

Washington State
CERTIFIED PEER COUNSELOR CURRICULUM

Bridge Training
Recovery Coach to Certified Peer Counselor

Washington State
Health Care Authority

Division of Behavioral Health and Recovery
Recovery Supports Unit

*Developed in Partnership with
WSU Peer Workforce Alliance*

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BRIDGE Training

From Recovery Coach To Certified Peer Counselor



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Welcome to the Bridge training!

Welcome to the Bridge Training for Recovery Coaches. In this training, you will be able to review what you learned in Recovery Coach Academy while learning what peer support workers in the behavioral health system (known as Certified Peer Counselors, or CPCs) are taught. When you have completed this training, you will take the state's CPC exam. Once you pass the exam you will receive a certification letter from the Division of Behavioral Health and Recovery (DBHR) stating that you are now a Certified Peer Counselor. In order to work in a Medicaid funded agency you will need to obtain an agency affiliated counselor credential through the Department of Health. You will be able to apply for this credential once you are hired by an agency.

This course is a continuation of the online training for Certified Peer Counselors. The online course has information you will need to succeed in this class and in becoming certified.

You are all here because you have found your way forward on a recovery journey. Peer support workers are not just people who have experienced mental health or substance use challenges, or parented a child with behavioral health challenges. Peer supporters are people who have experienced recovery and resiliency, and have a message of hope to share. This journey of discovery is not about the challenges you have faced; it is about the strengths you found within yourselves to overcome challenges, to reclaim a full life and a healthy family.

Course Expectations

What are the course expectations?

- Come every day, and show up on time.
- Remember that you can miss no more than one-half hour from this class, unless excused by an instructor, in order to complete the class. Excused absences are only given for unavoidable conflicts and emergent situations. Absences include any personal needs for coming late, long breaks, and leaving early. In no cases may a person miss more than two hours total and complete the class. Sorry, no exceptions.
- Dress and demonstrate behavior appropriate for a work setting.
- Participate in class discussions as indicated by your instructor.
- Work with classmates in small and large groups, to learn new skills.
- Foster a good learning environment: listen, support, participate, and celebrate each other.

- Be respectful of different views, opinions, and recovery choices in a way that feels welcoming and safe for everyone to express themselves.
- Bring learning aids (your workbook, pen or pencils, and anything else you may personally need in order to participate in this training).
- Perform new skills in the skill checks. **You must pass all skill checks to qualify for the Certified Peer Counselor test.** You may have more than one opportunity to pass, if necessary.
- Take good care of yourself. Full days of training can be exhausting, so make sure to do what you need to do to be well throughout.

NOTE: There are possible circumstances in which a person might be asked to leave the training. These include being disrespectful to others, being disruptive to the learning environment, and being inattentive or not participating in class activities. If the instructor is noticing a problem, they will discuss it with you. The training is designed to support each of you to succeed and for the entire class to have a valuable experience.

Activity Develop Additional Classroom Agreements

As a group, come up with additional guidelines that will make this a successful learning experience for everyone. Your instructor will write them on paper that can be hung on the wall. They may be reviewed and added to during the training.



Course Overview

*Transformation in the world happens when people are healed
and start investing in other people.
~Michael W. Smith*

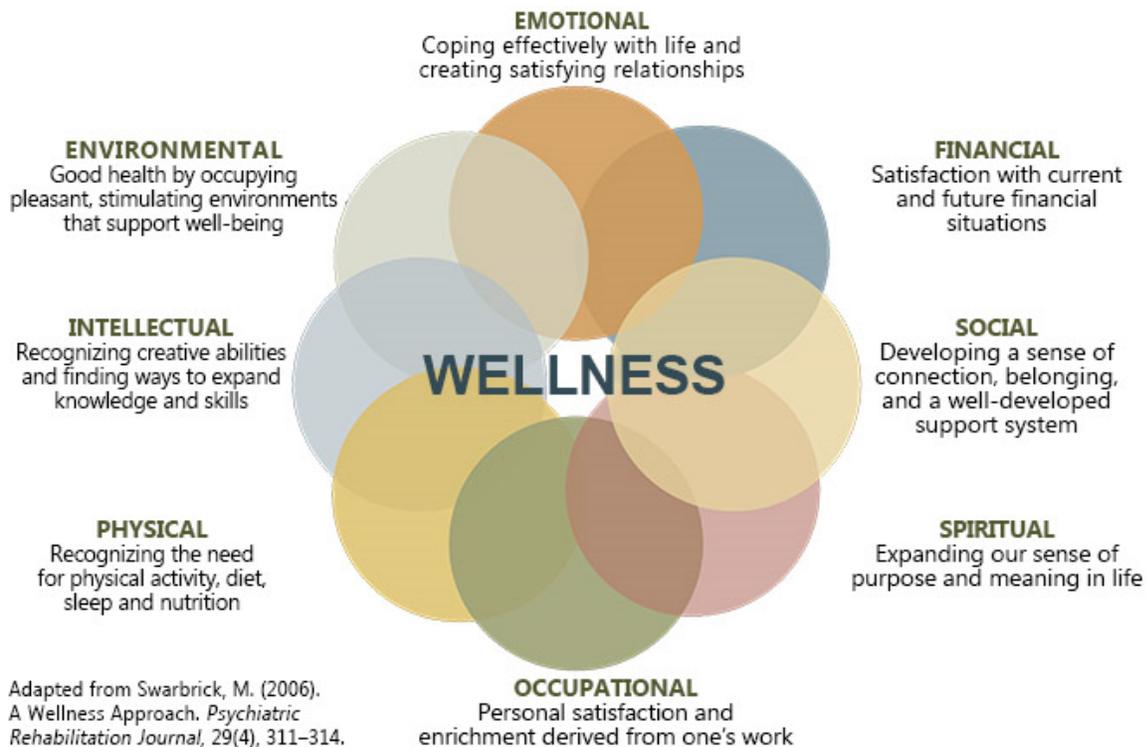
POINTS TO PONDER:

Why take part in this training? If you take part in this training, you will have the opportunity to add competencies, or skills, to what you already have learned about peer support. You will have discussions with new colleagues, learn how to do the work of peer support, and see examples of, and practice, new skills in peer support.

Format of the training: There are seven modules in this training. The modules each correspond to sets of skills that you must have in order to provide peer support in any of a variety of peer roles.

Remember: you are the most valuable asset—protect your wellness, practice self-care.

What is Wellness? The Substance Abuse and Mental Health Services Administration (SAMHSA) offers eight dimensions of wellness:



Module 1: Recovery and the CPC Role

In Recovery Coach Academy, you explored the role of a Recovery Coach as compared to the role of a counselor or a sponsor. The Recovery Coach has much more in common with the sponsor than with the counselor! Similarly, a Certified Peer Counselor has much more in common with a peer or the peer's natural supports, than we would with therapists or prescribers. In the mental health system funded by Medicaid, the role is unique and powerful.



Thinking Ethically: Remember that we cannot “give” recovery to anyone, or even “instill” hope and recovery. What we can do is support people to find their own way in their recovery by walking with them, sharing our stories, listening carefully to people’s perspectives and for their strengths. Your job as a CPC is not to “recover people,” rather, to support people to find *their own inner wisdom*.



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Who Can Be A Certified Peer Counselor?

In Washington State, a Certified Peer Counselor is a person who has shared or has had a similar experience with someone using services. A Certified Peer Counselor may also be the parent or primary caregiver of a child receiving behavioral health services, which qualifies them to provide peer support to other parents or caregivers living with children receiving services. Certified Peer Counselors who work with families are sometimes referred to as **Parent Partners** and **Youth Partners**. The peer support role was first designed in the mental health system and has now been expanded to include substance use challenges. The CPC works to inspire hope, to model healthy relationships, to encourage mutual respect and dignity, and to support people in services connect to resources in the community. While we cannot “recover” or “fix” another person, we can certainly hold onto hope that they can find a full life in the community, while honoring their own definition of recovery.

Certified Peer Counselors work in a wide variety of settings, but most often they work in licensed community behavioral health agencies (CBHAs) or peer-run organizations (PROs). Peer support may be provided:

- One-on-one
- By facilitating groups and classes
- In community settings such as the person’s home, courtrooms, hospitals, schools, churches, or any comfortable and safe location
- In crisis agencies, on warm lines, or on crisis lines
- In agencies, clubhouses, and drop-in centers
- In residential centers
- In youth programs
- In programs focusing on employment or housing

What about Medicaid Funding?

The CPC training was designed to prepare people to work in the Medicaid-funded system, and this bridge training is designed to give you the skills necessary to work in that environment. The state of Washington has a Medicaid State Plan that defines what services may be provided, by credential. The State Plan allows for peer support services to include scheduled activities that promote **recovery, self-advocacy, community living skills**, the development of **natural supports**, and **social skills**. Self-help groups may be included in this definition. Services provided by a peer supporter and funded by Medicaid must be:

- Provided by a Certified Peer Counselor under the supervision of a Mental Health Professional (MHP) OR a Substance Use Disorder Professional (SUDP) who understands peer support, recovery and resiliency;
- Included in the treatment plan, with specific goals that are driven by the needs and desires of the peer and/or the peer's family, designed to connect them to community resources and supports; and
- Documented in a way that demonstrates progress toward goals. Documentation does not need to be clinical; we'll learn more about documentation later.

While this bridge training will prepare you to work in a Medicaid-funded environment and the state defines generally what peer supporters will do, your employer may use peer support in a wide variety of ways which we cannot anticipate. This training provides the information needed to apply the core competencies to your role as a certified peer counselor. Training prepares you to begin this work and then you are expected to continue to learn in your workplace, adding skills related to your unique job role.



The Importance of Hope

“Hope is not managing illness. It is discovering wellness. Hope does not fix what is broken but finds wholeness within. Meaning, purpose and a love for life where there was once only dread. Hope reconnects us to self, others, nature and spirit.”

~Duane Sherry

With that definition of hope in mind, what does this tell you about your role as a peer supporter?

Exercise

Take five minutes to share with a partner how you define peer support. Write down a few notes. Then share what you discussed with the rest of the class.

The more you see yourself as the “helper,” the more need for people to play the passive “helped.” You’re buying into, even juicing up, precisely what people who are suffering want to be rid of: limitation, dependency, helplessness, and separateness.”

~How Can I Help? Reflections on Service, by Ram Dass and Paul Gorman

Modeling Hope and Possibility

Modeling hope and possibility is a key part of the peer support role. This means we remember that we're not there to "fix" anybody, we're not there to tell people what to do, or what goals they should choose. Our role as a CPC is to support the individual in reaching those goals. But what if the person is making a choice that we believe is not wise? Should we intervene and tell them what to do? Why or why not?

Consider this: I have been seeing you regularly for peer support, to help me recover from my heroin habit and feelings of low self-worth. After about five months of complete abstinence, I tell you I think I'm going to try having a drink every other day. I tell you not to bother trying to talk me out of it, I know what I'm doing. How will you respond?

1. You might say: "Now, you know that if you start using *any* mood-altering chemicals (aside from what is prescribed), you'll probably go right back to heroin."
2. You might think, "I better go report this to the person's prescriber so they know about the alcohol."
3. You might say, "Hmmm. Sounds like your goals have changed. I'm interested to hear more about that."

If you chose answer #1, chances are the person has stopped listening to you.

If you chose answer #2, you're at risk of losing the person's trust if you don't tell them what you're doing. It may also be a HIPAA violation.

If you chose answer #3, congratulations. Because you haven't shamed or scolded the person, if their actions aren't successful, they are much more likely to come back to you for support.

Studies late in the last century showed that there is no way to predict who will recover from mental health challenges, substance use disorder, or any combination thereof. What does that mean? It means we have to expect that *anybody* can recover. Let's watch a brief video of a woman talking about her recovery from major mental health challenges.

https://www.ted.com/talks/eleanor_longden_the_voices_in_my_head

Discussion

After watching Eleanor Longden describe her experiences with hearing voices, hospitalization, and despair, is it difficult to imagine that she was once hospitalized? Can you imagine people to whom you provide services giving a TED talk? Why or why not?

Hope and Hopelessness

Thinking about hope and hopelessness, we can see some similarities between people recovering from substance use disorder and people recovering from mental health challenges. Most of us found recovery because at some point we *made a decision*: to seek services, to believe in a better future, to be willing to do the hard work of recovery for ourselves or for our families. This decision is very clear for people recovering from substance use disorder because the decision is typically marked by a plan for abstinence. Ideally this includes a plan to move into recovery and resiliency. For many people, the decision point isn't always so clear, but it's present.

When a person has been in behavioral health services for some period of time, they often become conditioned to the story that they have a lifelong disability, that they will never work or have a family, and that they should apply for disability benefits and avoid stress. This may result in internalized stigma. For this individual, the decision point is when the person sees a window of opportunity, a ray of hope, a note of support—often from a close friend but maybe from a CPC or Recovery Coach as well. Some common experiences in the behavioral health system include:

- ❖ Assuming a “patient” or “addict” role and losing identity
- ❖ Falling behind friends in education and jobs, losing those relationships
- ❖ Having your every move or statement analyzed carefully
- ❖ Becoming demoralized by the barriers imposed by systems
- ❖ Having ordinary emotions redefined as symptoms or addictive behavior
- ❖ Losing control of your life, your choices, your freedom, your self-determination
- ❖ Having other major life losses such as home, family, job, friends
- ❖ Facing stigma and discrimination

This legacy of loss and despair leads to hopelessness and learned helplessness. Because of this, peer support workers must be able to offer hope, inspire possibilities, and hold high expectations for recovery, for everyone. While we can't instill hope in another, we can inspire it by being present and being hopeful ourselves.

“I practice courage so that if I'm not feeling very courageous, I remember I'm still practicing.”

Empowerment

We can't "give" someone hope, just as we cannot "give" someone empowerment.

People seeking recovery already have power; our role is to help them become aware of their own power and learn to use it in a way that helps them get their needs met. In order to develop resilience, a person must see different options for their life choices, and have attitudes and beliefs that empower those choices. Throughout the rest of this training, we will be working from a framework of encouraging empowerment and inspiring hope.

Some peer support values that help us do that are:

- ✿ *Mutual support.* We support each other in our recovery, sharing stories, strategies, hopes and fears.
- ✿ *Power together, not power over.* As a paid peer support worker, our relationship with the individual in services is different than that of a friend or other natural support. As "formal support," peer support workers do their best to walk beside the person instead of trying to lead. We encourage the person to recognize that they are the expert in their own life, and we support them in finding their own solutions.

Exercise

In this activity about power in peer support, your instructor will divide you into small groups and give each group a piece of flip chart paper. On the flip chart paper, one large person will be drawn on the left and several small people will be drawn on the right. After you move into your small groups, you will receive small slips of paper with scenarios on them. Each slip of paper will be placed on the page: if the scenario describes an action that is "power together," tape it next to the smaller people. Scenarios describing an action that is "power over" will be taped next to the large person. As a group, you will decide where to place each slip of paper. When you're finished, hang your flip chart paper on the wall. Walk around the room and view the other flip chart pages. Answer the following questions:

- How did the placement of scenarios differ amongst groups?
- Where did the biggest disagreement or discussion come up?
- Where did questions arise for your group?

Learned Helplessness

When a person struggles with challenges over time, they may lose sight of their own ability to solve problems. They may come to believe that a “mental health” or “behavioral health” challenge means that they aren’t capable of finding answers, and that they need to hand all their power to providers, family members and friends. They come to believe that providers will “fix” their problems. It can be challenging to work with a person who has learned helplessness, and we must proceed thoughtfully. Remember that a person may have worked and waited for years to receive disability benefits, and challenging them to take steps toward recovery might feel scary. What will it mean for their source of income?

We might hear the following statements from someone with learned helplessness:

- This is my life, and it’s always going to be my life.
- They say I’m “unmotivated.” I might get motivated if I thought anything would get better.
- You’re the expert, tell me what to do!

It’s possible to overcome learned helplessness if we approach it with care.

We could:

- See the whole person—not just the challenges
- Hear their perspective
- Ask open-ended questions
- Display empathy
- Share your story—if it relates
- Share resources, such as

Wellness Recovery Action Plan, Pathways to Recovery, etc.



Behavioral Health Recovery: 10 Guiding Principles of Recovery

The Substance Abuse and Mental Health Services Administration (SAMHSA) polled a large community of people in recovery, early in the 21st century. With this information, SAMHSA put forth a Consensus Statement containing a working definition of recovery as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. In addition to this definition of recovery, SAMHSA developed the “**10 fundamental Principles of Mental Health Recovery**”, which have evolved into “**The 10 Guiding Principles of Recovery.**” You learned about recovery principles in the Recovery Coach training. These principles use the word “consumer” to describe people in services; in recent practice, that word is no longer used. The debate over language continues: in some places, the word “peer” is used to denote people using services. This workbook may use “peer” or “participant.”

