they can be used as building blocks to achieve goals.

- Have a clear and simple registration process that includes name and contact information of every participant.

- Share your contact information with participants, which should include the best way to contact you and how to cancel if they cannot make a class.

- Practice each session in advance of the training. The best way to do this is with two or three people who can give you constructive feedback.
  Remember: preparation = comfort

- Arrive at least 30 minutes early for each session to set up projector, computer or any technology.

- Create a warm and welcoming environment for participants. A sincere smile and "hello" are powerful welcoming tools.

- Start and end all sessions and breaks on time. This demonstrates respect for participants who are punctual and their time.

- Express respect for all participants. One's perspective is no less valid than another's. Each of us brings a unique perspective to the course based on our life experiences.

- Be prepared for each class with pens, handouts, extension cords, flip charts, markers, etc.

- Plan for things to go wrong. In spite of best efforts, something may go wrong. Keep a sense of humor and use the "problem" as a learning opportunity. Flexibility is the key to good mental health.

- While all participants should be encouraged to participate, sometimes there may be a concern that makes it difficult to do so. Allow participants to "pass" on an interaction, group discussion, or activity. Sometimes it is helpful to sit quietly to integrate material and thought processes.

- Explain to participants that they may not pass on homework, however. It is expected that all assignments be completed before they come to the next class.

- If a participant is not doing the work, take them aside and discuss the expectations of the training. Modeling open communication, explore whether there are some things you could do to help them be successful. At no time should the class be punitive. If homework is consistently not completed, then, perhaps, this is not a good time to take the class.

- Offer individual assistance to participants. Demonstrate your commitment as a facilitator by offering one-on-one attention before or after the sessions.

CURRICULUM FORMAT

This curriculum is designed as a process based on the core competencies for the Peer Specialist. Each session builds on previous information with important core competencies often repeated several times.

It is designed to be an active process giving participants not only information to be a Wisconsin Certified Peer Specialist but also tools that they can use in their own recovery process. It is based on the recognition that participants are in various stages of recovery and benefit from additional information.

Information on mental health and substance abuse is integrated throughout but the focus is on the helping relationship and peer support. This is intentional as the Peer Specialist is a supportive role, not a clinical role.

The format is based on adult learning principles and includes readings, didactic information and experiential exercises for practice. It is designed to be flexible so facilitators can easily adjust the format and customize for the group. While timeframes are given, they are only suggestions and facilitators can adjust based on their expertise and the group dynamics.

The homework for each session has been designed to give varying views, ideas, and information to participants. It is, by all means, not exhaustive. It is designed to be informative and, at times, controversial. This gives the facilitator opportunities for discussion and exploration of various views. The facilitator is encouraged to bring in readings and articles that would be of interest to the group.

It is encouraged and expected that facilitators will also bring additional resources and information that customize the training for the group. For example, every facilitator needs to present local resources to the group. Facilitators may also want to bring guest speakers to the class from local groups or use videos to enhance learning. The format can be adjusted for these types of activities.

A book report is suggested for participants but it is not an academic exercise. The goal is to introduce important literature, readings, and books that enhance the Peer Specialist's knowledge and can be used as a resource when working with peer recipients. Again, there are many options for the facilitator; i.e., use the included book list, ask the class what books have been helpful for them, or bring in additional resources. The facilitator may also determine how reporting on the reading is done; i.e., group discussion, written report, or verbal presentation.

In short, please view the process outlined as a creative process for facilitators with many opportunities to individualize based on the composition and dynamics of the group. You are the experts and your background and experience are essential to the process.

"I can't change the direction of the wind,
but I can adjust my sails to always reach my destination."
-JIMMY DEAN

Section One

The Basics of Peer Support

Session 1

FACILITATOR INFORMATION:

Session 1 is focused on helping participants feel comfortable and to introduce the course. The basics of peer support are presented. SAMHSA's Definition of Recovery is introduced, discussed and further reading given for homework. Facilitators may also bring in information on other recovery models that they have found useful.

The concept of strength-based recovery is introduced. This concept is further integrated in other parts of the curriculum and should be referenced by facilitators throughout the training.

The Positively Charged exercise introduces the concept of the Peer Specialist's outlook and self-care recognizing that their attitude is a key component of working with peers.

The assignment, "Why Peer Support?" is given as homework. Facilitators may also want to assign additional readings or videos for participants.

Peer Specialist Facilitator Curriculum Guide

SESSION 1

20 MINUTES Introduction of Facilitators and Participants

20 MINUTES Guidelines for the Program

10 MINUTES Course Outline

50 MINUTES Group Discussion: "What is a Peer Specialist?"

15 MINUTES Break

45 MINUTES Strength Based Recovery

15 MINUTES Break

30 MINUTES Positive Thinking

5 MINUTES Homework: "Why Peer Support? " Reading assignments include "SAMHSA's Working Definition of Recovery," Wisconsin Certified Peer Specialist Code of Ethics, Core Competencies for Wisconsin Certified Peer Specialists.

Choose a book from the book list in the homework session and begin reading to prepare a book report. The books are available at your local library or from Amazon.

CPS CORE CRITERIA COVERED

1.3 Believes that personal growth and change are possible
2.1 Knowledge of SAMHSA'S Definition of Recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential"
2.4 Knowledge of the stages of change and recovery
4.1 Ability to bring an outlook on peer support that inspires hope and recovery

Introduction of Facilitators and Participants (20 MINUTES)

OBJECTIVE

To get to know one other person in the group and pass information on to everyone.

METHOD

Divide the group into pairs. Give each person a pad of paper and pen. Ask each pair to go to a separate area of the room and get answers to the following questions or the facilitator can develop other questions customized to the group:

1. Name
2. Where they grew up
3. Their greatest accomplishment
4. Their most prized possession
5. What they like to do in their spare time

After about 10 minutes, call the group back together. Have each pair introduce their partner to the group.

Guidelines for the Program (20 MINUTES)

Discuss the guidelines outlined below. Ask the class if they would like to make any changes or additions. It is important that the group agree to the guidelines. Write the guidelines on an easel and post for the group at each session.

GROUP GUIDELINES

- The class will start and finish on time. Please be punctual.
- Let the group and the facilitator know if you can't come to a class or if you are dropping out.
- To receive a completion certificate at the end of the program, you cannot miss more than two (2) sessions.
- Confidentiality must be respected at all times. What is said in class stays in class.
- Participation is the key to success. Please respect everyone's airtime.
- There will be periodic breaks in each class.
- Assigned homework must be completed before the beginning of the next class.
- Relax, have fun and enjoy yourself!

Course Outline (10 MINUTES)

Facilitators will present the outline for the course, and distribute the Code of Ethics and Core Competencies. Each session is designed to be 3 hours long, with two 15-minute breaks, except for Session 12 and 13. These both are 3 ½ hours long. The facilitator may vary the time of an exercise as needed, but needs to keep the total session time to 3 or 31/2 hours. Each session has a mixed format, with lecture, interactive discussion, and skill exercises.

Section One – The Basics of Peer Support

SESSION I

- Introduction of Facilitators and Participants
- Guidelines for the Program
- Course Outline
- Group Discussion: "What is a Peer Specialist?"
- Strengths Based Recovery
- Positive Thinking
- Homework: "Why Peer Support? Readings.

SESSION 2

- Discussion of homework. Review of recovery models
- The Helpful Responses (Empathy) Questionnaire
- Intentional Peer Support
- Beliefs and values
- Legal Considerations: Summary of Duties
- Confidentiality
- Peer Support role-play
- Homework: Self-Assessment Handout. Readings.

Section Two – Communication Skills

SESSION 3

- Group Discussion of Working Values in the Helping Relationship, Trauma-informed peer support.
- Attending Skills
- Active Listening
- The Skill of Paraphrasing
- Accurate Empathy Exercise
- Homework: The First Visit. Readings.

SESSION 4

- Homework review and Poem "Listen"
- Accurate Empathy, Conveyance of Ownership in Empathy,
- Uses of Empathy
- Non-empathetic statements
- Exploring
- Open questions
- Accurate Empathy and Exploring Exercise
- Advanced Accurate Empathy Exercise
- Homework: Begin book report. Due by session 7. Readings.

SESSION 5

- Giving Information and Self-Disclosure
- Boundaries
- Gentle Refusal
- Summarizing and Peer Support Exercise
- Setting limits with "Gentle Refusal"
- Homework: Continue book report. Readings.

SESSION 6

- Strengths-Based Recovery plans
- Brainstorming and Balance Sheet Technique
- Person Centered Planning and Wellness Recovery Action Planning
- Guidelines for strength-based recovery plans
- Homework: Strength-based recovery worksheet. Reminder book report due next time. Readings.

Section Three – A Trauma-Informed Approach to Mental Illnesses and Substance Use Disorders (SUDS)

SESSION 7

- Review of homework. Book reports due.
- Trauma-Informed Approach and Trauma-Specific Interventions
- Recovery
- Dual diagnosis/Co-Occurring Disorders
- Anxiety Disorders –including panic disorders, panic attack, coping skills, phobic neuroses, OCD, Post-traumatic stress disorder and generalized anxiety disorder.
- Eating disorders and peer support exercise.
- Alcohol Use Disorder (AUD), tobacco and cannabis use disorders.
- Homework: Readings.

SESSION 8

- Review of homework
- Spirituality and Mental Illness and Substance Use Disorders
- Mood Disorders-Trauma experienced by peers, characteristics of a depressive episode, characteristics of a manic episode, pharmacological treatment of mood disorders.
- Stimulant Use Disorder and Hallucinogen Use Disorder
- Homework: Readings.

SESSION 9

- Review of homework
- Anger Management
- Advocacy and self-advocacy
- Personality Disorders
- The Functions of Anger
- Contrasting Assertive, Passive and Aggressive Behavior
- Assertion Skills Worksheet
- Homework: Readings.

SESSION 10

- Review of homework
- Stress and Stress Management
- Schizophrenia and Other Psychotic Disorders
- Stigma and Cultural Competency
- Stress Test
- Homework: Readings.

SESSION 11

- Review of homework
- Personal attitudes towards prescription medication
- Medication-Assisted Treatment
- Opiate Use Disorders
- Peer support exercise
- Homework: Readings.

Section Four – Other Important Issues

SESSION 12

- Review of homework
- Suicide and self-harm, myths about suicide
- Loss and the Grieving Process, Self-Stigma
- Federal and state laws regarding client rights, civil rights, and the American with Disabilities Act (ADA) Involuntary commitment in Wisconsin
- Wisconsin's Community Mental Health & Substance Abuse Services System
- Homework: Readings

SESSION 13

- Review of homework
- Ending the support relationship
- Peer support exercise
- Helpful responses questionnaire
- Course evaluation
- Wrap-up and celebration

What is a Peer Specialist?
(50 MINUTES)

The Peer Specialist role includes activities and actions that help **improve/enhance** a peer's recovery of quality of life and ability to cope with daily life.

The Peer Specialist provides a helping **relationship** between peers that promotes respect, trust and warmth and empowers individuals to make changes and decisions to enhance their lives.

The Peer Specialist approach is based on a **recovery model** and the belief that people with psychiatric and substance use disorders can recover, reclaim, and transform their lives.

The Peer Specialist focuses on individual **strengths**, not deficits.

The Peer Specialist is part of the process to help individuals **connect** with resources in the community.

Peer Support is getting help from someone who has been there. People with similar experiences may be able to listen, give hope and guidance toward recovery in a way that is different, and may be just as valuable, as professional services. Peer support services include support groups, peer-run programs, services in traditional mental health agencies and substance abuse agencies.

The official Department of Health Services (DHS), Division of Mental Health and Substances Abuse Services (DMHSAS) approved definition of Certified Peer Specialist:

A Certified Peer Specialist is a person who has not only lived the experience of mental illness and/or substance use disorder but also has had formal training in the peer specialist model of mental health and/or substance use disorder supports. They use their unique set of recovery experiences in combination with solid skills training to support peers who have mental illness and/or substance use disorder. Peer Specialists actively incorporate peer support into their work while working within an agency's team support structure as a defined part of the recovery team.

A Certified Peer Specialist is not a mental health or substance use disorder technician limited to providing ancillary services without a clear therapeutic role, but as an active participant on the consumer's treatment and recovery team.

Scope of Practice

Peer Specialist provide peer support, a nationally recognized evidence-based practice which consists of a qualified peer supporter assisting individuals with their recovery from mental illness and substance abuse disorders. The role of a peer specialist can be quite variable. While some peer specialists focus on issues such as housing, transportation, and employment, others work one-on-one with others to offer support.

Some may believe that certain tasks are not "true" peer specialist functions. For example, some administrators believe a person without a recovery experience can accomplish transportation or gathering intake information. While that may be true, a peer specialist can bring special value to these types of tasks.

Peer specialists, like no other class of mental health or substance use disorder workers, offer the advantages of shared experiences. We have been there, done that. We know the journey to recovery is real and attainable because we have traveled the path. Through contacts with others struggling with mental illnesses and substance use disorders, we can share our experiences and instill hope.

Core Competencies, Principles and Values

Core competencies for peer workers reflect certain foundation principles identified by members of the mental health consumer and substance use disorder recovery communities.

These are:
Recovery-oriented: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.
Person-centered: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the individual served and to respond to specific needs the individuals has identified to the peer worker.
Voluntary: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.
Relationship-focused: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.
Trauma-informed: Peer recovery support utilizes a strength-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities

Although there is a range of duties that peer specialists perform, these are some of the basic attributes of peer specialists:

- True caring for others struggling to find or proceed on their recovery journey.

- Enthusiasm for the role and a willingness to listen.
- Flexibility and creativity.
- Knowledge and a desire to keep learning.
- Problem-solving ability.
- The ability to communicate clearly with compassion and empathy.

Peer specialists provide the following services:

- Provide information to their peers.
- Act as a referral source to clinicians, mental health, and substance use disorder professionals.
- Provide support and understanding to their peers.
- Help peers in problem solving, decision-making, and setting goals through a partnership with the service recipient.[1]

The official Department of Health Services (DHS), Division of Mental Health and Substances Abuse Services (DMHSAS) approved Certified Peer Specialist Core Competencies, Principles and Values.

Wisconsin Certified Peer Specialist Scope of Practice

Summary: The primary function of the Wisconsin Certified Peer Specialist (CPS) is to provide peer support. The CPS engages and encourages peers in recovery from mental health and/or substance use disorders. The CPS provides peers with a sense of community and belonging, supportive relationships, and valued roles. The goal is to promote wellness, self-direction, and recovery, enhancing the skill and ability of peers to engage in their chosen roles. The CPS works with peers as equals.

ESSENTIAL FUNCTIONS:

Providing Support
Certified Peer Specialist will:

1. Identify as a person in mental health and/or substance use recovery.
2. Be mindful of the ethics, boundaries, power, and control issues unique to the CPS role.
3. Establish supportive relationships with peers which promote recovery.
4. Assist peers to understand the purpose of peer support and the recovery process.

[1] National Association of Peer Specialists, adapted from Chapter 1 of the Peer Specialist Training Manual, third edition.

5. Provide peers with the Substance Abuse and Mental Health Services.

   Administration (SAMHSA's) definition of recovery and its components.

   (http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/)

6. Intentionally share his or her own recovery story as appropriate to assist peers, providing hope and help in changing patterns and behaviors.
7. Create an environment of respect for peers which honors individuals for taking charge of their own lives.
8. Mutually establish acceptable boundaries with the peers and agree to discuss on an ongoing basis as needed.
9. Demonstrate understanding of how trauma affects mental health and substance use disorder recovery, develop trauma-informed relationships, and support peers in obtaining appropriate resources for help.
10. Demonstrate an understanding of how substance use disorder affects mental health recovery.
11. Encourage and assist peers to construct their own recovery/wellness plans, which may also include proactive crisis and/or relapse prevention plans.
12. Support peers in crisis to explore options that may be beneficial to returning to emotional and physical wellness.
13. Provide culturally-sensitive and age-appropriate services.
14. Provide a welcoming environment of recovery, wellness, and hope.
15. Encourage peers to focus on their strengths, exercise use of natural supports, develop their own recovery goals, and strengthen their valued roles within the community
16. Use active listening skills.
17. Together with peers, research and connect with resources that are beneficial to peers' needs and desires (e.g. employment, housing, health, and peer-delivered services).
18. Understand and be able to explain the rights of the peers.

Wisconsin Certified Peer Specialist Scope of Practice

Communicating with Supervisors and Interacting with Staff Certified Peer Specialists will:

1. Understand and utilize the established supervisory structure to communicate needs, ask questions (especially about ethics, boundaries, and confidentiality), mention concerns, etc.
2. If employed in a Medicaid-funded and/or clinical program, understand the requirement of clinical supervision by a qualified mental health or substance use disorder profession.
3. Understand his or her role and fully participate as an integral part of the professional recovery team.
4. Demonstrate and model to staff that recovery is achievable, and that peer support is an Evidence Based Practice.
5. Complete all required documentation timely, accurately, and respectfully.
6. Develop healing and trauma-sensitive relationships with peers and staff.

7. Report all intended, serious harm to self or others immediately to the appropriate person.

Demonstrating Confidentiality Certified Peer Specialists will:

1. Know state and federal confidentiality standards, including directives from his or her own agency.
2. Maintain the utmost confidence concerning all verbal and written information, whether obtained from peers or otherwise.
3. Know information that is not to be kept in confidence: intended, serious harm self or others, and know how to handle these situations.

"Hope is the thing with feathers, that perches in the soul
And sings the tune without the words
And never stops at all."
— EMILY DICKINSON

OBJECTIVE

To allow the members of the group to express any concerns they may have about the Peer Specialist training and to develop personal and group goals for the training.

To learn about SAMHSA's Definition of Recovery.

METHOD

Have the participants form three groups to discuss the following topics:

- Hopes for the training
- Fears about the training
- Goals for the training, both as a group and individually
- Introduce SAMHSA's Definition of Recovery

(Have the groups move to separate areas in order to have their discussions).

- ✓ Each group chooses someone to record the ideas and present them to the class at the end of the exercise.
- ✓ After about 30 minutes the recorders are asked to share their information with the rest of the group.
- ✓ Facilitators will discuss with the group the hopes, fears and goals created by the members. Everyone develops a list of group goals; facilitators need to review them occasionally to make sure the group is on track with them. (Take approximately 30 minutes for this portion).
- ✓ Review SAMHSA's Definition of Recovery and reference the handout. Introduce other recovery models if desired.

Ask the class the following question. Discuss for five minutes and give them the correct answer.

Key Point …

What is the primary role of the peer specialist in working with a peer recipient?

Answer: **Sharing experience, techniques and tools that have assisted the Peer Specialist in their own recovery.**

SAMHSA's Definition of Recovery

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

• • • Break 15 minutes • • •

Strength-Based Recovery (45 MINUTES)

The traditional mental health and substance abuse delivery systems were highly influenced by the medical model, which emphasizes pathology, focusing on problems and failures in people with mental illnesses and substance use disorders. The basic approach is diagnosis and treatment.

The strength-based approach allows practitioners and Peer Specialists to acknowledge that every individual has a unique set of strengths and abilities that he/she can rely on to overcome problems. This approach is **person-centered** as opposed to disease centered.

The strengths perspective is fundamental to a true recovery approach. If you believe that a peer recipient has their own strengths to deal with challenges, you empower them to solve problems now and in the future. The six principles of strength-based recovery are:

1. **The focus is on the person's strengths, not pathology, symptoms, weaknesses, problems or deficits.** Focusing on problems at best restores a person to the status quo. Developing their strengths and encouraging their goals leads to growth and accomplishments. The focus is person-centered and positive.

2. **Social interactions within the community are viewed as a source of support, not as an obstacle to working with peers.** The wider community is the foundation of mental health and substance use disorder treatment. There are far more naturally occurring resources than those that can be provided by traditional mental health and substance abuse treatment teams. The emphasis is on engaging peers in existing, normal services, as opposed to creating services for use only by one group.

3. **Interventions are based on the principle of peer's self-determination.** Nothing is done without the peer's approval. The peer is the director and as such has the right to make decisions that succeed—or mistakes to learn from.

4. **The Peer Specialist/Peer Recipient relationship is primary and essential.** The Peer Specialist needs to be there beside the peer recipient when the going gets tough. Peers need trusted relationships to confide in, and to share their joys and sorrows.

5. **Assertive outreach is the preferred mode of intervention.** It is preferable to interact with a peer in the community, such as; at the park, their home, or a café, rather than to see them in an office. Peer Specialist will learn more about their peer recipient when they engage in the context of their environment.

6. **Peers with serious mental illness or addiction continue to grow, to learn, and to change.** The strengths-based recovery approach is goal oriented. The

central and most crucial element is the extent of which peers set goals would like to achieve in their lives.

OBJECTIVE

To provide trainees with a process to use a strength-based approach.

METHOD

- Review with the participants the six principles of strength-based recovery.
- Have each participant pick a partner and share a simple problem that they do not mind sharing with the class. It can be relatively simple like watching too much TV or wanting to eat healthier.
- Participants will practice with each other the three-step approach to identify issues, strengths and formulate plans.

STAGE 1 – EXPLORING THE PRESENT STATE OF AFFAIRS[2]

The first step of Stage 1 is for the Peer Specialist to help the individual look at, identify and clarify a problem or concern in the peer's life.

- This step involves helping the peer to focus on his/her main concerns and to talk about them in terms of real feelings, experiences, and behaviors.
- The second step of Stage 1 is helping the peer identify strengths that have worked in the past or the peer could try in the future.
- To assess for strengths, Peer Specialists need to review four areas:

    - Personal attributes
    - Skills/abilities/talents
    - Cultural strengths
    - Environment strengths

STAGE 2 – DEVELOPING A PREFERRED SCENARIO

During Stage 2, the Peer Specialist helps the peer develop a vision of a better future and begin to plan actual changes that are necessary to make it happen.

- The Peer Specialist helps the peer set realistic goals for change and commitment for action to attain those goals.

[2] Adapted from Eagan's Helping Model

STAGE 3 – FORMULATING STRATEGIES AND PLANS

During Stage 3, the Peer Specialist helps the peer brainstorm a range of approaches for reaching the desired goals and then helps him/her put together solid action plans that are realistic in terms of the resources available. The Peer Specialist focuses on the person's ability and strengths to help them build confidence.

Positive Thinking (30 MINUTES)

A belief that personal growth and change are possible is one of the core beliefs for a Peer Specialist. The Peer Specialist must bring an outlook on peer support that inspires hope and recovery. To do so, they must maintain an attitude that is positive and reaffirming. This exercise can help participants take a quick snapshot of where they are currently and help identify areas for improvement.

OBJECTIVE

To encourage positive thinking in the Peer Specialist, and evaluate their overall attitude towards other people and situations.

METHOD

- Read the following information and briefly discuss with class.
- Ask trainees to answer the survey "Am I Positively Charged?"
- A short recap on attitudes is completed with the class.

POSITIVE WORKS![3]

Positive attitudes make life … more exciting. No matter what we do, attitudes go a long way toward making life a joy or a pain. Friendliness, cooperation and dependability make life easier. Days pass quickly and our environment should be pleasant places to be. Positive attitudes are emotional lifts that give an optimistic outlook to life in general.

BEING POSITIVE

Being positive works! It helps us thrive. Having a positive approach can help us make lives more satisfying, and can fulfill many of our personal needs.

Being with positive people can make us feel good because their "positiveness" is infectious—for some, we could even say it's explosive! When we are with these positive people, we often feel their energy; there's excitement in the air. They get us charged up, feeling great and ready to tackle anything. Having a positive outlook makes us more exhilarating and dynamic to be around as well. These positive charges easily rub off on others. You can have that same thrilling effect on people.

[3] Adapted from Positive Works, a public publication by Alberta Career Development and Employment.

Being negative, on the other hand, is an emotional drain that deflates those around us and us. This attitude makes us feel unhappy and unfulfilled. Since our personal outlook affects our work and the people we work with, let's make our attitudes work for us, not against us.

Not surprisingly, when things are difficult, it might be hard to be positive at all. Dealing with tough problems or situations can make it difficult for us to focus on any activity and often takes away our ability to be positive. By taking a closer look at our situation, we may see where and how we could become more positive. And being more positive can help us cope with and maybe even resolve those problems.

To determine if your attitudes are working for you and not against you, try the following survey, "Am I Positively Charged?"

"The remarkable thing is, we have a choice everyday regarding the attitude we will embrace for that day."
— CHARLES R. SWINDOLL

Am I Positively Charged?

Here's an opportunity for you to evaluate your attitude toward others and the situations you may find yourself in. This survey may help you to assess how positive or negative you tend to be overall, and determine if any areas need some attention. Beside each question, write the number that most closely represents your answer most of the time. Go with your first reaction!

3 – Mostly Yes **2 – Sometimes** **1 – Mostly No**

1		Am I friendly?
2		Do I refrain from being a complainer?
3		Can I be optimistic when others are depressed?
4		Do I have a sense of duty and responsibility?
5		Do I control my temper?
6		Do I speak well of my employer?
7		Do I feel well most of the time?
8		Do I follow directions willingly, asking questions when necessary?
9		Do I keep promises?
10		Do I organize my work and keep up with it?
11		Do I readily admit my mistakes?
12		Is it easy for me to like nearly everyone?
13		Can I stick to a tiresome task without being prodded?
14		Do I realize my weaknesses and attempt to correct them?
15		Can I take being teased?
16		Do I avoid feeling sorry for myself?
17		Am I courteous to others?
18		Am I neat in my personal appearance and work habits?
19		Do I respect the opinions of others?
20		Can I adapt to new and unexpected situations readily?
21		Am I tolerant of other people's beliefs?
22		Do I refrain from sulking when things go differently than I'd like?
23		Am I a good listener?
24		Am I the kind of friend I would like others to be?
25		Can I disagree without being disagreeable?
26		Am I normally punctual?
27		Do I consider myself a courteous driver?
28		Do I generally speak well of others?

29		Can I take criticism without being resentful or feeling hurt?
30		Do I generally look at the bright side of things?
31		Can I work with someone I dislike?
32		Am I pleasant to others even when I feel displeased about something?
33		Am I enthusiastic about the interests of others?
34		Do I tend to be enthusiastic about whatever I do?
35		Am I honest and sincere with others?

Add up your total score: _____

SCORING:

There are 35 questions so the maximum score would be 105. Total your score and rate yourself according to the following scale:

95-105 You are a positive marvel. Keep it up as you bring sunshine into the world.

75-94 Your positives are definitely admirable! You have much to give to others.

45-74 Your positives could use a bit more polish. Look at some small changes that would help your attitude.

Below 45 Your positives have almost fizzled. Take a close look at your attitude. You may need to pay particular attention to those questions you answered with a 1. Can you see any room for improvement?

Key Point …

Remember, peer support is strengths-based and focuses on helping peers live a self-directed life.

Common characteristics Of a Recovery Vision

	Mental Illness	Addiction
Goals	To assist people affected by mental illnesses reduce the impairment and disability, and improve quality of life	To assist people affected by addiction disorders, reduce the impairment and disability, and improve quality of life
Role of person with disability	Person is agent of recovery. Active involvement is necessary for recovery	Person is agent of recovery. Active involvement is necessary for recovery.
Principles	• Broad heterogeneity of population and outcomes • Focus on person and environment • Long-term perspective • Recovery is a process and a continuum • Non linear process of recovery • Family involvement is helpful • Peer support is crucial • Spirituality may be critical component of recovery • Multiple pathways to recovery	• Broad heterogeneity of population and outcomes • Focus on person and environment • Long-term perspective • Recovery is a process and a continuum • Non linear process of recovery • Family involvement is helpful • Peer support is crucial • Spirituality may be critical component of recovery • Multiple pathways to recovery
Values	• Person-centered • Partnership {person involvement) • Growth • Choice • Strengths perspective • Focus on wellness and health	• Person-centered • Partnership {person involvement) • Growth • Choice • Strengths perspective • Focus on wellness and health
Strategies to Facilitate Recovery	• Treatment i.e.: Crisis intervention, medication, therapy, illness management education • Community support (connection to peer-support and recovery organizations) • Skills for valued roles • On-going, flexible recovery-enhancing serv1ces • Advocacy	• Treatment i.e.: post-treatment monitoring, early re-intervention, medication, therapy • Community support (assertive linkages to communities for recovery) • Skills for valued roles • Ongoing, flexible recovery-enhancing serv1ces • Advocacy

Essential ingredients of Recovery-oriented System	• Treatment • Rehabilitation • Peer support • Community Support • Legal Aid • Enrichment • Basic Support • Family education and support	• Treatment • Rehabilitation • Peer support • Community Support • Legal Aid • Enrichment • Basic Support • Family education and support
Societal Attitudes	• Historically, prognosis was considered hopeless • Debates about cause(s) and nature of illness • Criminalization of illness • Prejudice and discrimination	• Historically, prognosis was considered hopeless • Debates about cause(s) and nature of illness • Criminalization of illness • Prejudice and discrimination

[4]

[4] White, W., Boyle, M, & Loveland, D. "Recovery from addiction and recovery from mental illness: Shared and contrasting lessons," American Psychological Association, Washington, D.C., 2004.

Homework: Why Peer Support?

(5 MINUTES)

OBJECTIVE

To have the potential Peer Specialist think about how meeting with a peer will benefit them and the peer.

METHOD

- Trainees are instructed to answer the question "Why peer support?" They are asked to look at this question in the role of a Peer Specialist and from the role of a peer.

- They can graph their answers according to the example below.

Benefits to the peer:	**Benefits to you:**

WHY PEER SUPPORT EXAMPLE

Benefits to the peer:	**Benefits to you:**
Exposure to management skills that emphasize strengths	Experience of connection and giving back
Friendship	Learn how to cooperate better
Real person to talk to rather than on the phone or feeling like a number	Sense of pride and accomplishment with friends and family
Sense of worth	Self-esteem builder
Social skills	Provides a true sense of worth
Confidence builder	Confidence builder
Comfort and compassion	Work-type experience
Hope	Learn about yourself
Support	Supporting others
Sense of humor	Friendship
Better understanding of what help is available	Giving back to the community
Someone who can relate	Helping yourself to stay well and mentally healthy
Exposed to a different perspective of mental illness	Sharing your experiences and knowledge with others who might benefit from it.

It is one of the beautiful compensations of this life that no one can sincerely try to help another without helping himself."

- CHARLES DUDLEY WARNER

Additional Homework:

Participants are asked to do the following reading before the next session:

- SAMHSA's Working Definition of Recovery
- National Consensus Statement on Mental Health Recovery
- Wisconsin Certified Peer Specialist Code of Ethics
- Core Competencies for Wisconsin Certified Peer Specialists
- Select a book on mental health and begin reading for book report. You can select one below or another of your choosing. Books can be obtained at your local library or online at Amazon.

Brampton, Sally, *Shoot the Damn Dog: A Memoir of Depression,* W.W. Norton & Co., June 2008.

Chamberlin, Judi, *On Our Own: Patient-Controlled Alternatives to the Mental Health System,* National Empowerment Center, November, 2012.

Copeland, Mary Ellen, *Living Without Depression and Manic Depression: A Workbook for Maintaining Mood Stability,* New Harbinger Workbooks, October 1994.

Copeland, Mary Ellen, *Wellness Recovery Action Plan & Peer Support: Personal, Group and Program Development,* Peach Press, 2004.

Coates, Eric, *Hearing Voices: A Memoir of Madness,* Create Space Independent Publishing Platform, 2012.

Cronkite, Kathy, *On the Edge of Darkness: Conversations About Conquering Depression,* Delta, July 1995.

Inman, Lora, *Running Uphill,* High Pitched Hum Publishing, January, 2008.

Jamison, Kay Redfield, *An Unquiet Mind: A Memoir of Moods and Madness,* Vintage, October, 1996.

Kramer, Peter D., *Against Depression,* Penguin Books, July, 2006.

Martha Manning, *Undercurrents (A Therapist's Reckoning with Depression)* Harper One, November, 1995.

Mead, Shery, *Intentional Peer Support: An Alternative Approach*, Amazon Digital Services, 2015.

Rapp, Charles A., *The Strengths Model: A Recovery-Oriented Approach to Mental Illness,* Oxford University Press, October, 2011.

Solomon, Andrew, *The Noonday Demon: An Atlas of Depression,* November, 2011.

Styron, William., *Darkness Visible: A Memoir of Madness,* Vintage, January 1992.

Whybrow, Peter C., *A Mood Apart: Depression, Mania, and Other Afflictions of The Self,* Basic Books, May 2015.

Additional Readings and Resources:

"What is Substance Abuse Disorder? (SUD)"
https://www.dhs.wisconsin.gov/aoda/sudindex.htm

"Mental Health and Addiction Treatment Systems: Philosophical and Treatment approach Issues,"
http://www.dualdiagnosis.org/resource/patient-assessments/treatment-systems/

Recovery Stories from the National Empowerment Center website.
http://www.power2u.org/recovery-stories.html

Eleanor Longden, ***Hearing Voices in My Head***
https://www.youtube.com/watch?v=syjEN3peCJw

"Recovery" by the Mental Health Association
http://www.mentalhealth.org.uk/help-information/mental-health-a-z/r/recovery/

"Declaration of Peer Roles"
http://www.psresources.info/declaration-of-peer-roles

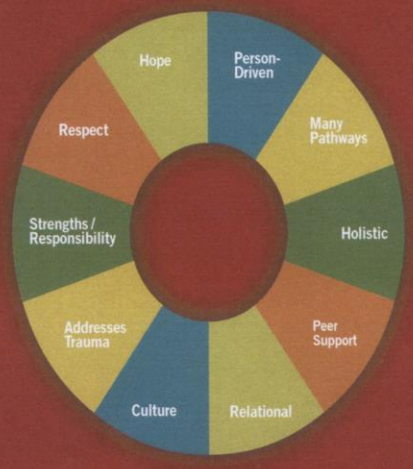
REVIEW QUESTIONS:

1. **What do you think helps people change and grow? What do you think can stand in the way of positive change?**
2. **What is strengths based recovery?**
3. **It is important to bring an outlook of peer support that inspires hope and recovery. What are some activities you can use to maintain a positive and supportive attitude?**
4. **After reading the information from SAMHSA's, what are the 10 guiding principles of recovery?**

Session 1 Homework Handouts

(The following handouts from SAMHSA and the National Consensus Statement can be put into participant's folders.)

SAMHSA's
WORKING DEFINITION OF
RECOVERY



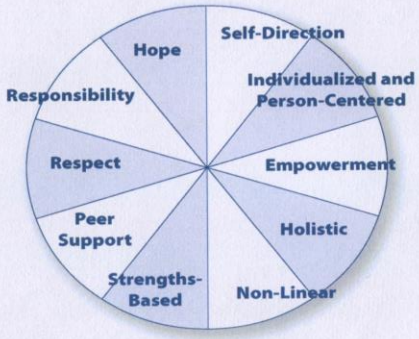
10 GUIDING PRINCIPLES OF RECOVERY

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

- **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect:** Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Components of Recovery



Resources
www.samhsa.gov
National Mental Health Information Center
1-800-789-2647, 1-866-889-2647 (TDD)

NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

Background

Recovery is cited, within *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, as the "single most important goal" for the mental health service delivery system.

To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004.

Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings.

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

The 10 Fundamental Components of Recovery

- **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

WISCONSIN CERTIFIED PEER SPECIALIST CODE OF ETHICS

The following principles will guide Certified Peer Specialists in their professional roles and relationships:

1. I understand that my primary responsibility is to help peers understand recovery and achieve their own recovery needs, wants, and goals. I will be guided by the principle of self-determination for each peer.

2. I will conduct myself in a manner that fosters my own recovery and I recognize the many ways in which I may influence peers, and others in the community, as I serve as a role model.

3. I will be open to share with peers and coworkers my stories of hope and recovery and will likewise be able to identify and describe the supports that promote my recovery and resilience.

4. I have a duty to inform peers when first discussing confidentiality that intended serious harm to self or others cannot be kept confidential. I have a duty to accurately inform peers regarding the degree to which information will be shared with other team members, based on my agency policy and job description. I have a duty to inform appropriate staff members immediately about any intended serious harm to self or others or abuse from caregivers.

5. I will never intimidate, threaten, harass, unduly influence, physically force or restrain, verbally abuse, or make unwarranted promises of benefits to the peers I support.

6. I will not practice, condone, facilitate or collaborate in any form of discrimination on the basis of ethnicity, race, sex, sexual orientation, gender identity, age, religion, national origin, marital status, political belief, disability, or any other preference or personal characteristic, condition or state.

7. I will advocate with peers so that individuals may make their own decisions when partnering with professionals.

8. I will never engage in any sexual/intimate activities with peers I support. While a peer is receiving services from me, I will not enter into a relationship or commitment that conflicts with the support needs of the peer.

9. I will keep current with emerging knowledge relevant to recovery and openly share this knowledge with my coworkers and peers. I will refrain from sharing advice or opinions outside my scope of practice with peers.

WISCONSIN CERTIFIED PEER SPECIALIST CODE OF ETHICS

10. I will utilize supervision and abide by the standards for supervision established by my agency. I will seek supervision to assist me in providing recovery-oriented services to peers.

11. I will not accept gifts of money or items of significant value from those I serve. I will not loan or give money to peers.

12. I will protect the welfare of all peers by ensuring that my conduct will not constitute physical or psychological abuse, neglect, or exploitation. I will practice with trauma awareness at all times.

13. I will, at all times, respect the rights, dignity, privacy and confidentiality of those I support.

14. As a professional, if I find that my own recovery journey is compromised and interferes with my ability to provide support to my peers, I will engage in my own self-care until such time that I am once again capable of providing professional care.

Wisconsin
Department of Health Services
Division of Mental Health and Substance Abuse Services

P-00972A (02/2015)

CORE COMPETENCIES FOR WISCONSIN PEER SPECIALISTS

DOMAIN 1: VALUES

1.1 Believes that recovery is an individual journey with many paths and is possible for all
1.2 Believes in and respects people's rights to make informed decisions about their lives
1.3 Believes that personal growth and change are possible
1.4 Believes in the importance of empathy and listening to others
1.5 Believes in and respects all forms of diversity (As included in Wisconsin State Council on Alcohol and Other Drug Abuse Cultural Diversity Committee's definition of Cultural Competency: http://scaoda.state.wi.us/docs/main/CulturalCompetencyDefinition.pdf)
1.6 Believes in the importance of self-awareness and self-care
1.7 Believes in lifelong learning and personal development
1.8 Believes that recovery is a foundation of well-being
1.9 Believes that recovery is a process
1.10 Believes in the healing power of healthy relationships
1.11 Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery

DOMAIN 2: IN-DEPTH KNOWLEDGE OF RECOVERY

2.1 Knowledge of SAMHSA's definition of recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/)
2.2 Knowledge of mental health and substance use disorders and their impact on recovery
2.3 Knowledge of the basic neuroscience of mental health and addiction
2.4 Knowledge of stages of change and recovery
2.5 Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.6 Knowledge of trauma and its impact on the recovery process
2.7 Knowledge of person-centered care principles
2.8 Knowledge of strengths-based planning for recovery
2.9 Knowledge of the impact of discrimination, marginalization, and oppression
2.10 Knowledge of the impact of internalized stigma and shame

CORE COMPETENCIES FOR WISCONSIN PEER SPECIALISTS

DOMAIN 3: ROLES AND RESPONSIBILITIES OF A CERTIFIED PEER SPECIALIST

3.1 Knowledge of the rights of peers seeking support, such as state and federal law regarding client rights, civil rights, and the Americans with Disabilities Act (ADA)
3.2 Knowledge of ethics and boundaries
3.3 Knowledge of the scope of practice of a Certified Peer Specialist
3.4 Knowledge of confidentiality standards
3.5 Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
3.6 Knowledge of appropriate use of self-disclosure
3.7 Knowledge of cultural competency (As defined by Wisconsin State Council on Alcohol and Other Drug Abuse Cultural Diversity Committee: http://scaoda.state.wi.us/docs/main/CulturalCompetencyDefinition.pdf)

DOMAIN 4: SKILLS

4.1 Ability to bring an outlook on Peer specialist that inspires hope and recovery
4.2 Ability to be self-aware and embrace and support own recovery
4.3 Ability to problem-solve
4.4 Ability to assist people in exploring life choices, and the outcomes of those choices
4.5 Ability to identify and support a person in crisis and know when to facilitate referrals
4.6 Ability to listen and understand with accuracy the person's perspective and experience
4.7 Effective written and verbal communication skills
4.8 Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.9 Ability to recognize and affirm a person's strengths
4.10 Ability to foster engagement in recovery
4.11 Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.12 Ability to facilitate and support a person to find and utilize resources
4.13 Ability to work collaboratively and participate on a team
4.14 Ability to know when to ask for assistance and/or seek supervision
4.15 Ability to set, communicate, and respect personal boundaries of self and others
4.16 Ability to utilize own recovery experience and skillfully share to benefit others
4.17 Ability to balance own recovery while supporting someone else's
4.18 Ability to foster the person's self-advocacy and provide advocacy when requested by the person
4.19 Ability to advocate for self in the role of a Certified Peer Specialist

Session 2

FACILITATOR INFORMATION:

Session 2 begins with a discussion of the homework and review of SAMHSA's working definition of recovery. As this is the recovery model referenced in the Core Competencies, it is emphasized in the curriculum. Facilitators are encouraged to share material on other models based on the interests and composition of the group.

The concept of empathy is introduced to participants. This concept is further developed in future sessions. The principles of intentional peer support are introduced with an opportunity for participants to identify examples.

Participants are encouraged to look at their own beliefs and values with information on legal considerations and confidentiality explained. It is important that facilitators reference this information in future sessions as examples arise.

There is an opportunity for participants to role-play the Peer Specialist role. Facilitators are encouraged to promote the role-play as a fun and creative exercise designed to increase skills and confidence.

Peer Specialist Facilitator Curriculum Guide

SESSION 2

15 MINUTES Discussion of homework using list of possible responses.
Review of the recovery models of SAMHSA, National Consensus Statement, and facilitator's information.

20 MINUTES The Helpful Responses (Empathy) Questionnaire

20 MINUTES What is Intentional Peer Support?

15 MINUTES Break

40 MINUTES Beliefs and values

35 MINUTES Ethics and Legal Considerations

15 MINUTES Break

20 MINUTES Confidentiality

25 MINUTES Peer Specialist role-play

5 MINUTES Homework: Self-Assessment Handout.

CPS CORE CRITERIA COVERED

1.1 Believes that recovery is an individual journey with many paths and is possible for all
1.2 Believes in and respects people's rights to make informed decisions about their lives
1.4 Believes in the importance of empathy and listening to others
1.7 Believes in lifelong learning and personal development
1.9 Believes that recovery is a process
3.4 Knowledge of confidentiality standards

Discussion of Homework (15 MINUTES)

METHOD

- The trainees will be asked to read their answers to the homework question – "Why Peer Support?"
- One of the facilitators will write the answers down on an easel pad.
- The group will compare their answers to the answers given in the facilitator's guide.
- Ask participants for comments regarding the recovery models they read. What did they learn? What have they learned about recovery from their own experiences?

Key Point …

Remember, each person on an individual basis defines recovery. What works for one person may not be the best approach for someone else. Recovery is lifelong learning and personal development.

The Helpful Responses (Empathy) Questionnaire (20 MINUTES)

Empathy is defined by Webster's as: The ability to understand and share the feelings of another.

It is one of the most helpful tools for the Peer Specialist. Empathy validates the feelings of another person and helps them feel understood and accepted.

OBJECTIVE

To provide a base line of the capabilities trainees have prior to the training. A comparison will be made at the end of the training course.

METHOD

- The Helpful Responses Questionnaire is reviewed.
- Trainees are asked to give short responses to the scenarios given in the questionnaire. Questionnaires need to have the trainees name and date written on them.
- After approximately 20 minutes the facilitators will gather the questionnaires and save them for comparison with the questionnaire completed at the last class.

The Helpful Responses (Empathy) Questionnaire[5]

PRE AND POST TRAINING FEEDBACK

Instructions: The following six paragraphs are things that a person might say to you. For each paragraph imagine that someone you know is talking to you and explaining a problem that he or she is having. You want to help by saying the right thing. Think about each paragraph as if you were really in the situation, with that person talking to you. In each case, write the next thing that you would say to be helpful. Write only one or two sentences for each situation. Please print or write clearly.

1. A 41-year-old woman says to you: "Last night Joe got really drunk and he came home late and we had a big fight. He yelled at me and I yelled back and then he hit me really hard! He broke a window and the TV set too! It was like he was crazy. I just don't know what to do!"

YOUR RESPONSE:

_____

_____

2. A 36-year-old man tells you: "My neighbor is really a pain. He's always over here bothering us or borrowing things that he never returns. Sometimes he calls us late at night after we've gone to bed and I really feel like telling him to get lost."

YOUR RESPONSE:

_____

_____

3. A 15-year-old girl tells you: "I'm really mixed up. A lot of my friends, they stay out real late and do things their parents don't know about. They always want me to come along and I don't want them to think I'm weird or something, but I don't know what would happen if I went along either."

YOUR RESPONSE:

_____

_____

[5] Adapted from CMHA BC Division Consumer Development Project.

4. A 35-year-old parent says: "My Maria is a good girl. She's never been in trouble, but I worry about her. Lately she wants to stay out later and later and sometimes I don't know where she is. She just had her ears pierced without asking me! And some of the friends she brings home…Well, I've told her again and again to stay away from that kind. They're no good for her, but she won't listen."

YOUR RESPONSE:

_____

_____

5. A 43-year-old man says: "I really feel awful. Last night I got drunk again and I don't even remember what I did, but my wife isn't talking to me. I don't think I'm an alcoholic, you know, because I can go for weeks without drinking. But this has got to change."

YOUR RESPONSE:

_____

_____

6. A 59-year-old unemployed teacher tells you: "My life just doesn't seem worth living anymore. I'm a lousy father. I can't get a job. Nothing good ever happens to me. Everything I try to do turns rotten. Sometimes I wonder whether it's worth it."

