

Crisis Awareness and Communication in Peer Support **Student Manual**

Washington State
Health Care Authority

In partnership with



HCA 82-0445 (06/23)

Crisis Awareness and Communication in Peer Support



This course is dedicated to the memory of those we have lost to suicide. We honor their memory with this work.

Acknowledgements

This manual was created in partnership with Peer Workforce Development.

We'd also like to extend a special acknowledgement to the efforts of community members invested in peer support who used their direct lived and living experience with peer support and crisis services to lend their expertise and invaluable points of view.

Nothing about us, without us!

Let us take a moment of silence to honor all survivors of suicide, their families and especially those who are no longer with us due to the completion of suicide.

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Welcome

This course, “Crisis Awareness and Communication in Peer Support,” is designed for licensed and credentialed peer support workers who wish to increase their skills in working with individuals experiencing crisis. It is expected that, if you are in this class, you are already working (or have worked) in peer support, and you are seeking to add new skills to your toolbox. Therefore, the basic skills of peer support will not be covered in detail in this course, except for a quick review of a few concepts. We seek to expand on the knowledge you have gained through not only your Certified Peer Counselor (CPC) training, but your work in the field as a peer.

Discussions about crisis can be difficult. The topics covered, and personal experiences contributed by participants in this course, may activate trauma responses in some individuals. We will give particular attention to self-care throughout the course. We invite you to think now about the strategies you use to manage your own distress, including how to minimize activated responses when they occur. As part of your learning, we hope you will take from this course some new strategies for managing your own wellness, in addition to skills for working in crisis.

We know that crisis work is NOT for everybody. Completing this course may help you decide if this specialty area of practice is right for you. During this course, if you find that some of this material is activating, please use your self-care tools. Notify the trainer(s) if you need additional support. Peer support may be available to you during this course. Your trainer will let you know.

Culture plays an important role in how people define crisis, how people define “help,” and what individuals find helpful in difficult times. We will explore cultural differences throughout each module. We invite you to remember what you learned about cultural humility in the standard CPC class, and we will learn more along the way. We will be exploring peer support and recovery values throughout this training.

This curriculum was developed in partnership with the Peer Washington Workforce Development, the Leadership Work Group, involving CPCs, clinicians, and others working in the crisis system. We like to start each day with a hopeful inspiration, which your trainers will offer you today. You are invited to bring hopeful inspiration to share each day, as well.

Getting started

We'd like to get to know each other first. We recognize that participants represent a wealth of knowledge and experience, and networking is important. You are invited to tell us your name, your pronouns, a land acknowledgment should you choose what kind of work you do now, one interesting thing you think we should know about you, and what you are hoping to take from this course.

Now that we've been introduced, let's talk about how we will work together. In many classes, participants will make a "Comfort Agreement" or something similar. We recognize that the best learning experiences involve a bit of *dis*comfort, a little bit of a "stretch" to stay engaged. Too much discomfort makes learning difficult, and too much comfort can be boring. We want to find that spot in the middle: where we are excited, expectant, and challenged.

Together, we will make a classroom agreement, a "Stretch Agreement," to identify what we need from each other to take the risks involved in learning and growing. What do you need from others to feel safe in this learning community?

While we work to make our training feel safe for all participants, we can't know for sure what constitutes safety for each of you. Instead, we invite you to step into a brave space, in which we feel supported in taking risks and discussing difficult topics.

Housekeeping and overview

Time and days

Generally, this class will be held Monday through Friday. Class times on Monday through Thursday are 9:00 AM to 4:00 PM. On Fridays, class time will be a half day only, completed by noon. Here are the modules:

- Module 1: Crisis and Self-Care
- Module 2: Trauma-Informed Approaches in Crisis
- Module 3: Communication in Crisis
- Module 4: Crisis Systems in Washington State
- Module 5: Self-Advocacy in Crisis
- Module 6: Interventions
- Module 7: Conflict and Crisis
- Module 8: Suicide Prevention
- Module 9: Prevention and Support
- Module 10: After-Crisis Possibilities

Materials

You will be given a hard copy of this manual and you will provide:

- A quiet, private place to participate (if on Zoom)
- A blank notebook or journal
- Writing utensil: pen, pencil, computer—something with which to take notes or jot down any information you might need during class
- Your personal learning goals for this course

To complete this course and earn a certificate of completion, participants must:

- Miss not more than one (30) minutes of unexcused time from class
- Miss not more than a total of four (3) hours of time excused from class. Excused absences are only in special circumstances and only when pre-approved by instructor
- Complete the activities with other participants each day
- Participate in classwork fully

Overview

This course is designed to introduce you to crisis services as they are offered in local communities in Washington State. We will also introduce other methods of preventing and supporting people in crisis, whether they are currently practiced in Washington or not. We can find ways to bring promising practices to Washington if we know about them.

During this training, we will offer an overview of crisis awareness, cultural humility, intervention techniques and skills, and self-care through the lens of peer support and recovery values. This is generalized information and should be considered in partnership with your employer's policies and procedures around crisis. Your supervisor is your best resource if you have questions about crisis procedures.

There will be activities throughout the day to deepen your learning. Some of the skills you will be learning include:

- Recognizing, validating, and reframing “crisis”
- Best practices for working in crisis
- Interventions for peer support workers
- Crisis and wellness planning
- Keeping everyone safe, including staff
- Suicide prevention
- Ethics and boundaries in crisis settings
- Trauma-informed practices
- Cultural humility, recognizing where and how culture impacts crisis
- Recognizing and preventing suicide
- Self-care for individuals in the helping field

Module 1: Crisis and Self-Care

Let us prepare: Are you built for crisis work?

Any job has stressors. Many jobs come with built-in stressors, and crisis work can feel like that. Before you choose crisis work, consider these questions:

- Do you have a high tolerance for noise and confusion?
- Are you able to be comfortable with other's discomfort?
- Can you remain patient and empathetic with someone experiencing private reality?
- Are you able to set clear boundaries?

If you are not sure of the answers, working through this course may help you decide.

When we feel overwhelmed, we need a method of regaining control and feeling safe. Grounding exercises anchor us to the present moment and away from panic or flashbacks. You may use grounding techniques yourself, and you can also teach them to peers.

OPTIONAL: Please choose this activity or one from Appendix I

Practice

Think about what you can feel right now. What surface do your fingers touch? Is the surface smooth or rough? Cold or warm? Flat or lumpy? Now think about what your feet feel. Can you feel the firmness of the floor beneath your feet? Can you feel the texture of your socks? How do your legs feel against the chair? Your back? What else can you feel? Your clothing? The air? A fan?

What do we mean by crisis?

"Crisis" means different things to different people. In our training we are referring to a "behavioral health emergency" or "behavioral health crisis." This language indicates that it's an urgent situation and clarifies that it's about behavioral health as opposed to a serious accident, heart attack, or something else.

Crisis (noun):

1. A time of intense difficulty, trouble or danger.
2. A time when a difficult or important decision must be made.
3. The turning point of a disease when an important change takes place.

In peer support, we think about crisis as a time when someone is no longer able to make good choices or take healthy action on their own behalf, and they may be at risk of harm to self or others.

What has crisis been like for you?

It is important to remember that crisis does not mean the person is violent or may be a danger to others. Please remember that the people facing behavioral health challenges are often survivors of violence rather than perpetrators. It does mean the person may need additional support to ensure they stay safe and healthy. We are going to examine what crisis might look like before we return to self-care.

What is "crisis awareness"?

Crisis awareness is having the understanding that people can go into crisis at various times for various reasons. We do not *expect* people to go into crisis, and we want to be prepared for it.

What might crisis look like?

Crisis is a very personal experience, and it can look different from one individual to another. Some people will tell others about their distress, while some will keep it quiet. Some people stop eating or sleeping. Some people may sleep constantly or eat too much. Some people experiencing crisis can be loud, very agitated, and aggressive. A person may also be completely withdrawn and incommunicative. There will, of course, be variations of what this looks like, and some of these elements may not be obvious. Some people, especially trauma survivors, may try to disguise their suffering. Keep in mind that often, these actions are self-protective and arise from fear. Family members may be able to give you more information about the person, especially about what would be helpful for the person who is in crisis. Be sure to check with adults, and any young person who is 13 or older, before involving family members. You can find more information on the [Age of consent for behavioral health treatment fact sheet](#) or look up “age of consent WA State.”

A person experiencing crisis may struggle to concentrate, or just to navigate everyday challenges. They may feel suspicious of people they usually trust. This lack of focus and trust means that it can be incredibly challenging for a person to follow suggestions (or demands) from providers, law enforcement, or family members. At some point, the person begins to feel they cannot emerge from their despair without support. It is not unusual for individuals to feel—and express—hopelessness. Hopelessness and despair may lead to thoughts of self-harm or suicide.

People who work in crisis settings generally see peers on the worst day of their lives. When peers are discharged from crisis settings, they will typically transfer to a different provider, and a different peer support worker. Because crisis workers do not see us when we’re well, it’s important that we remind our coworkers that people can and do recover.

Remember that crisis is temporary. We view crisis through the lens of trauma, using our curiosity and our connection with the peer to understand what is happening, and how that might be an expression of trauma survival. A focus on the peer’s strengths will help us approach support from that peer perspective.

Crisis looks different for everyone. It’s important that we do not **assume** someone is in crisis, just because we see behavior or emotional expression that seem intense. Intense expression could be a person blowing off steam, or it might be their “normal.” Do not try to label someone else’s experience. Connect with the person; engage with them and invite the peer to share. Listen with the intent to hear and understand, not the intent to respond. Ask what would be helpful for the peer right now. Reflect strengths. Validate and reframe.

Use your partnering skills.

Certified Peer Counselors aim to use strength-based support and communication with peers. This is even more important when working with an individual experiencing crisis. While language should be clear and simple, it should also be hopeful. We are honest with the peer (the person we are supporting) while keeping an eye on opportunities for things to get better. Our aim is to do more than just support peers through a crisis: we want to support them in developing a life worth living. Natural supports are an important source of strength, one we can start inviting in right away, with the person’s approval of course.

If a child or young person is in crisis, the family will be an important source of both information and support. Depending on your role (Parent Partner or Youth Partner), your focus may be more on the family members than on the young person. Remember to stay in your lane; family members need support for their own wellness and resiliency when their youth or child is in crisis. It is just as important for a young person to have their own peer support especially on WISE teams. WISE Teams are Wraparound with Intensive Services, the model used in Washington to serve youth and families. For more information on WISE, [read the WISE fact sheet](#).

Optional: Please choose this activity or one from Appendix I

Practice

Work in small groups, discuss how your family defines crisis and how you think about “help.” How are these ideas shaped by your culture? Why is this knowledge important to our work?

Self-care corner

Make sure that you have your own self-care action plan when you decide to start working in the helping profession. Remember: “You need to put your own oxygen mask on first.” Do some self-care planning research. Watch a video or take a class to see what is right for you. Remember that self-care is not just bubble baths and candles. Sometimes self-care is setting tough boundaries with people you love and risking them not understanding or being upset that you prioritized yourself before them. Self-care is NOT selfish!

Multicultural peer support

Multicultural peer support is offering interventions that are effective to individuals from culturally diverse backgrounds and identities. Race, ethnicity, culture, and identity influence our lives greatly, as do gender, gender identity, sexual orientation, age, socioeconomic status, religion, veteran status, ability or disability, and many other factors. Keep in mind that these cultural influences dictate:

- How people perceive and define extreme experiences
- How people relate to families and friends
- How individuals define “help”
- How individuals define “illness” and “wellness”



The way we think about and define “crisis” is influenced by culture. You need at least a basic understanding of cultural differences and cultural humility to be effective working in crisis settings. Cultural supports may be important in helping a person regain and sustain balance. For example, some 12-Step programs in Arizona regularly use sweat lodge ceremonies to support Native American/Indigenous people in recovery. In New Zealand, a group of Māori people in recovery take a river journey through their ancestral homelands as a way to connect to traditional strengths. The person’s values and strengths will direct the type of support they want, and what they find helpful.

Refresher: CPC partnering skills

Think back to the Certified Peer Counselor “partnering skills.” Those are foundational communication skills for peer support work. Peer support in crisis is not different in its communication skills, so we already have those skills we need to start. Learning to use partnering skills in crisis is just a matter of how and when to use those skills.

- **Orienting** is crucial in crisis work. Surprising a person who feels out of control is guaranteed to make them feel even more out of control and may escalate the crisis. Orienting in this context starts with telling people what’s going to happen next: if there will be meetings, whether a specific provider is going to come speak with them, if there is staffing happening, and anything else that will help the person feel better informed. Be sure to tell the person if you must report their behavior or speech, before you report it.
- **Reflecting and paraphrasing** are two partnering skills we use a lot in crisis. As much as possible, we avoid giving commands because we want the person to regain control. Reflecting the emotion we think we’re hearing can help the person clarify their thinking. Paraphrasing helps make sure you’re understanding the person’s meaning.
- **Reflecting meaning and values** clarifies what the person wants most, which may be more important than what they want in the moment.
- Use **open-ended questions** as much as possible, issuing an invitation to keep talking. You might even skip the questions and use phrases such as “tell me more.” “Say more about that.” We want to avoid narrowing the topic, allowing the peer to take the conversation where they want it to go.

Optional: Please choose this activity or one from Appendix I

Practice

Work in small groups. Thinking about these partnering skills, which you learned in CPC class and have been practicing, how does culture impact the use of these skills? Have you seen cultural variations? Are there cultural variations you would suggest to your group?

SAMHSA's Recovery Principles

Recovery principles apply to recovery from crisis, just like they apply to recovery in general. Crisis is a temporary challenge, and people can and do recover in spite of having challenges. Research conducted toward the end of the last century showed that there are no specific indications that any one person is more likely to recover than anyone else: diagnosis does not determine whether people recover, nor does number of hospital admissions or times in crisis. There is hope for all.

SAMHSA's working definition of recovery: "Recovery is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life."

Because crisis is not an "ordinary" experience, it can feel extremely uncomfortable. Before we do this work, we reflect on our own wellness and recovery. Maybe it's time to review our own wellness plans and see if they meet our current needs. If we plan to work in a crisis setting, we may need additional, or simply different, self-care related to our work. The Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with the National Mental Health Information Center U.S. Dept. of Health and Human Services, **developed these Ten Guiding Principles of Recovery**. These principles form a basis for our own self-care, and for developing and providing crisis peer support. You learned about these principles in CPC class, and we just highlight them here.

Person-driven

The first principle is that recovery is *person-driven*. This means that individuals lead, control, and exercise choice over any services that they choose to access, over their own recovery, and over personal control of resources.

Hope

When we are at our lowest point, our most hopeless, it's crucial that hope be part of the message. Without a better future to imagine, it feels overwhelming to keep moving forward. We need to hear that a better future is possible, that people can and do recover, that we can overcome the challenges we face. We want to be careful not to minimize the person's struggles while at the same time remaining optimistic that a way forward will be found.

Holistic

Crisis isn't about just one thing. Often the peer's entire life is impacted in a crisis. Peer supporters remember to consider the person as a whole.

What does that mean?

- Housing
- Employment
- Education
- Overall healthcare (preventative check-ups) and dental care
- Complementary services such as acupuncture and massage
- Physical activity
- Spirituality
- Creativity
- Social networks
- Community activities, and
- Family support (however that's defined)

Peer support

It is a basic human need to feel connected to others, to feel that we belong to some community. Before we reach crisis, we may have alienated our family members and friends, or we may be embarrassed about our behavior and reluctant to ask for support. Peer support can provide that human connection when natural supports fail. By our presence in crisis settings, we demonstrate that people can and do recover.

Peer support for families may look different than it does for adults. Parent Partners may be focused on supporting the parents and building family resilience. Youth Partners will be more directly involved with the young person (typically the "peer" in the crisis setting). Some providers combine this role into a "Family Partner." When possible, best practice suggests that those roles are different and are best filled by two different people. Be aware of the differences in systems and what resources are available for everyone, at your employer and in the community.

Relational

People do not recover in isolation. We recover in relationship with other people. Think about what relationships were important for you. Invite in those people who support the peer's recovery. Family support will always be important for a child under thirteen and will often be important for older youth and adults. Check with the peer to see who they would find supportive.

Cultural

As we have mentioned, culture has an important impact on how each person defines crisis, how they think about "help," and what they want from others when they are struggling. We think we know what people look like when they experience distress, but again, what we present to others is mediated by culture and may look different than what we expect. Watch your assumptions. Do not be afraid to ask, or to talk about differences. Respect the peer's and/or family's values.

Strengths and responsibility

Individuals have strengths that support recovery and will help them solve their problems. We always reflect strengths and how they might support recovery, and it's even more important during a crisis. As peer supporters, we also reflect the courage it is taken for people to confront their challenges and take responsibility for solving them. Families also have strengths that will support the peer in crisis if that's the peer's choice.

Trauma-informed

In a behavioral health emergency, remember that healing from trauma starts with **safety**. Finding places and people that feel safe to the individual in crisis is important. Helping the peer find that safety should be the first step. Ask, "What would feel safest to you right now?" Be careful not to assume what will help the person feel safe.

Non-linear or many pathways

Simply put, this principle says that people are unique! Setbacks are an expected part of recovery. We also recognize that we may have unique needs in crisis. Understanding the person's culture gives us insight into what might be helpful for the person. When we know the person's and family's strengths and preferences, we can help them discover approaches and resources that they can use.

Respect

Traditional systems often exclude peers from decision-making, especially when the peer is experiencing crisis. Respect for the peer means that we work hard to involve the peer, to the fullest extent possible, in decision-making and in all services. We find our way back to balance more quickly when we make our own decisions and choose our path. Family members should always be included for children under 13, and may be included for older youth if that's their choice.

Stigma

Dictionary.com defines stigma as "a mark of disgrace or infamy; a stain or reproach, as on one's reputation." People who struggle with behavioral health challenges are often seen as unworthy by others, as though these struggles were intentional bad behavior. Part of our work in peer support is to counter this stigma, to be living examples of people thriving in recovery. We are the evidence that recovery is possible. Stigma can lead to discrimination in services, which is illegal and unethical.

Eight Dimensions of Wellness

In the CPC prerequisite class, you were introduced to the Eight Dimensions of Wellness. This outline is a way of thinking about overall wellness that can be used for our personal self-care and wellness, and we can also share the ideas with peers and support them in their self-care. Self-care is crucial in crisis work.



View [a handy workbook](#) with self-assessments, worksheets, and a daily planning format. This workbook can be downloaded and printed at no cost. It includes a daily plan that addresses each dimension of wellness.

We know that when our self-care routine starts to slip, we may be headed for a behavioral health emergency. Self-care is crucially important for peers, and it's also important for us as peer support workers. Working in a crisis setting is stressful, and your own self-care may determine how successful you are working in crisis settings. Today we invite you to **think deeply about your own self-care**, how you manage now and what you might want to try. Self-care needs change depending on many circumstances. Monitoring our wellness gives us an opportunity to make “course corrections” before lack of self-care causes problems. A link to an outline for making your own plan based on the Eight Dimension of Wellness is included in the resources section in Appendix D.

The Eight Dimensions of Wellness are interconnected. Imagine that you lost your job, and suddenly you're experiencing stress in the “financial” domain of your life. That financial stress may create emotional stress, and this could lead to physical challenges (illness, poor nutrition, loss of sleep). You would also feel less effective in the occupational domain, which can interrupt your social connections and even your sense of meaning and purpose (spiritual domain). When one domain suffers, chances are one or more of the others will be impacted.

- Emotional wellness:
 - The capacity to recognize our feelings, the ability to express them.
- Physical wellness:
 - Managing chronic health conditions, being active, eating well.
- Spiritual wellness:
 - May be a source of strength or a source of trauma.
- Social wellness:
 - Feeling connected, belonging to some community.
- Intellectual wellness:
 - Exploring creativity, being lifelong learners, critical thinking.
- Occupational wellness:
 - Reflecting various roles we inhabit throughout our lives.
- Financial wellness:
 - Having access to resources to support basic needs.
- Environmental wellness:
 - Feeling safe and comfortable in our environment.

*View [a shortened version of the Daily Wellness Planning](#), specifically using the Eight Dimensions of Wellness.

NAPS Core Principles of Peer Support

The SAMHSA Recovery Principles are our primary guide as we review the crisis system in Washington State. Each principle defines practices for peer support and guidance for supervisors and peers related to the core values. These principles are foundational to peer support, and the practices associated with the core values are our tasks in peer support. The National Association for Peer Supporters (NAPS) has developed a set of principles for peer support. They have also published a webcast for supervisors, along with a page of resources specifically for people supervising peer support workers.

National Practice Guidelines for Peer Specialists and Supervisors, with just the core values and the basic practice standard. Read more detail about [the National Practice Guidelines](#).

Core value	Practice
Peer support is voluntary	Support choice
Peer supporters are hopeful	Share hope
Peer supporters are open-minded	Withhold judgment about others
Peer supporters are empathetic	Listen with emotional sensitivity
Peer supporters are respectful	Be curious and embrace diversity
Peer supporters facilitate change	Educate and advocate
Peer supporters are honest and direct	Address difficult issues with caring and compassion
Peer support is mutual and reciprocal	Encourage peers to give and receive
Peer support is equally shared power	Embody equality
Peer support is strengths-focused	See what's strong, not what's wrong
Peer support is transparent	Set clear expectations and use plain language
Peer support is person-driven	Focus on the person, not the problem

Summary

Need to know

"Crisis" means different things to different people. Crisis work is not for everyone. Crisis is temporary. The experience of crisis is mediated by culture. Self-care is crucial, both for crisis prevention and for ongoing wellness. We are always doing peer support!

Good to know

Crisis workers use strengths-based supports and work to involve the peer's natural supports. CPCs will use the same partnering skills as we learned in CPC class. Peer support is unique: stay in your lane!

Resources

Dimensions of Wellness:

- [Eight Dimensions of Wellness](#)

Supervision:

- [Supervision Self-Assessment William White](#)
- [SAMHSA Supervision for Peers](#)

Module 2: Trauma-Informed Approaches in Crisis

Trauma-informed approaches

What do you remember about trauma-informed approaches from the CPC training?

The first thing you might remember is that this approach changes the question from “*what’s wrong with you?*” to “*what happened to you?*” Remember, that’s not a literal question: in practice, we might just ask people to tell us their story or tell us what’s going on. Crisis settings definitely lend themselves to asking, “What happened to you,” since many experiences of crisis can be traced to an event or other circumstance, such as an anniversary or relational violence.

What is the difference? “What is wrong with you?” implies that there’s something *not right*, perhaps broken or nonfunctional: at the very least, not “working.” It also implies that whatever is going on is the person’s fault. Asking “what happened to you?” recognizes that it’s not the peer’s fault. In fact, many people experience *post-traumatic growth* after a crisis. We’ll look at post-traumatic growth in more detail later in this course.