SAMHSA Working definition of recovery from Behavioral Health challenges includes mental disorders and/or substance use disorders.

10 guiding principles of recovery

Recovery emerges from **hope**

Recovery is **person-driven**

Recovery occurs via **many pathways**

Recovery is **holistic**

Recovery is **supported by peers** and allies

Recovery is **supported through relationship** and social networks

Recovery is **culturally-based** and influenced

Recovery is supported by **addressing trauma**

Recovery involves individual, family, and community **strengths and responsibility**

Recovery is based on **respect**

Discussion

What similarities do you see between mental health recovery and what you’ve learned about substance use recovery? What differences?



Exercise

Select a partner, preferably someone with whom you have not yet worked. Consider three possible barriers to recovery and, with your partner, develop strategies that you as the Certified Peer Counselor could use to overcome them. You will be reporting back to the class about your answers.

Barriers

1. _____
2. _____
3. _____

Solutions

1. _____
2. _____
3. _____

As your classmates report out their ideas, write down a few notes so you can add those tools to your toolbox too.

Language and Stigma

The language we use in our work is very important. Words have the power to create meaning. When we use language such as “patient,” “low functioning,” “crisis,” and referring to persons as their diagnostic label, we create a reality for people that results in long-term disability and feelings of hopelessness. In addition, using clinical language reinforces a hierarchy in which we have higher standing than people in services. As much as possible, Certified Peer Counselors should be using the language of ordinary human experience rather than clinical language. Here are some non-medical uses of language that suggest that recovery is possible:

- ☛ People are not “cases” who need to be “managed.” We refer to service coordination or resource coordination rather than “case management.”
- ☛ Certified Peer Counselors work in partnership, instead of focusing on compliance. Language that implies compliance or any other force should be avoided.
- ☛ Watch out for language that conveys judgment: what are the implications of saying someone is “resistant to treatment,” or “refuses treatment”? Speaking about cooperation, partnership, and involvement are much more hopeful and suggestive of a person taking active responsibility for recovery.
- ☛ Instead of saying someone “is schizophrenic,” we might say “a person diagnosed with schizophrenia” or “a person living with schizophrenia.” Diagnosis is not identity. We don’t say someone is “suffering from” a diagnosis or symptom. Only the individual knows whether they are suffering. Instead of saying “the homeless person,” we might say “the person living on the streets” or “a person experiencing homelessness.” A person is not defined by their living experience.
- ☛ People in services don’t belong to us. We don’t say “my” client or participant; they are people using services at this agency. Note that the term “using services” is active and implies agency.

Some of these are examples of person-first language, in which we describe the person (the whole human being) before the challenge. Referring to a person by their diagnosis or living conditions is dehumanizing and emphasizes disability, rather than possibility. Certified Peer Counselors use person-first, non-clinical language when working with individuals, and also when documenting their work. We will revisit this when we discuss documentation.

Exercise

Divide the class into four or five groups, each with notebook paper and pens or markers. Each group will have up to three minutes to think of language that is discouraging, judgmental, and does not support recovery. Then each group will have three minutes to consider what language we might use instead. Each group then passes their paper to the group directly on their right. Groups will then discuss the language on the paper that was passed to them, asking questions of the original writers as needed.



*If you have come here to help me,
you are wasting your time. But if
you are here because your
liberation is bound up with mine,
then let us work together.*

~ Lilla Watson, Australian

Note: There has been a difference, historically, between how addiction recovery and mental health recovery are approached. Many informal community-based recovery models for substance use challenges are directive in nature, generally turning over autonomy to someone who advises them within the context of a structured recovery belief system.

In behavioral health peer services and recovery coaching, workers/coaches strive to encourage the person to speak up and figure out their own solutions. This seems like a contradiction, and in practice, it can be difficult to navigate when the direction of the recovery method conflicts with the direction of the treatment plan. It is essential to recognize when these conflicts arise so that the participant can be given the space to make the right decision for them given all of the facts without any inference of the peer worker's personal views on the matter.

We believe that everyone—no matter their challenge—can find their own solutions, with support. We believe that each person is the expert in their own life. Peer support workers can navigate this by working to empower the person to make healthy choices, no matter what challenges they face.

Skill Check 1: The CPC Role



Demonstrate the following skills:

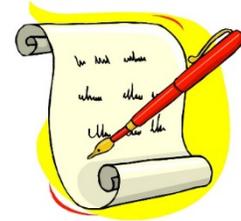
Describe the basic role of a peer supporter

Describe the type of relationship a peer supporter has with people served

Describe the kind of work a peer supporter might do

Get into groups of three to four people. Each group will have a piece of flip-chart paper and a set of markers. Put your first names on the top of the page, and number your answers. Discuss the following questions as a group, and write your answers on the paper.

1. What are the three most important things you have learned about the role of a CPC?
2. How would you describe what a CPC does? Without looking at the book, write a definition of a CPC together, and be prepared to read this definition to the class.
3. List the three most important things you have learned about the relationship of a peer supporter with people in services.



When the groups are finished, walk around the room and look at what others have done. Be prepared to present your ideas to the group.

Summary: Defining the Role of the CPC

In this module, you reinforced your ideas about the role of peer support. You learned about some common recovery principles and about the importance of empowering participants. You practiced overcoming barriers and changing your language, and you passed a skill check.

As you move on to Module Two, keep in mind how you're using language. Think about the Ten Principles of Recovery, and how they will apply to your work. Remember from Recovery Coach Academy the roles of peer support, as well as those roles that are *not* like peer support (sponsor, counselor, nurse/doctor, attorney, faith community). Most of all, don't forget that we work side by side with people. We aren't leaders, fixers, or problem-solvers. Our role is to empower people to find their own solutions, and to support them on that journey.

Module 2: Peer Support Skills

In Recovery Coach Academy, you learned some skills for active listening, for telling your story, for countering stigma, and what to do when your buttons get pushed. Certified Peer Counselor training describes peer support skills as Partnering. These specific skills include:

- Listening actively
- Listening to understand
- Listening for meaning, feeling, values
- Demonstrating understanding
- Orienting
- Supporting voice and choice
- Asking open-ended questions
- Asking clarifying questions
- Sharing your recovery story

“The foundation of genuine helping lies in being ordinary. Nothing special. We can only offer ourselves, neither more nor less, to others—we have in fact nothing else to give. Anything more is conceit; anything less is robbing those in distress.” (Pearson, 1988)



Listening Actively

This activity involves several important skills. You learned in Recovery Coach Academy that you should focus your attention on the person speaking, avoid distractions, sit near the person, monitor your own emotional state, watch your own opinions, listen with all your senses, and be careful not to interrupt. Eye contact is typically encouraged, though there are many valid reasons why someone might not want to make eye contact with you.

But there's more to active listening. *Listening to understand* is different than *listening to respond*. Which is easier for you? Listening to respond means we're listening somewhat, while at the same time considering how we will respond. When we do this, we are more likely to interrupt or to jump in as soon as the person takes a breath. On the other hand, when we listen to understand, we set aside the need to respond immediately and instead focus on what's being conveyed. What does the person mean? Am I making assumptions about what is being said? Do I need to clarify?



How do we listen for meaning, feeling and values?

1. **Listen quietly while the person talks.** Don't interrupt, don't judge what they are saying. Use your curiosity to find out more about the peer. Pay attention to body language—yours and the other person's. Get comfortable with silence: it shows you're really listening and also leaves room for the person to collect their thoughts.
2. **Ask yourself, what is this person trying to communicate?** Take a moment to think about the meaning, without considering any argument or response. What do you hear? How does their body language support or contradict what you think you heard?

Once we've explored the meaning of what was said, we can demonstrate understanding, or at least check to be sure we understand. We might try paraphrasing, reflecting feeling, or responding to meaning.

Paraphrasing: Paraphrasing is saying back to the peer, using different words, what you heard the person say. Try to avoid saying this in a way that doesn't imply your interpretation is correct; this should be more of a question. "If I'm hearing you right . . . : or "If I'm understanding you correctly . . . "

Reflecting Feeling: Sometimes it's more effective to respond to the emotional content of a message rather than its literal meaning. What emotion is the person expressing? "It sounds like you're really angry about that." This tool is especially useful when you're not sure what else to say. It also invites the person to keep speaking. Don't worry if you have to guess: they'll tell you if you guess wrong.

Responding to Meaning: This is how we show another person that we understand their message.

Read the scenario that follows, then consider the responses below.

Tai to Camelia: “I’m sick and tired of what my sponsor is telling me. I have to get my shot this month and they say I’m not totally sober if I still need medication. I’m really confused. Who are they to tell me what to do? I’m sick of it!”

Not-So-Supportive Responses:

Not Demonstrating Understanding:	What’s wrong with it?
“Oh, you think that’s bad? You should hear what my sponsor says to me!”	One-upping the peer It becomes about you, not the peer
“Oh, I’m sorry, your sponsor doesn’t sound fair	Sympathy, not empathy
“You should just quit! I wouldn’t take it!”	Advising, not listening
You’re sick and tired of what your sponsor is saying to you. Who is he to tell you what you should be doing? You’re sick of it!	“Parroting” or repeating the same exact words back (which can be annoying)

Supportive Responses: What might be helpful to Tai?

Demonstrating Understanding	What’s right with it?
“You don’t like the advice you’re getting.”	Paraphrasing Tai’s content
“You seem angry at your sponsor.”	Reflecting Tai’s feeling
“Sounds like you want to be heard.”	Responding to Tai’s meaning
“Sounds like you feel angry because you want to be heard, not advised.”	Demonstrating all three together

Here’s another example of the skills of paraphrasing, reflecting feeling and responding to meaning:

LaTonya, to Viv: “I’m blown away by what I’m hearing in meetings. You just don’t know how I feel hearing stories that sound so much like mine.”

Viv, **Paraphrasing:** “Sounds like the stories in meetings are really impactful for you.”

Viv, **Reflecting feeling:** So you’re surprised? You enjoy hearing those stories like yours.”

Viv, **Responding to meaning:** “Seems like it’s inspiring to you to find out you’re not alone.”

Exercise

Now it's your turn to try. Read the paragraph below, and then write one to two sentences for each skill. Be prepared to share one with the class.

Jennifer: "It's too hard to find work. Every time I apply for a job, they run a background check and find my felony conviction. They also find out I didn't finish high school. It's so frustrating, then I find it hard to get out of bed. If I don't get a job in the next month, I will have to find another place to live. I'm really stuck."

How would you **paraphrase** Jennifer's situation?

How would you **reflect** Jennifer's feelings?

How would you **respond to the meaning** of Jennifer's comments?



Skill Check 2: Listening to Understand



Paraphrase, reflect a feeling, or respond to meaning

Partnering Practice: Your instructor will read the following instructions out loud, and then help you find a partner. Work on this exercise with your partner.

1. Sit with a partner. Each of you will have the opportunity to practice and demonstrate your skills in Listening to Understand. Take turns being the Listener and the Speaker. Each of you will have five minutes to talk about something that's going on in your life. Your instructor will tell you when to switch roles.
2. When you are the Speaker, allow a little space for the Listener to respond with one of these skills. While it's your turn to be the Listener, **do not ask questions**. Instead, practice Paraphrasing, Reflecting Feelings, and Responding to Meaning.
3. Your instructor will come around and listen as you practice your Listening Skills. They may also coach and support you as you practice.

A word about Listening: every time you ask a question, you narrow the universe of possible answers. You've told the person what kind of information you seek. Try using statements such as you've practiced here to encourage the person to talk about whatever's on their mind.



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Engagement: Orienting, Supporting Voice and Choice, and Asking Good Questions

What is **engagement**? This word describes how a peer support worker goes about gaining the trust of a person with whom we are working. Engagement matters because disengaged people aren't willing to take personal responsibility for their recovery; they aren't able to advocate for themselves; and they have a hard time working toward recovery goals.

How do we help engage people? Engagement is built on trust. Until a person knows they can trust us, they may not be as willing to participate in their recovery journey. We know that peer support workers, just by their presence, can often help with engagement. We are trusted because we've walked in their shoes. Building a relationship with a peer is how we develop the trust that supports recovery.



Think about relationships you have had in your life. How many were trusting relationships? How many were untrusting relationships? What made a relationship either trusting or untrusting?

Discussion

Read the scenario below. Discuss the questions as a class.

Sally is the peer support worker for **Rachel**, who currently uses services for both substance use disorder and compulsive gambling. Rachel has been told that the staff are having a team meeting to work on her plan. She has been told to sit in the waiting room until they call her in. When Sally and Rachel finally enter the meeting in its final ten minutes, Rachel is informed that her plan includes regular attendance at Narcotics Anonymous meetings, step work with her sponsor, attendance at Problem Gambling meetings, and weekly meetings with her therapist. The team discusses ways to get Rachel involved in their problem gambling support groups.

1. Is Rachel engaged in her own services? In what ways is she engaged or not?
2. What do you know about Rachel's goals for her recovery and wellness?
3. How could Sally be supportive of Rachel so that she is more actively involved in services, including planning?

Orienting is an activity that helps a peer understand a process, its activities, and the people who will be involved. For example, in the exercise just preceding, Rachel may have had no

idea what was happening in the meeting, and therefore she was not well prepared to participate in the meeting or to advocate for her own needs and desires. We orient peers to upcoming events and activities because it helps increase engagement, lowers feeling of anxiety and nervousness, and supports individual empowerment.

How do we **orient**? Talk about the **what, why, and how.**

What: If the person voices concern about an upcoming meeting or other event, mention what you've heard and suggest that you can talk about the upcoming event to see if that will help the person feel more comfortable about it.

Why: Find out why the event matters, what it means to the person. Explain why it might be important for the person to understand the event and be prepared for it.

How: Ask the person what would be helpful for them in preparing for the event. Support them in making a plan.

Orienting relieves the feelings of uncertainty and nervousness that many of us experience when headed into a new situation. Orienting helps people engage with you and with other services because they feel more confident in their role and in their right to be heard. When people are more confident about situations, they are more likely to have **voice** and **choice**. **Voice** is the right and the opportunity to take the lead in one's own recovery journey, to have our voices heard. **Choice** means we have the right to choose the path we will take and the services we will use.



Asking Good Questions: When we ask the right questions, we are able to support the peer in determining his or her choices and goals, without the peer feeling that we are being nosy or just getting clinical information to fill out a form. These kinds of questions can support participants:

- * Direct questions
- * Open-ended questions
- * Clarifying questions



Direct questions are useful when you are gathering concrete information, such as, “do you want me to attend the team meeting with you?” Direct questions often begin with “Do you . . .” “are you . . .” “will you . . .” Direct questions can often be answered with yes or no, or some other single word.

Open-ended questions cannot be answered with yes or no. Use this type of question when you are inviting the person to express themselves, or you’re looking for general (rather than specific) information. Open-ended questions often begin with “How do you . . .” “What do you like about . . .” “Who would . . .” “Why did you . . .”

Which one of these statements is open-ended?

Tom says to Mary: What did you do on the weekend? Yes ___ No ___

June says to Susan: Did you make your bed? Yes ___ No ___



Thinking Ethically

While asking questions is a crucial partnering skill, it’s possible to ask too many questions.

Sometimes questions are used to steer the conversation in the direction we want it to go, so that we control the agenda. Keep the focus on the person.

Questions can also be aimless, especially if it’s our baseline strategy. We may find ourselves using questions because we don’t know what else to say. We should continue to develop our listening skills, learning from practice and experience when to ask a question, when to make a statement, and when to remain silent.

Questions can be too clinical, or unrelated to peer support work. Try to avoid asking overly personal questions, highly clinical questions, or anything unrelated to your work together.

Skill Check 3: Asking Open-Ended Questions

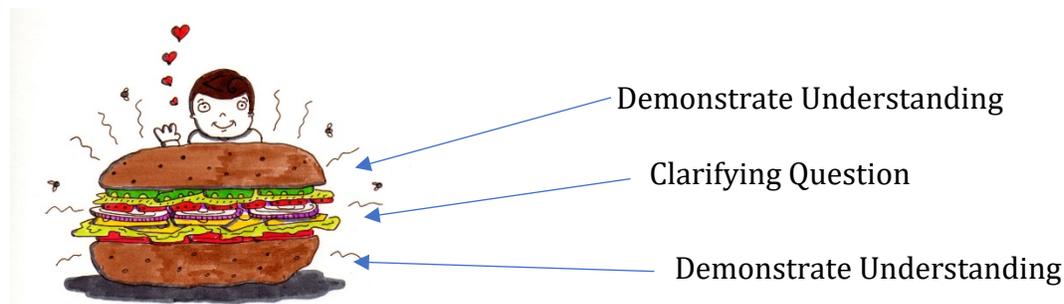


Your instructor will invite a volunteer to come to the front of the room. The person will describe some recent event, such as what they did over the weekend or where they took a recent trip.