YOUR RESPONSE:

_____

_____

Name _____ Date_____

What is Intentional Peer Support[6]

(20 MINUTES)

Intentional Peer Support is a way of thinking about and inviting transformative relationships. Peers learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and support and challenge each other in trying new things.

IPS is different from traditional service relationships because:

- **IPS relationships are viewed as partnerships** that invite and inspire both parties to learn and grow, rather than as one person needing to 'help' another.
- **IPS doesn't start with the assumption of a problem.** With IPS, each of us pays attention to how we have learned to make sense of our experiences, then uses the relationship to create new ways of seeing, thinking, and doing.
- **IPS promotes a trauma-informed way of relating.** Instead of asking "What's wrong?" we learn to ask "What happened?"
- **IPS examines our lives in the context of mutually accountable relationships and communities –** looking beyond the mere notion of individual responsibility for change.
- **IPS encourages us to increasingly live and move towards** what we want instead of focusing on what we need to stop or avoid doing.

Intentional Peer Support utilizes four basic principles or tasks to accomplish its goals:

Connection

When an individual enters the road to recovery, there may be something unresolved in their lives at that moment. A disconnect…a force that potentially can separate people from themselves, their loved ones, their higher power, and sometimes humanity. A disconnect is alienating and lonely. Connection is the antidote to alienation. It provides a sense of belonging, an awareness or feeling united to something or someone.

Learning to connect with one's self and with others in a healthy way is the essence of what we mean by support. Connection provides the basis for addressing and overcoming the effects of mental illness and substance use disorders. Having healthy connections to self and others means that our method of communicating and relating serves to support and encourage rather than to deplete and discourage. Boundaries…direct, honest,

[6] Adapted from "Intentional Peer Support," www.IntentionalPeerSupport.com

respectful communication and hopefulness are some of the components that are used for making and sustaining healthy connections.

Worldview

Worldview is becoming self-aware of how we have learned to think about and understand our experiences in the world around us…while at the same time being curious and interested in the worldview of others. When a trusting and open relationship develops (which takes time) we gently begin to challenge the ways each of us has learned to make meaning of our experiences.

Mutuality

It is in a relationship that is based on mutual respect and trust that we allow ourselves to "try on" new ideas and take risks to learn and grow. One person is not more important than the other because in IPS, the relationship is based on "we" or "us".

In this mutual relationship, we consider each person to have needs and expertise, thus we learn from each other. It is *not* power over another, or even working to support one person in the relationship. It is "we" creating a new story that has the potential to change both persons' lives.

Moving Toward

In Intentional Peer Support, we do not ask, "What are we here to avoid or stop? Instead, we ask, "What are we here to create?" or "What are we here to do?" We don't practice moving away from what we don't want…we practice the focus of what we want to move toward.

Intentional Peer Support practices these four tasks by changing the language of fear to conversations of hope.

- Hope-Based Responses see every situation as an opportunity to learn and grow.
- Hope-Based Responses are non-judgmental and avoid assumption about what peoples' experience means.
- Hope Based Dialogues are created through each other's willingness to seek out different ways of talking about their experiences.

OBJECTIVE

To introduce the concept of Intentional Peer Support (IPS)

METHOD

- Have the class read the information of IPS.
- Divide the class into four groups assigning one of the basic principles or tasks to each group.
- Instruct the groups to list examples of each principle and how they can be put into action.
- Have each group pick a spokesperson.
- After 10 minutes, have the groups return and report on the principles.

Break 15 minutes

Beliefs and Values (40 MINUTES)

OBJECTIVE

- To encourage participants to be aware of how the beliefs and values that people have influence the decisions they make.

METHOD

- Have the class read the section on beliefs and values.
- Provide trainees with an opportunity to discuss the information they have just read.
- Facilitators encourage the group to express their opinions about the material on beliefs and values.
- Ask participants the following question.

Question:
How could you effectively support a peer whose values were very different from your own?

Answer: Acknowledge the differences and ask the peer if they would like to discuss them.

"Your beliefs become your thoughts,
Your thoughts become your words,
Your words become your actions,
Your actions become your habits,
Your habits become your values,
Your values become your destiny."

— MAHATMA GANDHI

Beliefs and Values

- Beliefs and values strongly influence the choices individuals make and their resulting behavior. For example, someone who believes in having "lucky days" may gamble away large sums of money.

- Individuals are not always aware of the beliefs and values that are affecting their behavior. For example, a person might constantly sabotage his chances for success because deep down inside he feels unworthy. Another example would be a person who believes that she is not racist but every time she encounters a black male on the street, she unconsciously holds her purse tighter. Such a person's behavior is being affected by racist stereotypes that she is not necessarily aware of at the conscious level.

- Beliefs and values are sometimes taken as undisputed "truths" that are not questioned by an individual or a culture as a whole. For example, some individuals believe that the bible is the word of God and represents an undisputable "truth." Another example would be a culture that believes that women are the "weaker sex" and as a result, have little power in that society.

- Cultures and individuals frequently profess to hold certain beliefs and values but end up behaving in an opposite manner. For example, even though the Charter of Rights gives equal status to gays and lesbians, until the recent Supreme Court Ruling, state law could still discriminate against them. Likewise, a father might profess to be non-racist but reacts when his daughter informs him that she is marrying a black man.

- The development of beliefs and values is strongly influenced by the person's social environment. In early years, parents play a major role. During adolescence, parental values are often rejected for those of peers. As adults, individuals may revert to parent's beliefs and values. Also, cultural factors such as religion, the media, and laws also influence the beliefs and values that an individual adopts during the course of their life.

- Most beliefs and values are formed in response to some basic needs. For example, a young child adopts parental beliefs and values out of a need to be loved and approved of by the parents. Similarly, a teenager might drastically change his beliefs in response to the need for a sense of belonging and approval from peers.

- Effective Peer Specialists will ideally exhibit an attitude of tolerance towards other people's beliefs and values and constantly question whether they are judging someone through their own personal biases. Thus it is important for Peer Specialists to continually examine their own beliefs, values and attitudes.

Ethics and Legal Considerations:

(35 MINUTES)

It is important that Peer Specialists are familiar and understand the code of ethics for Peer Specialists and how to provide safe and ethical peer support. It is important to emphasize the team approach to care with the Peer Specialist as an important member of the team.

OBJECTIVE

- To give the trainees an understanding of the ethical and legal obligations as a Peer Specialist.
- To provide an opportunity for trainees to discuss and understand the roles of a Peer Specialist.

METHOD

- Facilitators will review the Code of Ethics assigned as homework last session.
- Facilitators will also read the following page; "Legal Considerations."
- Facilitators will discuss these readings with the group.
- Facilitators will then ask the class the following questions:

1. You notice large bruises on the service recipient you are visiting. What you ask her about them, she insists they are nothing. What, if anything, should you do?

2. One of your service recipients has informed you that she is drinking daily increasing amounts of alcohol. What would you do?

3. A service recipient discusses with you a counselor at another organization reporting that she overheard the counselor labeling her to another counselor. As a Peer Specialist, what should you do?

5. During a home visit, a service recipient share that they feel like killing themselves. What should you do?

Key Point …

Supervision and consultation promote safe and ethical peer support.

Legal Considerations

EXERCISE CAUTION IN YOUR WORK

Being careful means exactly that: **Don't do anything rash that could have harmful consequences for you or your peer**. Follow the guidelines laid down by the Peer Specialist training. Perform the duties and services described in your job description; if you wish to perform other services or tasks for your service recipient, discuss them first with your supervisor. Always observe the rules and regulations of the organization you are working with, or any instructions from their doctor. Whenever you are in doubt about what you should do, talk with your supervisor.

CONFIDENTIALITY

In the course of your regular visits, a peer may reveal intimate details of his or her life, family relationships, or various problems. What is told to you in confidence must remain just that – confidential. To ensure confidentiality, many peer programs require that Peer Specialists understand the rules of HIPPA, DHS94, and policies and procedures related to confidentiality. Peer Specialists are able to share information within a treatment team as this is not a breach of confidentiality.

Confidentiality is broken frequently in the medical and mental health fields. Unfortunately, it is not uncommon for even professionals to talk about a client on an elevator or a public place. Sign in sheets at physician offices often display confidential information that anyone can read in spite of handing out information on HIPPA.

A celebrity or public figure may have confidentiality breached. One of the most famous examples of this is Thomas F. Eagleton, a former United States senator. His legislative accomplishments were overshadowed by his removal as the Democratic vice presidential candidate in 1972 after it was revealed that he had a history of treatment for depression. It was never clarified how information about Mr. Eagleton became public but it forced him to step down for the candidacy after just 18 days.

Confidentiality is the cornerstone of trust in relationships and Peer Specialists must use the utmost caution in protecting peer recipients.

Key Point …

One of the most important roles of the Peer Specialist is to maintain confidentiality.

• • • Break 15 minutes • • •

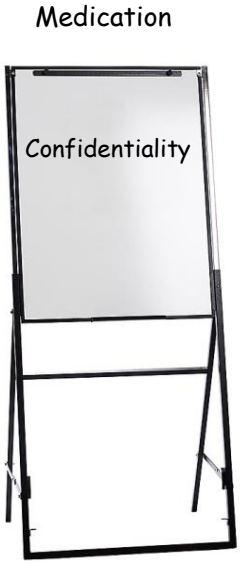
Confidentiality (25 MINUTES)

OBJECTIVE

Trainees to develop an understanding of confidentiality and the legal limits in the Peer Specialist relationship.

METHOD

Write the following on the flip chart as a starting point for the following discussion.



Confidentiality is the Cornerstone of Trust

Read the following scenario, and ask the group to discuss if and how confidentiality was breached:

Jane is a Peer Specialist meeting with her peer at a local restaurant when Sally, a friend of hers, comes up and starts talking

"Hi Jane, whatcha up to?"

"Hey Sally, I'm just hanging out, doing my Peer Specialist stuff. This is Paula, my peer. We're having a meeting right now, so I'll call you later."

Lead a discussion with the group about how important it is to maintain confidentiality, and what this means. This is especially important in smaller communities, where people are more likely to know each other.

WATCH FOR:

- Using a person's name where someone can hear it and draw conclusions.
- Talking with other people about the individual.
- When/if confidentiality can and should be broken.
- Giving information that would let people recognize a person.

Key Point …

You do not keep confidentiality if a person is a danger to himself or others. Immediately discuss with your supervisor.

Peer Specialist Role Play (25 MINUTES)

OBJECTIVE

To demonstrate the impact of "positive" or "negative" listening skills in the helping relationship.

METHOD

- Divide the group into pairs. Take one member of each pair to a separate area and give each person a set of the following instructions. Explain that the idea is for the person to exaggerate the "negative" listening role to provide a clear picture of what makes for a poor listener. Have people rejoin their partners.
- Each pair goes to a private area of the room to complete the exercise.

For the first five minutes you will start the role-playing by being a Peer Specialist and your partner will be the peer. You will be a Peer Specialist who does the following:

NEGATIVE LISTENING SKILLS

- Makes little eye-contact with your partner, looks around the room or anywhere but at them.
- Moves about nervously in your chair like rocking back and forth or swinging a leg.
- After approximately 3 minutes you move closer to your partner (to within 3 feet) and stare at them.
- Gives any verbal responses that you feel are appropriate.

After about 5 minutes, you will get a signal to switch roles and become a Peer Specialist who does the following:

POSITIVE LISTENING SKILLS

- Makes good eye contact with your partner.
- Sits in an open posture, avoid crossing arms or legs.
- Leans slightly forward towards the other person at some points during the conversation; does not get too close.
- Gives responses that paraphrase what your partner is telling you. (Repeats what they have just told you in your own words).

After about five minutes, signal the individuals to stop and return to the group. Talk with the trainees to see how they felt with each of their roles.

Homework (5 MINUTES)

OBJECTIVE

To give trainees the chance to review some of their strengths and weaknesses and look at what Peer Specialist means to them.

METHOD

- Distribute "Self-Assessment for Peer Specialists" to trainees.
- The handout is to be filled out for homework, and trainees may keep their answers private.
- Facilitators are also encouraged to assign other reading and background material for the class.

"The most beautiful people I've known are those who have known trials, have known struggles, have known loss, and have found their way out of the depths."

– ELISABETH KÜBLER-ROSS

Additional Readings and Resources:

"Speaking from Experience: The Power of Peer Specialists, ***Helping Hands,*** from the National Health Care for the Homeless Council.
http://www.nhchc.org/wp-content/uploads/2013/11/healinghandsfall2013.pdf

National Association of Mental Health (NAMI). See fact sheets and resources.
https://www.nami.org

Mendota Mental Health Institute—Program of Assertive Community Treatment (PACT)
Information on the history, mission and services of PACT
https://www.dhs.wisconsin.gov/mendota/programs/pact-history.htm

The Transformation Center. Articles, self-assessment and resources.
http://transformation-center.org/home/training/certified-peer-specialists/

Brown, Brene, "On Empathy."
https://www.youtube.com/watch?v=1Evwgu369Jw

Brown, Brene, "Empathy, Not Sympathy."
https://www.youtube.com/watch?v=1Evwgu369Jw&list=PLmHmICyEzbjZELowSuV5_mM6Xv1kJ_wDc

Reamer, Frederic G., "Eye On Ethics: Challenge of Peer Support Programs," Social Work Today, Vol. 15, No. 4, August 2015.
http://www.socialworktoday.com/archive/072115p10.shtml

Articles on Empathy.
https://www.psychologytoday.com/basics/empathy

"Recovery and Wellness Lifestyle: A Self-Help Guide"
https://store.samhsa.gov/shin/content/SMA-3718/SMA-3718.pdf

Horvath, Tom, "What is Self-Empowering Recovery?" ***Addiction Treatment Methods, Living With Addiction***, June 2014.
http://www.rehabs.com/pro-talk-articles/what-is-self-empowering-recovery/

REVIEW QUESTIONS:

1. **How many approaches are there to recovery and is it possible for all?**
2. **Does everyone have a right to make informed decisions about their lives?**
3. **Give some examples of helpful empathy responses.**
4. **How do you integrate the belief on lifelong learning and personal development into your own life?**
5. **Does recovery have a beginning and end? Describe.**
6. **What are the circumstances where confidentiality can be breached?**

Session 2 Homework Handouts

Self-Assessment for Peer Specialists[7]

Name _____

Date _____

My strengths are:

_____

_____

I would like to learn/improve:

_____

_____

I get nervous when:

_____

_____

I am at my best with people when:

_____

_____

When people disagree with me, I:

_____

_____

As a volunteer I like to be rewarded by:

_____

_____

[7] Adapted from CMHA BC Division Consumer Development Project.

I feel intimidated by/when:

_____

_____

I feel good about myself when:

_____

_____

My personal support systems include:

_____

_____

I like people who:

_____

_____

Some things/activities that make me feel good:

_____

_____

When my illness challenges me I:

_____

_____

I get bored when people:

_____

_____

"Peer Specialist" for me, means:

_____

_____

Meeting new people is:

_____

_____

I handle disappointment by:

_____

_____

Being a team player means:

_____

_____

_____

_____

Section Two

Communication Skills

Session 3

FACILITATOR INFORMATION:

This is the first of four sessions focused on communication skills. Facilitators are encouraged to have participants practice skills both in the classroom and during the week with friends and family. Preparation and practice create confidence.

The group discussion of working values in the supportive relationship introduces the concept of trauma-informed peer support. This is an important framework for participants to understand and integrate into their approach with peers. It should be emphasized throughout the training and within exercises.

Communication skills of attending, active listening, paraphrasing are introduced and empathy revisited to build on Session 2. Again, emphasis to participants that practice is key to their skill development.

SESSION 3

10 MINUTES Discussion of homework and any additional reading assigned.

45 MINUTES Group Discussion of Working Values in the Supportive Relationship, Trauma-Informed Peer Support.

15 MINUTES Attending Skills

15 MINUTES Break

25 MINUTES Active Listening

20 MINUTES The Skill of Paraphrasing

15 MINUTES Break

60 MINUTES Accurate Empathy Exercise

5 MINUTES Homework: The First Session. Continue reading book for book report.

CPS CORE CRITERIA COVERED

1.3 Believes that personal growth and change are possible
1.6 Believes in the importance of self-awareness and self-care
1.10 Believes in the healing power of healthy relationships
4.6 Ability to listen and understand with accuracy the person's perspective and experience
4.8 Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.10 Ability to foster engagement in recovery

Group Discussion – Homework

(10 MINUTES)

OBJECTIVE

- To reinforce the learning from the homework material.
- To give participants a chance to ask questions.

METHOD

- Have participants break into groups of three.
- Ask each group to list key points from the homework and any reactions to the material.
- After 5 minutes, have each group report key points from their discussion to the larger group.

"Recovery is an idea whose time has come. At its heart is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms."

–GEOFF SHEPHERD, JED BOARDMAN & MIKE SLADE, ***MAKING RECOVERY A REALITY***

Group Discussion – Working Values in the Supportive Relationship (45 MINUTES)

OBJECTIVE

- To look at trainees' experiences with their own recovery.
- To relate personal experiences to values which are helpful for a peer support relationship.

METHOD

- Read Trauma-Informed Peer Support
- Divide the group into two.
- Ask the group to choose a group leader and give the person pen and paper.
- Have groups go to separate areas of the space in order to work independently.
- Instruct the groups to discuss the attributes of a counselor, peer supporter, friend, or other professional, that they found helpful or interfered with the supportive relationship.
- Give the groups approximately 35 minutes to discuss and then call the group back together.
- Group leaders can share with the class their responses.
- Facilitators summarize and link the main attitudes, values and beliefs that are important for trauma-informed peer support.

Key Point…

Healthy relationships have a healing power for people.

Trauma-Informed Peer Support

More than 90% of persons served by behavioral health organizations have a history of trauma, which can affect their ability to form relationships, keep a job, or live in stable housing.[8] Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening. The trauma may have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

A trauma-informed approach seeks to resist re-traumatization of peers. The six key principles of a trauma-informed approach include:

1. SAFETY

- Both the Peer Specialist and peer must feel physically and psychologically safe. The setting and the interpersonal interactions must promote a sense of safety.

2. TRUSTWORTHINESS AND TRANSPARENCY

- Decisions, goals, and processes are conducted with transparency to build and maintain trust with peers, family members and others involved in the recovery process.

3. PEER SUPPORT

- Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing stories and lived experience to promote recovery and healing.

4. COLLABORATION AND MUTUALITY

- Importance is placed on partnering and collaborating. The Peer Specialist demonstrates that healing happens in relationships where there is a mutual sharing of power and decision-making.

5. EMPOWERMENT, VOICE AND CHOICE

- Peers are supported in shared decision-making, choice, and goal setting to determine the plan of action they need to heal and move forward. They are supported in cultivating self-advocacy skills. Peer Specialists are facilitators of recovery rather than controllers of the process.

6. CULTURAL, HISTORICAL, AND GENDER ISSUES

[8] "Training Trauma-Informed Peers," National Council for Behavioral Health.

- The peer support approach actively moves past cultural stereotypes and biases and uses processes that are responsive to the racial, ethnic and cultural needs of the peer.

Attending Skills (15 MINUTES)

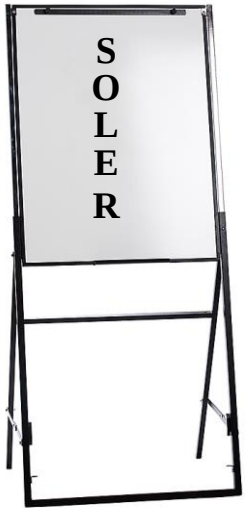
This easy to learn acronym for communication can provide a baseline for working with people. It is important to emphasis, however, that there may be individual or cultural differences present where the approach needs to be modified. Some people may find the square stance too abrupt or may feel uncomfortable with eye contact. Different cultures have different norms for personal space, eye contact, and posture. It is important for the facilitator to emphasize these differences and acknowledge local populations that Peer Specialists may have contact with.

OBJECTIVE

To emphasize the importance of developing and using attending skills in order to improve communication.

METHOD

- Remind trainees of the Helper Role Play done in the last class and how it felt in the respective roles of Peer Specialist and the person being supported.
- Use the easel and write out the 'Attending Acronym' as below.



S – Square Stance

O – Open Posture

L – Lean Toward

E – Eye Contact

R – Relaxed Stance

- Review each item of the following with the class. Emphasize the importance of learning and practicing this acronym.
- Have participants pick a partner and practice with each other.

Attending Acronym

Listening is the basis of communication, and this is one example of a method that can be used to improve your listening skills. Egan uses the acronym **S-O-L-E-R** to outline basic physical attending skills.

S	Square Stance
O	Open Posture
L	Lean Toward
E	Eye Contact
R	Relaxed Stance

S – SQUARE STANCE

Face the person you are talking with squarely. Physical distance between you is important as well. In North American culture, 3 ½ feet to 4 ½ feet is usually appropriate. Some people will want more or less distance between you and them.

O – OPEN POSTURE

You need to say through your posture that you are willing to be involved and accessible. Crossed arms and legs can be seen as defensiveness or withdrawal.

L – LEAN TOWARD

People tend to draw closer together physically when one leans in. This helps create understanding.

E – EYE CONTACT

This is a strong sign of involvement and can directly influence trust. Maintaining eye contact does not mean that you stare fixedly at the person, this is often uncomfortable for people. We are likely to feel more positive about people who use a lot of eye contact and less trusting with people who avoid eye contact.

R – RELAXED STANCE

Stay still and avoid fidgeting that might make it seem that you are preoccupied, nervous or uncomfortable with the discussion. If you are relaxed you show that you are not embarrassed and that you are able and willing to listen. If a person feel that you are judgmental or overwhelmed, they may stop the conversation or change to a subject they feel you would be more comfortable with.

.

• • • Break 15 minutes • • •

Active Listening (25 MINUTES)

OBJECTIVE

Learn the principles and practice the skill of active listening.

METHOD

- Handout the following pages to the class and have participants read different parts.
- Ask trainees if they have ever experienced their own cultural, familial or personal biases getting in the way of understanding a peer.
- Read and discuss the poem: ***I believe…***

Key Point …

One of the most important roles of a Peer Specialist is listening.

"Wisdom is the reward you get for a lifetime of listening when you'd have preferred to talk."

–DOUG LARSON

Active Listening

Active listening involves paying careful attention to what the peer is saying so that you can gain an understanding of his point of view. However, understanding her perspective does not mean that you have to agree with it. Peers sometimes have perceptions of themselves and others that are not completely accurate, or there are other views. Therefore, active listening also involves careful attention to details in the peer's story, which might be challenged at appropriate times. Before you challenge the discrepancies, however, it is essential that you first convey your understanding of the person.

For example, *you might be supporting someone who perceives herself as being overweight even though appearing to be of average weight. Before you challenge her on her distorted perception of herself, it is important that she first gets the sense that you understand and empathize with her distressed feelings regarding her weight. The most useful method to convey your understanding and empathy is through Active Listening.*

OBSTACLES TO ACTIVE LISTENING

Obstacles to active listening include: becoming distracted with your own thought, interrupting unnecessarily, personal cultural and familial biases, labeling and becoming too emotionally involved.

- Avoid becoming distracted with your own thoughts since it will prevent you from fully listening to the peer. This is especially a problem for Peer Specialists who become so preoccupied with their next response that they stop paying attention to the peer. It is better to fully pay attention and then allow yourself some time to respond.
- Avoid interrupting the peer when it is not necessary. However, under some circumstances it is appropriate to gently interrupt the person

For example, *if your peer has been talking non-stop and you are having a hard time following him, it is quite appropriate to interrupt by saying something like: "Before you go on, let me check with you whether I've been following you correctly." Then paraphrase, briefly, what you have heard.*

- Another obstacle in active listening is when you own cultural, familial or personal biases get in the way of understanding the peer.
- Labels that we use to categorize people also distort listening.

For example, *you are supporting a peer who has been diagnosed with schizophrenia. He tells you he has been hearing noises at night. It would be wrong to assume that the noises are in the person's imagination or are hallucinations.*

- Listening can also be compromised when you allow yourself to get too emotionally involved with the peer. In other words, if you feel too much sympathy for the person, you may accept their perspective without question, and be unable to be objective.
- Nonverbal communication – although we are not always aware of it, much of our communication takes place through body language. Non-verbal cues such as body

posture, facial expression and tone of voice send out messages that confirm or deny what is being said verbally. Nonverbal behavior also adds emotional intensity to the words being said and sometime, nonverbal cues speak louder than words.

For example, *a peer might express with words that she is not upset but a worried look on her face and a flat tone of voice might be telling you otherwise. Under such circumstances, it would be appropriate to point out the discrepancy to the peer with a statement, such as, "Even though you are telling me that you are not feeling upset, your expression looks worried."*

- Effective Peer Specialists learn to read nonverbal cues such as bodily behavior, facial expressions, voice related behavior, autonomic physiological responses, physical characteristics and overall appearance of the peer. Peer Specialists must also learn to pay attention to their own body reactions while interacting with peers.

Key Point…

People who have experienced trauma must feel safe before their will share their experience and feelings with a peer specialist.

I Believe…

I believe
the greatest gift
I can conceive of having
from anyone
is
to be seen by them,
heard by them,
to be understood
and
touched by them.
The greatest gift
I can give
is
To see, hear, understand
and to touch
another person.
When this is done
I feel
contact has been made.

-VIRGINIA SATIR

The Skill of Paraphrasing (20 MINUTES)

Paraphrasing is an important skill for connecting with others, letting them know that you are listening and clarifying information. Peer Specialists can use this skill to help a peer express their view, feelings and ideas.

OBJECTIVE

To learn and practice the skill of paraphrasing.

METHOD

Discuss with trainees the following information:

Paraphrasing is giving responses that reflect back to a person what he is saying. A good paraphrase has the following components:

- Gives the same meaning but uses your own words, avoids parroting.
- Brief, clear, concise, captures the spirit of the message and leaves out unnecessary details, helps clarify, not confuse.
- Worded as a question to leave room for the person to correct you.

Following are some examples of how to start a paraphrase to make it sound questioning:

- "Sounds like you are…"
- "Let me see if I got it right…"
- "So I hear you say…"
- "Is that correct?"

Key Point…

The primary role of the peer specialist is to help the peer recipients identify their personal strengths that will help them achieve their goals.

• • • Break 15 minutes • • •

Accurate Empathy Exercise (60 MINUTES)

OBJECTIVE

- To develop and practice the skill of active listening.
- To develop and practice the skill of giving constructive feedback.
- To develop and practice observation skills.

METHOD

- Divide group into groups of 3.
- Each person in the group will take turns role-playing a person who is receiving support that they are to discuss a problem they feel comfortable sharing, or they may ask for one of the scenarios below to use.
- Instruct Peer Specialists to use the skill of accurate empathy as much as possible. They may ask questions when necessary to keep the conversation going.
- Instruct the observers to record their observations on the following sheet (have enough copies for all to use). Observers give feedback to the Peer Specialists before the group switches roles. Everyone gets an opportunity to practice as a Peer Specialist and to receive feedback.
- Facilitators circulate through the groups to observe and give feedback.
- After each trainee has a turn in each role, they return to the main group for discussion.

Key point …

Empathy is understanding and sharing the feelings of another.

Scenarios: Empathy

ROLE PLAY SCENARIO #1

It's been a terrible week – my stepdaughter and I have been fighting all the time. The worst thing is that my wife always takes her side. It makes me mad.

ROLE PLAY SCENARIO #2

My friend who goes to the mood disorder group with me always puts me down in from of others. He makes me angry.

ROLE PLAY SCENARIO #3

She likes to hurt me by making sure I can hear her inviting others out for coffee and not me.

ROLE PLAY SCENARIO #4

I used to play tennis but the medication has wrecked my coordination and I'm shaky all the time.

Scenarios: Paraphrasing

ROLE PLAY SCENARIO #5

I saw some old friends from high school yesterday. It's been a few years since I've seen them but they acted like they didn't even know who I was.

ROLE PLAY SCENARIO #6

I want to get my life back. I'm tired of being sick. I have so much to do. I don't have time for this.

ROLE PLAY SCENARIO #7

I haven't had a drink since summer. I do feel better, but I miss having a beer.

ROLE PLAY SCENARIO #8

I want my clothes back. They took my clothes and won't let me leave. This hospital is like a jail.

ROLE PLAY SCENARIO #9

I don't trust anyone. I've been burnt so many times because I'm too nice to people.

ROLE PLAY SCENARIO #10

I don't think this medication is working. All it does is make me have a dry mouth and feel

spaced out.

ROLE PLAY SCENARIO #11

He's such an idiot. First he tells me to do this and then he changes his mind. The other day I had to walk the dog. I always have to walk the dog. And the kids, well he doesn't do much there either. I tell the kids to do their homework and the next thing I know he's letting them go to their friends.

ROLE PLAY SCENARIO #12

Several of my friends are smoking cannabis. I want to do it too. I don't think its fair that my counselor tells me not to.

Observer Checklist

Categorize each Peer Specialist response by placing a check mark and specific examples in the appropriate place. The purpose is for the observer to give feedback on how the Peer Specialist is using the skills that have been taught.

PARAPHRASE ☐ for each time used

Examples: _____

_____

EMPATHY ☐ for each time used

Examples: _____

_____

QUESTIONS ☐ for each time used

Examples: _____

_____

Describe body posture

_____

Describe eye contact

Homework: The First Session

(5 MINUTES)

OBJECTIVE

To help trainees think about what their peer might want from seeing a Peer Specialist.

METHOD

- Refer class to the following page, "What if I were receiving peer support?"
- Ask group members to answer the questions, and think of other possible conversation starters.
- Refer the class to, "The First Session." Ask them to practice with at least three people before the next class.
- Continue reading book for book report.

Additional Readings and Resources:

Mead, Shay, "Trauma Informed Peer Support," Wichita State University
http://webs.wichita.edu/depttools/depttoolsmemberfiles/ccsr/TIC/Trauma%20informed%20Peer%20Support.pdf

"Cultural Barriers to Effective Communication," Conflict Research Consortium, University of Colorado.
http://www.colorado.edu/conflict/peace/problem/cultrbar.htm

"Communicating Across Cultures," American Management Association.
http://www.colorado.edu/conflict/peace/problem/cultrbar.htm

REVIEW QUESTIONS:

1. **Do you believe that personal growth and change are possible for any person?**
2. **What types of relationships have helped your own healing in recovery?**
3. **What is the Attending Acronym for active listening?**
4. **How can you use paraphrasing to draw out a person's perspective, experiences, goals, dreams, and challenges? Give an example.**
5. **What are some techniques you can use to engage others in the recovery process?**

Session 3 Homework Handouts

What if I were receiving peer support?

This can be used to develop empathy and give you a chance to "put yourself in the other person's shoes."

Picture yourself as a peer recipient. Think of some of the problems you have had to grapple with or are struggling with now. Jot down words, phrases, or simple sentences in response.

What would I want to get out of seeing a Peer Specialist?

_____

_____

_____

What would I want the Peer Specialist to be like?

_____

_____

_____

How would I want to be treated?

_____

_____

_____

"As you grow older, you will discover that you have two hands, one for helping yourself, the other for helping others."

–AUDREY HEPBURN

The First Session

- Introduce yourself with your name and that you are from the peer support program.
- Ask where they would like to go to sit and visit, or, if they would like to walk.
- They will be as nervous as you are! Just be warm and friendly.
- Most people enjoy talking about themselves. As you listen you can comment on their feelings, the content of what they are saying or ask questions.
- Let them know you understand and accept them.

CONVERSATION STARTERS

- How long have you lived here?
- Where were you born?
- What kinds of hobbies do you have?
- Are you a Packer/Brewer/ fan?
- Do you have any siblings?
- Do you like dogs/cats?
- What is your favorite season?
- Do you play any sports?
- What types of music do you like?

USE OPEN QUESTIONS

- What are some things you like to do?
- How do you spend your day?

Session 4

FACILITATOR INFORMATION:

This session is designed to build on previously presented material on communication. The concept of empathy is further explored with exercises for participants to practice. Facilitators are encouraged to practice a role-play demonstration on empathy and exploring before the class.

History timelines are given as homework but facilitators may also want to bring in additional information that is more locally based. The language in the timelines has not been corrected to language currently used in the field, as it is felt to be reflective of public attitudes of that time.

Peer Specialist Facilitator Curriculum Guide

SESSION 4

5 MINUTES Homework review and Poem "Listen"

25 MINUTES Accurate Empathy
Conveyance of Ownership in Empathy
Uses of Empathy

15 MINUTES Non-empathetic statements

30 MINUTES Exploring
Open questions
Facilitators Role Model to the Group the Skills of Empathy and Exploring

15 MINUTES Break

50 MINUTES Accurate Empathy and Exploring Exercise

15 MINUTES Break

50 MINUTES Advanced Accurate Empathy Exercise

5 MINUTES Homework: Begin book report. Due by Session 7. Read ": "A Brief History of Mental Illness and the U.S. Mental Health Care System," "Timeline of Significant Events in Mental Health Services in the U.S.," "History of the Consumer Movement in Wisconsin," and "Significant Events in the History of Addiction Treatment and Recovery in America."

CPS CORE CRITERIA COVERED

1.11 Believes and understands there are a range of views regarding mental health and substance use disorders and their treat, services, supports, and recovery
3.5 Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
4.3 Ability to problem-solve
4.4 Ability to assist people in exploring life choices, and the outcomes of those choices
4.9 Ability to recognize and affirm a person's strengths

Homework Review and Poem "Listen"

(5 MINUTES)

- Open class with a discussion of the homework assignment.
- Read poem, "Listen," to provide inspiration to the group members and remind them that one of the most important roles of a peer specialist is listening.

Listen

When I ask you to listen to me and you start giving
Advice you have not done what I asked.

When I ask you to listen to me and you begin to tell me why
I shouldn't feel that way, you are trampling on my feelings.

When I ask you to listen to me, and you feel you have to do something
To solve my problems, you have failed me, strange as that may seem.

Listen! All I ask is that you listen, not talk or do – just hear me.
Advice is cheap: 60 cents will get you both Dear Abby and Billy Graham
In the same newspaper. And I can do for myself: I'm not helpless: maybe
Discouraged and faltering, but not helpless.

When you do something for me that I can and need to do for myself,
You contribute to my fear and weakness.

But, when you accept as a simple fact that I do feel, no matter how irrational,
Then I can quit trying to convince you and get about the business of
Understanding what's behind the irrational feeling.
And when that's clear the answers are obvious and I don't need
Advice. Irrational feelings make sense when you understand
What's behind them.

Perhaps that's why prayer works, sometimes, for some people,
Because God is mute, and doesn't give advice or try to fix things.
God listens and lets you work it out for yourself.

So, please listen and just hear me. And if you want to talk,
Wait a minute for your turn, and then I'll listen to you.

–ANONYMOUS

Accurate Empathy (25 MINUTES)

OBJECTIVE

- Explain the difference between sympathy, empathy and identification.
- Provide examples of empathic statements.
- Discuss the need for ownership in empathic responses.
- Discuss the role of accurate empathy in the helping process.
- Discuss common inappropriate responses by a Peer Specialist.

METHOD

- Read –Accurate Empathy
- Read—Conveyance of Ownership in Empathy

Write on the easel the following statements and ask for someone to give an "I" message according to this formula**: I feel _____when you _____.**

1. An individual is insisting anyone who does not share his particular religious beliefs is stupid and trying to make you agree with him.
2. An individual is using abusive language and this is distracting you.
3. An individual insists on asking you your marital status.
4. An individual is talking in circles and this is confusing you.

- Read—The Uses of Empathy
- Read—Non-Empathic Statements

Key Point …

One of the most important roles of a peer specialist is listening.

Accurate Empathy

Accurate empathy is a response by the Peer Specialist, which shows their understanding of the peer's problem situation. The most powerful empathic responses are those that reflect the peer's feelings and emotions and link it to the corresponding experiences or behaviors.

For example: "It's been a terrible week, my stepdaughter and I have been fighting non-stop. The worst think about it is that my husband seems to take her side and is constantly undermining me in front of her…He makes me so angry!"

Empathic response:
"You are angry at your husband because he fails to support your authority with your stepdaughter."

Non-empathic response:
"My husband is such a jerk, too. He really makes me mad."

Peer Specialists may also respond selectively as to highlight feelings, behaviors or experiences. ***For example:***

Response emphasizing experience:
"Sounds like you've had a lousy week with your family."

Response emphasizing behavior:
"You have been fighting with your stepdaughter and getting angry with your husband."

Response emphasizing feelings:
"You are feeling really angry."

An effective Peer Specialist develops the skill to assess what is emphasized in an empathic response.

For example, a peer who shows resistance in talking about feelings might feel threatened by empathic responses, which emphasize affect. This peer might initially benefit more from empathic responses that emphasize experiences and behaviors until enough trust has been established to talk about feelings.

Conveyance of Ownership in Empathy

Peer Specialists need to be careful in wording their empathic statements so as not to imply that others are responsible for the peer's feelings. Empathic statements always give a feeling of honoring the peer's ownership of his/her feelings.

For example:

Do not respond:
"Your brother makes you feel angry because he puts you down. He especially causes you to feel hurt when he does it in front of your friends.

Respond instead:
"You feel angry at your brother because he frequently puts you down. It is especially hurtful when he does it in front of your friends."

The first response suggests the brother is responsible for the peer's angry and hurtful feelings. It might also give the impression to the peer that s/he is a victim at the mercy of the brother with no power to change circumstances. S/he might not see there may be another choice for how he reacts to the brother's behavior.

A useful communication skill which can be taught to peers is the use of "I" statements to increase their sense of ownership over their feelings.

For example: You can suggest your peer respond:

> "I feel hurt because you ignored me at the party;" instead of, "You have caused me so much pain by ignoring me." Another advantage of using "I"statements is that they tend to make a person less defensive and more sensitive to the other person's feelings.

Key point …

One of the most important components in person-centered planning is the peer recipient's life experiences and goals.

The Uses of Empathy

The skill of empathy can serve several functions in the helping relationship. As suggested by Egan (1994) empathy works because it:

- Helps build the relationship. Peer feels understood, supported, and taken seriously.
- Helps the peer explore their feelings in a non-judgmental manner.
- Can be used to help peers identify strengths and resources.
- Is a tool that the Peer Specialist can use to focus the attention of the peer in the direction that may help lead to deeper understanding.
- Is a perception-checking tool. Allows the peer to set the record straight.
- Paces the helping process. Keeps the Peer Specialist from asking too many questions.

Non-empathic Statements (15 MINUTES)

Sometimes Peer Specialists do not give empathic responses and instead respond with an out of place statement, which may get in the way of the helping relationship. Following are examples of common types of non-empathic responses, which are to be avoided.

Example: "I think that my agoraphobia is acting up again. The last few times I went to the mall, my heart started racing and I just wanted to run out of there."

Responding with a question:
"When did the agoraphobic attacks start again?

Responding with a cliché:
"This is not unusual; many people have small relapses."

Responding with an interpretation:
"I think your relapse was triggered by the breakup of your marriage."

Responding with advice:
"I think you should increase your medication."

Responding with an overly sympathetic response:
"Oh, you poor thing, that is so awful!"

Responding with a rescuing statement:
"Oh, don't worry about it, it's just a little relapse. I am sure you will get over it."

These statements are not helpful because they do not recognize the peer's feelings.
Instead an appropriate empathic response could be:

"Sounds like you are afraid of being unable to cope in public places again."

Note that some of the above non-empathic responses might be appropriate at some points in the helping relationship.

For example, after an empathic response, it might be appropriate to ask the question,

"When did the agoraphobic attacks start again?"

Facilitators Role Model Skills

(30 MINUTES)

OBJECTIVE

- Introduce and discuss the skill of exploring.
- Practice peer support skills of empathic listening and exploring.

METHOD

- Read—Exploring.
- Read—Open ended questions.
- Read—Open vs. Closed Questions
- Facilitators' role model Empathy and Exploring—facilitators need to decide before hand on a topic they will talk about; it is helpful to use personal situations to make clear the skills of empathy and exploring.

Exploring

Exploration statements are verbal statements that help explain relevant issues. Good exploring statements help define problems in terms of real and specific experiences, behaviors, and/or feelings.

For example: "That's it, I am ready to walk out of this relationship. My husband's attitude just sucks and I don't think he's going to change… It's hopeless!"

In this situation, the helper could use an empathic response followed by an exploring statement.

> "You feel pessimistic about your relationship ever getting on the right track again. Maybe you can describe to me what your husband does that you find so difficult to accept."

Or an empathic response followed by an exploring question:

> "You are feeling pretty bad about your marriage and don't see any hope. What specifically does he do that you find objectionable?"

An exploration statement does not have to be a full question or sentence. It can simply be a word or phrase.

> ***For example:*** "Hopeless?"

Open Ended Questions

The following are examples of open-ended questions. What makes these unique is that they cannot be answered with a yes or no. Try to use as many different ones as you can.

What does that feel like?
Can you tell me more about …?
How are you feeling right now?
Would you like to talk about?
Where would you like to begin?
How is that (use specific example) for you?
How do you feel now about…?
Can you tell me what that means to you?
How would you like things to be?
What do you imagine…?
What have you thought of?
What would it be like?
How do you see things changing?
What would you like to do about…?
I'm wondering…?
What's that like?
What can you think of?
What's more important for you now?
Does it sound reasonable to you?
Could this be what's going on, you…
From where I stand, you...
This is what I think you are saying…
You appear to be feeling…
Perhaps you're feeling…
I somehow sense that you feel…
Is there any chance that you…
Let me see if I understand; you…
Let me see if I'm with you …

You can make positive deposits in your own economy every day
by reading and listening to powerful, positive, life-changing content
and by associating with encouraging and hope-building people.
–ZIG ZIGLAR

Open vs. Closed Questions

CLOSED	**OPEN**
Restrictive	***Broad***
Limits responder's answer to "yes," "no," "maybe," or "I don't know."	Responder has an opportunity to figure out their own response; opens door to further discussion.
Helps to focus on a specific piece of information or clarify a point.	Encourages the responder to expand on and describe their experience.
May encourage defensiveness, imply a 'right' answer or push someone into a position.	Invites exploration.
Examples: "Don't you think that's unreasonable? "Are you planning to go then? "Do you have enough information to make that decision?" "Aren't you going to try?"	***Examples:*** "What does 'fair' mean to you?" "What did I do that gave you the impression I don't care?" "How did his response affect you?" "What will you do now?"

Closed questions sound like statements, but they are not as clear. Often they sound aggressive. Below are some closed questions that have been changed to form open questions.

CLOSED	**OPEN**
Do you understand what I mean?	What do you think of what I just said?
Do you agree that the contract is clear?	What do you think about the clarity of the contract?
Have you noticed low morale with your staff?	How would you describe the morale of your staff?
Don't you think this is basically a financial problem?	What do you feel is the root of the problem?

• • • Break 15 minutes • • •

Accurate Empathy and Exploring Exercise (50 MINUTES)

OBJECTIVE

Practice peer support skills of empathic listening and exploring.

METHOD

- Divide the group into sets of 3 (class can decide if they wish to stay with the same group as last class or if they wish to change group member.)
- Each person in the group will take turns role-playing a person who is receiving support that they are to discuss a problem they feel comfortable sharing, or use one of the scenarios below.
- Instruct Peer Specialists to use the skill of accurate empathy as much as possible. They may ask questions when necessary to keep the conversation going.
- Instruct the observers to record their observations on the following sheet (have enough copies for all to use). Observers give feedback to the Peer Specialist before the group switches roles. Everyone gets an opportunity to practice as a Peer Specialist and to receive feedback.
- Facilitators circulate through the groups to observe and give feedback.
- After each trainee has a turn in each role, they return to the main group for discussion.

ROLE PLAY SCENARIO #1

I'm overweight—always have been. I try to diet but it's so frustrating. Now this medication is making me gain weight.

ROLE PLAY SCENARIO #2

(Client has a bruised and swollen left side of face and eye.) My partner is a good man/woman. Sure, he/she hits me sometimes but I hit him/her too. It's not all the time, just when there is drinking.

ROLE PLAY SCENARIO #3

I don't have a family anymore. The powers that be won't let my partner come home and they took my daughter. I just moved here. I'm trying to get work. No one is helping—Oh, what's the use?

• • • Break 15 minutes • • •

Advanced Accurate Empathy

(50 MINUTES)

OBJECTIVE

- To learn and practice the skill Accurate Empathy.

METHOD

- Read—Advanced Accurate Empathy.
- Practice skills using the same method as described.

Advanced Accurate Empathy

Advanced accurate empathy is an empathic response which reflects deeper meanings that the peer is only half saying or implying in his/her statements. It is considered a difficult skill because it brings to light what the peer is frequently not fully conscious of, and this new awareness might challenge the peer's worldview in some way.

For example: "This job here sounds like something I would enjoy doing…but I don't even feel like trying anymore. I have become really discouraged with this job-hunting. With so many unemployed people, I don't stand a chance to even make it on the short list."

> **Basic empathic response:**
> "You feel discouraged in finding a job because of a competitive job market."
>
> **Advanced empathic response:**
> "It's been painful being turned down so many times before and now you hesitate in taking a chance. I wonder whether your reluctance has something to do with fearing rejection."

In the last example, the peer is tentatively challenged on his world-view (i.e. looking for a job is a waste of time because of the economic situation) by focusing him on the possibility that he might have become immobilized because of fear of rejection.

Advanced accurate empathy can also be used to make peers aware of themes or patterns in their feelings, behaviors and/or experiences.

For example: "I can't believe it, it started as an argument over a quiz question and then he starts calling me ignorant…and the next thing I knew, I lost control and started fist-fighting with this guy."

> **Advanced empathic response:**
> "Seems like you were feeling hurt because he called you ignorant. I recall a similar incidence with your brother where you reacted with a physical confrontation when he called you a weakling."

The above statement tentatively challenges the peer to look at his pattern of reacting violently when he feels hurt.

It is important to word advanced empathic statements tentatively because they involve a lot of guesswork on the part of the Peer Specialist. By being tentative, the peer will feel more comfortable in disagreeing with the Peer Specialist's statement. Also, non-verbal responses by the peer to the advanced empathic statements will give useful cues as to their accuracy. Advanced accurate empathy is not to be used too soon. It is most useful when rapport and trust have already been established in the peer support relationship.