One of the leaders in trauma-informed work is Sandra Bloom, M.D. Her book, *Creating Sanctuary* (Sandra L. Bloom, 1997), outlined her work in understanding how trauma shows up in humans. Bloom developed training on trauma for agencies, which she still conducts. She proposes a set of **Sanctuary Commitments** for providers, aimed at creating safety in the environment. These commitments include:

- A commitment to nonviolence:
 - A shared definition of safety, safety skills, trust, and resilience to stress.
- A commitment to emotional intelligence:
 - Development of emotional management skills, respect for emotional labor, limiting paralyzing fear, and awareness of limiting cognitive-behavioral patterns with willingness to change.
- A commitment to social learning:
 - Building cognitive skills, improving decision-making, promoting healthy dissent, developing needed skills.
- A commitment to open communication:
 - Agencies overcome barriers to communication, discuss the “unmentionables,” increase transparency, and reinforce healthy boundaries.
- A commitment to democracy:
 - Developing skills of civic participation, self-control; working to find fair, non-violent solutions to conflict.

- A commitment to social responsibility:
 - Keeping us tethered to the community, ensuring that we work for the common good.
- A commitment to growth and change:
 - Mourning losses, releasing the past, and moving into a better future.

Trauma-informed approaches are, at their heart, informed, holistic, strength-based, and collaborative. In other words, all agency staff must understand the agency’s approach to trauma; they understand that recovery from trauma involves the whole person and not just their emotions; that staff focus on the strengths of peers to remind them of their capacity for change; and that services are collaborative with the peer. Since trauma generally involves loss of control, ensuring that peers are active participants in services, that they control as much as possible, is crucially important.

SAMHSA developed what they call the **Four Rs of Trauma-Informed Care**, from 2014. The Four Rs are:

- **Realize:** We *realize* the widespread impact of trauma and understand potential paths for recovery
- **Recognize:** We *recognize* the signs and symptoms of trauma in individuals, families, staff, and others involved with the system
- **Respond:** We *respond* by fully integrating knowledge about trauma into policies, procedures, and practices
- **Resist:** We *resist* re-traumatization, especially of children, as well as the adults who care for them

What does this mean in practice? First, that all employees understand that trauma is widespread, and that people can and do recover despite major trauma. It means that when we meet with peers, their families and other employees, we are aware of the signs that people are trauma survivors. It demands that we examine agency policies and procedures to see if they unnecessarily activate a trauma response in a peer, or if they have the potential to do so. And we work hard to ensure that we do not create more trauma.

Has your agency taken these steps? If so, when? If not, why not?

Optional: Please choose this activity or one from Appendix I

Practice

In the adult standard CPC class, you did an activity with these Six Principles of Trauma-Informed Approaches. Today we'd like you to consider whether these principles are observed in your work, and if so, what that looks like. Answer the question associated with the principle(s) assigned to your group. The facilitator will assign the principles. (10-20 min)

Principles of trauma-informed approaches

- **Safety:** How do peer support workers in your agency create an environment of safety for peers?
- **Trustworthiness and transparency:** How often are you completely transparent with a peer? How often do you keep things from peers? Does agency policy support transparency?
- **Peer support:** Is peer support available to everyone? Is it voluntary? Are we able to share stories of hope?
- **Collaboration:** There will always be power differences between staff and peers. How does your employer minimize this power differential? How do you?
- **Empowerment:** Supporting voice and choice leads to empowerment. How does your employer honor the peer's voice? How fully are peers able to make their own choices? Consider choices in the services they choose and choices in which services are offered by the provider agency.
- **Humility and responsiveness:** How do you personally monitor biases, assumptions and stereotypes? Is your agency supportive of cultural humility and does it provide opportunities for ongoing learning?

Optional: Please choose this activity or one from Appendix I

Practice

Your instructor will provide you with flipchart paper for each participant, and markers. Draw an iceberg on your paper. Await further instructions.

Once everyone has reported back, let's talk about how we might advocate for a more trauma-informed approach in areas we have identified as needing support.

If you are interested in learning more about trauma, we invite you to look further. Better understanding makes us better peer support workers. You can find videos, websites, and articles in the Resources section in Appendix D.

Different perspectives

Most traditional, medical-model and crisis services have a specific perspective about mental health challenges, generally referred to as "medical model." But that's only one perspective. What changes when your perspective on the problem changes?

As we're exploring resources for recovery after a crisis, recognize that their perspective may be different than the "medical model" perspective. This is not an argument for or against psychiatry, simply the idea that psychiatry's take on behavioral health challenges is *one* perspective out of many. When we are supporting a person's recovery journey, and especially supporting them to find reasons to live, it's important to support their own understanding of their experience, as long as it's useful in recovery. Exploring meaning is important and can be crucial in a crisis. If a peer tells us their challenges are caused by oppression and inequality (sociology) instead of brain chemistry, we support the peer to use that understanding in formulating a recovery plan.

Optional: Please choose this activity or one from Appendix I

Practice

Around the world, there are many ways to think about the experiences we call "distress" We know that psychiatry's perspective on behavioral health challenges is that psychiatry treats organic disease. Consider the perspective of these other viewpoints. Share your perspectives with the rest of the class.

- Spirituality
- Mythology
- Culture
- Sociology
- Race
- Economics
- Nutrition
- Trauma

Post-traumatic growth

The concept of post-traumatic growth is that many people, following an intense traumatic experience, will find some way to turn that experience into a strength, or something good. One example might be a parent whose child develops a chronic illness, and the parent then starts a charity to support children with similar illnesses.

Tedeschi and Calhoun (1996) developed the Post-Traumatic Growth Inventory (PTGI) to assess post-trauma growth and self-improvement following a traumatic event. A 21-item scale built on the five-factor model of Tedeschi, this inventory is one of the most valid and reliable resources for evaluating personal growth that follows a stressful encounter.

The statements included in the inventory are related to the following five factors:

- **Factor I** – Relating to Others—reflecting feelings of closeness, recognition of others’ emotions and needs
- **Factor II** – New Possibilities—Recognizing what we want to change
- **Factor III** – Personal Strength—demonstrates confidence gained
- **Factor IV** – Spiritual Enhancement—depending on the peer’s beliefs
- **Factor V** – Appreciation of Life—including recognizing the value of one’s own life, appreciation for our time

*The inventory is included in this workbook as Appendix B.

Some people find it helpful to track their steps toward reaching a goal. The following goal tracker is adapted from www.positivepsychology.com. The actual goal would be written in the top row so the person can track steps toward each specific goal, for each day of the week. Print it out in a full page and there will be lots of room to write.

Day	Goal	Goal	Goal
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Want to use an app to track your goals? Many simple apps range from free plans to fee for service plans. Some of the most popular apps include:

- ClickUp (productivity tracking, free plans up to \$5/month/user).
- Strides tracks SMART goals and habits, with built-in trackers and reminders; Strides also has a free version and a plan starting at around \$5/month.
- Coach.me calls itself “a home for ambitious people.” In addition to a habit tracker and milestone check-in, personal coaching is available. Coach.me plans start free, but personal coaching adds weekly costs of around \$25.
- Way of Life is known for its simplicity and “beautiful design.” It has a color-coded tracker system, and the diary function lets you note when something triggers a bad habit. Plans start at free and go up at \$5/month.

Each person will have preferences: whether to use an app or not, and which app to use. Learn about some of the apps yourself, so you can share with peers.

Summary

Need to know

Crisis and trauma are often closely related. Trauma-informed approaches are especially important in crisis settings. People can recover from the effects of trauma.

Good to know

Crisis can create opportunities.

Resources

- Sandra Bloom's **The Sanctuary Module Through the Lens of Moral Safety**
- Van der Kolk, B. A. (2015). *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma*. United Kingdom: Penguin Books.
- Bloom, Sandra (1997). *Creating Sanctuary: Toward the Evolution of Sane Societies*, New York: Routledge.
- Hamilton, M. C. (2017). *Going Reptile: How Engaging Your Inner Lizard Leads to More Fulfilling Work and Personal Relationships*. United States: CreateSpace Independent Publishing Platform.

Module 3: Communication in Crisis

In crisis settings, our communication will become even more important as the crisis affects how people see, hear, and understand others. We may need to adapt our communication to ensure that it doesn't feel threatening, judgmental, or bossy.

When a peer feels overwhelmed and out of control, they will respond more readily to **body language** than to words. This will not be a conscious process. Because the peer is reading body language so closely, we want to think about how we move and when. If you are tense, it may be contagious. Move slowly and deliberately, avoiding sudden movements. Keep your hands where they can be seen, not in pockets or behind your back. Keep your body and your voice as relaxed as possible. Stay focused on the peer in crisis and let other staff take care of anyone else in the area.

If the person is standing, don't approach their face directly. Walk up to their side and stand at an angle. Standing directly in front of a person can be perceived as a challenge. It may also be perceived as blocking the person in place, preventing them from feeling that they can leave. You may choose to avoid eye contact, which can also be perceived as a challenge. Keep your voice soft, so the person must lower their voice to hear you.

Communication blockers

In addition to body language, some other habits may block our ability to communicate and instead, send the wrong message.

- **Mind-reading:** This is when the listener cuts off the speaker in an attempt to speed up the process or get to the heart of the matter, because we think we know what they're going to say. You can't always predict exactly what someone else is going to say. If you cut off the speaker before they have finished speaking, then you won't hear the complete message and the peer won't feel heard. It also gives the peer the message that you're impatient, that they aren't important enough for you to want to finish the interview.
- **Rehearsing:** This happens when you review and create your response before a person has finished speaking. When you do this, you are not hearing the full message, as you are not present and not listening fully. It's okay to take a few brief moments after the other person stops speaking, to clarify your response.
- **Filtering and dreaming:** You hear only part of the message because you are listening only for certain things. People may start daydreaming when they do this and are no longer hearing what is being said. This gets in the way because, again, you do not hear the full message.

- **Judging:** You are judging people when you apply labels or otherwise judge people before or even when they are speaking. You must listen from a **neutral** standpoint in order to hear the full message being broadcast. Rather than judging, try hearing and understanding the person's point of view. Use your curiosity. The best Certified Peer Counselors are curious not critical.
- **Identifying:** The identifier is always referring to their own experiences while someone is talking. It is good to try to relate with the person speaking, and to share your story as a way of supporting and showing you understand. And, if you identify too much, then you completely miss how the person is feeling in a given situation because you are too caught up in how you felt or how you would feel in a similar situation.
- **Advising:** Advisors want to "solve" someone's problems and only listen until they can tell them what to do. It is natural to want to help, but it's best to support people through exploring and supporting them in solving their own problems. Be careful not to jump in with a suggestion.
- **Derailing:** This refers to changing the subject from what the peer wanted to talk about because you are either bored or **uncomfortable** with the subject. Expect to be uncomfortable. Learn to sit with your discomfort and explore it together with the peer.
- **Placating:** We placate when we agree with everything a person is saying in order to get their approval or make a connection. While it is important to validate someone, if you are constantly trying to agree with that person, then you are not truly listening, and you may not be honest and authentic.

Think about your body language **and** some of the communication blockers mentioned here. How often are you using one of the blockers?

Sharing our recovery story may also look different in crisis settings. Often a peer in crisis will not want to listen to a long story; they need to see how it relates to them. In these situations, sharing our story is short. If a peer is talking about a situation, you have also experienced, you might say, "When that happened to me, I felt _____. How do you feel about it?" In two sentences, you tell the peer that you've also had that experience, and you've turned it right back to them.

Communicating during a crisis

Humans use all their senses to communicate, not just our voice and our hearing. We use eye contact, movement, and occasionally a gentle touch. When a person is in crisis, senses may be heightened, and the person will be highly aware of everything you communicate, with every sense. Fear is also heightened in a crisis. Body language must match our words when we're trying to communicate with someone in crisis. If your words are calm and soothing but your body language is tense, the peer will not trust your words.

It takes practice to be able to keep your body calm when others are tense. Be intentional and find ways to practice. When voices get loud or people start moving quickly, take a couple of deep breaths before you respond. Practicing some breathing or grounding exercises for relaxation is a good daily practice, as it trains your body to respond to those cues. Start a meditation or grounding exercise with the same few breaths every time, and your body will learn to respond to that cue by relaxing. These tools are not always right there when we want them, until we train our body to have them ready.

We've mentioned giving clear and direct guidance. Remember that, when a person is caught up in intense emotions, they are literally unable to think rationally. Their brain is busy sending adrenaline to muscles, preparing them for action, and their thoughts are unreliable. Don't attempt to reason or negotiate with a person in crisis, and don't give them complicated demands.

Watch out for "Lizard Brain!"

Optional: Please choose this activity or one from Appendix I

Practice

Each group will receive a "Going Reptile" book. Read pages 65-69. Have a discussion with your group.

What makes you "go reptile?" How do you bring yourself back? How will this help you when working with peers? How does this help you understand others better?

Nonviolent communication

Nonviolent Communication (NVC) is a communication tool developed by Marshall Rosenberg; Ph.D. NVC is designed to help people get their needs met in a manner consistent with their values. As the title implies, NVC specifically aims to avoid conflict and violence, instead laying a path to a more authentic voice.

Rosenberg says, "All communication is an attempt to get needs met." That statement simplifies everything. If we do, in fact, view all communication as an attempt to get needs met, then we can understand any communicative behavior by attempting to understand the unmet needs. Communication is not confined to language, either. Our body language speaks loudly, as we have discussed. See if you can identify a possible need for each of these communications and enter your own example in the blank space.

- **Communicated:** "Hi! How are you?"
Need: To connect (nonviolent)
- **Communicated:** No response, silent scorn
Need: To let you know I am angry without having to say it or be accountable for my feelings. (violent)
- **Communicated:**

Need:

Nonviolent communication is a format to communicate our needs directly, without blame, shame, guessing, or judgment. It's a very simple method, and it takes practice. The four components are an observation, a feeling, a need, and a request. It's easy to remember as I see, I feel, I need, and I want. Each component is framed from our perspective only.

Observation

NVC starts with naming what I observe, or what I hear—such as a statement by you. It can be challenging to make this observation without any judgment or evaluation, but it's important to make this as neutral as possible. Consider the difference between “you act depressed” and “I notice you're wearing the same clothes you've worn all week. What's that about?” When we are able to avoid judgment and evaluation, it's easier for others to hear us because it sounds less like an accusation.

Feeling

This is an expression of what I actually feel related to the observation. If my observation was that I notice you wearing the same clothes all week, I might add the feeling as, “I feel worried when I see that because I remember what happened last time you looked like that.” Naming my feeling can be tricky. “I feel like hurting myself” is not a feeling, neither is “I feel that you were wrong.” Anytime the word “feel” is followed by either “like” or “that,” you're describing a thought instead of a feeling. There is a list of common human feelings and needs, from Nonviolent Communication, included in this workbook as Appendix E.

Need

This will be a genuine human need, something related to the observation that will contribute to my sense of wellness and satisfaction. It might be something like acknowledgment, respect, or connectedness. A statement that begins with “I need you to” is not a statement of need but instead a demand disguised as a need. Expressing the need part of NVC is often the hardest. Check the resource in Appendix E.

Request

Finish this with a request, perhaps an invitation to keep talking, or to do something that will work for both of us. NVC should never use the request to ask for something that will not also improve the other person's life. Some examples of a request might be, “I'd like to figure out how we both can be happy with this.” Or “Would you be willing to consider doing your laundry another time instead?” Some people are tempted to leave out the request part of this full statement, as it's a little scary to ask so directly for what we want. If I don't add the request, I leave the other person guessing at what I want, asking them to read my mind.



Here's a sample of NVC in full:

"I heard you saying again today that you didn't know what you had to live for. I feel confused and frustrated when I hear you say that every day. I need to understand what you mean. Can you tell me how I can support you when you say those kinds of things?"

This form of NVC starts with us observing or beginning the exchange. We can also use NVC to respond to something we hear, especially when we hear something unpleasant or threatening. Remember that **all communication is an attempt to get needs met**. When a person approaches you, your question is always, what need is this person trying to get met?

Let's say a peer comes up to me and says, "I don't like you, you're selfish." I could offer my knee-jerk, defensive response to the word "selfish," and we're probably going to argue. Or I could start wondering what need you are expressing. I might even consider whether I had done something you might interpret as selfish. "Were you needing to get some water this morning, but I got in line ahead of you?" Don't assume the person is saying random things just because you don't understand it. It probably makes sense to the person.

NVC suggests that the request should always be to **do** something, instead of to **stop doing** something. A **don't** leaves the person uncertain about what to do except to stop doing what they're doing now. A **do** gives some positive direction. It's the same idea as telling a person to keep talking but not as loudly, instead of asking them to stop shouting. Clarity in language is important in crisis settings.

Empathy is central to NVC. Rosenberg defines empathy as being completely present for the other person. We practice empathy when we are listening for the other person's needs. Those needs may be at the heart of a peer's crisis. Rosenberg also says we should give empathy to ourselves first: especially in settings in which emotions are high and we feel stressed. Stop for a few breaths to notice what you're feeling, where it is in your body, and to give yourself some empathy for difficult feelings. Once we have acknowledged our own emotion, our own vulnerability, we can turn our attention to the peer.

NVC is an effective tool for de-escalation purposes. If you've practiced NVC and feel confident in your use of the method, use this communication skill to invite the peer to explore the meaning of their crisis, the reasons for behavior. Reflecting what you hear from the person and guessing at needs behind the feelings invites the peer to keep talking, in a self-reflective manner. This close attention to the person's needs often has a calming effect.

Language matters

The language we use matters. Peer support workers use the language of ordinary human experience, not clinical language. We are careful about our word choices, and sometimes we need to check to be sure that what we meant is what was heard.

In this table, write in the left column language that you find stigmatizing, discriminatory, or otherwise hurtful. We'll ask the full learning community for contributions to this list. When the left column is filled, we'll see if we can think of words to replace stigmatizing language, words that convey more hope.

Stigmatizing language	Hopeful language
Defiant, non-compliant	
Treatment resistant	
Lazy	
Manipulator	

Think about how it felt to hear the language on the left. What was different about the language on the right? Now, think about words you might use every day, without thinking: "That's crazy!" "I have this client . . ." Now is a good time to work on replacing those words. Remember that "peer" and "client" are not the same: a power imbalance is implied in the client relationship.

Consider the language used routinely by your coworkers who are not peer support workers. We expect that they will use clinical language, but do they also use stigmatizing language, even in private? If so, what would you like to do about it?

Language reflects how we think, our values and beliefs. If our values include kindness toward others, respect, and acceptance of differences, we will consistently use language that reflects that. What does your language say about your values?

Following what's alive

There is a concept in mediation called “following what’s alive.” It means we focus our attention and questions on where the energy is. Remembering that people tell us their story based on who they think we are, the story they tell us is typically not complete. They will tell us about their “symptoms,” generally, rather than their feelings. They will describe how their symptoms progressed instead of telling us what happened, or what they need. And because the content of the peer’s speech is typically intense, we’re tempted to respond to *that*. Imagine a peer comes into your office and says:

I’m so depressed I can hardly even walk in here. I haven’t been sleeping, I’m disgusted at the thought of food, and I can’t seem to drag myself off the sofa. I really miss my weekly lunch with friends. Do you think I should talk to the doctor?

What do you want to respond to? What’s alive here? Think about what doesn’t fit with the rest of the statement.

If you said, “I miss my weekly lunch with friends,” congratulations! That’s where the energy is. That’s the part that doesn’t really fit, but it got snuck in there. While peers can sometimes tell us what’s happening using as much clinical language as they know, we don’t want to respond to the clinical language as much as the everyday feelings that are behind what they are saying. Respond to the human language. Respond to the emotion and follow from there. Look for the need.

Asking open-ended questions is one way to get to what’s alive. And, when we ask a question, we effectively narrow the universe of possible responses. Our questions direct the conversation. If you’re interested in what’s alive and not just in what’s needed for clinical assessment, skip the questions, and use statements. “Tell me more.” “Say more about that.” This leaves it open for the peer to talk about whatever they want to talk about. Following what’s alive, the feelings and needs, leads you—and the peer—to the source of the suffering in the moment. It’s the problem that needs to be solved.

We’re talking about following what’s alive because that’s what is needed to help peers survive crisis and learn to avoid crisis. It’s what we need to do to support peers who struggle with thoughts of suicide, and shame over attempts. We have the tools we need to keep people alive, including detention and other measures to force compliance. Without tools to help build a life worth living, we’re just sentencing people to endure their misery.

We work to help the peer stay alive, but also to build the life that will invite them to live it to the fullest.

Summary

Need to know

In a crisis, a peer may use different communication techniques. Pay attention to nonverbal and paraverbal signals.

Good to know

Our language defines our peer support role. Specialized language techniques like Nonviolent Communication may support our work.

Resources

- **A free resource for learning NVC**
The Center for Nonviolent Communication (CNVC) is a global organization that supports the learning and sharing of Nonviolent Communication (NVC) and helps people peacefully and effectively resolve conflicts in personal, organizational, and political settings.
- **The 9 Unconscious Body Language Signs To Read Someone Like A Book**
- **Body Language Activities for Adults**

Module 4: Crisis Systems in Washington

This module will introduce you to the crisis system as it exists in Washington State. If you work in behavioral health in Washington, you are likely to encounter one or more of these system components. Federal guidelines have influenced how our system is structured, and some of that guidance is changing.

National Guidelines for Crisis Care: Best Practices and Core Services

The Substance Abuse & Mental Health Services Administration (SAMHSA) suggests a no-wrong-door approach to an integrated crisis system. “No-wrong-door” means a person can access the services they need, no matter where they enter the system. This is a relatively new approach, improved over an old standard in which the services you got depended more on where you went instead of what you needed. It’s not considered best practice to provide services only for mental health challenges or substance use disorder when the person is struggling with both. SAMHSA’s approach proposes a regional crisis call center, crisis mobile response teams, and crisis receiving and stabilization facilities. We’ll look at each of these in turn.

The crisis system

There are multiple layers to crisis services in Washington State. Remember that state funds cover crisis services; any person can access crisis services when needed, regardless of insurance coverage or ability to pay. Crisis mental health services include telephone lines, crisis outreach services, crisis stabilization services, crisis peer support, and involuntary treatment for both adults and children. Crisis services for mental health are defined in WAC 182-538C-220, and include phone support, outreach, crisis stabilization, crisis peer support, and emergency involuntary detention. For substance use disorder detoxification, services include counseling regarding motivations and continuing care needs; offering appropriate community resources; tuberculosis screenings; HIV/AIDS information and risk assessment.