Each person in the room, one at a time, will ask an open-ended question relating to the story. The questions should keep the person talking and should not be answerable with a single word such as yes or no.

If you ask a question that is answered with a single word, you replace the person at the front of the room, tell a story, and the activity begins again.

Clarifying questions help ensure that the meaning is transmitted fully between the sender and the receiver of the message. We ask clarifying questions when we're unsure what the person meant by their words, or when we don't understand the message for any reason. We may also ask clarifying questions to demonstrate that we're listening, and to show genuine curiosity rather than judgment. One approach to Clarifying Questions involves making a statement (to Demonstrate Understanding), then asking a Clarifying Question, then making another statement to Demonstrate Understanding. This makes a "sandwich."



Sharing Our Recovery Stories

In recovery from substance use disorders, sharing our stories is a commonly used method of inspiring hope and supporting others on their recovery journey. In the same way, Certified Peer Counselors share their stories of recovery to support and inspire others seeking recovery from behavioral health challenges.



Thinking Ethically

We tell only the parts of our story that apply in the moment. If we're telling a story for our own benefit, we may be crossing an ethical line.

Frame your story in a way the person can hear. What's the link between your story and what the person is experiencing? Will your story inspire, or are you telling "war stories"? Be careful not to share in a way that "one-ups" the peer, or implies that your experiences were harder.

Don't share stories until you're sure the person is ready to hear it. **Leave out traumatic details.**

Pay attention to the person when you're sharing your story to be sure they can hear your meaning and it's not upsetting them. If the person seems distracted or upset, stop telling your story and ask about the response. Be careful not to interrupt the person's story with your own. Make sure they're finished talking.

It's a good idea to ask if you can share your experience.

Are you telling a recovery story or an illness story? What's the difference?

<i>Recovery Story</i>	<i>Illness Story</i>
<ul style="list-style-type: none"> ▪ Describes how your experiences led to your recovery journey ▪ Is focused on hope, strengths, and more positive elements ▪ Describes barriers in the context of how they were overcome ▪ Shows hope that the peer can find recovery as well ▪ Always focused on hope and resilience ▪ May include spirituality 	<ul style="list-style-type: none"> ▪ Includes traumatic details and graphic images ▪ Entirely or largely about the hard parts, the struggle ▪ Laughs about drug or alcohol use, or suicidal thoughts ▪ Uses stigmatizing or clinical language ▪ Focuses on anger, hopelessness, etc. ▪ Never has time to get to the part of the story about hope and recovery

Why do we share our stories?

- To inspire hope
- To build or deepen a relationship with the person
- To show that people can and do recover; to talk back to stigma
- To advocate for change
- To educate others about recovery
- To share skills and strategies for recovery
- To bridge cultural gaps

How do we share our story?

Our stories are very personal, and they are also very powerful. We tell different parts of our story for different reasons. Before the opportunity to share our story arises, it's a good idea to consider what to include, how you will describe your journey.

Understand your own story. Think about major highlights (and lowlights) in your story. What things happened in your life that are likely to be shared with people you work with? What happened to open the door to hope? How did you get started on your recovery journey? What obstacles did you overcome on that journey, and what strengths did you use?

Share parts of your story that are relevant. If the person is talking about domestic violence and you want to share about experiencing homelessness, the person will likely tune out and may in fact think you're trying to "one-up" their experience. If you have had an experience similar to what the person is describing, say so: leave out the details.

Share only what's truly yours. If you don't share the experience the person is describing, don't try to fake it. Use a different partnering skill instead.

Share your story only when you feel comfortable. Your story belongs to you and it's not available on demand. You are not required to share every single detail or experience of your life. You are also not required to share your story "on demand" from anyone. Your story is personal, and you get to decide when and what to share.

Share your story only when it's intentional. Share your story to build the relationship with the person, to inspire hope, to demonstrate how to identify strengths, and to help break down stigma and other negative attitudes towards people who use services. Sometimes it's better to just listen than to share our story. Use your best judgment. Make sure you get to the hope!

Navigating Difficult Conversations

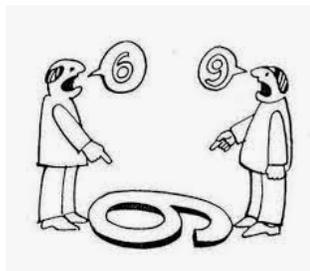
When our primary work is about relationships, we are bound to encounter conflict. We won't always get along with everyone, and people may not seem interested in what we have to offer. We may have different opinions or misunderstandings. What do we do then? We use our partnering skills to:

- **Reflect**
- **Relate**
- **Re-define**

Reflect: Listen to the person carefully, and reflect meaning, feeling and values back to the person. Clarify your understanding of the person's perspective, experience, concerns or positions.

Relate: Share a piece of your story, if you have one. Share a time when you had a similar emotional experience. Sharing our experience is a good way to deepen your connection with the person.

Re-define: Ask the person, what would be helpful right now? Move the focus from the conflict to something more proactive. Watch out for power struggles. It's better to avoid a conflict, instead focusing on what will work better.



Exercise: Consider for a few minutes what kinds of experiences you might encounter at work that make you nervous. For example, would you feel confident working with someone who hears voices? How about a person who self-injures? Read the questions below, then read the scenarios on the following two pages and discuss.

- What experiences are so new to me that I wouldn't know what to do?
- What kinds of situations raise my feelings of anxiousness and lower my confidence?
- What kind of information or support would I need to work in those situations?

What NOT to do in a conflict:

The following conversation is an example of what NOT to do:

(Have two volunteers read from the script)

John: Hi Norm, I'm a new CPC here and I wanted to meet you. I work with Julian as a Peer Bridger.

Norm: Hi John. As you know, I'm Julian's case manager. What do you think of Julian so far?

John: Well, you know my role is to support him in his goals and to help him get where he wants to go. He says he wants to finish his GED and go to college.

Norm: Oh yeah? (Laughs)

John: Yes, he's really interested in studying ecology. He said he was sort of an amateur naturalist, and he wants to learn more about it.

Norm: Okay, whatever. Yeah, I hear that from patients here in the hospital all the time. They have big grandiose ideas about what they want to do. But he's been hearing voices for a long time, and sometimes they really bother him. I don't think he can concentrate that much. It's better if we don't give him false hope, lead him on, you know?

John: Wait, are you saying there's no hope for Julian? He seems pretty smart to me, and I think he really wants to do this.

Norm: You know, I've been doing this for a long time. I never see people actually do something about all these big ideas. Just never happens. I don't want to see Julian get hurt because we encourage him to think he can actually do something.

John: Um, that doesn't sound very recovery oriented . . .

Discussion: What did it feel like to hear this?

Where did the conversation go wrong?

If this were really taking place, what do you think would happen for Julian?

What TO do in a conflict

This conversation is a more recovery-oriented approach to the same conversation.

(Have two volunteers read from the script)

John: Hi Norm, I'm a new CPC here and I wanted to meet you. I work with Julian as a Peer Bridger.

Norm: Hi John. As you know, I'm Julian's case manager. What do you think of Julian so far?

John: Well, you know my role is to support him in his goals and to help him get where he wants to go. He says he wants to finish his GED and go to college.

Norm: Oh yeah? (Laughs)

John: Yes, he's really interested in studying ecology. He said he was sort of an amateur naturalist, and he wants to learn more about it.

Norm: Okay, whatever. Yeah, I hear that from patients here in the hospital all the time. They have big grandiose ideas about what they want to do. But he's been hearing voices for a long time, and sometimes they really bother him. I don't think he can concentrate that much. It's better if we don't give him false hope, lead him on, you know?

John: Hmm . . . I guess I don't know a lot about what he's done in the past, whether he enjoyed school or what he means when he says he wants to study ecology. Maybe we could have that conversation with him.

Norm: Well, now that you mention it, I don't really know anything about his education or vocational interests. But trust me, people who hear voices like Julian hears voices, they just don't do well. You know?

John: Actually, I do know. There were many years when nobody thought I would ever work again, but here I am. I started working and it changed my life. I wonder if you and I could sit down with Julian and learn more about his background and his hopes for the future.

Norm: I'm willing to consider that.

Discussion: How did it feel this time?

What was different about the conversation? Would it have served Julian's needs better?

Summary: Peer Support Skills

The skills you learned in Recovery Coach Academy are very similar to those taught in the Certified Peer Counselor curriculum. The primary difference is in the kinds of challenges faced by the people with whom we are working, and in the setting in which we work. Some of the most important tools you will use as a peer support worker include:

- Listening actively
- Listening to understand
- Listening for meaning, feeling, values
- Demonstrating understanding
- Orienting
- Supporting voice and choice
- Asking open-ended questions
- Asking clarifying questions
- Sharing your recovery story

The exercises and the discussion in this module are designed to review what you know and prepare you to pass the exam. However, reading about skills is not the same as practicing those skills. The more you practice and use good communication and peer support skills, the easier it will become to apply them effectively.

Module 3: Working from a Trauma-Informed Perspective

Working from a trauma-informed perspective means recognizing that very often, emotional distress, substance use and other compulsive behaviors have their roots in trauma. With this recognition comes a better understanding of some behaviors, attitudes and challenges that arise among trauma survivors, which can sometimes be a barrier to recovery.

Understanding Trauma

*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, and that has lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

Trauma is a normal response to extreme events.

People can experience recovery from the effects of trauma.

~ SAMHSA 2014

First: Many of the people in this training will have experienced trauma in their lives. For some people, talking about trauma can awaken difficult memories, which may make it uncomfortable to be here. Consider now what you can do to take care of yourself throughout this module. What coping skills do you have handy that you might practice here?



What Causes Trauma?

Many kinds of experiences may be traumatic for an individual. An experience considered traumatic by one person might be experienced only as uncomfortable by another. These are some of the primary contributors to trauma.

Emotional, physical or sexual abuse	Domestic violence	Medical procedures
Historical violence against a specific group (as in slavery or genocide)	Experiencing or witnessing violent crime	Terrorism, war, combat
Abandonment or neglect (especially for small children)	Experiencing or witnessing accidents	Prolonged, repeated racism and poverty
Sexual assault	Institutional abuse	Natural disasters
Grief, losses	Cultural dislocation or sudden loss	What would you add?

How Common Is Trauma?

This is an important question for peer supporters. Here are some facts about trauma.

- ✓ 70% of adults in the U.S. have had some kind of traumatic experience at least once. That's over 223 million people. (SAMHSA/HRSA)
- ✓ 90% of people being served in the mental health system have been exposed to trauma. (Rosenberg 2010)
- ✓ Most people in mental health, substance use and compulsive gambling programs exposed to trauma have had multiple experiences of various types of traumatic stress. (Menser 2004 and 1997, Felitti 1998)
- ✓ 97% of homeless women with mental health diagnoses have experienced physical and sexual trauma in childhood and adulthood. (Goodman, et a. 1997)
- ✓ At least 75% of adolescents involved in the criminal court system have trauma histories.
- ✓ People who have challenges related to trauma often end up diagnosed as “mentally ill” when those challenges are likely rooted in traumatic life experiences. (National Council for Behavioral Health 2014)

Discussion

Do these figures surprise you? Do they sound about right?

Why do you think it's important that we recognize the impact of trauma?

The ACE Study

The Adverse Childhood Experience (ACE) study (Felitti & Anda, 2010) showed that, the more adverse childhood experiences a person had, the more likely they will be to develop problems with a wide variety of chronic physical illnesses, mental health challenges, substance use, compulsive gambling, and early death. The ACE study was conducted by Kaiser Permanente using approximately 17,000 people enrolled in weight loss programs. While trying to discover why some people had so much difficulty losing weight when others lost weight readily, they stumbled across the finding that certain types of adverse childhood experiences have traumatic effects that may cause long-lasting health problems. You can find the ACE study questions online at

<https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf>.

The ACE quiz includes 10 questions: five are about experiences that happened directly to the child, and the remaining five are about experiences in the family. The maximum score is 10: for each named experience you've had, no matter how many times it happened to you, you score one point. People with ACE scores of 4 or higher tend to have a markedly increased risk for a wide array of health challenges.



Think about it: All forms of abuse, neglect, abandonment, and natural events *can* be traumatizing, but not every event causes trauma. The earlier in life the trauma occurs, the more severe the long-term consequences may be. Deliberate and intentional violence is particularly damaging, especially when it's disguised with the “betrayal trauma” of “love” and “care.” (Blanch *et al* 2012)

What Does Trauma Look Like?

Humans are creative and resilient organisms. When we encounter trauma, we develop creative and resilient ways to survive those experiences. As we grow older, the survival strategies we used previously turn into problems all on their own. For example, a trauma survivor may turn to alcohol or drugs for help in the immediate aftermath, and then be unable to stop using. It's not uncommon for our creative and resilient strategies to look like a psychiatric symptom. Peer support workers who are aware of the impact of trauma will know to look out for this.



Thinking Ethically

Peer support workers should *never* attempt to diagnose or otherwise determine if someone has experienced trauma. That's outside the scope of our practice. However, we should be aware of some common trauma responses so we understand.

Trauma shows up in the behaviors or “symptoms” that are often relied on to make a diagnosis. Humans use all kinds of behavior—intentional or unconscious—as a way to communicate our feelings and get our needs met. Because trauma creates an unhealthy model of relationships, it also impacts feelings of self-worth, trust, and purpose. When we partner in our work with trauma survivors, we must be aware of this.

Is it a symptom or a coping strategy?

Feeling helpless	Feeling fearful	High-risk behaviors	Not showering	Being “manipulative”
Flashbacks and frequent nightmares	Sensitive to noise and touch	Extreme startle response	Feeling numb and disconnected	Feeling anger, anxiety and shame

Fight, Flight or Freeze: When humans sense danger, our bodies respond by pouring hormones, such as adrenaline, into our blood to prepare us for action. Blood is pumped to the muscles and *away* from the brain. Most of us have a preferred strategy: fight, flight, or freeze, but we may choose different strategies for different situations. Note that this is a *normal, healthy* process. However, that behavior removed from its trauma connection can be interpreted as defiance, manipulation, non-compliance, service-resistance, “denial,” laziness, or lack of motivation. If we interpret behavior in this way, we risk re-traumatizing people.

When Coping Stops Working: At some point, one of our coping “behaviors” may stop working. People struggling with behavioral health problems may find themselves engaging in activities that may have a short-term effect on coping, but do not have the desired effect on long-term recovery. Everybody deals with life challenges differently. People may not participate in activities with friends and family, lack a desire to be creative or exercise or may not feel well enough to leave the house for long periods of time. Others may self-medicate, spend money in excess, engage in risky behavior, threaten suicide or practice self-harm as a way to cope. Sometimes these behaviors are repeated over and over again. What happens then?

It’s important that we remember to think about trauma, especially when we find ourselves applying words like “denial,” “manipulation,” or “lazy.” Behavior is a coping strategy and a language. Behavior that confuses or disturbs us is a message—to ourselves. Sometimes a “behavior,” or what we have been doing, has been useful in the past in getting our needs met but isn’t working so well anymore. Our role is to find out more. Use curiosity instead of judgment to find out what the person really wants or needs, rather than simply shutting down behavior we find unappealing or uncomfortable.

Discussion

What happens when someone using services is labeled?

- Aggressive
- Passive
- Unmotivated
- In denial
- Uncooperative
- Not ready

So, what now? Remember, it’s our role to empower people, no matter their challenge. We focus on mutuality, support, choice, and sharing our story. We know from our own experience that not having a voice or a choice about our lives can be traumatizing and can stall our recovery journey.

Trauma-Informed Approaches to Peer Support

The shift from traditional care for people with behavioral health challenges means we move from wondering “what’s wrong with you?” to “what happened to you?” This isn’t a literal question we ask, any more than “what’s wrong with you?” is a literal question we ask. However, it begins to shift our thinking from looking at someone who’s broken to working with a person who has creatively overcome traumatic experiences and is learning to make healthier choices. In practice, we might ask someone to share their story with us. Because the impacts of trauma are so profound, peer support workers recognize that trauma is widespread, and that our systems of care need to consider this in all service design and environments. This includes things like:

- ★ Posted signs in the building
- ★ Glass barriers between participants and staff
- ★ “Staff-only” bathrooms
- ★ Keys and badges worn prominently (display of power)
- ★ Developing programs without input from participants
- ★ Declining to work with people with some kinds of challenges

All of these things send a message to trauma survivors: we have power and you don’t. Since trauma typically involves a loss of control, having choice and some degree of personal power are extremely important for recovery. We want to help shift thinking from an illness paradigm to one of a trauma-informed *environment, organization, system, and practice* that:

- ✧ **Realizes** the widespread impact of trauma,
- ✧ **Understands** potential paths for recovery,
- ✧ **Recognizes** the signs and symptoms of trauma in clients, families, staff and others,
- ✧ **Responds** by integrating knowledge about trauma into policies, procedures, and practices, and
- ✧ **Seeks** to actively **resist re-traumatization** (SAMHSA/HRSA)

Thinking Ethically

Peer support workers are not qualified to evaluate, diagnose, or determine whether someone has been impacted by trauma. *We are* expected to see that most of the people we work with have been touched by a traumatic event(s), and may have long-lasting effects from those events. Partner in a way that respects what the person may have gone through, responds to the humanity of the person, and works to avoid re-traumatization.