Key Point…

A person is considered "recovering" from mental illness and/or substance use disorders when he or she can comfortably manage his or her life in the community.

Homework – Book Report (5 MINUTES)

OBJECTIVE

To explain to the group the book report requirement and to make sure that all participants have begun the assignment.

METHOD

- Ask each participant what book they are reading for their book report.
- If any participant states that they haven't chosen one, gently explain that the reading is required to successfully complete the course.
- Facilitators outline to the group the format for book reporting. Many options are available; ie. A written report, verbal descriptions, group reporting, or small group sharing.
- Also ask participants to read: "A Brief History of Mental Illness and the U.S. Mental Health Care System," "Timeline of Significant Events in Mental Health Services in the U.S.," "History of the

Consumer Movement in Wisconsin," and "Significant Events in the History of Addiction Treatment and Recovery in America."

Additional Readings and Resources:

Articles and information from The Trauma Informed Care Project
http://www.traumainformedcareproject.org

Sally Clay, "A Personal History of the Consumer Movement,"
http://sallyclay.net/Z.text/history.html

"Pathways to Recovery"
http://www.facesandvoicesofrecovery.org/sites/default/files/resources/recovery_pathways.pdf

"Tip 57: Trauma-Informed Care in Behavioral Health Services"
http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

"Trauma-Informed Care" by Wisconsin Department of Health Services
https://www.dhs.wisconsin.gov/tic/index.htm

"Strengths-Based Approach for Mental Health Recovery"
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3939995/

REVIEW QUESTIONS:

1. **What are some of the significant views on mental health presented in the history homework?**
2. **How can you use empathy and exploring to create a safe, trauma-sensitive environment for the peer recipient?**
3. **What are some techniques to help a peer problem solve identified issues?**
4. **What is the primary difference between an open and closed question?**
5. **What is your understanding of a strengths focus model of recovery?**

Session 4 Homework Handouts

History of Mental Health Services and Treatment

The history of mental illness in the United States is a good representation of the ways in which trends in psychiatry and cultural understanding of mental illness influence national policy and attitudes towards mental health. The U.S. is considered to have a relatively progressive mental health care system, and the history of its evolution and the current state of affairs is outlined below.

EARLY HISTORY OF MENTAL ILLNESS[9]

Many cultures have viewed mental illness as a form of religious punishment or demonic possession. In ancient Egyptian, Indian, Greek, and Roman writings, mental illness was categorized as a religious or personal problem. In the 5th century B.C., Hippocrates was a pioneer in treating mentally ill people with techniques not rooted in religion or superstition; instead, he focused on changing a mentally ill patient's environment or occupation, or administering certain substances as medication. During the Middle Ages, the mentally ill were believed to be possessed or in need of religion. Negative attitudes towards mental illness persisted into the 18th century in the United States, leading to stigmatization of mental illness, and unhygienic (and often degrading) confinement of mentally ill individuals.

MENTAL HEALTH HOSPITALS AND DEINSTITUTIONALIZATION

In the 1840's, activist Dorothea Dix lobbied for better living conditions for the mentally ill after witnessing the dangerous and unhealthy conditions in which many patients lived. Over a 40-year period, Dix successfully persuaded the U.S. government to fund the building of 32 state psychiatric hospitals.[10]

This institutional inpatient care model, in which many patients lived in hospitals and were treated by professional staff, was considered the most effective way to care for the mentally ill. Families and communities struggling to care for mentally ill relatives also welcomed institutionalization. Although institutionalized care increased patient access to mental health services, the state hospitals were often underfunded and understaffed, and the institutional care system drew harsh criticism following a number of high-profile reports of poor living conditions and human rights violations.[11]

By the mid-1950's, a push for deinstitutionalization and outpatient treatment began in many countries, facilitated by the development of a variety of antipsychotic **drugs.** Deinstitutionalization efforts have reflected a largely international movement to reform the "asylum-based" mental health care system and move toward community-oriented care, based on the belief that psychiatric patients would have a higher quality of life if treated in their communities rather than in "large, undifferentiated, and isolated mental hospitals."[12]

Although large inpatient psychiatric hospitals are a fixture in certain countries, particularly in Central and Eastern Europe, the deinstitutionalization movement has been widespread, dramatically changing the nature of modern psychiatric care. The closure of state psychiatric hospitals in the United States was codified by the Community Mental Health Center Act of 1963, and strict standards were passed so that only individuals "who posed an imminent danger to themselves or someone else" could be committed to state psychiatric hospitals.[13]

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[9] Adapted from PBS Online's "Timeline: Treatments for Mental Illness," June 2012.
[10] I.B.I.D.
[11] Novella, E. J. "Mental health care and the politics of inclusion: a social systems account of psychiatric deinstitutionalization, Theor Med Bioeth, 31: 411-427, 2010.
[12] I.B.I.D.
[13] Interlandi, J. "A Madman in Our Midst," The New York Times, June 2012.

By the mid 1960's, many severely mentally ill people had been moved from psychiatric institutions to local mental health homes or similar facilities. The number of institutionalized mentally ill patients fell from its peak of 560,000 in the 1950's to 130,000 by 1980. By 2000, the number of state psychiatric hospital beds per 100,000 people was 22, down from 339 in 1955. In place of institutionalized care, community-based mental health care was developed to include a range of treatment facilities, from community mental health centers and smaller supervised residential homes to community-based psychiatric teams.[14]

Though the goal of deinstitutionalization – improving treatment and quality of life for the mentally ill – is not controversial, the reality of deinstitutionalization has made it a highly polarizing issue. While many studies have reported positive outcomes from community-based mental health care programs, (including improvements in adaptive behaviors, friendships, and patient satisfaction), other studies have found that individuals living in family homes or in independent community living settings have significant deficits in important aspects of health care, including vaccinations, cancer screenings, and routine medical checks.[15] Other studies report that "loneliness, poverty, bad living conditions, and poor physical health" are prevalent among mentally ill patients living in their communities.[16] However, some studies argue that community-based programs that have proper management and sufficient funding may deliver better patient outcomes than institutionalized care, and are "not inherently more costly than institutions."[17]

Critics of the deinstitutionalization movement point out that many patients have been moved from inpatient psychiatric hospitals to nursing or residential homes, which are not always staffed or equipped to meet the needs of the mentally ill. In many cases, deinstitutionalization has also shifted the burden of care to the families of mentally ill individuals, though they often lack the financial resources and medical knowledge to provide proper care. Others argue that deinstitutionalization has simply become "transinstitutionalization," a phenomenon in which state psychiatric hospitals and criminal justice systems are "functionally interdependent." According to this theory, deinstitutionalization, combined with inadequate and under-funded community-based mental health care programs, has forced the criminal justice system to provide the highly structured and supervised environment required by a minority of the severely mentally ill population.[18]

Opponents of the transinstitutionalization theory contend that it applies to a small fraction of mentally ill patients, and that the majority of patients would benefit from improved access to quality community-based treatment programs, rather than from an increase in the number of inpatient state psychiatric beds. These opponents claim that the reduced availability of state hospital beds is not the cause of the high rates of incarceration among the mentally ill, arguing that deinstitutionalized patients and incarcerated individuals with serious mental illnesses are "clinically and demographically distinct populations." Instead, they suggest that other factors such as "the high arrest rate for drug offenses, lack of affordable housing, and underfunded community treatment" are responsible for the high rates of incarceration amount the mentally ill.[19]

Though the deinstitutionalization debate continues, many health professionals, families, and advocates for the mentally ill have called for a combination of more high-quality community treatment programs (like intensive case management) and increased availability of intermediate and long-term psychiatric inpatient care for

[14] Novells, et al. 2010
[15] I.B.I.D.
[16] I.B.I.D.
[17] Knapp, M., Beecham,J., McDaid, D., Matosevic, T., Smith, M. "The Economic Consequences of Deinstitutionalization of Mental Health Services: lessons from a systematic review of European experience, Health and Social Care in the Community, 19 (2): 113-125, 2011.
[18] Prins, S. J., "Does Transinstitutionalization Explain the Overrespresention of People With Serious Mental Illnesses in the Criminal Justice System? Community Mental Health Journal, 47: 716-722, 2011.
[19] I.B.I.D.

patients in need of a more structured care environment.[20] Many experts hope that by improving community-based programs and expanding inpatient care to fulfill the needs of severely mentally ill patients, the United States will achieve improved treatment outcomes, increased access to mental health care, and better quality of life for the mentally ill.

Timeline of Significant Events in Mental Health Services in the United States[21] [22]

MENTAL HYGIENE ERA (1930-1955): THE FOCUS WAS ON PREVENTION WITH REGARDS TO THE SERVICES IN MENTAL HOSPITALS AND PSYCHIATRIC CLINICS.

1773: The first hospital for the mentally ill in the United States opened in Williamsburg, Virginia.

1841: Boston schoolteacher Dorothea Dix visits the East Cambridge Jail, where she first sees the horrible living conditions of the mentally ill. Believing they could be cured, Dix lobbies lawmakers and courts for better treatment until her death in 1887. Her efforts lead to the establishment of 110 psychiatric hospitals by 1880.

1987: On assignment for New York World, Nellie Bly feigns lunacy in order to be admitted to the Women's Lunatic Asylum on New York's Blackwell's Island. Her expose, "Ten Days in a Mad-house," detailing the appalling living conditions at the asylum, leads to a grand jury investigation and needed reforms at the institution.

1907: Indiana is the first of more than 30 states to enact a compulsory sterilization law, allowing the state to "prevent procreation of confirmed criminals, idiots, imbeciles and rapists." By 1940, 18,552 mentally ill people are surgically sterilized.

1936: Dr. Walter Freeman and his colleague James Watt perform the first prefrontal lobotomy. By the late 1950's, an estimated 50,000 lobotomies are performed in the United States including one on Rosemary Kennedy, older sister of President Kennedy.

[20] Sontag, D., "A schizophrenic, a slain worker, troubling question

s," The New York Times, June, 2011.

[21] Adapted from the Consumers as Providers (CAP) Training Program with permission of The University of Kansas School of Social Welfare.

[22] Pam, Deanna, "TIMELINE: Deinstitutionalization And Its Consequences, How deinstitutionalization moved thousands of mentally ill people out of hospitals—and into jails and prisons," Mother Jones Online, April, 2013.

1938: Italian neurologist Ugo Cerletti introduces electroshock therapy as a treatment for people with schizophrenia and other chronic mental illnesses.

1946: The National Mental Health Act of 1946 was formed which lead to the creation of the National Institute of Mental Health (NIMH).

1949: Lithium was discovered.

1950: National Committee for Mental Hygiene became the National Association for Mental Health.

1952: LSD was used in attempts to treat mental illness.

1954: Thorazine (Chlorpromazine) was first introduced. Chlorpromazine is the first antipsychotic drug approved by the Food and Drug Administration. It quickly becomes a staple in asylums.

1955: The number of mentally ill people in public psychiatric hospitals peaks at 560,000.

COMMUNITY MENTAL HEALTH ERA (1955-1980): SERVICES WERE FOCUSED ON DEINSTITUTIONALIZATION TO COMMUNITY INTEGRATION.

1955: Mental Health Study Act: National Institute of Mental Health appointed by Joint Commission on Mental Illness and Health to "…evaluate the needs of the mentally ill and make recommendations to Congress…"

1959: Haldol (Haloperidol) introduced.

1961: Joint Commission on Mental Illness and Health recommends upgrading of hospitals and establishing community-based treatment centers.

1962: ***One Flew Over the Cuckoo's Nest,*** a novel by Ken Kesey, is published. The bestseller is based on his experience working as a nurse's aide in the psychiatric wing of Menlo Park Veteran's Hospital in California. The book is made into a popular movie starring Jack Nicholson.

1963: President John F. Kennedy signs the Community Mental Health Act to provide federal funding for the construction of community-based preventive care and treatment facilities. Between the Vietnam War and an economic crisis, the program was never adequately funded.

1965: With the passage of Medicaid, states are incentivized to move patients out of state mental hospitals and into nursing homes and general hospitals because the program excludes coverage with people in "institutions for mental diseases."

1967: The California Legislature passes the Lanterman-Petris-Short Act, which makes involuntary hospitalization of mentally ill people vastly more difficult. One year after the law goes into effect, the number of the mentally ill people in the criminal-justice system doubles.

1970: Lithium is released as a treatment for bipolar illness.

1970's: The Program of Assertive Community Treatment (PACT) first began as a demonstration project to both implement initial research findings of Mendota researchers and to further investigate new approaches to providing integrated, long-term treatment to persons with severe and persistent mental illnesses.

1975-1977: Hospitals begin deinstitutionalization.

1979: NIMH created Community Support Programs for individuals with a Serious Persistent Mental Illness.

1977: There are 650 community mental health facilities serving 1.9 million mentally ill patients per year.

COMMUNITY SUPPORT ERA (1980-1995): SERVICES WERE FOCUSED ON SOCIAL PROBLEMS SUCH AS HOUSING, ENTITLEMENTS AND EMPLOYMENT.

1980: President Jimmy Carter signs the Mental Health Systems Act, which aims to restructure the community mental health center program and improve services for people with chronic mental illness.

1981: Under President Ronald Reagan, the Omnibus Budget Reconciliation Act repeals Carter's community health legislation and establishes block grants for the states, ending the federal government's role in providing services to the mentally ill. Federal mental health spending decreases by 30 percent.

1982: Strengths Model of case management used.

1984: An Ohio-based study find that up to 30% of homeless people are thought to suffer from serious mental illness.

1985: Federal funding drops to 11% of community mental health budgets.

1987: Prozac released for depression, followed by other Selective Serotonin Reuptake Inhibitors (SSRI).

1990's: Atypical antipsychotic medications are released such as Clozaril, Risperdal, Zyprexa, and Seroquel.

RECOVERY ERA (1995-PRESENT): SERVICES ARE IN THE COMMUNITY PROVIDED BY COMMUNITY MENTAL HEALTH CENTERS, CONSUMER PROVIDERS AND CONSUMER RUN ORGANIZATIONS. FOCUS IS ON DEVELOPING A SATISFYING, HOPEFUL AND MEANINGFUL LIFE IN SPITE OF A MENTAL ILLNESS.

1996: Mental Health Parity Act barred insurance companies and large self-insured employers from placing annual or lifetime dollar limits on mental health coverage**.**

1997: Wellness Recovery Action Planning (WRAP) written by Mary Ellen Copeland.

1999: First White House Conference on Mental Health: A Report of the Surgeon General Pilot Project of The University of Kansas Consumers as Providers Training Program.
2000: MHC's begin embracing recovery ideas and consumer empowerment.

2001: Mental Health: Culture, Race and Ethnicity: A supplement to Mental Health: A Report of the Surgeon General is released.

2004: Studies suggest approximately 16% of prison and jail inmates are seriously mentally ill, roughly 320,000 people. This year, there are about 100,000 psychiatric beds in public *and* private hospitals. That means there are more than three times as many seriously mentally ill people in jails and prisons than in hospitals.

2009: In the aftermath of the Great Recession, states are forced to cut $4.35 billion in public mental-health spending over the next three years, the largest reduction in funding since deinstitutionalization.

2010: There are 43,000 psychiatric beds in the United States, or about 14 beds per 100,000 people—the same ratio as in 1850.

TRANSFORMING MENTAL HEALTH CARE IN AMERICA

The President's New Freedom Commission Report on Mental Health vision statement is:

> *We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses can be detected early and a future when everyone with a mental illness at any state of life has access to effective treatment and supports – essentials for living, working, learning and participating fully in the community.*

The Interim Report concluded that the "system" is not oriented to the single most important goal of the people it serves—the hope in recovery. This implies that the mental health system is in need of transformation. This transformation rest on two principles:

1. Services and treatments must be consumer and family centered, geared to give consumers of mental health services real and meaningful choices about treatment options and providers.
2. Care must focus on increasing consumer's ability to successfully cope with life's challenges, on facilitating recovery and on building resilience, not just to managing symptoms.

Goals and recommendations were developed in order to aid in transforming the mental health system. Such recommendations have led to the development of Peer Support/Consumer services in the field of mental health. These services are traditionally based on equality and mutuality—each person playing both roles of the supported and the supporter as the situation demands.

History of the Consumer Movement in Wisconsin

1880: The Milwaukee Asylum for the Chronic Insane opens in Wauwatosa.

1971: There are 1609 public psychiatric beds in Milwaukee County.

1979: New Milwaukee County Mental Health Complex opens with 900 beds replacing the 100 year old facility.[23]

[23] Imminent Danger, A Special Report, Milwaukee Journal Sentinel, December, 2012.

1980: The Wisconsin Network of Mental Health Consumers (WINMHC) was organized[24] with an office in Madison regional offices.

1987: The first statewide consumer conference was held in Madison.

Late 1980's: The statewide Community Support Program (CSP) conference began including consumers on the conference planning.

1992: Federal Mental Health Block Grant (FMHBG) was significantly increased because consumers diligently spoke at public hearings and $480,000 was allocated for consumer and family self-help, peer support programs.

1994-2008: Consumer and family self-help, peer support programs were funded with the FMHBG.

1995: Grassroots Empowerment contract was awarded to the National Alliance on Mental Illness (NAMI) – Wisconsin.

1995: Crossroads Conference on trauma was held in Milwaukee. Consumers played a major role in planning the conference as well as presenting workshops at the conference.

1996-1997: Winnebago Mental Health Institute hired a consumer to run peer support groups.

1997: The Governor's Blue Ribbon Commission on Mental Health (BRC) convened. Initially, only a few consumers were appointed; however, consumers approached the Governor's Office and eventually, several additional consumers were appointed, changing the tone of the committee.

1998: The BRC published its Final Report that emphasized recovery and consumer involvement. This report became Wisconsin's foundational document on how to deliver mental health service.

2006: Discussion began within the Department of Health Services about developing a Certified Peer specialist (CPS) program. Research of other states regarding their programs was done. Georgia has the most established CPS Programs in the country with over 1,000 CPS to date.[25]

2007-2009: The Core Competencies, Code of Ethics, and generalized job description were developed for Wisconsin.

2010: The first certification exam was proctored in January. The first year of exams produced approximately 100 Certified Peer Specialists.

2015: There are currently 427 CPS in Wisconsin. The core competencies for WI-CPS program were changed to include the area of substance use disorder.

[24] Adapted from the Consumers as Providers (CAP) Training Program.
[25] Adapted from Peer Specialist Igniting Recover, www.wicps.org.

Significant Events in the History of Addiction Treatment and Recovery in America[26]

1750 to Early 1800s: Alcoholic mutual aid societies (sobriety "Circles") are formed within various Native American tribes. Some are part of, or evolve into, abstinence-based Native American cultural revitalization movements and temperance organizations.

1774: Anthony Benezet's ***Mighty Destroyer Displayed*** is published. It is the earliest American essay on alcoholism.

1784: Dr. Benjamin Rush's Inquiry into the Effects of Ardent Spirits on the Human Mind and Body catalogues the consequence of chronic drunkenness and argues that this condition is a disease that physicians should be treating. Rush's writing marks the beginning of American temperance movement.

1830: Dr. Samuel Woodward calls for creation of "inebriate asylums.

1844-1845: Lodging Homes and a Home for the Fallen are opened in Boston—marking the roots of the 19th century inebriate home. As inebriate homes spread, they will spawn several alcoholic mutual aid societies such as the Godwin Association.

1849: The Swedish physician Magnus Huss describes a disease resulting from chronic alcohol consumption and christen it *Alcoholismus chronicus.* This marks the introduction of the term alcoholism.

1864: The New York State Inebriate Asylum, the first in the country, is opened in Binghamton, NY. A growing network of inebriate asylums will treat alcoholism and addiction to a growing list of other drugs: opium, morphine, cocaine, chloral, ether, and chloroform.

1867: The opening of the Martha Washington Home in Chicago marks the first institution in America that specialized in the treatment of women.

1880's: Cocaine is recommended by Sigmund Freud, and a number of American physicians for the treatment of alcoholism and morphine addiction. Bottled home cures for the alcohol and drug habits abound; most will be later exposed to contain alcohol, opium, morphine, cocaine, and cannabis.

1901: The Charles B. Towns Hospital for Drug and Alcoholic Addictions in New York City marks the beginning of a new type of private "drying out" hospital for affluent alcoholics and addicts.

1907-1913: First of two waves of state laws is passed calling for the mandatory sterilization of "defectives": the mentally ill, the developmentally disabled, and alcoholics and addicts.

1919-1924: Forty-four communities establish morphine maintenance clinics (run by public health departments or police departments) to care for incurable and medically infirm addicts. All eventually close under threat of federal indictment. Treatment for narcotic addiction virtually disappears for all but the most affluent Americans.

1935: The meeting of Bill W. and Dr. Bob S. (and Dr. Bob's last drink) mark the beginning of Alcoholics Anonymous (AA).

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[26] Adapted from White, W., Slaying the Dragon: The History of Addiction Treatment and Recovery in America, Chestnut Health Systems, 1998.

1939: The book, ***Alcoholics Anonymous***, is published.

1940-1945: Recovery alcoholics in AA are recruited at Remington Arms, Dupont, Kaiser Shipyards, and North American Aviation to work in the first modern industrial alcoholism programs – forerunners of today's employee assistance programs (EAPS).

1944: Marty Mann founds the National Committee for Education on Alcoholism (today the National Council on Alcoholism and Drug Dependence).

1948-1950: The "Minnesota Model" of chemical dependency treatment emerges in the synergy between three institutions: Pioneer House, Hazelden, and Willmar State Hospital.

1950's: The Twelve Traditions are formally adopted to govern the group life of AA. The National Institute of Mental Health establishes a special division on alcoholism.

1960: E.M. Jellinek publishes ***The Disease Concept of Alcoholism***.

1963-1966: Provision for local alcoholism and addiction counseling are included in federal legislation funding the development of local comprehensive community mental health center, anti-poverty programs, and criminal justice diversion programs. Such federal funding increases throughout the 1960s.

As alcoholism programs spread, there is a heated debate over the question of who is qualified to treat the alcoholic. Tensions abound between "paraprofessional" recovering alcoholics and psychiatrists, psychologists and social workers within newly-emerging alcoholism treatment programs.

1964-1975: The insurance industry begins to reimburse the treatment of alcoholism on par with the treatment of other illnesses. This leads to a dramatic expansion in private and hospital-based inpatient treatment programs.

1967-1971: Special alcoholism counseling/treatment initiatives begin within all major branches of the U.S. Armed Forces.

1968: The Federal Advisory Committee on Traffic Safety acknowledges substantial role alcohol plays in car crashes. New impaired driving laws are created along with a rise of remedial education and treatment services for those arrested for alcohol-impaired driving.

1970's: ***The American Journal of Psychiatry*** and the ***Annals of Internal Medicin***e publish the "Criteria for the Diagnosis of Alcoholism."

The Joint Commission on Accreditation of Hospitals develops accreditation standards for alcoholism treatment programs.

The Food and Drug Administration approves use of methadone for treating heroin addiction.

U.S. investigators first describe fetal alcohol syndrome (FAS), a pattern of birth defects observed in children born to alcoholic mothers.

Arguments rage over whether alcoholism and "drug abuse" treatment (which have been separate fields for most of the 20th century) should be administratively and clinically merged. Such integration will become widespread at the state and local (but not the national) levels during the 1980s.

1975: Women for Sobriety is founded by Dr. Jean Kirkpatrick.

1978: First Lady Betty Ford speaks to the nation about entering recovery from addiction to alcohol and other drugs.

1980's: Mothers Against Drunk Driving, a powerful grassroots advocacy group, is formed.
The U.S. Postal Service issues a first-class stamp imprinted with "Alcoholism. You can beat it!"

Nancy Reagan's "Just Say No" anti-drug campaign is launched within a broader "zero tolerance" campaign that will reduce federal support for treatment and mark the beginning of the dramatic rise in the number of drug users incarcerated.

Addiction treatment becomes increasingly concerned about "special populations" and launches specialized treatment tracks for women, adolescents, the elderly, gays and lesbians, and the "dually diagnosed."

1987: President Reagan formally announces a renewed "War on Drugs;" the shift away from treatment toward punishment and incarceration intensifies.

1989-1994: Following an erosion of alcoholism treatment reimbursement benefits by insurance carriers, an aggressive system of managed care all but eliminates the 28-day inpatient treatment program in hospitals and private, free-standing center. The downsizing and closure of hospital-based treatment units sparks a trend toward the integration of many psychiatric and addiction treatment units and a renewed community trend of incorporating addiction treatment services under the umbrella of mental health or "behavioral health" services.

1990s: The explosive growth of the internet leads to a proliferation of on-line recovery support groups and services, creating a virtual recovering community without geographical boundaries.

2000s: New and renewed grassroots recovery advocacy organizations are christened the "New Recovery Advocacy Movement."

In a milestone article in the Journal of the American Medical Association, Drs. McLellan, Lewis, O'Brien, and Kleber call for the re-conceptualization and treatment of addiction as a chronic medical illness.

Session 5

FACILITATOR INFORMATION:

This session continues the communication section of the curriculum with a focus on skill building and practice. This is a good opportunity for participants to practice self-disclosure and receive feedback from the group. Facilitators have an opportunity to role-play for the group how to give information and utilize beneficial self-disclosure.

Ethics and boundaries are introduced and an opportunity to practice gentle refusal. It is recommended that facilitators re-introduce the Wisconsin Certified Peer Specialist Code of Ethics at this session and assign further reading for homework.

Participants practice the skill of summarizing. This is also an opportunity for facilitators to model support and encouragement for the group.

Peer Specialist Facilitator Curriculum Guide

SESSION 5

5 MINUTES Homework review

45 MINUTES Giving Information and Self-Disclosure

20 MINUTES Role Model giving information and self-disclosure

15 MINUTES Break

45 MINUTES Boundaries

10 MINUTES Gentle Refusal

15 MINUTES Break

50 MINUTES Summarizing and Peer Support Exercise

5 MINUTES Homework: Continue book report.

CPS CORE CRITERIA COVERED

1.10 Believes in the healing power of healthy relationships
3.2 Knowledge of ethics and boundaries
3.6 Knowledge of appropriate use of self-disclosure
4.4 Ability to assist people in exploring life choices, and the outcomes of those choices
4.8 Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.10 Ability to foster engagement in recovery
4.12 Ability to facilitate and support a person to find and utilize resources
4.15 Ability to set, communicate, and respect personal boundaries of self and others
4.16 Ability to utilize own recovery experience and skillfully share to benefit others
4.17 Ability to balance own recovery while supporting someone else's

Homework Review (5 MINUTES)

- Open class with a discussion of the homework assignment.
- Ask if there are any comments regarding the review questions.

Giving Information, Self-Disclosure

(45 MINUTES)

OBJECTIVE

To introduce and practice the skills of information giving and self-disclosure.

METHOD

- Read—Giving Information and Self-Disclosure.
- Discuss with class the material read and have participants give examples of self-disclosures that may be helpful to a peer.

GIVING INFORMATION

Lack of accurate information can keep peers from looking at problems objectively and seeing all the options that are available to them. For example, a recently immigrated woman in an abusive relationship might feel that staying with her partner is her only option because she lacks the awareness of services such as transition houses and income assistance. An effective Peer Specialist is familiar with the various resources in the community and makes that information available as appropriate.

Information giving is considered a challenging skill because it can bring to awareness uncomfortable facts that the recipient may not want to hear. For example, a peer who smokes marijuana might not like hearing all the negative side effects this drug has.

When giving information, Egan (1994) suggests the following pointers:

1. Make sure that you fully understand the worldview of the peer before sharing information. Also, be sure that the information you are giving is true. If you are not certain of the facts, it is better not to say anything.
2. Only give information that is relevant to the problem. Do not overwhelm the person with information not directly related to the problem.
3. Be tactful when giving challenging information. Be prepared to provide emotional support and help in dealing with the new information.
4. The Peer Specialist offers options and resources that support self-determination and choice.
5. Avoid giving advice disguised as information. For example, a Peer Specialist who discusses only psychiatric services with a peer is really giving their opinion of the only choice.

6. Remember, the path of recovery is different for all of us. The role of the Peer Specialist is to assist the peer to find their own path.

SELF-DISCLOSURE

The skill of self-disclosure involves the sharing of important personal information by the Peer Specialist. The most helpful self-disclosures are those related to similar past issues that the Peer Specialist has successfully resolved but with which the peer is still working through or experiencing. Therefore, this skill is also a form of modeling since it provides peers with an option for conflict resolution and challenges them to take similar action.

For example: A person with a mental illness or substance use disorder might be bothered about his weight but feels discouraged after several attempts of crash dieting. Professionals have told him that his diet contains too much fat. A Peer Specialist with a similar past weight problem might use the following self-disclosure:

> "Ten years ago I was feeling self-conscious about my weight but didn't seem to have enough will power to stop eating all that junk food. I used food as a way of soothing myself. But one day I decided to do something about it and joined a weight loss support group. I received the emotional support to change my eating habits and slowly I began to lose weight for a total of 50 pounds. I also learned to accept the fact that I was never going to be a size 5 if I wanted to eat balanced meals without starving myself."

When using self-disclosure, Egan suggests that the following guidelines be kept in mind:

1. Avoid extravagant and rambling stories about yourself.
2. Do not use self-disclosure as a means of unburdening your own unresolved issues on to the peer. This may result in the peer feeling as though they are supporting the Peer Specialist.
3. Be sure you don't use self-disclosure too early or too often.
4. Remember, self-disclosure should be for the benefit of the recipient, not you.

"If you have been in the abyss, the hopeless dark hole,
and have had the courage and tenacity to pull yourself out;
the most generous thing you can do is reaching a hand back to those still there."

Role Model Giving Information and Self-Disclosure (20 MINUTES)

OBJECTIVE

To introduce and practice the skills of information giving and self-disclosure.

METHOD

- To role model the skills described above.
- Trainers use a situation that they have encountered or one of the scenarios below to demonstrate appropriate information giving and self-disclosure.

ROLE PLAY SCENARIO #1

I saw some old friends from high school yesterday. It's been a few years since I've seen them but they acted like they didn't even know who I was.

ROLE PLAY SCENARIO #2

I want to get my life back. I'm tired of being sick. I have so much to do. I don't have time for this.

ROLE PLAY SCENARIO #3

It's been a crappy week. I'm tired and sick of everything.

ROLE PLAY SCENARIO #4

I want my clothes back. They took my clothes and won't let me leave. This hospital is like a jail.

• • • Break 15 minutes • • •

Boundaries (45 MINUTES)

OBJECTIVE

- To discuss what boundaries are and the types of boundaries that exist.
- To discuss how to set limits.

METHOD

- Ask group members to discuss types of boundaries. Use easel to list answers from participants. Add to list if needed.
- Read—Boundaries and Setting Limits.
- Read—Setting Limits with Gentle Refusal.
- Read – Wisconsin Certified Peer Specialist Code Of Ethics
- Break group into pairs and using the model for gentle refusal role-play the situations outlined. Instruct pairs to alternate roles—making the request and refusing the request. (For the purposes of this exercise, act as if you do not want to do what the other person is asking of you.)

Boundaries and Setting Limits

BOUNDARIES

Definition: a boundary is a limit or an edge that defines you as separate from others.

This limit can be violated and, depending on the nature of the violation, can cause a person to suffer. Our body is our most obvious boundary, but we also have an invisible boundary that extends beyond our skin. We know this boundary has been violated when someone feels too close. Sometimes we will say, "that person has invaded my space."

Each of us have the right to state what our boundaries are and we have a responsibility to respect other's boundaries regardless of whether or not we agree or understand. Healthy boundaries help people have safe and healthy relationships.

When we have grown up in environments that lacked healthy boundaries, then we are deprived of developing our own limits and how to protect ourselves. We learn about boundaries from our early life experiences.

Healthy boundaries are respectful and safe for both the peer and the Peer Specialist. They demonstrate respect of strength based recovery and the peer's right to self-determination and choice.

BOUNDARIES AND HEALTHY RELATIONSHIPS

Boundaries can be too close, both physically and other wise. If you have to be physically nose-to-nose with someone, if you have to have answers to all your questions, or if you feel you must reveal your thoughts and

feelings to everyone, then your boundaries may be too close. We all have a right to privacy. You need not feel what all your peers or friends feel, you need not comfort them, and you need not burden them with your own difficulties.

A boundary becomes too wide when people feel disconnected from you, when you feel neglected or abandoned. People who have been hurt may keep wide boundaries because it protects them from harm; but if you are working with people you must ask why the boundary is so wide. The Peer Specialist can do so with exploring questions and validation of the peer's experiences.

Boundaries are extremely important in doing peer support. Your ability to define your own boundaries will impact on how you identify yourself in your role and how respectful you will be of peers' boundaries. As a Peer Specialist you will be in a more powerful position and you must take on the responsibility of making the relationship between yourself and the person you are supporting a safe one. This can only be done if you have established appropriate boundaries for yourself and the person you are supporting.

A healthy relationship between a peer and Peer Specialist is grounded in mutual respect and consideration. The roles and expectations are clear and the relationship is sensitive to previous trauma. Some of the characteristics of healthy relationships include:

- ✓ **Respect –** Listening to one another, valuing each other's opinions, and listening in a non-judgmental manner. Respect also involves attempting to understand and affirm the other's emotions to build a trauma-sensitive relationship.
- ✓ **Trust and Support –** supporting each other's goals in life, and respecting each other's right to his/her own feelings, opinions, friends, activities and interest. It is valuing each other as an individual.
- ✓ **Honesty and Accountability –** communicating openly and truthfully, admitting mistakes or being wrong, and accepting responsibility for one's self.
- ✓ **Shared Responsibility –** Mutually agreeing on goals, strategies, and activities that the peer would like to pursue.
- ✓ **Non-threatening Behavior** – Talking and acting to produce feelings of safety in the relationship. Both the peer and the Peer Specialist should feel comfortable and safe in expressing feelings and emotions.
- ✓ **Belief in the Healing Power of Relationships** – Positive relationships help us all in feeling safe, confident and capable for the future.

The Wisconsin Certified Peer Specialist Code of Ethics

The following principles will guide Certified Peer Specialists in their professional roles and relationships:

1. I understand that my primary responsibility is to help peers understand recovery and achieve their own recovery needs, wants, and goals. I will be guided by the principle of self-determination for each peer.

2. I will conduct myself in a manner that fosters my own recovery and I recognize the many ways in which I may influence peers, and others in the community, as I serve as a role model.

3. I will be open to share with peers and coworkers my stories of hope and recovery and will likewise be able to identify and describe the supports that promote my recovery and resilience.

4. I have a duty to inform peers when first discussing confidentiality that intended serious harm to self or others cannot be kept confidential. I have a duty to accurately inform peers regarding the degree to which information will be shared with other team members, based on my agency policy and job description. I have a duty to inform appropriate staff members immediately about any intended serious harm to self or others or abuse from caregivers.
5. I will never intimidate, threaten, harass, unduly influence, physically force or restrain, verbally abuse, or make unwarranted promises of benefits to the peers I support.
6. I will not practice, condone, facilitate or collaborate in any form of discrimination on the basis of ethnicity, race, sex, sexual orientation, gender identity, age, religion, national origin, marital status, political belief, disability, or any other preference or personal characteristic, condition or state.
7. I will advocate with peers so that individuals may make their own decisions when partnering with professionals.
8. I will never engage in any sexual/intimate activities with peers I support. While a peer is receiving services from me, I will not enter into a relationship or commitment that conflicts with the support needs of the peer.
9. I will keep current with emerging knowledge relevant to recovery and openly share this knowledge with my coworkers and peers. I will refrain from sharing advice or opinions outside my scope of practice with peers.
10. I will utilize supervision and abide by the standards for supervision established by my agency. I will seek supervision to assist me in providing recovery-oriented services to peers.
11. I will not accept gifts of money or items of significant value from those I serve. I will not loan or give money to peers.
12. I will protect the welfare of all peers by ensuring that my conduct will not constitute physical or psychological abuse, neglect, or exploitation. I will practice with trauma awareness at all times.
13. I will, at all times, respect the rights, dignity, privacy and confidentiality of those I support.
14. As a professional, if I find that my own recovery journey is compromised and interferes with my ability to provide support to my peers, I will engage in my own self-care until such time that I am once again capable of providing professional care.

Wisconsin
Department of Health Services
Division of Mental Health and Substance Abuse Services

P-00972A (02/2015)

Key Point …

Many people with mental illness and substance use disorders have had their boundaries violated on numerous occasions. They may have difficulty knowing when this is occurring. The Peer Specialist can help model, support and establish healthy boundaries.

Setting Limits

The capacity to set limits is essential to feeling good about yourself. Many people have not known how to define their own time, to protect their bodies, to put themselves first, or to say "no."

Learning to say "no" can be a difficult challenge; but it is a relief to be able to stop doing what you don't want to. By setting limits, you protect yourself and give yourself freedom at the same time. Encourage peers to look for situations in their lives that they may want to say "no." Start with what's easiest and build up to the harder ones. Share with the peer that saying "no" may feel awkward at first if he has a history of not saying "no." Saying no does not have to be loud or hostile. But, with practice, setting limits can become a simple "no, I don't want to," "no thanks" or "no, I would rather not," and will become easier.

People may react as the peer becomes firm on their boundaries. They may try to convince the peer that things should be back where they were or they may feel hurt or you don't like them anymore. But encourage peers to stay with the boundaries they are comfortable with and people will soon realize and appreciate the new you.

In conclusion, boundaries are the foundation of a strong and safe relationship whether that relationship is with friends, peers, supervisors, doctors, etc. If you do not feel safe within a relationship, or a person you are supporting does not feel safe in the relationship, then little will be accomplished and more harm than good may result. Remember that boundary violations, regardless of how small, can cause harm. As a Peer Specialist, you must be aware of boundary issues and the potential for problems.

SETTING LIMITS WITH "GENTLE REFUSAL"

Have you ever been in a situation where you've been asked to do something you really didn't want to do, but didn't know how to say "No"? Can you think of recent times where you wanted to help out—but not to the extent that you did become involved?

If during a conversation, you find that you have to set limits, one effective way is to set limits with gentle refusal. This skill provides you with a way to say "no" as gently and caringly as possible, while inviting the other person to continue to explore with you on a more constructive level.

A Peer Specialist will find it helpful to use gentle refusal when:

- ✓ A person makes unrealistic demands on you
- ✓ A person wants guarantees
- ✓ A person demands advice
- ✓ A person asks personal questions and you feel uncomfortable

- ✓ A person is verbally abusive
- ✓ A person seems to continually to say, "Yes, but…" to many of your reflections or opinions

THE MODEL FOR GENTLE REFUSAL

Example: A peer asks to borrow money

Reflection:
Let the person know that you hear the request behind the question or demand. This will demonstrate that you understand what is happening.

"It sounds like you really need money right now."

The refusal:
Setting your limits or saying "no". Say as clearly as you can what your limits are (and if you choose—your reason.)

"I can't lend you money right now, (because…") or
"I'm not willing to lend you money."

Offering the invitation—Say clearly what you can, and/or are, willing to do.

"However, maybe we can look at other resources you might tap into."

This invitation shows that even though you can't meet the specific request, you are still concerned and want to keep your focus on that peer and her or his feelings.

GENTLE REFUSAL EXERCISE (10 minutes)

With a partner, go through the following role-plays alternating roles. In one situation you will be the person making the request, in the next situation you will be refusing the request.

In making your refusal, follow the model for gentle refusal:

- Reflect back the feelings or need behind the request
- Refuse by setting your limit or saying "no"
- Offer an invitation (what you are willing to do)

Situation #1:
Your peer wants to take you to her favorite hangout, "Doc's Burgers and Fries." You have been there before and found it so loud from the music they play and the large number of young people who hang out there, that you could not hear a thing and left with a major headache. You dread going back there.

Situation #2:
The peer outreach coordinator phones you at the last minute and asks if you will go to the impatient psychiatric unit right away. Other volunteers have cancelled and there are two people who have requested to see someone from peer outreach. The coordinator is really in a bind and doesn't want to let these people down. You are

feeling overwhelmed and have been reluctant to be a Peer Specialist on the unit and are at this point feeling scared.

Situation #3:
Another Peer Specialist phones you at night and says he needs to talk as he has had an awful day. You really like this person and he has been supportive to you, but you also had an awful day today and don't feel like you can be much support. The idea of listening to anyone right now seems beyond you.

Situation #4:
A peer asks if he can borrow five dollars for cigarettes and says he will pay you back when you get together. He is unusually short of money this month as his car broke down and he had to pay $150.00 in repairs. He has never asked for money before, but you are uncomfortable lending any money.

Key Point…

To foster engagement in recovery, the Peer Specialist helps the peer identify strengths, develop a wellness/recovery plan and discusses dreams and goals with the peer.

• • • ***Break 15 minutes*** • • • *(15 minutes)*

Summarizing and Peer Support Exercise (50 MINUTES)

OBJECTIVE

To introduce and practice the skill of summarizing.

METHOD

- Read—Summarizing
- Practice peer support skills using the same method as used for boundaries.

Summarizing

Summarizing refers to the ability of capturing the main points that have been covered during a single or several sessions. This skill can be helpful in making sure that the peer has been heard correctly and focus both the Peer Specialist and peer on the main issues. ***For example:***

> "Maybe I could summarize what we have covered in the last session. We explored some of your reservations in applying for the nursing program this fall. You're afraid you will not have enough knowledge of the sciences because you've been out of school for 15 years. You're worried the added stress might trigger another episode of depression. However, you've been thinking about going into psychiatric nursing for a long time and feel you have something valuable to contribute. Would it be helpful to look at ways you can prepare for school and stay healthy?"

Summarizing can also function as a challenging skill that prompts the peer to shift perspective. By bringing isolated pieces of information together, the person might gain a new perspective and insight into possible goals and courses of action.
For example:

> **Peer Specialist:**
> "You have told me that your husband drinks, gambles, does not allow you to have friends or see your family, controls your money, tell you how you should dress, has jealous fits of rage, and most of the time, you feel controlled and unsafe around him. That seems like a heavy burden to carry."

Peer:

"It is a heavy cross to bear. I just feel so tired and depressed all the time... Sometimes I wonder what it would be like to be on my own again, with just me and the kids."

Summaries are particularly useful at the beginning of a session since they decrease the chances of peers repeating themselves, and challenge them to move forward. A summary can also be used to help focus a session that is going nowhere. It is particularly useful at this time to challenge clients to do the summarizing.

For example:

"It might be useful at this point to pull together the main concerns you have talked about during our session. Would you like to try giving me a summary of what you feel are the main issues you want to tackle?"

To conclude, summaries by the Peer Specialist act as a link of relevant information in a concise manner so that potentially, the peer can gain more awareness of problem areas and move forward towards setting goals and action plans for change.

"Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around."

— LEO BUSCAGLIA

Homework – Book Report and Additional Readings

(5 MINUTES)

OBJECTIVE

- To reinforce that the book report is due by the beginning of Session 7.
- To encourage participants to read suggested materials.

METHOD

- Ask participants if they have any questions about the book report. Again, let them know the due date.
- Facilitators encourage the group to read additional information. This is also an opportunity for facilitators to bring in readings and information that has been helpful with other groups.

Additional Readings and Resources:

Copeland, Mary Ellen, ***Wellness Recovery Action Plan***, Peach Press, 2011

"Mental Health Recovery"
https://waops.sharepoint.com/Pages/default.aspx

Trauma Informed Care
https://waops.sharepoint.com/Pages/default.aspx

Wisconsin Certified Peer Specialist Code of Conduct, For Mental Health and Mental Health/Substance Use Disorder Peer Delivered Services
http://www.wicps.org/uploads/1/8/1/4/1814011/cps_code_of_conduct.pdf

Information and resources to build resilience, inclusion and hope for mental health in Wisconsin Communities.
http://wisewisconsin.org

Additional information on boundaries and limits.
http://mentalhealthrecovery.com/info-center/peer-support-boundaries-and-limits/

REVIEW QUESTIONS:

1. **What is the definition of "boundaries" in personal relationships?**
2. **What are Egan's guidelines for self-disclosure?**
3. **List some of the benefits of summarizing in the helping relationship.**
4. **When is it appropriate to use "gentle refusal?"**
6. **How can self-disclosure be used to foster engagement in recovery?**
7. **What are some local resources that you can use as a Peer Specialist?**
8. **How can you set boundaries in your role as Peer Specialist?**
9. **What are some ways you can share your own recovery experience to benefit others?**
10. **How can you keep balance in your own recovery while supporting others?**

Session 6

FACILITATOR INFORMATION:

This is the last session in the communication section of the curriculum. Information on strength-based recovery plans is presented. This is a good opportunity for facilitators to give examples and share with the group any formats or templates that they have found helpful in collaborating with peers.

Skill building continues as participants learn brainstorming and balance sheet techniques to assist peers. Concrete information on goal setting, developing strategies and action plans is given with opportunities for practicing.

Peer Specialist Facilitator Curriculum Guide

SESSION 6

5 MINUTES Homework review

60 MINUTES Strengths-Based Recovery plans

15 MINUTES Break

50 MINUTES Brainstorming and Balance Sheet Technique

15 MINUTES Break

60 MINUTES Person Centered Planning (PCP) and Wellness Recovery Action Planning (WRAP)

5 MINUTES Homework: Strength-based recovery worksheet.
Reminder book report due next time.

CPS CORE CRITERIA COVERED

2.8 Knowledge of strengths-based planning for recovery
3.3 Knowledge of the scope of practice of a Certified Peer Specialist
4.7 Effective written and verbal communication skills
4.12 Ability to facilitate and support a person find and utilize resources
4.16 Ability to utilize own recovery experience and skillfully share to benefit others
4.18 Ability to foster the person's self-advocacy and provide advocacy when requested by the person
4.19 Ability to advocate for self in the role of a Certified Peer Specialist

Homework Review (5 MINUTES)

- Open class with a discussion of the review questions from last session.
- Ask if there is any comments regarding any previously presented material.