A peer’s first contact with crisis services may be with a crisis line. A **regional crisis call center** is a hub that provides opportunities for crisis interventions through the telephone, through text, and through chat. Regional centers minimize the expense of housing such a center in every big city or county. Resources are pooled, especially in more rural areas, so that larger areas can be consistently served with the same quality.

The next point of contact for many peers is a **mobile crisis unit**. This unit may or may not involve the **designated crisis responder (DCR)**, the person with the authority to detain the peer. **Crisis stabilization units** are available in other states, and **evaluation and treatment centers** (E&Ts) provide short-term, secure services here in Washington. Finally, Washington State passed an **Involuntary Treatment Act (ITA)** that describes the conditions under which an individual may be detained for behavioral health reasons. We’ll look more closely at each of these services to see how peer support may be involved.

Changes in the crisis system

In October 2020, Congress passed a law designating 988 as a new behavioral health emergency number nationwide. As a result of that legislation, in 2021, Washington State passed its own legislation—the first in the nation—designed to overhaul the behavioral health crisis system. Our 988 number in Washington went live in July 2022. A Tribal 988 line is used in Washington to route calls for tribal members to tribal members specifically.

Historically, in many states, concerned family members or friends called law enforcement for loved ones in a behavioral health emergency. However, law enforcement is often not trained to recognize mental health challenges and they may misinterpret signs of intoxication or psychosis. A person experiencing a behavioral health emergency may be unable to follow directions or respond to questioning. Any behavior that is not immediately compliant with law enforcement can result in life-threatening harm to the person in crisis. Asking law enforcement to resolve behavioral health crises has at times resulted in further trauma to people in crisis, and sometimes physical harm.

Emergency department (ED) referrals are another common suggestion for behavioral health emergencies. Some people may get what they need in the emergency department. However, the ED can be very busy and chaotic, they may not have room to put the person in a quiet place, there can be long waits, and if the person needs an inpatient setting, it's not always available. Emergency departments are required to move individuals out of the ED as quickly as possible; they may not just hold people there until a bed opens somewhere.

The new legislation suggests additional investments in the crisis system. In addition to the services mentioned earlier, the role of crisis teams is expanded. These crisis teams will be known as ***mobile rapid response crisis teams***. To support the most intensive crisis services, a variety of crisis stabilization services should be implemented, such as 23-hour crisis stabilization units based on the living room model, crisis stabilization centers, short-term respite facilities, peer-run respite centers, and same-day walk-in behavioral health services. The overall crisis system shall contain components that operate like hospital emergency departments that accept all walk-ins and ambulance, fire, and police drop-offs. Certified Peer Counselors as well as peers in other roles providing support must be incorporated within the crisis system and along the continuum of crisis care.

Optional: Please choose this activity or one from Appendix I

Practice

As we've discussed, how we ask for help is often culturally determined. Some common behaviors in crisis have been described. In small groups, discuss how expression of help might look in a culture other than your own. How can we learn to recognize asking for help from other cultures?

Mobile Crisis Units (MCU)

A “mobile rapid response crisis team” is defined as a team that provides professional, on-site, community-based interventions for individuals in a behavioral health emergency. Those services may include outreach, de-escalation, stabilization, resource connection, and follow-up support. Mobile crisis teams are available to reach any person or family in the covered service area, whether that person or family is at home, at work, or anywhere else in the community.

These mobile crisis units should include licensed and credentialed Certified Peer Counselors as a best practice. The state allows units to operate without a Certified Peer Counselor if one is not available to employ. It would be ideal to have Parent and Youth Partners available for calls to families, but funding constraints make that unlikely. Any Certified Peer Counselor working on a Mobile Crisis Unit should have a clear working understanding of the differences in role between peer support for adults, and peer support as a Parent or Youth Partner. Stay in your lane!

As part of the *Trueblood* settlement, the Health Care Authority tasked regions with developing plans for MCUs specifically to serve returning citizens from incarceration, or those at risk of returning to incarceration. Pierce, Spokane and Southwest regions led the way in 2021, followed by the rest of the state phasing in specialized plans.

Why mobile crisis?

Mobile crisis units are designed to bring services to an individual in a behavioral health emergency. Mobile crisis units typically consist of two individuals: a peer support worker, when available; a social worker; a therapist; sometimes a person from a faith community; perhaps a paramedic or law enforcement. There are various reasons for making specific choices, allowing for the unique needs of each community. The law that launched mobile crisis units does require that peer support be available on these teams—**as the workforce allows**. In other words, if they can’t find a qualified Certified Peer Counselor to hire, they may omit peer support.

Mobile crisis units recognize that it can be challenging and scary to be forcibly relocated to a different place when in crisis. Remaining in one’s home (or other original location) is more likely to feel safe to the peer in crisis. The team will work with the person, and family members if applicable, to understand the nature of the person’s crisis. Once they’ve engaged the person and/or the family, the team will make an assessment and decide whether they feel the person is safe where they are, or they might be safer somewhere else. Depending on the region there may be a variety of options for the person if the team believes they are

not safe at home. The goal is always to create a safe situation for the person, without having to detain them. The law demands that we consider the person’s right to “least restrictive alternative” (LRA), which means detaining them is always the last option.

If you are the peer support worker on a mobile crisis unit, remember that your role is to do **peer support**. It is tempting to always agree with our work partner, and we may often agree with them when they suggest that a person be detained. Remember that it is our job to hold space for the peer, to invite them to lead the planning process, to respect their wishes. Preservation for life is always our highest value, and whenever possible, we want to honor the person’s desires.

Optional: Please choose this activity or one from Appendix I

Practice

In small groups, imagine that you are responsible for developing Mobile Crisis Units in your area. Your MCU can have a **maximum** of three people. Who do you think those three people should be, e.g., CPCs, social workers, paramedics, law enforcement, etc.? Be prepared to tell us who is on your team, and why you chose those roles. Does your MCU support peer support values, as shown in the National Practice Guidelines? Finally, how is your MCU culturally responsive to people in your area?

Crisis receiving and stabilization units

Crisis receiving and stabilization units are comfortable settings, often furnished with chairs instead of beds, where an individual may remain under observation and receive crisis stabilization services for under 24 hours. These settings are home-like and often felt less confining than a hospital. Some other states use what is known as a "living room model." These use recliners and peer support to assist people for just a few hours. This type of service is not available in Washington State (at the time of this course's first release).

Evaluation and Treatment Centers

Evaluation and Treatment Centers (E&T) typically have 16 beds or fewer to comply with federal licensing requirements. Most of these facilities are locked and detain individuals. Some have beds in an unlocked section and a few more beds in a secure section. Individuals generally remain in an E&T for a very short period, typically 10 days or fewer. Peers may be referred to hospitals if a longer stay is needed. They may also be released and referred to outpatient services. The primary requirement for a crisis stabilization unit is that they must be prepared to admit individuals in need at any time, day, or night, when they have capacity. They must also have at least some beds that are secure, for law enforcement to drop off people in need. E&T settings may hold people with justice involvement who are waiting for evaluations to determine their status in the legal system. This short-term, emergency stay model is used in other states but may have a different name.

Youth crisis centers

The "Becca Bill" (named after a runaway youth who was subsequently killed) established Secure Crisis Residential Centers (SCRC) for runaway youth. The Becca Bill authorizes law enforcement to pick up runaway youth, or youth found in "dangerous circumstances," and place them in these physically secure, short-term residential facilities. SCRC counselors work with families to resolve immediate conflict, facilitate a reconciliation between parent and youth, and provide referral to additional services.

- Youth may not remain in a detention based SCRC longer than five consecutive days or in a non-detention facility more than 15 days.
- Youth may transfer between a SCRC and a Crisis Residential Center (CRC), but the total length of stay at these short-term, semi-secure facilities for runaway youth, and adolescents in conflict with their families still cannot be more than 15 consecutive days.

Counselors at the CRC (typically, in collaboration with a social worker) work with the family to resolve the immediate conflict. Counselors will also help the youth and family develop better ways of dealing with conflict in the future. The goal is to reunite the family and youth wherever possible. The family will also be referred for additional services if other needs are identified.

Designated Crisis Responder

When a person experiences a behavioral health emergency that might pose a threat to the safety of the individual in crisis, or to others, the law allows that person to be detained for a set length of time. RCW 71.05.240 allows the court to detain a person for fourteen days of involuntary treatment, or ninety days of “less restrictive alternative” treatment. Courts may detain an individual for a mental health crisis or for withdrawal management and stabilization for substance use disorder.

The petition for detention is considered in a court hearing. The individual has a right to an attorney in this hearing. The petitioner, who is typically the Designated Crisis Responder, presents to the court evidence that the person “presents a likelihood of serious harm, or is gravely disabled.” The petitioner must also show that the individual has not entered voluntarily into treatment. Orders for a less restrictive alternative must name the provider that will be responsible for services to the person. Should the petitioner desire to lengthen the person’s detention, the individual must be notified in writing and the person has a right to a full hearing or jury trial.

The Designated Crisis Responder (DCR) is a specialized role and is typically a licensed therapist with many years of experience. Generally, an agency is identified as the DCR in each region. The agency then staffs qualified providers to fulfill the requirements of the DCR role.

When a DCR is called to assess a person in crisis, their primary role is to determine whether that person meets criteria to be detained. While they do this, they have multiple tasks. Their first task will be to interview family or friends, or any other person who may be with the individual experiencing crisis. The DCR will inform the person of their involuntary treatment rights and will then interview the person. Depending on where you are in the state, there may be a variety of options for the person. When less restrictive alternatives such as peer-run respite are available, those resources may be offered. If the DCR decides the person meets criteria for involuntary treatment, they will seek a suitable treatment bed for 120 hours. If no involuntary bed is available, the DCR will not detain the person.

What is the peer support role when the DCR is involved? Chances are, you will have had an opportunity to speak with the peer before the DCR is called in. The DCR may ask for your perspective and observations before meeting with the person. Speaking with the DCR will be no different than speaking with the rest of a treatment team in an office: represent the peer’s position as they want you to, not as you think they should be represented. Whether you agree with the person or not, tell the DCR what the person wants. If you are aware of natural supports or other community resources that might help this peer, don’t hesitate to tell the DCR.

If a peer is refusing medication, use your curiosity to find out why they don’t want to take it. Medications work differently for different people. A medication that works very well for one person may not work at all for another, or there may be intense additional effects of medications such as akathisia or metabolic syndrome. Some additional effects of medication can be fatal. If you think the peer is voicing distress over medication side effects, be sure to communicate that to the mobile crisis unit and/or the DCR.

The Involuntary Treatment Act

The Involuntary Treatment Act (ITA) in Washington was revised in June 2020. The guidance about detention is different for youth than it is for adults. The primary change to the ITA is an expansion of initial detention from three days to five days. People held under the ITA will be detained for a maximum of 120 hours, *excluding* weekends and holidays.

Providers may choose to detain a person for fewer days, but not more. New rights were added, which must be posted in any facilities in which individuals are detained. Medical staff are permitted to compel patients to take antipsychotic medications—both adults and minors, and they may be used for short-term and emergency use, either during inpatient stays or during LRA orders. Some people who initially spend some of their ITA time in an inpatient setting may later be released to complete that time in a Less Restrictive Alternative (LRA), often outpatient services.

Another addition to the ITA law is the ability of staff to conduct ITA evaluations by video if hospital staff are present. Patients may be transferred out of county at the request of the DCR. The definitions of “gravely disabled” and “likelihood of serious harm” have been expanded to allow detention under more conditions.

Medication (usually antipsychotic medication) may be compelled under the following conditions:

Short-term treatment (RWC 71.05.215(2))

- The person is found to be gravely disabled or presenting a likelihood of serious harm as a result of a behavioral health disorder
- Medication is for short-term treatment up to 30 days
- Informed consent was refused, and
- There is a concurring medical opinion approving medication by a qualified prescriber with prescriptive authority (second medical opinion)

Emergency treatment (RCW 71.05(d) and RCW 71.01.217(1))

- The person presents an imminent likelihood of serious harm
- Informed consent was refused
- Medically acceptable alternatives to the administration of antipsychotic medications are not available or are unlikely to be successful; and
- In the opinion of the qualified prescriber, the person’s condition constitutes an emergency requiring the treatment be instituted prior to obtaining a second medical opinion

For non-emergency treatment, a peer has a right to refuse antipsychotic medication 24 hours before the ITA hearing. The prescriber must document their attempts to obtain informed consent and the reasons why medication is administered over the peer’s objections.

Under the new rules, video evaluation by a qualified provider is allowed if a qualified clinician is available to be present with the peer. Video is not required but may allow providers to complete evaluations within the time frame required by law, especially when staffing is a challenge. Video evaluation also offers an additional layer of safety during a pandemic.

Minors are subject to the ITA laws, and the revised law makes guidance about minors more consistent with that for adults. Minors may be brought to secure evaluation and treatment facilities (E&T) by law enforcement, or to a secure withdrawal management facility, and that minor may be held for up to eight hours if the minor was arrested. The Mandatory Reporter Duty to Warn guidelines apply to minors, as does Joel’s law. Joel’s law allows a family member, guardian, or conservator of a minor to petition the court directly to have a minor detained, if the DCR has failed to detain that minor. The DCR and the courts are to consider the minor’s behavior at school and at home when considering if the minor meets the definition of “gravely disabled.”

Optional: Please choose this activity or one from Appendix I

Practice

In small groups, discuss how involuntary detention might impact various communities. How will it impact veterans? Native Americans? Seniors? People with disabilities? People experiencing homelessness? LGBTQ-ia+? Families? Other communities? What kind of conversation might you have with a peer about the possibility of being detained?

Inpatient settings

Guidelines for inpatient settings come from Medicaid and from Washington State.

- State guidelines are found at WAC 246-337.
- Rights for individuals in residential treatment facilities are at WAC 246-337-075.

These rights must be posted and visible to residents and visitors in any licensed residential facility, whether for adults or minors. Each person admitted to an inpatient setting must have an individual service plan developed based on the person's health on admission. These plans must be prepared by staff, with participation by the peer. In other words, this is different than the outpatient standard, in which the person takes the lead. Individual service plans must also include a discharge healthcare plan. Discharge is to be considered from the admit date, with that goal always in mind.

An individual who is subject to ITA for a period longer than ten days may be referred to either Western State Hospital or Eastern State Hospital. Some private hospitals also accept referrals for longer-term stays. Whenever possible, the goal is to keep the stay as short as possible. Studies consistently demonstrate that most people do better in the community.

Ricky's Law

Ricky's Law, House Bill 1713, aligns Washington's substance use and mental health statutes addressing the way we deliver care to individuals.

When secure detoxification facility beds were not available, patients like Ricky ended up in emergency rooms, mental health facilities or even jail cells where they were not always able to get the appropriate care. The goal of legislation was to create a unified involuntary commitment law that allows those who are at-risk due to a substance use disorder to get the necessary care to protect them and the community. The law is named after Ricky Garcia, a young man who suffered for years from substance use disorders and was hospitalized several times due to feeling suicidal. During his last involuntary hospitalization, he agreed to go into drug treatment and has reportedly been clean and sober for many years.

Read [Ricky's Law fact sheet](#) to learn more.

Joel's Law

On July 24, 2015, a new section of Washington State's involuntary mental health treatment law (RCW Chapter 71.05), went into effect. This new section is called "Joel's Law." This allows a person's immediate family member, legal guardian, or conservator to petition the superior court for initial detention under certain conditions, which are outlined below.

When can someone file a Joel's Law Petition?

A Joel's Law Petition may be filed under the following circumstances:

- You are an immediate family member, legal guardian, or conservator of the person that you seek to have detained. The law defines "immediate family member" as a spouse, domestic partner, child, stepchild, parent, stepparent, grandparent, or sibling;
- A Designated Crisis Responder (DCR) has conducted an investigation and decided not to detain that person for evaluation and treatment;
- It has been 48 hours since the DCR received a request for investigation and the DCR has not taken action to have the person detained.

Crisis care core principles

In addition to the structure recommended by SAMHSA and adopted by most states, some essential qualities must be “baked in” to any thorough crisis system. These are the Crisis Care Core Principles. We start with the most important: recovery.

- We are always addressing recovery needs. We can never lose sight of recovery as the ultimate goal; however, the peer defines it. For families, we’re addressing recovery and resiliency needs.
- Peer support is an important element, there is a significant role for peer support, supporting the peer and supporting families.
- Focusing on recovery needs means we use a trauma-informed perspective to care.
- Zero suicide is always the goal.
- Working environments must be safe and secure.
- There must be collaboration with emergency medical services and law enforcement.

With these clear expectations, crisis providers understand their obligations to peers, to families, and to employees. These crisis services, especially services that come to the person in the community, are always preferable over a law enforcement or jail response and are often preferable to a standard emergency room. We will continue to talk about trauma, recovery needs, suicide, and physical safety throughout the rest of our time together.

Addressing recovery needs

Recovery goals are important even when a person is experiencing a behavioral health emergency. Goals related to things such as employment may be less important at this time. This does not mean that we focus only on goal work during the crisis. It does mean that we are always aware of the person’s recovery goals, and that we keep them in mind when thinking with the peer about next steps. When children, youth and families experience crisis, we support them in regaining balance and strengthening resiliency. Recovery and resiliency goals are a great way to bring hope and possibility into a challenging time. We want to remind the peer that they can lead happy, productive, connected lives when the current emergency has passed.

While peer supporters may be the first ones to consider recovery needs, everyone working in crisis care should be focusing on those recovery goals. One important way to engage peers in recovery goals is just to ask about them. When possible, ask about recovery work in writing and verbally, in the person’s primary language. Ask the peer if they have a Mental Health Advance Directive, a Wellness Recovery Action Plan (WRAP), or any other kind of crisis plan. If they do, get a copy of the plan and share it (with permission!) with everyone who works directly with the peer. Recovery goals should be outlined in this document and the guidance will support services that are truly helpful for the individual.

Whenever possible, we want to include the peer’s natural supports (family or friends) in the planning process. These natural supports will be supporting the person when they leave your care, so they need to be aware of what’s working well and what plans are made. Involvement of natural supports is important for everyone!

We can focus on recovery goals even when a peer has been detained. The peer may not want to be there and may be unwilling to engage with you. If you can make a connection, begin talking about the peer’s recovery goals—goals for after the current crisis is over—and keep the focus on what’s possible. When people become invested in their own recovery, they are able to start the work to get there. That focus on the future brings the peer back to their goals.

Significant role for peers

Adding peer support to crisis services has been transformative. Our presence reminds everyone—staff and peers alike—that people can and do recover. We know that adding a peer to the crisis team can have a dramatic impact: Pierce County paired a Certified Peer Counselor with a social worker in an area hospital's emergency department, and their admission rate dropped significantly. The peer support role is *intended* to be transformative.

What do we do in a crisis?

Peer support increases engagement through the shared experience of crisis, and through the peer modeling that recovery is possible. On a mobile crisis unit, the peer might make the initial contact (depending on situation) and attempt to engage the person, or the family. In a short-term crisis setting, a peer supporter may be available to listen to peers, to share stories, to reflect strengths, to inspire hope. A peer supporter might also support the peer in finding their path out of the crisis situation. Making sure to stay in our own lane, peer supporters can encourage the person in crisis to remember reasons for hope, to think about making a life worth living, and to start to plan for those hopes.

Providers of crisis services are encouraged to hire licensed and credentialed Certified Peer Counselors, with experience and skills reflecting the community served. Providers should look for common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experience, gender identity, sexual orientation, age, and ability or disability. Consider Parent Partners and Youth Partners to support children and families. Matching your workforce to the anticipated population using your services makes those services that much more effective. Peer support workers should be integrated into crisis line operations; should be one of two mobile team members; and should be the first person to greet a peer at a crisis facility. Providers are encouraged to develop supervision practices that embody peer support and recovery values, and that respect the role of peer support. For more information about supervision of peer support, check out the National Association of Peer Supporters' [library of supervision resources](#).

Safe working environments are a must for peers and for the people who work there. Consistent use of trauma-informed practices is the most effective way to ensure a safe workplace. We recognize that safety is important for the peers who use crisis services. Staff also have a right to safety, and to the best protections available. Treating peers with dignity and respect will go a long way toward making the setting safe for everyone.

Collaboration between emergency medical services and law enforcement supports the use of these specialized crisis services as the preferred alternative to emergency departments or jails. Providers of crisis services must be prepared to accept referrals of any person at any time, as long as they have open beds. To the fullest extent possible, we want to avoid sending a peer in crisis to jail or to the emergency room. Communication among partners in the healthcare system is key.

System Intercept Model

A System Intercept Model (SIM), as developed by SAMHSA, is a crisis prevention model for people at risk of incarceration, or newly released from incarceration. This model is aimed primarily at law enforcement. It has two mutually reinforcing aims: to help people avoid incarceration, and to prevent suicide in a population at risk of incarceration. The model helps communities identify resources and gaps in services at each level of intercept, so communities can develop local strategic action plans to keep people out of incarceration. The mapping process brings together leaders, agencies and systems that are involved in crisis services in any way, to continually improve their ability to divert people away from the justice system and into appropriate treatment, whether mental health or substance use disorder services.

We know that our state has vast rural areas, and in those parts of the state, many services may not be available. First contact with services for any person in crisis may well be law enforcement. Using the SIM model to map resources, communities are able to identify gaps in services that might be met by existing providers, or by adding services to the mix.

Trueblood

Trueblood v. DSHS was a class-action lawsuit brought by Disability Rights Washington (DRW) against the Department of Social and Human Services (DSHS) in 2014. Trueblood class members include individuals who are detained in jails awaiting a competency evaluation or restoration services, and individuals who received those services in the past but have been at risk and may be at risk for re-arrest or re-institutionalization.

The case was settled with a Contempt Settlement Agreement that included a plan to phase in additional services and supports to meet the timeliness deadlines: court-ordered competency evaluations must be provided within 14 days and competency restoration services must be provided within seven days. Beyond the deadlines for services, the agreement emphasized arrest diversion and community-based supports, such as the Intercept Model mentioned above.

Peer support for Trueblood is a specialty area of peer support practice. This specialty area is sometimes called “forensic peer support.” If you have a history of justice involvement and you are interested in helping returning citizens, Trueblood might be the work for you. Peer support workers in forensic peer support may enter jails to meet with peers who are awaiting evaluation and restoration, especially those who are likely to be referred to community services. This meeting in jail can help ensure a smooth transition after release, meaning fewer people get lost. Once the person is released, the peer support worker will

help encourage the person to engage in services and to begin their recovery journey. Work in this program might include outreach, contacting peers who may be at risk of re-offending and re-incarceration.

Ethics and boundaries in crisis

In the standard Certified Peer Counselor training, we learned that our role is to support what the peer wants. In crisis work, our highest ethical standard is preservation of life. When a peer is expressing thoughts of suicide, we want to prevent that in every case, no matter what the peer wants. We work hard to allow the person to make healthy choices to stay safe, and if everything fails, we bring in other people to ensure that the person is safe.