Six Principles guide a trauma-informed approach to environments, organizations, systems and practice. They are:

1. **Safety**
2. **Trustworthiness and Transparency**
3. **Peer Support**
4. **Collaboration and Mutuality**
5. **Empowerment, Voice and Choice**
6. **Cultural, Historical, and Gender Issues**

Exercise

Your instructor will help divide you into groups of approximately five people. Find your group and take this book with you. The instructor will give each group six index cards and some tape. One person in each group will number the index cards from one to six. Assign one person to be the “scribe” and write down one or two answers to each of the following questions from your discussion, in as large a print as you can on one side only of each card. Note that the questions are related to the numbered principles above. The instructor will post flip-chart paper with each principle number labeled at the top. When your group completes the exercise, tape the card to the page with the matching number. Walk around and read all the cards. Discuss.

Questions:

1. What does **safety** mean in trauma-informed peer support?
2. How can we be **trustworthy and transparent**?
3. How can we offer **peer support** and our own recovery stories to inspire hope?
4. How can we work in **collaboration and mutuality**?
5. How can we support **empowerment, voice and choice**?
6. How can we keep **cultural, historical and gender issues** in mind?

Sharing Our Story: Trauma-Informed



Do we treat everyone like a trauma survivor? It's safer to assume that everyone we encounter has survived some traumatic experience. However, it's not our job to diagnose or evaluate for trauma. Seeing people through a trauma-informed lens, however, will ensure that we use curiosity instead of judgment to learn more.

Think about how you might share your recovery story to support recovery and resilience. Make sure your story focuses on hope. Check your motives. Why am I talking? What am I thinking? If your intention is to bring hope to a person who has none, you're on the right track.

Discussion

What do you remember about how to share your recovery story? When should you share it? How do you pick what part of your story to share? And how do we share recovery stories in a trauma-informed manner?



Thinking Ethically

When you share your story, avoid any traumatic details. Too many details can be traumatizing to the listener, making it harder for them to trust us.

Avoid encouraging the person to share details of their trauma. That's outside our scope of practice.

Keep a clear ethical line between sharing experiences and providing counseling. The peer support role is listening and support. It may be challenging to stay in the peer role when discussing trauma. Do it anyway.

Trauma-Informed Peer Support

The following skills will help you practice from a trauma-informed perspective.

- **Express confidence and hope** that we can find healing and recovery after trauma.
- **Form authentic, supportive relationships.** Your peer support relationship is the anchor that brings hope to people without any, understands their stories, lifts up their voices, and supports them to regain control of their lives. People who have experienced trauma often find it hard to trust others, and their relationship models may not be healthy. The peer support relationship is a safe space in which people seeking recovery can learn how to trust and discover what healthy relationships feel like. Ask yourself:
 - How can I show unconditional regard and respect?
 - How do I convey that this relationship is mutual?
 - How do I support the person in expressing needs, wants, feelings, strengths?
 - How do I collaborate with the person, inviting them into partnership?
 - How well do I accept and understand big feelings?
 - How can I see each person's experience as unique, that each one finds meaning in their own way?
 - How can I be sure I'm not making assumptions about another person's trauma experience?
 - How do I encourage people to use crisis as an opportunity for learning and growth?
 - How well do I use the language of common experience, instead of clinical, symptom and diagnostic language?
- **Support a trauma-informed environment.** Encourage your employer to be trauma-informed. Consider these steps:
 - Avoid having separate staff bathrooms
 - If you must wear a name badge, make it inconspicuous
 - Put keys in a pocket so they're not jingling
 - Encourage all staff to understand the effects of trauma; encourage your employer to learn more.

Self-Care: Put On Your Own Oxygen Mask First!

Self-care is a crucial skill for peer support workers, and for anyone who works in a behavioral health setting. The work itself can be stressful, and interacting with trauma survivors can bring on secondary or vicarious trauma in workers. Take a few minutes to consider what self-care you will undertake, how you will plan to cope with sudden stressors, and who you might be able to talk to if you have intense feelings, doubts, or other questions.

Thinking Ethically



You are responsible for your own wellness.

Be careful of your expectations: if you expect that everyone is going to get well because of your great work, that's a set-up for burn-out. Do your best work and remember that each person must do their own recovery work.

Ask other peer support workers about self-care if you need some ideas.

We are ethically bound to work with anyone who is assigned to work with us, whether we like them or not, and even if we find it challenging. It's important that peer support workers have done their own trauma work before embarking on the peer support journey.



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✱ **Protect your empathy.** Anyone can find themselves in "compassion fatigue." We get tired, overwhelmed, and anxious. It's crucial that we hold onto our empathy, as the tool we have to support others. You may need to also:

- ✱ **Know the impact** of trauma on your own life.
- ✱ **Be aware** of any experiences, sounds, sights, smells and environments that may be challenging for you because of past experiences
- ✱ **Know your limits:** we all have them. Think ahead, create and employ personal strategies to ensure you get and keep a life, have a strong support network of friends and/or family, and make sure you have other interests in your life aside from work and recovery.

Skill Check 5: Making Agencies Trauma-Informed



Your instructor will separate you into small groups of four or five people. Gather your group near flip-chart paper with your group number on it, with a set of markers. You have ten minutes to think of and create a poster that can be used to convince your employer to become more trauma-informed. Use any portions of the material in this module to inform your design. Be as creative as you can be. At the end of your ten minutes, your instructor will invite each group to present their poster to the rest of the class.

How will you use these ideas to encourage your co-workers to become more trauma-informed? To help your agency become more trauma-informed?

Summary: Working in a Trauma-Informed Environment

“Recovery unfolds in three stages.

The central task of the first stage is the establishment of safety.

The central task of the second state is remembrance and mourning.

The central task of the third stage is reconnection with ordinary life.

~Judith Lewis Herman, Trauma and Recovery

In this module, we learned how trauma is defined, what it could look like in people with whom we are working, how we might recognize underlying trauma, and how to focus on recovery and resiliency by using our stories and our partnering skills. We learned how some of the behaviors that we struggle with may be not symptoms, but creative responses to trauma that have outlived their usefulness. We learned the importance of self-care in this work, and finally, we developed some creative ways to educate others including our co-workers about trauma. Continue to think about what trauma looks like, and how you will develop your self-care routine as you continue your recovery journey.

Module 4: Ethics and Boundaries in Peer Support

Every person working in healthcare, including in behavioral healthcare, is guided by a set of ethical standards and boundary guidelines. Most clinicians find their boundary guidelines included in their profession’s statements of ethics. However, for peer support workers, our boundaries are somewhat different. They require the use of good judgment, a willingness to check in with a supervisor, and an understanding that *all* decisions should be made with the best interest of the person using services in mind.

Discussion

What do you think is the difference between **ethics** and **boundaries**?

Ethics are designed to strengthen your relationships with peers and to protect you as an employee. If you know and act in accordance with your agency’s ethical standards, your work will be more effective and less likely to result in challenges for you. Think of ethical standards as “carved in stone:” there is no “wiggle room,” no gray area. Not following the ethical standards is serious and can result in loss of your job or action by the Department of Health.



Boundaries are relational and can be difficult to navigate for peer support workers. They are not always black and white. Boundaries are not only what separate us from other people, they are also the choices we make in how we are going to interact with people. Some boundaries are for the protection of the people you work with, and some boundaries will be for your own protection. You have a right to set some personal boundaries, such as how much of your story you’re willing to tell or whether you will discuss your medication. Whatever you learn in this module, be sure you know your agency’s standards for ethics and boundaries. You will be held accountable to those standards in your work.

What do you remember about ethics and boundaries from the online course? _____

Exercise

Your instructor has posted pages on the wall around the room. Each page describes an action. You will be given dot stickers in green, yellow and red. Read each page and decide: Is this action always ethical? Is there a question about this action? Do I need to consult my supervisor? Does it depend on context or some other condition to be ethical? Is this action always unethical? Use the dots like a stoplight: green for always, yellow for maybe/sometimes, red for never. The word “peer” indicates person using services of any kind.

Giving a small gift	Accepting a gift worth under \$10	Giving a hug
Telling a peer “you’re one of my favorite people”	Invitation to come to your home for holiday dinner	Telling a peer they look attractive
Giving out your personal cell phone number	Borrowing money or accepting a loan from a peer	Sexual relationship with family member of a peer
Using drug culture slang	Telling a child their parents are too strict	Agreeing to sponsor someone you work with
Asking youth in services to babysit your children	Engaging in online chat room flirting with a peer	Hiring the peer to do work at your home
Going to church with a peer	Telling a peer about the difficulties in your divorce and how upset you are	Describing your culture and identity to a peer
Convincing a peer why they should try medication-assisted treatment	Telling a youth they should go to college	Convincing a peer they should remain sober
Not documenting something a peer asks you not to	“Friending” a peer on Facebook	Discussing a peer with another CPC not on the peer’s team
Reading an electronic health record of someone you’re not working with directly	Educating a peer about their diagnosis	Sharing how spirituality is important to you in your recovery
Describing how your spouse was able to stop gambling	Describing how it feels to be in recovery	Helping a peer plan how to talk to the team about not taking medication

Some Ethical Standards

You may remember some of this from the online course. Ethical standards include:

1. **Confidentiality** is important for trust, and to abide by the HIPAA standards (see Appendix 3). You may not release written information about a person with whom you work without a written Release of Information (ROI). You may not discuss people with whom you're working with anyone not employed by the agency where you work, and not directly on the person's team, without an up-to-date ROI. If someone presents you with an ROI for written data, take it to your medical records department. If you are given an ROI for verbal information, speak with your supervisor first.
2. **Relationships** are always and only for the benefit of the person using services. Peer supporters may not engage in *any* kind of sexual relationship, including innuendo about having more of a relationship when services end. This includes flirting, showing photos or videos about sex, inappropriate touching, talk in chat rooms, dating and sexual intimacy. We have to consider any type of intimate relationship, even if it is not physical as being inappropriate in a professional peer role. Family members of people using services are also off limits. We begin this work to support others in their recovery journey, not to find our soul mate or best friend.
3. **Scope of Practice**, otherwise known as "stay in your lane," defines the kinds of activities for which you are trained and otherwise qualified. Peer support workers are **not qualified to diagnose, explain diagnoses, recommend or question medications, or attempt therapy**. We should not do anything for which we cannot show adequate training and the required credential. Peer work addresses the person, not the problem. ("Nice to see you" versus "How's your bipolar?")
4. Peer support workers engage only in activities included in a person's treatment plan and **that support the peer's recovery goals**. If in doubt, always check with your supervisor!

Remember that the Recovery Coach role and the Certified Peer Counselor role are both different than the role of a sponsor. In peer support work, we know that each person's recovery journey is unique and what worked for us may not work for everybody. While we may have strong feelings about program(s) that helped us on our own recovery journey, the people to whom we provide peer support may feel more comfortable in a different program. We support their choices, even if they seem unreasonable to us.

Dual Relationships are what happens when someone already in your life comes to your organization for services, and you are asked to work with that person. This might mean a friend, neighbor, your child's teacher, the person who cuts your hair or mows your lawn, etc. In larger communities, you should avoid dual relationships by informing your supervisor about pre-existing roles. Smaller, rural communities face this challenge often. If you are the only peer support provider, you will need to work with your supervisor about structuring that relationship to ensure that you're in the peer support role at work, and you leave that behind when you're not at work. Be honest and transparent about these relationships. It's for your protection.

Exercise: Working Through Ethical Dilemmas

Your instructor will divide you into small groups and assign one of the scenarios described below. In your group, read the scenario and **answer these questions**:

- **Are there ethical or boundary dilemmas here?**
 - **If so, what are they?**
 - **What should the peer support worker do?**
1. Shanna has been working as a peer support worker in an agency that provides mental health, substance use, problem gambling and primary health care services. She thinks her job is the best thing ever. She attends recovery support groups in the community to support her own wellness. One day at work, she happened to see the name of a person who also attends her recovery support group. The person has an appointment with one of the prescribers for medication-assisted treatment. Shanna thinks, “I wonder if this person’s sponsor knows they’re using medication. They’d probably be angry. Maybe I should tell their sponsor.”
 2. Darnell provides peer support to Susan, a 19-year-old young woman who’s been using services for under a year. Every time Susan has an appointment with Darnell, she brings him homemade food: cookies, brownies, cakes, even containers of meat loaf and stew. Darnell is afraid that Susan is flirting with him and he’s starting to dread his appointments with Susan.
 3. Juana is working in peer support and she’s also in college, working toward a bachelor’s degree in social work. She has started sitting down with the Diagnostic & Statistical Manual every time she meets with someone, so she can read out loud the criteria for their diagnosis and explain it to them.
 4. Brett is a Youth Partner to Gene, a 15-year-old young man who just came out as gay to Brett. He’s asked Brett not to write that in his notes because he hasn’t come out to his parents.

An **ethical dilemma** exists when two or more ethical standards may conflict and it’s not clear which is most important. A choice is always involved in ethical dilemmas, deciding which standard is most important and how to resolve the conflicting standard. Resolving an ethical dilemma may require that you **discuss it with your supervisor**.

Peer support work requires us to use our best judgment at all times. Sometimes our best judgment is not enough. Supervisors appreciate when peer support workers ask them about ethical and boundary challenges, so don’t hesitate.

Skill Check 6: Identifying Ethical Dilemmas



The goal of this skill check is to identify an ethical dilemma or boundary issue. Following the instructions, you will find numbered scenarios. Your instructor will break you into groups and assign you a scenario, by number. With your group, read through your assigned scenario and decide how to answer the following questions. Make notes and select someone to report out your results to the group. Remember: in skill checks, all group participants must be seen to participate in the group activity.

- ❖ Is there an ethical dilemma in your assigned scenario? Keep in mind the ethical standards discussed earlier in this module, the online course, and the guidelines discussed earlier.
- ❖ Is there is an ethical dilemma, what is it?
- ❖ What should the peer support worker do to respond in an ethical manner?
- ❖ Who could the peer support worker ask for support and/or guidance, if anyone?
- ❖ If an ethical dilemma is identified in your scenario, how could you avoid this kind of situation in your work?
- ❖ What would you say to the peer or supervisor in the scenario? Be specific.

Scenarios

1. Eman, a peer support worker, is facilitating a group on the Eight Dimensions of Wellness. This week they've been discussing spirituality. One of the group's participants says to Eman, "You're a Muslim, aren't you? You wear that scarf all the time. Can you tell us about Islam? I've been wondering about that." Eman practices Islam, but she worries about discussing her religion in the context of this group. **Would it violate ethical standards for her to do so?**
2. Steven provides peer support to Maria, who struggles with compulsive gambling. Steven has no experience with gambling at all and he is having a hard time connecting with Maria. He tells her a story about his use of heroin and a serious auto accident in an attempt to connect. **Will this violate any ethical standards?**

3. Diana is a Recovery Coach who uses 12-Step meetings for personal recovery support. Diana has heard over and over again in meetings that taking medication means one is not completely sober. Diana is supporting Sheila, who has been struggling for about six months to stop using street drugs. Sheila asks Diana to attend a meeting with her prescriber because Sheila wants to ask for medication-assisted treatment. Diana thinks about calling Sheila's sponsor to "straighten her out." **Does this violate any ethics?**
4. Jeff is a CPC who has been working with Anthony to support Anthony's recovery from addiction and mental health challenges. Anthony tells Jeff that she is a transgender woman, she prefers to be called Toni, and her mental health challenges are made worse by her provider team's refusal to call her by her chosen name and pronoun. Jeff is uncomfortable because he's never met a transgender person. He isn't sure if his religious beliefs will allow him to support Toni. **Does this violate any ethics?**
5. Lucy is 21 years old and is working through services for addiction. Lucy's peer support worker, Tom, listens to Lucy at their weekly meetings, and Tom is starting to think that Lucy may have more than one personality. Tom is kind of excited but also very nervous, having never met someone with more than one personality. Tom begins asking very detailed questions about trauma and Lucy's "alters." **Does this violate any ethics?**
6. Camille has been using services at a behavioral health agency for the last two years. Today Camille is being discharged from services, having come a long way in their personal recovery journey. Camille comes to see Stephen, who has provided peer support for Camille, and brings along a handmade work of art as a gift for Stephen. Because Camille is Maori, Stephen knows that Camille would be greatly offended if he doesn't accept the gift, but his agency has a policy against accepting any gifts. **Does this violate any ethics? How might you respond?**
7. Teresa has worked with a Recovery Coach, Noah, while Teresa struggled to overcome compulsive gambling. While in services for compulsive gambling, Teresa also worked with a therapist and a prescriber to manage a mental health challenge, which continues to disturb her. Teresa announces to Noah one day, "I'm done taking these stupid pills. They just make me sleepy. I'm flushing them all down the toilet. And I don't want you to tell my stupid doctor, they don't listen to me at all! You said everything I tell you is confidential unless I'm going to hurt someone, didn't you?" **Should Noah leave this out of the medical record? If Noah does leave it out, does that violate any ethics? Will sharing the information violate any ethics? What might you do about this?**

Mandated Reporter Guidelines

Peer support workers become Mandated Reporters for most situations the minute they become employed. Being a Mandated Reporter means that you **MUST** report to the authorities should you learn about or suspect any of the following situations. Reporting is, as the title implies, *not optional*. Once you are employed in a behavioral health agency, you have this obligation even in your personal life; when you are at work, at home, out in the community—all the time. Your obligation as a mandatory reporter ends only when you cease to work in this field. Here are the guidelines.