Strengths-Based Recovery Plans
(60 MINUTES)

OBJECTIVE

- Provide information and guidelines for Peer Specialists to assist people in recognizing their strengths they can use for recovery.
- To complete a personal Strengths-Based Assessment.

METHOD

- Read—Strength Based Recovery Plans
- Read—Pros and Cons of Using Labels.
- Have participants complete Worksheet 1 and Worksheet 2. Lead a group discussion of the Pros and Cons of Labels.
- Using the Strength-Based Assessment Form that follows, have participants' pair up and interview each other to identify personal strengths. Have each participant complete the first column of the assessment for his or her partner.

Strengths-Based Recovery Plans

What Is It?

The Strengths-Based approach to recovery focuses on the inherent strengths of a person, then builds on them. This method uses peoples' personal strengths to aid in recovery and empowerment.

Why Use It?

- It is an empowering alternative to traditional therapies, which typically describe personal functioning in terms of psychiatric diagnoses or deficits.
- It avoids the use of stigmatizing language or terminology which people use on themselves and eventually identify with, accept, and feel helpless to change.
- It is at odds with the "victim identity" – epitomized in popular culture by the appearance of individuals on television or talk radio sharing intimate details of their problems—, which is inherently self-defeating.

- It fosters hope by focusing on what is or has been historically successful for the person, thereby exposing precedent successes as the groundwork for realistic expectations.
- It inventories (often for the first time in the person's experience) the positive building blocks that already exist in his/her environment that can serve as the foundation for growth and change.
- It reduces the power and authority barrier between the person and Peer Specialist by promoting the person to the level of expert in regards to what has worked, what does not work, and what might work in their situation.
- Individuals are more invested in a process where they feel they are an integral part.

Implications for The Peer Specialist

Effective Strengths-Based Recovery requires that we acknowledge people have the ability and strength to manage their own lives. Ideally, in the long run, we will not have an ongoing significant role in their lives—we will empower them to be the experts. However, we can help by locating and integrating those who are significant into the helping process. Most importantly, we must change the way we perceive, and the way we speak. Stigmatizing labels and person behavior descriptors must be avoided:

- Non-compliant
- Addict
- Resistive
- Unwilling to change
- Unmotivated
- Poor insight
- Uncooperative
- Dysfunctional
- Oppositional
- Defiant
- Delinquent

Additionally, never refer to a person by his or her diagnosis. Describing someone as a "schizophrenic" is no different from referring to another person as "cancerous." A person is not their illness—a person is a person, with a psychiatric or substance use disorder. The following chart gives concrete information on the differences between deficit-based language and strength-based, trauma-informed language.

Deficit-Based Language	Strength-Based, Recovery-Oriented, Person-First, Trauma-Informed Alternative
Describing a Person	
Schizophrenic, a borderline, bipolar	Person diagnosed with…, person who experiences the following…, in recovery from…
Addict, junkie, substance abuser	Person who uses substances; a person with substance use issues
Consumer, patient, client	Person in recovery, a person working on recovery, a person participating in services
Frequent flyer, super utilizer	Frequently uses services and supports, is resourceful, a good self-advocate, attempts to get needs met
Describing Behavior	
Good / bad, right / wrong	Different, diverse, unique
High- vs. low-functioning	Doing well vs. needs supports
Suffering from	Person is experiencing, living with, working to recover from
Acting-out, "having behaviors"	Person's behaviors may indicate a trauma memory has been triggered, person is upset
Attention-seeking	Seeking to get needs met, seeking assistance to regulate
Criminogenic, delinquent, dangerous	Specify unsafe behavior, utilizing unsafe coping strategies
Denial, unable to accept illness, lack of insight	Person disagrees with diagnosis, person sees themselves in a strength based way (Honor the individual's perception of self)
Manipulative	Resourceful, trying to get help, able to take control in a situation to get needs met, boundaries are unclear, trust in relationship has not been established
Oppositional, resistant, non-compliant, unmotivated	Constraints of the system don't meet the individual's needs, preferred options are not available, services and supports are not a fit for that person (Assume that people do well if they can)
DTO, DTS, GD (Danger to Others, Danger to Self, General Danger)	People should not be reduced to acronyms; describe behaviors that are threatening
Entitled	Person is aware of her/his rights, empowered
Puts self and/or recovery at risk	Person is trying new things that may have risks
Weakness, deficits	Barriers, needs, opportunity to develop skills

Deficit-based Language	Strength-Based, Recovery Oriented, Person-First, Trauma Informed Alternative
Describing Service Activity	
Baseline	Self-determined quality of life that was established at the first meeting
Clinical decompensation, relapse, failure	Crisis as an opportunity to develop and or apply coping skills and to draw meaning from an adverse event; recovery is not linear - relapse is expected and support is increased as necessary
Discharged to aftercare	Person is connected to long-term recovery support
Maintaining clinical stability, abstinence	Promoting and sustaining recovery, building resilience
Minimize risk	Maximize growth, presume competency
Non-compliant with medications, treatment	Person prefers alternative strategies, therapies and interventions; not reliant on medical model treatment; has a crisis or WRAP plan; person is thinking for herself
"Treatment works"	Person uses treatment to support his/her recovery
Case manager	Recovery guide, recovery support, care coordinator ("I'm not a case, and you're not my manager")
Enable	Empower through empathy, emotional authenticity, and encouragement
Front-line staff, "in the trenches"	Avoid using war metaphors and develop language that promotes strong relationships
Treatment team	Recovery team, recovery support system, care team

[27]

[27] Information adapted from Tandor, et al., Yale University Scool of Medicine Program for Recovery and Community Health, 2007.

Pros and Cons of using labels

There are pros and cons to using labels. The same person may choose to use a label in one situation, while in other situations they will not use labels. In worksheet 1, we will explore some of the pros of using labels, then in worksheet 2, we will explore some of the cons. Note that most pros have a naturally corresponding con. The choice to use labels is often dependent upon context. Take a few minutes to consider some of the pros below. Put checks next to the reasons that especially stand out for you. Are there others? Add them in the blank lines in the worksheet.

"When you are spiritually connected, you are not looking for occasions to be offended, and you are not judging and labeling others. You are in a state of grace in which you know you are connected to God and thus free from the effects of anyone or anything external to yourself."

— WAYNE DYER

Worksheet 1

Pros of Using Labels to Describe Experiences with Mental Health

1. Legitimizes the Experience to Self and Others Self-understanding, relief. "I finally understand why I've been dealing with this." Labels and diagnoses can reduce shame and blame. They can help other people see that you are not just being difficult, lazy, choosing to be depressed, etc., but that it is a legitimate condition that you can manage with support and treatment. A label provides a concise way to describe the complexities of the particular mental health challenge you face.	
2. Access to treatment and recovery A label or diagnosis is the beginning of recovery for many people. Having a diagnosis means you are more likely to have access to treatment, and that it will be covered by insurance. Having a diagnosis can help you access certain types of treatment that have worked well for others with that diagnosis. Our culture often avoids making change, or addressing need of treatment until something is defined as an illness. You are able to ask for reasonable accommodations at work and school.	
3. Support You can find peers and get support from those with similar experiences as you. Focus to plan recovery. Better understanding of trends of self.	
4.	
5.	
6.	
7.	

Worksheet 2

Again, many of the pros of using labels have naturally corresponding cons. Worksheet 1.3 lists some of them. Put checks next to the reasons that especially stand out for you. Are there others? Add them in the blank lines in the worksheet.

Cons of Using Labels to Describe Experiences with Mental Health

1. Limiting Limits my self-perception; puts a complex experience into a box. Reinforces rigidity in: care, family's perception, and view of self. Limits sense of potential. Having the label can create a sense of permanency, and the idea that you can't move beyond it. Drives you in the direction of fixed solutions and one-size fits all approaches.	
2. Focus on Negative aspects Can increase impact of co-occurring stigma. Additional labels that are seen as negative may have impact our view of self, and others' view of us. Labels can be disempowering. The positive aspects of your experience are lost.	
3. Everything is seen through the lens of the illness. Typical human experiences and emotions are blamed on the illness. Physical health concerns are not taken as seriously. The individual with the diagnosis is not seen as capable.	
4.	
5.	
6.	
7.	

Types of Strengths

- **Character strengths.** These are our capacity for thinking, feeling, willing, and behaving. They reflect what is best in you and can be viewed as your positive identity. People frequently underestimate their positive character traits.
- **Talents.** These are innate abilities, which typically have a strong biological loading and may or may not be well developed.
- **Skills.** These strengths are specific proficiencies that have been developed through training and practicing. For example, learning a specific trade or skill.
- **Interests.** These strengths are areas or topics you feel passionate about and are driven to pursue; such as, playing sports, engaging in hobbies or working with art or music.
- **Values.** These are the enduring beliefs, principles, or ideals that are of prime importance to you. Values reside in your thoughts and feelings, not behavior.
- **Learning Styles.** These are ideas or hypotheses about how people approach new material. Some people learn best by reading, some by discussion, etc.
- **Resources.** This is the one type of strength that is external. These are external supports such as living in a safe neighborhood, a supportive family, and a positive group.
- **Other strengths.** These are the strengths that are unique to the individual. Traits that may be viewed by the peer as "negative' can be reframed by the Peer Specialist to a positive strength. For example, a peer may share that they are "stubborn." The Peer Specialist might frame this as a positive strength for long-term recovery.

Strengths-Based Questions

To gain confidence in conducting a Strengths-Based Assessment, it is helpful to choose a small number of questions that you can practice. Here are some suggestions that can be used like a springboard to further questions.

- What is working well?
- Can you think of things you have done to help things going well?
- What have you tried? And what has been helpful?
- Tell me about what other people are contributing to things going well for you?
- Tell me about what a good day looks like for you? What makes it a good day?
- What are you most proud of in your life?
- What inspires you?
- What do you like doing?
- What kind of supports have you used that have been helpful to you?

STRENGTHS—ASSESSMENT

RESOURCES— PERSONAL/SOCIAL What have I used in the past?	INDIVIDUAL'S GOALS— ASPIRATIONS What do you want? What would you like to happen?	STRATEGIES What is going on today? What strategies can you use?
		Strategy: Pros: Cons: **Strategy:** Pros: Cons:

Brainstorming and Balance Sheet Technique (50 MINUTES)

OBJECTIVE

To introduce brainstorming and the balance sheet technique as tools for building a strengths-based plan.

METHOD

- Read: Brainstorming Technique
- Read: Balance Sheet Technique
- Take approximately 30 minutes: ask someone in the group to provide a problem they are working on. Using the easel, have the group brainstorm solutions.
- Using another 30 minutes, have the group use the balance sheet technique to select possible solutions.

Brainstorming Technique

The technique of brainstorming can be used to tap into the creative resources of a person. It encourages the peer to come up with as many ideas and strategies as possible about a particular situation. For example, in the early stages of the helping process, the Peer Specialist might suggest: "let's brainstorm and make a list of as many strengths you can think of that have worked in the past." At later stages of the helping process, brainstorming might be used as a tool for helping a peer come up with goals and strategic action plans to accomplish desired change.

Keep in mind the following points when helping someone brainstorm:

1. There is no such thing as a bad idea. The practicality of the possibilities generated during brainstorming can be discussed at a later stage.
2. Help the person use ideas already generated as a takeoff point to come up with additional ideas. This can involve expanding on one idea or combining several ideas to form new possibilities.
3. Help the person clarify their brainstorming ideas using open-ended questions. This process may generate further possibilities
4. If a peer is having difficulty coming up with ideas, the Peer Specialist may offer some "wild" possibilities to encourage the client to do the same. Wild

possibilities may contain the seeds of useful ideas that can be uncovered with further exploration. This is also a good time to use some humor with outlandish ideas.

Balance Sheet Technique

After the peer has been encouraged to brainstorm and come up with as many strategies as possible, the next step is to help him/her look at each possibility critically. To help in this process, the Peer Specialist now needs to focus possible consequences, positive and negative, of each alternative generated. One way of doing so is to look at each strategy with pros and cons. What are the:

- Possible outcomes to the peer
- Possible outcomes to significant others
- Possible outcomes to the peer's environment

The above decision making process can help a peer move out of his/her uncomfortable situation without making impulsive or rash decisions which might be regretted later.

Key Point…

As a Peer Specialist, always make sure that you thoroughly understand issues and communicate information clearly.

"If we ask people to look for problems, they will quickly find them. But if we ask people to look for strengths, their view of the situation will be colored by this."

• • • Break 15 minutes • • •

Person Centered Planning
(60 MINUTES)

OBJECTIVE

- To introduce Person Centered Planning
- To discuss the role of the Peer Specialist in helping set goals.
- To develop skills in setting goals.
- To discuss ways of developing strategies and action plans to achieve goals.

METHOD

- Read—Person Centered Planning
- Read—Wellness Recovery Action Planning (WRAP)
- Read—Goal Setting
- Read—Developing Strategies and Action Plans
- Using the peer support exercise format, break into groups of 2 and complete the goals and strategy sections of your Strengths-Assessment.

Person Centered Planning[28]

Person Centered Planning is an ongoing problem-solving process used to help peers plan for their future. In person centered planning, the focus is on the peer and that person's vision of what they would like to do in the future. The Peer Specialist helps the peer identify opportunities to develop personal relationships, participate in their community, increase control over their own lives, and to develop the skills and abilities needed to achieve these goals.

Person Centered Planning is a way for peers to plan their lives with the support and input from those who care about them. The process is used for planning the life that the peer aspires to have—taking the peer's goals, hopes, strengths, and preferences and weaving them in plans for a life that is rewarding. PCP is used anytime a peer's goals, desires, circumstances, preferences, or needs change.

Through the PCP process, a peer and the Peer Specialist:

[28] Michigan Department of Community Health Mental Health and Substance Abuse Administration, "Person-Centered Planning Policy and Practice Guideline, 2011.

- Focus on the peer's life goals, interests, desires, preferences, strengths and abilities as the foundation for the planning process.
- Identify outcomes based on the peer's life goals, interests, strengths, abilities, desires and preferences.
- Make plans for the peer to work toward and achieve identified outcomes. Identify the services and supports that the peer needs to work toward or achieve outcomes.

Meaningful PCP is at the heart of supporting peer choice and control. Person centered planning focuses on the goals, interests, desires and preferences of peer, while still exploring and addressing a peer's needs which include food, shelter, clothing, health care employment opportunities, educational opportunities, legal services transportation, etc.

Essential elements for Person Centered Planning include:

- ✓ **Person-Directed.** The peer directs the planning process with necessary supports and accommodations.

- ✓ **Person-Centered.** The planning process focuses on the peer, not the system or the individual's family, guardian, or friends. The peer's goals, interests, desires, and preferences are identified with an optimistic view of the future.

- ✓ **Outcome-Based.** Outcomes in pursuit of the peer's preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires. The way for measuring progress toward achievement of outcomes is identified.

- ✓ **Information, support and accommodations.** As needed, the peer receives comprehensive and unbiased information on services and community resources

Person centered work begins within each and every one of us and radiates out toward others. Our deep-seated belief systems guide the way in which we interact with other human beings. In other words, the planning processes we engage in with peers are a mirror image of what we believe about that person or a group of people. Theses core beliefs help to define our degree of "person centeredness." Simply thinking that we are being person-centered does not make us person-centered; it is what we actually do that demonstrates this concept.

Person centered planning requires a personal commitment to engaging conscious awareness and self-reflection about the relationship between how one feels, thinks, and acts. It is a way in which the Peer Specialist listens to peers and learns about important aspects of the peer's interests and needs. Person-centeredness is about intentionally being with others. It is helpful to reflect upon our actions with peers against the seven touchstones identified by Michael Kendrick:[29]

[29] Kendrick, Michael, "When People Matter More Than Systems," keynote presentation for the conference "The Promise of Opportunity," 2000.

1. A commitment to know and seek to understand
2. A conscious resolve to be of genuine service
3. An openness to being guided by the person
4. A willingness to struggle for difficult goals
5. Flexibility, creativity, and openness to trying what might be possible
6. A willingness to enhance the humanity and dignity of the person
7. To look for the good in people and help to bring it out

Wellness Recovery Action Planning (WRAP)[30]

Wellness Recovery Action Plan was developed by a group of people in 1997 who were searching for ways to overcome their own mental health issues and move on to fulfilling their life dreams and goals. WRAP was later trademarked by Mary Ellen Copeland and is included on the SAMHSA National Registry for Evidenced-Based Programs and Practices.

WRAP is a strengths-based approach to recovery. Peers are encouraged to manage their own wellness and recovery in a manner that is comfortable to them and within their means. The key recovery concepts of WRAP are:

- Hope—People who experience mental health difficulties or SUDS get well, stay well and go on to meet their life dreams and goals.
- Education—Leaning all you can about what you are experiencing so you can make good decisions about all aspects of your life.
- Personal responsibility—It's up to you, with the support of others, to take action and do what needs to be done to keep yourself well.
- Support –While working toward your wellness is up to you, receiving support from others, and giving support to others will help you feel better and enhance the quality of your life.
- Self-advocacy—Effectively reaching out to others so that you can get what it is that you need, want and deserve to support your wellness and recovery.

[30] Adapted from the WRAP website, http://mentalhealthrecovery.com/wrap-is/

The first part of WRAP is developing a personal "Wellness Toolbox." This is a list of resources for developing a recovery plan. It includes contacting friends and supporters, journaling, creative and fun activities, exercise, diet, and getting a good night's sleep.

A Wellness Recovery Action Plan has six sections:

1. A daily maintenance plan with three parts: a description of the person when they are doing very well, the wellness tools to use every day to maintain wellness, and a list of regular daily activities.

2. A list of external events or triggers that might make the person feel worse—like an argument with a friend or getting a big bill—along with the wellness tools that can be used to deal with them.

3. A list of the early warning signs, subtle internal signs that let a person know they are beginning to feel worse—like being unable to sleep or feelings of nervousness—along with an action plan for responding to these signs and to help the person feel better and avoid difficulties.

4. A list of the signs that things are breaking down and the person is feeling much worse—like feeling sad all the time, or hearing voices—along with an action plan based on the wellness tools to help the person feel better and prevent an even more difficult time.

5. A crisis plan or advance directive: A list of signs that lets others know they need to take over responsibility for care and decision making, including who takes over and supports through this time. It also lists what others can do that would help and things they might choose to do that would not be helpful. This type of proactive advanced planning keeps the person in control even when it seems as though they are not.

6. Post crisis plan: This art of the plan is thought out in advanced of a crisis or as one begins to recover from the crisis—when there is a clearer picture of what needs to be done to stay well.

WRAP is one of the most popular recovery-oriented programs for peers and is used in many contexts. There are numerous other programs including Pathways to Recovery developed by Kansas State University and BRIDGES developed in Tennessee. SAMHSA developed a program called TAMAR, which is designed for women and men with histories of trauma in residential systems.

The Peer Specialist will find it helpful to learn about other models and how they can be used with peers.

Goal Setting

Helping a peer set realistic goals is an important part of person centered planning. Goals provide a sense of direction for action that encourages the peer to think of strategies for realizing them.

The goal setting process always involves an assessment of whether the peer's goals are well matched with his/her values. Sometimes it is necessary to backtrack and help the peer reassess his/her values before defining desired goals For example, a peer might want to end her marriage but feels conflicted because her religious values do not support that option. If this peer ends her marriage without first resolving her conflict in values (i.e., Valuing freedom from an unhealthy marriage vs. valuing her religious belief that marriage is a life-long commitment), her decision might result in feelings of guilt that can affect her future emotional well-being.

Egan (1994) gives some excellent examples of open-ended questions that can help peers generate future scenarios out of which desirable goals might be generated. These include:

- "What would have to happen for this situation to work better for you?"
- "What patterns of behavior would be eliminated?"
- "What new patterns of behavior would help you manage the situation?"
- "What would this opportunity look like if you developed it?"
- "What things do you think it would be helpful to change?"

It is important that the Peer Specialist does not force his/her own agenda or goals on his peers, no matter how worthwhile and sensible these goals might seem.
For example:

> A Peer Specialist might think a useful goal would be get more exercise because the peer's inactivity is detrimental to his health. However, if the peer does not see her inactivity as an issue the Peer Specialist has to respect that and follow the peer's agenda.

The helping process suggested here is one in which peers take ownership and responsibility for their choices.

It is also important that you assist peers to set goals which can be stated in <u>specific</u> and <u>concrete</u> terms as opposed to supporting vague goals. For example, the goal of wanting to be a more spiritual person is too vague. The Peer Specialist can help the peer state this goal in more specific goals by asking a question like, "What in particular can you do that will give you the sense of being a more spiritual person?" With such exploration, the peer might come up with very concrete goals such as making a commitment to do volunteer work or joining a church.

In some instances, it is also helpful to break down a long-term goal into smaller more immediate goals that are steps towards realizing the larger goal. For example, a peer who failed to graduate from high school might decide as a long-term goal to get a university degree in Psychology. To realize this long-term goal, the peer could first set the more immediate goal of attending night school to get the courses necessary for a high school diploma.

As a Peer Specialist, it is important that you help peers assess whether their desired goals are realistic considering the inner and outer resources available. For example, it would not be helpful to encourage a peer to set a short-term goal of becoming a professional sailboat racer if she presently lacks the financial resources necessary for such an expensive sport. Encouraging unrealistic goals may set peer up for failure that can potentially damage their self-esteem and discourage them from trying again. Instead, small successes build confidence, which can motivate people to move forward toward challenging long-term goals.

"There is no small act of kindness.
Every compassionate act makes large the world."
— MARY ANNE RADMACHER

Developing Strategies and Action Plans

Once a peer has decided what goals to pursue, the next step in the helping relationship involves facilitating the development of action plans and strategies to attain desired change.

Frequently people know exactly what they want but have no clear idea on how to get there. The brainstorming technique can be a useful starting point in assisting people to develop strategies/action plans which best fit their situation and resources. For example, a peer who has decided to make a commitment to lose weight might use the brainstorming technique to generate a list of possible strategies to achieve this goal. The options generated might look like:

- Stop eating junk food
- Join Weight-Watchers
- Have surgery to reduce the size of his/her stomach
- Help of a friend
- Retreat to a health farm
- Stop eating at restaurants
- Start exercising at a gym
- Exercise at home with the aid of a videotape
- Go on a fast
- Have his/her mouth wired shut and only consume a liquid diet
- Join a self-help group
- Join an exercise class
- Consult a dietician
- Go for daily walks

If the peer has difficulty coming up with strategies during the brainstorming phase, the helper might give tentative suggestions. For example, the Peer Specialist could say:

"Here are some strategies that have worked for other people with similar problems…Do any of them make sense to you?" Or he might use self-disclosure such as: "I used to have the same problem and I found it really useful to…Does that appeal to you?" However, the final choice of strategies to be used is always left up to the peer.

The next step involves a critical assessment of the various strategies that have been generated. The balance-sheet method is a useful tool to increase awareness of the pros and cons of the various options.

The criteria for choosing strategies are similar to the ones suggested earlier for goal setting. They are concrete, specific, realistic, and compatible with the peer's values. Following the above example, after careful consideration, the peer might decide on the following strategies:

- Take a walk everyday
- Join an exercise class
- Stretch every morning
- Find a partner to exercise with

The final step involves developing a clear step-by-step plan with a time frame whenever possible, to achieve the desired goals. To improve the chance for success, an action plan will take into account the things in the peer's life that stop or help them reach their goals. For example, the above person who wants decides to exercise more might decide that it will be easier to follow through if he joins a gym. The final action plan might look something like this:

- ***Starting tomorrow,*** I will stretch every morning
- ***Starting tomorrow,*** I will join my friend three times a week for a half hour walk.
- ***Within the next week,*** I will register in a beginner's aerobics class. I will participate at least twice a week

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Key point…

People only change when they identify what they want different. It has to come from within.

• • • Break 15 minutes • • •

Guidelines for Choosing Issues/Problems

People often experience multiple problems and issues in day-to-day living. Following are some guidelines suggested by Egan (1994) for choosing the problems or issues to be worked on through peer support:

- Assist the peer in choosing a problem they would like to work on.
- Assist the peer in identifying issues that seem to be causing discomfort and pain to the peer.
- Assist the peer in identifying problems where changes can lead to an improvement in their life.
- Complex problems may be broken down to manageable sub-problems that can be worked on first.

As suggested by Egan, the Peer Specialist can help the peer choose issues she wants to work on by using simple exploring questions, such as:

- "What do you want?"
- "What would you like to happen?"
- "If you could have one thing you don't have, what would it be?"
- "What would you want to be different in your life?"
- "What changes do you want in your present lifestyle?"
- "What would you like to do differently?"
- "What would you want that you don't have now?"
- "What do you need in your life that you don't' have now?"

Homework – Book Report and Reading

(5 MINUTES)

OBJECTIVE

- To assist participants to feel comfortable with the Strengths-Assessment.
- Participants to complete book report by next session.
- To begin studying trauma informed peer support.

METHOD

- Ask participants to complete a Strengths Assessment on a friend or colleague.
- Instruct participants to bring completed book report next session. Ask if there are any questions or concerns regarding the book report.
- Ask the class to read the material in Session 7 *before* next session.

REVIEW QUESTIONS:

1. **When you encounter an issue that you are not sure about, what is the best course of action for the Peer Specialist?**
2. **What is person centered planning?**
3. **Give some examples of effective open-ended questions.**
4. **What are some local resources that can be used to assist peers in achieving their goals?**
5. **How can you use your own recovery experience to help the peer consumer generate strategies to reach a goal?**
6. **How can you assist a peer in identifying specific and concrete goals?**
7. **What can you do to advocate for yourself in your role as Peer Specialist?**

Section Three

A Trauma-Informed Approach to Mental Health and Substance Use

Session 7

FACILITATOR INFORMATION:

This is the first of five sessions on mental illness and substance use disorders (SUDS) and begins with an overview of the trauma-informed approach and review of recovery models. While SAMHSA's definition of recovery is used in core competencies for Peer Specialists, it is recognized that there are other models and frameworks that are also effective. Facilitators are encouraged to share these models, or have the group research and discuss ideas.

The concept of dual diagnosis is explained with information given on anxiety disorders, eating disorders, alcohol use disorder, tobacco and cannabis use disorders. Common diagnosis and descriptions are provided. This is not to promote or endorse "the medical model", rather it is the recognition that these are terms widely used, often with misunderstanding, and the Peer Specialist needs to have an accurate knowledge of what they mean.

As research into mental health and substance use disorders is ongoing, facilitators are urged to have the class research issues or study literature in the field. Important websites are also listed for other reading for the class.

This session and Session 8 are 3½ hours in length instead of 3 hours.

Peer Specialist Facilitator Curriculum Guide

SESSION 7

5 MINUTES Review of homework

40 MINUTES Trauma-Informed Approach and Trauma-Specific Interventions

35 MINUTES Recovery

15 MINUTES Break

10 MINUTES Dual diagnosis/Co-Occurring Disorders

45 MINUTES Anxiety Disorders –including panic disorders, panic attack, coping skills, phobic neuroses, OCD, Post-traumatic stress disorder and generalized anxiety disorder.

15 MINUTES Break

20 MINUTES Eating disorders and peer support exercise

45 MINUTES Alcohol Use Disorder (AUD), tobacco and cannabis use disorders.

5 MINUTES Homework: Readings, "Self-Care Assessment Worksheet."

CPS CORE CRITERIA COVERED

1.11 Believes and understands there are a range of views regarding mental health and substance use disorder and their treatment, services, supports, and recovery.
2.1 Knowledge of Samhsa's definition of recovery:
"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."
2.2 Knowledge of mental health and substance use disorders and their impact on recovery
2.3 Knowledge of the basic neuroscience of mental health and addiction
2.4 Knowledge of stages of change and recovery

2.5 Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.6 Knowledge of trauma and its impact on the recovery process
2.7 Knowledge of person-centered care principles
2.8 Knowledge of strengths-based planning for recovery

"Faith is taking the first step, even when you don't see the whole staircase."

—MARTIN LUTHER KING, JR.

Review of Homework (5 MINUTES)

OBJECTIVE

- To have book reports submitted.
- To review the homework information and elicit questions from the group.

METHOD

- Ask the group to turn in book reports. If any participant did not complete the assignment, ask to speak with them after class.
- Ask if there are any questions regarding the homework.

Trauma-Informed Approach (40 MINUTES)

OBJECTIVE

- To introduce peers to the trauma informed approach.
- To assist peers in recognizing the effects of trauma on recovery.

METHOD

- Read—Trauma-Informed Approach and Trauma Specific Interventions
- Lead a discussion on trauma, encouraging participants to share as they are comfortable. This can be done in a large group or have participants pick a partner.

Trauma-Informed Approach

Trauma is a near universal experience of individuals with mental health issues and/or substance use disorders. According to the U.S. Department of Health and Human Services Office on Women's Health, 55%-99% of women in substance use treatment and 85%-95% of women in the public mental health system report a history of trauma, with the abuse most commonly having occurred in childhood.

The Adverse Childhood Experiences study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente, is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and wellbeing. Almost two-thirds of the study participants reported a least one adverse

childhood experience of physical or sexual abuse, neglect, or family dysfunction, and more than one of five reported three or more such experiences.[31]

The trauma-informed approach suggests that peers, clinicians, organizations, and whole systems of care are in an active and reflective process of engaging consumers with histories of trauma. A trauma-informed approach transcends the isolated "individual session" designed to treat symptoms and results of trauma. Rather, trauma-informed care implies that peers and others involved in care recognize that trauma can have broad and penetrating effects on a peer's personhood. These effects can range from sensory sensitivities, (to harsh noise, light, for example) stemming from being sensitized through experience to more existential challenges, like distrust of others, despair, and a sense of powerlessness.

According to SAMHSA's concept of a trauma-informed approach, a program or approach is trauma informed when it:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization.[32]

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

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[31] National Council for Behavioral Health. www.TheNationalCouncil.org

[32] "Trauma-Informed Approach and Trauma-Specific Interventions, SAMHSA website, www.SAMHSA.gov.

Trauma-Specific Interventions

Trauma-specific intervention programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma such as substance use, eating disorders, depression, and anxiety
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

Trauma Informed Peer Support[33]

Program That Is Not Trauma-Informed Asks "What Is Wrong with You?"	**Trauma-Informed Program Asks "What Happened to You?"**
Examples:	**Examples:**
• "I am hearing voices." • "I want to hurt myself." • "I'm depressed/can't stop crying." • "I feel like dying." • "I feel like hurting someone." • "I can't manage my anger. I'm in trouble with the law." • "I keep using even though I can't pay my rent now."	• "I was raped, so now I'm scared and afraid to leave my house and go to work." • "I don't think I've ever felt like someone cared." • "My partner of thirty years died suddenly. I'm all alone now." • "I was called crazy and locked up while I was a teenager, so I don't know how to make friends." • "I was sentenced to prison and lost custody of my child, so now I can't keep her safe." • After I was diagnosed, all my dreams and hopes died."
What Does "Help" Look Like?	**What Does "Help" Look Like?**
• Focus is on his/her "needs" as defined by staff: "He/she needs to stop hearing voices." • The "helper" decides what "help" looks like.	• Creating and sustaining a sense of trust and safety in relationships. • Safety is mutually defined by both people. • Collaboration and shared decision-

[33] "Engaging Women in Trauma-Informed Peer Support: A Guidebook," National Association of State Mental Health Program Directors, 2012.

- Relationships are based on problem-solving and resource coordination, not on creating meaningful connections.
- Safety is defined as risk management.
- Common experience between peer staff and clients may be assumed and defined by the setting; i.e., common experience in a clinic is based on "illness" and coping with "illness."

making.
- Understanding and acceptance of big feelings.
- Crisis becomes an opportunity for growth.
- Authentic relationships are emphasized, rather than common experience. Everyone recognizes that people rarely have the same experience or make the same meaning out of similar events.

Impact of Trauma

- Invalidates personal reality
- Creates mistrust and alienation
- Loss of power and control
- Feelings of helplessness and hopelessness
- Feelings of voicelessness
- Being dominated, controlled, or manipulated
- Violates personal boundaries and sense of safety

Principles of Peer Support

- Non-judgmental
- Empathetic
- Respectful
- Honest and direct communication
- Mutual responsibility
- Power is shared
- Relationships are reciprocal

In peer support, self-awareness and self-care are essential to the development of mutually satisfying relationships. Self-awareness is defined as knowing enough about yourself—what nurtures you, what your vulnerabilities are, what upsets you—to be able to stay connected to yourself and to others. Self-care is defined as using that self-knowledge to create routines that keep you healthy, whether these are things you do alone or in groups, and understanding how this contributes to building communities of intentional healing.

Self-Awareness and Self-Care

In peer support, self-awareness and self-care are essential to the development of mutually satisfying relationships. Self-awareness is defined as knowing enough about yourself—what nurtures you, what your vulnerabilities are, what upsets you—to be able to stay connected to yourself and to others. Self-care is defined as using that self-knowledge to create routines that keep you healthy, whether these are things you do alone or in groups, and understanding how this contributes to building communities of intentional healing.

Self-care

Anyone who offers support to others probably knows how easy it is to slip into caretaking or rescuing behavior. Rescuing others or taking care of them can happen when the decisions others make feel risky and uncomfortable, or if a peer supporter does not

really believe in a woman's ability to manage her own life. Rescuing and caretaking can be ways you deal with your own distress. Most peer supporters realize how necessary risk is to growth and change, so being able to sit with your own discomfort when you do not agree with the decisions of women you support is very important. Learning ways to manage your own stress and being able to respect your own limits and needs is important.

Four Components of Self-care

There are four primary components of self-care: physical health, intellectual health, emotional health, and spiritual health. All four are equally important. You might think of self-care as the four legs of a chair. If any one leg is short, the whole chair rocks; if it is too short, the chair tips over!

Physical health includes playing sports, participating in exercise classes, dancing, walking, swimming, and stretching, as well as getting enough sleep and eating healthy, fresh food.

Intellectual health comes with reading, having stimulating conversations, learning a new skill or language, doing crossword puzzles, exploring new areas of interest by taking classes, going to museums and libraries, or listening to lectures.

There are many ways to enrich our emotional lives, including journaling, writing poetry, listening to or playing music, or spending time with people or companion animals. Many people have found that animals are especially attuned to the emotional needs of their caretakers, and both the human and the animal find reward in their bond.

PHYSICAL SELF-CARE TECHNIQUES TO TRY Cook's Hookup.

If you are experiencing anxiety on a regular basis, practice this exercise twice a day for approximately 2 minutes. Also, do it if you feel as though you are about to be flooded with feelings.

• Sit on a chair.
• Place left ankle behind right ankle.
• Place right hand on left knee.
• Place left hand on right knee.
• Place tip of tongue where teeth and gum meet.
• Holding these positions, do slow deep breathing for 2 minutes.

Slow, Deep Breathing

Practice doing this daily and gradually work up to 15 minutes a day. This exercise, done on a daily basis, will lower levels of excessive adrenaline and cortisol in the body. After a couple of weeks, you will feel more centered, more in control, more in touch with what you need. In addition, this exercise will boost your immune system.

• Sit in a chair with your back straight and supported, your feet flat on the floor or in a traditional meditation position.

•*Begin to breathe slowly and deeply by doing the following:
• Inhale all the way down to your navel. Your ribs will expand.
• Hold your breath for a count of 3.
• Exhale slowly by blowing through your mouth.
• When you think you've exhaled all the air, exhale a little more.
Repeat from *

Anger Release #1

Take bunches of old newspaper and forcefully rip them up!

Anger Release #2

• Kneel with pillow under knees at bed or couch.
• Fold hands, as if in prayer. Lay them on mattress or couch with arms straight.
• *Inhale. At the same time, raise clasped hands and straighten arms up over your head.
• As you exhale, quickly bring clasped hands down forcefully on the bed. Feel free to make noise as you do this.
Repeat from *

Keep doing this. It will pick up speed and assume a life of its own. Keep deep breathing as you do it. This is very important for your physical safety. After 3-5 minutes, you will suddenly stop and need to catch your breath. Notice your feelings. You may still feel angry, you may feel a need to cry, or you may feel incredibly light and relieved. If you still feel angry, repeat the exercise. If you feel like crying, allow your breathing to help you cry and release the pain. If you are feeling better, relax and do something self-nurturing.

Sleep If you experience difficulty falling asleep, try this simple little exercise: as you are lying in bed, use your finger to repeatedly trace an infinity sign (a figure eight on its side) in the air. After a few minutes, you will notice your eyelids are getting heavy.

Key Point …

If a peer has a long history of trauma, they may find it very difficult to develop trust with the Peer Specialist.

Recovery (35 MINUTES)

OBJECTIVE

- To provide Peer Specialists with an understanding of Recovery as a process.

METHOD

- Read and discuss—Defining Recovery and Supporting Feelings.
- Refer the class back to SAMSHA's definition of recovery.
- Provide a list of local resources that support recovery and review with class.

Defining Recovery and Supporting Feelings

Being diagnosed with or experiencing a mental illness or substance use disorder can be traumatic. While some peers feel relief to learn of a diagnosis, for many it changes how they feel about themselves. It may affect the way the peer's friends and family relate to him, and him to them. Because there is often trauma, peers need more than "learning the facts." They also need to learn how these traumatic experiences affect emotions. We call this part "supporting feelings."

Peers may feel frustration when they have tried to talk about feelings with mental health or substance abuse professionals, or with loved ones. In those situations, many peers end up feeling that no one is really listening and personal feelings are not important. They may have been told "this is just part of your illness." In this course we can talk about our emotions. We can openly discuss how we feel and how recovery affects our lives.

WHAT DOES RECOVERY MEAN FOR YOU?

When we talk about recovery, we are not talking only about the symptoms of mental illness or substance use disorders. We are talking about regaining a sense of ourselves as a valuable person who has something to live for. Recovery will mean different things to each of us. It is a process we go through *within ourselves, but not by ourselves.* We can ask for help from service providers, from family and friends, but ultimately, we are the ones who are responsible for making decisions about ourselves.

Learning to express our feelings effectively is a tall order. But we believe we *can* do it, have the *right* to do it, and that it *will* help us in our recovery.

> *Recovery does not refer to an end product or result. It does not mean one is 'cured.' In fact, recovery is marked by an ever-deepening acceptance of our limitations. Recovery is a process. It is a way of life. Like a plant, recovery has its seasons, its downward growth into darkness to secure new roots and then the times of breaking into the sunlight. But most of all,*

recovery is a slow, deliberate process that occurs by poking through one little grain of sand at a time.[34]

Emotional Stages of Recovery

Experiencing or being diagnosed with a mental illness or substance use disorder can change the lives of peers. People tend to respond to changes in similar ways. The "Emotional Stages of Recovery" include three "mental events" with one of three stages (recuperation, rebuilding or recovery) that follow each mental event.[35]

Event	Stage	Emotions	Needs
1. Crisis—psychosis, suicide attempt, mania, panic attack, excessive chemical usage	1. Recuperation—a state of dependence	Denial, confusion, despair, anger	Safe place, food, lots of sleep, a caregiver; medication
2. Decision—"time to get going"	2. Rebuilding—independence	Grief, self-doubt, hope, anxiety, frustration, pride	To be heard and accepted; learning about mental illness and substance use disorders, people skills, work skills; money, food, clothes, good place to live
3. Awakening—"I am somebody, I have a dream.	3. Recovery/ Discovery—building healthy interdependence	Acceptance of self and others, confidence, anger at injustice; helpfulness to others	A dream to strive for; people who appreciate me; intimacy—someone to love; meaningful work, play and physical activity; to advocate for self and others

EVENT 1: CRISIS

Crisis events can arise from emotional, psychological, and life challenges. The emotions we may feel during this phase may be painfully intense, or "numbing." If we are numb, it must be understood that this is the body's way of protecting us from stress we cannot handle.

STAGE 1: RECUPERATION

[34] Deegan, P.E., "Recovery and empowerment for people with psychiatric disabilities," Social Work in Health Care, 25, 3, 1997, P. 11.24.

[35] Based on the writings and research by Patricia Deegan, Courtenay Harding, John Strauss, William Pat Sullivan and Bill Anthony from the BC Division Consumer Development Project.

This stage of recuperation follows a crisis and is a time of dependence. For many of us with major mental illness or a substance use disorder, after the chaos and trauma of a crisis, we are exhausted (physically, emotionally, mentally and spiritually). This is a time when we feel down on ourselves, on those around us, and on life in general.

EVENT 2: DECISION

The time comes when we have recuperated enough to decide, "It is time to get going again." That time is different for each of us. It may be a couple of months, or it may take a couple of years. No one can make this decision for us. If we don't make the decision when we are ready, we will feel increasingly bored and empty.

STAGE 2: REBUILDING

After the decision to get going, we start rebuilding our life. This is a stage of rebuilding independence, our ability to take care of ourselves. When this time comes, it is up to us to take responsibility for getting the help we need to learn and practice our living and working skills. We may feel very uncertain about what to do. We may have mixed feelings about going back into the world.

Because we are growing during this time, we can expect setbacks and successes. Think of the setbacks as steps on the road to success. Nevertheless, we will feel "up" when we succeed and "down" when we have a setback. So will those who try to help us.

We may have to try many times to find people who will respect us enough to help us grow and believe in our potential even when we fall.

EVENT 3: AWAKENING

"I am somebody. I have a dream." As we rebuild, we come to a new sense of the "new me." It's like we have been through the fire and have come out a different person. We start to realize, there is more to me than mental illness. I am a whole person." It is not that we are better or worse than we started out to be – just different. We start to dream again about who we are and who we can be. This is the beginning of "recovery." For many of us, this is a first-time thing: "discovery."

STAGE 3: RECOVERY/DISCOVERY

This is the stage of building healthy interdependence. We develop a sense of "Who we are and what we want to be, who we care about and who cares about us." One of the things Sigmund Freud passed on to us is that people, at the deepest level of self, need to love, work and play. In the recovery/discovery stage we start to feel "good" more and more often.

"Dare to love yourself as if you were a rainbow with gold at both ends.
—ABERJHANI, JOURNEY THROUGH THE POWER OF THE RAINBOW:
QUOTATIONS FROM A LIFE MADE OUT OF POETRY

Needs

IN THE "RECUPERATION" STAGE, PEOPLE NEED:

1. a safe place to rest; to sleep a lot,
2. a caregiver to provide for basic needs: nutritious food, personal hygiene, clean clothes, and support.

The help at this point is not 'therapy,' but foundations, or building blocks for recovery. Peers need a safe place to sleep, regular nutritious food, a shower, clean clothes, and someone to let them know they care. Peers need to be free of the pressure to "get going" or "snap out of it." They may need an effective combination of medications and it may take some trial and error to find medications and the right dosages that work.

By stage 2 of Rebuilding, peers have a different set of needs

THE REBUILDING NEEDS ARE:

1. to be heard and believed
2. learning; about mental illness, people skills, work skills
3. money, food, clothes, and a good place to live

This is the point at which the peer may find therapy useful; although anyone who is a good listener, such as a Peer Specialist, can be helpful in hearing and believing the peer. It is good to have someone who has gone through similar struggles, who can say, "Hey, I hear you!" The classes on communication have given you some skills to be good listeners for each other. We also need to learn about mental illness and substance use disorders, how it affects us, and what we can do.

By stage 3 of Recover/Discovery, we are getting it together. We need to restore the balance in our life, to find purpose in work and volunteering, to reconnect with others and the world around us. We need to play.

NEEDS DURING THE RECOVER/DISCOVERY STAGE INCLUDE:

1. a dream to strive for
2. people who appreciate us
3. intimacy—someone to love
4. meaningful work—a chance to leave footprints
5. fun and physical activity
6. to advocate for self and others.

In the recovery stage we develop the capacity to love other people again and to be loved in return. We start to want things again. We feel hopeful about developing meaningful work, and grateful to those who help us along the way.

Key point …

The biggest barrier to recovery is a belief that recovery is not possible.

Dual Diagnosis/Co-Occurring Disorders[36]

(10 MINUTES)

OBJECTIVE

- To provide Peer Specialists with an understanding of dual diagnosis.

METHOD

- If possible, invite someone who has experience in dual recovery to present their knowledge and experience.
- Read and discuss—Dual Diagnosis/Co-Occurring Disorders.
- Discuss what resources are available in the community to assist people who experience co-occurring disorders.
- Peer support exercise. Have participant pick a partner and use scenarios to practice how the Peer Specialist can respond to a peer with a dual diagnosis.

Dual diagnosis is a term for when someone experiences a mental illness and a substance use problem simultaneously. Dual diagnosis is a very broad category. It can range from someone developing mild depression because of binge drinking, to someone's symptoms of bipolar disorder becoming more severe when that person uses heroin during periods of mania.

Either a substance use disorder or mental illness can develop first. A person experiencing a mental health condition may turn to drugs and alcohol as a form of self-medication to improve the troubling mental health symptoms they experience. Research shows though that drugs and alcohol only make the symptoms of mental health conditions worse.[37]

Using substances can also lead to mental health problems because of the effects drugs have on a person's moods, thoughts, brain chemistry and behavior.

How Common is a Dual Diagnosis?

Many people experiencing mental illness also experience substance use disorders. These statistics are mirrored in the substance use disorder community, where about a third of all alcohol users and more than half of all drug users report experiencing a mental illness.

Men are more likely to develop a co-occurring disorder than women. Other people who have a particularly high risk of dual diagnosis include individuals of lower socioeconomic status, military veterans and people with more general medical illnesses.

[36] "Dual Diagnosis," by National Alliance on Mental Illness, March 2015.
[37] "The Connection Between Mental Illness and Substance Abuse," Dual Diagnosis.org

Symptoms

The defining characteristic of dual diagnosis is that both a mental health and substance use disorder occur simultaneously. Because there are many combinations of disorders that can occur, the symptoms of dual diagnosis vary widely. The symptoms of substance use disorder may include:

- Withdrawal from friends and family.
- Sudden changes in behavior.
- Using substances under dangerous conditions.
- Engaging in risky behaviors when drunk or high.
- Loss of control over use of substances.
- Doing things you wouldn't normally do to maintain your habit.
- Developing tolerance and withdrawal symptoms.
- Feeling like you need the drug to be able to function.