As Mandatory Reporters, we may have an obligation to call in a clinician or a DCR. If you make this choice, be sure to tell the peer that you’re making that call. Surprising a person in crisis does not make us trustworthy. Be transparent and authentic. Remember that, in crisis, a person may return to coping strategies they’ve used before, even when those behaviors aren’t useful in the moment. Behavior may be unpleasant, predictable, or even hostile.

Duty to warn/protect

Mandatory Reporters have an obligation to report when a person threatens to harm another. The guidance has changed recently and it's important that we know the rules around this, and how and when to apply this guidance.

In May 2017, the Washington Supreme Court decision in *Volk v. DeMeerleer* altered the scope of the “duty to warn or protect” in at least three critical ways:

- It questions exactly which health care professionals are subject to this mandatory reporter obligation, in the voluntary inpatient and outpatient setting,
- The duty is now clearly applied in the voluntary inpatient and outpatient setting, and
- Crucially, outside the context of involuntary commitment proceedings, the scope of person in the “warn” or “protect” category now includes anyone who may be a “foreseeable” victim, not reasonably identifiable victims subject to an actual threat.

This last section is the most important for our purposes. Prior to this decision, our mandatory reporter obligation required reporting of threats to “reasonably identifiable” or named potential victims. Now the law is much less concrete, and therefore can be very confusing.

The State Supreme Court established this new standard, which is now binding on treatment providers, even before the case was decided. The court said that, in the outpatient and voluntary inpatient setting, the duty of health care providers to warn or protect potential victims of violence extends to all individuals who may be “foreseeably” endangered by a patient, even if no specific target was identified. Notice that the language in this standard moves more toward a duty to **protect** potential victims, which is consistent with a finding in *Tarasoff II*, the second California court case to adjudicate this obligation.

The Washington State Medical Association issued guidance regarding this new standard. They advised clinicians to use reasonable care to act within professional standards, and to complete and update suicide and violence risk assessments with those documented in the person’s medical record. Clinicians must document why and how they reach clinical decisions, especially decisions to mitigate risk. Anything done by employees to mitigate risk must be documented thoroughly. These actions include those taken to support the peer and to warn or protect potential victims. Contact with intended victims must be documented, along with attempts to contact those with whom contact was not made.

When a clinician or peer support worker decides to warn potential victims, they are instructed to notify law enforcement before contacting potential victims.

Again, document all these contacts and attempts to contact. Document the reasons why the action taken is necessary to protect the person or potential victims. The Supreme Court held that it is a jury’s responsibility to determine who may be a “foreseeable victim.” Therefore, no guidance was made on how to identify such a person. They suggested that potential victims might be those close to the person, such as family members, work colleagues, friends, neighbors, and any person with whom the peer may have had a disagreement or argument.

The duty in this ruling is clear: we are obligated to notify law enforcement **and** warn potential victims. If the peer is expressing violence without naming someone specific, consider family members, friends, neighbors, coworkers, etc. There are other ways in which clinicians may take action to keep others safe, but those are steps for clinicians to take if they are deemed necessary. Be sure to check with your supervisor if you have **any** questions or concerns about implementing this obligation.

Staying in your lane

In a crisis setting, we may be tempted to start assessing for safety, thinking of questions such as, “Do you have a plan?” “Do you have a weapon?” Remember to ***stay in your lane***. Assessment and evaluation are for clinicians. When we start to assess, we stop listening. Our role is to listen, to engage, to invite the person to talk about their struggles, and to invite choices that will help the person feel calmer, more in control, and safer.

Of course, we will remember general ethical guidance from the Certified Peer Counselor course. Confidentiality is crucial here: don’t share details about the person with anyone not working with the peer, and don’t share information to anyone outside your agency without a valid release of information. (You may want to ask someone in medical records what constitutes a “valid” release of information). Remember that we don’t give advice about diagnoses, symptoms, or medication, and it’s not a good idea to share these details about your own story in crisis settings.

Boundaries are critically important when a person is in crisis, for several reasons. First, the person may be highly attuned to every sound and movement from others, and they may not be interpreting sounds and movements in the way they are intended, or the person may be hearing voices and/or seeing visions. Second, people in crisis are much more vulnerable and often more susceptible to suggestions. Our obligation is to set clear boundaries and ensure that we keep them. Be careful not to ***touch*** a person in crisis unless you ask and get clear permission. Don’t make promises about anything, including services or what will happen when the person is released. Don’t lie to peers. If you don’t know an answer, it’s okay to say so, and invite the peer to find out the answer with you.

Setting boundaries in a crisis setting can guide the peer into healthier behavior while keeping everyone safe. Think carefully about the language you use. Instead of saying, “stop shouting” (which might be heard as “shut up”), try something like, “It’s hard for me to listen when you’re shouting. Can we keep talking, only a little more softly?” You can use similar boundaries if a peer is standing too close or making movements that others find frightening.

Summary

Need to know

Washington’s crisis services are layered. Crisis services are paid for with state funds—everyone can use crisis services. How we ask for help is mediated by culture. Washington State law allows detention of individuals with behavioral health challenges under certain conditions. We never lose sight of working toward recovery. Peer support workers may be impacted by the Duty to Warn law.

Good to know

The new 988 system will change some of the structure.

Resources

- [Peer Support Works supervision resources](#)
- [Involuntary Treatment Act overview](#)
- [Involuntary treatment RCW](#)

Module 5: Self-Advocacy in Crisis

Self-advocacy and empowerment

During a behavioral health emergency, it may be hard for a peer to get what they need. They may not be expressing themselves well, and staff may not understand what they're trying to convey. Self-advocacy is a critically important skill in recovery because it's the skill that helps us get what we need. Teaching self-advocacy skills, especially when people are well, can facilitate a crisis experience that is supportive, rather than frightening. Two documents, prepared before a crisis occurs, could greatly facilitate getting the care that's truly helpful for a peer: a Mental Health Advance Directive, and/or a Wellness Recovery Action Plan (WRAP).

Behavioral health advance directive

A Behavioral Health Advance Directive (BHAD)—also sometimes called a Mental Health Advance Directive, or MHAD—is a written document that describes the person's directions and preferences for services and care when they are unable to make good decisions or take actions to keep themselves safe. The BHAD informs staff what the person does or doesn't want, and it can also identify an “agent,” someone the person trusts to carry out their instructions and act on the person's behalf. State law requires providers to honor the person's wishes to the fullest extent possible, with only a few exceptions allowed:

- The person's instructions are against medical standards or are unavailable
- Following the directive would violate state or federal law, and
- The person is hospitalized under the Involuntary Treatment Act, or is in jail

Included in the BHAD is consent for services, or refusal. A peer should spell out the medication they take, who prescribes it and what it's taken for. The person can also indicate medications they do *not* want to take. The peer should indicate why they aren't willing to take those medications and indicate if they know any alternatives to the meds they don't want. Include if the person prefers a specific hospital over others, or specific providers who already know the person.

Decide who can visit the person while they're in the hospital (if anyone), and assign tasks to others, such as picking up mail, caring for pets or children, or communicating with an employer. Assigning tasks works well for people who may care about the person and want to help, but the person doesn't really want them to visit (this includes children).

In a BHAD, a person can communicate any of the particulars that work well for them: meditation, yoga, acupuncture, music, art, etc. Some people develop complete plans to stay with friends, a sort of informal respite, instead of having to go to a crisis facility. If a peer chooses to make a plan to stay with friends, consider all their needs, such as safety, medication, food, rest, etc.

Finally, a person may choose to appoint an agent who can speak for them and make decisions for them. An agent should be somebody the person trusts completely to make those decisions for them, understanding what the person would want, instead of deciding on their own what the person needs. Agents must be at least 18 years of age and cannot be any person who is paid to provide services to the individual writing the BHAD (unless that person is a close relative).

Who gets a copy of a BHAD?

First, anybody named in the document who has been asked to provide some support, such as picking up mail or being the agent. When writing a BHAD, the person should get agreement from anyone included in that BHAD before delivering it to anyone.

Any provider responsible for that person's care should have their BHAD, and any hospital system that person might be a part of, such as Franciscan or MultiCare.

Beyond that, the peer may give the BHAD to anyone else who might need it, such as family members and an attorney if they have one. If the peer knows they are going to a hospital, they should bring a copy with them. Any treatment provider who gets a copy of a BHAD is required to make it part of the person's medical record. Anyone can change or revoke their BHAD at any time when that person is deemed to have "capacity" (in other words, they are not deemed incompetent or detained under an ITA). Any time a peer changes or revokes the BHAD, encourage them to give current copies to everyone who has one. Should there ever be a conflict between a BHAD and any other directive, the most recent document will be honored. If you wish to create your own BHAD, or work with a peer to develop a BHAD, you can find more information and the form at the [mental health advance directives webpage](#).

If you believe that providers are not honoring a BHAD, a peer can call the Washington State Department of Health (DOH) at 360-236-2620. All complaints are reviewed by DOH to decide if there is a violation of the law or if DOH has the authority to take action.

Optional: Please choose this activity or one from Appendix I

Practice

In small groups, review the Behavioral Health Advance Directive form, included as Appendix F. Discuss with the group how you might use this to work with peers. How will you support peers in developing their own BHAD?

Wellness Recovery Action Plan

Wellness Recovery Action Plan (WRAP) is another way to ensure that you get what you need in an emergency. WRAP is a simple and powerful process for creating the life and wellness you want. With WRAP, you can:

- Discover simple, safe, and effective tools to create and maintain wellness.
- Develop a daily plan to stay on track with your life and wellness goals.
- Identify what throws you off track and develop a plan to keep moving forward.
- Gain support and stay in control even in a crisis.

The WRAP process supports you to identify the tools that keep you well and create action plans to put them into practice in your everyday life. All along the way, WRAP helps you incorporate key recovery concepts and wellness tools into your plans and your life. Many people say that, after creating a WRAP, they stopped having crises. WRAP is an evidence-based practice; if you become trained to facilitate WRAP groups, your employer is reimbursed at a higher rate for those services.

A WRAP plan begins by identifying what you look like when you are 'well'. Each section starts with describing how you look in each state, so that your supporters can reflect to you if you don't notice how you are doing. Each section then has an action plan, so the daily wellness plan outlines the things you need to do on a regular basis to stay well: things like nutrition, sleep, activity, work or school, therapy, or healthcare. The next section allows you to identify red flags, things that might activate a trauma response. Then you will decide what you need to do if you encounter a red flag, so you don't get knocked out of balance.

The next section, Early Warning Signs, identifies the first signs of not doing well: maybe missing appointments, not eating, sleeping too much, whatever it might be for you. The action plan suggests what you might do to get back on track. "When Things Are Breaking Down" indicates you haven't turned things around and are headed toward crisis. "My Action Plan" will be more directive because you want to stay out of crisis.

WRAP defines crisis as a state in which I can't make good decisions or take action to keep myself safe. The WRAP crisis plan is thorough and can improve your chances of getting what you need in a crisis setting. Crisis plans are prepared when we are well and can be appended to a Behavioral Health Advance Directive. In this part of the plan, I identify how I look when I want others to step in and take over for me. I can describe what medication I take and why, what meds I would be willing to take, and what meds I will refuse (and why). I can identify hospitals I prefer and those I don't. I can describe treatment that is helpful and things that will be unhelpful. A crisis plan allows me to identify who will manage my life for me: who will care for children or pets, who will pay the bills, speak with my employer, pick up the mail, etc. This ensures that the peer has a life to return to when they are released. I might even make a plan to go to a friend or family member's house when I'm not well, instead of to formal services.

A post-crisis plan invites me to look back on what led to the crisis. Did I stop doing my daily maintenance? Did I miss some warning signs? Does the WRAP need an update? What might I do differently next time? This section is where people learn to stop going into crisis. Learning how to spot crisis before it's inevitable is an important skill!

If you are interested in either BHAD or WRAP as a tool for working with participants, anyone can pull up the BHAD forms and support a peer in developing that document. No instruction is required. You will not be able to sign as a witness if you were part of the process of making the plan, but having the plan is the most important part for the peer. Young people can also be invited to make a BHAD or WRAP, perhaps using pictures for younger children. WRAP classes come in several levels: the first level prepares you to make your own WRAP plan. After that, any person can sit with a peer and go over the WRAP workbook. However, if you want to be able to facilitate WRAP groups—the best practice model—you will need to take more courses. Teaching WRAP in a group is considered best practice because participants in the group learn from each other, they hear coping strategies or wellness tips from others in the group that they may want to try. WRAP groups are peer support for and from everyone in the group. WRAP courses are offered regularly around the state, sometimes as continuing education and sometimes as private classes. You can learn more at the [WRAP website](#).

Self-advocacy

You may remember some of the self-advocacy tools you learned in the standard Certified Peer Counselor class. First: start with strengths! There are many ways in which to engage in advocacy. Choose methods that engage the peer's strengths to support the peer's confidence in advocacy. In the CPC class, we learned an advocacy planning process that we will briefly review here.

When planning for self-advocacy with the peer, take these steps to develop a thorough plan:

- Name the need for advocacy.
- Help do research.
- Identify the gatekeeper(s).
- Make a plan.
- Role-play the interaction.
- Repeat as necessary.
 - Ask if anyone else can help.
 - Try one of the other options you identified.
 - Ask, "Why Not?"

The most common way people give up their power is by thinking that they don't have any.
—Alice Walker

Self-advocacy in crisis settings

A person experiencing a behavioral health emergency is not in the best position to learn and/or practice self-advocacy skills. In these settings, it may be appropriate for us to advocate on behalf of the peer. However, if you intend to advocate for someone else, be sure you clearly understand what it is they want. Certified Peer Counselors are not qualified to decide what each person needs in a crisis, and we should not be advocating on the peer's behalf unless we have permission and clear instructions. Make sure the peer wants you to speak for them.

The peer may ask you to advocate for something that the rest of the team opposes. Remember that our first value in this work is preservation of life: when the person's life is in danger, we may have to take action they dislike. Beyond this, however, it is still our role to advocate for the person's wishes. Before you advocate for something the team opposes, be sure you are clear about the peer's reasons for this choice. Tell the peer if you are worried about what they want; have a discussion with them about their choice and how it will work. Some people will have clear ideas about what will be helpful for them in a crisis, and we can engage with them to discover if those ideas are helpful and if we can support them in getting what they want.

Remember that the original role for peer support was to **transform** the behavioral health system. While working to help people stay safe and avoid crisis in the first place, we also want to ensure that services exist that will be helpful. Listen to what peers in crisis say would be helpful for them. Advocate for the development of those services and supports. Peer-run respite is coming to Washington. What other kinds of services or supports have you heard about, but you don't think they're here yet? What else might be helpful?

Optional: Please choose this activity or one from Appendix I

Practice

In pairs, take turns talking about a need you have. Make a brief advocacy plan to pursue your goal. Be prepared to share it with the learning community.

Wellness plan for work

Unless you work in a crisis setting, you will not routinely be around people experiencing a behavioral health emergency. When it happens, it can be frightening, exhausting, or it can activate a trauma response. Any time our work is challenging, especially emotionally challenging, it's important to give special attention to self-care.

If you have a WRAP plan, or some other type of wellness plan, now is a good time to take it out and review it. Do you have action plans in place for intense and overwhelming situations at work? If not, now is a good time to make a plan.

If you don't have a WRAP plan, you can still make a simple wellness plan to stay well at work. Here is what one might look like:

Time of Day	Action	When
Morning: Getting out of bed	Wash face, brush teeth, eat breakfast, pray	On awakening
Mid-morning	Take my 15-minute break, walk outside if it's not raining	Every workday
Midday	Eat lunch. Step away from my desk/office. Walk around the block.	Every workday
Mid-afternoon	Take my 15-minute break, review my day, gratitude	Every workday
Evening	30 minutes at gym, healthy dinner, shower, sleep by 10:00 p.m.	Every day
Any time	Step outside. Breathe, yoga breathing. Repeat mantras. Physical grounding exercises. Chat with supervisor. Chat with sponsor.	When I'm having big feelings.

A wellness plan for work does not have to be complicated. It should include some of your routine self-care, such as hygiene, sleep, and nutrition. Anything in your life that supports your ability to be well, including being well at work, can go into a work wellness plan. Having this plan allows you to check your own wellness daily just by examining if you're missing something on the plan. Did I not get enough sleep? Did I have junk food instead of healthy food for dinner? Am I not considering gratitude? Am I making someone else responsible for my unhappiness? We may want to review the wellness plan any time we're a little bit "off," or when there's an unexpected event that's disturbing.

A work wellness plan is a personal wellness plan and is not for your supervisor. You may, of course, share it with a supervisor if you choose to do so, but they may not demand it of you. Our supervisors are not therapists or sponsors; they are not responsible for monitoring our wellness. That's our job.

Supervision: supporting work wellness

Supervisors in behavioral health settings are generally supportive of self-care, for everyone working there. Self-care is important for everyone, not just peer support workers. We know that not every individual supervisor will be as supportive. However, we can use self-advocacy with our supervisor to ensure that we have the support we need when emergencies arise.

If you have a wellness plan, or even just an awareness of what you need after an intense experience, don't be afraid to tell your supervisor what kind of support you need. You are never required to disclose anything about any kind of disability unless you are asking for an accommodation. But just asking for support after a crisis should not require any self-disclosure: it's *human* to need support after experiencing a crisis with someone.

You might discuss this with your supervisor in a one-on-one supervision. Some supervisors will want to talk about crisis debriefing in group supervision, as the whole team is likely to be impacted by a peer in crisis. Tell your supervisor what you might need after working with a peer in crisis. If you have paid time off that you can use, don't be afraid to use it. Many agencies will routinely conduct a debriefing session with everyone affected by an intense situation. If such a debriefing session is not offered, you can ask for it. It's helpful to be able to share any feelings of fear, anxiety, helplessness, etc., and to have those feelings validated by our coworkers.

Americans With Disabilities Act

The Americans with Disabilities Act (ADA) was signed into law in 1990. Its intent is to prohibit discrimination against people with disabilities in employment, state and local government activities, public accommodations, public transportation, telecommunications, and public services. Employers with 15 or more employees are obligated to follow this law.

The ADA protects people with disabilities in a variety of ways.

- Protects from discrimination in hiring.
- Requires employers to make "reasonable" accommodations for people with disabilities.
- Provides recourse when our rights are violated.

Disclosing a disability is an individual decision, and often a complex one. You are never required to disclose a disability unless you are requesting accommodation, and an employer may not demand details about disability in an interview or supervision. There is substantial information regarding the ADA in Appendix 6 in the Certified Peer Counselor workbook dated January 2019. You can learn more about the ADA at the [ADA website](#).

Every state that receives federal funding to serve people with disabilities is required to have a protection and advocacy agency (called P&A), to help protect the rights of people with disabilities in that state. These are generally public interest law firms that offer these services at no cost to those served. [Disability Rights Washington](#) (DRW) is Washington's P&A. You can find the protection and advocacy agency for other states at the [National Disability Rights Network website](#).

Complaint and grievance process

In Washington State, any expression of dissatisfaction with providers or services is called a ***grievance***. Any person using services may file a grievance, typically grievances will go to the Office of the Behavioral Health Advocates (OBHA).

Behavioral Health Advocates

Behavioral Health Advocates are people with lived experience in behavioral health who know services well and can help people navigate and resolve problems. Behavioral Health Advocate services (formerly known as Behavioral Health Ombuds Services) are available throughout the state. Advocates can assist with resolving issues with behavioral health services in both mental health and substance use. Advocate services are primarily for individuals receiving Medicaid services.

What do Behavioral Health Advocates do?

They can help people resolve:

- **Complaints and grievances:** any dissatisfaction with services, written or verbal.
- **Appeals:** a reconsideration of denials, reduction, or termination of services.
- **Administrative (Fair) Hearings:** a formal court procedure when all other avenues have been unsuccessful.

Behavioral Health Advocate services are voluntary. If a person chooses to file a grievance themselves, the Advocate can direct them to the right process. An advocate can help a person understand how to advocate for themselves effectively, or advocate on their behalf, as well as find resources. They can advocate for adequate resolution and assist in setting up meetings and negotiations. The goal is always to resolve issues at the lowest level possible.

Optional: Please choose this activity or one from Appendix I

Practice

On your own, develop a rough outline of a wellness plan for work. Include both routine wellness tasks and anything you might want to do when things get challenging. You might also include some new wellness strategies you might want to try. Be prepared to share one or two with the learning community.

Summary

Need to know

Self-advocacy can support peers in preventing and recovering from crisis. Post-crisis self-care should not be overlooked. Peer support workers are protected by labor law and by the ADA.

Good to know

BHAD and WRAP are useful tools for preventing crisis.

Resources

For BHAD:

- [HCA mental health advance directives webpage](#)

Protection and advocacy:

- [Disability Rights Washington website](#)
- [National Disability Rights Network website](#)

Wellness Recovery Action Plan:

- [Wellness Recovery Action Plan website](#)

Module 6: Interventions

Safety is a concept that differs for each of us. While no one can predict what will feel safe for every person, we can make some guesses about what might work best. This module takes a quick look at the online course, followed by a discussion of “safety” and some practice with de-escalation skills.

Traditional crisis services remove every element of risk from the person’s environment. We know that just removing “harm” does not by itself alleviate suffering. Simply detaining someone does not alleviate suffering. Detention law is generally designed to allow time for providers to attempt relief with medication, or for other natural resolution.

Safety must mean more than removing any possibility of harm. People need to find some relief from their suffering, some hope for the future, and a path to move forward. Sometimes crisis is about a pain we must endure, such as the loss of a loved one, and sometimes crisis requires that we just wait until it recedes. Everyone experiences painful challenges in life. Peer support workers provide support for people seeking a way through a problem that has no real solution other than time.

Practicing de-escalation skills necessarily involves having someone “act out” a crisis, and this may activate a trauma response in some people. Please consider what will work for you in these role-playing situations, to help you stay present.

Crisis intervention for peer support

This is a quick overview of the online, short class on crisis interventions for peer support. In this class, six stages of crisis intervention for peer support are identified as:

- Listen to and for
- Ask
- Plan
- Share
- Natural supports
- Communicate with team

We learn in CPC class that we always honor the peer’s choice, even when we disagree. In crisis, we still want to fully honor that person’s choice possible, remembering that the highest value in crisis work is preserving life. If we cannot ensure that a peer will be safe without other intervention, we take steps to help ensure that person’s safety, and our own.

Listen to and for

Listen to make a connection, to invite the person to keep talking. Listen for the peer’s perspective on why they are in crisis.

Ask

Ask, what would be helpful for you right now? What do you want to tell me?