Abuse or Neglect of a Child: Any known or suspected abuse of a child must be reported. Keep in mind that you may see evidence of abuse or neglect at work, at home, or out in the community. You must report *even if that means reporting a family member*. Child Protective Services will follow up on your report by investigating and offering services to the family. You may consult your supervisor when in doubt. To report suspected abuse or neglect of a child, call 1-866-END-HARM. In an emergency, call 911.

Abuse or Neglect of a Vulnerable Adult: A “vulnerable adult” is more than just an adult with a disability. To qualify as a vulnerable adult, a person must be unable to leave the situation: for example, when the person abusing or neglecting an adult is a family member living in the home, or a paid caretaker, or a fiscal agent who keeps the person’s money. If the adult is unable physically, cognitively, or financially to leave the situation, they are considered vulnerable. To report suspected abuse or neglect of a vulnerable adult, call 1-866-END-HARM.

Duty to Warn, or Intent to Harm: The definition for this has changed in recent years. The first requirement to warn when a person threatens to harm another was for a specific threat against an identifiable individual, when the threatening person has the means to carry out that threat. Now we are required to report *any* threat, including vague threats to “kill someone” or “hurt someone.” If you believe the threat to harm is imminent, call 911 first and then attempt to notify any identifiable intended victim. If the harm is not imminent, you may choose to speak to your supervisor and then decide how to report.

Reporting others with a Department of Health Credential: Once you have your Agency Affiliated Counselor certificate from the Department of Health, you are obligated to report any other person holding a similar credential, if you believe they are practicing unethically or they are incompetent to practice (dementia, drug or alcohol use, etc.). Again, the Department of Health will conduct an investigation. You can report online at the Department of Health website: www.doh.wa.gov, Licenses, Permits and Certificates. Click on Health Professions Complaint Process.

Summary: Ethics and Boundaries in Peer Support

In this module, you learned more about ethical standards and boundaries. Remember that ethical standards are non-negotiable, while boundaries **may be** (but aren't always) more fluid. Be sure you understand what's taught in this course and learn what your employer requires as well. Decisions about boundary issues should always be made considering the best interests of the person using services, and often by consulting a supervisor.

Ethical dilemmas occur on a regular basis, and the nature of these dilemmas may differ depending on whether you live in a city or a more rural area. Supervisors are your best source of support for boundary decisions.

In the rest of this training, as in previous modules, we will consider ethics and boundaries as an important feature of our work. Consulting a supervisor is an excellent way to build that relationship. Keep in mind that staying within our scope of practice (staying in our lane) is another important consideration, both in this class and in our work.



Module 5: Modeling Self Advocacy

Module Three covered trauma-informed approaches to peer support. Modules One and Two outlined the reasons why we support voice and choice: it's all about **empowerment**. This concept is as important to our role in general as it is crucial for trauma survivors.

The mental health system and, to some extent, the substance use system, is structured so that the provider holds most of the power. Providers often set goals for participants and the people using services are asked to adapt to the system. Participants who don't enjoy a particular program or group are told they're "not motivated" instead of examining whether the program is a good fit for that individual.

People who simply accept what they're given in a system may get along well with those providers, and they may experience some level of stability or even recovery. However, for individuals to experience full wellness and recovery, they must be able to speak up for themselves, to ask for what they need in a way that supports getting their needs met.

Peer supporters are in the perfect position to support people in learning self-advocacy skills. We have overcome our own struggles with making our voices heard, and we understand those skills.

Discussion

- When have you had to advocate for yourself?
- How were you able to get your needs met?
- What steps did you take?
- Who helped you?



Supporting advocacy means we support people using services to find their voice in a way that helps them get their needs met, while enhancing confidence and self-esteem. Many of us have some skills for getting our needs met; those are the skills we learned on the streets, or from our voices, or just from desperation to get what we needed. If we have only one tool, we'll use that tool even if it doesn't meet our needs. Supporting self-advocacy is a process of teaching people that they do have power, that their voice counts, and then teaching specific skills to support those efforts. In other words, giving them more tools.

What does this look like in practice?

- * Our own recovery story might be helpful here, if we have a story about advocating to get our needs met
- * Avoid doing things “for” people, instead support them in learning how to do those things themselves (such as calling about housing, talking to prescribers, etc.).
- * Teach a specific process for self-advocacy
- * Involve the local **Ombudsman** when appropriate
- * Model community advocacy

Using Your Recovery Story

Module Two included a discussion of how to share your recovery story. Self-advocacy is one area in which our story of hope can be important to others. Advocacy can be a lonely endeavor and people just starting to advocate for themselves may feel that their advocacy is unimportant. We can support people in developing these skills by asking them to watch how we ask for things, encouraging them to write notes about what they want to say, being present when the person begins self-advocacy, and supporting evaluation of advocacy efforts.

*Be the change you wish to see in the world.
--Mahatma Gandhi*

Exercise

This is a pair’s exercise, in which you will decide how to use part of your recovery story to inspire another. Read the scenario and then consider for a few minutes what you might share. Then meet with a partner and discuss why you chose that part of your story. Ask your partner if the story was effective, and why or why not.

Recovery Story: Jordan is in an eating disorder treatment center after having been through treatment several times before without achieving recovery. Jordan is 20 years old, and worried that the future will be defined by this challenge. They tell you, “That’s not in my life plan. I want a job, a family, a home, you know, a life!” Important people in their life have told Jordan to slow down and keep the focus only on the eating disorder. What part of your own story will you use to inspire hope for self-advocacy?

Getting There: Steps to Effective Advocacy

Advocacy can seem like an advanced, impossible skill for someone who isn't used to being heard. But advocacy is a learned skill with specific tasks to be completed. We can teach these skills.

1. **Describe the need.** Be careful to define it as a need and not as a solution. Make a clear “need” statement.
2. **Research.** How did this need come about? When did the problem begin? Who have you talked to about it? What did they say or do? Write down all this information including eligibility issues, available resources, and what help from the peer support worker would look like.
3. **Identify helpers, or gatekeepers.** Who can help us get this need met? Start with the person closest to the problem. They may not have the final decision, but they can help you (or hinder you!) in getting needs met. Be polite.
4. **Plan your approach.** Once you've identified the need, see if there are some possible solutions in mind. Write out a plan starting with the need, its history, and possible solutions. Make a copy for the helper/gatekeeper. Decide whether you plan to send a letter or email, make a phone call, or visit a gatekeeper in person.
5. **Rehearse the plan.** A participant may be more willing to attempt self-advocacy if they can practice with someone first. Practice is helpful, especially practice in which the gatekeeper doesn't meet the demand right away. How will you respond if they say no? (The suggested answer is, “why not?”) Practice the approach in advance. Participants are more likely to be able to handle strong emotions if they're prepared for possible rejection and have rehearsed their responses.
6. **Evaluate your success.** Did you get your need met? Did you solve a problem? Examine the approach you used, including how you chose the gatekeeper, how you presented your need, and how you responded to barriers. When we are able to review a strategy to improve on its future successes, we are more likely to feel confident trying that strategy again.



Thinking Ethically

Self-advocacy means we speak for ourselves; we don't need someone else to do it for us. Before you start self-advocacy with a participant, be sure you know how much they expect from you. Be careful that you're letting the person take the lead. Don't speak for the person unless you have agreed in advance and you both know who will say what. Find out if the person wants you to model the behavior, rehearse with them, or just help them learn the process.

Supporting Self-Advocacy

Start by reviewing the steps for advocacy. Be sure the participant understands each step, and how and when to use each one. We can also do the following to support self-advocacy:

- ✓ **Model self-advocacy.** In your own life, including in your peer support work, speak up for what matters to you. Self-advocacy is a healthy relationship skill that many people using services need to learn. Respecting others' voices is equally important.
- ✓ **Understand your rights.** It's easy to claim, "I have a right to this!", but are you sure? Learn how to find out about your rights as a person using services, including the rights given to people using Medicaid. Make sure participants know how to find out their rights, and how to use a citation of rights in self-advocacy. Don't forget that rights come with responsibilities, too, and work to help participants understand that as well.
- ✓ **Start with strengths.** Advocacy can seem intimidating. Remind participants of strengths they possess that will support them in getting their needs met. Making change requires resources, both internal and external.
- ✓ **Support self-advocacy efforts** by people using services. Listen to their concerns. Help them develop an advocacy plan. Rehearse with them. Point them toward resources. Model respect for other viewpoints. Encourage others.



Community Advocacy: Systems are typically structured because mental health professionals made decisions about what services to offer. This includes schools that train clinicians. If we hope to change what kind of services are offered, we must engage in community advocacy, working to change the system. Many peer support workers find that community advocacy (including legislative advocacy) is an important part of their personal recovery. Note that, if you work in a nonprofit agency or with people covered by Medicaid, it is **not legal to discuss politics, or to let participants know if we support or oppose any candidate for any office.** We can and should focus on initiatives and other legislation that will support or harm services, and we can involve participants in this type of community advocacy. This is often called being a **change agent.** Peer support workers are change agents just by being present in a workforce. We demonstrate that recovery is possible. It's part of our role to advocate for other people who use services, to strive to make available the best possible variety of services and supports so that individuals have genuine choices.

Skill Check 7: Supporting Self-Advocacy



In this skill check, work with a partner. Try to find someone you haven't worked with yet. You will take turns being the **Speaker** and the **Listener**. You will switch roles when the instructor tells you to do so. First decide which role each of you will start with.

When you are the **Speaker**, think about an unmet need in your life currently. You will be discussing this with the Listener. It doesn't have to be a major challenge, just something you need.

When you are the **Listener**, your *goal* is to work through as many of the steps of self-advocacy as you can in 5-10 minutes:

- Define the need
- Outline the history
- Identify a helper or gatekeeper
- Make a plan

As the **Listener**, use your partnering skills and remember to start with strengths.

Because this is a skill check, your instructor will come around and listen in. They are listening for the skills you use, so focus on demonstrating your understanding of self-advocacy skills.

Hearing

- Accidental
- Involuntary
- Effortless

Listening

- Focused
- Voluntary
- Intentional

Summary: Self-Advocacy Skills

In this module, you learned some basic skills that help people get their needs met. Self-advocacy is a crucial skill for recovery: until we acquire the skills to help us get our needs met and our voice heard, we will not be fully invested in our own recovery. Self-advocacy skills teach empowerment, a core value of recovery work. Self-advocacy is fundamentally about participating fully in one's life. These skills range from making your own voice heard with regard to your treatment choices, all the way to community advocacy and system change.

Start your own self-advocacy journey here:

- Learn about your rights—and your responsibilities in relation to those rights
- Make your voice heard in your own life, in your own recovery choices
- Model self-advocacy in your life and your work
- Teach advocacy skills to participants
- Encourage self-advocacy as a step toward empowerment and recovery
- Model and encourage community advocacy



Module 6: Service Planning, Goal Setting & Documentation

In Washington State, peer support was developed as a specifically defined position within the Medicaid system. As Medicaid coverage is expanded to include people with substance use challenges.

Medicaid requires specific things from everyone whose funding comes from Medicaid. Many peers see these requirements as stifling their ability to work creatively with people, doing whatever will support that person on their recovery journey. Medicaid rules are specific, but they don't have to rule out what you think will help someone. If you can fit your plan into the right format, you can make it work.

This training will help you learn some of the basic skills you will need to work in a Medicaid Behavioral Health system. Your employer's requirements may vary to meet their specific needs, and based on each individual's specific challenges.

Medicaid requires documentation on how a **person is making concrete steps toward a measurable goal**. This means that we need to show evidence of working toward their goal. It also means that we must work with each individual to **make a plan, set goals, and demonstrate progress in progress notes**. To prepare you for work in this system, this module will focus on:

1. Planning for services
2. Goal-setting, and
3. Documenting services

You learned in Module One that Certified Peer Counselors must be clinically supervised by a Mental Health Professional or a Substance Use Disorder Professional (SUDP); depending on the service setting. Developing a productive relationship with your supervisor is a crucial skill for this work, no matter who that person will be. You will learn more about how to develop this important relationship in the next module.

Overview of the Behavioral Health System

The layers of funding and administration have changed recently. Most funding originates at the federal level, with the Centers for Medicare and Medicaid Services (CMS). Funding then enters the state at the Health Care Authority (HCA), which administers Medicaid funding in Washington. The HCA contracts with Managed Care Organizations (MCOs) and Behavioral Health Administrative Service Organizations (BHASOs). These entities then contract with local service providers to deliver direct services to individuals and families.

The funding stream looks like this:

Federal	Centers for Medicare and Medicaid Services (CMS)
State	Health Care Authority (HCA)
Regional	MCO, BHASO
Local	Provider agencies



Under the Medicaid State Plans, funds are provided to deliver services to individuals who meet certain standards, including a qualifying diagnosis and evidence of impairment in function and relationships. Therefore, Medicaid-level services (which includes peer support) are generally available only after an individual has undergone an intake assessment to determine whether the person meets those standards. Other services, such as those not covered by Medicaid or for individuals not eligible for Medicaid, may be funded by **Mental**

Health Block Grant or **Substance Abuse Block Grant** funds from the federal government. **Crisis services** are available to any person, at any time or place, with no need to qualify, through state funds. Any person may access crisis services without worrying about financial eligibility.

Planning for Services

In the mental health and SUD systems, service planning is sometimes called treatment planning. The Medicaid-required document is referenced in the Washington Administrative Code (WAC) as an Individualized Service Plan, or ISP. Your employer may call it something different depending on what kind of services are provided. Whatever the services or challenges, Medicaid requires planning that ensures services are focused on solving the problems for which the person is seeking treatment. Typically, service planning is done after an initial assessment by a qualified professional. Service plans should be revised and updated at least every 180 days. Individualized Service Plans are living, breathing documents that should be revisited whenever the individual chooses.

While Certified Peer Counselors are qualified under the rules to develop service plans, many agencies assign that task to other members of a team. Your peer support role may be focused on helping the person take the lead in planning. All plans should be person-centered, positioning the person using services as the leader. The WACs define service planning as a team process, in which the person using services takes the lead. Other persons providing services should take part in this meeting, along with any other person identified by the participant.

Entering a service planning meeting can be intimidating if an individual is new to this process. They may feel that they are surrounded by “experts” who are supposed to “fix” their problem. This passive approach is often assisted by the team members who fail to engage the participant. If you begin working with an individual prior to planning, or before updating the plan, your role may be in helping to prepare the individual so they can take an active role and lead the process.

Preparing for Service Planning

As a peer support worker, you can use your partnering skills to help an individual prepare for service planning.

You can:

- Help the person understand the process, the types of questions that will be asked, and what part they will play
- Be present at the meeting if the person wants you there
- Offer support and encouragement
- Support the person in defining specific goals and ensuring that their voice will be heard in the planning process



- Offer perspective, keep hope in the forefront
- Teach self-advocacy skills and rehearse if the person desires
- Share your recovery story, when pertinent
- Help make goals SMART
- Model recovery and recovery values throughout the process

Exercise: This exercise is about service planning. Your instructor will help you divide into groups of 3-5 people. One of the scenarios will be assigned to your group. Read your assigned scenario. Then consider and respond to the questions below. Choose a group member to report out your findings.