The symptoms of a mental health condition also can vary greatly. Knowing the warnings signs, such as extreme mood changes, confused thinking or problems concentrating, avoiding friends and social activities and thoughts of suicide, can help identify if there is a reason to seek help.

How is Dual Diagnosis Treated?

The most common method of treatment for dual diagnosis today is integrated intervention, where a person receives care for both a specific mental illness and substance use disorder. Because there are many ways in which a dual diagnosis may occur treatment will not be the same for everyone.

Detoxification. The first major hurdle that people with dual diagnosis will have to pass is detoxification. During inpatient detoxification, a person is monitored 24/7 by a trained medical staff for up to 7 days. Inpatient detoxification is generally more effective than outpatient for initial sobriety. This is because inpatient treatment provides a consistent environment and removes the person battling addiction from exposure to people and places associated with using.

Inpatient Rehabilitation. A person experiencing a serious mental illness and dangerous or dependent patterns of substance use may benefit most from an inpatient rehabilitation center where she can receive concentrated medical and mental health care 24/7. These treatment centers provide her with therapy, support, medication and health services with the goal of treating her addiction and its underlying causes. Supportive housing, like group homes or sober houses, is another type of residential treatment center that is most helpful for people who are newly sober or trying to avoid relapse.

Outpatient Treatment. Many communities have outpatient partial hospitalization programs that can be of value for substance use disorders and mental health. They meet several times per week and offer education, resources and support for those in recovery.

Medications. They are a useful tool for treating a variety of mental illnesses and substance use disorders. Depending on the symptoms a person is experiencing, different medications may play an important role in one's recovery. Medications to ease withdrawal are used during the detoxification process.

Psychotherapy. This is often a large part of an effective dual diagnosis treatment plan. Education on a person's illness and how their beliefs and behaviors influence their thoughts has been shown in countless studies to improve the symptoms of both mental illness and substance abuse. Cognitive behavioral therapy (CBT) in particular is effective in helping people with dual diagnosis learn how to cope and to change ineffective patterns of thinking.

Self-help and Support Groups

Dealing with a dual diagnosis can feel challenging and isolating. Support groups allow members to share frustrations, successes, referrals for specialists, where to find the best community resources and tips on what works best when trying to recover.

Harm Reduction[38]

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet people who use/misuse drugs "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve people reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

Key point …

Most healthy relationships include support and encouragement that is mutual to both people.

• • • Break 15 minutes • • •

[38] http://harmreduction.org/about-us/principles-of-harm-reduction/

Anxiety Disorders (45 MINUTES)

OBJECTIVE

To increase understanding of mental health disorders and their impact.

METHOD

- If possible, invite someone who has experience with anxiety disorders to present their knowledge and experience.
- Read—Anxiety Disorders, Panic Disorders, Panic Attack Coping Skills, Obsessive Compulsive Disorder (OCD), Post-Traumatic Stress Disorder and Generalized Anxiety Disorder.
- Discuss what resources are available in the community to assist people who experience anxiety disorders.
- Peer support exercise. Have participant pick a partner and use scenarios to practice how the Peer Specialist can respond to a peer with an anxiety disorder.

Anxiety Disorder Classifications

The main characteristics of anxiety disorders are the personal experience of anxiety and avoidance behavior. The disorders are further classified into Panic Disorders, Phobic Neuroses, Generalized Anxiety Disorder, Obsessive Compulsive Disorder and Post-traumatic Stress Disorder.

PANIC DISORDERS

The essential features of these disorders are recurrent "unexpected" panic attacks that do not seem associated with a specific stressful situation. In other words, the panic attacks seem to come out of nowhere with no apparent triggers.

At the subjective level, panic attacks can include the following symptoms:

1. Shortness of breath
2. Dizziness, faintness
3. Palpitations or accelerated heart rate
4. Trembling or shaking
5. Sweating
6. Choking sensation
7. Nausea and/or abdominal distress
8. Numbness or tingling sensation
9. "Hot flushes" or chills
10. Chest pain or discomfort

11. Fear of dying
11.Fear of going crazy or becoming out of control
12. Depersonalization * or Derealization**

*Depersonalization—A feeling of being detached from oneself, one's body and environment. Occurrences involving the self are observed from the perspective of a detached outsider.

**Derealization—The sense of self is preserved but occurrences are experienced as unreal.

Many individuals confuse their first few panic attacks with an asthma or heart attack. Furthermore, doctors themselves might make a misdiagnosis.

Individuals who experience "unexpected" panic attacks frequently develop anticipatory anxiety where they continually worry about the start of another attack. This may lead to social isolation for fear of embarrassment. In some cases the person might also develop Agoraphobia—the person develops a morbid fear of unfamiliar or open spaces. In extreme cases, the person might become totally housebound.

Panic Attack Coping Skills

The first step is to educate the person and make them aware that panic attacks are not life threatening and the symptoms experienced are the result of a sudden adrenalin surge.

The second step involves helping the individual gain awareness of particular sensations preceding the full-blown attack.

The third step involves using these preceding sensations as cues to engaging in some form of physical activity, such as exercise, running or brisk walking.

These exercises serve to use up excess adrenalin and prevent a full-blown panic attack. If the panic attack cannot be short-circuited, the person can train themselves to "go with it" by using positive self-statements such as:

- "I've gotten through this before, I will get through this one."
- "I have to take deep breaths."
- "It's only going to last a few minutes longer."

As a Peer Specialist, it is important for you to encourage peers to discuss their panic attacks with their therapist/doctor since their symptoms may reflect a medical condition such as Angina (reduced blood flow to the heart muscle). Also, medication is available to lessen the onset of panic attacks and/or control anticipatory anxiety. Peer Specialists should encourage the use of the above coping skills.

OBSESSIVE COMPULSIVE DISORDER

The essential feature of this disorder is recurrent time-consuming obsessions (i.e. intrusive and persistent ideas, thoughts and/or images) or compulsions (repetitive behaviors usually in response to an obsession) that significantly interfere with the person's functioning at the occupational, social and/or interpersonal level. Attempts to control the compulsions usually result in a sense of mounting tension that is immediately relieved by performing the ritualistic behaviors.

For example, a peer might be obsessed by the idea of being contaminated by germs. Such an obsession might lead her to engage in ritualistic behaviors like washing her hands 20 times a day, spending hours each day cleaning and disinfecting the house and avoiding physical contact with others for fear of germ contamination.

Obsessive Compulsive behaviors can sometimes be treated successfully with intensive therapy involving a one to one professional worker who helps them to resist the compulsive behaviors through behavior modification techniques. (This is not the role of the Peer Specialist.)

POST-TRAUMATIC STRESS DISORDER

This disorder might result as a response to a traumatic event that is outside the range of usual human experience. The original distressing event is usually experienced with extreme fear, terror and feelings of helplessness. The traumatic event is continually experienced again by intrusive though recollections, dreams, and/or flashbacks. Even exposure to events that resemble in some way the original trauma can result in extreme psychological distress. Other symptoms may include:

- Avoidant behavior toward thoughts or activities that may arouse recollection of the trauma
- Hypervigilance
- Restricted range of affect
- Irritability and angry outbursts
- Recurring bouts of depression and anxiety
- Numbed or exaggerated startle response
- Negativity about the future
- Insomnia or disrupted sleeping patterns
- Concentration difficulties
- "Survivor's guilt" if others died during the traumatic event

The original trauma may be due to naturally occurring (e.g. earthquake), accidental (e.g. plane crash) or purposeful events or crime (e.g. sexual assault).

Post-traumatic Stress Disorder can often be successfully treated with debriefing therapy.

GENERALIZED ANXIETY DISORDER

The main characteristic of this disorder is the all-encompassing, chronic experience of excessive anxiety and worry. Symptoms might include:

- Trembling, twitching, shakiness and/or restlessness
- Muscle soreness or tension
- Fatigue
- Shortness of breath
- Palpitations/accelerated heart rate
- Sweating, hot flashes or chills
- Dry mouth, difficulty swallowing
- Dizziness
- Nausea, diarrhea, abdominal distress
- Exaggerated startle response, irritability
- Disturbance in sleeping patterns
- Difficulty in concentrating

"Our anxiety does not empty tomorrow of its sorrows, but only empties today of its strengths."

—CHARLES H. SPURGEON

• • • Break 15 minutes • • •

Eating Disorders (20 MINUTES)

OBJECTIVE

To increase understanding of mental health disorders and their impact.

METHOD

- Invite someone who has experience with recovery from an eating disorder to present their knowledge and experience.
- Read—Eating Disorders, Anorexia Nervosa, Treatment for Anorexia and Bulimia Nervosa, Compulsive Eating, and The Pitfalls of Dieting.
- Discuss what resources are available in the community to assist people who experience eating disorders.
- Peer support exercise. Have participant pick a partner and use scenarios to practice how the Peer Specialist can respond to a peer with an eating disorder.

Eating Disorder Classifications

Eating disorders are common in our society and have steadily increased over the last three decades, especially among women, where approximately 1 in 10 is affected.

Reasons for such an increase are probably multifold, but many clinicians feel that a major factor in eating disorders is the world of fashion and entertainment, where the image of a beautiful body has become increasingly defined as thin.

The idea that ‘thin is beautiful’ is mostly a phenomenon of the western culture in the twentieth century. In previous times, the ideal shape for women was a much plumper figure. Other cultures, which have not yet adopted western ideals, still prefer full-figured women. For example, in Mexico, women with large breasts and wide hips are considered beautiful and desirable. However, the more cosmopolitan woman in such cultures is beginning to shift her ideals to the “Hollywood” standards.

The ‘thin is beautiful’ standard excludes the majority of women, who, without overeating, have been genetically predetermined to have fuller figures but are nonetheless considered fat in our culture. These unnatural standards put incredible pressure on the teenage population whose self-esteem is so linked to body image.

Other predisposing factors to eating disorders include dysfunctional families that create unrealistic standards, expecting perfection in their children and demanding parenting skills that are not encouraging to the development of autonomy in children. Some

pubescent girls may resort to drastic weight control to prevent development of a woman's body because they fear the responsibilities and autonomy necessary for survival in the adult world. Being able to control their appetite and weight gives them a sense of control that is otherwise lacking in their lives.

Eating disorders might start out with a diet that results in a weight loss that is usually validated by the peers of the teenager. Unfortunately, most diets fail in the long run, setting up a vicious circle of weight gain followed by more dieting. Eventually the young women may resort to drastic life-threatening measures such as starvation, vomiting, compulsive exercising and the use of diuretics and laxatives.

ANOREXIA NERVOSA

The onset of this disorder typically begins in adolescence or early adult life. The essential features include an extreme fear of gaining weight/becoming fat, and distortion in body image.

BULIMIA NERVOSA

The essential feature of this disorder is recurrent episodes of secret binge eating (usually involving high caloric foods and sweets) accompanied by the feeling of being out of control over the binging. Abdominal discomfort due to binging is initially alleviated by the self-induced vomiting, however, for people who have experienced bulimia for a long time, vomiting may eventually become an automatic response.

Medical problems include gastrointestinal difficulties, poor teeth due to acid damage from the vomiting, and heart irregularities due to electrolyte disturbances caused by the purging. This disorder can also be lethal if untreated.

COMPULSIVE EATING

Although not everyone who is obese overeats, there are some individuals who have a weight problem because of compulsive eating. There are many reasons why a person might feel compelled to overeat. Following are some common underlying reasons:

- Some women with a history of sexual abuse use obesity as a protective shield to discourage attention from men
- Individuals may use food as a substitute for emotional nourishment
- Overeating may be a coping mechanism for stress, boredom
- Overeating may be the result of side-effects from medications
- Overeating may be a side-effect of depression (chocolate has been related to lessening of depressive moods)

If a peer is interested in overcoming compulsive eating, a first step may involve increasing awareness of triggers and underlying reasons that are related to their binges. This can be accomplished by keeping a journal which includes documenting feelings at

the time the urge to eat is first noticed, what is eaten to satisfy the need, and feelings after eating.

Individuals can substitute high caloric foods with healthier snacks to satisfy the urge to eat. A healthy eating plan can be developed, preferably with a dietician, coupled with regular exercise. Following is a discussion as to why people are not encouraged to go on restricted diets.

The Pitfalls of Dieting

Peer Specialists should never encourage anyone to go on a restricted caloric diet. Although in the short-term the person's appearance might improve by rapid weight loss, the majority of people gain back the weight once they stop dieting. Furthermore, restricted caloric intake tends to slow down the metabolism rate, which remains low, even after the dieting has ended. The usual result is a weight gain that levels off at about 10% above the weight before the diet was started. With each episode of dieting, the resulting weight becomes increasingly higher. This is known as the "yoyo" effect where people who have dieted for many years become increasingly obese without overeating.

Long-term restricted dieting has been associated with spontaneous, out of control binging. For some individuals it may lead to serious eating disorders. Depression, without previous history of a mood disorder has also been associated with long-term restricted caloric intake.

Developing healthy eating habits is beneficial to mental and physical health. In addition, regular exercise uses up calories and tends to increase the metabolic rate. It also helps the body use up the fat intake instead of storing it as fat tissue. This is a much slower process of losing weight but in the long run it is more successful.

Alcohol use disorder (AUD), tobacco and cannabis use disorders[39] (45 MINUTES)

OBJECTIVE

To increase understanding of alcohol use disorder, tobacco and cannabis use disorders.

METHOD

- Invite someone who has experience in recovery from addiction to alcohol, tobacco, and/or cannabis, to present their knowledge and experience.
- Read—Substance use disorders, alcohol use disorder, tobacco and cannabis use disorders
- Discuss what resources are available in the community to assist people who AUD, tobacco or cannabis use disorder.
- Peer support exercise. Have participant pick a partner and use scenarios to practice how the Peer Specialist can respond to a peer with an AUD, tobacco or cannabis use disorder.

Substance Use Disorders

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual.

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Acoording to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacologocal criteria.

The following is a list with descriptions of the most common substance use disorders in the United States.

Alcohol Use Disorder (AUD)

Excessive alcohol use can increase a person's risk of developing serious health problems in addition to those issues associated with intoxication behaviors and alcohol withdrawal

[39] "Substance Use Disorders," SAMHSA Publications, samhsa.gov, 2015.

symptoms. According to the centers for Disease Control and Prevention (CDC), excessive alcohol use causes 88,000 deaths a year.

Data from the National Survey on Drug Use and Health shows that in 1014, slightly more than half (52.7%) of Americans ages 12 and up reported being current drinkers of alcohol. Most people drink alcohol in moderation. However, of those 176.6 million alcohol users, an estimated 17 million have an AUD.

Many Americans begin drinking at an early age. In 2012, about 24% of eight graders and 64% of twelfth graders used alcohol in the past year.

The definitions for the different levels of drinking include the following:

- Moderate Drinking—According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.
- Binge Drinking—SAMHSA defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on a least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dl. This usually occurs after 4 drinks for women and 5 drinks for men over a 2 hour period.
- Heavy drinking—SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Excessive drinking can put you at risk of developing an alcohol use disorder in addition to other health and safety problems. Genetics have also been shown to be a risk factor for the development of an AUD.

To be diagnosed with an AUD, individuals must meet certain diagnostic criteria. Some of these criteria include problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

There are many treatment options for those who want to limit or quit alcohol usage. These include:

- Individual and group counseling
- Inpatient and residential treatment
- Intensive outpatient treatment
- Partial hospitalization programs
- Case management
- Medication
- Recovery support services
- 12-Step fellowship

As many programs for substance use treatment incorporate the 12 Steps and 12 Traditions of A.A., it is helpful for Peer Specialists to become acquainted with this traditional framework.

Medications are also available that can assist in the treatment of alcohol use disorder. Acamprosate is a medication that reduces symptoms of protracted withdrawal and has been shown to help individuals with alcohol use disorders who have achieved abstinence go on to maintain abstinence for several weeks to month. Naltrexone, a medication used to block the effects of opioids, has also been used to reduce craving in those with alcohol use disorders. Disulfiram is another medicaito which changes the way the body metabolizes alcohol, resulting in an unpleasant reaction that includes flusing, nausea, and other unpleasant symptoms if a person take the medication and then consumes alcohol.

Tobacco Use Disorder

According to the CDC, more than 480,000 deaths each year are caused by cigarette smoking. Tobacco use and smoking do damage to nearly every organ in the human body, often leading to lung cancer, respiratory disorders, heart disease, stroke, and other illnesses.

In 2014, an estimated 66.9 million Americans aged 12 or older were current users of a tobacco product (25.2%). Young adults aged 18 to 25 had the highest rate of current use of a tobacco product (35%), followed by adults aged 26 or older (25.8%), and by youths aged 12 to 17 (7%).

While quitting smoking is very difficult, it has been shown that people who keep trying to quit eventually are successful. While many people attempt to quit "cold turkey," success is more likely if multiple treatment approaches are used. These may include: group meetings, educational groups, counseling, hypnosis, and medication.

There are three medications approved by the Food and Drug Administration (FDA) to treat tobacco use disorders. Nicotine replacement medications assist with reducing nicotine withdrawal symptoms including anger and irritability, depression, anxiety, and decreased concentration. Because nicotine delivered through chewing of gum containing nicotine, via transdermal patch, or in lozenges has a slower onset of action than does the systemic delivery of nicotine through smoked tobacco; these medications have little effect on craving for cigarettes. These medications are available over-the-counter. However, the nicotine inhaler and nasal spray deliver nicotine more rapidly to the brain and so are available only by prescription.

Bupropion is a medication originally developed and approved as an antidepressant that was also found to help people to quit smoking. This medicaiton can be used at the same dose for either smoking cessation or depression treatment (or both). Varenicline reduces craving for cigarettes and has been helpful in smoking cessation for many. Bupropion and varenicline are prescription medications.

Cannabis Use Disorder

Marijuana is the most-used drug after alcohol and tobacco in the United States. According to SAMHSA data:

- In 2014, about 22.2 million people ages 12 and up reported using marijuana during the past month.
- Also in 2014, there were 2.6 million people in that age range who had used marijuana for the first time within the past 12 months. People between the ages of 12 and 49 report first using the drug at an average age of 18.5.

In the past year, 4.2 million people ages 12 and up met criteria for a substance use disorder based on marijuana use.

Marijuana's immediate effects include distorted perception, difficulty with thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure to cancer causing compounds. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Some symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use.

A major issue in the treatment of cannabis use disorder is whether patients should be encouraged to give up marijuana altogether, or whether reduction in use is enough. It varies from person to person with many clinicians having different views. While abstinence has traditionally been a goal of substance abuse treatment, for some reduction may be a more reasonable goal. If there is a substantial reduction of use, for example, smoking 10 marijuana cigarettes per day to half a joint before bedtime, with substantial improvement in functioning, this may be considered a reasonable outcome. There are no medications currently approved by the ADA for treatment of cannabis use disorder.

Key Point …

It is critical that the Peer Specialist have information on recovery resources including basic needs, medical, mental health and substance use disorder care and supports.

Homework (5 MINUTES)

OBJECTIVE

To reinforce learning of mental health and substance use disorders and their impact on recovery.

METHOD

- Ask participants if they have any questions about Anxiety Disorders or Eating Disorders.
- Ask participants if they have any questions regarding AUD, tobacco and cannabis use disorders.
- Read: Twelve Steps and Twelve Traditions of A.A. Assign additional articles and resources.
- Ask participants to complete the "Self-Care Assessment Worksheet."

Additional Readings and Resources:

Bennett, Carole, MA, "The Road to Addiction: Loneliness and Depression," Huffpost Healthy Living, Nov. 17, 2001. http://www.huffingtonpost.com/carole-bennett/the-road-to-addiction---1_b_232674.html

Moyers, William Cope, ***Broken: My Story of Addiction and Redemption***, Penguin Books, August, 2007.

"Duel Diagnosis" NAMI Fact Sheet. http://www.nami.org/getattachment/Learn-More/Fact-Sheet-Library/Dual-Diagnosis-Fact-Sheet.pdf

O'Connell, Kathleen R., ***Bruised by Life?: Turn Life's Wounds into Gifts***, Fairview Press, Dec. 1994.

"People in Recovery from Addictions and Mental Health Problems" published by SAMSHA. http://mentalhealthrecovery.com/info-center/peer-support-boundaries-and-limits/

"Stages of Change" http://www.amhc.org/1408-addictions/article/48539-motivation-for-change-the-stages-of-change-model

"Stages of Recovery" http://www.crchealth.com/find-a-treatment-center/washington-treatment-information/5-stages-addiction-recovery/

REVIEW QUESTIONS:

5. **What is the Trauma Informed Approach?**
6. **How can you use SAMHSA'S definition of recovery in your work as a Peer Specialist?**
7. **What are the emotional stages of recovery?**
8. **Recovery and wellness involves the integration of the whole person. What does this all include?**
9. **What are some of the treatments for alcohol, tobacco and cannabis use disorders?**
10. **Is there one "right" way for recovery?**
11. **Peer Specialists use strengths-based planning for recovery. What does this mean to you?**

Session 7 Homework Handouts

FACILITATOR INFORMATION:

The twelve-step program of A.A. is the most widely used program in the world to promote recovery. The steps are used in numerous other programs including Narcotics Anonymous (NA), Overeaters Anonymous (OA) and Spenders Anonymous (SA). Due to its popularity in the field, it is included here for participants to review. Facilitators may also recommend to participants that they attend some open meetings to experience the community that A.A. provides.

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

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

THE TWELVE TRADITIONS OF ALCOHOLICS ANONYMOUS

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

Self-Care Assessment Worksheet[40]

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following:

5 = Frequently
4 = Occasionally
3 = Rarely
2 = Never
1 = It never occurred to me

Physical Self-Care

_____Eat regularly (e.g. breakfast, lunch and dinner)
_____Eat healthy
_____Exercise
_____Get regular medical care for prevention
_____ Get medical care when needed
_____Take time off when needed
_____Get massages
_____Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
_____Take time to be sexual—with yourself, with a partner
_____Get enough sleep
_____Wear clothes you like
_____Take vacations
_____Take day trips or mini-vacations
_____Make time away from telephones
_____Other:

Psychological Self-Care

_____Make time for self-reflection
_____Have your own personal psychotherapy
_____Write in a journal
_____Read literature that is unrelated to work
_____Do something at which you are not expert or in charge
_____Decrease stress in your life

[40] Saakvittne, Pealman & Staff of TSI/CAAP, ***Transforming the Pain: A Workbook on Vicarious Traumatization,*** Norton, 1996.

_____Let others know different aspects of you

_____ Notice your inner experience—listen to your thoughts, beliefs, attitudes, and feelings

_____ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance

_____Practice receiving from others

_____Be curious

_____ Say "no" to extra responsibilities sometimes

_____ Other:

Emotional Self-Care

_____ Spend time with others whose company you enjoy

_____ Stay in contact with important people in your life

_____ Give yourself affirmations, praise yourself

_____ Love yourself

_____ Re-read favorite books, re-view favorite movies

_____ Identify comforting activities, objects, people, relationships, places and seek them out

_____ Allow yourself to cry

_____ Find things that make you laugh

_____ Express your outrage in social action, letters and donations, marches, protests

_____ Play with children

_____ Other:

Spiritual Self-Care

_____ Make time for reflection

_____ Spend time with nature

_____ Find a spiritual connection or community

_____ Be open to inspiration

_____ Cherish your optimism and hope

_____ Be aware of nonmaterial aspects of life

_____ Try at times not to be in charge or the expert

_____ Be open to not knowing

_____ Identify what in meaningful to you and notice its place in your life

_____ Meditate

_____ Pray

_____ Sing

_____ Spend time with children

_____ Have experiences of awe

_____ Contribute to causes in which you believe

_____ Read inspirational literature (talks, music, etc.)

_____ Other:

Workplace or Professional Self-Care

_____ Take a break during the workday (e.g. lunch)
_____ Take time to chat with co-workers
_____ Make quiet time to complete tasks
_____ Identify projects or tasks that are exciting and rewarding

_____ Set limits with your clients and colleagues
_____ Balance your caseload so that no one day or part of a day is "too much"
_____ Arrange your work space so it is comfortable and comforting
_____ Get regular supervision or consultation
_____ Negotiate for your needs (benefits, pay raise)

_____ Have a peer support group
_____ Develop a non-trauma area of professional interest
_____ Other:

Balance

_____ Strive for balance within your work-life and workday
_____ Strive for balance among work, family, relationships, play and rest

Session 8

FACILITATOR INFORMATION:

Session 8 is 3½ hours long and begins with a discussion of spirituality. This is an opportunity to further explore this recovery concept and share individual observations and beliefs.

Further information on Trauma Informed Care is presented and participants are encouraged to share experiences. Information on mood disorders is presented with an emphasis on how a Peer Specialist can support peers struggling with these issues. Stimulant use disorder and hallucinogen use disorder are explained with current research referenced.

Peer Specialist Facilitator Curriculum Guide

SESSION 8

5 MINUTES Homework review

60 MINUTES Spirituality and Mental Illness and Substance Use

15 MINUTES Break

70 MINUTES Mood Disorders—Trauma characteristics of a depression, characteristics of mania, pharmacological treatment of mood disorders.

15 MINUTES Break

70 MINUTES Stimulant Use Disorder and Hallucinogen Use Disorder

5 MINUTES Homework: Readings.

CPS CORE CRITERIA COVERED

2.2 Knowledge of mental health and substance use disorders and their impact on recovery.
2.3 Knowledge of the basic neuroscience of mental health and addiction
2.5 Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
4.11 Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals

Homework Review (5 MINUTES)

Open class with a discussion of the homework assignment.

Ask if there are any comments regarding the review questions.

Spirituality and Mental Illness and Substance Use (60 MINUTES)

OBJECTIVE

- To provide an opportunity to discuss the importance of spirituality in the recovery process.
- To allow peer supporters an opportunity to discuss their personal feelings about spirituality.

METHOD

> "While hope springs partly from the array of tools science has developed to combat the symptoms of serious mental illness and substance abuse, these are not the entire picture. Hope and courage are at the core of the person, at that dimension we call spirit. How a person taps that wellspring of spirit, how a person both nurtures and is nurtured by the spirit, is what I call spirituality. It is not the same as religion, although the great religious traditions at their best foster a healthy spirituality."[41]

- Religion and spirituality may be a difficult issue to discuss as some people have very strong views. Lead a discussion about the importance of spirituality in recovery, emphasizing the fact that Peer Specialists need to be neutral.
- Read the following information. Use it as a starting point for a discussion on the difference between religion and spirituality.
- Break into groups of two and ask participants to discuss the role of spirituality in their own recovery.

"We are not human beings having a spiritual experience. We are spiritual beings having a human experience."

— PIERRE TEILHARD DE CHARDIN

[41] Stack, Jerome; article "Spirituality is not the same as religion."

Spirituality and Recovery

SPIRITUAL VERSUS RELIGIOUS

In all corners of the world and in all eras of history, humans have wondered about the origins of the universe, the purpose of life, what it means to be human, and what happens after death. Many people express their spirituality through a commitment to a religion.

There are 19 major religious groupings in the world, and from them a total of 10,000 distinct religions, although only about 270 of those have half a million or more followers. In the U.S. alone, over 2,500 different religious faith entities can be observed. That's a lot of different ways of formulating cultural and belief systems. And yet, most of them have common sources. The religions of Abraham (Judaism, Christianity, and Islam) all believe in one universal God, experienced as personal, who is the creator of the universe and the primary source of values, while the main Eastern religions (Hinduism, Buddhism, and Shintoism) grew out of local traditions and focus on insight.[42]

For those who practice religion and identify God as their Higher Power, spirituality likely already makes sense. They can fit spirituality into the framework of their current religion. For someone who has never practiced, no longer practices or who feels harmed by religion, it can be difficult to grasp how spirituality can exist without the presence of religion. But spirituality and religion are very different.

WHAT'S THE DIFFERENCE?

It is helpful to separate spirituality and religion. We often unconsciously link the two. But spirituality does not need to be defined through the lens of religion. Religion can be thought of as a set of beliefs, rituals and practices regarding belief in God or gods to be worshipped. Spirituality is a personal search for meaning in life, for connection with all things and for the experience of a power beyond oneself.

Some find it helpful to think of religion as rules or practices agreed to by a number of people, whereas spirituality is completely related to one's individual experience and connections. Spirituality is recognizing a power greater than ourselves which is grounded in love and compassion. It is a power that gives us perspective, meaning, and a purpose to our lives. It is a desire to connect with more than ourselves, to connect with everyone.

[42] Baksa, Peter, adapted from, "Are You 'Spiritual' but Not Religious?" Huffpost Religion, September 2014.

Spirituality means different things to different people and people express their spirituality in varied ways. It may be:

- Their religion or faith
- Meaning and direction in their life, sometimes described as their "journey"
- A way of understanding the world and their place in the world
- A belief in a higher being or a force greater than any individual
- A core part of their identity and essential humanity
- A feeling of belonging or connectedness
- A quest for wholeness, hope or harmony
- A sense that there is more to life than material things

Spirituality is often seen as broader than religion. Being able to express and explore our spirituality is a basic human need and a universal human right.

SPIRITUALITY AND RECOVERY

There is a substantial body of experience and slowly growing research that supports the use of spiritual values and/or religion in relation to mental health and substance use recovery. Spirituality can help people maintain good mental health. It can help them cope with everyday stress and can keep them grounded. Tolerant and inclusive spiritual communities can provide valuable support and friendship. There is some evidence of links between spirituality and improvements in people's mental health, although researchers do not know exactly how this works.[43]

Spirituality can bring a feeling of being connected to something bigger than yourself. It can provide a way of coping in addition to your own mental resilience. It can help people make sense of what they are experiencing.

HOW RELIGIOUS TRADITIONS HINDER RECOVERY

Ironically, organized religious traditions may get in the way of spirituality and recovery. They may hinder recovery when:

- They deny the reality of mental illness and substance use disorders
- They exclude others
- Ignorance, fear, and judgment predominate
- The theologies they espouse about sin, grace, and demons reinforce one's sense of evil
- Exacerbate symptoms
- Present harsh God representations

[43] Mental Health Foundation, "Spirituality," Scotland, SC, 2015.

It is essential that spiritualty provide a positive aspect of recovery that gives peers support and encouragement.

PRACTICING SPIRITUALITY

People may develop and express their spirituality through:

- Religious practices such as worship, prayer and reading religious texts
- Coming together as a spiritual community
- Living by certain values
- Rituals such as burning incense
- Wearing particular clothes or eating particular foods
- Cultural or creative activities such as making music or creating art
- Activities that develop self-awareness or personal control such as contemplation or yoga
- Physical activity
- Friendship or voluntary work
- Getting closer to nature

THE POWER OF NATURE

There is a growing body of research that getting closer to nature improves mental health. Most of us today live in cities and spend far less time outside in green, natural spaces than people did several generations ago. City dwellers have higher risk for anxiety, depression, and other mental issues than people living outside urban centers.[44]

Stanford University had been studying the psychological effects of urban living. They found that volunteers who walked briefly through a lush, green portion of the Stanford campus were more attentive and happier afterward than volunteers who strolled for the same amount of time near heavy traffic.

Brooding, which is known among cognitive scientists as morbid rumination, is a mental state familiar to most of us, in which we can't seem to stop chewing over the ways in which things are wrong with ourselves and our lives. This broken-record fretting is not healthy or helpful. It can be a precursor to depression and is disproportionately common among city dwellers compared with people living outside urban areas, studies show. Rumination is also strongly associated with increased activity in a portion of the brain known as the subgenual prefrontal cortex.

Researchers have found less blood flow and activity in the subgenual prefrontal cortex when volunteers got closer to nature. They were not dwelling on the negative aspects of

[44] Reynolds, Gretchen, "How Walking in Nature Changes the Brain," The New York Times, July, 2015.

their lives as much and brooding was decreased. It appears that greenery, quiet, sunniness, and natural smells are soothing.

While some people may not associate the activities listed with 'spirituality', the research supports the value of these behaviors in recovery.

PEER SUPPORT AND SPIRITUALITY

The Peer Specialist respects peer's spirituality as a human right. A Peer Specialist who responds to spiritual needs:

- Acknowledges the spirituality in people's lives
- Gives peers opportunities to talk about spirituality
- Encourages peers to identify their needs to grow in this area
- Help peers to express their spirituality
- Uses person centered planning to incorporate spiritual needs in the recovery process

Encouraging peers to explore what is important to them spiritually can be a valuable self-help strategy, as people often want to talk about their spirituality. The Peer Specialist is curious, not judgmental, and recognizes the complex interaction between faith and psyche. Some possible questions to explore include:

- How does your connection with your tradition help you cope in your life?
- Do you have a spiritual practice or meditation practice?
- What does that consist of?
- What gives you hope?
- What brings you a sense of peace, of courage?
- When you are troubled or stressed, what helps you?

Clinicians sometimes refer to this effort as Gold Mining—the discovery of rich inner resources that can assist recovery.

"Some questions can't be answered by Google."

Key Point …

Healthy relationships, recovery and spirituality are foundations for personal well-being.

• • • Break 15 minutes • • •

Mood Disorders (70 MINUTES)

OBJECTIVE

- To recognize the trauma experienced by persons who experience mental health and addiction challenges.
- To increase understanding of mood disorders.
- To become familiar with resources that are available to assist people who experience mood disorders.

METHOD

- Invite someone who has experience with a mood disorder to present his or her knowledge and experience.
- Read: Trauma and Mental Illness and Substance Use Disorders
- Read: Mood Disorders
- Peer support exercise; focus on scenarios where peer supporters can use skills to communicate with people who deal with a mood disorder.

Trauma and Mental Illness and Substance Use Disorders

The kinds of trauma experienced by peers are usually not associated with "single blow" traumatic events such as natural disasters, accidents, terrorist acts, or crimes occurring in adulthood such as rape and domestic violence. Rather, the traumatic experiences of persons with mental health problems are often interpersonal in nature, intentional, prolonged and repeated, occur in childhood and adolescence, and may extend over years of a person's life. They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional and psychological abuse. They may also include the witnessing of violence, repeated abandonments, and sudden and traumatic losses.

As adults, these individuals often experience trauma and re-victimization through domestic violence, sexual assaults, gang and drug related violence, homelessness, and poverty. They are traumatized further by coercive interventions and at times sexual and physical abuse in inpatient or institutional settings, jails, etc. Trauma is often shrouded in secrecy and denial and is often ignored. Unfortunately, "treatment" may also traumatize with use of isolation, restraints, and other confinement.[45]

[45] SAMHSA Technical Assistance Package, Implementing Trauma-Informed Approaches in Access to Recovery Programs, 2009.

Trauma-Informed Principles

Safety and trustworthiness are top priorities for trauma-informed approaches because they are trauma survivors' most basic needs. Trauma-informed care (TIC) emphasizes the following principles:

- **Peer choice—**Peers are given dignified choices in care.
- **Collaboration—**The Peer Specialist is in no way superior to any peer; instead, the Peer Specialist must earn the peer's trust so they can work together on a recovery plan.
- **Empowerment—**The trauma-informed approach emphasizes self-direction and empowerment. Recognizing that trauma survivors may have lost their ability to speak out due to years of abuse, the Peer Specialist can help them learn skills so they can exercise their own voices and advocate for themselves to get their needs met.
- **System-wide education and training—**Trauma-informed services require all administrators, managers, and staff to be informed and knowledgeable about the dynamics of trauma and abuse. Equally important, all staff need to understand how social services sometimes inadvertently re-traumatize peers.
- **Peer Involvement—**Peer Specialists bring a unique perspective and are familiar with how their community can support people seeking recovery. This in and of itself is a trauma-informed strategy because it is peer-driven and values the unique contribution that peers can make in decisions.

Key Peer Subgroups and Their Trauma Histories

The Peer Specialist must obtain comprehensive information about any special populations with which they work. Cultural competency means understanding the history, the experience and the effects of oppression on specific groups. Here are some of the common populations that the Peer Specialist may work with.

Gender Awareness and Responsiveness—Peers' gender and gender presentation are linked to trauma history, substance abuse, and recovery. Trauma-informed mental health and substance use services need to be responsive to peer's gender as part of understanding trauma history and strengthening recovery. For example, men and women in addiction treatment both have high trauma rates, but women have higher rates of sexual and physical abuse.[46]

Military Members—Military members from all the armed forces are susceptible to war- and combat-related trauma, regardless of their roles. Posttraumatic stress disorder and depression are the most common mental health problems of returning military members and substance use disorders may also be present. Peer Specialists working with this

[46] Markoff & Finkelstein, 2007.

population should have a basic understanding of military culture and resources through the Veterans Administration.

Criminal Justice-Involved—Peers who have been in prison or jail usually have both substance use and mental health problems. Justice-involved peers are also more likely to have family members with a history of incarceration and/or co-occurring disorders, making a holistic, trauma-informed approach to recovery a key aspect of avoiding re-traumatization or relapse.

American Indians/Alaska Natives—The cumulative effects of historical injustices against American Indians and Alaska Natives are called the community's "soul wound," the mark of historical trauma. Historic, community-level trauma coexists with individual trauma such as physical or sexual abuse among American Indians. Trauma informed support of peers in these groups must take into account not only individual histories of victimization and violence, but also the historical trauma suffered by American Indians and Alaska Natives.

African Americans—In addition to individual trauma histories, African Americans may be affected by historical trauma stemming from slavery, ongoing racism and discrimination. In the ***Handbook of African American Health***, the authors suggest that the severe trauma of slavery still affects African Americans hundreds of years later. This intergenerational history of severe trauma is intertwined with individual traumatic experiences of racism and discrimination.

It is important that the Peer Specialist be familiar with special populations that they work with. Additional training and education are helpful to provide trauma informed support.

Mood Disorders

Introduction

Mood Disorders are characterized by the presence of a prolonged and all-encompassing emotion, such as depression or elated mood.

A mood disorder distorts the person's awareness of him/herself and the world. There are two main categories:

a) Bipolar Disorders—where the individual fluctuates between manic and depressive episodes, and
b) Depressive Disorder—where the individual only shifts towards depressive moods.

Characteristics of a Depression

- People often describe depression using words like: hopelessness, emptiness, despair, misery, pain, sadness, etc…

- The individual usually describes his/her mood as depressed, sad, with an inability to experience pleasure. The person might also engage in excessive negative self-talk and self-blaming that creates feelings of guilt, shame, worthlessness, and powerlessness, which engenders an attitude of "giving up." Life's outlook is one of doom and gloom and thought of death and suicide are common.

- Eating patterns are usually disturbed. Loss of appetite, which results in major loss of weight, is common. Less frequently, the individual might engage in food bingeing.

- Sleeping patterns are frequently disturbed. The disturbances can include difficulty in falling asleep, early morning awakening, or the opposite, excessive sleeping with difficulty getting up in the mornings.

- Some individuals may pace, have difficulty sitting still or pull/scratch skin, hair or objects. Others experience slowed speech and body movements. Difficulty concentrating, making decisions and slowed thinking are also common.

- Individuals may be diagnosed with Dysthymia when they suffer from chronic mood disturbances such as a depressive mood and/or inability to experience pleasure.

Characteristics of a Mania

- People often describe mania as elated, expansive or irritable mood with feelings that may include grandiosity, flight of ideas, distractibility, restlessness, hyperactivity, engagement in risky behaviors, and decreased need for sleep. They may also experience delusions and hallucinations.

- People may be diagnosed with hypomania when their experiences are perceived as less severe or intense.

- A person may be diagnosed as having Bipolar Disorder when manic or hypo manic feelings or experiences are associated with depressive feelings or experiences. If these mood swings are frequent but not as severe, the person may be diagnosed with Cyclothymia.

Pharmacological Treatment of Mood Disorders

- There is a wide range of antidepressants available for the treatment of depression. At the biological level, these medications seem to restore the balance of neurotransmitters in the brain.

Peer Support with People Experiencing Mood Disorders

- When you work with peers who are experiencing mood disorders, it is important that you give empathic statements that reflect understanding of their feelings. Also, encourage them to talk about their depression in concrete and specific terms. Examples of useful questions include:

    a) What specifically is getting you down?
    b) How do you experience depression?
    c) What makes the depression worse?
    d) What makes your mood better?

- Since it is common for persons who are depressed to feel overwhelmed and helpless in solving their problems, it is useful to break down their issues and focus on those that are to some extent controllable.

- Individuals who are depressed tend to have a negative outlook on themselves and their world and may find it helpful to be reminded of their strengths and resources.

- Encourage them to take small steps and take part in activities in which they are likely to succeed. Individuals who are depressed and very lethargic need to be motivated to set small task goals for each day such as having a bath or going for walk around the block.

- Explore with them past pleasurable experiences and encourage them to take part in such activities again.

- If applicable, you can use self-disclosure describing briefly your experience of depression and reminding them the "black hole" feelings usually pass.

- Severe feelings of depression may put people at risk for suicide. Frequently people will give you hints when they are seriously considering suicide. These hints can include:

    a) Has recently made out a will
    b) Has given away possessions
    c) Has recently written several personal letters to friends and relatives
    d) Has recently bought a weapon

- If you believe that someone is at significant risk of serious harm to themselves, such as suicide, it is important to discuss your concerns with the peer first and then share these concerns with the treatment team. The procedure for handling these types of emergencies may vary depending on the program; make sure you know the policies and procedures that are being used.

Key Point …

A central tenet of recovery is that growth and change are possible.

"I made a commitment to completely cut out drinking and anything that might hamper me from getting my mind and body together. And the floodgates of goodness have opened upon me, spiritually and financially."

- DENZEL WASHINGTON

• • • Break 15 minutes • • •

Stimulant Use Disorder and Hallucinogen Use Disorder

(70 MINUTES)

OBJECTIVE

- To increase understanding of stimulant use disorder and hallucinogen use disorder.
- To become familiar with resources that are available to assist people with substance use disorders.

METHOD

- Invite someone who has experience in recovery from addition to stimulants and/or hallucinogens to present their knowledge and experience.
- Read: Stimulant Use Disorders and Hallucinogen Use Disorder
- Read: Peer Support with People Experiencing Substance Use Disorders
- Read: The Power of Language.
- Lead group discussion of language and implications for recovery.
- Discuss what resources are available in the community to assist people who experience these substance use disorders.
- Peer support exercise; focus on scenarios where peer supporters can use skills to communicate with people who deal with substance use disorders.

Stimulant Use Disorders

Stimulants increase alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. They include a wide range of drugs that have historically been used to treat conditions, such as obesity, attention deficit hyperactivity disorder and, occasionally, depression. Like other prescription medications, stimulants can be diverted for illegal use. The most commonly abused stimulants are amphetamines, methamphetamine, and cocaine. Stimulants can be synthetic (such as amphetamines) or can be plant-derived (such as cocaine). They are usually taken orally, snorted, or intravenously.

In 2014, an estimated 913,000 people, ages 12 and older had a stimulant use disorder because of cocaine use, and an estimated 476,000 people had a stimulant use disorder as a result of using other stimulants besides methamphetamines. In 2014, almost 569,000 people in the United States ages 12 and up reported using methamphetamines in the past month.[47]

[47] "Substance Use Disorders," SAMHSA Publications, samhsa.gov, 2015.

Amphetamines are frequently prescribed for Attention Deficit Hyperactivity Disorder (ADHD) in both children and adults. Amphetamines appear to have a calming effect on individuals with ADHD. They are also used to treat narcolepsy, treatment resistant depression and obesity.

Over time, the effects of stimulants can become increasingly problematic. These include:

- Aggression, violent behavior or hostility
- Paranoia and anxiety
- Emotional numbing with sadness, fatigue and social withdrawal
- Entitlement regarding obtaining positions of power or influence
- Lowered social inhibitions leading to engaging in behaviors with negative consequences
- Altered sexual behavior—often increased sexual promiscuity but may lead to decreased sexual activity as well
- Unrealistic evaluation of ones' abilities, talents and level of leadership at work or school
- Delusions and confusion
- Amphetamine-caused psychosis
- Impaired judgment
- Loss of important relationships
- Problem at school or work or legal problems
- Muscle tension, chest pain, or irregular heart beat
- Headaches, blurred vision seizures, coma, and death

In the brain, stimulants cause the release of chemicals called catecholamines, in particular dopamine. The effects of dopamine are especially strong in areas of the brain responsible for producing pleasure, which is known as the "reward pathway." The effect produced on this pathway heavily contributes to the addicting quality of stimulants.

Hallucinogen Use Disorders

Hallucinogens can be chemically synthesized (as with lysergic acid diethylamide or LSD) or may occur nationally (as with psilocybin mushrooms, peyote.) These drugs can produce visual and auditory hallucinations, feelings of detachment from one's environment and oneself, and distortions in time and perception.

In 2014, approximately 246,000 Americans had a hallucinogen use disorder. Symptoms of hallucinogen use disorder include craving for hallucinogens, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, use in risky situations like driving,

development of tolerance, and spending a great deal of time to obtain and use hallucinogens.

Peer Support with People Experiencing Substance Use Disorders

- As many people struggling with substance use disorders find it difficult to acknowledge the seriousness of the problem, the Peer Specialist will want to explore carefully, chemical usage of any kind.

- It is important to recognize that substance use disorders can negatively impact recovery efforts as they affect brain chemistry. For example, alcohol is a depressant and may impact the effectiveness of antidepressants. It is like having a foot on the gas and the break at the same time. This issue can be carefully explored with a peer.

- It is important that the Peer Specialist has a comprehensive knowledge of resources and supports for the peer struggling with a substance use disorder or dual diagnosis. In addition to A.A., here are some other resources.