Plan

Review the peer’s BHAD or WRAP or invite the peer to make a quick plan. Include natural supports.

Share

Encourage the peer to share any plan they make, with the rest of the team.

Natural supports

Identify people who may be supportive of the person in crisis

Communicate with the team

Document your interaction and be sure the rest of the team is aware.

Crisis as opportunity

Surviving a crisis and emerging on the other side may be terrifying. It can also be invigorating, depending on your response and how the peer makes meaning out of crisis experiences. Crisis settings can support peers in reframing the meaning of crisis as an opportunity—but not without validation first.

Reframing crisis is not the first response we should make when a person is struggling. Always start responding to a crisis experience with validation: make sure the peer hears that you recognize how hard it is for them. If we move into reframing without validating, the person may feel that we didn't understand how difficult it was. Once the peer begins to emerge from the most intense emotions, you can begin to invite a different perspective.

You already know how to validate feelings: a simple comment like “That was really hard!” or “I would be angry too if that happened to me!” can ensure that they get that validation. Lack of validation for our experience can leave us wondering if our own experience was true and valid.

After validation, use what you know about the person to point out their strengths. You might acknowledge the strengths the person displayed while moving through the crisis. Look for strengths such as perseverance, willingness to work hard and take risks, willingness to make difficult choices, asking for help, and an ability to find a recovery path in difficult times. The better you know the person, the more likely it is that you will know some of that person's strengths. Remember: strengths are what we use to solve problems. Reminding the peer that they possess and have used strengths gives them confidence in their ability to continue on their recovery journey and to overcome hard times.

Crisis services are designed to provide “safe spaces” in which people feeling at risk of harm can be safe, authentic, and get the assistance they need. Intentional Peer Support, an advanced, skills-based peer support training that is sometimes offered here, views safety instead as a product of strong communities and supportive relationships. If we work in crisis services, part of our role may be working toward those supportive relationships with our peers. Consider what peers might need in your specific setting. Some crisis settings, for example, because of their sparse furnishings may be very loud, which in turn can increase distress for peers in that setting. Ask if they can offer soft earplugs. Use your empathy to see what peers need.

Respite settings, unlike some other crisis settings, have a high tolerance for unusual behavior and thinking. In many cases, guests report that their experience is less intense because they felt supported

and safe. On the other hand, guests with intense experiences who are loud and active may feel unsafe to other guests in the respite. Staff involvement following an intense outburst is important for everyone, staff and all guests included.

Following an outburst or intense event, traditional crisis settings will typically speak with other peers briefly and then have staff debriefing. They typically focus on managing one peer's behavior, or several if more were involved in an event. Respite communities debrief staff and peers together. The entire community is impacted when one person loses control, and the entire community debriefs together. In this type of debriefing, they keep talking until everyone feels heard and the guests begin to feel safe again. Debriefing might also include planning to prevent future events. What might have prevented this? What will help people feel safe now?

Practice

In small groups, discuss what “safe space” means to you, as the person in services and as the Certified Peer Counselor.

How do you create a “safe space” for peers in crisis?

Sometimes we invite people into a “safe space,” where we may not know exactly what's safe for them, but we invite them to be brave in the face of this fear. What partnering skills would you use to find out what “safe space” means to the peer? How can we invite people into this “brave space”?

De-escalation skills

When we experience a crisis and emotions are intense or unpredictable, we may feel like we're out of control. If we feel out of control, we may rely on others to keep us safe: by giving orders, putting us into seclusion, or applying restraints (physical or chemical). When this happens often—this reliance on external means of control—we may forget that we can control our behavior and survive our emotions. And that can be terrifying. Remember how important control is to trauma survivors, and you will recognize the depth of the fear.

When someone seems out of control, simple choices will help them return to being in control of themselves. People in crisis may be at basic survival levels of need; offering food or drink may be comforting and offering it as a choice gives the person a chance to assert some control. Start with offering water or coffee (or something similar). Gradually offer more complex choices, such as sitting down or walking, talking or staying silent, thinking of the future or continuing to talk about the present moment. As the person exerts more control, they typically become calmer.

Unless and until a person demonstrates that they cannot keep themselves or others safe, we allow the person to continue expressing emotion, even when it's loud or hostile. This takes patience, diplomacy, and respect. Don't take outbursts personally. Don't assume the person is trying to personally hurt you if they are insulting or unkind. Don't assume you know what the person is feeling. And don't ask the person questions that require thought! When emotions are high, adrenaline diverts blood flow to muscles and away from the brain, so rational thought is not at its best. Use your curiosity to help the peer express themselves.

Crisis Prevention and Intervention

Crisis Prevention and Intervention (CPI) is a set of behavior management techniques to help prevent workplace violence using evidence-based de-escalation and crisis prevention techniques for many kinds of settings. CPI is commonly taught and practiced in many (if not most) inpatient and residential behavioral health facilities. CPI serves healthcare professionals, dementia and behavioral health care professionals, educators, security and corrections staff, and service-oriented professionals. These techniques are designed to be used in a wide variety of settings, and they apply intensity gradually over time.

Nobody ever wants to apply physical restraint on a peer at work, for any reason. However, there are some situations that require it, and those situations are more likely in crisis settings. While we do everything to avoid physical force, there are some safe ways to counter violence that are taught to staff. Our response to the person in distress can be the key to avoiding a physical confrontation. These tips are for when a person seems to be out of control and in significant distress. CPCs, and other staff, can step in and begin to help the peer calm down. Consider your own safety and that of others in the same area as you help the peer get calmer.

CPI teaches a set of ten de-escalation tips for working with people in intense emotion, no matter what the setting.

CPI de-escalation techniques

Tip 1: Be empathic and non-judgmental.

When someone says or does something you perceive as weird or irrational, try not to judge or discount their feelings. Whether or not you think those feelings are justified, they're real to the other person. Pay attention to them. Keep in mind that whatever the other person is going through, it is the most important thing in their life at the moment. If you're a Parent Partner, focus on the needs of the parent(s).

Tip 2: Respect personal space.

If possible, stand one and a half to three feet away from a person who's escalating. Try not to face the person directly but stand off to the side so you're not blocking that person from leaving. Allowing personal space tends to decrease a person's anxiety and can help you prevent violent behavior. If you must enter someone's personal space to provide care, explain your actions first so the person feels less confused and frightened.

Tip 3: Use nonthreatening nonverbals.

The more a person loses control, the less they hear your words—and the more they react to your nonverbal communication. Be mindful of your gestures, facial expressions, movements, and tone of voice. Keeping your tone and body language neutral will go a long way toward defusing the situation. Sometimes our nonverbals can be activating to family members or friends on the scene as well. Be aware of relationship dynamics.

Tip 4: Avoid overreacting.

Remain calm, rational, and professional. While you can't control the person's behavior, how you respond to their behavior will have a direct effect on whether the situation escalates or defuses. Positive thoughts like, "I can handle this" or, "I know what to do" will help you maintain your own rationality and calm the person down.

Tip 5: Focus on feelings.

Facts are important, but how a person feels is the heart of the matter, what's "alive." Yet some people have trouble identifying how they feel about what's happening to them. Watch and listen carefully for the person's real message. Try saying something like, "That must be scary." Supportive words like these will let the person know that you understand what's happening—and you may get a positive response. Don't be afraid to guess what the person is feeling: they will tell you if you get it wrong. Allow "venting" as much as possible, without disturbing or threatening other guests.

Tip 6: Ignore challenging questions.

Answering a challenge often results in a power struggle. When a person challenges your authority, bring them back to the issue at hand. Ignore the challenge, but not the person. Bring their focus back to how you can work together to solve the problem.

Tip 7: Set limits.

If a person's behavior is belligerent, defensive, or disruptive, give them clear, simple, and enforceable limits. Offer concise and respectful choices and consequences. A person who's upset may not be able to focus on everything you say. Be clear, speak simply, and offer the positive choice first.

Tip 8: Choose wisely what you insist upon.

It's important to be thoughtful in deciding which rules are negotiable and which are not. For example, if a person doesn't want to shower in the morning, can you allow them to choose the time of day that feels best for them? Or is there some other way of bathing the peer would prefer? If you can offer a person options and flexibility, you may be able to avoid unnecessary altercations. Remember the impact of trauma; find out why.

Tip 9: Allow silence for reflection.

We've all experienced awkward silences. While it may seem counterintuitive to let moments of silence occur, sometimes it's the best choice. It can give a person a chance to reflect on what's happening, and how they need to proceed. Believe it or not, silence can be a powerful communication tool.

Tip 10: Allow time for decisions.

When a person is upset, they may not be able to think clearly. Give them a few moments to think through what you've said. A person's stress rises when they feel rushed. Allowing time brings calm.

The Untold Story

Intentional Peer Support (IPS) works to understand the “untold story.” Here’s what that means.

People tell us their story based on who they think we are and how safe they feel. What does this mean for our purposes? We work in a behavioral health (or medical or human services) setting. Therefore, peers will think we are one of those “behavioral health people,” whatever that means to them. Because we are perceived as a “behavioral health person,” the peer will start by telling us all about their behavioral health. This may or may not be the point of the crisis! Remember that the iceberg’s top—the **told** story—is only 10% of the real thing. We can support the peer exploring and articulating the untold story—the full reason why they are in crisis.

When clinicians meet with the peer, they may be listening for “symptoms,” things that make sense in the context of a given diagnosis. We should be listening for “what happened,” specifically if something happened that provoked the crisis. This is a distinct difference between our role and that of clinicians: not less important, just different. Here we will use the language of ordinary experience, not the language of symptoms and diagnosis, to explore what happened.

Exploring the untold story means we don’t immediately act or respond to the first thing the person says. When you do respond, use the language of ordinary human experience; avoid using any clinical language. Ask open-ended questions, or just say “tell me more.” Invite the person to keep talking. When you reach the untold story, it will be clear. The untold story is the real problem you’re trying to solve with this person. Remember the untold story when you see a peer in crisis. Let your curiosity lead you.

Post-crisis staff support

When a peer has an intense experience, whether in a crisis setting or not, it can be frightening and disturbing for all staff, not just Certified Peer Counselors! Neglecting staff support can lead to vicarious trauma, the secondary traumatic experience acquired by exposure to trauma survivors. Following an intense incident, be sure to follow your employer’s guidance about incident reporting. You may need to complete a report describing the incident, what you witnessed, and what you did. These are routine.

The first priority following an outburst or other intense event is to check on other participants who will have been affected by the event. Make sure they have what they need, such as moving them to a quiet location or providing support.

As soon as all participants have what they need to restore calm, the team should debrief. This should always include:

- What happened: details about what led up to it, who was involved. BE HONEST, not defensive
- Begin work on the Incident Reports, required by everyone involved and all staff witnesses
- Check on staff well-being: ask what each person needs. It may be helpful to go outside, walk around, take some deep breaths. Some people may want time off the next day. Consider your agency policy, your paid time off, and what you need to maintain your wellness
- Supervisors should consider whether any staff need to be reassigned; a participant may be focusing on that person, or the person doesn’t feel safe with the participant

Every employer has workers’ compensation insurance. Should you be injured in a crisis event, your medical care will be covered by this insurance. Be sure to notify your supervisor and ask if they have preferences for where you get care. Workers’ compensation covers counseling too, should that be indicated after an event. If you are assaulted by a peer, that’s absolutely an option. While we’re talking about what to do if you are injured, let’s remember that this is an extremely rare occurrence. We’ll look more at your ongoing wellness on Friday.

If you need additional support after an incident with a peer—ask for it! Certified Peer Counselors are not the only people affected by intense outbursts. Don’t forget to check on other peers in the building to see what they need after another peer’s outburst.

Documentation

As soon as the individual in need is no longer in crisis, it is time to document and debrief with the team. A good debrief will include:

- What happened and who was involved?
- Is there an incident report that is needed?
- Check staff wellbeing and implement any post crisis plan you have with your agency.
- Supervisors implement any policies and document

Documentation style will be dictated by the type of employer in which you work, and by their funding. We won't focus on the details of documentation in this class, but we will discuss how to document for crisis situations.

- **What did the person say?** Use their words. It's especially important that you don't try to "interpret" what the peer is saying. Detail matters in crisis, and specific wording may lead to solutions.
- **How did the person behave?** Try not to use clinical language here. If the person is walking in circles, say they're walking in circles. If they're changing topics quickly, use that simple language. Remember that peer support workers use the language of ordinary human experience in documentation, not the language of symptoms and diagnoses.
- **Does the person seem threatening?** If the peer is making verbal or physical threats to another peer or employee, that should be documented. It's important that all staff have access to information that may pose a safety hazard. In addition, if the person is making threats about someone outside the facility, you may have an obligation to warn that person about the threats. Remember what you learned about the Duty to Warn obligation in Module Five.
- **Is the person very quiet?** Some peers will just want to hide in crisis. They may stay in their room or as far away from other peers as possible. Of course, peers have a right to choose privacy and quiet, that may be very important for the peer's recovery. Quiet peers in crisis settings may be overlooked. Make sure the peer is getting what they need.
- **Is the peer being heard by staff?** As the peer supporter, it may be our job to ensure that the rest of the team actually listens to the peer. It's especially common in crisis settings for the staff to make their plan and implement it without any real input from the peer. If you see staff making plans *about* the peer and not *with* the peer, talk with the peer and see if they have wishes you can mention to the rest of the team. Find out if you can get the peer more involved, if the peer chooses.

Always document:

- Threats to staff, other peers, people outside, or anyone else
- Changes in behavior or mood
- Attempts to de-escalate peers in crisis
- Anything the peer wants staff to know
- **Tarasoff** warnings

Remember that the medical record is a legal document. It will protect you and your employer, as long as you are writing accurate and timely notes.

Writing a DAP or a SOAP note after a crisis can be daunting. Stick to the facts and write the note when you are not having strong emotions. You may use some quotes from the interaction, and you would want to document if you used your lived experience in growing through a crisis to assist the peer in their recovery journey.

Sample DAP Note:

- **D:** Peer came in today without an appointment, asking to see me. Peer was crying, short of breath, and picking at their arms. There is evidence of fresh scratches on peer's arms. Peer did not sit down but walked in small circles around the office. Peer said, "I'm so tired of the neighbors, always watching me, peering through their curtains to see what I'm doing. I better go over and tell them to knock it off. I'm gonna go buy a gun before I go over there, to make sure they listen to me." I validated the peer's concern that she feels watched all the time. I asked the peer what the gun was for, if they intended to use it at the neighbors. Peer denied intent to harm the neighbor, saying the firearm was only to "scare" the neighbor and make them stop. The peer and I discussed whether the gun might escalate matters and make things worse and invited the peer to think with me about other options. Peer was adamant that this was the best way to make the surveillance stop. I consulted with my supervisor, since peer's words may require a **Tarasoff** warning. Supervisor advised to continue discussion and report back. Additionally, there has been no real evidence that surveillance by the neighbors is actually happening, it may be private reality. Peer and I together developed a plan for peer to feel more confident in her neighborhood: Peer said she could wave at them every time she goes out, so they know she sees them. Peer will try this out and report to me later this week. Peer agreed to postpone purchasing a firearm until we meet again.
- **A:** Peer's goal in our work together has been to develop natural supports. Today the peer is concerned about a belief that her neighbors are surveilling her; we did not make progress toward the goal today.
- **P:** Will continue discussion with peer regarding plans to feel safer. Will invite problem-solving for solutions around the neighbors that wouldn't require firearms or direct confrontations, since "surveillance" may be a private reality for this peer. Will report content of discussions to supervisor for further consideration of our duty to protect.

Summary

Need to know

De-escalation steps use CPC Partnering Skills, among other tools such as CPI. Thorough documentation is critical. Write your note as if the person's family will be reading it while capturing the critical data.

Good to know

Practice is important in de-escalation skills; confident workers are more likely to remain calm and supportive in a crisis.

Resources:

- [Crisis mental health services WAC](#)

De-escalation:

- [Live Through This website](#)
- [Suicide n Stuff website](#)

Peer Documentation General Guide:

- [Peer specialist documentation](#)

Module 7: Conflict and Crisis

Conflict is a common occurrence among trauma survivors, in part because we are all human, and conflict is a human experience. We may struggle with conflict because our worldview is altered by our traumatic experience. Approaching peers as trauma survivors reminds us to listen carefully, check our assumptions, and focus on meaning.

Conflict happens when human differences become an issue. Though they are always there, differences sometimes don't matter. When difference gets in the way, conflict results.
—Littlejohn and Domenici, 2001

Mediation training is available to the public at dispute resolution centers throughout Washington State. If you find conflict extremely challenging, mediation training can help minimize anxiety around conflict. Learning ways to manage conflict makes it less intimidating.

Conflict is sometimes an important factor in crisis situations, or behavioral health emergencies. A conflict may be the precipitating factor of a crisis: conflicts are scary and difficult, and a peer who isn't confident in conflict may be pushed to crisis.

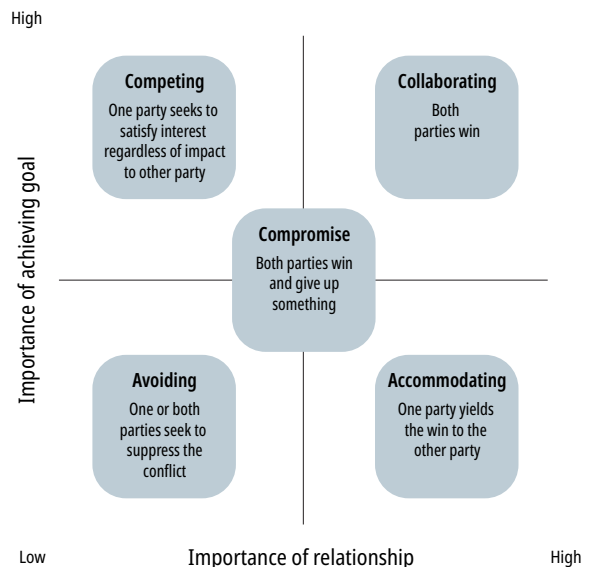
Unmet needs are another important source of conflict. When peers are unable to get important needs met, like housing, food, or medicine, conflict may arise. If the peer is not confident or lacks advocacy skills, they may be unable to effectively access the resources they need, engaging in conflict but not productively.

Conflicts can actually **strengthen** relationships, when we know how to navigate them. Unfortunately, most of us don't learn skills for managing conflict. Instead, we learn to blame others when we don't get what we need. When we know how to work through conflicts, we are able to handle conflicts when they arise, as they do in **all** human relationships. We're more secure in relationships that have productively managed conflicts, and we know we can do it.

In the behavioral health system, we may encounter conflict with the peers assigned to work with us, and we may experience conflict with our coworkers or even our supervisor. Conflict has an impact on getting needs met, but also on relationships among people in conflict. Managing conflict with coworkers and peers will likely have some differences, but more elements in common. First let's look at how you, as an individual, respond to conflict.

Conflict styles

Some theories of mediation suggest that there are five styles of conflict response. Most of us have a favored style that is our “knee-jerk” or automatic response to conflict, but we may use more than one style. A person who is able to use all styles is better able to get their needs met in a way that's in line with their values.



Take the short quiz in Appendix G to identify your primary style(s).

Note that conflict styles are often about **safety**. Conflict is scary for many people, and our first instinct may be to protect ourselves. These styles reflect the relative **importance of the person's own needs** and the **importance of the relationship** with the other person in conflict.

Avoid

Avoiders don't have much motivation to get their own needs met, they are comfortable doing without as long as it avoids conflict. Additionally, keeping the relationship with the other person is not of high importance. Complying is easier than fighting, and taking a low profile feels safe. We might use the Avoiding style with a neighbor we don't care for, or with an intrusive salesperson. “Lose/lose”.

Compete

Competitors want to get their needs met, while they care less about the relationship with the other person. Competitors see conflict as all-or-nothing, losing would crush them, and winning is everything. Taking a stand to win feels safest. We might choose this style at work, in sporting activities, or with friends and family. “Win/lose”

Accommodate

Accommodators are not motivated to get their needs met, the relationship with the other person is more important than their needs. Conflict feels scary and the person may feel terrified that the relationship will be lost. Ensuring the other person gets what they need feels safest. We might choose to Accommodate with family or friends, or in any situation in which the other person has significant power over us. “Lose/win”

Compromise

Compromisers have only moderate motivation to get their needs met, and also moderate motivation to keep the relationship. Conflict is seen as a game: an intellectually challenging maneuvering procedure. Compromisers look for the fairest, most even-handed solutions. Winning or losing isn't important. We often think of compromise as the fairest solution, but it's only fair in terms of “keeping score” and not always in terms of actual outcomes.

Collaborate

This style is for people who really want to get their needs met, and for whom the relationship is also very important. Collaborators see conflict as a natural part of human relationships, potentially constructive if the people can find creative solutions. Trust and openness in this process feel safest. Collaborating is hard work, and it's not always valued. Depending on the situation, Collaborating may give both people the most satisfying outcomes. “Win/win”

Remember, *all* of these styles are useful in some settings, and some types of conflict. When we are able to choose a style, rather than blindly falling into it, and when we can match our conflict style to the specific conflict, we are better able to get needs met in a way that does not harm others or myself. Understanding our personal style also allows us to examine whether that style is truly working for us, or if it's perhaps a remnant of a survival strategy.

When you are a person in conflict, whether at work or in your personal life, you can choose which style to use. Decide how important it is for you to get what you need, and how important it is to keep the relationship. When we're working with a peer in conflict, we take a different stance. Both considerations are still important

(getting needs met and keeping the relationship), and the peer decides what matters to them. If you are trying to help peers resolve a conflict, be sure you ask about those important factors.

Peer support workers who are not trained as mediators should not attempt mediation of conflicts. That would be outside our scope of practice. We can, however, coach and support peers who are struggling with conflict. Depending on the nature of the conflict, peer support workers should generally commit to being impartial, especially if the conflict is between two peers. In a conflict in which one person is being taken advantage of or even abused, seeking a win/win solution may not be in the peer's best interests. However, in ordinary daily conflicts, impartiality is best. “Impartiality” means we don't have a stake in the outcome: we're looking for an outcome that is best for both people.

Power imbalances can be a major source of conflict. While we do our best to achieve mutuality with peers, there will always be an imbalance because we have a name badge and keys, and we get paid. Acknowledging the power imbalance can be useful, noticing it and doing our best to minimize the use of our power may help. Wear a badge discreetly and keep keys in a pocket. Emblems of power should not be prominently displayed when it's preventable. Likewise, bringing in uniformed law enforcement officers may sometimes increase tension and anxiety, since uniforms are visible symbols of power and authority. Remember that what feels safe and supportive to me may be just the opposite to someone else.