1. You are a youth partner for Robyn, a 15-year-old who has just recently been diagnosed with an eating disorder. She has told you that she does not want to be a part of the team meeting that is happening in one week. You know she wants to learn to drive and try out a volunteer job for the first time, but she says, “They’re just going to make their own plans anyway. And my mom, she doesn’t listen to me. Why bother?”
2. You provide peer support for Garrett, a 23-year-old man who is expressing dissatisfaction with taking medications and is not sure he is willing to continue with medication-assisted treatment. He has an appointment with his prescriber in two weeks. He says, “This is too hard, I can stay sober without any meds.”
3. You are a peer counselor for Amy, a woman who lives with co-occurring disorders. Her goal has been sobriety and medication treatment for mental health concerns. She has decided that she doesn’t want to be completely sober, but that she would like to drink in moderation.

Answer these questions about your scenario:

- How will you provide support and encouragement to this person?
- How will you **orient** to the planning process, assist the person in **identifying benefits**, and how to **prepare** for the meeting?
- How will you support the family, if appropriate?
- How can you offer perspective and hope for the meeting?



Goal-Setting

Medicaid services are always focused on the person's goals for recovery. Whether you write the service plan or you support the participant in preparing for a planning meeting, be prepared to develop goals that are SMART. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Time-delineated.

Why is SMART important? We may already know that vague, fuzzy goals are hard to meet, and if they are hard to go after, we may tend to forget about them. When we support people to write goals that meet the following SMART criteria, it may help the peer to see concrete steps that can be taken toward that goal. It may be easier for the individual to see progress and to know when a goal has been achieved and they are ready to move on.

Specific: Who, what where, and when, sometimes how, and maybe even why

Measurable: The more specific an objective is, the more measurable it is—but be sure to consider how it will be measured

Achievable: Can the objective be attained in the three to six-month life of the plan? Can it be achieved in the way and on the time lines chosen by the peer?

Reasonable: Does the person and/or their family think this goal is reasonable?

Time-Delineated: By what date does the person intend to accomplish this goal? When will the person start taking these steps toward the goal?

Example: “I will sign up for a trial college class at the local community college at the next quarter enrollment. I will evaluate my success in this class at the end of the quarter and decide whether to set a goal for more classes.”

Note the use of the active verb “will.” Using an active verb instead of words such as “wants to” or “hopes to” is a semantic trick that encourages action.

Documenting Your Work

Medicaid funding requires that work be documented in a way that demonstrates your efforts to resolve the problem. This is true whether you work with individuals who have mental health challenges, compulsive behaviors, eating disorders, or general health challenges. To accomplish this, the medical record must demonstrate that:

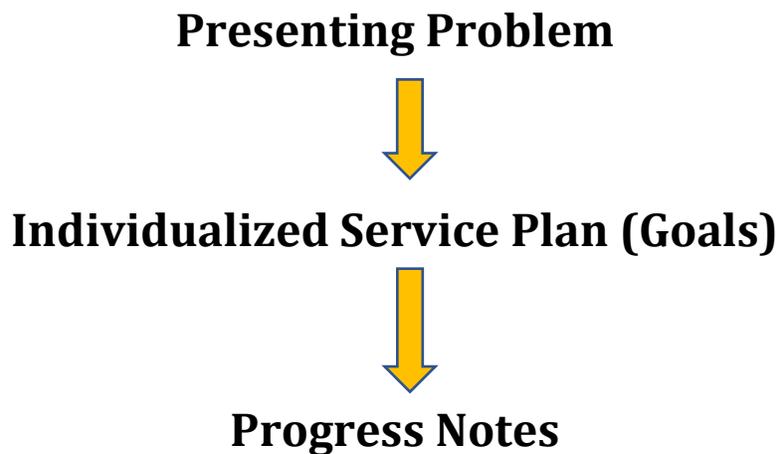
- The person has a challenge that can benefit from your services (the “presenting problem”)
- The person, along with the team, has set goals to resolve the problem, with support from the team
- Every service after the plan is developed must reflect a connection to goals outlined in the plan

Documentation of services to the individual has the same protections as any medical record: confidentiality is paramount. Medical records are legal documents, they may not be altered to conceal previous notes. Medical records have a specific structure that follows the individual's journey through services. It begins with an intake assessment.

The **Intake Assessment** is generally done by a clinician or other professional designated to offer this service, identified in the WACs. In the mental health system, that person is a mental health professional. In primary care it would be a physician or ARNP. In addiction services, it's a chemical dependency professional. The Intake Assessment begins with the **Presenting Problem**. Note that the presenting problem is *not* the diagnosis. It's related to the diagnosis, but it's described as the problem(s) caused by the diagnosis. Peer support workers don't work with diagnoses. We don't need to know a person's diagnosis. We should, however, be aware of the presenting problem. All services must be aimed at resolving this problem.

Service Planning follows the intake assessment. It's generally called an Individualized Service Plan (ISP). The service plan defines **goals** that work toward a resolution of the presenting problem. This plan should be reviewed and updated whenever goals are met or there are other changes. It is essentially your guide to services; it shows you where the person wants to go in their recovery.

The Golden Thread (or "Goal-den Thread") describes a thread of content that begins in the intake assessment with the presenting problem. The service plan lays out goals that are aimed at resolving the presenting problem. The goals are connected to the presenting problem by the Golden Thread. Each progress note must reflect a connection to one or more of the goals, and whether the person has made progress during that encounter. The thread continues through all the notes. Here's what it looks like:



Progress Notes are written by every person on the team, to document work toward achieving the goals on the service plan. Peer support workers write notes too. There are some differences between clinical notes and peer support notes, which are shown here.

<i>Peer Support Notes</i>	<i>Clinical Records</i>
Use the language of ordinary human experience	Use the language of diagnoses, symptoms, and medication
Focus on recovery and resiliency	Focus on symptom management and compliance
Include the person’s strengths	Include the problem(s)
Use the person’s goals for recovery	Use the providers goals for compliance
Are all about the person	May be too much about compliance

Progress notes are important to the participant, to the rest of the team, and to your funders. For the participant, notes help track progress and record plans and agreements. For the team, notes let every member of the team see what’s happening and note progress. For funders, your progress note is the mechanism by which your agency is paid for your work.

Progress notes may be written in a variety of formats, depending on your agency and the funding source. Medicaid-funded services follow a structure which is always reflected in the format. Your employer will give you more detailed instruction based on your agency’s electronic health record (or paper record) and their preferences. Whatever the format, make sure you’re reflecting the Golden Thread in each note. In other words, each note must be connected to one or more of the goals on the service plan.

DAP: A Common Format

This format can be used for almost any Medicaid-funded service. DAP is an acronym for:

- **D**ata (or Subjective, Objective)
- **A**ssessment (or Impression)
- **P**lan

You can use this format to help you remember what to include in a note, and what goes where.

Data is the information that you see, hear, touch or smell. Data is what happened today: what did the participant say? What did you say? Were there any discoveries or “ah-ha” moments?” Did you notice anything different about the person? Did you do a role play or rehearse for a meeting? Quotes from the participant belong in this section, along with any observations you make. This is also where you note what *you* did (known as the “intervention”). Document if you shared part of your recovery story. It might start with:

D: John’s problems with gambling have resulted in him losing all his friends. He feels lonely and isolated, and these feelings make it harder to avoid the casino. Today we went to a book discussion group, and John made a few comments. He told me, “It was really scary, but I did it.” I celebrated this success with him, confirming that he has some strengths.

Assessment is the interpretation you make about your work today, and how it relates to the goal. This demonstrates the Golden Thread. Remember that peer support workers are not qualified to assess or evaluate symptom management, medication compliance, or any other clinical measure. We *are* qualified to evaluate progress toward goals. We should not pass judgment on anyone in the assessment, nor should we use symptom or diagnosis language. This is a simple way to write an assessment:

*A: John’s **goal for our work** is to make some friends, develop natural supports. Today John spoke to several people, showing that he’s **making progress**.*

Plan is simple: what happens next? Will the person return to this group next week? Do they have a meeting with you soon? Have they agreed to try something new next week? Did you make any agreements to do something? The plan might look like this:

- 1. John will attend the book discussion group again next week, without me.*
- 2. John will return to see me in ten days to discuss the book group and how much progress he is making.*

Thinking Ethically

Passing judgment on someone in the context of a note is unprofessional.

Watch out for personal bias. This can occur in the context of the person, the plan, or the team. Edit your note carefully with an eye for this.

People who use services have a legal right to view their medical record in this state. Write your notes as though you *expect* the person will read them.

HIPAA laws apply to all medical records. You may share information about an individual *only* with other members of the team working directly with that person, or your supervisor. You may not read notes about someone with whom you are not directly working. Valid releases of information are required for such disclosure; information about releases of information should go through your agency’s medical records department.



Whose Record Is It?

A medical record is the story of a person's recovery journey. As much as possible, peer support workers include the person in writing the notes. If you use an electronic health record (EHR), you might allow the person to see the screen while you type the note. You could read aloud as you type. Some peer support workers will ask the individual, "what should I say we did today?" You can ask groups at the end of the session, "what should I write that we did today?" As much as possible, use the person's own words.



All professionals struggle to find time for their documentation. Practice making it simple. Talk with your supervisor if you are having trouble finding a balance.

Skill Check 8: Writing Progress Notes



Find a partner to work with. You will take turns being the **peer supporter** and the **person using services**. When you are playing the role of the **person using services**, talk about a challenge you are facing in your own life. It doesn't have to be a major challenge, and you can choose what to talk about. Make sure you have a goal! When you are playing the role of the **peer supporter**, your job is to invite, and then to listen. Use your best partnering skills. Use any and all tips from the pages preceding this exercise. Make notes as needed so you can write a progress note.

You will have about five minutes in each role: five minutes as peer support worker and five minutes as person using services. Your instructor will tell you when to change roles. After you have each played both roles, you will have five to ten minutes in which to **write a progress note**. Use the outline below. *Note: your instructor will come around and check your work as you create this note. Each of you will write a note with your partner, about your partner's challenge.*

DATA:

ASSESSMENT:

PLAN:

Summary: Treatment Planning, Goal-Setting and Documentation

Peer support is a valuable service that has been integrated into both mental health and substance use treatment. Any setting in which you work, if the funding source is Medicaid, will have these standards for planning and documentation. Be sure to follow your employer's guidance for writing individualized service plans and progress notes. These topics will typically be considered part of your supervision, and your supervisor will help you become more comfortable with documenting your work.

Module 7: Supervision

Supervision in Peer Support

Supervision is a practice-focused relationship that enables you to reflect on the way in which your role as peer supporter is developing. Supervision aims to bring you and a skilled supervisor together to reflect on what you do, to develop skills, to identify solutions to problems, to increase awareness, and to provide information about agency policy and procedures.

Ideally, clinical supervision should be provided at least weekly, with access to a supervisor in between meetings. There is no legal requirement for how much supervision a CPC should get, this can vary depending on the demands of your position and the culture within your agency. Depending on what type of behavioral health agency or treatment program you are employed in; you will be receiving supervision from an MHP or a SUDP. Some agencies use group supervision or peer supervision. Group supervision is supervision with several or all staff members, and peer supervision may include staff members keeping each other informed and accountable. Often agencies have a dual supervision process, where you may receive the required clinical supervision from an MHP or SUDP and then coaching and support from a veteran peer.

In the best-case scenario, clinical supervision can: *Read out loud as directed by instructor.*

- Support you in your work
- Guide you
- Help you make decisions
- Help you prioritize
- Drive you forward
- Give critical and constructive feedback

What is Clinical Supervision for?

- Helping you learn your responsibilities, including policies and procedures
- Manage workload
- Getting help with working with any peer or family
- **Dealing with ethical dilemmas:** relationship not working, receiving gifts, dual relationships, attractions to or by people you serve,
- Cultural misunderstandings (or the potential for it)

Clinical Supervision is not:

- Time for complaints about peers, about agency policies, or about colleagues
- Disciplinary action
- Friendship
- Gossip
- Wasted time (unless you make it so)

Your Role in Clinical Supervision

Your approach to clinical supervision can help make the relationship productive for both of you. When you first meet your clinical supervisor, tell him or her a little about you. You don't have to share details of your recovery story—or really *any* of your recovery story, unless you choose to. However, it will help your supervisor to know where you think you have strengths and where you think you need to learn more. Tell your supervisor the kinds of tasks you most enjoy. You may not be able to influence the kinds of work assigned to you, but letting your supervisor know where you excel will help to support your supervisor's decisions about the kind of work that will suit you best.

Preparing for Supervision

In order to get the most out of clinical supervision, it's helpful to do some preparation before the meeting. Your exact preparations will depend on the kind of supervision for which you are preparing. Supervisors generally come to group supervision with a plan and to individual supervision without of a plan. In group supervision, the supervisor is more likely to discuss issues that impact everybody, such as updates on agency policy or challenges with a particular program. Individual supervision is specific to your unique needs as a CPC, and what you need to continually improve your skills.

If you are preparing for group supervision, your preparation may be minimal. Find out if the supervisor has an agenda and if anything is expected of you during group supervision. Give yourself enough time to make any preparations your supervisor asks for.

If you are preparing for individual supervision, you may want to do more. Consider what has happened since your last individual supervision. Some things you may want to bring up with your supervisor include:

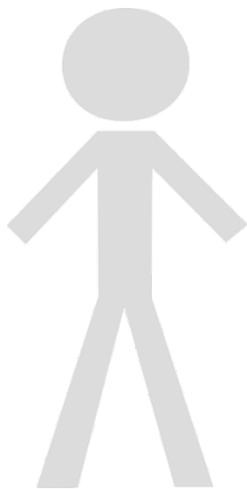
- Ethical questions
- Boundary issues
- Uncertainty about what to do next with a particular peer
- Need to know more about resources
- Questions about how agency policy applies to you
- Requests for additional training or continuing education

Exercise: Using Supervision Effectively

Exercise

Small Group Draw: In a small group of three to four people, draw an outline of a person on a large piece of paper.

- Around the figure, and corresponding with parts of the body, write in characteristics you think supervisors respect the most.
- For example, around the mouth, you might write: “talk positively with peers and colleagues.” Around the legs, you could say, “likes to get things moving.”
- Be creative! Feel free to add artwork or other graphics.
- Share your artwork with the class, and compare features of your outlines.



Skill Check 9: Using Supervision Effectively

Demonstrating understanding of the use of supervision



Read the scenario below, then consider answers to the question that follows, using the prompts below. Write your answers in the space following the questions. *Your instructor will come around to look at your answers and support you.*

“Red” and you have been working together for three months now. She’s been doing great on her goal of going back to school after quitting at 16. She applied for a GED program, has researched tutoring options, and seems excited about school. She just came out to you as bisexual and she shyly mentioned that she’s “available.” She says she wants your support for getting her studies on track again because, in her words, “you get me.” You really like her, and even have some feelings for her, but you wish she would just focus on school.

Q

How would you use supervision effectively to work with this situation, before and during a supervision meeting about your work with Red?

BEFORE: What would you plan to think about, bring, or do before meeting with your supervisor? Be specific.

DURING: What would you ask, explore, or do during the meeting with your supervisor? Be specific.

Congratulations! You have made it!

You will continue to learn even more about how to provide peer support as you do it. You will continue to build on peer support skills, as well as develop new skills, as you practice and work and practice more.

What Change Agents Do!

When challenges try to scuttle your scheme,
And adverse conditions pound hard at your team,
When no one but you shows belief in your dream . . .

Don't toss in the towel!

Don't let baddies win!

Double your efforts!

Go at it again!

When the big thing you've thunk of for years upon years
Is rejected by jerks who jab junk in your ears,
When the toughest of toughies gob gunk in your gears . . .

Don't shut off your shooter!

Don't mothball your no!

Revive your horn-tooter!

And give it a blow!

When downhill turns uphill and joy's out of sight,
When confidence turns into fear overnight,
And storm clouds appear to the left and the right . . .

It's not time to run!

Don't look for the door!

It's just getting fun!

That's what we're here for!

So when change gets hard, do what I do:
Crack out your Change Agent Ching-Changeroo.
Zap 'em with stuff that we know will get through.

Now fight through the queasy!

It's what Change Agents do!

'Cause changing ain't easy,

That's why we need YOU!

**-Steven J. Chihos,
theBigRocks.com**

The folks who wrote this poem about being agents of change were honoring Dr. Seuss' writing while encouraging change agents to keep going in hard times.

Appendix 1: Glossary

Adverse Childhood Event (ACE)—is an experience during childhood that is difficult or traumatic. Experiences can include abuse, neglect, accidents, and divorce and loss.

Advocacy—promotes the cause of a person or idea.

Advocacy groups—are organizations that work in a variety of ways to create change with issues that affect society. (NAMI and Youth 'n Action are examples)

Alcohol abuse—means a pattern of alcohol use leading to significant impairment or distress; see also substance abuse and substance dependence.

Appeal process—is a series of steps you must follow to get a decision about services reviewed and changed.

Assessment—is the gathering and appraisal of information in order to identify a person's needs and strengths.

Bias—a belief a person has about a thing, person, or group of people. Biases can be conscious or unconscious, positive or negative, but are most often considered unfair.