    - ✓ **Narcotics Anonymous (NA).** This is the most well-known and widely available self-help group for drug users in treatment and recovery. Unlike Alcoholics Anonymous, which is limited to alcohol problems, Narcotics Anonymous is open to substance abuse problems of all kinds. NA members attend group meetings facilitated by other members—all recovering drug addicts.
    - ✓ **Cocaine Anonymous (CA).** A program for cocaine users that is based on the 12 step program like AA and NA. Has limited availability, especially in rural areas.
    - ✓ **Crystal Meth Anonymous (CMA).** Again modeled on the 12 step program, it's primary purpose is to help people lead a sober life and to carry the message of recovery to crystal meth users who are struggling.
    - ✓ **Secular Organization for Sobriety (SOS)** is an international organization that takes a science-based, self-empowerment approach to abstinence and recovery from drug and alcohol addiction. This consists of a network of independent meetings with an alternative recovery method. It credits the individual for achieving and maintaining his or her own sobriety, without reliance on any higher power.
    - ✓ **Smart Recovery (Self-Management and Recovery Training)** is a program that aims for abstinence from alcohol or drugs through self-empowerment and self-directed change. Based on the principles of cognitive-behavioral therapy, it is focused on managing thoughts, feelings, and behaviors.

The Power of Language[48]

Recovering people need a pro-recovery language to interpret their own experience, to communicate with each other, and to give the larger culture more accurate and respectful words to depict the nature of severe and persistent AOD problems and how those problems may be resolved. By claiming the right to speak publicly and to frame their experience in their own language, recovering people are politicizing (in the best sense of this term) what up until now have been their own private experiences. Words have been used to wound addicted and recovering people—to declare their status as outcasts. Words can also be used to heal addicted and recovering people and invite them into fellowship with each other and the larger society.

Words/Concepts We Need to Abandon

Abuse

Of all the words that have entered the addiction/treatment vocabulary, "abuse" is one of the most ill-chosen. To suggest that the addict mistreats the object of his or her deepest affection is a ridiculous notion. Alcoholics do not "abuse" alcohol, nor do addicts "abuse" drugs. Addicts, more than anyone, treat these potions with the greatest devotion and respect.

In addition to being technically incorrect, references to alcohol/drug/substance "abuse" drip with centuries of religious and moral censure. In 1673, Increase Mather in his sermon, "Woe to Drunkards," proclaimed that alcohol was the "good creature of God," but that the "abuse of drink" was "from Satan." Terms, such as, *alcohol abuse, drug abuse, substance abuse,* all spring from religious and moral conceptions of the roots of severe alcohol and other drug problems. They define the locus of the problem in the willful choices of the individual, denying how that power can be compromised, denying the power of the drug, and denying the culpability of those whose financial interests are served by promoting and increasing the frequency and quantity of drug consumption.

Abuse has long implied the willful commission of an abhorrent (wrong and sinful) act involving forbidden pleasure. It was the very weight of this history that led the National commission on Marihuana and Drug Abuse to criticize the term "drug abuse" in 1973. The commission suggested that "continued use of this term with its emotional overtones, will serve only to perpetuate confused public attitudes about drug using behavior. The term gained even greater prominence following the Commission's report.

To refer to people who are addicted as alcohol, drug or substance abusers misstates the nature of their condition and calls for their social rejection, sequestration and punishment. There is no other medical condition to which the term "abuse" is applied. If we truly

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[48] Adapted from: White, W., "The Rhetoric of Recovery Advocacy: An essay on the power of language," ***Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movemen***t., Johnson Institute and Faces and Vo8ices of Recovery, Washington, D.C., 2006.

believe that addiction is a serious health problem, then why do we continue to have departments and centers of substance *abuse*?

Self-Help

It is common to refer to Alcoholics Anonymous, Narcotics Anonymous, Women for Sobriety and other such organizations as "self-help" groups or refer to a broader "self-help" movement. Ernest Kurtz and William Miller have noted that such designation conveys a "pulling-oneself-up-by-the-bootstraps" image of addiction recovery. They noted, in contrast to this image, that people who seek help from such groups usually do so as an acknowledgement that all attempts at self-help have failed. Recovery in many support groups is not "self-help" but the utilization of resources and relationships beyond the self.

Untreated Alcoholics/Untreated Addicts

In lobbying for parity (the funding of addiction treatment on par with other medical disorder), one endlessly hears about the personal and social costs of "untreated addiction" and about the number of "untreated alcoholics" and "untreated addicts" that are now denied access to treatment. While such language well-serves the parity argument, it implies that the pathway into recovery inextricably requires passage through professionally-directed treatment. This is simply not true. Referring to people still suffering from addiction as "people not yet in recovery" is a far more accurate and preferable term than depicting such people as "untreated."

Consumer

The term, *consumer*, when used as a synonym for recovering people, is a misnomer. Like "untreated alcoholics" or "untreated addicts", the term implies that all people in recovery have been, or need to be, consumers of treatment services. By speaking of "consumer representation", the language narrows participation in policy development to people who have participated in treatment rather than to the larger pool of addicted and recovering people. Those who seek treatment and those who do not seek treatment constitute different populations of people, making it impossible for the former to speak for the experiences and needs of the later. The focus should be not on "consumer representation" but on "constituency representation" or "recovery representation" and all that the latter terms imply by way of diversity.

The Language of Self-Pity

America has lived through the "me decade" of the 1980s and the security of widespread prosperity of the 1990s, but a new century is opening with many themes worth noting; heightened financial insecurity, a growing sense of depersonalization and diminished sense of control over most aspects of our lives, and a diminishment of respect for professions that historically protected the vulnerable (physicians, clergy, lawyers, etc.). The New Recovery Advocacy Movement must position itself in this cultural stew.

Any language that even hints at self-pity will doom the legitimate aims of this movement. What is needed are themes that strike strong emotional cords in the culture at large. What will get America's attention is not a call for sympathy or redress of past and present insults to addicted and/or recovering people, but articulating themes of gratitude, responsibility and service. What will grab the attention of the culture is a movement whose members are coming together not in supplication but in service; not asking for something, but offering something; not advocating for themselves, but for others; not acting as individuals, but in communion; and not seeking solutions through formal institutions but through the community itself.

"Good humor is tonic for mind and body. It is the best antidote for anxiety and depression. It is a business asset. It attracts and keeps friends. It lightens human burdens. It is the direct route to serenity and contentment."

- GREENVILLE KLEISSER

Homework (5 MINUTES)

OBJECTIVE

To increase the knowledge base for Peer Specialists

To encourage participants to read suggested materials.

METHOD

Facilitators assign readings on anger management from Session 9.

Emphasize that it is important they read this material *before* the next session.

Suggest additional readings from the list or other resources.

Additional Readings and Resources:

Bloch, Douglas, ***Words That Heal: Affirmations and Meditations for Daily Living***, Pallas Communications, January 1998.

Duke, Patty, ***Brilliant Madness: Living with Manic Depressive Illness***, Bantam, 1993.

Lamott, Anne, ***Help—Thanks—Wow, The Three Essential Prayers***, Riverhead Books, November 2012.

SAMHSA Technical Assistance Package, ***Implementing Trauma-Informed Approaches in Access to Recovery Programs***, 2009.

"Spirituality, Science, and Addiction Counseling"
http://www.williamwhitepapers.com/pr/2006Spirituality%26AddictionCounseling.pdf

"Recovery Matters," Thoughts On Spirituality and Recovery from Hazelden Betty Ford
http://www.hazelden.org/web/public/spirituality_recovery_matters_apr13.page

Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)
http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/resources

"Drugs, Brains, And Behavior: The Science Of Addiction," Free Publication To Order From The National Institute On Drug Abuse (Nida)
https://drugpubs.drugabuse.gov/publications/drugs-brains-and-behavior-science-addiction

"New Addiction Recovery Support Institutions: Mobilizing Support Beyond Professional Addiction Treatment and Recovery Mutual Aid."
http://www.naadac.org/assets/1959/whitewkellyjrothj2012_new_addiction_recovery.pdf

REVIEW QUESTIONS:

12. **What are some questions the Peer Specialist can use to help a peer explore spirituality in recovery?**
13. **What are the trauma-informed principles?**
14. **List some of the characteristics of a mood disorder.**
15. **What are some supportive activities that the Peer Specialist can do to help a peer struggling with a mood disorder?**
16. **What are some supportive activities that the Peer Specialist can do for a peer struggling with a substance use disorder?**
17. **List local resources that can be used for a peer with a mood disorder or substance use disorder.**

Session 9

FACILITATOR INFORMATION:

Session 9 is focused around an emotion that many people find difficult: Anger. Participants were asked to read the sections on anger as homework for session 8. Facilitators will lead a discussion with participants on how they deal with anger. This emotion is explored with information on assertive behavior. The homework for this session will include the Assertion Skills Worksheet.

The important role of the Peer Specialist in fostering self-advocacy and providing advocacy is explained. There is an exercise to practice these skills.

Personality disorders are described including borderline personality disorder. Skill development includes a Peer Support exercise using "I" statements. This session and the remaining sessions are all three hours in length.

Peer Specialist Facilitator Curriculum Guide

SESSION 9

5 MINUTES Homework review

60 MINUTES Anger Management

15 MINUTES Break

25 MINUTES Advocacy and self-advocacy

50 MINUTES Personality Disorders

15 MINUTES Break

35 MINUTES Peer Support Exercise

5 MINUTES Homework: Readings.

CPS CORE CRITERIA COVERED

1.6 Believes in the importance of self-awareness and self-care
2.2 Knowledge of mental health and substance use disorders and their impact on recovery.
2.3 Knowledge of the basic neuroscience of mental health and addiction
3.5 Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interaction
4.2 Ability to identify and support a person in crisis and know when to facilitate referrals
4.6 Ability to listen and understand with accuracy the person's perspective and experience
4.7 Effective written and verbal communication skills
4.18 Ability to foster the person's self-advocacy and provide advocacy when requested by the person

Homework Review (5 MINUTES)

Open class with a discussion of the homework assignment.

Ask if there are any comments regarding the review questions.

Anger Management (60 MINUTES)

OBJECTIVE

- To facilitate a discussion of how people deal with anger.
- To outline some methods of dealing with anger

METHOD

- Facilitators lead a discussion with participants about how they deal with anger. Peer Specialists need to be able to manage their anger, and help diffuse angry situations and people.
- Review Angry Behavior: An Ecological View, The Functions of Anger, Contrasting Assertive, Passive and Aggressive Behavior, Assertive Behavior, and The Keys to Being Clear When You Are Being Assertive.
- Use the following Anger Questionnaire to lead a group exercise regarding anger. Write participant's responses on board or flipchart.

Angry Behavior: An Ecological View

The feeling of anger is always valid. It is merely a signal from your body that something is wrong or that a problem exists. That problem or conflict may have arisen between you and the outside world, or within your needs and beliefs. It may be a real conflict or an imagined one. Rather than judge the feeling of anger in yourself or others, try to find the source of the problem and see if it can be resolved.

Angry behavior on the other hand may or may not be a direct expression of angry feelings. In our society, angry behavior has many payoffs. It is important, therefore, to assess angry behavior in ourselves and others to determine the meaning of the behavior in context.

Angry behavior may be:

- An appropriate expression of feeling.
- A displaced expression of feeling.
- A confused expression of feeling.
- A purposeful behavior, which has the goal of intimidating or confusing the target person.
- A ritual or tantrum behavior which has a goal of:

    - ❖ Getting attention
    - ❖ Getting control
    - ❖ Communicating helplessness
    - ❖ Getting revenge

The Functions of Anger

Anger can serve a positive or a negative function.

POSITIVE FUNCTIONS

Anger is an energizer.

Anger can facilitate expression of tension, conflict and feelings.

Anger is a cue that a problem exists Which is causing us discomfort. This may be environmental, interpersonal or intrapersonal.

Anger can help us feel more empowered and in charge of ourselves.

NEGATIVE FUNCTIONS

Anger can disrupt our thoughts and actions.

Anger can be used to avoid other feelings.

Anger can quickly lead to aggression or withdrawal.

Anger can result in overreaction or Intimidation when we confront others about their behavior, feelings, or values.

Other Functions of Anger

Anger may actually reduce stress. It can block awareness of an emotional or physical pain. The kinds of stress which anger can dissipate include:

- **Painful affect**
  A mother scolds her child for returning home at 8:00 p.m. instead of 6:00 p.m. Her anger is serving to block her fear. The terror of losing a child is blocked by the angry words and angry behavior. Other emotions blocked by anger include sadness, hurt, guilt, shame, and feelings of failure or unworthiness.
- **Painful sensation**
  Anger can discharge stress created by rushing to meet deadlines, physical pain, the arousal from too much stimulation, muscle tension or fatigue.
- **Frustrated drive.** Anger can discharge the stress arising from blocked needs or desires, the frustration experienced when things are 'out of whack', or when being forced to do something against one's will.
- **Threat**
  Anger may diminish the threat when one feels attacked, controlled or abandoned. The feeling of anger blocks feelings of fear, loneliness, and loss.

Anger Questionnaire[49]

1. Complete this sentence: Anger is…

2. What did you learn about anger as a child?

3. How did you express anger as a child?

4. Describe the angriest moment in your life?

5. List 3 different ways you deal with angry feelings.

6. How do you feel after you have been angry?

7. What pleasure or benefit do you get from anger?

8. How do you use anger as a weapon against others?

9. Do you have any positive ways of dealing with angry feelings? What are they?

[49] Center for Conflict Resolution Training, Justice Institute of B.C., Dealing With Anger, 1990.

Key Point …

Everyone's journey of recovery is unique.

• • • Break 15 minutes • • •

Peer Support Exercise (35 MINUTES)

OBJECTIVE

To practice "I" statements.

To practice skills for dealing with anger.

METHOD

Read the section on using "I" statements.

Ask participants to pick a partner and take turns being an angry peer meeting with a Peer Specialist.

Using "I" statements, explore feelings as the peer and the Peer Specialist.

Use of "I" Statements

One of the best ways of dealing with anger may be to say it aloud using "I" statements. For example:

- ✓ "I feel angry because you did not do your chores."
- ✓ "I felt hurt and angry when you called me stupid."
- ✓ "I am really angry at you because you failed to call me."

A technique that may be helpful is to remember to use a format like this:

I feel_____(describe the emotion you are feeling)

When you_____(tell the person what they did)

I need you to _____(tell them what they can do to help you feel less angry)

Avoid saying:

- ✓ "You make me so angry, you never do your chores."
- ✓ "You make me so angry and unhappy when you call me names."
- ✓ "You make me so angry. You never call me."

The first set of statements suggests the person who is experiencing the anger is responsible for, or "owns" their feelings. Also, the statements are more likely to trigger considerate responses from the person they are directed at. Alternatively, the latter statements are blaming and tend to make others defensive.

Contrasting Assertive, Passive and Aggressive Behavior[50]

Passive Behavior	Assertive Behavior	Aggressive Behavior
PERSON	PERSON	PERSON
Does not feel good about self. Demonstrates a lack of respect for their own needs and rights.	One feels good about self.	Feels good about self at the expense of another.
Does not achieve desired goal(s). Many do not express honest feelings, needs, values and concerns.	May achieve desired goal(s).	May achieve goal(s)—almost always wins arguments but hurts/angers other.
Allows others to choose for self, deny their rights, ignore their needs.	Chooses for self.	Chooses for others—tends to overpower other people. This is what I want. What you want is of less importance or not important at all.
Feels hurt, anxious.	Feels satisfied.	May feel regret.
OTHER PERSON	OTHER PERSON	OTHER PERSON
Feels guilty, angry, indifferent.	Feels good.	Does not feel good.
Dislikes person.	Appreciates person.	Feels hurt, defensive.
Achieves goals at person's expense.	May achieve desired goals.	Does not achieve desired goal.

Assertive Behavior Guidelines

1. Assertion does NOT involve the intent to hurt the other person whereas aggression does.

[50] Center for Conflict Resolution Training, Justice Institute of B.C., Asserting yourself Under Pressure, 1996.

2. Assertive behavior aims at equalizing the power between two people.

3. Assertive behavior involves expressing our legitimate rights.

4. Remember: Other individuals have a right to respond to your assertiveness.

5. An assertive encounter with another individual may involve coming to an agreeable compromise or to a solution which is different than either of you had imagined in the first place.

6. By behaving assertively, you open the way for honest relationships with others.

7. Assertive behavior is not only concerned with WHAT you say, but HOW you say it.

8. Assertive behavior is a skill that can be learned with frequent practice.

Keys to Being Clear When You Are Being Assertive[51]

BE CLEAR	✓ Think about what you're going to say; don't react in the moment. ✓ Speak clearly and slowly. ✓ Describe what you want, then why. ✓ Check for understanding.
BE SPECIFIC	✓ About the problem. ✓ About what is acceptable. ✓ About what you can and cannot do. About consequences.
BE OBJECTIVE	✓ Describe behavior clearly and without guessing about motives. ✓ Describe behavior without judging it. ✓ Describe alternatives without judging them.

[51] i.b.i.d.

Advocacy and Self-Advocacy (25 MINUTES)

OBJECTIVE

- To assist participants in understanding the Peer Specialist role advocacy and self-advocacy.

METHOD

- Read: Advocacy and Self-Advocacy and excerpts from "Opening the Door."
- Have participants chose a partner and take turns practicing examples of starting difficult conversations in the areas of partnering, decision making, medications and respect.

Advocacy and Self-Advocacy

Advocacy means getting support from another person to help you express your views and wishes, and to help make sure your voice is heard. Someone who helps you in this way is called your advocate.

Unfortunately, having a mental health or substance use problem can sometimes mean that your opinions and ideas are not always taken seriously, or that you are not always offered all the opportunities and choices you would like. This can be difficult to deal with, especially when regular communication is needed with health care or other professionals.

One of the roles of the Peer Specialist is to foster a peer's self advocacy and provide advocacy as requested. How you advocate for a peer is up to *them*—you are there to support his/her choices. For example, you may:

- Listen to their views and concerns
- Help the peer explore options and rights (without advising them in any particular direction)
- Give information to help a peer make informed decisions
- Help the peer contact relevant people
- Accompany a peer and support them in meetings or appointments

As an advocate, you do not:

- Give a peer your personal opinion
- Solve problems or make decisions for a peer
- Make judgments about a peer or their decisions

The Peer Specialist can assist the peer in starting difficult conversations with family, friends, and service providers. It can be helpful to use a general opening statement that sets the stage. For example:

This is difficult for me to talk about, but I feel it is important to discuss_____.

Here are some examples of how to start conversations about partnering and decision-making, medications, and respect.

Partnering and Decision Making[52]

Part of my recovery is working toward things that matter to me. The goals in my treatment plan do not fully match what is most important to me. I'd like to talk about how to change the plan so I can get or keep what is important to me in my life.

I want to be able to do the things that give my life meaning and pleasure now, not just in the future. For me, some of these things are _____(for example, having friends, playing music, sexual intimacy, spending time with animals, finding work I like to do, etc.)

I want to be more involved in making decisions about my life. I want you to listen to my point of view and respect how I feel. I want you to help me understand and think about things so I can make better decisions.

Medications

I am not happy with the medication I am using. I want to talk to you about options for other medications. I am experiencing some medication side effects that are bothering me.

You have suggested I take these medications, but I want more information on options before I decide. I want to understand the benefits, risks, and side effects of the new medication. Why do you think it might be useful for me? How is it better than the medication I am using now?

I have been taking the medications you recommended, but I do not like what they do to my body or how they make me feel. I want to take a break. I want to talk with you about my options.

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[52] Adapted from, Peterson, C.A., Jonikas, J.A., Cook, J.A, & Priester, F., "Raising Difficult Issues with Your Service Provider, Self Determination Series, University of Illinois at Chicago, 2003.

Respect

I want to talk about how we can improve our communication. I know you are very busy. But sometimes I feel you are rushed and impatient with me. I do not think you always listen to what I say.

I would like to talk about ways we can have a more respectful relationship—especially when we disagree about something. There are times when we see things differently. Sometimes I feel that my point of view does not matter.

You make some good suggestions. But sometimes it sounds like I have no choice. It would be helpful if we could always talk about more than one option. I want to be a partner in making decisions about my treatment and not feel like I am just being told what to do.

Social Action Principles for Trauma Survivors[53]

- ❖ We express our rage nonviolently and humanely.
- ❖ We are focused and strategic; we are aware of the effects of our actions on others.
- ❖ Our means are consistent with our ends.
- ❖ We are committed to not acting abusively, regardless of—and in resistance against—how we have been abused.
- ❖ We maintain compassion for ourselves and compassion for others.
- ❖ Our actions are linked to positive visions. We react against our own mistreatment and broader conditions of social injustice. We also take responsibility for translating that reaction into ideas and possibilities for a more just society.
- ❖ We know that we are not powerless in the present, despite the ways that we have been overpowered by abuse and trauma in the past.
- ❖ We act from a commitment to equal power relations. Our goal is to share power to the greatest extent possible—to step outside of the oppression paradigm which places people in subordinate and dominant roles.

[53] Adapted from Wineman, Staven, "Power-Under: Trauma and Non-violent Social Change."

Personality Disorders (50 MINUTES)

OBJECTIVE

- To assist participants in understanding personality disorders and the Peer Specialist Role.

METHOD

- Invite someone who has experience with a personality disorder to present on their knowledge and experience.
- Read—Personality Disorders and Borderline Personality Disorder.
- Discuss resources available in the community to assist people who experience a personality disorder.
- Peer support exercise. Have participants pick a partner and use scenarios to practice how the Peer Specialist can respond.

Personality Disorders

Personality disorders exist on a range so they can be mild to more severe in terms of how pervasive and to what extent a person exhibits the features of a particular personality disorder.

Those with a personality disorder typically experience the following:

- Disturbances in self-image
- Inability to have successful interpersonal relationships
- An inappropriate range of emotions, ways of perceiving themselves, others and the world
- Difficulty with impulse control

These disturbances come together to create an all-encompassing pattern of behavior and inner experience that is quite different from the norms of the individual's culture. Their behaviors appear more dramatic than what society considers usual. Therefore, those with a personality disorder often experience conflicts with other people and vice-versa.

There are as many potential causes of personality disorders as there are people who suffer from them. They may be caused by a combination of parental upbringing, one's personality and social development, as well as genetic and biological factors. Research has not narrowed down the case to any factor at this time. We do know, however, that these disorders will most often manifest themselves during increased times of stress and interpersonal difficulties in one's life. Therefore, treatment most often focuses on increasing one's coping mechanisms and interpersonal skills.

The most commonly diagnosed personality disorder seems to be Borderline Personality Disorder (BPD).

Borderline Personality Disorder[54]

Borderline Personality Disorder (BPD) is characterized by impulsivity and instability in mood, self-image, and personal relationships. It is fairly common and is diagnosed more often in females than males.

What are the Symptoms of BPD?

Individuals with BPD have several of the following symptoms:

- Marked mood swings with periods of intense depression, irritability, and/or anxiety lasting a few hours to a few days.
- Inappropriate, intense, or uncontrolled anger.
- Impulsiveness in spending, sex, substance use, shoplifting, reckless driving, or binge eating.
- Recurring suicidal threats or self-injurious behavior.
- Unstable, intense personal relationships with extreme, black and white views of people and experiences, sometimes alternating between "all good" idealization and "all bad" devaluation.
- Marked, persistent uncertainty about self-image, long term goals, friendships, and values.
- Chronic boredom or feelings of emptiness.
- Frantic efforts to avoid abandonment, either real or imagined.

How are Personality Disorders Treated?

A combination of psychotherapy and medication appears to provide the best results for treatment of personality disorders. Medications can be useful in reducing anxiety, depression, and disruptive impulses. Relief of such symptoms may help the individual deal with harmful patterns of thinking and interacting that disrupt daily activities.

Long-term outpatient psychotherapy and group therapy (if the individual is carefully matched to the group) can be helpful. Short-term hospitalization may be necessary during times of extreme stress, impulsive behavior, or substance misuse.

Periods of improvement may alternate with periods of worsening. Fortunately, over time most individuals achieve a significant reduction in symptoms and improved functioning.

[54] Borderline Personality Disorder Association, Kelowna, BC.

Can Other Disorders Co-Occur with Personality Disorders?

Yes. Personality disorders may be accompanied by serious depressive illness (including bipolar disorder), eating disorders, and alcohol or drug misuse. About 50% of people with BPD experience episodes of serious depression. At these times, the "usual" depression becomes more intense and steady, and sleep and appetite disturbances may occur or worsen. These symptoms, and the other disorders mentioned above, may require specific treatment.

What Medications Are Prescribed for Personality Disorder

Antidepressants, anticonvulsants and short-term use of neuroleptics are common. Decisions about medication use should be made cooperatively between the individual and the therapist. Issues to be considered include the person's willingness to take the medication as prescribed, and the possible benefits, risks, and side effects of the medication, particularly the risk of overdose.

"Having a resentment is like drinking poison and expecting someone else to die."

- ANONYMOUS

• • • Break 15 minutes • • •

Homework (5 MINUTES)

OBJECTIVE

To increase the knowledge base for Peer Specialists

To encourage participants to read suggested materials.

METHOD

Ask participants to complete Assertion Skills Worksheet and bring to Session 10.

Ask participants to read the sections on Stress and Stress Management from Session 10 before the next class.

Suggest additional readings from the list or other resources.

Additional Readings and Resources:

Carter, Les, *The Anger Trap: Free Yourself from the Frustrations that Sabotage Your Life*, Jossey-Bass, September, 2004.

Seals, James, *Anger: Natural Treatments to Manage Frustration and Stress*, Healing Habits Publishing, February, 2015.

Chapman, Alexander L., The Borderline Personality Disorder Survival Guide: Everything You Need to Know About Living With BPD, New Harbinger Publications, December, 2007.

REVIEW QUESTIONS:

1. **What are some of the functions of anger?**
2. **Why is assertive behavior important in creating trauma-sensitive environments for peers?**
3. **What are the psychological features of a personality disorder?**
4. **What is the basic format of an "I" statement? Give an example.**
5. **What are some local resources that can be used for peers with characteristics of a personality disorder?**

Session 9 Homework Handouts

Assertion Skills Worksheet[55]

Using "Contrasting Assertive, Passive and Aggressive Behavior" as your guide, read the following statements and create an appropriate assertive message for each.

Example:

You car pool to work every morning from Kenosha to Milwaukee. For the last few weeks you have arrived to pick up Jennifer and she has not been ready. You therefore end up in early rush hour traffic and arrive late for work.

Response:

"Jen, I understand things have been hectic for you in the mornings lately. When I arrive to pick you up at 7:00 and you're often not out to the car until 7:30, I get frustrated and anxious. We end up caught in traffic and I've been late for work. It would be better for me if you could be outside by 7:00."

Please complete the following:

1. You share a classroom with Sandra. She teaches art and you teach math. You arrived to teach your block of Math and discovered the classroom in a mess. This has happened repeatedly. It takes time for you to clean the room before your class can begin.

Response:

2. You went to the equipment room for supplies and discovered Kelly had not stocked the storeroom. You are unable to begin work without the equipment and supplies you need. You are under pressure to complete your work on time.

Response:

[55] Ibid, page 26-28.

3. Your colleague has the habit of double-checking the information you give him/her as well as the figures you submit to accounting. You're getting frustrated by his/her lack of trust in you.

Response:

4. Your boss has changed the time of the managers' meeting with almost no notice. The new time conflicts with a meeting you have arranged with one of your key clients. Both meetings are very important for you to attend.

Response:

5. One of your staff just walked out "in a huff" because you asked him/her to redo a portion of a report she/he submitted. You don't feel good about the conversation and are wondering if you were being too picky. You decide to address it.

Response:

6. You work with a committee that has been meeting regularly for the last few months. One of your colleagues on this committee continually interrupts while you are speaking. You have decided to address it with them privately.

Response:

7. You and your best friend are having dinner together. You have just told him/her about your frustrations at work and she/he has said, "You're too sensitive—you're always over-reacting." You feel dismissed.

Response:

8. You lent your car to your brother with a full gas tank. He returned it with no gas and covered in mud. You recently had it cleaned thoroughly.

Response:

9. An angry parent confronts you aggressively about your style of teaching. "My Sally used to like school before she met you. You're an incompetent teacher and I won't put up with it any longer."

Response:

10. Your boss just threw a report on your desk and stated, "It's got some typing errors—when are you going to take that typing course? I need this on my desk by 4:00!"

Response:

Session 10

FACILITATOR INFORMATION:

This session begins with an exploration of stress and stress management. It emphasizes the importance of balance; for both the peer and the Peer Specialist. The widely misunderstood diagnosis of schizophrenia is explained as well as other psychotic disorders.

Stigma and cultural competency are presented with an opportunity for a class discussion around stigma and current events. Participants are encouraged to share some of their experiences around stigma.

Peer Specialist Facilitator Curriculum Guide

SESSION 10

5 MINUTES Homework review

45 MINUTES Stress and Stress Management

15 MINUTES Break

75 MINUTES Schizophrenia and Other Psychotic Disorders

15 MINUTES Break

50 MINUTES Stigma and Cultural Competency

5 MINUTES Homework

CPS CORE CRITERIA COVERED

1.6 Believes in the importance of self-awareness and self-care
2.2 Knowledge of mental health and substance use disorders and their impact on recovery.
2.3 Knowledge of the basic neuroscience of mental health and addiction
2.9 Knowledge of the impact of discrimination, marginalization, and oppression
2.10 Knowledge of the impact of internalized stigma and shame
3.5 Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interaction
4.11 Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals

Homework Review (5 MINUTES)

Open class with a discussion of the homework assignment.

Ask if there are any comments regarding the review questions.

Stress and Stress Management (45 MINUTES)

OBJECTIVE

To discuss the role stress may have for a Peer Specialist

To discuss the importance of managing stress.

To identify ways to help the Peer Specialist manage stress and assist their peers to manage stress.

METHOD

Review Stress and Stress Management with participants.

Ask participants to complete their personal Stress Assessment.

Discuss the results of the Stress Assessment with participants emphasizing the importance of self-awareness and self-care.

Stress

- Change in life is unavoidable and every living being is continually trying to adapt to new stimuli that are first seen as stressful. Even positive changes such as getting a promotion or marrying can be experienced as stressful in the beginning. For the most part, unexpected changes are felt as more stressful than expected ones. For example, a person who has been warned ahead of time of a work lay-off will most likely experience less stress than if the job loss is unexpected.

- People are complex creatures, on the one hand they need a certain amount of reliability but on the other hand crave stimulation through change. People vary in their tolerance towards change. Some individuals become "creatures of habit" where even minor changes are experienced as disruptive to their well-being. For example, an elderly person might find it extremely stressful to move into a new residence while a younger person might look forward to such a chance. A third person might not necessarily experience the stress of the move at the conscious

level but nonetheless reacts by developing a disorder such as a skin rash or tense muscles. Individuals differ in the way they react to stressors. The same stimulus, which is stressful to one person, might be experienced as exhilarating to someone else. Furthermore, lack of stimulation, which is experienced subjectively as boredom, can also be a source of stress.

- Sources of stress (stressors) can be external factors such as an earthquake or internal ones like negative self-statements. However, in most cases, the experience of stress is the result of a combination of external and internal components. For example, a person who loses their job because of a lay-off (external stressor) might engage in negative self-talk (internal stressor) such as "I will never find a job again," thus increasing the levels of stress experienced.

- As a Peer Specialist, it is always important for you to validate the peer's expression of stress. For example, a teenager might experience a great deal of stress and worry after a haircut, which did not turn out to her liking, but nonetheless suits her. Statements such as "Don't worry about it, to me your hair looks fine, and besides your hair will grow back" are not very helpful. Instead, use a statement that shows understanding of her subjective experience like: "You feel really disappointed in the way your hair turned out (empathy) and you probably worry what your friends might think of your new look (advanced empathy). If you want to hear my opinion, I think the haircut really suits you" (immediacy).

- Individuals do not always cope with stress in positive ways. Some rely on alcohol/drugs and other harmful addictions to lessen anxious feelings. A word of caution, prescription drugs for anxiety are usually addictive. Furthermore, some individuals with addictive tendencies end up overusing prescription drugs, sometimes mixing them with alcohol, which can result in a potentially lethal combination. Therefore, it may be wise to encourage peers to explore alternatives with their therapist/psychiatrist before resorting to prescription drugs.

Stress Management

Breaking Down Stress into Components

- Sometimes peers complain of feeling stressed or anxious but lack real awareness of the external and internal factors, which are "feeding" their uncomfortable state. In such cases, the first step is to help the peer recognize possible sources of stress by exploring with questions such as:

    a) Where do you think the stress is coming from?
    b) What areas of your life do you find stressful?
    c) In what situations do you feel stress?

- The goal with exploring is to break down the perceived stressors into several parts.

For example, a peer might decide the major areas of stress in her life are as follows:

- ✓ Rejecting behavior by a teenage daughter
- ✓ Constant fighting with the husband over the children's behavior
- ✓ Financial difficulties because of only one income
- ✓ Anxiety over a possible recurring episode of depression

- The next step involves looking at each part separately and helping the peer generate strategies and action plans for each stressor.

Simple strategies may include:

a) Get some books from the public library for gaining understanding of the teenage years of development.
b) Get a referral for family counseling.
c) Keep better track of expenses by developing a monthly budget. Also, make extra money by babysitting.
d) Join a depression group for emotional support and to learn coping skills. Also, discuss with the psychiatrist a possible change of medication.

- This process usually helps the peer begin to gain a sense of control over his/her situation. The newly gained awareness of stressors combined with potential solutions might in itself reduce the stress experienced.

The Skill of Time Management

- Many individuals in our culture feel overwhelmed with commitments, which can create a lot of worry and stress. The skill of time management is a useful tool that can help a person organize their commitments with the aid of a calendar/date book. This process may help the person use time more efficiently.

- In addition to time management, peers can also train themselves to focus only on the most immediate or highest priority commitments, blocking out of awareness the tasks that have to be done further along in time.

Escape

- Distractions such as immersing oneself in a book, a movie, TV, music, daydreaming, can all be useful activities to help the person take a break from worrying. Unfortunately for some people, distractions can become addictive to the point where they avoid dealing with the stressors in a solution-oriented manner.

Meditation

- Meditation is a technique, which can be used to stop worrisome internal dialogues by putting the person in a deeply relaxed state. Research suggests meditation increases endorphins, an opiate-like substance naturally produced by the body. Endorphins are related to feelings of well-being and relaxation and rise naturally just before a person falls asleep. Therefore, meditation may function for some individuals as an alternative to sleeping pills.

- The meditative state can be achieved in a variety of ways which include:

    a) The use of a mantra, which involves repeating the same word, sentence or prayer to oneself over and over again, either aloud or through internal dialogue.
    b) Focusing on one's breathing and trying to be aware only of the inhaling and exhaling rhythm.

Relaxation Exercises

- Relaxation exercises are especially useful for individuals who experience stress at the physical level. The first step involves becoming aware of the tense muscle areas in one's body. The second step involves some form or relaxation exercise such as deep breathing, systematic tensing and relaxing of the various muscles in the body and/or mental visualizations of "dissolving" the tense areas.

Replacing Negative Self-Talk with Positive Thoughts

- Individuals with low self-esteem tend to use negative self-talk and as a result experience more stress. For example:

    ❖ A person who lacks confidence in his/her ability to do well in a course might say to herself "I am not smart enough and I will fail this course", thus compounding his/her perceived stress in relation to her course.

- The first step in overcoming negative self-talk is becoming more aware of self-defeating internal dialogues. This can be done by keeping a written record of specific negative self-statements, under what circumstances they happen, and their emotional affect at the time. It is also helpful to write beside the negative self-statements a positive affirmation. For example:

    ❖ The peer might write, "I feel proud for challenging myself to take this course and I will try to do my best."

- The second step involves practicing stopping the negative self-talk by focusing on a pre-selected visual image such as a serene landscape.

- The third step involves repeating the positive affirmation.

Proper Nutrition

A balanced diet, which includes five servings of fruits and vegetables (Five Alive), can provide the necessary amount of vitamins or minerals that are essential to keep the body and mind healthy. It is important for the Peer Specialist to emphasize to peers that nutritious food is needed to provide the nutrients for healthy brain chemicals. Too often, fast food and other empty calories contribute to poor physical and mental health.

The Exercise Effect

If you have ever gone for a walk after a stressful day, chances are you felt better afterward as there is a positive link between exercise and mood. Usually within five minutes after moderate exercise you will experience a mood-enhancement effect.[56] But the effects of physical activity extend beyond the short-term. Research shows that exercise can also help alleviate long-term depression.

Duke University explored the mood-exercise connection through a series of randomized controlled trials. In one study, researchers assigned sedentary adults with major depressive disorder to one of four groups: supervised exercise, home-based exercise, antidepressant therapy or a placebo pill. After four months of treatment, patients in the exercise and antidepressant groups had higher rates of remission than did the patients on the placebo. Researchers concluded that exercise was comparable to antidepressants for patients with major depressive disorder.[57]

Researchers have also explored exercise as a tool for treating, and perhaps preventing, anxiety. When we're spooked or threatened, our nervous systems jump into action, setting off a cascade of reactions such as sweating, dizziness, and a racing heart. People with heightened sensitivity to anxiety respond to those sensations with fear. They're also more likely to develop panic disorder down the road, according to research at Southern Methodist University in Dallas.[58]

Researchers hypothesized that regular workouts might help people prone to anxiety become less likely to panic when they experience fight-or-flight sensations. After all, the body produces many of the same physical reactions—heavy perspiration, increased heart rate—in response to exercise. They tested their theory among 60 volunteers with heightened sensitivity to anxiety. Subjects who participated in a two-week exercise program showed significant improvements in anxiety sensitivity compared with a control group. The exercise was like exposure treatment where subjects learn to associate the symptoms with safety instead of danger.

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[56] Weir, Kirsten, "The Exercise Effect," American Psychological Association, December 2011.
[57] Blumenthal, James, PhD, Psychosomatic Medicine, 2007.
[58] Smits, Jasper, PhD, and Otto, Michael W., Exercise for mood and Anxiety: Proven Strategies for Overcoming Depression and Enhancing Well-Being, Oxford University Press, July 2011.

Of all the questions that remain to be answered, perhaps the most perplexing is this: If exercise makes us feel so good, why is it so hard to do it? According to the Centers for Disease Control and Prevention, 25% of the U.S. population reported zero leisure-time physical activity.

Starting out too hard in a new exercise program may be one of the reasons people disdain physical activity. When people exercise above their respiratory threshold—that is, above the point when it gets hard to talk—they postpone exercise's immediate mood boost by about 30 minutes. For people just starting, that delay could discourage them from exercising. It is important to start out slowly with moderate exercise like walking. It is also helpful to mark on a calendar the days for exercise. Remember: "If you don't measure it, it won't happen."

Key Point …

As a Certified Peer Specialist, it is important to work your own wellness/recovery plan and maintain a healthy social network.

Measure Your Stress[59]

How stressful has the last year been for you? Evaluate each statement in this quiz and for each item that applies, list the stress value in the points column. Add up all the values to get your stress level for the last year.

Life Event (Past 12 Months)	**Stress Value**	**Your Points**
Death of a spouse	100	_____
Divorce	73	_____
Marital separation from mate	65	_____
Detention in jail or other institution	63	_____
Death of a close family member	63	_____
Major personal injury or illness	53	_____
Marriage	50	_____
Being fired from work	47	_____
Marital reconciliation with mate	45	_____
Retirement from work	45	_____
Major change in the health or behavior of a family member	44	_____
Pregnancy	40	_____
Sexual difficulties	39	_____

[59] Bartlein, Barbara, "Managing Stress—Tips, Tricks and Checklists," Great Lakes Consulting Group, 2001.

Gaining a new family member…….39 _____

Major business readjustment (merger, reorganization)…….39 _____

Major change in financial state (either a lot worse or better off)……...……38 _____

Death of a close friend……..37 _____

Changing to a different line of work…….36 _____

Major change in the number of arguments with spouse……35 _____

Taking on a mortgage greater than $10,000……..31 _____

Foreclosure on a mortgage or loan……30 _____

Major change at work (promotion, demotion)……..29 _____

Son or daughter leaving home……..29 _____

In-law problems……29 _____

Outstanding personal achievement……..…….28 _____

Spouse beginning or ceasing work outside of the home……..…26 _____

Beginning or ceasing formal schooling……26 _____

Major change in living conditions (building a home)……..…25 _____

Revision of personal habits (quit smoking, drinking)……..24 _____

Troubles with the boss……..23 _____

Major change in working hours or conditions……..……20 _____

Change in residence……..20 _____

Changing to a new school……...……..20 _____

Major change in usual type and/or amount of recreation……..19 _____

Increase or decrease in church attendance……..……...…19 _____

Major change in social activities (clubs, dancing)…….....18 _____

Taking on a mortgage or loan less than $10,000……17 _____

Major change in sleeping habits…….16 _____

Major change in number of family get-togethers……15 _____

Major change in eating habits…….15 _____

Vacation……..13 _____

Christmas……...….12 _____

Minor violations of the law (traffic tickets, etc)…….11 _____

Scoring: Add up your score.

Above 300	***High Stress***
150-300	***Moderate Stress***
75-150	***Average Stress***
Less than 75	***You're on vacation!***

• • • Break 15 minutes • • •

Schizophrenia and Other Psychotic Disorders (75 MINUTES)

OBJECTIVE

- To provide knowledge about schizophrenia and other psychotic disorders.
- To practice skills that will help Peer Specialists communicate with individuals experiencing schizophrenia or other psychotic disorders.
- To discuss resources available in the community to assist people experiencing schizophrenia or other psychotic disorders.

METHOD

- Invite an individual who has experienced schizophrenia or another psychotic disorder to present to the class their experience and knowledge about the disorder.
- Read—Schizophrenia and other psychotic disorders.
- Discuss available resources in the community for people who experience schizophrenia or other psychotic disorders.
- Conduct a peer support exercise using scenarios that will help peer supporter improve skills in communicating with people who live with schizophrenia.

Schizophrenia and Other Psychotic Disorders

Introduction to Schizophrenia

- Schizophrenia is a psychiatric disorder, characterized during the acute phase by severe thought and/or affect (expression of feelings) disturbances which can include:

    - ✓ Hearing voices, hallucinations that may affect any or all senses
    - ✓ Delusions
    - ✓ Confused thinking—feeling ambivalent because cannot make a decision
    - ✓ Disjointed thoughts
    - ✓ Overwhelming thoughts—thoughts snowball, build until your senses are over stimulated
    - ✓ Righteousness
    - ✓ Social withdrawal
    - ✓ Feeling that objects or events are meant as personal signs or omens
    - ✓ Religious preoccupation
    - ✓ Lack of motivation

- Schizophrenia has been one of the most misunderstood illnesses. One long-tern held belief is that people with Schizophrenia only get worse over time. Currently, there are 10 national and international longitudinal studies of 20 to 30 years demonstrating that recovery is possible for at least one half of people with schizophrenia and other severe mental illnesses. Many individuals with Schizophrenia experience recovery and lead fulfilling lives.[60]

Brief Reactive Psychosis

This disorder is usually triggered by severe stress and the essential feature is the sudden onset of psychotic symptoms such as delusions, hallucinations, bizarre behavior and disturbances in affect (expression of feelings). However, this experience is brief in nature.

Schizoaffective Disorder

This is the term used when a person has a combination of a mood disorder and a psychotic disorder. The essential feature of this disorder is the presence of psychotic symptoms and mood disturbances. However, the presence of psychotic symptoms might not correspond to the mood disturbances.

Delusional Disorder

The essential feature of this disorder is a persistent delusion or system of delusions that are non-bizarre in the sense that they involve situations that may occur in real life. Auditory and visual hallucinations are not prominent and usually are short lived. Apart from the delusions and their ramifications, behavior is not particularly odd.

Pharmacological Treatment of Psychotic Disorders

- The symptoms of schizophrenia may be controlled with the use of major tranquilizers (antipsychotic drugs). These medications seem to lower the levels of dopamine which in turn results in the cessation of thought disturbances.

- Medication used to treat schizophrenia and other psychotic disorders will be discussed next session.

- Individuals with schizophrenia might also be prescribed antidepressants to combat the commonly associated dysphoric mood.

- Brief reactive psychosis and schizoaffective disorder are similarly treated with major tranquilizers and/or depressants

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[60] Bleuler,1972;Ciompi & Muller, 1976; Desisto, Harding et al., 1995 a and b; Harding, Brooks et aI., 1987, a, b; Hinterhuber, 1973;Huber, Gross & Schuttler, 1979; Kreditor, 1977; Marinow, 1974; Ogawa et al., 1987; Tsuang, Woolson & Fleming, 1979.

Peer Support

- The Peer Specialist can support a peer diagnosed with schizophrenia by bringing the perspective that seeing mental distress is human and, ultimately, understandable: Rather than seeing voices, visions and extreme states as symptoms of an underlying illness, we believe it is helpful to view them as meaningful experiences – even if we don't yet know what that meaning is. We believe it's important to use human language when describing human experiences rather than medical terminology. Given the role of trauma and adversity, we need to start asking 'what has happened to you?' rather than 'what is wrong with you?'[61]

- The Peer Specialist reinforces the belief in peers that they are human beings with rights that include the opportunity to be an active contributing member of society.

- Peer Specialists can also educate the community, including family members about the disorder. Ignorance and misconceptions about schizophrenia has largely contributed to the marginalization and isolation of those who experience schizophrenia. One of the most important jobs you can do is to help an isolated peer reestablish a social network. Feeling a sense of belonging within a community, which offers validation and emotional support, will most likely decrease the chances of a relapse.

61 http://www.hearing-voices.org/about-us/position-statement-on-dsm-5/

Stigma and Cultural Competency

(50 MINUTES)

OBJECTIVE

- To further develop an understanding of stigma, marginalization and oppression in mental health and addiction.

METHOD

- Read: Stigma.
- Read: Cultural Competency
- Conduct the exercise, "Diversity Shuffle."

Stigma

In 1999, the U.S. Surgeon General labeled stigma as the biggest barrier to mental health and substance use care. This stigma manifests particularly in a phenomenon known as social distancing, whereby people with mental health and substance use disorders are more isolated from others.