Conflict in crisis settings

Peers who are in crisis are generally overwhelmed, and they may have less patience and be more irritable than they would ordinarily. Loss of control is an important factor in crisis, and impending loss of control can be terrifying for trauma survivors. Housing multiple people in crisis in one small setting is guaranteed to provoke conflict, just because people are shut up together.

Crisis facility staff will generally respond to conflict quickly, moving to separate the two people before a conflict escalates. Peers should be escorted (not sent) to a quiet place (NOT a seclusion room) where they can take the time to regain control and calm down. When both people are calm, a staff person may offer to help clarify what each person needs.

It's important not to take things personally when working in a crisis setting. A person in crisis may be angry, irritable, frightened, and defensive. Words aimed at us typically aren't really about us but are just an expression of their suffering. It may take some practice to learn not to respond to unpleasant or taunting comments from peers in crisis. However, you are feeling, always keep your face calm and your body relaxed. Remember that, in crisis, peers will respond to body language more readily than to speech.

Classroom discussion questions

Managing conflict when we are a party to the conflict is different than managing conflict when we're trying to support a peer. Having taken the quiz about conflict styles, were you surprised by the outcome?

How have you seen this conflict style playing out at work? Think of an example when you were in conflict and used one of these styles. What was the conflict? What did you do?

Would you have preferred to use a different style? Which one? Why?

Optional: Please choose this activity or one from Appendix I

Practice

Talk about a recent conflict you had with someone *other than* a peer (a coworker, friend, family member, etc.). How did you resolve the conflict, or did you? Are you satisfied with the resolution? Does the conflict need more work for a resolution?

Some tips for when I find myself in conflict:

- **Slow down.** We often want to rush through conflict conversations because they're painful and scary. But rushed solutions aren't effective solutions, and they may not last. Take the time to really talk about the problem.
- **Listen for meaning.** What does this issue mean to the other person? What does it mean to you?
- **Listen for values.** What values are important to the other person? What values are important to you?
- **Suggest solutions.** Bringing up problems without suggesting a solution makes you sound like a whiner. Your solution might not be the one that is eventually adopted, but you've shown that you're interested in finding a solution.
- **Give the other person the benefit of the doubt.** Assume they are arguing in good faith for something that's important to them. Don't treat it like a game.

When a peer is in conflict

Again, if you are not a trained mediator, do not attempt mediation. However, you can help your peer clarify their needs and values. Ask the peer to consider how important it is to get their needs met, and how important they consider the relationship with the other person. Discuss respectful communication styles.

Underlying most conflicts is the idea that "I'm being treated with disrespect." As soon as we start arguing, we may feel that the other person is disrespecting us because of the way they speak, or the argument they choose to counter mine. It's important to understand that "respect" may look different to different people. When someone says they're disrespected, ask what respect would look like. Put yourself in that person's place. Most people can work through conflict more easily when they feel respect from the other person.

Summary

Need to know

Conflict may be an element in crisis and can make crisis more difficult to resolve.

Good to know

Understanding our own conflict styles will help us manage conflict more effectively.

Resources

- [**What is Conflict Resolution, and How Does It Work? Program on Negotiation at Harvard Law School**](#)
- [**Resolution Washington website**](#)
- [**Disability Rights Washington website**](#)

Module 8: Suicide Prevention

This module's focus is on suicide prevention. The material can be challenging for those of us who have been affected by suicide. Take a minute to review your wellness tools, have a few ready. Please do what you need to do in order to take care of yourself.

We have said at the outset that the primary value in crisis work is the preservation of life. In every other situation, Certified Peer Counselors support the peer's choice and advocate for their rights.

We cannot, however, support a person choosing suicide. Remember that not every **crisis** involves a risk of suicide.

This module looks at some responses to suicide and programs for suicide prevention that are currently in use around the world today. The next module reviews some newer, largely peer-run options for people who experience thoughts of suicide. We'll review how some peer support programs think about suicide prevention and preventing all kinds of crises.

According to the Centers for Disease Control and Prevention, nearly 6,000 people in Washington completed suicide in the five years between 2015 and 2020. Washington's suicide rate has increased 36% in the past decade. There are indicators that those numbers have increased even more during the pandemic. Suicide is now the single leading cause of death for Washington young people ages 10 through 24, with total deaths 22% higher than for vehicle crashes. Groups with suicide rates higher than the general population include veterans, American Indians/Alaska Natives, LGBTQ youth, and people living in rural counties across the state. Suicide is a genuine behavioral health emergency, and we want to do everything we can to prevent it. In reviewing various ways to help prevent suicide, consider what might work best in the communities where you work. Remember to think about this through the lens of peer support, with peer support values.

Although prior suicide attempts are one of the strongest risk factors for suicide, the vast majority of people who attempt suicide—nine in ten—do not ultimately die by suicide. We take seriously any talk of suicide, and we can hold on to the hope that for most peers, talking about suicide is an indication they want to continue to live.

What crisis looks like

Behavioral health emergencies are unique to each person. Some things might alert us to a person who may be experiencing an impending emergency, and we pay attention and ask questions when we see any of these behaviors. ***Remember that not every crisis poses the risk of suicide.*** We reviewed what crisis might look like in Module One and will expand on that here.

Some people will be able to articulate their distress, while others are unable to describe it or even say they're struggling. Some people stop sleeping and/or eating while others won't get out of bed. Many will look for any kind of relief, no matter how extreme. Such relief-seeking may look like excessive use of drugs or alcohol, driving too fast, extreme risk-taking, etc. Some people self-injure, though self-injury is not always an indicator that the person is at risk for suicide.

A person experiencing a behavioral health emergency generally feels very anxious and even afraid. These feelings may impact their ability to focus, concentrate, and solve problems. If a person is hearing voices, concentration can be challenging. The individual may not be able to think clearly and rationally and may find it challenging to evaluate events and respond to others. They will have trouble responding to complicated requests or orders.

While crisis does not always involve violence or the risk of harm, a person in crisis may be highly agitated, loud, or aggressive. While we are concerned about the person's well-being, we always keep our own safety in mind as well. Trust your instincts and your experience.

Some people will experience physical symptoms such as pain, twitching, or muscle spasm. The peer may be frustrated and feel helpless because they cannot find relief or communicate their needs clearly. A person approaching crisis may lose interest in normal activities, or may find that they're much too difficult, activities such as work, play, and self-care. The person may not be sleeping well, and sleeplessness can spiral into all kinds of other challenges. Fatigue, frustration, and confusion mean the person is unable to complete simple problem-solving and these feelings continue to build. Ultimately, the person's whole sense of self is impacted: they don't recognize that they lack ordinary competence in routine tasks, and they try to push ahead with life while continuing to fail. It's not uncommon to hear people express hopelessness.

Alternately, some peers who have decided to attempt suicide will suddenly appear calm, even relieved. They may give away belongings or attempt to resolve conflicts. A person who has struggled with suicidal thoughts and who has finally made a decision to proceed may show signs of relief, signs of saying

farewell and ensuring care for loved ones after the person's death.

Any of these signs *may* indicate that a person is considering suicide or having thoughts of suicide. Or, they may not be having suicidal thoughts. It's important not to make assumptions about such behavior. Don't panic or overreact until you have more information, simply use your curiosity. Tell the person what you notice, using language that describes their behavior without judgment or evaluation. "I notice that you have been really quiet for the past couple of weeks, and you weren't interested in getting ice cream yesterday. What's going on?"

If the person does not disclose thoughts of suicide, you have several choices. You can ask directly: "Have you been thinking of hurting yourself?" Don't be afraid to ask if you think it's important, asking will not "give someone the idea" if they're not already considering it. Take the peer at their word, believe them, and ask if they need any support because you've still noticed that they're not themselves. You might also choose to wait and watch. Note: This is NOT the same as conducting a lethality assessment (a formal clinical assessment of suicide risk), which is outside the scope of our practice. If you're concerned about a person's safety, you can ask this as a simple screening question. Regardless, we will still listen, support, and consider bringing in a clinician or DCR if that is indicated. Unless the person is holding a weapon or has taken an overdose, you have *all the time in the world* to listen to the peer, to sit with them, to be present. You can always call a clinician later if you need them. Be aware of your employer's guidelines about time: they may prefer that you not spend that much time listening. The point is, don't panic, and don't rush.

Waiting and watching may be an option. If you are concerned about a peer possibly having thoughts of suicide, don't keep it a secret. You should not presume that they are suicidal unless you're pretty confident you're right, but you could tell other members of the treatment team about the behavior you've noticed. Be sure you're *describing* behavior and not evaluating it: say, "I notice that Ted has been really quiet for a couple of weeks and not interested in usual activities," instead of "Ted seems suicidal." Tell the team also about any conversations you've had with the peer about this, and how the peer responded.

Remember: If a peer is telling you about thoughts of suicide, they are asking for help. This is not the same as "attention-seeking." When someone is engaging in extreme behavior to get your attention, they *probably need attention*. Don't assume that, if they're talking about it, they won't take action. If they're talking about it, they're asking for your help, so they *won't* take action.

Optional: Please choose this activity or one from Appendix I

Practice

Suicide is a problem for many people, but it's a bigger problem in some communities. In what communities or cultures do you think suicide is especially prevalent right now? What factors work to make it more prevalent in those communities? What resources and supports are available for people in those communities?

Peer support workers may be the first to learn about a peer's thoughts of suicide. It can be confusing or even scary the first time this happens. We should have this conversation with patience and empathy. The primary purpose for peer support here is to ensure that the peer *feels heard*. Ask questions out of genuine curiosity, not clinical guidance. Allow the peer to just express themselves. Take a few notes, because you will want the rest of the team to know about this. You will need to ask direct questions.

1. Are you suicidal?
2. Do you have a plan?
3. Have you felt like this before?

Remember, it's not our role to assess suicidality, but we can notice any changes in the peer and ask about anything that concerns us. If the peer indicates that they are thinking about suicide, keep them talking.

Don't leave them alone. Let them know you need to call your supervisor to get them the help they need.

Taking time to hear what the peer wants to say does not mean we leave out the clinicians and the rest of the treatment team. You may want a clinician to see the peer before they leave you, to ensure the person will be safe. If the peer has agreed to a safety plan with you, such as going to a friend or family member's home to stay, share that with the team as well. Note: A safety plan is not the same thing as a suicide contract. It goes beyond a commitment to no harm, and actively outlines positive steps to feel better. Sharing peer-devised solutions to crisis expands the possibilities for everyone else by showing our coworkers what's possible. Thoughts of suicide should never be kept secret from other members of the team. Nor should creative solutions to those thoughts.

Optional: Please choose this activity or one from Appendix I

Practice

Using one of the scenarios provided, work with a partner to support a person thinking of suicide. One partner will play the role of the peer in crisis according to the scenario, and the other will provide peer support. Then switch roles. You will be asked to identify what the CPC did that was effective for you.

For some people, suicidality can become a learned response. Whenever they're struggling or things get hard, they say they're suicidal and they get support. This sounds simple, and accusatory, and in fact the system teaches them that it's a surefire way to get providers to pay attention. Thoughts of suicide occur to many people, for many reasons. We think of suicide when we feel trapped, or hopeless, or when our pain feels unbearable. We may think of suicide as a final option we might need some day. Thoughts of suicide are different than compulsions or obsessions. If a person feels compelled to suicide, or they are obsessed with it, that person is not safe. However, thoughts of suicide may recur, as a subconscious way of reminding ourselves that there is a way out of our pain. Framing it as an option, albeit one we don't need right now, can make the thoughts less troubling and eventually, less frequent.

Living one's chosen life is risky and will bring on stressors. When life is more difficult, challenges—such as negative symptoms, hallucinations, delusions, aggression, and self-injury—emerge. Resiliency is about discovering and building up a sense of empowerment with regard to these stressors and experiences. One of the greatest gifts we can collaboratively develop with someone is for them to recognize that when things do not work out, it is not a catastrophe—not all hope is lost, and they can still get what they want.

—National Association of State Mental Health Program Directors (NASMHPD)

Myths and facts about suicide

Some things that many people believe to be true about suicide:

- People think about dying.
- People die by suicide.
- Dying by suicide is not morally wrong.
- Nonjudgmental approaches can lead to connection.
- Connection is valuable, powerful, and can be healing.
- Everyone has intrinsic value.
- Self-determination and risk are essential to dignity.
- Some of us have been personally impacted by suicide.
- Conversations about death and dying are a regular aspect of the human experience.
- Talking about suicide is not inherently dangerous.
- People can experience suicidal thoughts and be in recovery.
- People who experience suicidal thoughts may not take action.

What do you think about the above principles? Do they make sense to you? Do you agree with them? Why or why not?

Traditional suicide prevention tools

While studies show many newer modalities have better outcomes in suicide prevention, peer support workers are likely to encounter or even work with some of the traditional suicide prevention and safety programs. This course reviews some of the most used programs, both traditional and newer alternative (next module). Some of these programs are for other professions, such as law enforcement or primary care. We will identify them so you can recognize these programs, and where they are offered. After learning about the different ways to think about and work with behavioral health emergencies, you may have preferences for a particular theory or practice.

In 2012, changes were made to the National Strategy for Suicide Prevention by adding a new Goal 8: "Promote suicide prevention as a core component of health care services." Note that the emphasis is on all healthcare, not just behavioral health. This document suggested that two transformational commitments should be made by every healthcare provider:

1. Adopt suicide prevention as a core responsibility.
2. Commit to dramatic reductions in suicide among people under care.

Zero Suicide

Zero Suicide, also known as ***Suicide Safer Care***, holds that suicide deaths for people under the care of health and behavioral health systems are preventable, and we should be doing more to prevent patient deaths by suicide. “Suicide safer” care is a program to **train primary care providers** to spot worrying signs of suicidal thoughts. Primary care providers are an integral part of ensuring safety in crisis, including pediatricians, who may be the first to spot trouble in young people. Their knowledge of the individual can help inform strategies for services, and they may also spot early signs of impending crisis. Primary care has not been an important part of the crisis system in the past, but it’s recognized as an important part of overall crisis care. The Zero Suicide framework is designed **primarily for healthcare settings**, both behavioral health and primary care.

Seven key elements of Zero Suicide, or Suicide Safer Care, apply to crisis care:

- Lead
- Train
- Identify
- Engage
- Treat
- Transition
- Improve

Zero Suicide suggests guidelines for safety and security in crisis settings. Most importantly, all crisis settings using this philosophy will use evidence-based, trauma-informed crisis training for all their employees, and specific to each employee’s role. Staffing ratios will be adequate for the number of people using services. There should be adequate privacy and noise control; some crisis settings can be very loud, and it’s hard to rest and heal when it’s loud. Staff watch for any items that could be harmful, such as belts and shoelaces, hairspray, lighters, and those items are removed for safekeeping.

Many crisis settings work toward a policy of zero restraint and seclusion. While staff sometimes fear this puts them at greater risk from peers who lose control, research indicates that facilities that do not use seclusion or restraint are safer for both staff and people using services. There are fewer injuries, and employees report a higher level of satisfaction. In facilities that do still utilize seclusion and restraint, a policy of “no force first” should always be in place. Nobody puts their hands on a peer unless everything else has been tried unsuccessfully, and/or until the peer poses a true danger to someone. If it’s safe to wait them out, it’s always better.

Any crisis employer should have a strong management policy for any incident in which an employee is threatened, no matter by whom. Such incidents are rare. While people may be loud and agitated while in crisis, it’s actually rare for a peer to be violent toward staff.

Crisis Prevention & Intervention (CPI)

We introduced Crisis Prevention & Intervention (CPI) in Module Seven, with its ten tips for de-escalation. It’s a program specifically designed to help employees manage disruptive situations and violent behavior. CPI was developed for use in behavioral health settings, and it’s also used in schools, businesses, and other settings where staff may encounter a hostile person or other tense encounter.

CPI focuses first, and most importantly, on prevention of violence. De-escalation skills, body language, and when to call for help are all covered. CPI does include some physical holds for use when people are threatening violence. Most crisis settings offer training in CPI or something similar to all their staff.

Certified Peer Counselors are often reluctant to learn and/or practice CPI skills. It seems counterproductive and outside of our lane to learn to put hands on someone. Research has demonstrated that, when people feel confident in their ability to manage another’s behavior, they wait **longer** before they have to physically intervene. Having the skills and knowledge to protect ourselves helps us feel confident enough to stay in the conversation, to use de-escalation skills, to give the person time to regain control. If you are offered training in CPI at your crisis employer, it’s a good idea to take it. If nothing else, it will give you more confidence in your ability to protect yourself and keep peers safe. Expect this to be mandatory at many crisis workplaces.

Applied Suicide Intervention Skills Training (ASIST)

ASIST is a two-day training program that teaches participants how to assist those at risk for suicidal thinking, behavior or attempts. Families, friends and neighbors who may be the first ones to hear a person's thoughts of suicide but don't know what to do, are good candidates for this. Clinicians also take ASIST training, as it offers some strategies not necessarily common in their training. Anyone 16 years or older can take the training, regardless of their professional background. School groups, family members, and others who may need to support a person considering suicide are all good candidates for this class. ASIST workshops have a cost to attend, and costs may vary from site to site, though your employer may cover the cost. ASIST cannot be delivered by webinar; availability of classes will depend on pandemic guidance in your community.

The two-day ASIST workshop features video, discussions, simulations and role plays. The course is designed to prepare participants to recognize the signs of suicide risk, offer an intervention informed by the training, and support the person in making a safety plan. ASIST trainers expect that participants will, after completing the class, be able to:

- Recognize that caregivers and persons at risk are affected by personal and societal attitudes about suicide.
- Discuss suicide in a direct manner with someone at risk.
- Identify risk alerts and develop related safe plans.
- Demonstrate the skills required to intervene with a person at risk of suicide.
- List the types of resources available to a person at risk, including themselves.
- Make a commitment to improving community resources.
- Recognize that suicide prevention is broader than suicide first-aid and includes life promotion and self-care for caregivers.

ASIST is evidence-based. More than 30 peer-reviewed studies and government reports indicated that ASIST:

- Improved the skills, confidence, and knowledge of participants.
- Is safe for participants, with no harmful effects from the class.
- Teaches interventions that have been shown to increase hope and reduce suicidal thoughts.
- Teaches skills that actually improve general counseling and listening skills (that includes peer support).

The emphasis is on teaching suicide first aid to help a person at risk stay safe and seek further help as needed. Participants learn to use a suicide intervention model to identify people with thoughts of suicide, seek a shared understanding of reasons for dying and living, develop a **safe plan** based upon a review of risk, be prepared to do follow-up, and become involved in suicide-safer community networks. The learning process is based on adult learning principles and is highly participatory. Graduated skills development occurs through mini lectures, facilitated discussions, group simulations, and role plays. ASIST is included in SAMHSA's National Registry of Evidence-Based Programs and Practices.

Alternatives to Suicide

Alternatives to Suicide is a program developed by Wildflower Alliance (formerly the Western Massachusetts Recovery Learning Center) in 2009. This approach is about openly exploring the meaning behind thoughts and feelings of suicide, as well as what might be worth living for. In “Alt2Su” groups, peers find strength in coming together to support one another in times of distress. Wildflower Alliance says, “Our collective wisdom and individual stories have taught us that making space for this topic can be powerful and healing, whether in a peer support setting or anywhere else these conversations come up. There are many myths and fears around this sort of approach and around suicide in general that Wildflower Alliance trainings seek to dispel and move past.”

In an interview with Caroline Mazel-Carlton for Community Psychology, she said that Alt2Su groups are an alternative to risk assessment. Risk assessments move the conversation about suicide toward determining who will act on thoughts of suicide and how. Risk assessments typically focus on the standard questions, “Do you have a plan?” etc. instead of focusing on predicting a person’s behavior, or paying attention to *why* they are having thoughts of suicide. Alt2Su does not frame thoughts of suicide as the problem, instead seeking to understand them in the context of many other challenges, such as sexual violence, war, poverty, homophobia, racism, etc. Alt2Su conversations move from the “why” to the “why not,” seeking reasons why people choose to continue living.

Second, Alt2Su is an alternative to pathology. It’s a de-medicalized approach that looks beyond brain chemistry or genetics for suicidal thoughts. Nonclinical human experience language is used to explore the context of these thoughts. Consider a standard clinical response to someone saying “I want to die because I feel worthless.” A first response might be about medications and dosages. Alt2Su responds instead to where the person got this message, or how they felt before this. Discussions look at life events or prevailing social messages that might contribute to suicidal thoughts.

And finally, Alt2Su is an alternative to coercion. Full, authentic conversations cannot be achieved when there is an element of control. Participants consider what would make a more attractive life, a life worth living. Think about what this alternative to coercion looks like. Typical crisis units are austere, removing virtually anything that might be used to harm oneself or another. For example, musical instruments would not be allowed because you might get hurt with a guitar string, or you could hit someone else with it. In an Alt2Su type group, musical instruments would be encouraged as part of healing, inviting people to

make music and sing. Safety in this instance would involve strong community and supportive relationships, instead of removing every possibly harmful thing. This is the approach of Intentional Peer Support, which we will review briefly in the next module.

Alternatives to Suicide groups are effective for people for whom suicidal thoughts are a kind of “safety blanket,” the imagined “way out” if things get too bad. Having repeated thoughts (*not* compulsions) of suicide can be frightening and having the ability to explore them without fear of being detained is powerful. For some people, recognizing that they are merely thoughts about a strategy they don’t need right now is enough to dispel suicidal thoughts. Whether a peer has constant thoughts of suicide, or they just began, Alternatives to Suicide groups don’t simply force someone to stay alive from moment to moment. The groups support peers to create meaning and a life that they want to live. Not killing oneself is simply a side effect of all that. What better way to avoid suicide than to build a life worth living? The following Charter statements are from Alt2Su.

Consent and choice

We honor that suicidal thoughts are valid responses to painful experiences in peoples’ lives. That pain often comes from a lack of choice related to resources, housing, relationships and community, healthcare, income, work, exposure to violence, and so on. In contrast, these groups prioritize consent and self-determination, and recognize and respect the many ways that people live with, sit with, cope with, or move through these experiences.

Responses to injustice

In these groups, we validate and explore the hurt and pain we experience of systemic oppression and injustice—for example, rape, interpersonal violence, and discrimination or being devalued based on race, gender, ability, sexual orientation, immigration status, class, employment status, generational traumas and other inherited struggles. Together, we make space to explore the unique ways each of us makes meaning of and responds to these injustices.

Healing in communities

These groups emphasize being part of community by choice. For many people, moving through suicidal moments includes acknowledging the pain that can come from feeling like they don't belong, or from being hurt or rejected by people with whom they have been connected. In groups we make space for envisioning a world where one consistently has a sense of belonging and can find meaning and purpose."

In addition to its Charter, Alternatives to Suicide has developed these statements of values, to guide others in creating groups consistent with these values. Following are the practices and intentions considered essential to Alternatives to Suicide groups.