Boundaries—refer to the degree of closeness we have with an individual.

Case manager—is the health care professional who works directly with an individual or children and their families to coordinate various activities, services and supports, and acts as the consumer's primary contact with other members of their treatment teams.

Case management—is a service that helps people arrange for appropriate services and supports. A case manager coordinates mental health, social work, educational, health, vocational, transportation, advocacy, respite care, and recreational services, as needed.

Certified Peer Counselor (CPC)—is a person who has completed the DBHR approved training and has passed the state exam.

Child abuse or neglect—means the injury, sexual abuse, or negligent treatment or maltreatment of a child by any person where a child's health, welfare, and safety are harmed.

Clinical Supervision – is provided by either a Mental Health Professional (MHP) or a Substance Use Disorder Professional (SUDP) depending on the service setting. Clinical supervision focuses on improving skills and coaching.

Credential—is the approval by the Department of Health to work in the counseling field. The credential may vary by level of education; however, most CPCs apply for an Agency Affiliated Counselor credential. A credential is required to work in a Medicaid setting.

Clubhouse—is derived from the Fountain House model of psychiatric rehabilitation; it is a club that belongs to everyone who participates in it, providing supportive companionship with a focus on opportunities for employment.

Collaboration—is where professionals and/or agencies with linked functions work effectively together on common issues, including the provision of care to an individual person.

Community—is a group of people residing in the same locality or sharing a common interest.

Community care—is the provision of services and support for people who are affected by a range of problems, including mental health challenges, to enable them to live as independently as possible in their own homes or in other home-like settings.

Community behavioral health agencies (CBHAs)—are groups of professionals providing behavioral health services locally.

Confidentiality—is the protection and proper use of patient information. Information given or received for one purpose may not be used for a different purpose or passed to anyone else without the consent of the provider of the information.

Consumer—is a term not generally preferred to describe someone who uses or has used behavioral health services.

Continuum of care—is a term that implies a progression of services that a consumer or child moves through, usually one service at a time. More recently, it has come to mean comprehensive services. Also see system of care and wraparound services.

Co-occurring disorder—see dual diagnosis.

Coordination—means bringing people together to work together efficiently.

Coordinated services—means that several child-serving or peer-serving organizations talk with the family or consumer and agree upon a plan of care that meets the child's or peer's needs. These organizations can include mental health, education, juvenile court, adult criminal court and child welfare. Case management is necessary to coordinate service. Also see family centered services and wraparound services.

Counseling—aims to help people develop insight into their problems and identify resources within themselves that they can use to cope more effectively with their situation; see also psychotherapy

Criminal court system—includes all agencies involved in criminal court including the police, probation service, courts and prisons.

Crisis—is a time of extreme trouble and an opportunity for growth.

Crisis residential treatment services—are short-term, round-the-clock help provided in a non-hospital setting during a crisis.

Cultural competence/culturally appropriate services—means a set of values, attitudes and practices held by an organization or individual service provider that are sensitive and responsive to cultural differences. These differences can include race and ethnicity, national origin, language, beliefs, religion, age, gender, sexual orientation, physical disability, or family values and customs.

Culture—is the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith or social group.

De-escalate—means to lower the intensity of a situation; often refers to a way of communicating with a person when they are upset or in crisis.

Dilemma—a situation where a difficult decision must be made.

Disability—is a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

Discharge plan—is a care plan for people being discharged from a hospital or residential center.

Discharge planner—is the person on the hospital or residence staff who makes plans for an individual's health care outside of the hospital; this can be a nurse, doctor, resident/intern, or social worker.

Disclose—means to share or make known.

Discrimination—is treating a person differently, usually in a negative way, based on differences in culture, beliefs, or other characteristics.

Diverse—means differing from one another.

Diversion—refers to the movement of an individual from the criminal court system or hospital to health and/or social care.

Drop-in centers—are centers without structured activity where peers can socialize.

Drug dependence –occurs when an individual persists in using a drug despite problems related to the use of the drug, such as legal, health, family, occupational or other problems resulting from the drug use. It can be diagnosed either with or without physical dependence, which means issues of tolerance to and withdrawal from the substance.

Duty to Warn—a mandatory reporting requirement for an employed certified peer counselor to directly warn a person who has been seriously threatened.

Dual diagnosis—is the combination of mental health challenges with other conditions, including alcohol abuse, substance abuse, compulsive gambling, a learning disability, or a physical disability. Also called comorbidity or co-occurring disorders.

Early intervention—is a process used to recognize warning signs for mental health challenges and to take early action against factors that put individuals at risk.

Eligibility criteria—are guidelines used when a person seeks mental health services to determine the priority of their need and the degree of risk, in order to make decisions about the appropriate use of services. These may include age, disability, income, or type of insurance.

Emergency and crisis services—a group of services that is available 24 hours a day, seven days a week, to help during a mental health emergency. Examples include telephone crisis hotlines, suicide hotlines, crisis counseling, crisis residential treatment services, crisis outreach teams, and crisis respite care.

Empathize—means to identify with or develop an understanding of another’s situation, feelings, or motives.

Empower—means to give authority, control and confidence to a previously disadvantaged group or person.

Environmental approach—is an approach to mental health treatment that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Evaluation—is the systematic investigation of the value and impact of an intervention or program.

Ethics—refer to principles of right and wrong as well as to rules an organization or group agrees to.

Evidence-based practices (EBP)—are activities or programs that have been shown to be effective through scientific testing and reproduction of practices. Various organizations have lists of these practices.

Facilitation—is the practice of working with several people or a group to aid in learning and discussion.

Family-centered services—are services designed to meet the specific needs of each individual child and family; see also appropriate services, coordinated services, wraparound services, and cultural competence.

Family focused—means an approach to designing and providing services that views the child as a member of a family and recognizes that everyone in a family can be affected by how the others act, what they say, or how they feel or are doing in school or work. Decisions about services are made considering the strengths and needs of the family as a whole as well as the individual child with a mental health challenge.

Family support services—are services designed to keep the family together, while coping with behavioral health challenges that affect them. These services may include peer information workshops, in-home supports, family therapy, parenting training, crisis services, and respite care.

Frequency—refers to the number of occurrences of a disease or injury in a given unit of time.

Goal—is a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work. In behavioral health, goals are designed to increase recovery and resilience.

Hallucination—is a false or distorted perception of objects or events, including sensations of sight, sound, taste, smell, or touch, typically accompanied by a powerful sense of their reality.

Health care—is medical and nursing care.

Holistic—means considering the whole person in the treatment of their illness; i.e., their physical, emotional, psychological, spiritual and social needs.

Home-based services—refers to help provided in a family's home either for a defined period of time or for as long as it takes to deal with a mental health problem without removing the child from the home; these can include parent training, counseling, and working with family members to identify, find, or provide other necessary help. Also called in-home supports.

Homelessness—describes people living in a broad spectrum of unsatisfactory housing conditions ranging from cardboard boxes and park benches through night shelters and direct access hostels to bed and breakfast accommodation or even sleeping on a friend's floor.

Imminent—means likely to happen at any moment.

Internalized stigma—are negative beliefs about a condition held by a person having the condition.

Individual—is defined in behavioral health state law as a person receiving or who has received services. For the purpose of services, a parent or legal guardian meets these criteria.

Individual Service Plan (ISP)—also known as a Treatment Plan. It is a written document that lists and describes all the services and supports an individual will receive.

Intake—is the process an agency or program uses to find out about a peer or child and family for the first time and determine their eligibility for services; also called initial referral; see also eligibility criteria.

Integration—refers to treatment that approaches multiple challenges, such as substance use and mental health, or behavioral health and physical health.

Intervention—an action taken, often by a professional to assist a person.

Learned helplessness—is a belief that nothing a person can do will change their circumstances.

Managed Care Organization (MCO)—is a private health organization that provides comprehensive health care. These organizations may contract with the state to provide public services.

Medicaid services—Medicaid recipients have access to behavioral health (mental health and substance use disorder treatment) services, including crisis services, short-term mental health treatment, and inpatient psychiatric services. (HCA website)

Mental health—refers to the way a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; explore choices; handle stress; relate to other people; and make decisions.

Mental Health Advance Directive—a legal document that describes what a person wants to happen if their mental health problems become so severe that they need help from others. This might occur when their judgment is impaired and/or unable to communicate effectively.

Mental Health Professional—a professional who meets the requirements for this designation.

Mental health services—services that are specially designed for the care and treatment of people with mental health challenges, including those with co-occurring substance use disorders.

Mental injury—non-accidental damage to intellectual, emotional or psychological functioning, which is a Mandatory Reporting requirement.

Motivational interviewing—is a collaborative conversation to strengthen a person’s own motivation for and commitment to change.

Mutual support groups—are groups where service users and/or family members share their experiences and feelings about mental health challenges and generally help each other; also called self-help groups.

Needs assessment—is the process of assessing and monitoring health and social care needs of a population.

Objective—is a specific and measurable statement that clearly identifies what is to be achieved, often to meet a larger goal.

Open-ended question—is a question that cannot be answered “yes” or “no” but invites a person to discuss a question more fully.

Outcomes—are measurable results, such as a change in the health of an individual or group of people that is attributable to an intervention.

Orienting—means discussing activities, processes and/or reviewing plans, often at the beginning of a meeting.

Outreach programs—are programs that send staff into communities to deliver services or recruit participants.

Parent Partner—is an individual who has been trained to help other families get the kinds of services and supports they need and want. Parent advocates are usually family members who have raised a child with a behavioral or emotional problem and have worked with the system of care and many of the agencies and providers in your community. If a parent advocate is working in a Medicaid agency, they must be certified as a peer counselor.

Partnership—is working closely with others to achieve agreed-upon common goals.

Peer—is one term used for an individual (typically an adult) who receives or has received services; see also consumer. Parents may be referred to as peers when they are in a peer relationship with another parent.

Physical abuse—is a non-accidental serious physical injury or injuries whose effect may be permanent or temporary, which is a Mandatory Reporting requirement.

Policy—is a plan of action or an agreed position adopted by an organization.

Post-Traumatic Stress Disorder (PTSD)—can occur after one is exposed to a traumatic event, such as war, natural disasters, major accidents, or severe abuse. The person may then develop an intense fear of related situations, heightened general anxiety, flashbacks and/or recurring nightmares.

Prevention—is a strategy or approach that delays or reduces the likelihood of onset of a behavioral health problem.

Privilege—in terms of culture, refers to rights, perceptions, and advantages a group has in society.

Protective factors—are factors that make it less likely that individuals will develop a disorder; these may include biological, psychological or social factors in the individual, family or environment.

Provider—is any organization, agency, group of people or individual who supplies a service in the community, home or hospital in return for payment.

Psycho-education—is education offered to those with psychiatric disabilities and often their families with the intent of helping them to better understand and cope with their psychiatric disability.

Public sector—refers to any facility maintained or controlled by a central government, local government, or other statutory body; Medicaid services are public services, while other medical treatment may be private.

Recovery—the process in which people are able to live, work, learn, and participate fully in their communities.

Recovery story—is one individual's experience leading them to improve their lives and their behavioral health.

Rehabilitation—restores skills (e.g., vocational, social, or daily living skills) through treatment or by training.

Resilience—refers to the capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors such as difficult experiences that might otherwise place that person at risk for adverse health outcomes.

Revised Codes of Washington (RCW's)—are laws that the state government creates; see also Washington Administrative Codes (WAC's). RCWs are the highest form of state legislation.

Risk assessment—is an assessment of whether a person is at risk to themselves or others.

Risk factors—are certain factors that make it more likely that individuals will develop a mental disorder. Risk factors may include biological, psychological or social factors in the individual, family and environment, and are especially significant for children.

Screening—refers to the administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment; see also eligibility criteria, intake.

Screening tools—are those instruments and techniques (questionnaires, check lists, self-assessments forms) used to evaluate individuals for increased risk of certain health problems; see also eligibility criteria, intake.

Self-advocacy—is action taken by a person to get their needs and wants met.

Self-help groups - see mutual support groups

Service—is a type of support or clinical intervention designed to address the specific mental health needs of a peer or a child and his or her family. A service could be provided only one time or repeated over a course of time.

Side effects—are the unwanted physical effects of taking medication.

Social support—refers to assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Social worker—is a graduate of a school of social work who holds either a bachelor's or master's degree and who is trained in effective ways of helping people living with mental health challenges, and other groups in need of assistance. Some case managers are referred to as 'social workers' even without the credential.

Spiritual—relates to the spirit or soul as distinct from physical matters; it includes religion but goes much wider to embrace, for example, art and music.

Stages of change—a theory describing stages a person may consider and make life changes. Stages include pre-contemplation, contemplation, planning, action, maintenance, and termination.

Stakeholder—is anyone, including organizations, groups and individuals that is affected by and contributes to decisions, consultations and policies.

Strengths—are personal skills and abilities, personal qualities and values that are used or can be used to increase recovery.

Strengths-based—is the practice of focusing on strengths, not deficits, in assisting a person or family.

Statutory—relates to organizations set up by law, statute or regulation (e.g. county council, local authority).

Stigma—is a general term for the widespread fear and misunderstanding of behavioral health challenges, together with the stereotyping and negative attitudes toward those who suffer from them.

Street drugs—drugs that are not prescribed by doctors for the person using them; also called illicit drugs.

Strengths—are the positive characteristics of any individual, child or family, including things they do well, people they like and activities they enjoy.

Substance abuse—is the use of a substance (e.g., alcohol, prescription drugs, street drugs, solvents, etc.) to the point that it has a negative impact on one's life (e.g., leads to fights, arrests, relationship problems, etc.); compare to substance dependence.

Substance dependence—is addiction to a substance (see above); i.e., the substance is taken more frequently, in higher doses, in inappropriate situations, or in spite of the user's desire to quit; compare to substance abuse.

Substance use disorder—is the preferred term for a person with addictions to harmful substances and behaviors.

Substance Use Disorder Professional (SUDP) – formerly known as a Chemical Dependency Professional (CDP) is a professional role certified by the Washington State Department of Health to work with individuals of all ages who are experiencing problems with substance use, abuse, and addiction.

Support—means to help provide for and encourage a person.

Supported employment—is when a person is supported (usually by an organization or program) to obtain and retain open employment in the community; compare to sheltered work.

Supported housing—is where residents have their own accommodation, but a member of staff is available to provide support when necessary.

Symptom—is a reported feeling or specific observable physical sign of a person's condition.

System of care—is a coordinated network of agencies and providers that make a full range of mental health and other necessary services available to peers or children with mental health challenges and their families.

Trauma—is an event, series of events, or circumstances experienced by an individual as physically or emotionally harmful or life threatening and that has lasting negative effects on the individual’s functioning and mental physical, social, emotion, or spiritual well-being.

Treatment—means a medical or psychological therapeutic intervention.

Treatment plan—see individual service plan

Treatment team—is a group of professionals, service providers, family members and/or support people who meet to develop, implement and review a comprehensive service plan for an adult consumer or child and family.

Value—a principle that is important to an individual as a standard of value.

Vulnerable adult—is someone who is physically or economically dependent on another and unable to leave a situation without assistance, or a person who has a paid aide or home service provider.

Washington Administrative Codes (WACs)—specific guidance on the operation of legislation. These rules are derived from the Revised Codes of Washington (RCWs), the laws that the state legislature has created.

Wellness Recovery Action Plan (WRAP)—refers to training on and use of the Wellness Recovery Action Plan developed by Mary Ellen Copeland.

WISe—The Washington State Wraparound with Intensive Services (WISe) Program is designed to provide comprehensive services and supports to eligible clients. The purpose is to create a sustainable service delivery system for intensive home and community based mental health services to Medicaid-eligible children and youth with high intensity needs.

Wraparound services—are individualized community-based services that focus on the strengths and needs of a child and family. Wraparound services are developed through a team-planning process, where a team of individuals who are relevant to the well-being of the child (such as family members, service providers, teachers, and representatives from any involved agency) collaboratively develop and implement an individualized plan of care, known as a wraparound plan.

Youth—an individual who is between 13 and 25 years old. This definition varies in different parts of the state, nation and by organization. It may also refer to an individual under the age of 18.

Youth culture—the norms, values, language and music that define who a young person is.

Youth in transition—a young person between the ages of 16 and 25 generally. This term is applied to youth who are aging out of the youth systems and moving into adult systems, which includes education to higher education, and does not necessarily mean that a young

person who is in the mental health system will automatically move into the adult mental health system.

Youth partner—a person who provides peer support to youth. Individuals providing services in Medicaid agencies must be certified as peer counselors and should be of a younger age and have good rapport with youth.