Research suggests that the majority of people hold negative attitudes and stereotypes towards people with mental health and substance use disorders. From a young age children may refer to others as "crazy" or "nuts". This language and attitude frequently carry into adulthood. Often the negative stereotypes involve perceptions that people with mental illness or a substance use disorder are dangerous. This perception is fueled by media stories that paint violent perpetrators as "mentally ill" without providing the context of the broad spectrum of mental illness and substance use. In fact, health care providers and even some mental health professionals hold these very same stereotypes.[62]

These negative attitudes often manifest as social distancing with respect to people with mental health and substance use disorders. In particular, when people feel that an individual is dangerous, this results in fear and increased social distance. This social distancing may result in the experience of social isolation and loneliness. This stigma and social distancing have the potential to worsen the well-being of peers in several ways.

[62] Friedman, Michael, "The Stigma of Mental Illness is Making Us Sicker," Psychology Today, May, 2014.

First, the experience of social rejection and isolation that comes from stigma has the potential for direct harmful effects. It has long been understood that social isolation is associated with poor mental and physical health outcomes and even early mortality. Further, social isolation predicts disability among individuals with mental illness.[63]

People with mental health and substance use issues recognize and often internalize this stigma and develop a "self-stigma". This self-stigma will often undermine self-efficacy, resulting in a "why try" attitude that can worsen prospects of recovery. Further, as people begin to experience symptoms, such as anxiety or depression, stigma may cause some people to try to avoid, separate from or suppress these feelings, all of which have been linked to the worsening of well-being.

This stigma doesn't just worsen outcomes on a personal level, but also complicates the care and resources available to people with mental illness or substance use disorder. In its "Attitudes Towards Mental Illness" report, the Centers for Disease Control (CDC) noted that stigma can result in a lower prioritization of public resources and poorer quality of care.[64] A review of 22 studies that focused on barriers to care and mental illness determined that stigma and embarrassment were the top reasons why people with mental illness did not engage in treatment. The effects of stigma work both ways – mental health conditions are not typically screened in most health care settings, losing an important opportunity for care.

Further, the discrepancy between the cost of mental health disorders as compared to the funding of research is striking, and is believed to be caused by stigma associated with mental health issues. Worse, this stigma and need for social distancing may influence what has become the criminalization of people with mental illness and substance use disorders. People with these issues are 10 times more likely to be in prison than in psychiatric care, leading some to call prisons "The New Gulags for the Mentally Ill."[65] Many consider this a human rights violation that contributes to the cycle of prison, poverty and homelessness for many people with mental health or substance use disorders.

Stigma remains the biggest barrier to addiction treatment faced by patients. The terminology used to describe addiction has contributed to the stigma. Many derogatory, stigmatizing terms were championed throughout the "War on Drugs" in an effort to dissuade people from misusing substances. Education took a backseat, mainly because little was known about the science of addiction. That has changed, and the language of addiction medicine should be changed to reflect today's greater understanding. By choosing language that is not stigmatizing, we can begin to dismantle the negative stereotype associated with addiction.

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[63] Shulevitz, Judith, "The Lethality of Loneliness-We now know how it can ravage our body and brain," New Republic, May, 2013.
[64] CDC, "Attitudes Towards Mental Illness," www.cdc.gov
[65] McCambridge, Ruth, "The Prison System as a Gulag for People With Serious Mental Illness, " Non-Profit Quarterly, January, 2012.

Changing the stigma will benefit everyone. It will allow patients to more easily regain their self esteem, allow lawmakers to appropriate funding, allow doctors to treat without disapproval of their peers, allow insurers to cover treatment, and help the public understand this is a medical condition as real as any other.

Choosing the words we use more carefully is one way we can all make a difference and help decrease the stigma.

What Can Be Done?

Increased awareness is one of the most important things that can be done to counteract stereotypes. Groups, such as, the National Alliance on Mental Illness and the Rosalynn Carter Foundation have fought to reduce stigma. More recently, Molly Knight Raskin, who received the Rosalynn Carter Fellowship for Mental Health Journalism, is developing a movie, "Still We Rise," to bring awareness to the epidemic of global mental illness.

In Wisconsin, the WISE statewide coalition of organizations and individuals promoting inclusion and support for all affected by mental illness by advancing evidence-based practices for stigma reduction efforts. People with lived experience of mental health challenges strategically sharing their story is the current, primary, evidence-based practice and drives the focus of WISE. WISE promote the power of story.[66]

It is also crucial that those working directly with people with mental health or substance use disorders receive the education and support needed to manage bias. Training more people across the medical field in mental health and substance use issues creates the possibility of integrating mental health screenings in primary care settings.

Recent legislation holds promise that people with mental health issues will receive care comparable to those with physical health issues. The Affordable Care Act of 2013 expanded upon the Mental Health Parity and Addiction Equity Act of 2008, providing more possibility that mental health conditions will be covered on par with physical health conditions.

Fighting Stigma

DO use respectful language.

DO emphasize abilities, not limitations.

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[66] http://wisewisconsin.org/what-is-wise/who-we-are/

DO tell someone if they express a stigmatizing attitude.

DON'T portray successful persons with disabilities as super human.

DON'T use generic labels such as retarded, or the mentally ill.

DON'T use terms like crazy, lunatic, manic depressive, or slow functioning.

Cultural Competency

What is Culture?

Culture may be defined as the behaviors, values and beliefs shared by a group of people, such as an ethnic, racial, geographical, religious, gender, class or age group. Everyone belongs to multiple cultural groups, so that each individual is a blend of many influences.

Culture includes or influences dress, language, religion, customs, food, laws, codes of manners, behavioral standards or patterns, and beliefs. It plays an important role in how people of different backgrounds express themselves, seek help, cope with stress and develop social supports. Culture affects every aspect of an individual's life, including how we experience, understand, express, and address emotional and mental distress.

What is Cultural Competence?

Cultural competence is the ability to relate effectively to individuals from various groups and backgrounds. Culturally competent services respond to the unique needs of members of minority populations and are also sensitive to the ways in which people with disabilities experience the world. Within the behavioral health system, cultural competence must be a guiding principle, so that services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment and intervention.

Cultural competence recognizes the broad scope of the dimensions that influence an individual's personal identity. The Peer Specialist should be familiar with how these areas interact within, between and among individuals. These dimensions include:

- Race
- Ethnicity
- Age
- Language
- Sexual orientation

- Gender
- Disability
- Class/socioeconomic status
- Education
- Religious/spiritual orientation

Diversity in the United States

The U.S. population is rapidly diversifying:

- The decade between 1990 and 2000 saw the largest increase—from 20% to 25%--in population growth of persons of color.
- According to the 1990 census, the number of persons who speak a language other than English rose 43%, to 28.3 million, compared with 1980 census figures.
- Nearly 45% of these 28.3 million people indicated having trouble speaking English.
- One in 10 Americans are now foreign-born.
- One in three Americans belongs to a group or groups identified as minorities.

Disparities in Mental Health and Substance Use Services

The Surgeon General's report, ***Mental Health: Culture, Race and Ethnicity***, discusses disparities in behavioral health services for members of racial and ethnic minority populations. People in these populations:

- Are less likely to have access to available mental health services;
- Are less likely to receive necessary mental health and substance use care;
- Often receive a poorer quality of treatment;
- Are significantly under-represented in mental health research.

Members of racial minority groups, including African Americans and Latinos, underuse mental health and substance use services and are more likely to delay seeking treatment. Consequently, in many cases, individuals seek services when they are at an acute stage of illness. This delay can result in a worsening of untreated illness and an increase in involuntary services.[67]

[67] U.S. Department of Health and Human Services, Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General-Executive Summary, Rockville, MD, November 2006.

Cultural Biases and Stereotypes

In general, discrimination refers to the hostile or negative feelings of one group of people toward another. It can cause bias in service and can prevent people from seeking help. Cultural competency must address the biases and stereotypes that are associated with an individual's culture and various identities.

Forms of discrimination include:

- **Racism:** prejudice or discrimination based on a person's race, or on the belief that one race is superior to another.
- **Ageism:** bias toward an individual or group based on age. For example, young people may be stereotyped as immature and irresponsible; older adults may be called slow, weak, dependent and senile.
- **Sexism:** discrimination or prejudice based on gender.
- **Heterosexism:** prejudice against people who are gay, lesbian, bisexual, transgender, or intersex. It is also the assumption that all people are heterosexual and that heterosexuality is correct and normal.
- **Homophobia:** the fear and/or dislike of homosexual people or homosexuality.
- **Classism:** any form of prejudice or oppression against people who are members of (or who are perceived as being similar to those who are member of (a lower social class.
- **Religious intolerance:** an inability or unwillingness to tolerate another's beliefs or practices.

The Peer Specialist must be aware of how stereotypes and stigma influence not only their peers, but also their own thoughts and views of others.

Common Cultural Mistakes in the Trauma Field

Below is a chart showing some of the most common cultural mistakes and alternative responses to the same situation. Read through the chart and consider how you can make your own peer support relationships more culturally sensitive. Notice that using these "alternative" responses can help you be more trauma-informed in your interactions with all the people you work with, not just those from other cultures.[68]

[68] Blanch, Andrea, Filson, Beth, and Penney, Darby , Engaging Women in Trauma-Informed Peer Support: A Guidebook,.

Common Cultural Mistakes About Trauma	More Culturally Sensitive Approach
Assuming everyone who has experienced violence needs professional help	Assuming people are resilient and giving them many opportunities to tell you if they need help
Focusing on the most extreme instances of violence as the most damaging	Allowing the individual to define what aspects of her experience have been most traumatic and recognizing that this may change over time
Assuming that violence is unusual, an aberration, and generally perpetrated by individuals	Recognizing that violence is perpetrated by groups and institutions, not only individuals, and may be so common that people become desensitized to it
Applying norms and standards of behavior without considering political and social context	Recognizing that political and social oppression may affect priorities and values; allowing the individual to define the meaning of what she has experienced
Relying on DSM diagnoses or lists of trauma "symptoms"	Recognizing that trauma responses are varied and that different cultures express grief and loss and understand trauma differently; learning how this person and her culture expresses distress
Assuming that one woman's story represents the "typical" story for the group	Recognizing that "one woman's story is just one woman's story"
Inadvertently highlighting the stories of women that fit cultural stereotypes	Providing opportunities for many women to share their stories, and noticing what is unique; making sure many points of view are represented
Assuming that if people speak English, you don't have to worry about an interpreter or translated documents	Recognizing that some topics are very difficult to talk about in anything other than your first language; knowing and acting within the law about provision of language assistance services
Assuming that people always (or never) want to tell their stories and that if people want help they will ask for it	Being aware that self-disclosure and help-seeking vary widely across cultures and may be dependent upon whether a woman feels safe with you; learning from each woman

Some populations are more likely than others to experience a traumatic even or a specific type of trauma.

- Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence.
- Culture influences not only whether certain events are perceived as traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- Traumatic stress symptoms vary according to the type of trauma withing the culture.
- Culture affects what qualifies as a legitimate health concern and which symptoms warrant help.
- In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

How to Incorporate Cultural Competency Standards into Practice

Peer Specialists can improve their cultural competence by taking the following steps:

- ✓ Use open-ended questions to identify each peer's unique cultural outlook.
- ✓ Developing an understanding of the cultural backgrounds of peers you have contact with.
- ✓ Use the strengths-based approach when working with peers promoting resiliency.
- ✓ Identify resources, such as natural supports, within the community that will help a peer in their recovery.

Key Point …

The Peer Specialist should strive for cultural competency to incorporate elements of culture that are important to the peer they are working with.

Diversity Shuffle (Power Shuffle)[69]

Diversity in the population allows communities to grow and to learn from one another's differences. However, these differences are often used to fragment communities rather than to encourage mutual understanding. One of the ways in which societies have segregated different categories of people has been along lines of power. Individuals who are perceived by the majority population to be "different" often have less power than the majority population. These may be differences in gender, racial or ethnic heritage, sexual orientation, religion, age, physical ability, and many other categories.

The power takes the form of access to resources, work, housing, education, physical security, protection by law, and representation in government. Some groups are given more power than others by society, but they are permitted to have this power at the expense of other groups, whose access to resources is correspondingly diminished or denied.

The following exercise helps to encourage discussion about differences and similarities within our communities. This can be used as a springboard for a dialogue about power differences in our communities and how they can be addressed.

The Diversity Shuffle should be performed in a room which is large enough to comfortable hold the expect number of participants. Prior to the exercise, all furniture, etc., should be moved aside to allow space for people to walk from one side of the room to the other. Everyone stands and gathers at one end of the room. The facilitator stands to the front and side of the group and says the following:

> ***"In this exercise, we will be dealing with some sensitive issues. Before we begin, we ask that everyone agree to the following guidelines:"***

- Honor confidentiality. Anything shared in this room stays within this group.
- Unconditionally respect yourself and others.
- Speak for yourself only.
- Actively listen: consider other people's words as gifts.
- No put-downs or analysis. Avoid interpreting other people's experience.
- Give caring feedback.
- This exercise includes a dialogue, not a debate. There are no losers or winners in these exercises.

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[69] Social Justice Advocacy of GLBT Students: Empowering Students Through Campus Initiatives—NACADA Conference—October 2011.

- Agree to disagree.
- Everyone has the right to pass.
- It is okay to express your emotions.
- No "rescuing."
- Take responsibility for your own learning—ask for what you need.

"Are these guidelines acceptable to everyone? Remember you can participate as much or as little as you feel comfortable with. However, I encourage you to take some risks with this exercise, because it is the best way for all of us to learn and grow."

"I will be giving you a series of instructions during the first portion of the exercise. Please follow the instructions in complete silence, paying attention to who is with you and who is separated from you. Note the feelings that come up while performing the exercise.

You do not have to identify yourself as a member of a group that is called out if you do not wish to, but you should notice any feelings that come up about not identifying yourself. If you are not sure about which group you belong to, decide for yourself where it makes sense to go."

For each of the categories below, say the following: "Please step to the other side of the room if you are (the category). (Pause.) Notice who's standing with you. Notice who's not. (Pause). Notice how you feel. (Pause.) Come back together again.

1. You are a woman.

2. You are Asian, East Asian, South Asian/Indian, or Pacific Islander.

3. You are Latino/a, Chicano/a, or mestizo/a.

4. You are of Arabian descent.

5. You are Native American or at least one of your parent is full-blooded Native American

6. You are African-American or black, or of African descent.

7. You are of Jewish heritage.

8. You are over 50 years old.

9. You were raised poor.

10. You were raised by a single parent or currently are a single parent.

11. You were raised Catholic.

12. You have a visible or hidden physical disability or impairment.

13. You have been diagnosed with a mental health disorder.

14. Your native language is other than English.

15. You come from a family where alcohol or drugs were or are a problem.

16. You are lesbian, gay, bisexual, or transgender.

17. Someone in your family, or a close friend, is lesbian, gay, bisexual or transgender.

18. You are a veteran.

19. You or a member of your family has been labeled "addicted" to alcohol or drugs.

20. You or a member of your family has been incarcerated or been in the juvenile justice system.

Other categories may be added as appropriate or deleted based on the composition of the group. The participants are instructed to walk to the center of the room and, for a few moments, mingle silently, making eye contact and acknowledging each other as people present together in this group. They then return to their original places.

After conducting the "Shuffle" with several categories, lead a discussion based on the following questions:

- How did it feel to be in the group which had to walk across?
- How did it feel to be in the main group and watch others cross?
- Did you walk a little or a lot? How do you feel about that?
- What surprised you during this exercise?

- What is the significance of what you experienced during this exercise…for your school or community?

- How would you feel if your doctor belonged to one of the groups mentioned in this exercise (not your own)?

- How does this activity build community and individual courage?

- If you were refraining from crossing the line at first but later started to cross, why was that?

General Prejudice and Cultural Awareness Questions:

- What cultural/racial group(s) do you belong to?

- When you meet people for4 the first time, what cultural or racial group do thy usually think you belong to?

- What do you enjoy or appreciate most and least about your group?

- What incorrect assumptions or stereotypes do people make about your group?

- How might these assumptions or stereotypes impact you?

- What makes you feel more comfortable with some groups and less with others? Why?

- What issues do you have with the members of certain groups that you would be willing to discuss, but don't for fear of being misunderstood or for some other reason?

- What experiences have you had communicating with individuals from different groups?

- What do you think you need to be able to communicate with people from different groups?

- If you've become aware of a prejudice you have, what are some ways you have tried to deal with it?

- When you hear prejudiced comments or jokes, what are some things you might do or say to interrupt this behavior? Share any successful experiences you have had in stopping this behavior.

Homework (5 MINUTES)

OBJECTIVE

To recognize stigma and lack of understanding of mental health and substance use disorders.

METHOD

Ask participants to bring in one example of a recent event, public statement or news that demonstrates stigma and lack of understanding of mental health and substance use disorders.

Additional Readings and Resources:

Corrigan, Patrick W., Larson, Jon E., and Michaels, Patrick J., ***Coming Out Proud to Erase the Stigma of Mental Illness: Stories and Essays of Solidarity***, Instant Publisher, May 2015.

Eliot, Robert S., ***From Stress to Strength***, Bantam, January, 1995.

Fielding, Polly, ***Breaking The Silence: The Stigma of Mental Illness***, Create Space Independent Publishing Platform, July 2015.

Smits, Jasper, PhD, and Otto, Michael W., ***Exercise for mood and Anxiety: Proven Strategies for Overcoming Depression and Enhancing Well-Being,*** Oxford University Press, July 2011.

Information on stigma. www.wisewisconsin.org

Longden, Eleanor, ***Learning from the Voices in My Head*** (TED Books Book 39), TED Conferences, August, 2013.

REVIEW QUESTIONS:

1. **List three things you can do for better balance and self-care.**
2. **What are some techniques you can suggest to peers to better manage stress?**
3. **List things the Peer Specialist can do to be helpful to a peer diagnosed with a psychotic disorder?**
4. **Give some examples of stigma and its impact on recovery.**
5. **What is cultural competency and why is it important?**

Session 11

FACILITATOR INFORMATION:

Many of us, at some point or another, probably have been prescribed medication for symptom relief. This session begins with an opportunity for participants to explore their personal attitude towards prescription medication recognizing that there is a broad spectrum of opinions. Medication assisted treatments for mental health and substance use disorders are explained with information on commonly used medications. This is not to promote a certain view on the use of medication; rather, it is a resource for the Peer Specialist.

Addiction is further explored with an emphasis on how the Peer Specialist can support peers. Opiate use disorders are discussed in some detail as their use is at epidemic proportions. There is an opportunity to practice skills with the peer support exercise.

Peer Specialist Facilitator Curriculum Guide

SESSION 11

5 MINUTES Homework review

20 MINUTES Personal attitudes towards prescription medication

60 MINUTES Medication-Assisted Treatment

15 MINUTES Break

45 MINUTES Opiate use disorders

15 MINUTES Break

45 MINUTES Peer support exercise

5 MINUTES Homework: Readings.

CPS CORE CRITERIA COVERED

1.11 Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery
2.2 Knowledge of mental health and substance use disorders and their impact on recovery.
2.3 Knowledge of the basic neuroscience of mental health and addiction
2.7 Knowledge of person-centered care principles
3.5 Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
4.11 Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.12 Ability to facilitate and support a person to find and utilize resources

Homework Review (5 MINUTES)

OBJECTIVE

To recognize stigma, discriminatory behavior, and lack of understanding of mental health and substance use disorders.

METHOD

Participants were asked to bring in one example of a recent event, public statement or news that demonstrates stigma and lack of understanding of mental health and substance use disorders.

Lead a discussion with the class on examples they were able to find.

Encourage participants to share a personal experience with stigma or discrimination as they are comfortable.

Personal Attitudes Towards Prescription Medication (20 MINUTES)

OBJECTIVE

- To provide an opportunity for participants to explore beliefs and attitudes towards use of prescription medication.
- To learn information about medications used in medication assisted treatment.

METHOD

- Using the flip chart or board, have participants discuss common beliefs and attitudes that people have towards medication.
- Ask participants to disclose their attitudes towards prescription drugs.
- Encourage participants to share any personal experience with addiction that people feel comfortable sharing.

Medication Assisted Treatment (60 MINUTES)

OBJECTIVE

To provide Peer Specialists with current information regarding medication assisted treatment for mental health and substance use disorders.

To demonstrate how attitudes and treatment modalities have changed in recent years.

To facilitate a conversation on different perspectives regarding the use of medication.

METHOD

Read: Medication Assisted Treatment for Mental Health Disorders.

Read: Medication Assisted Treatment for Substance Use Disorders

Discuss ways in which the Peer Specialist can assist peers who are experiencing medication assisted treatment.

Medication Assisted Treatment for Mental Health Disorders[70]

Medications can play a role in treating several mental health conditions. Treatment may also include psychotherapy, support groups, peer counseling and a comprehensive recovery plan. Information regarding medication is presented in this section so that the Peer Specialist can have a working knowledge of medications that may be used by peers.

Programs that the Peer Specialist may work for often offer medication management as a service to the peers they serve. Medication management can consist of the agency storing the medication for, delivering it, and watching the peer take the medication. In other forms, medication management can consist of education about medication uses and side effects, support to establish a routine regarding medication, and discussion and support around side effects.

While a Peer Specialist may feel uncomfortable participating in the first form of medication management because it, inherently, has power imbalance, the Peer Specialist can provide peer support to the peer regarding medication in other ways. Some elements of peer support include:

- ✓ Having mutually empowering conversations regarding the peer's likes and dislikes of medications
- ✓ Offering potential coping skills and routines
- ✓ Supporting the peer regarding conversations with medical professions

[70] Adapted from the Peer Support Training Manual, CMHA, 2005.

- ✓ Encouraging wellness, self-direction and recovery of the peer by supporting their chosen goals

Following are the descriptions of common prescription drugs used to treat mental health disorders, their side effects and helpful hints for safe use.

Antidepressants

Antidepressants are primarily used for the treatment of depression. Antidepressants are also used for other health conditions, such as anxiety, pain and insomnia. Although antidepressants are not FDA approved specifically to treat ADHD, antidepressants are sometimes used to treat ADHD in adults.

Antidepressants are used for:

- ❖ Elevating depressed mood
- ❖ Restoring appetite
- ❖ Normalizing sleep patterns
- ❖ Restoring ability to experience pleasure
- ❖ Decreasing anxiety/controlling panic disorders
- ❖ Controlling obsessive compulsive disorders

There are four main types of antidepressants:

- ❖ Tricyclics
- ❖ Monoamine oxidase inhibitors
- ❖ Second generation antidepressants
- ❖ Selective serotonin reuptake inhibitors (SSRI)

Some common side effects are as follows:

- Drowsiness, dizziness
- Dry mouth
- Constipation, difficulty urinating
- Hypersensitivity to sun
- Weight gain
- Fine rapid tremor in upper extremities
- Blurred vision
- Skin rashes
- Possible bone fractures and cardiovascular problems in elderly

Some of these side effects disappear after the body gets used to the medication. Peers should be encouraged to discuss any side effects with their physician or primary therapist. Abrupt withdrawal is to be avoided as it may cause nausea and vomiting or other side effects.

Monoamine Oxidase Inhibitor Antidepressants (MAOI)

These antidepressants are second choice to tricyclics since they have more adverse side effects and require a special diet.

Common side effects include:

- Drowsiness/dizziness
- Lightheadedness
- Weakness
- Constipation
- Urinary retardation

The above side effects may disappear as the body adjusts to the medication.

Serious side effects that require immediate medical assistance are:

- Severe headaches
- Rapid heart rate
- Nausea and vomiting
- Stiff or sore neck

Second Generation Antidepressants

These antidepressants are not related to tricyclics or MAO inhibitors.

Desyrel (Trazodone)

This antidepressant is especially effective for treatment of depression accompanied by anxiety. Optimum effect is seen in two to four weeks.

Common side effects include:

- Drowsiness, dizziness, lightheadedness
- Tiredness, decreased blood pressure
- Nausea, vomiting, constipation
- Dry mouth, blurred vision
- Increased libido, prolonged erection
- Loss or increase in appetite

Lithium (Carbolith, Lithane)

Lithium is a naturally occurring salt and is mostly used for the treatment of bipolar mood disorders.

Dangerous side effects which require immediate medical attention include:

- Severe nausea, vomiting, diarrhea
- Marked shakiness or tremor
- Slurred speech and confusion
- Blurred vision
- Unusual tiredness and weakness

Wellbutrin, Zaban (Bupropion)

This drug is an antidepressant that works as a Central Nervous System (CNS) stimulant. It is used for the treatment of mood disorders, depressive disorder, substance-use disorders: Nicotine Withdrawal Syndrome associated with the cessation of tobacco smoking.

Common side effects of this drug include:

- Chest pain, edema, fainting, high blood pressure
- Anxiety, change in sex drive, confusion, seizures
- Dry skin, hair loss, itching and rash
- Impotence, menstrual complaints, urinary frequency and vaginal irritation

Selective Serotonin Reuptake Inhibitors (SSRI)

Fluoxetine (Prozac)
The antidepressants Luvox, Paxil and Zoloft are closely related in molecular structure to Prozac and seem to have fewer side effects.

Presently, this antidepressant is widely prescribed for the treatment of depression. It is used to elevate mood and to treat the symptoms associated with moderate to severe depression. Depression is believed to be partially related to an imbalance of certain chemicals in your brain.

It has also been found useful in some individuals for the treatment of obsessive compulsive behaviors and some eating disorders.

Common side effects include:

- Anxiety, nervousness, agitation
- Insomnia
- Nausea, diarrhea
- Headaches
- Loss of appetite, weight loss

Anticonvulsants

Anticonvulsants are primarily used for controlling epileptic seizures and bipolar mood disorders.

Common anticonvulsant side effects include:

- Drowsiness, dizziness
- Clumsiness
- Slurred speech
- Confusion
- Blurred vision
- Loss of appetite
- Nausea
- Rashes
- Easy bruising (Tegretol and Depakene)

Neuroleptic Agents (Major Tranquilizers)

Neuroleptic agents also known as major tranquilizers or antipsychotics are used to treat a variety of symptoms, which include hallucinations, delusions, behavioral disturbances and nervous afflictions.

Antipsychotics usually start working within two weeks but maximum effect is usually reached in four to six weeks.

Common side effects that are not serious include:

- Drowsiness
- Dizziness
- Dry mouth
- Constipation
- Hypersensitivity to sun
- Skin rashes
- Sexual dysfunction
- Body's ability to regulate temperature and avoid over heating

The above side effects usually diminish as the body gets used to the drug. However, if they persist, medical attention is needed. Other more serious side effects that should be brought to the attention of a physician include:

- Muscle spasms usually involving the neck, eyes and back
- Stiffness of arms and legs
- Trembling hands
- Restlessness, unable to sit still
- Lip smacking

Medication Assisted Treatment for Substance Use Disorders

Medication Assisted Treatment (MAT) is one way to help those with opioid, heroin and alcohol addiction. In combination with counseling and behavioral therapies, it provides a whole patient approach to the treatment of substance use disorders. It is often the best treatment choice for opioid and heroin addiction and includes:

- Medication
- Counseling
- Support from family and friends

These three parts work together to help people recover. MAT is an evidence-based practice meaning research has proven the effectiveness and clinicians endorse it. There is strong evidence that use of MAT in managing Substance Use Disorders (SUDS) provides substantial cost savings.

For instance:

- Persons with untreated alcohol use disorder use twice as much health care and cost twice as much as those with treated alcohol use disorders.[71]

- For individuals with alcohol dependence, MAT was associated with fewer inpatient admissions. Total healthcare costs were 30% less for individuals receiving MAT than for individuals not receiving MAT.[72]

- Medical costs decreased by 33% for Medicaid patients over three years following their engagement in treatment. This included a decline in expenditures in all types of health care settings including hospitals, emergency departments, and outpatient centers.[73]

Several medications have been found effective in treating addiction to opioids, alcohol, and nicotine in adults. There are currently no FDA-approved medications to treat addiction to cannabis, cocaine, or methamphetamine.

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[71] Holder, HD., "Costs Benefits of Substance Abuse Treatment: An Overview of Results from Alcohol and Drug Abuse," J. Mental Health Policy Econ, March, 1998.
[72] Baser. O., Chalk, M. Rawson, "Alcohol treatment dependence, comprehensive healthcare costs, utilization outcomes, and pharmacotherapy persistence.", The American Journal of Managed Care 178 (8), 2001.
[73] Walter, L, "Medicaid Chemical Dependency Patients in a Commercial Health Plan," Robert Wood Johnson Foundation, Princeton, New Jersey, 2006.

Three main choices for medication for opioid use disorder

The most common medications used in treatment of opioid addiction are methadone, buprenorphine, and naltrexone. Used properly, the medication does not create an addiction. It helps people manage their addiction so that the benefits of recovery can be maintained.

Methadone

Methadone is a synthetic agent that prevents opioid withdrawal symptoms and reduces craving by activating opioid receptors in the brain. Methadone requires daily visits to a methadone clinic when first starting on the medication. Methadone:

- Blocks the euphoric and sedating effects of opiates
- Relieves the craving for opiates that is a major factor in relapse
- Relieves symptoms associated with withdrawal from opiates
- Does not cause euphoria or intoxication itself (with stable dosing), thus allowing a person to work and participate normally in society
- Is excreted slowly so it can be taken only once a day

Benefits include:

- Reduced or stopped use of injection drugs
- Improved family stability and employment potential
- Improved pregnancy outcomes

Buprenorphine Products (suboxone/subutex)

Buprenorphine reduces or eliminates opioid withdrawal symptoms, including drug cravings, without producing the euphoria or dangerous side effects of heroin and other opioids.

Buprenorphine:

- Stop opiates from getting you “high”
- Stop withdrawal symptoms and cravings (the strong feeling that you need to have it)
- Does not get you high if you use according to prescription and does not cause strong side effects. It is hard to get sick or overdose from it.
- Is prescribed by a doctor and can be taken at home.
- Have a low risk of physical dependence.
- Are very long acting. This means that after an initial period, the doctor may have the dosage decreased.
- Improve pregnancy outcomes.

Vivitrol

This is the brand name for extended release naltrexone. It is used to treat both opiate dependence as well as alcohol dependence. It is injected once every 4 weeks.

- Stops cravings for the drug.
- Has no risk of physical dependence.
- Is long acting as it is administered with a monthly injection.

Naloxone

This medication is used to prevent opioid overdose deaths. Naloxone can very quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of heroin use or the misuse of prescription opioids.

Medications to Treat Alcohol Use Disorders

Three medications have received FDA approval for treating alcohol use disorders:

Acamprosate

This reduces symptoms of protracted withdrawal (i.e., insomnia, anxiety, restlessness, and dysphoria) by normalizing brain systems disrupted by chronic alcohol consumption in adults.

Disulfiram

This drug inhibits an enzyme involved in the metabolism of alcohol, causing an unpleasant reaction (i.e., Flushing, nausea, and heart palpitations) if alcohol is consumed after taking the medication.

Naltrexone

This blocks receptors involved in the rewarding effects of drinking and in the craving for alcohol similarly to how it blocks the effects of opioids. It reduces relapse of heavy drinking behavior and is highly effective in some but not all patients.

Behavioral Therapies

To improve outcomes, the medications discussed above are recommended in combination with behavioral therapies. Research shows that when treating SUDs, a combination of medication and behavioral therapies is the most effective. Behavioral therapies to help patients engage in the treatment process, modify their attitudes and behaviors related to drug and alcohol use, and increase healthy life skills. These treatments can also enhance

the effectiveness of medications and help people stay in treatment longer. Treatment programs that combine pharmacological and behavioral therapy services increase the likelihood of cessation relative to programs without these services. There are a number of treatment strategies that can be used in combination with medications to successfully address SUDs. These include:

- *Individual therapy, group counseling, and family behavior therapy* each provide different types of support for individuals in recovery from SUDs:
    - Individual therapy can help people learn new skills to maintain a substance free life, address co-occurring mental health issues, address the benefits of utilizing prescription medication in treatment, and support individuals to pursue meaningful work, school and family goals.
    - Group counseling can help reduce a person's sense of isolation, provide peer support and feedback, and develop social and problem-solving skills.
    - Family behavior therapy provides education, allows family members to express their feelings and concerns, and helps secure the family's support for the person in recovery.
- *Cognitive-behavioral therapy* seeks to help patients recognize, avoid, and cope with the situations in which they are most likely to misuse drugs.
- *Motivational enhancement* capitalizes on the readiness of individuals to change their behavior and enter treatment.

Key Point …

In Wisconsin mental health systems, a person who is "dual diagnosed" has mental illness and substance use disorder.

• • • Break 15 minutes • • •

Opiate Use Disorders (45 MINUTES)

OBJECTIVE

- To allow participants the opportunity to discuss their own attitudes and experiences around addiction and opiate use disorders.

METHOD

- Read: Prescription Drug Misuse and Abuse
- Read: Opiate Use Disorders and Trends in Heroin and other Opioid Abuse
- Read: Trauma and mental health and substance use
- Discuss the opiate epidemic and other local trends.

Prescription Drug Misuse

Prescription drug misuse is the intentional or unintentional use of medication without a prescription, in a way other than prescribed, or for the experience or feeling it causes. Results from the 2014 National Survey on Drug Use and Health, indicate that about 15 million people aged 12 or older used prescription drugs non-medically in the past year, and 6.5 million did so in the past month. This issue is a growing national problem in the United States.[74] Prescription drugs are misused more often than any other drug, except marijuana and alcohol.

This growth is fueled by misperceptions about prescription drug safety, and increasing availability. A 2011 analysis by the center for Disease Controls and Prevention found that opioid analgesic (pain reliever) sales increased nearly four-fold between 1999 and 20; this was paralleled by an almost four-fold increase in opioid (narcotic pain medication) overdose deaths and substance use treatment admissions almost six times the rate in the same time period.

Prescription drug use-related emergency department visits and treatment admission have risen significantly in recent years. Other negative outcome that may result from prescription drug misuse include overdose and death, falls and fractures in older adults, and, for some, initiating injection drug use with resulting risk for infections such as hepatitis C and HIV.

The problem of prescription drug use and overdose is complex, involving insufficient oversight to curb inappropriate prescribing, insurance and pharmacy benefit policies, and a belief by many people that prescription drugs are not dangerous.

[74] SAMHSA, "Prescription Drug Misuse and Abuse," www.SAMHSA.org

Opiate Use Disorders[75]

Opioid pain relievers reduce the pain associated with many conditions, including cancer, arthritis and other degenerative conditions. They are also used to alleviate short-term pain related to injuries, surgery, or dental work.

There are different kinds of pain medications, including non-steroidal anti-inflammatory drugs and opioid analgesics, each type with various advantages and risks.

The use of opioid pain relievers exposes users to risks of overdose, dependence, and addiction.

Opioid misuse continues to be a major public health problem in the United States. From 1999 to 2013, the rate of death from opioid pain reliever overdose nearly quadrupled. Examples of opioid pain relievers include drugs that contain the active ingredient codeine, hydrocodone, and oxycodone, to name a few.

Trends in Heroin and other Opioid Misuse

Heroin is a highly addictive opioid that is illegal and has no accepted medical use in the United States. Although heroin may be smoked or "snorted" (inhaled through the nose), heroin is often "cut" with products such as sugars, starch, or powdered milk and then injected as a liquid. It is an extremely dangerous drug regardless of the method of delivery. Heroin users may develop physical dependence on the drug and experience withdrawal symptoms, such as diarrhea and vomiting, if use is suddenly stopped. Overdose on heroin can seriously depress breathing and may lead to death.

According to government research, heroin overdose deaths in the United States nearly quadrupled between 2002 and 2013, fueled by lower costs as well as increased misuse of prescription opiate pain killers.[76] Nationwide, only 11 percent of people with substance use disorders get help from treatment centers, according to a 2012 study in American Journal of Drug and Alcohol abuse. Reportedly many fail to access treatment due to long wait lists.

Fentanyl, a powerful synthetic opioid, is similar to but more potent than morphine or heroin. It is a major factor in the increase of lethal overdoses as it can be 100 times more potent than heroin.[77]

[75] SAMHSA, "Opioid Pain Relievers, SAMHSA.org
[76] Gile, Charlie, "As Heroin Epidemic Grows, So Does Rehab Wait," NBC News online.
[77] Evans, Laura, "Fentanyl overdose deaths on the rise," FOX NEWS, March 2016.

Know the signs. The signs of an overdose, which may result in death if not treated, include:

- Face is extremely pale and/or clammy to the touch
- Body is limp
- Fingernails or lips appear blue or purple
- The individual is vomiting or making gurgling noises
- The individual cannot be awakened from sleep or is unable to speak
- Breathing is very slow or stopped
- Heartbeat is very slow or stopped

Don't run, call 911. It is important to get help from someone with medical expertise as soon as possible. Wisconsin law protects individuals from arrest for possessing drugs or drug paraphernalia if seeking medical help for someone overdosing.

Substance Use and Trauma

Many people diagnosed with a substance use disorder have a history of childhood sexual, emotional and psychological trauma. Survivors of trauma often turn to substance use to sedate or numb the pain of traumatic events. For many, substance use is viewed as needed for their psychological and emotional coping with victimization.

Individuals diagnosed with a substance use disorder are at risk for various traumatic experiences while also experiencing the adverse consequences of prolonged substance use. Loss of relationships, financial problems, unemployment, homelessness, incarceration, hospitalizations, physical assault, accidents, and other illnesses are some of the possible trauma that can occur.

Trauma, brought on by shocking or unexpected circumstances or events, can overwhelm a person's ability to cope in many ways. Trauma can:

- Result in feelings of helplessness, and extreme fear and horror.
- Be perceived as psychological and/or bodily violation, threat of death, or serious injury to self or a loved one.
- Be witnessed or experienced directly or indirectly.
- Leave people feeling powerless.
- Have lasting effects on the ability to trust others and form intimate relationships.
- Impact relationships with self, others, communities, and environment.
- Create distance between people.

Healing from trauma requires regaining a sense of control over one's life and one's environment. There needs to be a sense of safety so reconnecting with others can take place.

Trauma-informed support for peers:

- Is based on the universal expectation that trauma has occurred
- Focuses on understanding "What happened to you? Not "What's wrong with you?"
- Seeks to understand the meaning people make of their experiences
- Strives to be culturally responsive
- Focuses on resilience, self-healing, mutual support, and empowerment
- Ensures voice, safety, autonomy, choice, and elimination of coercion
- Incorporates knowledge about trauma in all aspects of service delivery

It is essential that the Peer Specialist provide a trauma sensitive approach to working with peers with the understanding that many if not most have experienced trauma. Trauma-informed approaches need to be integrated throughout all systems of care.

Knowing a peer's strengths can help the Peer Specialist reframe the peer's stated concerns. It moves attention away from trauma-related problems and toward a perspective that honors and uses adaptive behavior and strengths to assist peers in the recovery process. Some possible strengths-oriented questions include:

- The history that you provided suggests that you've accomplished a great deal since the trauma. What are some of the accomplishments that give you the most pride?
- What would you say are your strengths?
- What are some of the creative ways that you deal with painful feelings?
- You have survived trauma. What characteristics have helped you manage these experiences and the challenges that they have created in your life?
- What coping tools have you learned from your experience?
- How do you gain support today?
- What does recovery look like for you?

"The best time to plant a tree was 20 years ago. The second best time is now."

— CHINESE PROVERB

Peer Support Exercise (45 MINUTES)

OBJECTIVE

To practice communicating with a peer using a supportive approach.

METHOD

- Peer support exercise; practice scenarios below or of your choosing where the Peer Specialist communicates with peers who have substance use issues. Remember to focus on creating a trauma sensitive environment.

Role Play Scenarios

- ❖ I don't like the people my wife gets to baby-sit. Do you think it's okay to smoke dope out on the patio? Do you think it's right?
- ❖ They've changed my meds again. I don't think they know what they are doing. This one makes me feel like I'm going to have a panic attack.
- ❖ I have to take a lot of my pain meds to feel better. Do you think it's OK to drink a little wine while taking them?

Key Point …

Trauma undermines the development of brain regions that normally help manage fears and control impulses.

Homework (5 MINUTES)

OBJECTIVE

To increase the knowledge base for Peer Specialists

To encourage participants to learn local resources for treatment and recovery.

METHOD

Suggest additional readings from the list or other resources.

Ask participants to bring in information regarding recovery and supports that are available in the community.

Additional Readings and Resources:

"Adverse Childhood Events as Risk Factors for Substance Dependence: Partial Mediation by Mood and Anxiety Disorders."
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2763992/

"Adverse Childhood Experiences and Prescription drug use in a Cohort Study of Adult HMO Patients."
http://www.ncbi.nlm.nih.gov/pubmed/18533034

Decision Aid –A computer based tool to help you consider the role of antipsychotic medication in your recovery plan.
http://archive.samhsa.gov/BRSS-TACS-Decision-Tool/

"Informational Bulletin: Medication Assisted Treatment for Substance Use Disorders"
https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-11-2014.pdf

"Pathways to Recovery: Recovery Advocacy Toolkit"
http://www.facesandvoicesofrecovery.org/sites/default/files/resources/recovery_pathways.pdf

Falk, Neil, Fisher, Daniel B., and Hall, Will, "Optimizing Medication in the Service of Recovery—Is There a Path for Reducing Over-Utilization of Psychiatric Medications?" ***Oxford University Press,*** February, 2013.
https://www.power2u.org/downloads/ch24OptimizingMedicationintheServiceofRecovery(with-cover).pdf

Wurtzel, Elizabth, ***Prozac Nation***, Riverhead Books, April 2002.

REVIEW QUESTIONS:

1. **What are some of the common attitudes you hear in regards to using prescription medication?**
2. **What can you do to create a trauma-sensitive environment for peers?**
3. **What are some of the resources in your community for treatment of substance use disorders?**
4. **What are some activities you can do to support a peer to find and utilize resources?**
5. **How do you help a peer find what programs they are eligible for?**

Section Four

Other Important Issues

Session 12

FACILITATOR INFORMATION:

This session begins the last section of the curriculum with other important issues for the Peer Specialist. The discussion begins with a quiz, "Myths about Suicide." This is a good opportunity to emphasis accurate information regarding suicidal behavior. Suicide prevention and crisis intervention are addressed.

The grieving process is discussed with an opportunity for participants to share losses in their lives and how they dealt with them. The issue of stigma and self-stigmatization are explored with tips how the Peer Specialist can assist a peer.

Federal and state laws regarding client rights, civil rights and the ADA are presented. Peers are also given information on involuntary commitment and Wisconsin's Community Mental Health & Substance Abuse Services.

Peer Specialist Facilitator Curriculum Guide

SESSION 12

5 MINUTES Homework review

60 MINUTES Suicide and self-harm

15 MINUTES Break

60 MINUTES Loss and the grieving process, self-stigma

15 MINUTES Break

35 MINUTES Federal and state laws regarding client rights, civil rights, and the American with Disabilities Act. Involuntary commitment.

20 MINUTES Wisconsin's Community Mental Health & Substance Abuse Services System.

CPS CORE CRITERIA COVERED

1.5 Believes in and respects all forms of diversity
2.6 Knowledge of trauma and its impact on the recovery process
2.9 Knowledge of the impact of discrimination, marginalization, and oppression
2.10 Knowledge of the impact of internalized stigma and shame
3.1 Knowledge of the rights of peers seeking support, such as state and federal law regarding client rights, civil rights, and the Americans with Disabilities Act (ADA)
3.7 Knowledge of cultural competency (As defined by Wisconsin State Council on Alcohol and Other Drug Abuse Cultural Diversity Committee)
4.5 Ability to identify and support a person in crisis and know when to facilitate referrals
4.13 Ability to work collaboratively and participate on a team
4.14 Ability to know when to ask for assistance and/or seek supervision

Homework Review (5 MINUTES)

OBJECTIVE

To encourage participants to learn local resources for treatment and recovery.

METHOD

Lead a discussion with the class on what resources they have explored in the community for treatment, support and recovery.

Suicide and Self-Harm (60 MINUTES)

OBJECTIVE

- To provide an opportunity for participants to explore their beliefs and attitudes towards suicide and self-harm.

METHOD

- Give participants quiz on "Myths of Suicide."
- Go through the answers and discuss.
- Ask the group what they feel some of the warning signs of suicide are. Write them on easel or board. Using the list that follows, "The Warning Signs of Suicide," add any that have been missed.
- Read and discuss: "Helping a Peer Who is Having Suicidal Thoughts," and "Suicide Prevention and Crisis."
- Ask the group for input into how they believe a Peer Specialist can assist a peer who is experiencing suicidal ideation.

Myths about Suicide[78]

1. Once someone decides on suicide, he or she cannot be stopped.

   True False

2. Talking about suicide gives people the idea.

   True False

3. People who talk about suicide never actually do it.

   True False

4. Suicide occurs without warning.

   True False

5. The suicidal act is a well-thought-out expression of an attempt to cope with serious personal problems.

   True False

6. People who have tried suicide and did not succeed are less likely to try it again because they have gotten it out of their system.

   True False

7. There is a "typical" type of person who takes their own life.

   True False

8. Once someone is suicidal, he or she will be suicidal forever.

   True False

9. If a depressed or person with suicidal thoughts feels better it usually means that the problem has passed.

   True False

10. The suicide rate is highest for middle aged, white males.

    True False

[78] CMHA BC Division Consumer Development Project, "Peer Support Training," 2005.

Answers

1. **False.** Most people contemplating suicide` have mixed feelings. Most do not want death, they want to end the pain (physical and/or psychological). They may be miserable, but they wish to be saved.

2. **False.** Asking someone about their suicidal feelings may actually make them feel relieved that someone finally recognizes their emotional pain.

3. **False.** Almost everyone who has attempted suicide has given some warning or clue. When someone talks about committing suicide, they may be giving a warning that should not be ignored by others who hear such comments.

4. **False.** Many people, including adolescents, give warnings of their suicidal intent.

5. **False.** Moat people are "irrational" at the time of a suicidal crisis. They have very strong mixed feelings. They want to live, but are overwhelmed with despair, anxiety and hopelessness. They cannot see any other solution.

6. **False.** Eight per cent of those people who die by suicide have made at least one previous attempt.

7. **False.** The potential for suicide exists in all of us. There is no typical type of suicidal person.

8. **False.** People who want to kill themselves are "suicidal" only for a limited period of time. During this time they move beyond it, get help or die.