- We invite conversations with the freedom to:
 - Make meaning and share about one's own experiences in one's own words.
 - Challenge and explore social roles and expectations impacted by gender, class, race, productivity, parenthood, etc.
 - Talk about anything, not just thoughts of suicide.
- Groups meet in community spaces, rather than clinical or treatment group settings where conflicting practices are or have been in place.
- Facilitators openly identify with the experience of suicidal thoughts in groups and are willing to be vulnerable and share about this and other relevant life experiences during groups.
- No pressure of any kind is placed on facilitators to report back (to funders, supervisors, or other authorities) about details of who attends or what gets shared in groups.
- Value of privacy is stated, and everyone is asked to maintain that "what's said here, stays here" or to "leave the names, take the lessons."
- Responsibility for what happens during the group and how the values are held among all people attending and is not solely the responsibility of the facilitators.
- Everyone present is asked to speak from their personal experience, avoid harmful generalizations, and honor that each individual is the expert on themselves.
- Where language is concerned:
 - Facilitators use open, non-clinical language that makes space for a variety of perspectives.
 - There is no assumption that suicidal thoughts are linked to "mental illness," and everyone is supported to use words that make the most sense to them when speaking about their own experiences.
- The group recognizes that suicidal thoughts are often rooted in experiences of systemic oppression, and therefore:
 - People's experiences of systemic oppression are validated; and
 - We strive to consistently interrupt words and actions rooted in systemic oppression, and explore where these ideas come from whenever possible.
- We value relationships, embracing and working through imperfections to learn and grow, rather than trying to fix or change each other.
- Groups are only for people attending for their own support. Observers such as media, students, providers, and anyone else wanting to come for any reason other than to explore their own experiences are not able to attend.
- Decisions are made by group consensus as much as possible and transparency is prioritized when decisions are made outside of that format.
- Attendance is completely voluntary and self-determined, being open to people:
 - Without regard to where they live.
 - Whether or not they use particular services.
 - Without intake, discharge, referral, or other 'gatekeeping' requirements.
 - Whether or not someone chooses to speak when there (silence and acting as a witness to other people's pain are named as valuable).
- Value is placed on meeting and accepting people as they are—validating the stories people share about themselves.
- Emphasis is placed on a harm reduction approach which includes avoiding assumptions when someone shares about self-injury, drug use, or any other coping practice.
- Relationships are based in respect and curiosity instead of fear and judgment.
- Groups prioritize an overall willingness to sit with people in deep distress and explore thoughts and feelings without jumping to clinical or other interventions.
- All participants agree not to call to involuntary interventions like police, crisis services, people's family members, or other outside entities about something that's happened in the group unless there is an act or direct threat of violence to someone in the group.

Optional: Please choose this activity or one from Appendix I

In small groups, use flipchart paper (or whiteboard on Zoom) to make a poster. Your poster will be used to inspire hope and prevent suicide(s) in one or more of the vulnerable communities you identified earlier. Share your poster/whiteboard with the rest of the class.

Summary

Need to know

Suicide rates are rising. Some communities are at greater risk than others. We always pay attention to thoughts of suicide. Lethality assessments are outside our scope of practice.

Good to know

Not every crisis poses the risk of suicide.

Resources

- [Zero Suicide website](#)
- [Crisis Prevention website](#)
- [ASIST website](#)
- [988 website](#)

Module 9: Prevention and Post Crisis Support

We've reviewed some of the approaches to crisis and suicidal thinking that are commonly in use and have been for the past several decades. We also looked at the peer-run Alternatives to Suicide. In addition to Alt2Su, other newer programs for supporting people in distress have shown promise in helping people prevent and/or recover from crisis, avoid future crises, and find a recovery path. Some of these have come from peer-run programs (peer-run respite, Intentional Peer Support, WRAP), and some come from fruitful partnerships between clinician and peer (Hearing Voices Network). Some of these are available in Washington State now, and some are coming soon.

Prevention of a crisis looks different for everyone. Sometimes it is sticking to a routine or plan and sometimes it is digging into the recovery toolbox and getting down to basic self-care. Peer support and peer run respite are excellent tools to prevent and/or deescalate an oncoming crisis. It is important to remember that a crisis can happen when all of these things are in place. Crisis happens and it can be an opportunity for growth.

Peer-run respite

Dictionary.com defines "respite" as "a delay or cessation for a time, especially of anything distressing or trying; an interval of relief." *Respite* has, in recent decades, most often meant outside help for children (or adults) with disabilities, so the adult caretakers get a break for a few hours or days. In our use, *respite* means a place run entirely by peer support where a person experiencing a behavioral health emergency can go to feel safe and supported, and to work through what they need to emerge from crisis.

Peer-run respite has been a service on the East Coast since at least the 1990s. New York and New Hampshire had some of the earliest peer-run respites. Stepping Stone, in New Hampshire, is a good example. It's in a two-story house in an ordinary neighborhood. The ground floor, with a large living and dining room and commercial kitchen, functions as a peer support center during the day, with regularly scheduled activities, socializing, and meals. There is a strong focus on preventing a return to crisis. Because peer-run respite is entirely peer-run, guests bring their own medication and are responsible for self-administering medication, which is securely stored on site.

Respite is one end of a continuum of possible supports away from home in crisis. Respite might look like a homey place, with common rooms and dining rooms more like a home than an institution. This photo was taken in an actual peer-run respite.

Many people would choose this setting but be careful not to assume it's best for everyone. Having a wide range of services in local communities is preferred, so we can access the service that works best for us.

The far end of that continuum might be a seclusion room: often a bare mattress with nothing on it and nothing else in the room. Seclusion rooms should be used only under specific circumstances, defined by WAC.

We recognize that we don't always get to choose where we go in a crisis.

How can we advocate for the services we prefer in our community?

Optional: Please choose this activity or one from Appendix I

Move your body. Stretch. Move away from your chair briefly if you like and come back. In small groups, talk about the strategies you use to stay grounded when discussing difficult topics.

Hearing Voices Network

Working in a crisis setting, you are likely to work with peers who are hearing difficult voices. To be clear: hearing voices is about as common as being left-handed, approximately 10% of the population hears voices, and they aren't all bad. Of course, people whose voices are pleasant and supportive don't typically visit a psychiatrist because they aren't disturbed by the voices. Sometimes, voices can become very threatening and even seem compelling. If you are uncertain if a peer is hearing voices, just ask. You might also ask what messages the voices are giving the peer.

Never suggest that voices aren't real; they are very real to the person experiencing them. This is also true for visions and unusual beliefs—called in clinical language, “delusions.” A person may be so caught up in voices and/or visions that they struggle to identify what shared reality looks like. A “private reality” is often more compelling in a crisis situation. Understand that this *is* their current reality and ask them to tell you about it.

Support for a peer hearing difficult voices might mean simply listening and validating the peer's feelings. You may ask open-ended questions, as long as the peer allows it. Questions should be out of curiosity, to understand the person's experience, not to evaluate or check boxes on a form.

A useful resource for people who hear voices, once the person has rebounded from crisis, is a Hearing Voices Network (HVN) group. This approach was developed by Dr. Marius Romme and Dr. Sandra Escher in the Netherlands, in the late 1980s. It's designed to help voice hearers change their relationship with the voices. For most people, they are able to live relatively comfortably with voices once the relationship changes. Hearing Voices Network takes no position on psychiatric medication: they are neither for nor opposed and consider medication not to be an important topic in their approach to voices. Hearing Voices-style groups may also welcome people who see visions and have unusual beliefs.

Seeking Safety

Seeking Safety is a treatment program for trauma survivors who struggle with substance use or other unsafe coping strategies, developed by Lisa Najavits. Originally designed in 2002 for use by clinicians in inpatient settings, Seeking Safety is easily adaptable to peer support uses. Seeking Safety workbooks can be purchased by individuals, and there is a limited duplication license outlined in the introductory pages: individual purchasers may copy specific pages in the workbook for use with peers. Those pages are clearly identified. (Remember that most other copyrighted materials may not be copied for use in groups unless the material specifically approves that).

Seeking Safety is based on five central ideas:

- Safety is the priority of this as a first-stage treatment
- Integrated treatment of PTSD and substance use disorder
- A focus on ideals
- Four content areas:
 - Cognitive
 - Behavioral
 - Interpersonal
 - Case management
- Attention to therapist processes

Topics covered in Seeking Safety include Grounding (with many excellent grounding exercises), Asking for Help, Honesty, Creating Meaning, Setting Boundaries, Coping with Strong Emotional Responses, and more. Each of the 25 topics features a safe coping skill. Groups begin with a short, structured “check-in” and conclude with a similarly structured “check-out.” Participants are asked to make a recovery commitment in each meeting and invited to try new and healthier coping strategies. Seeking Safety is an evidence-based practice.

Attempt survivor groups

Alternatives to Suicide groups are the best-known version of an attempt survivor group. This is a peer-supported group model in which participants are free to explore suicidal thoughts without fear of being detained. Attempt survivor groups can be facilitated with just about any kind of open process, simply inviting people to explore the reasons behind their attempts and any ongoing thoughts. These groups are especially useful for people who have recently survived a suicide attempt, people who are actively thinking of suicide, and people who think of suicide frequently as a coping strategy.

Keep in mind that the mere act of attempting suicide is not indicative of “mental illness.” Many people have what they think are valid reasons to take their own life. These reasons include:

- Major life loss or grief
- Hopelessness
- Perceived helplessness to change the situation
- Incurable medical condition
- Akathisia (a side effect of newer antidepressants and antipsychotics, causing muscle quivering, restlessness, irritability, an inability to sit still)

If your agency will support an attempt survivor group, you can start by asking participants at your agency how they want it to work. You might also follow some of the guidelines of Alternatives to Suicide. The most important part of having an attempt survivor group is the agreement that participants can speak freely about thoughts of suicide, and those statements won’t automatically result in detention.

Attempt survivor groups are built on the premise that empathic discussion of suicide coupled with an exploration of various coping strategies will decrease suicide. The New Hampshire Office of Consumer and Family Affairs published a manual for the Operation of Suicide Attempt Survivor Support Groups. It suggests that “Attempt survivors most want and need someone they can just talk to who will listen and let them mull things over without rushing to intervene.” Some guiding principles in the manual are:

- Maintain participants’ safety and manage risk
- Increase comfort of speaking about suicidal thoughts to reduce likelihood of future attempts
- Develop a peer support network
- Increase the ability to plan for the future
- Help an individual to cope with the flood of emotions following an attempt
- Develop a toolbox of coping skills, supports, resources and wellness tools to prevent another attempt, and
- Develop and reinforce protective factors for suicide risk

[View an example guide for attempt survivor groups.](#)

Post-crisis possibilities

Surviving a crisis and emerging on the other side can be terrifying. It can also be invigorating, depending on your response and how the peer makes meaning out of crisis experiences. We can begin reframing the situation as soon as we see the peer beginning to emerge from the crisis. Start reframing with validation. Make sure the peer hears that you recognize how hard or frightening the experience was for them. Remember, we don't want to move to reframing too fast, or the peer will think we didn't understand how hard it was.

When intense experiences are not validated by trusted others, we can start to doubt our own experience, to wonder if that experience was real. After validation, use what you know about the person to reflect strengths displayed during the crisis. Look for strengths such as perseverance, trust, honesty, courage, and willingness to work hard. Reminding the peer that they have strengths—and they used them—can give them confidence to stay on the recovery path. Remembering with the family how they grew resilient in the face of challenges grows their confidence to overcome future challenges.

When a peer has come through a behavioral health emergency, the aftermath may present a challenge. Many peers find their way to crisis services after breaking connections with family and friends, perhaps engaging in behavior that feels embarrassing or shameful in retrospect. It may feel to the peer that there is a lot of personal and professional damage to repair. Be sure to be honest with the peer about possible fallout related to pre-crisis actions. If you know or suspect there will be consequences, don't hide them and don't lie about them. Be honest and straightforward, and in the same sentence ask how we can support them. Facing the consequences of our pre-crisis actions unsupported can keep people stuck in crisis, afraid of facing people and other consequences from their behavior. Parent Partners may be able to provide support for youth and family crisis; their perspective may be useful to adults seeking to repair family relationships following a crisis.

Think about having this discussion as soon as the peer seems to be recovering from the crisis. Ask the peer if it's a good time to talk about the after-effects, and be sure the peer knows they can say no. When the peer is ready to talk about it, assure the peer that you won't judge them for their behavior. If you have personal experience of cleaning up the effects of a crisis, now is a good time to share that story if the peer wants to hear it.

Next, ask the peer what would be helpful for them. Try not to make assumptions about how the peer should resolve their challenges; if the peer honestly can't come up with any ideas, ask if they would like you to share some. Remember that the peer's ideas may be more effective because that person knows what will work for them. If you're working with a young person, ask the Youth Partner to do some visioning or brainstorming about next steps with the young person. Invite a Parent Partner to support the parent(s).

Wellness Recovery Action Plan

We introduced Wellness Recovery Action Plan (WRAP) in Module Six, as a self-advocacy tool to ensure that we get what we need in a crisis. When a peer is returning home from crisis services, a WRAP group might be a good place to start. If the peer does not have a WRAP, see if there are WRAP groups available where you live. If your employer does not offer them, find out about becoming qualified. Anyone can work through the WRAP book with a peer, though it's better if you've done your own in a formal setting first. In order to facilitate WRAP groups, in which participants support each other in thinking of wellness tools, you must take classes. As an evidence-based practice, WRAP groups are reimbursed to your employer at a higher rate.

Returning home

Returning home following a crisis is a critical time for the peer. If arrangements have not been made in advance, like in a WRAP or BHAD, it is not uncommon for a peer who is detained to lose their home, their belongings, even companion animals. We aren't helping people regain wellness if they lose everything they have while they are in the hospital. Either before or during a crisis, we can remind the peer to consider these things when they are making a plan in case they are hospitalized. You can make a checklist to help them identify who will help with each task. Some of these tasks will not apply to every peer, and some peers will need other tasks.

Make a checklist like this sample that supports your peer's specific needs, for while they are inpatient and when they are about to go home. Don't forget any other medical conditions that may need to also be addressed. This checklist is duplicated in Appendix H for ease of copying.

Who will do the following tasks?

Care for children	
Care for pets	
Water plants	
Pick up and sort mail	
Speak to our employer	
Pay bills	
Speak to our landlord	
Negotiate late payment of rent or utilities	
Arrange for food upon return home	
Clean home (including throwing out spoiled food)	
Pick up new prescriptions	
Stay with us for first few hours or evening	
Make follow-up appointments for health care	
Other (specific to peer)	

Preparing the home

Whether the peer has a checklist or not, we want to remember a couple of things that will help make their return home smooth and uneventful. There may have been food in the refrigerator that now is spoiled and should be discarded. They will also need fresh food when they return home, and they may not feel up to the grocery store! After some weeks of limited meals in the hospital, the many choices can feel overwhelming, and crowds may be uncomfortable. Ask the peer about food, what they will need, and whether they have identified someone to do this for them. Don't assume it's your job to do this: it's your job to identify a natural support who can do it, and only as a last resort should it be you.

The home may need cleaning before the peer returns. It's not uncommon for a peer to neglect routine housecleaning tasks when approaching a crisis and returning home to a disordered setting may be overwhelming. Ask the peer if their home could

use some cleaning before they return home. This will be especially important for peers who live alone; roommates or family members may have taken care of a shared home.

Children are another consideration for returning home. If the children have been at home with another parent or relative, the return home may be somewhat easier than if the children were in another home. Ask the peer if they feel up to parenting right away when they get home. If the children are in another home, it may be possible for them to stay there another few days, or at least sleep there, to give the peer a little time to adjust. Older children staying with friends may especially appreciate this. Another adult in the home can provide a buffer so the peer can take their time adjusting. Talk with the peer about how they will talk about their hospital stay with their children. They may be confused and discussing it and/or practicing that conversation can be helpful.

A plan for care out of the home should include who will pick up mail. If mail piles up in a mailbox, the post office may stop delivery, adding additional challenges to the peer's return home. The person who checks mail should also sort: discard mail that isn't important, such as fliers for local services, catalogs, etc. Bills, checks, packages or magazines should be kept in separate piles for easy access. Ask the peer if someone has been identified to pay bills, such as rent and utilities, and if so, ensure that person is following through. Peers who live alone may have additional considerations. If a roommate or family member is not in the home, the peer may worry about being alone with medication and/or weapons in the home. It's okay to ask frankly about these things, and to ask if the peer would like assistance figuring it out. Again, be sure to suggest natural supports before you offer to help.

Wellness planning

After-care planning should include considerations that we have discussed previously, things such as stocking the refrigerator and ensuring the house is clean. We want to be sure the discharge plan also includes planning for wellness as a whole person. Think about future-oriented plans, hope-based plans, activities that support the person's return to a full life in the community. Focus on things the person can do to feel better when they're struggling. These will be unique to the individual and to each challenge. Focus also on steps to resume valued life roles and activities. How will they ease back into the life they had before crisis? How will they make life better following a crisis?

A wellness plan is not the same thing as a safety contract. Safety contracts ask the person to commit to not harming themselves. They generally include some "safety valve" language such as "call the crisis line" or "take a PRN" if the person is in distress. They do not, however, focus beyond the moment, and on to reasons to live. As we have mentioned, it's not enough to prevent someone from taking their own life. We want them also to be able to build a life worth living. If preservation of life is our highest value, then creating a life worth living is a close second.

When you and the peer have a good picture of what needs to be done after discharge, include support for those activities in the discharge plan. You will likely not be the peer support person once the peer is discharged, but you might suggest somewhere they can find good peer support as part of that discharge plan. Consider your resources, and what you think the person or family will need for support. When possible, you might introduce the person or family to their next provider—if you have that knowledge.

This is also a good time to review any crisis plan the peer or family may have had before the current

emergency. Review the plan. See if the peer or family may have missed some routine self-care or other activities that help them stay well and balanced. As the peer evaluates what led to the current emergency, see if they can imagine how they might have avoided this crisis. What might they have done to prevent it? What can they do to prevent it in the future?

If the peer has a Wellness Recovery Action Plan (WRAP), invite them to work on the Post-Crisis Plan to prepare for and/or prevent a next time. A Behavioral Health Advance Directive (BHAD) should also be reviewed after each crisis incident, to see if it needs updating. As our lives change, our needs change. Support needs will also change as people move away from crisis and into their recovery journey.

When working with a peer recovering from crisis, you can use the Post-Traumatic Growth Inventory to support the peer in setting some new goals. Keep in mind that the peer's or the family's service plan may need to be renewed, goals may need to be adapted or mechanisms for reaching those goals may need to be changed. After crisis is a good time to take an in-depth look at the service plan, the goals outlined in it, and the approach you're taking.

After crisis we want to look back at what happened. Did something important happen in my life to generate a crisis, that I had no control over? Did I neglect my self-care? Have I been ill or otherwise extra vulnerable? With that knowledge, we can develop a new plan with more effective goals.

An outline for creating a post-traumatic growth plan might include these items:

- Start with a strengths assessment. Don't forget outside resources! People, organizations, and funding are strengths too.
- Review healthy and unhealthy coping mechanisms.
- Review coping mechanisms used as a child vs. those used as an adult.
- As we recognize how our crisis may have impacted others we love, we take care to forgive ourselves.
- From here, choose 3-4 post-traumatic goals and add detailed objectives showing how you plan to achieve each one.
- Celebrate success and build on achievements.

Culture matters in crisis

In CPC class, you spent some time exploring culture and its impact on wellness. You learned that no person is a perfect stereotype of their culture, that most of us take part in multiple cultures. For example, a person may be involved with culture related to ethnicity, religion, gaming, sports, gender identity, veteran status, disability. This person may consider one aspect of those multiple cultures to be primary, and a different culture may be more important in a different situation. Consider also whether/how the person is housed; their socioeconomic status; access to services; and connection to community. When exploring culture with peers, remember that specific aspects of culture may be supportive for some people and can also feel oppressive to others. Avoid making assumptions about how people feel about their culture, cultural practices or traditions.

Cultural resources

It's a smart practice to make your own resource guide to support you in working with people of different cultures. Consider things such as access to interpreters and dialects, support for young people/children and elders, gender-based supports, religious supports and communities, refugee/immigrant supports, income support for people living in poverty, refugees' experience of war or torture, veterans' issues, and the general nature of ethnic relations in your community. Washington providers are required to always have access to interpreters; they may be over the phone, but they are important. NEVER ask a family member to interpret for a person in crisis. Remember to think about culture broadly: it's bigger than race, ethnicity, and religion. Consider LGBTQ resources, veterans' resources, supports for native people and specific tribal resources. If you have a good idea who lives in your community, you can find the resources available to serve those people.

Once you have a resource list, explore more about the cultures. How do other cultures think about suffering, pain, and death? How do they make meaning about these experiences? Who should be involved? Remember that some cultures are much more community-oriented, and the entire family should be included in every decision. Ask the person how they feel, what would be useful for them.

Post-crisis care for you

When you have supported a peer through a particularly intense outburst, it's important that you take some time to reflect for yourself. It's likely that your employer will initiate a debrief with all staff who were involved in the incident, and perhaps with some of the participants as well. In addition to this, it's advisable to spend a little time in self-reflection at the end of that day.

Self-care after a traumatic experience—one which may have activated old trauma responses or added new vicarious trauma—is critical to our ability to stay healthy. You made a simple wellness plan for work on Day 2 that reviewed some routine daily wellness practices. The Rape, Abuse, and Incest National Network (RAINN) publishes some self-care tips that might help you expand your routine self-care, and plan for those days when you need more than the routine.

We may first think about our emotional well-being when we consider wellness after crisis, as that seems like the most obvious impact. It's important also to think about our physical health. Don't neglect your usual wellness practices. In addition to those things you typically do, pay attention to these areas:

- How are you sleeping? In addition to any usual routine, make sure you get enough sleep and that your sleep is good quality. If your sleep is interrupted, look for other ways to get sleep. Sleep is crucial to recovery.
- How are you eating? When we are stressed or overwhelmed, it's tempting to eat "comfort foods," those things that just feel good to us. Often, those "comfort foods" are full of sugar, fats, and other unhealthy ingredients. Following any kind of trauma, our body will need replenishing with healthy food: plenty of fruits and vegetables, and reasonably balanced.
- How do you get exercise? Some people will be unable to sit still following an intense encounter, and they may burn off jittery energy by continually moving around. Others may freeze in place, becoming paralyzed. Our bodies need regular exercise to stay strong and functioning well. Make sure you don't skip regular physical activity and consider adding in a few short walks or some other fun activity that helps clear the adrenaline out of your system.
- Check your daily routine. When we're overwhelmed, we may skip some of the things we typically do every day, and those things may be important to our wellness. Pay attention to routines.
- Set aside time for self-reflection. Take some time to process the event. If you work with a therapist, that's a good place to do this. Even without a therapist, you can review the event, consider what led up to it,

look at your own actions, and decide if you want to do something different next time. This is not about placing blame, but about learning from experience.