Appendix 2: Acronyms

AA - Alcoholics Anonymous
AAA – Area Agency on Aging
ACS - Access to Care Standards
ACT – Assertive Community Treatment
ADA - Americans with Disability Act
ADHD - Attention Deficit Hyperactive Disorder
ADL – Activities of Daily Living
ADSA – Aging and Disabilities Services Administration
AFDC - Aid to Families with Dependent Children
AFH – Adult Family Home
AOT –Assisted Outpatient Treatment
APS – Adult Protective Services
BHASO – Behavioral Health Administrative Service Organization
BHSIA - Behavioral Health and Services Integration Administration
CBT – Cognitive Behavioral Therapy
CD – Chemical Dependency
CFR – Code of Federal Regulations
CHINS - Child In Need of Services
CIT – Crisis Intervention Training
CLIP - Children's Long-term Inpatient Programs
CMHA – Community Mental Health Agency
CMS – Centers for Medicare and Medicaid Services
CPC – Certified Peer Counselor
COD – Co-Occurring Disorders
COPS – Consumer Operated Programs & Services
CPS - Child Protective Service
CRC - Crisis Residential Center
CSO – Community Service Office
CSTC - Child Study and Treatment Center
CVAB – Consumer Voices Are Born
DBHR – Division of Behavioral Health & Recovery
DBT – Dialectical Behavioral Therapy
DCDP – Designated Chemical Dependency Specialist
DCR – Designated Crisis Responder
DD – Developmental Disability
DDD - Division of Developmental Disabilities
DL – Disability Lifeline
DOH – Department of Health
DRW - Disability Rights Washington
DSHS - Department of Social and Health Services
DSM-5- Diagnostic and Statistical Manual (5th edition)
DVA – United States Department of Veterans Affairs
DVR - Division of Vocational Rehabilitation

Dx - Diagnosis
E & T - Evaluation and Treatment facility
EBP – Evidence-Based Practice
EEOC – Equal Employment Opportunity Commission
EPSDT - Early Periodic Screening, Diagnosis & Treatment
EQRO – External Quality Review Organization
ESD - Educational Service District
ESL – English as a Second Language
ESH – Eastern State Hospital
FACT – Forensic Assertive Community Treatment
FAE/FAS - Fetal Alcohol Effects/Fetal Alcohol Syndrome
FERPA – Family Educational Rights & Privacy Act
FFCMH – Federation of Families for Children’s Mental Health
FRS - Family Reconciliation Services
GA – Gamblers Anonymous
LGBTQ –Lesbian Gay Bisexual Transgender Questioning
HHS – United States Department of Health and Human Services
HMO - Health Maintenance Organization
HIPAA - Health Insurance Portability and Accountability Act
HR – Human Resources
HWD – Healthcare for Workers with Disabilities
ICCD – International Center for Clubhouse Development
IDEA – Individuals with Disabilities Education Act
IDDT – Integrated Dual Disorder Treatment
IEP - Individualized Education Plan
IMR – Illness Management & Recovery
INAPS- International Association of Peer Specialists
ISP – Individualized Service Plan
IST - Interagency Staffing Team
ITA - Involuntary Treatment Act
ITC - Individualized and Tailored Care
JAN – Job Accommodation Network
JRA - Juvenile Rehabilitation Administration
L & I – Department of Labor and Industries
LCSW – Licensed Clinical Social Worker
LD – Learning Disability
LMFT – Licensed Marriage & Family Therapist
LOS - Length of Stay
LRA – Least/Less Restrictive Alternative
LRE – Least/Less Restrictive Environment
MCO - Managed Care Organization
MDT - Multidisciplinary Team
MHD - Mental Health Division (outdated; now Division of Behavioral Health & Recovery)
MHFA – Mental Health First Aid
MHHC - Mental Health Housing Consortium

MHP - Mental Health Professional
MHTP - Mental Health Transformation Project
MI – Motivational Interviewing
NA – Narcotics Anonymous
NAMI - National Alliance on Mental Illness
NIH – National Institute of Health
NIMH – National Institute of Mental Health
MHA – Mental Health America
OA – Overeaters Anonymous
OAH – Office of Administrative Hearings
OCP - Office of Consumer Partnerships
OCR - Office of Civil Rights
OEF/OIF – Operation Enduring Freedom/Operation Iraqi Freedom (veterans)
OSPI - Office of Superintendent of Public Instruction
OT - Occupational Therapist/Therapy
PACT – Program for Assertive Community Treatment
PASS – Plan for Achieving Self Support
PAVE – Partnerships for Action, Voices for Empowerment
PCP – Primary Care Provider OR Person-Centered Planning
PHI – Protected Health Information
PIHP - Prepaid Inpatient Health Plan
PSSP – Peer Support Service Plan
PT – Physical Therapist/Therapy
PTSD - Post Traumatic Stress Disorder
QA - Quality Assurance
QI - Quality Improvement
QRT - Quality Review Team
RC – Registered Counselor (outdated)
RCW - Revised Codes of Washington
RN – Registered Nurse
RTF - Residential Treatment Facility
Rx – Medical Prescription
SA – Substance Abuse OR Sexual Abuse
SAMHSA – Substance Abuse and Mental Health Services Administration
SBD - Serious Behavioral Disturbance
SE – Supported Employment
SED - Serious Emotional Disorder
SEIU – Service Employees International Union
SGA – Substantial Gainful Activity
SMI – Serious/Severe Mental Illness
SSA – Social Security Administration
SSDI - Social Security Disability Insurance
SSI - Supplemental Security Income
SUD – Substance Use Disorder
SUDP – Substance Use Disorder Professional (formerly known as CDP)
TANF – Temporary Assistance for Needy Families

TBI – Traumatic Brain Injury
TE – Transitional Employment
TWE – Trial Work Experience
TWP – Temporary Work Placement
Tx – Treatment
USPRA – United States Psychiatric Rehabilitation Association
VA – (United States Department of) Veterans Affairs
WAC - Washington Administrative Code
WCMHC – Washington Community Mental Health Council
WDVA – Washington State Department of Veterans Affairs
WIMHRT – Washington Institute for Mental Health Research & Training
WIPA – Work Incentives Planning & Assistance
WISe- Wraparound with Intensive Services
WPAS – Washington Protection & Advocacy Service
WRAP - Wellness Recovery Action Plan
WSCC – Washington State Clubhouse Coalition
WSH – Western State Hospital
YNA – Youth ‘N Action

Appendix 3: HIPAA

The Standards for Privacy of Individually Identifiable Health Information (“Privacy Rule”) establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services (“HHS”) issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The Privacy Rule standards address the use and disclosure of individuals’ health information—called Protected Health Information (“PHI”) by organizations subject to the Privacy Rule—called “covered entities,” as well as standards for individuals’ privacy rights to understand and control how their health information is used.

The Privacy Rule protects all “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information “Protected Health Information.”

“Individually identifiable health information” is information, including demographic data, that relates to: the individual’s past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

Appendix 4: The Americans With Disabilities Act (ADA)

What is the intent of the ADA?

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in employment; state and local government activities; public accommodations; public transportation; telecommunications; and public services. It was signed into law by President George H. W. Bush on July 26, 1990.

Does the ADA protect people with severe behavioral health challenges?

The definition of disability in the ADA includes people with mental health challenges who meet one of these three definitions: "(1) a physical or mental impairment that substantially limits one or more major life activities of an individual; (2) a record of such impairment; or (3) being regarded as having such impairment." A mental impairment is defined by the ADA as "any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental health challenges, and specific learning disabilities."

How and when should I disclose my disability to an employer?

Disclosure is a complex decision and should be made with care. Here's what you might want to think about:

Preparing to disclose

Assess your employment skills to determine whether you need help from your therapist or mental health agency to:

- Initiate contact or arranging an interview with the employer interview.
- Describe your disability.
- Negotiate the terms of employment.
- Negotiate accommodations.

Identify any potential accommodations you might need during the hiring process or on your first day of work.

Explore your feelings about having a mental health challenge and about sharing that information with others. Remember, no one can force you to disclose if you don't want to. Research potential employers' attitudes toward mental health challenges and screen out unsupportive employers.

- Have they hired someone with a psychiatric disability before?
- Do they personally know someone with a mental health challenge?

- What positive or negative experiences have they had in employing someone with mental health challenges?
- Do they show signs—newsletters, posted notices, employee education programs about mental health challenges, etc.—of encouraging a diverse workforce?
- Do they have a corporate culture that favors flex time, mentoring programs, telecommuting, flexible benefit plans, and other programs that help employees work efficiently and well?
- Does the job have certain requirements (e.g., child care, high security, some government positions) that would put you at a disadvantage if you disclosed your diagnosis?

Weigh the benefits and risks of disclosure

- Do you need to involve an outside agency to get or keep the job?
- Do you need accommodation or other employer support?
- When will you need this accommodation?
- Do other people in the company need similar accommodation?
- How stressful will it be for you to hide your disability?

If you decide not to disclose, find other ways to get the support you need

- Behind-the-scenes support from friends, therapists, etc.
- Research potential employers who provide these supports to all Employees

If you decide to disclose, plan in advance how you'll handle it

- Who will say it (you, your therapist, your job coach, etc.);
- What to say (see below); and,
- When to say it.

Under the ADA, a person with a disability can choose to disclose at any time, and is not required to disclose at all unless s/he wants to request an accommodation or wants other protection under the law. Someone with a disability can disclose at any of these times:

- Before the hiring interview;
- During the interview;
- After the interview but before any job offer;
- After a job offer but before starting a job;
- Any time after beginning a job;
- We recommend disclosing sometime before serious problems arise on the job; and,
- It is unlikely that you would be protected under the ADA if you disclosed right before you were about to get fired.

Do all employers have to comply with Title I of the ADA?

Private employers with 15 or more employees, state and local governments, employment agencies, labor organizations, and management committees are all subject to the ADA. The

ADA does not apply to the federal government; however, discrimination by the federal government or federally assisted programs is prohibited under Title V of the Rehabilitation Act of 1973.

Who is protected?

The ADA prohibits discrimination against "qualified individuals with disabilities" who are individuals with disabilities who meet the skill, experience, education, and other job-related requirements of a position held or desired and who, with or without reasonable accommodation, can perform the essential functions of a job.

What employment practices are covered?

All aspects of an employment relationship including recruitment, hiring, job assignments, pay, lay-off, firing, training, promotions, benefits, and leave.

How does one file a complaint under Title I of the ADA?

An individual who feels that they have been discriminated against in employment on the basis of disability can file a charge with the Equal Employment Opportunity Commission (EEOC) within 180 days of the alleged discriminatory act. (In certain states that have their own laws prohibiting employment discrimination based on disability this time limit may be extended to 300 days, but, as a general principle, the time limit is 180 days). The EEOC is authorized to mediate and negotiate a settlement between the individual who files the complaint and the employer. If this fails to resolve the matter, the EEOC has the option of either filing a lawsuit on behalf of the individual or issuing a "right to sue" letter. After a "right to sue" letter has been issued, the individual may file a lawsuit in a federal district court.

How does the ADA apply to state and local governments?

Title II of the ADA prohibits discrimination against qualified individuals with disabilities in all programs, activities, and services provided by state and local governments.

What are examples of state and local government activities covered under Title II of the ADA?

A state or local government must eliminate any eligibility criteria for participation in programs, activities, and services that screen out or tend to screen out or discriminate against persons with disabilities, unless it can establish that these requirements are necessary for the provision of the service, program, or activities. For example, a state may not refuse to grant a driver's license to someone merely because of their psychiatric diagnosis, unless the illness or medication taken for the illness interferes with the ability to drive. The ADA also requires that all new buildings constructed by a state or local government be accessible.

What is the purpose of Title III of the ADA?

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodations by any person who owns, leases, or operates a place of public accommodation.

What are places of public accommodations?

Places of public accommodation include a wide range of entities such as restaurants, hotels, theaters, doctors' offices, pharmacies, retail stores, or museums.

Filing a Complaint

How does one go about filing a complaint under title III of the ADA?

As with Title II, The U.S. Department of Justice is responsible for administering Title III of the ADA. An individual who believes he or she has been discriminated against in violation of Title III may either file an administrative complaint with the Department of Justice (1-800-541-0301) or file a private lawsuit in a federal district court.

Who can I call if there is evidence of an ADA violation?

**Equal Employment Opportunity
Commission (EEOC)**
for Title I concerns
www.eeoc.gov
800-669-4000

U.S. Department of Justice
Title II and Title III concerns
www.justice.gov
800-514-0301

Job Accommodation Network

<http://askjan.org/> 800-526-7234

State Protection & Advocacy Agency www.ndrn.org (in Washington, it's Disability Rights Washington, www.disabilityrightswa.org)

Legal services organization (legal aid) in your area local phone directory

Technical Assistance Manual on the Employment Provision (Title I) of the ADA. A resource directory published by the U.S. Equal Employment Opportunities Commission. To order a copy, call 800-669-EEOC or visit www.eeoc.gov/policy/docs/psych.html.

Appendix 5: Review of Online Course

Module 1 Recovery Principles

- What is the SAMHSA definition of recovery?
- Name three of SAMHSA's elements of recovery.
- What does resiliency mean?
- Describe the differing ideas about recovery in Substance Use Disorders.
- Describe how families are integral to recovery for children.
- What is the difference between a "medical" and a "recovery" model of care?
- What is person-first language?
- Describe two of the unique ways peer supporters support recovery.
- Describe why hope is essential for recovery.

Module 2 Role of a Peer Supporter

- When is certification as a peer counselor required by the State?
- Describe where peer supporters might work.
- Describe who can be a youth peer counselor and their role.
- Describe who can be a parent peer counselor and their role.
- Describe a Recovery Coach.
- Describe what is and what is not a peer role.
- Describe the process for becoming a certified peer counselor.

Module 3 Self-Advocacy

- Why is self-advocacy important, and what part does it play in recovery?
- How can a peer supporter help someone learn to self-advocate?
- What is the difference between advocacy and self-advocacy? When might a peer do each?
- How do strengths play a part in self-advocacy?
- Name some common steps in advocacy.
- Describe a grievance.
- Describe the Ombuds role.

Module 4 Structure of Behavioral Health Systems

- What two state agencies administer Medicaid behavioral health services?
- Describe the basic role of each:
 - Center for Medicare and Medicaid Services (CMS)
 - Division of Behavioral Health and Recovery (DBHR)
 - Managed Care Organization (MCO) or Behavioral Health Administrative Service Organization (BHASO)
 - Behavioral Health Agency (BHA)
- What kinds of behavioral health services are authorized by Medicaid?
- How does a person usually get services?
- Who has access to crisis services?
- What is an Evaluation and Treatment Center?
- What is CLIP? How do children qualify?
- What is WISe?
- What is a System of Care?
- Describe what involuntary inpatient services are for both mental health and substance use disorders.
- What are co-occurring services?

Module 5 Culture

- Define each of the following:
 - Stigma
 - Prejudice
 - Discrimination
 - Privilege
- Describe how values are a part of culture.
- Describe at least five words that describe sexual orientation, and what they mean.
- What role might spirituality play in a person's recovery?
- Describe how culture could influence behavioral health treatment.
- Describe how a peer could include culture in interactions.

Module 6 Movements

- Describe a 12-step program and the kinds of programs there are.
- Describe what the "consumer/survivor movement" is and some of its history.
- Describe two mental health national advocacy organizations.
- Name two large family organizations.

Module 7 Ethics and Boundaries

- Describe ethics regarding:
 - Romantic relationships
 - Medication
 - Drug and alcohol use
 - Confidentiality
- What is the difference between a peer supporter and a friend?
- Describe how a peer supporter sets his/her personal boundaries.
- What is a dual relationship and why should they be avoided?
- Are employed peer counselors Mandatory Reporters? What does this mean?
- What does Duty to Warn mean?
- Who are Vulnerable Adults?
- Describe some guidelines for confidentiality.
- Describe what a peer counselor should do when ethics in a situation are unclear.

Module 8 Holistic Health

- Define holistic health and 3 components.
- Describe how the following impact behavioral health:
 - Nutrition
 - Exercise
- Name three health concerns that are common to peers, and how a peer counselor might help a peer in those areas.

Module 9 Working with People in Challenging Times

- How might crisis be defined differently for different people?
- What kinds of things can cause a crisis?
- What are some ways a crisis might be resolved? (in addition to hospitalization)
- What is a Mental Health Advance Directive and what does it include?
- What are common warning signs of suicide?
- What is the basic assistance a peer can provide to a potentially suicidal person?
- Name three ways a peer supporter should maintain safety boundaries.
- What is Motivational Interviewing? Describe its characteristics.
- Name the Stages of Change and define each stage.
- Define W.R.A.P. *and how it is used.*

Appendix 6: Contributors

This bridge training was made possible by funding from the Healthcare Authority in Washington State. Funding was awarded to WSU's Peer Workforce Alliance led by Stephanie Lane. Other contributors to this project include:

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