9. **False.** If someone who has been depressed or suicidal suddenly seems happier, don't assume that the danger has passed. A person, having decided to kill himself or herself, may feel "better" or feel a sense of relief having made the decision. Also, a severely depressed person may lack the energy to put their suicidal thoughts into action. Once they regain their energies, they may well go ahead and do it.

10. **True.** Middle aged, white males have the highest rates of suicide. Men die by suicide 3.5 times greater rate than females.

"Sometimes you can only find Heaven by slowly backing away from Hell."

— CARRIE FISHER

The Warning Signs of Suicide[79]

Suicide is rarely a spur of the moment decision. In the days and hours before people kill themselves, there are usually clues and warning signs.

The strongest and most disturbing signs are verbal—"I can't go on," "Nothing matters any more" or even "I'm thinking of ending it all." Such remarks should always be taken seriously.

Other common warning signs include:

- Becoming depressed or withdrawn
- Behaving recklessly
- Getting affairs in order and giving away valued possessions
- Showing a marked change in behavior, attitudes or appearance
- Using drugs or alcohol
- Suffering a major loss or life change

The follow list gives more examples, all of which could be signs that somebody is contemplating suicide or experiencing feelings of wanting to die. Of course, in most cases these situations, behaviors, changes, and thoughts do not lead to suicide. But, generally, the more signs a person displays, the higher the risk of suicide.

Situations

- ✓ Family history of suicide or violence
- ✓ Sexual or physical abuse
- ✓ Death of a close friend or family member
- ✓ Divorce or separation, ending a relationship
- ✓ Failing academic performance, impending exams, exam results
- ✓ Job loss, problems at work
- ✓ Impending legal action
- ✓ Recent imprisonment or upcoming release

[79] www.befreinders.org/suicide/warning.htm

Behaviors

- ✓ Crying
- ✓ Fighting
- ✓ Breaking the law
- ✓ Impulsiveness
- ✓ Writing about death and suicide
- ✓ Previous suicidal behavior
- ✓ Extremes of behavior
- ✓ Changes in behavior

Physical Changes

- ✓ Lack of energy
- ✓ Disturbed sleep patterns—sleeping too much or too little
- ✓ Loss of appetite
- ✓ Sudden weight gain or loss
- ✓ Increase in minor illnesses
- ✓ Change of sexual interest
- ✓ Sudden change in appearance
- ✓ Lack of interest in appearance

Thoughts and Emotions

- ✓ Thoughts of suicide
- ✓ Loneliness—lack of support from family and friends
- ✓ Rejection, feeling marginalized
- ✓ Deep sadness or guilt
- ✓ Unable to see beyond a narrow focus
- ✓ Daydreaming
- ✓ Anxiety and stress
- ✓ Helplessness
- ✓ Loss of self-worth

Key Point …

Whenever there is a question about a peer's safety, consult with the team and/or your supervisor.

Helping a Peer Who is Experiencing Suicidal Thoughts

Let them know you care:

- Acknowledge their feelings, i.e.: "You're feeling _____, is that correct?
- Accept the person's feelings, i.e.: "I can see why you would feel that way."
- Reinforce help seeking, i.e.: "I'm glad you are talking to me about this."
- Convey involvement, i.e.: "I'm here to listen and I care."

Use active listening to find out what is happening:

- Listen to the feelings being expressed.
- Try to understand and reflect back what the person is saying.
- Focus on the present and the recent past.
- Reduce blame. Do not judge or criticize.

Ask direct questions about suicide:

- "Have you thought about it?"
- "Have you tried it before?"
- "Have you made any plans?" Do a S.L.A.P. assessment (see below).

Problem solve:

- Help the person think of alternatives. Explore consequences.
- Explore how the person feels about alternatives.
- Ask if they want to create specific plans to seek help or find other ways to help themselves.
- If the person is in a life-threatening situation, call police or ambulance (911).
- If the person's life is not in immediate danger, encourage them to seek professional help.
- Assure the person that you are still available to offer support.

Assessing the Risk: S.L.A.P.

1. How **SPECIFIC** is the person's suicide plan? The more detail, the higher the risk.
2. How **LETHAL** is the method chosen? If they plan to use a gun or hang themselves, for instance, the risk is high. If they have chosen to overdose on pills, you may not know how lethal that overdose would be. It is best to be on the safe side and get immediate help if you have any doubt.
3. How **AVAILABLE** is the method chosen to commit suicide? If they have decided to use a gun and are from a family that hunts, the risk is high.
4. What **PERSONAL RESOURCES** are available to the person? Does the person have friends, family, counselors, or ministers who are supportive? How often do they talk to these people? The fewer the people they have who are regularly available, the higher the risk.

Suicide Prevention and Crisis Intervention

FACT: Approximately one person dies for every 10 suicide attempts made.

What is a crisis?
A crisis is a brief period of time during which the peer involved has the potential for heightened maturity and growth, or for deterioration and greater vulnerability to to future stress. There are three phases involved in a crisis:

Phase One: Impact. This consists of the peer's initial reactions to the crisis and is the phase where learned helplessness may result if efforts produce no satisfactory resolution.

Phase Two: Coping. Renewed effort initiates the second stage of crisis and most crisis are resolved during this stage.

Phase Three: Withdrawal. This evolves if none of the coping attempts alleviate the distress.

Generally speaking suicide attempts or suicidal threats made during phase two are intended to end in rescue rather than in death. The purpose is to generate assistance rather than to end one's life. Two thirds of all attempts are actually pleas for attention and help.

When coping attempts fail, the person may enter into the third phase known as withdrawal. The person subsequently stops trying to resolve the problem. The voluntary suicide attempts seen in phase three are not a "cry for help" but a serious attempt to die. Death is seen as being preferable to the ongoing pain.

Depression in both adults and youth can be seen in a variety of ways. The majority of people who kill themselves are depressed. Symptoms can include: restlessness, sleep problems, change in eating habits, concentration difficulties, feelings of loneliness, loss of interest, and fatigue. Depression follows a cycle whereby the individual is on an even keel, then the mood worsens and eventually reaches bottom, followed by a gradual recovery. It is during the gradual recovery that most suicide attempts are made because of the increase in energy. When peers feel helpless to change their situations and at the same time they show the restless express of hostility, guilt, or anxiety, they are in danger of acting upon self-destructive impulses. It is also true, however, that persons who choose suicide may become calm; agitation and distress may decrease once these individuals decide on death as the means of controlling their destiny. Consequently, sudden calmness can be like the eye of a hurricane, a bad sign that indicate impending destructiveness.

Peer Specialists' Role in Suicide Prevention[80]

Peer Specialists who are current or former consumers of behavioral health services, are part of a paradigm shift in behavioral health: They embody the recovery model and, as they participate in greater numbers, promote system transformation.

Typically Peer Specialists:

- Listen, connect, and offer support without judgement
- Teach skills needed to facilitate self-advocacy and recovery
- Explain available service options
- Promote the use of natural supports in the community
- Encourage wellness and a sense of self-worth

The need for suicide prevention programs is clear, and there's a role for Peer Specialists in these efforts. Because Peer Specialists are already integral to many existing program, they may be available to step into new suicide prevention efforts. They can work close to those at risk, offering connection skills, and values that readily lend themselves to suicide prevention. Many also have personal experiences of recovery from serious suicidal behavior and suicide loss. They understand how the shame and stigma linked to suicide can affect recovery, and they are willing to offer their experiences to help other consumers.

These roles include showing empathy, caring, and concern; giving information and help in acquiring new life skills, and helping peers feel connected to others. At the First National Conference for Survivors of Suicide Attempts in 2005, it was recommended that Peer Specialists could participate in suicide prevention efforts by:

- ✓ Validating and normalizing similar experiences
- ✓ Increasing supportive community-based networks
- ✓ Communicating suicide risk/prevention information to families at hospital discharge
- ✓ Developing volunteer support systems
- ✓ Supporting peers in their aftercare and recovery

[80] Adapted from, Salvatore, Tony, "Peer Specialists Can Prevent Suicides," Behavioral Healthcare, October, 2010.

"You, yourself, as much as anybody in the entire universe, deserve your love and affection."

— BUDDHA

• • • Break 15 minutes • • •

Mental Illness, Substance Use Disorders and Recovery and Self Stigma (60 MINUTES)

OBJECTIVE

- To provide an opportunity for participants to explore their beliefs and feelings regarding the grieving process.
- To revisit the issue of stigma and internalized stigma and shame

METHOD

- Facilitators lead a discussion; participants' experiences with grief, loss, and anger.
- Read: "Mental Illness and Recovery."
- Read: "Substance Use Disorders and Recovery."
- Read: "When Mental Illness or Substance Use Stigma Turns Inward."
- Encourage participants to share experiences and feelings.

Mental Illness and Recovery

No one wants to feel unwell. Being diagnosed with anything can be hard, but a diagnosis of a mental illness can be particularly hard for a peer to deal with. He/she might wonder why this has happened to them and how the diagnosis will affect his/her life.

Why me?

When a peer is diagnosed with a health problem, particularly a long-term health problem, it is normal to feel many different things. Many people feel some combination of:

- **Relief—**My problem has a name, and now I know why I'm not feeling well.
- **Hope—**I can find a treatment that works. Now I can figure out how to cope with this.
- **Fear—**I'm scared of what I think my diagnosis means.
- **Shock/Denial—**This can't be happening. Not me. Mental health problems happen to other people.
- **Shame--**This is a reflection on who I am as a person. I feel flawed.

- **Confusion—**I don't understand what all of this means, or no one has given me the answers I need. I don't think my diagnosis matches how I see the problem.

- **Anger—**Why did this happen to me?

- **Guilt—**My life will never be the same. I feel like I've lost myself.

- **Loss of control and hope—**I feel powerless. I don't know what to do. I don't see how I'll ever copy with this.

Many peers experience difficult thoughts around the diagnosis. They may also be dealing with the confusing feelings that are part of many mental illnesses themselves. It can be challenging to take in all the new information from health providers and other professionals. In time, peers become experts on their own mental health, but it can take time to figure out how the mental illness fits in their lives.

What now?

Moving from "Why me?" to "What now?" can take a while for any diagnosis. Even if a peer suspects that he/she has been living with a mental health issue for a long time, it is likely that more information is needed to assist on the recovery journey. Some activities that the Peer Specialist can encourage include:

- ❖ Learning about the diagnosis; including symptoms, signs, etc

- ❖ Asking questions of healthcare providers including, "What investigations were done to arrive at the diagnosis?"

- ❖ Learning what treatments and supports are available.

- ❖ Identifying what to expect in treatment and recovery.

- ❖ Learning what can speed up the recovery journey.

Recovery from a mental illness is expected. It is not a life sentence. Treatment may include a combination of medication, talk therapy and health living skills. The exact combination for each peer will be unique—there is no set formula that works for everyone.

Substance Use Disorders and Recovery

Grief is a universal emotion that can arise any time a person loses someone or something they value. For many peers with substance use disorders, unresolved grief, loss or trauma contributed to the addiction, and those feelings get compounded in early recovery when the peer gives up drugs or alcohol and begins to see all that they've lost to their use. Here are some examples of what the recovering peer may grieve:

- The drug itself, and the quick, easy sense of relaxation or euphoria it provided
- The old support system, often made up of other drug users
- Time spent seeking out and using drugs, which must be filled with healthier pursuits
- Rituals surround drug or alcohol use (people, places and activities)
- Divorce, separation or loss of a significant relationship
- Loss of job, housing, health or income
- Missed time with loved ones who have grown up, moved or passed away
- Being absent for important milestones in other people's lives
- Loss of freedom, which is replaced by accountability
- Morals or values that were compromised in the pursuit of drugs or alcohol
- Sense of self, which became defined by drug use
- Dreams and goals for the future

When grieving, it is normal for people to have difficulties in daily functioning. They may feel lost, overwhelmed, forgetful, irritable, anxious, lonely or angry. Sleep and diet patterns may be irregular and the recovering peer may fantasize about returning to their old lifestyle. All of these symptoms typically pass with time and support.

It has been said that grief is not about forgetting, but remembering with less pain. According to J. William Worden, professor of psychology at Harvard Medical School, people must complete the following "tasks of mourning" to grieve a loss:

- Accept the reality of the loss
- Work through the pain (rather than avoiding or medicating it)
- Adjust to the environment (i.e., adapt to a new normal)
- Relocate the emotional energy once tied to the loss

Grief can be prolonged and made worse if guilt, shame and stigma cause the recovering peer to suppress their feelings rather than openly acknowledge them. Those who grieve the loss of their old, life position themselves to move forward in their recovery. Trying new activities and modes of self-expression (such as art or journaling), practicing self-care, using healthy coping strategies, setting goals for the future, and leaning on other for support are all signs of progress. These skills can be learned and practiced with the support of others.

Those who deny, minimize or ignore their loss or put a time limit on the grieving process may remain angry, sad or resentful for extended periods of time, become emotionally numb, have difficulty with relationships, or continually struggle with relapse.

Even the best things in life have tradeoffs. Recovery doesn't provide immediate relief or constant joy, especially in the early stages. It is a rewarding, though sometimes painful, journey that unfolds over a lifetime. Along with the blessing of a fresh start comes the

loss of giving up drugs and alcohol—a sacrifice that is well work the effort, but must be recognized as a loss nevertheless.

When Mental Illness or Substance Use Stigma Turns Inward

It is said that people diagnosed with mental illness or substance use disorder face a double-edged sword. Not only do they have to contend with serious, often disruptive symptoms, they still have to deal with rampant stigma, stereotypes, and misunderstanding.

Stigma leads to discrimination, and we see stigma everywhere. Every time violence is connected to mental illness in an article or news report, we see it. We see it in movies and other forms of media. We see it at work where stereotypes might be perpetuated, where employees are afraid to "come out" with their diagnosis.

We see it with our families or friends, who might say versions of "just snap out of it" or "get over it already" or offer "advice" like sleep more, eat less, look on the bright side and try harder.

But what happens when that stigma comes from within—when peers internalize these negative public perceptions?

Self-stigma and experiences of discrimination make people less likely to seek treatment. For example, a 2009 study from Leipzig University in Germany identified internalized stigma as "an important mechanism decreasing the willingness to seek psychiatric help" and of more influence than "anticipated discrimination."[81]

Even medical students—who are diagnosed with depression at high rates—report concerns about stigma. In a recent study published in the Journal of the American Medical Association, 53.3 percent who reported high levels of depressive symptoms worried that disclosing their diagnosis would be risky.[82]

Self-stigma also can lead to isolation, lower self-esteem and a distorted self-image. Peers struggling with self-stigma may refrain from taking an active role in various areas of life, such as employment, housing and social life. Here are some tips that you can use to help peers combat self-stigma.

- ✓ **Therapy and self-help groups.** Both are helpful to reframe life experience, improve self-image and replace negative self-talk with more positive language.

[81] Tartakovsky, Margarita, "When Mental Illness Stigma Turns Inward," PsychCentral, www.psychcentral.com

[82] Schwenk, Thomas, MD, Davis, Lindsay, BS, and Wimsatt, Leslie, PhD., "Depression, Stigma, and Suicidal Ideation in Medical Students" JAMA, September, 2010.

- ✓ **Use the Internet for peer support.** Join an online mental health forum (such as those at psychcentral.com or hopetocope.com.)
- ✓ **Practice strategic disclosure.** Encourage peers to tell their stories to trusted people with a realistic view of mental health and substance use disorders. The Honest, Open, Proud curriculum is a good resource to help people think about the story they tell themselves, about themselves to work through self-stigma, and also tools for effective and safe strategic disclosure.[83]
- ✓ **Get involved in outreach.** Encourage peers to join advocacy groups or participate in walkathons and other fundraising for local organizations. Write protest letters to media outlets that spread negative stereotypes.

In a presentation at the Sixth Annual Mental Health Services Conference of Australia and New Zealand, Patricia Deegan talked of "recovery and the conspiracy of hope."[84]

> It is not our job to pass judgment on who will and will not recover from mental illness and the spirit breaking effects of poverty, stigma, dehumanization, degradation and learned helplessness. Rather, our job is to participate in a conspiracy of hope. It is our job to form a community of hope, which surrounds people with psychiatric disabilities. It is our job to create rehabilitation environments that are charged with opportunities for self-improvement. It is our job to nurture our staff in their special vocations of hope. It is our job to ask people with psychiatric disabilities what it is they want and need in order to grow and then to provide them with good soil in which a new life can secure its roots and grow. And the, finally, it is our job to wait patiently, to sit with, to watch with wonder, and to witness with reverence the unfolding of another person's life.

"You don't always have to chop with the sword of truth. You can point with it too."

— ANNE LAMOTT

• • • Break 15 minutes • • •

[83] http://wisewisconsin.org/resources/honest-open-proud/

[84] Deegan, Patricia E., "Recovery and the Conspiracy of Hope," Presented at: "There's a Person in Here," The Sixth Annual Mental Health Services Conference of Australia and New Zealand, Brisbane, Australis, September 1996.

Federal Programs and State Laws Regarding Client Rights, Civil Rights, American Disabilities Act (ADA) and Involuntary Commitment (55 MINUTES)

OBJECTIVE

- To provide information on important legal concepts for Peer Specialists.

METHOD

- Read: Social Security, Supplemental Security Income, Social Security Disability Insurance, Medicare and Medicaid
- Read: Your Rights Under HIPAA
- Read: American Disabilities Act (ADA)
- Read: Wisconsin Client Rights
- Read: Involuntary Commitment
- Lead a discussion with the group on this information and its impact on peer support.

Social Security, Supplemental Security Income, Social Security Disability Insurance, Medicare and Medicaid[85]

The Peer Specialist may work with peers that are receiving financial benefits from the federal or state government because they are considered disabled by those entities. Individuals may also be receiving disability payments from an employer too. The most common federal and state benefits are Social Security, Social Security and Supplemental Security Income (SSI), Social Security Disability Insurance, (SSDI), Medicare and Medicaid.

The Social Security and Supplemental Security Income disability programs are the largest of several Federal programs that provide assistance to people with disabilities. While these two programs are different in many ways, the Social Security Administration administers both. Only individuals who have a disability and meet medical criteria may qualify for benefits under either program.

[85] Information from Social Security website. www.ssa.gov

Social Security Disability Insurance (SSDI) pays monthly benefits to you and certain members of your family if you are "insured," meaning that you worked long enough and paid Social Security taxes.

Supplemental Security Income (SSI) pays monthly benefits to you and certain members of your family with limited income and resources who are disabled, blind, or age 65 or older. Blond or disabled children may also get SSI.

Social Security pays monthly benefits to you and certain members of your family if you have worked long enough and paid Social Security taxes and retired at a certain age.

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-state renal disease. The different parts of Medicare help cover specific services. Depending on the individual's circumstance, they may only be entitled to certain benefits.

Medicaid or MA or Forward Health, as it is known in Wisconsin is a joint federal and state program that helps with medical costs for some people with limited income and resources.

Your Rights Under HIPAA[86]

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

The entities that must follow the HIPAA regulations include:

- **Health Plans—**including health insurance companies, HMOs, company health plans, and certain government programs that pay for health care, such as Medicare and Medicaid.
- **Most Health Care Providers—**those that conduct certain business electronically, such as electronically billing your health insurance—including most doctors, clinics, hospitals, psychologists, chiropractors, nursing homes, pharmacies, and dentists.
- **Health Care Clearinghouses—**entities that process nonstandard health information they receive from another entity into a standard (i.e., standard electronic format or data content, or vice versa.

[86] Office for Civil Rights, "Your Health Information Rights."

In addition, business associates of covered entities must follow parts of the HIPAA regulations. These include billing companies, collection companies and other entities that help administer health plans.

Many organizations are not required to follow these laws, including:

- Life insurers
- Employers
- Workers compensation carriers
- Most schools and school districts
- Many state agencies like child protective service agencies Most law enforcement agencies
- Many municipal offices

What Information is Protected

- ✓ Information your doctors, nurses, and other health care providers put in your medical record
- ✓ Conversations your doctor has about your care or treatment with nurses and others
- ✓ Information about you in your health insurer's computer system
- ✓ Billing information about you at your clinic
- ✓ Most other health information about you held by those who must follow these laws.

How This Information is Protected

- ✓ Covered entities must put in place safeguards to protect your health information and ensure they do not use or disclose your health information improperly.
- ✓ Covered entities must reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose.
- ✓ Covered entities must have procedures in place to limit who can view and access your health information as well as implement training programs for employees about how to protect your health information.
- ✓ Business associates also must put in place safeguards to protect your health information and ensure they do not use or disclose your health information improperly.

What Rights Does the Privacy Rule Give Me Over My Health Information?

Health insurers and providers who are covered entities must comply with your right to:

- ✓ Ask to see and get a copy of your health records
- ✓ Have corrections added to your health information
- ✓ Receive a notice that tells you how your health information may be used and shared
- ✓ Decide whether or not your health information can be used or shared for certain purposes, such as for marketing
- ✓ Get a report on when and why your health information was shared for certain purposes
- ✓ If you believe your rights are being denied or your health information isn't being protected, you can file a complaint with your provider or health insurer

Who Can Look at and Receive Your Health Information

The Privacy Rule sets rules and limits on who can look at and receive your health information. To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared:

- ✓ For your treatment and care coordination
- ✓ To pay doctors and hospitals for your health care and to help run their businesses
- ✓ With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills if you give them explicit, written permission
- ✓ To make sure doctors give good care and nursing homes are clean and safe
- ✓ To protect the public's health, such as by reporting when the flu is in your area
- ✓ To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider cannot:

- ✓ Give your information to your employer
- ✓ Use or share your information for marketing or advertising purposes or sell your information
- ✓ Share information with friends, family, or others

The American with Disabilities Act (ADA)[87]

The Americans with Disabilities Act (ADA) became law in 1990. The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as everyone else. The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications. The ADA is divided into five titles (or sections) that relate to areas of public life.

In 2008, the Americans with Disabilities Act Amendments Act (ADAAA) was signed into law and became effective on January 1, 2009. The ADAAA made a number of significant changes to the definition of "disability." The changes in the definition of disability in the ADAAA apply to all titles of the ADA. The titles include:

Title I—Equal Employment Opportunity for Individuals with Disabilities

This title is designed to help people with disabilities access the same employment opportunities and benefits available to people without disabilities. Employers must provide reasonable accommodations to qualified applicants or employees. A reasonable accommodation is any modification or adjustment to a job or the work environment that will enable an applicant or employee with a disability to participate in the application process or to perform essential job functions. Employers with 15 or more employees must comply with this law.

Title II—Nondiscrimination on the Basis of Disability in State and Local Government Services

Title II of the ADA prohibits discrimination against qualified individuals with disabilities in all programs, activities, and services of public entities. It applies to all state and local governments, their departments and agencies, and any other instrumentalities or special purpose districts of state or local governments. It clarifies the requirements of section 504 of the Rehabilitation Act of 1973, as amended, for public transportation systems that receive federal financial assistance, and extends coverage to all public entities that provide public transportation, whether or not they receive federal financial assistance. It establishes detailed standards for the operation of public transit systems, including commuter and intercity rail (e.g., AMTRAK).

[87] "What is the Americans with Disabilities Act (ADA)?" The ADA National Network.

Title III—Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities

This title prohibits private places of public accommodation from discriminating against individuals with disabilities. Examples of public accommodations include privately-owned, leased or operated facilities like hotels, restaurants, retail merchants, doctor's offices, golf courses, private schools, day care centers, health clubs, sports stadiums, movie theaters, and so on. This title sets the minimum standards for accessibility for alterations and new construction of facilities. It also requires public accommodations to remove barriers in existing buildings where it is easy to do so without much difficulty or expense. This title directs businesses to make "reasonable modifications" to their usual ways of doing things when serving people with disabilities.

Title IV—Telecommunications

This title requires telephone and Internet companies to provide a nationwide system of interstate and intrastate telecommunications relay services that allow individuals with hearing and speech disabilities to communicate over the telephone. This title also requires closed captioning of federally funded public service announcements.

Title V—Miscellaneous Provisions

The final title contains a variety of provisions relating to the ADA as a whole, including its relationship to other laws, state immunity, its impact on insurance providers and benefits, prohibition against retaliation and coercion, illegal use of drugs, and attorney's fees. This title also provides a list of certain conditions that are not be considered as disabilities.

Wisconsin Client Rights[88]

The Client Rights office with the Wisconsin Department of Health Services serves individuals receiving services for developmental disability, mental health, and substance use. Individuals can receive these services in group homes, community-based residential facilities, adult family homes, inpatient and outpatient clinics, and similar settings, as well as state run facilities, such as the centers for the developmentally disabled, mental health institutes, and Sand Ridge Secure Treatment Center. The Client Rights office does not serve inmates, emergency room patients, and single-person provider clinic patients.

[88] "Client Rights Office," Wisconsin Department of Health Services, https://www.dhs.wisconsin.gov/clientrights/index.htm

The following is a brief summary of the rights of patients under Wisconsin law and administrative code. Patient rights with an asterisk (*) behind them may be limited or denied for certain reasons.

Every patient has the right to:

Treatment Rights

- Receive prompt and adequate treatment.
- Participate in their treatment planning.
- Be informed of their treatment and care.
- Refuse treatment and medications unless court-ordered.
- Be free from unnecessary or excessive medications.

Records and Privacy Access

- Staff must keep patient information confidential
- Records cannot be released without patient consent with some exceptions
- Patients may see their records
- They can always see records of their medications and health treatments
- During treatment, access may be limited if the risks outweigh benefits
- Patients may challenge the accuracy, completeness, timeliness or relevance of entries in their records

Communication Rights

- Have reasonable access to a telephone *
- See (or refuse to see) visitors daily *
- Send or receive mail
- Contact public officials, lawyers or patient advocates

Personal Rights

- Have the least restrictive environment, except for forensic patients
- Not be secluded or restrained except in an emergency when necessary to prevent harm to self or others
- Wear their own clothing and use their own possessions *
- Have regular and frequent exercise opportunities
- Have regular and frequent access to the outdoors
- Have staff make reasonable (non-arbitrary) decisions about them
- Refuse to work – except for personal housekeeping tasks
- Be paid for work they agree to do that is of financial benefit to the facility

Privacy Rights

- Not be filmed or taped without his or her consent
- Have privacy in toileting and bathing *
- Have a reasonable amount of secure storage space for his or her possessions *

Miscellaneous Rights

- Be treated with dignity and respect by all staff of the provider
- Be informed of his or her rights
- Be informed of any costs of his or her care
- Refuse electro-convulsive therapy (ECT)
- Refuse drastic treatment measures
- File complaints about violations of his or her rights
- Be free from any retribution for filing complaints

The work of the Client Rights Office covers five key areas:

- ✓ **Promotion of Client Rights.** Client Rights office staff monitor changes in client rights laws and rules and, where appropriate, recommend changes for the benefit of all individuals served by the office.
- ✓ **Consultation on Client Rights.** Client Rights Office staff provide consultation on many topics and questions concerning client rights from individuals receiving services, their families, advocates, service providers, county staff, policy makers, and other interested parties.
- ✓ **Community Provider Grievance Process.** The State Grievance Examiner is a member of the Client Rights Office staff and conducts reviews of grievances from individuals dissatisfied with the outcome of their complaint about services proved in the community. The State Grievance Examiner also may review any complaints about the community grievance procedure itself.
- ✓ **State Facility Grievance Process.** Client Rights Office staff receive and process requests for reviews of grievances from patients of facilities operated by the Wisconsin Department of Health Services dissatisfied with the results of the first two levels of the grievance resolution process.
- ✓ **Approval of Research.** Client Rights Office staff reviews all research proposals involving anyone who is served by the office. Recommendations on whether to approve a research project are forwarded to the Administrator of the Division of Public Health, who then decides whether the study will receive final approval from the Wisconsin Department of Health Services.

All facilities and programs operating in the community are required to display client rights posters in public view and obtain client right's and informed consent annually. Programs are also required to have an internal client rights officer that assists consumers with grievances before complaints reach the level of the state.

Involuntary Commitment[89]

There are three Wisconsin state statutes that govern the detainment and involuntary commitment process: Chapter 51.15, 51.20, mental health, drug abuse and developmental disability commitments and 51.45, prevention and control of alcoholism. Below is a summary of the statutes and processes involved in involuntary commitment.

The first phase of an involuntary commitment is a detainment. This is when an individual, who has been diagnosed with a mental health disorder substance use disorder or a developmental disability is taken into custody for both of the following reasons:

- Individuals who are reasonably believed to be unable or unwilling to cooperate with voluntary treatment.
- Individuals who have probability of one of the following:
    - Physical harm to self
    - Physical harm to other persons
    - Physical impairment or injury to himself or herself due to impaired judgment
    - Unable to satisfy basic needs
    - For individuals with mental illness only: cannot make an informed decision to accept medication or treatment and there is probability that he/she needs treatment to prevent further disability or deterioration
- If these conditions exist, a law enforcement officer detains the individual and takes her/him to an approved facility that is the least restrictive environment needed
- Individuals diagnosed with an alcohol use disorder are placed in protective custody and taken to an approved facility. They are subject for commitment based on the following:
    - Person lacks self-control of alcohol
    - Uses alcohol to the extent that health is impaired or endangered and social or economic functioning is disrupted
    - Their condition and conduct is dangerous to the person or others

Once an individual is detained, the situation becomes a civil legal matter and the rest of the process is handled through the county civil court.

1. Probable cause hearing occurs within 72 hours of detention and determines if there is probable cause to believe what is alleged in the detention is true.
2. Final hearing is set to be within 14 days of probable cause hearing and determines if the person has a mental health disorder, substance use disorder or developmental disabilities and is a proper subject for a commitment.
3. At the final hearing one of the following occurs:
    - Dismissal
    - A determination whether a protective placement is a better option

[89] "Mandatory Treatment Laws in Wisconsin," Wisconsin State Law Library, http://wilawlibrary.gov

- A commitment order to the care and custody of the appropriate county department for six months, with potential renewals
- An individual with alcoholism is committed to county for 90 days

Voluntary Treatment

An individual can agree to participate in voluntary treatment at any time during the detention or commitment process, which will stop the process.

As a Peer Specialist you may participate with a team involved in an involuntary commitment. It is helpful to know the policies and procedures of the agency you are associated with.

Peer Support

Peer support can be invaluable to an individual who is currently under a civil commitment. While court commitments can require an individual to participate in treatment and services, some individuals under a court commitment actually voluntarily participate in treatment and services. Such an individual may want and can benefit from working with a Peer Specialist.

If a Peer Specialist is asked to work with someone under a court commitment, they can have a conversation with the peer to see of peer support is something they want. It is important for the Peer Specialist to engage with a peer in a mutually empowering relationship. If the peer, who is on a commitment, does not want peer support and feels that they are being forced to see the Peer Specialist, most likely the ensuing relationship will not be mutual. If that occurs, the Peer Specialist should meet with their supervisor and discuss the merits of the peer support relationship and the option of waiting to work with the peer until such time that they are interested in peer support.

Key Point …

A criterion for Chapter 51 commitment in Wisconsin is that the person is a danger to him or herself or others.

Wisconsin's Community Mental Health & Substance Abuse Services (20 MINUTES)

OBJECTIVE

- To acquaint participants with services for mental health and substance use disorders in Wisconsin.

METHOD

- Read: Department of Health Services
- Read: Documentation and Supervision
- Lead a discussion with the group on this information and any questions participants may have.

Wisconsin's Community Mental Health & Substance Abuse Services

Wisconsin's public mental health and substance abuse service system is a county based system. This means:

- State and counties are partners in the provision of services
- There are several State Departments and divisions that are involved
- Each has their own responsibilities and roles
- Services can vary from county to county
- Services are funded by a variety of sources

Since 1971, State Law (Section 51.42 of Wisconsin Statutes) has mandated that counties provide a system of community-based mental health care for:

- Individuals with serious and persistent mental illness
- Children with severe emotional disturbances
- Individuals dependent on alcohol and other drugs.

There are two populations served in the system: Adults, 18 and older and Children, birth to 18. Participation in the system or specific programs is based on:

- Diagnosis and functioning eligibility
- May be funding specific – Medicaid Recipient
- May be population specific – Pregnant Women
- County resident, county referral
- Age requirement
- Court Order Requirement

Mental health and substance use disorder services can be community programs, outpatient services, and hospitalization. To meet state requirements, counties may provide or fund the following:

- Outpatient Mental Health & Substance Abuse Services
- Crisis Intervention Services
- Targeted Case Management
- Comprehensive Community Services (CCS)
- Community Support Programs (CSP)
- Community Recovery Services (CRS)
- Inpatient mental health and substance abuse services
- Residential substance abuse services and/or mental health services

Admissions to county programs are determined through a functional screen. These are more intensive services than is provided by community mental health/substance abuse services and are paid for by the county and/or a combination of County, State and Medicaid funds.

Supervision

The Division of Mental Health and Substance Abuse Services (DMHSAS) oversees the certification of Certified Peer Specialists (CPS) which allows individuals to work within programs and/or agencies to provide peer support. DMHSAS strongly believes that Peer Specialists, like many professionals providing services to individuals with mental illness and/or substance use disorder, benefit from employer supervision. Below is guidance on what employer supervision should be.

For Certified Peer Specialists working in a program or agency that provides services that are reimbursed by Medicaid, DMHSAS adheres to Federal guidance that Peer Specialists must have supervision by a mental health professional, must be coordinated within the context of coordinated service plans and have continuing education. These programs have structured roles and supervision requirements that can be utilized by a CPS for employer supervision.

For Wisconsin Certified Peer Specialists working in a program or agency that provides services that are NOT reimbursed by Medicaid, such as Peer Run Respite, Peer Run Organizations and others; DMHSAS, anticipates that the program or agency will provide supervision, by a knowledgeable and skilled individual, who understands the roll of Peer Specialists. They will focus, not only on employment, but the Peer Specialist's work and skills in working with individuals with mental health and substance use disorders. Peer Specialists and employers should be aware if the program or agency's funding sources have supervision requirements and abide by those.

Documentation

For Peer Specialists that work in county operated programs such as CCS/CPS/CRS and Crisis will have a responsibility to document the services they provide. The documentation will serve two purposes: one; to provide a record of the services that are provided in the program and, two; to provide a mechanism for the program to receive reimbursement from Medicaid. This is often referred to as "billing." The most common form of documentation that a Peer Specialist would complete are progress notes or case notes.

Progress notes generally include the date, the amount of time, the name of the individual receiving the services, the name of the Peer Specialist providing the services and a relatively detailed description of the peer support provided by the Peer Specialist. Some Peer Specialist may be concerned that the peer told them information in confidence and that they should not document it. The programs listed above require documentation of services that are provided and the Peer Specialist will need to work with their supervisor to understand the type and content of the documentation that is needed. For example, some peer specialists prefer to use Collaborative Documentation as a way to include the peer in the process of documentation. Such documentation is done with the consumer present to include the consumer in the documentation process. This empowers the consumer to know what is being documented and gives him the ability to comment on the documentation and those comments can be included in the progress note.

A Peer Specialist may work in other programs than those listed above and should also work with their supervisor to understand any program requirements, including documentation.

Additional Readings and Resources:

"Alternatives to Suicide," peer support webinar.
https://www.youtube.com/watch?v=G2zrMv8C7CA&feature=player_embedded

Kubler-Ross, Elisabeth, *On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families*, Scribner, Reprint Edition, August, 2014.

Mead, Shery, and Copeland, Mary Ellen, "What Recovery Means to Us: Consumers' Perspectives," *Community Mental Health Journal*, Volume 36, Issue 3, pp 315-328.

"Healing Hands, Speaking From Experience: The Power of Peer Specialists"
www.nhchc.org/wp-content/uploads/2013/11/healinghandsfall2013.pdf

National Empowerment Center, Crisis Alternatives Information:
http://www.power2u.org/crisis-alternatives.html

National Empowerment Center, Danger and Opportunity in Crisis

http://www.power2u.org/downloads/dangerandopportunitiesInCrisis.pdf

National Alliance for Suicide Prevention
http://actionallianceforsuicideprevention.org/

Involuntary Commitment in Wisconsin
http://www.disabilityrightswi.org/wp-content/uploads/2008/09/civil-commitment-voluntary-treatment.pdf

"Addictions and Mental Health Recovery Dialogue: Similarities and Differences in Our Communities."
http://www.samhsa.gov/sites/default/files/similarities-differences-dialogue.pdf

"Suicide Prevention for Peer Specialists"
www.mces.org/PDFs/suicidepeers.pdf

"Buzzfeed: People Share Their Self-care Routines"
https://www.youtube.com/watch?v=VUKPrSMmbzc

REVIEW QUESTIONS:

1. **What are some of the myths regarding suicide?**
2. **What are some supportive actions that Peer Specialist can use to help a peer struggling with suicidal thoughts?**
3. **Please describe how to assess the risk of suicide using S.L.A.P.**
4. **What are the stages of grief and why is this important?**
5. **List some activities that the Peer Specialist can recommend to combat internalized stigma.**
6. **What are some of the rights of peers seeking support?**
7. **What are the criteria in Wisconsin for involuntary commitment?**

Session 13

FACILITATOR INFORMATION:

This is the last session of the curriculum. Information is presented on ending the helping relationship recognizing that there may be mixed feelings for both the peer and the Peer Specialist. The Helpful Reponses Questionnaire is filled out, as in the first session, and can be used for comparison by the facilitator and participants.

A course evaluation by participants can be used to evaluate the effectiveness of the training and to allow for positive future changes to the course.

A final wrap up is conducted with each participant given a certificate, (An example is attached), indicating completion. A celebration is encouraged which can include refreshments commemorating the success of completing the course.

Peer Specialist Facilitator Curriculum Guide

SESSION 13

40 MINUTES Ending the support relationship

15 MINUTES Break

45 MINUTES Peer support exercise

35 MINUTES Helpful responses questionnaire

15 MINUTES Break

15 MINUTES Course evaluation

45 MINUTES Wrap up and celebration

CPS CORE CRITERIA COVERED

1.3 Believes that personal growth and change are possible
1.7 Believes in lifelong learning and personal development
1.9 Believes that recovery is a process
1.10 Believes in the healing power of healthy relationships
4.1 Ability to bring an outlook on peer support that inspires hope and recovery
4.12 Ability to facilitate and support a person to find and utilize resources

Ending the Support Relationship (40 MINUTES)

OBJECTIVE

To provide participants with an opportunity to discuss the end of a peer support relationship

METHOD

- Read: Ending the Helping Relationship
- Lead a group discussion on how the Peer Specialist might feel ending this relationship

Ending the Helping Relationship

It is always wise for the Peer Specialist and peer to discuss in the initial meeting how long their involvement is going to be. The Peer Specialist also will remind the peer of this fact occasionally, especially when the supporting relationship is near its end. This avoids sudden endings that might leave the peer with feelings of abandonment.

Frequently, the Peer Specialist and peer, after working some time together, develop strong feelings for each other and the thought of ending the relationship can be felt as a significant loss for both of them. Some peers react to the coming loss of the supporting relationship by becoming superficial and distant. Other peers might deal with the future loss by bringing up new issues or talk about a crisis that they feel needs further peer support. These kinds of changes in a peer's behavior will serve as a red flag for talking about possible feelings of the coming separation, anxiety and loss. Such a process will help the Peer Specialist and the peer to put proper closure to the supporting relationship.

If further formal peer support/CPS services are not feasible or necessary, the Peer Specialist can help the peer look at other support systems that could be put into place before the support relationship comes to an end. Some helpful tips for the Peer Specialist:

- ✓ **Understand the process.** Talk over the prospective end of the relationship with the peer and see if, together, you can select a tentative date. The Peer Specialist needs to spend some time discussing how the peer may feel and give the peer an opportunity to discuss their feelings, fears, and successes. Anxiety, fear, and other emotions are normal.

- ✓ **Encourage the peer to ask questions.** Sometimes the end of the peer relationship brings up questions about the future. Peers may ask: What if things are not going well? Who do I call? Any books or support groups you can recommend to help me with everyday coping? It is helpful for the Peer Specialist

to emphasize key resources mentioned in previous conversations and reinforce these suggestions. Many Peer Specialists have a list of local resources that can be helpful to peers.

- ✓ **This is continuation of the recovery process.** It is a good time for the Peer Specialist to emphasize that this is a positive event and demonstrates the commitment and success of the peer. Encourage the peer to celebrate and enjoy the success they have earned. Reinforce that recovery is an ongoing process with change and growth.

    - ❖ Review achievements and focus on them.
    - ❖ Let your peer know you are proud of them and give them examples of how they have grown.
    - ❖ Point out your peer's strengths and the other relationships and skills they've developed.
    - ❖ Encourage them. Thank them. "I've gotten a lot out of this relationship as well."

On occasion, the helping relationship is ended prematurely or on a negative note. The peer may decide that the Peer Specialist is no longer helpful or he does not feel the relationship is a good match. The Peer Specialist may feel that another peer would be more helpful or that he is not comfortable. Whatever the reason, it is important that the ending is handled carefully. Some tips for the Peer Specialist.

- ✓ **Encourage the peer to express feelings and thoughts about the peer support.** While there may be some feedback or criticism that is difficult to hear, it can be a great leaning experience. Do not take comments personally, rather evaluate them, think about them, and choose which ones are helpful.

- ✓ **Carefully explain any premature ending from the Peer Specialist.** Peers may feel a sense of rejection if the Peer Specialist wants to transfer the peer to another specialist. It is important to outline the reasons and why it is in the peer's best interest.

- ✓ **Give the peer additional resources and referrals.** It is helpful for the Peer Specialist to have a listing of important community resources to share with peers. It is important that peers know how to access services that can be of assistance.

Peer Support Exercise (40 MINUTES)

OBJECTIVE

To provide participants with an opportunity to practice ending the helping relationship

METHOD

- Have participants pick a partner to practice saying good-bye to a peer, at least in the formal relationship. Have one participant be the peer and the other the Peer Specialist and then switch roles.
- Encourage the participant who is role-playing the peer to provide obstacles and objections to the participant playing the Peer Specialist.

Helpful Responses Questionnaire
(30 MINUTES)

OBJECTIVE

To identify skills the trainees have learned through the training sessions.

METHOD

- Ask trainees to fill out the Helpful Responses Questionnaire
- Facilitator will assist trainees in comparing the questionnaire that was completed in the first sessions.
- Ask participants to list areas where further training and/or study would be helpful

The Helpful Responses (Empathy) Questionnaire[90]

PRE AND POST TRAINING FEEDBACK

Instructions: The following six paragraphs are things that a person might say to you. For each paragraph imagine that someone you know is talking to you and explaining a problem that he or she is having. You want to help by saying the right thing. Think about each paragraph as if you were really in the situation, with that person talking to you. In each case, write the next thing that you would say to be helpful. Write only one or two sentences for each situation. Please print or write clearly.

1. A 41-year-old woman says to you: "Last night Joe got really drunk and he came home late and we had a big fight. He yelled at me and I yelled back and then he hit me really hard! He broke a window and the TV set too! It was like he was crazy. I just don't know what to do!"

YOUR RESPONSE:

_____

_____

_____

2. A 36-year-old man tells you: "My neighbor is really a pain. He's always over here bothering us or borrowing things that he never returns. Sometimes he calls us late at night after we've gone to bed and I really feel like telling him to get lost."

YOUR RESPONSE:

_____

_____

_____

3. A 15-year-old girl tells you: "I'm really mixed up. A lot of my friends, they stay out real late and do things their parents don't know about. They always want me to come along and I don't want them to think I'm weird or something, but I don't know what would happen if I went along either."

YOUR RESPONSE:

_____

_____

[90] Adapted from CMHA BC Division Consumer Development Project.

4. A 35-year-old parent says: "My Maria is a good girl. She's never been in trouble, but I worry about her. Lately she wants to stay out later and later and sometimes I don't know where she is. She just had her ears pierced without asking me! And some of the friends she brings home…Well, I've told her again and again to stay away from that kind. They're no good for her, but she won't listen."

YOUR RESPONSE:

_____

_____

_____

4. A 43-year-old man says: "I really feel awful. Last night I got drunk again and I don't even remember what I did, but my wife isn't talking to me. I don't think I'm an alcoholic, you know, because I can go for weeks without drinking. But this has got to change."

YOUR RESPONSE:

_____

_____

_____

6. A 59-year-old unemployed teacher tells you: "My life just doesn't seem worth living anymore. I'm a lousy father. I can't get a job. Nothing good ever happens to me. Everything I try to do turns rotten. Sometimes I wonder whether it's worth it."

YOUR RESPONSE:

_____

_____

_____

Name _____ Date_____

Course Evaluation (40 MINUTES)

OBJECTIVE

To provide facilitators with information about the course content, manner of presentation and the effectiveness of the trainers for positive changes to the course.

METHOD

- Give each participant a course evaluation to complete and return to the facilitator.
- Encourage participants to be as honest and specific as possible.

"I avoid looking forward or backward, and try to keep looking upward."

— CHARLOTTE BRONTE

Key Point …

In Wisconsin, a Certified Peer Specialist is required to complete 20 hours of continuing education every 2 years.

Course Evaluation-Peer Specialist Training

Date:_____Instructor_____

Please answer the following questions:

	Poor	**Average**	**Good**	**Average**
How well did you understand the information presented in the course?				
Did the instructor present the material in an interesting manner?				
How suitable to your level of experience was the instruction?				
How suitable to your level of learning was the instruction?				
Was the instructor available for adequate time to answer questions?				
What do you feel was the quality of instruction?				

Please give comments on how you benefited from this course:

What would you change in this course?

Wrap Up and Celebration (40 MINUTES)

OBJECTIVE

To encourage closure and celebrating success.

METHOD

- Give each participant a certificate indicating (see sample that follows), indicating completion of the course.
- Provide refreshments to conclude the classes on a very positive note.
- Facilitators can talk about celebrating successes as a way to encourage people in their recovery.

"Faith is taking the first step, even when you don't see the whole staircase."

— REV. MARTIN LUTHER KING, JR.

Peer Specialist Training Certificate of Completion

Is hereby granted to

_____

Granted on:

_____

By

_____

This Day____ of