Emotional wellness is next in our self-reflection. This will look different for everyone. To consider what we need to support emotional wellness following an intense event, RAINN suggests you think about a time when you felt balanced and grounded. Then think about these areas of your life.

- What fun or leisure activities do you (or did you) enjoy? When was the last time you took part in these activities? Is it time to do it again?
- Do you write down your thoughts in a journal or notebook? Journaling is an important self-reflective activity because writing uses a different part of the brain than speaking. Sometimes we learn things from our subconscious by writing. This isn't for everyone, but if you haven't tried it yet, consider it.
- Did you meditate or enjoy any specific relaxation activities, such as yoga? Meditation doesn't have to be fancy or formal, it can be as simple as practicing mindfulness in all we do. Our bodies hold stress in many ways. Unless we find ways to relax and unwind, the body will store it.
- Where do you find inspiration? Some people use a daily meditation book or website, where they can find a daily inspiration related to their spiritual or recovery path. Inspiration helps keep hope alive and reminds us why we do the hard work of recovery.
- Who do you spend time with? It's an important human need to feel that we belong to some community, some group of people whose values we share and who are supportive of us and we of them. Following a traumatic event, it's important that we surround ourselves with people in recovery, who will support us and our honest self-reflection. Beware of people who just want you to "move on" or who offer drugs or alcohol to relieve your "stress."
- Where do you spend your time? Remember that the first task in trauma recovery is finding people and places that are safe. Is there some place that feels particularly safe to you? It might be a place outdoors, in the woods, at the beach, or some other special place where you feel safe and at peace. It might be your home, or the home of a close friend. Make sure you're spending time in places that support your wellness and recovery; avoid places like the bar or the casino.

Self-care is part of our commitment to peer support. We cannot offer good peer support if we ourselves are not well. It is expected that peer support workers have done their own trauma work before entering peer support employment. And traumatic responses can be re-activated at any time, no matter how much recovery work we have done ourselves.

Summary

Need to know

Prevention of a crisis looks different for everyone. Sometimes it is sticking to a routine or plan and sometimes it is digging into the recovery toolbox and getting down to basic self-care.

Good to know

Not all crisis can be averted. It is important not to blame or ask why a person stopped taking medication or stopped following a care plan if that may have led to the crisis.

Resources:

- [Peer respites website](#)
- [Hearing Voices Network website](#)
- [Seeking Safety website](#)
- [Wellness Recovery Action Plan website](#)
- [Cultural Competence in Crisis Intervention webpage](#)

Final course summary

Certified Peer Counselors play a unique role in a behavioral health crisis. In this training you learned how to support peers in a crisis, and how to work in the Washington State crisis system. You had the chance to reflect on how it would be to staff these services, and how it would be as a person using those services. You were invited to build your own crisis system. When the peers we support go into crisis it is important to know that you are meeting them on one of the worst days of their lives. The crisis does not define them but with good peer support it can help them grow.

You learned about culture and how to have cultural humility when addressing an individual experiencing a crisis. Youth and families have unique needs and cultures, and they need to be addressed accordingly.

Selfcare for the CPC after a crisis event at work is very important. You learned how to identify your self-care needs and what post traumatic growth is. Remember, wellbeing is an ongoing process. There are eight dimensions of wellness that help make up our overall health: physical, intellectual, emotional, social, spiritual, occupational, financial, and environmental. All dimensions of wellness need our attention for us to truly flourish. There doesn't have to be a balance among all dimensions. Instead, the goal is to find a personal harmony with the dimensions that are most authentic for you.

Congratulations on finishing the Crisis Awareness and Communication in Peer Support training!

If you need to talk to someone, please use peer support or talk to your trainers.

Appendices

Appendix A: Acronyms and initialisms

AA - Alcoholics Anonymous	E & T - Evaluation and Treatment facility
AAA - Area Agency on Aging	EBP - Evidence-Based Practice
ACS - Access to Care Standards	ESL - English as a Second Language
ACT - Assertive Community Treatment	ESH - Eastern State Hospital
ADA - Americans with Disability Act	FACT - Forensic Assertive Community Treatment
ADHD - Attention Deficit Hyperactivity Disorder	FAE/FAS - Fetal Alcohol Effects/Fetal Alcohol Syndrome
ADL - Activities of Daily Living	FERPA - Family Educational Rights & Privacy Act
ADSA - Aging and Disabilities Services Administration	FFCMH - Federation of Families for Children's Mental Health
AFDC - Aid to Families with Dependent Children	FRS - Family Reconciliation Services
AFH - Adult Family Home	GA - Gamblers Anonymous
APS - Adult Protective Services	LGBTQ+ia - Lesbian Gay Bisexual Transgender (Questioning)
ASL - American Sign Language	HHS - United States Department of Health and Human Services
BHO - Behavioral Health Organization	HIPAA - Health Insurance Portability and Accountability Act
CA - Children's Administration	HWD - Healthcare for Workers with Disabilities
CASA - Court Appointed Special Advocate	ICCD - International Center for Clubhouse Development
CBT - Cognitive Behavioral Therapy	IDEA - Individuals with Disabilities Education Act
CFR - Code of Federal Regulations	IEP - Individualized Education Plan
CHINS - Child In Need of Services	IMR - Illness Management and Recovery
CIT - Crisis Intervention Training	ISP - Individualized Service Plan
CLIP - Children's Long-term Inpatient Programs	IST - Interagency Staffing Team
CMS - Centers for Medicare and Medicaid Services	ITA - Involuntary Treatment Act
CPC - Certified Peer Counselor	ITC - Individualized and Tailored Care
COD - Co-occurring Disorders	JAN - Job Accommodation Network
COPS - Consumer Operated Programs & Services	JRA - Juvenile Rehabilitation Administration
CPS - Child Protective Service	L & I - Department of Labor and Industries
CRC - Crisis Residential Center	LD - Learning Disability
CSO - Community Service Office	LOS - Length of Stay
CSTC - Child Study and Treatment Center	LRA - Least/Less Restrictive Alternative
DBHR - Division of Behavioral Health and Recovery	LRE - Least/Less Restrictive Environment
DD - Developmental Disability	
DDD - Division of Developmental Disabilities	
DMHP - Designated Mental Health Professional	
DOH - Department of Health	
DSHS - Department of Social and Health Services	

MCO - Managed Care Organization	RCW - Revised Codes of Washington
MDT - Multidisciplinary Team	SAMHSA – Substance Abuse and Mental Health Services Administration
MHFA – Mental Health First Aid	SBD - Serious Behavioral Disturbance
MHP - Mental Health Professional	SE – Supported Employment
NA – Narcotics Anonymous	SEIU – Service Employees International Union
NAMI - National Alliance on Mental Illness	SGA – Substantial Gainful Activity
iNAPS– International Association of Peer Specialists	SSA – Social Security Administration
NIH – National Institute of Health	SSDI - Social Security Disability Insurance
NIMH – National Institute of Mental Health	SSI - Supplemental Security Income
NMHA – National Mental Health Association	SUD – Substance Use Disorder
OA – Overeaters Anonymous	TACID - Tacoma Area Coalition for Individuals with Disabilities
OCP - Office of Recovery Partnerships HCA	TANF – Temporary Assistance for Needy Families
OCR - Office of Civil Rights	TBI – Traumatic Brain Injury
OSPI - Office of Superintendent of Public Instruction	Tx – Treatment
PACT – Program for Assertive Community Treatment	USPRA – United States Psychiatric Rehabilitation Association
PASS – Plan for Achieving Self Support	VA – (United States Department of) Veterans Affairs
PAVE – Partnerships for Action, Voices for Empowerment	WAC - Washington Administrative Code
PCP – Primary Care Provider OR Person-Centered Planning	WRAP - Wellness Recovery Action Plan
PHI – Protected Health Information	WSCC – Washington State Clubhouse Coalition
PTSD - Post Traumatic Stress Disorder	WSH – Western State Hospital
QA - Quality Assurance	
QI - Quality Improvement	
QRT - Quality Review Team	

Appendix B: The Post-Traumatic Growth Inventory

Scoring

0 = I did not experience this as a result of my crisis

1 = I experienced this change to a very small degree as a result of my crisis

2 = I experienced this change to a small degree as a result of my crisis

3 = I experienced this change to a moderate degree as a result of my crisis

4 = I experienced this change to a great degree as a result of my crisis

5 = I experienced this change to a very great degree as a result of my crisis

I changed my priorities about what is important in life

I have a greater appreciation for the value of my own life

I have developed new interests

I have a greater feeling of self-reliance

I have a better understanding of spiritual matters

I more clearly see that I can count on people in times of trouble

I established a new path for my life

I have a greater sense of closeness with others

I am more willing to express my emotions

I know that I can handle difficulties

I can do better things with my life

I am better able to accept the way things work out

I can better appreciate each day

New opportunities are available which wouldn't have been otherwise

I have more compassion for others

I put more effort into my relationships

I am more likely to try to change things that need changing

I have stronger religious faith

I discovered that I'm stronger than I thought I was

I learned a great deal about how wonderful people are

I better accept needing others

Totals

Total 1s

Total 2s

Total 3s

Total 4s

Total 5s

Limitations: This inventory has been validated in an adult female population (no other demographic information was included). There is no information about its validity in youth or children, or in adult males.

Appendix C: Post-Traumatic Growth Plan

After a behavioral health emergency, it can be helpful to look back at the experience and see what can be learned from it. You may use this outline.

What strengths did I use to overcome this challenge? (don't forget to identify outside resources that are strengths)

What *healthy* coping methods did I use during this challenge?

What *unhealthy* coping methods did I use?

How might I choose a healthier coping strategy next time?

Now think about what coping strategies I used as a child. What were they?

What coping strategies do I rely on as an adult?

Do I need to learn more adult coping strategies?

Did my behavior hurt someone else? Who and how?

Now it's time to forgive yourself.

As a result of what I learned this time, I'd like to achieve these goals? (Make this as detailed as you can)

Celebrate your success!

Appendix D: Other resources

Here are some resources that may be helpful when working with peers.

- **Mental Health Advance Directive website**
- **Behavioral Health Advocacy webpage**
- **Beyond Possible: How the hearing voices approach transforms lives (video)**
- **Bloom Sanctuary Model**
- **Hearing Voices Network website**
- **CPI Prevention First Training video**
- **Crisis Prevention and Intervention website**
- Eight Dimensions of Wellness: **Dimensions of Wellness Booklet**
- Hornstein, Gail A. (2009). *Agnes's Jacket: A Psychologist's Search for the Meaning of Madness*. New York: Rodale Press.
- **Intervoice Online website**
- **Nonviolent Communication website**
- RAINN (Rape, Abuse, and Incest National Network) **Self-Care After Trauma webpage**
- **SAMHSA Concept of Trauma and Guidance for a Trauma-Informed Approach webpage**
- **Trauma-Informed Care Curriculum**
- **Speaking of Suicide resources webpage**
 - This website lists voluminous resources, including specialty sites offering essentially peer support: lines for LGBTQ youth, for law enforcement, for veterans, and resources for survivors.

Appendix E: NVC common human feelings & needs

Some basic feelings we all have

Feelings when needs are fulfilled:

- Amazed
- Comfortable
- Confident
- Eager
- Energetic
- Fulfilled
- Glad
- Hopeful
- Inspired
- Intrigued
- Joyous
- Moved
- Optimistic
- Proud
- Relieved
- Stimulated
- Surprised
- Thankful
- Touched
- Trustful

Feelings when needs are not fulfilled:

- Angry
- Annoyed
- Concerned
- Confused
- Disappointed
- Discouraged
- Distressed
- Embarrassed
- Frustrated
- Helpless
- Hopeless
- Impatient
- Irritated
- Lonely
- Nervous
- Overwhelmed
- Puzzled
- Reluctant
- Sad
- Uncomfortable

Some basic needs we all have

Autonomy

- Choosing dreams/goals/values
- Choosing plans for fulfilling one's dreams, goals, values

Celebration

- Celebrating the creation of life and dreams fulfilled
- Celebrating losses: loved ones, dreams, etc. (mourning)

Integrity

- Authenticity
- Creativity
- Meaning
- Self-Worth

Interdependence

- Acceptance
- Appreciation
- Closeness
- Community
- Consideration
- Contribution to the enrichment of life
- Emotional safety
- Empathy

Physical nurturance

- Air
- Protection from life-threatening forms of life: viruses, bacteria, insects, predatory animals
- Shelter
- Food
- Rest
- Touch
- Movement, exercise
- Sexual expression
- Water

Play

- Fun
- Laughter

Spiritual Communion

- Beauty
- Harmony
- Inspiration
- Order
- Peace

Honesty (the empowering honesty that enables us to learn from our limitations):

- Love
- Reassurance
- Respect
- Support
- Trust
- Understanding

Appendix F: Behavioral Health Advance Directive Form

Mental Health Advance Directive Example

⚠ Notice to persons creating a Mental Health Advance Directive

This is an important legal document. It creates an advance directive for mental health treatment. Before signing this document, you should know these important facts:

This document is called an advance directive and allows you to make decisions in advance about your mental health treatment, including medications, short-term admission to inpatient treatment and electroconvulsive therapy.

**You do not have to fill out or sign this form.
If you do not sign this form, it will not take effect.**

If you choose to complete and sign this document, you may still decide to leave some items blank.

You have the right to appoint a person as your agent to make treatment decisions for you. You must notify your agent that you have appointed him or her as an agent. The person you appoint has a duty to act consistently with your wishes made known by you. If your agent does not know what your wishes are, he or she has a duty to act in your best interest. Your agent has the right to withdraw from the appointment at any time.

The instructions you include with this advance directive and the authority you give your agent to act will only become effective under the conditions you select in this document. You may choose to limit this directive and your agent's authority to times when you are incapacitated or to times when you are exhibiting symptoms or behavior that you specify. You may also make this directive effective immediately. No matter when you choose to make this directive effective, your treatment providers must still seek your informed consent at all times that you have capacity to give informed consent.

You have the right to revoke this document in writing at any time you have capacity.

You may not revoke this directive when you have been found to be incapacitated unless you have specifically stated in this directive that you want it to be revocable when you are incapacitated.

This directive will stay in effect until you revoke it unless you specify an expiration date. If you specify an expiration date and you are incapacitated at the time it expires, it will remain in effect until you have capacity to make treatment decisions again unless you chose to be able to revoke it while you are incapacitated and you revoke the directive.

You cannot use your advance directive to consent to civil commitment. The procedures that apply to your advance directive are different than those provided for in the Involuntary Treatment Act. Involuntary treatment is a different process.

If there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

You should be aware that there are some circumstances where your provider may not have to follow your directive.

You should discuss any treatment decisions in your directive with your provider.

You may ask the court to rule on the validity of your directive.

PART I

Statement of intent to create a mental health advance directive

I, _____, being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care. If a guardian is appointed by a court to make mental health decisions for me, I intend this document to take precedence over all other means of ascertaining my intent.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, my agent should make the decision that they determine is in my best interest. I intend this directive to take precedence over any other directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if a court, two health care providers, or one mental health professional and one health care provider find that I am an incapacitated person, unless, when I executed this directive, I chose to be able to revoke this directive while incapacitated.

I understand that, except as otherwise provided in law, revocation must be in writing. I understand that nothing in this directive, or in my refusal of treatment to which I consent in this directive, authorizes any health care provider, professional person, health care facility, or agent appointed in this directive to use or threaten to use abuse, neglect, financial exploitation, or abandonment to carry out my directive.

I understand that there are some circumstances where my provider may not have to follow my directive.

PART II

When this directive is effective

You must complete this part for your directive to be valid.

I intend that this directive become effective (you must choose only one):

Immediately upon my signing of this directive.

If I become incapacitated.

When the following circumstances, symptoms, or behaviors occur:

PART III

Duration of this directive

You must complete this part for your directive to be valid.

I want this directive to (you must choose only one):

Remain valid and in effect for an indefinite period of time.

Automatically expire _____ years from the date it was created.

PART IV

When I may revoke this directive

You must complete this part for your directive to be valid.

I intend that I be able to revoke this directive (you must choose only one):

Only when I have capacity.

I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.

Even if I am incapacitated.

I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated, I may not receive treatment that I specify in this directive, even if I want the treatment.

PART V

Preferences and instructions about treatment, facilities, and physicians

A. Diagnosis, Medication, and Treatment Preferences

In order to assist in carrying out my directive I would like my providers and my agent to know the following information:

I have been diagnosed with the following illness/illnesses:

I take the following medication to treat my illness/illnesses:

I also take the following other medications for other conditions:

I have found that the following treatments work best for me:

B. Preferences and Instructions About Physician(s) to be Involved in My Treatment

I would like the physician(s) named below to be involved in my treatment decisions:

Dr. _____ Contact information _____

Dr. _____ Contact information _____

I do not wish to be treated by:

Dr. _____

C. Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name _____ Profession _____

Contact _____

Name _____ Profession _____

Contact _____

D. Preferences and Instructions About Medications for Psychiatric Treatment *(initial and complete all that apply)*

I consent, and authorize my agent (if appointed) to consent, to the following medications:

I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:

I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include:

and these side effects can be eliminated by dosage adjustment or other means

I am willing to try any other medication the hospital doctor recommends.

I am willing to try any other medications my outpatient doctor recommends.

I do not want to try any other medications.

Medication Allergies

I have allergies to, or severe side effects from, the following:

Other Medication Preferences or Instructions

I have the following other preferences or instructions about medications:

E. Preferences and Instructions About Hospitalization and Alternatives

(Initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)

In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/ facilities designed as alternatives to psychiatric hospitalizations.

I would also like the interventions below to be tried before hospitalization is considered:

Calling someone or having someone call me when needed

Name

Telephone

Staying overnight with someone.

Name

Telephone

Having a mental health service provider come to see me.

Going to a crisis triage center or emergency room.

Staying overnight at a crisis respite (temporary) bed.

Seeing a service provider for help with psychiatric medications.

Other, specify:

Authority to Consent to Inpatient Treatment

I consent and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for _____ days (not to exceed 14 days). Select and sign one:

If deemed appropriate by my agent (if appointed) and treating physician.

Signature

Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization):

Signature

I do not consent or authorize my agent (if appointed) to consent, to inpatient treatment.

Signature

Hospital Preferences and Instructions

If hospitalization is required, I prefer the following hospitals:

I do not consent to be admitted to the following hospitals:

F. Preferences and Instructions About Pre-emergency

I would like the interventions below to be tried before use of seclusion or restraint is considered
(*Initial all that apply*):

- "Talk me down" one-on-one
- More medication
- Time out/privacy
- Show of authority/force
- Shift my attention to something else
- Set firm limits on my behavior
- Help me to discuss/vent feelings
- Decrease stimulation
- Offer to have neutral person settle dispute
- Other, specify

G. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen.

(*Choose "1" for first choice, "2" for second choice, and so on*)

- Seclusion
- Seclusion and physical restraint (combined)
- Medication by injection
- Medication in pill or liquid form

In the event that my attending physician decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part III C of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

H. Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

My wishes regarding electroconvulsive therapy are (*select and sign one*):

I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy.

Signature

I consent and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy.

Signature

I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

Signature

I. Preferences and Instructions About Who is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: _____ Name: _____

Name: _____ Name: _____

I understand that persons not listed above may be permitted to visit me.

J. Additional Instructions About My Mental Health Care

Other instructions about my mental health care:

In case of emergency, please contact:

Name _____ Work phone _____ Home phone _____

Address _____

Physician information in case of emergency:

Physician name _____ Physician phone _____

Physician address _____

The following may help me to avoid a hospitalization:

I generally react to being hospitalized as follows:

Staff of the hospital or crisis unit can help me by doing the following:

K. Refusal of Treatment

I do not consent to any mental health treatment.

Signature _____

PART VI

Durable power of attorney (appointment of my agent)

Fill out this part only if you wish to appoint an agent or nominate a guardian.

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document and my agent does not otherwise know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.

A. Designation of an Agent

I appoint the following person as my agent to make mental health treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective:

Name Relationship

Work phone Home phone

Address

B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name Relationship

Work phone Home phone

Address

C. When My Spouse is My Agent (*initial if desired*)

If my spouse is my agent, that person shall remain my agent even if we become legally separated or our marriage is dissolved, unless there is a court order to the contrary or I have remarried.

D. Limitations on My Agent's Authority

I do not grant my agent the authority to consent on my behalf to the following:

E. Limitations on My Ability to Revoke this Durable Power of Attorney

I choose to limit my ability to revoke this durable power of attorney as follows:

F. Preference as to Court-Appointed Guardian

In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I nominate the following person as my guardian:

Name Relationship

Work phone Home phone

Address

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

Signature (required if nomination is made)

PART VII

Other documents

I have executed the following documents that include the power to make decisions regarding health care services for myself: *(Initial all that apply)*

Health care power of attorney (chapter 11.94 RCW)

"Living will" (Health care directive; chapter 70.122 RCW)

I have appointed more than one agent. I understand what the most recently appointed agent controls except as stated below:

PART VIII

Notification of others and care of personal affairs

Fill out this part only if you wish to provide nontreatment instructions.

I understand the preferences and instructions in this part are **NOT** the responsibility of my treatment provider and that no treatment provider is required to act on them

A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible when this directive becomes effective:

Name Work phone Home phone

Address

Name Work phone Home phone

Address

B. Preferences or Instructions About Personal Affairs

I have the following preferences or instructions about my personal affairs (e.g. care of dependents, pets, household) if I am admitted to a mental health treatment facility:

C. Additional Preferences and Instructions

PART IX

Signature

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

Signature

Date

Printed name

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the principal is personally known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

- A person designated to make medical decisions on the principal's behalf.
- A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed.
- An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident.
- A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010
- An incapacitated person.
- A person who will benefit financially if the principal undergoes mental health treatment
- A minor

Witness 1

Signature

Date

Printed name

Telephone

Address

Witness 2

Signature

Date

Printed name

Telephone

Address

PART X

Record of Directive

I have given a copy of this directive to the following persons:

PART XI

Revocation of Directive

Do not fill out part XI unless you intend to revoke this directive in part or in whole

(Initial any that apply):

I am revoking the following part(s) of this directive (specify):

I am revoking all of this directive.

Do not fill out this part unless you intend to revoke this directive in part or in whole

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

Signature

Date

Printed name

Appendix G: Conflict Styles

How I act in conflict

The following statements describe strategies that some people use in conflict. Using this scale, indicate how typical it is for you to act this way in a conflict. Please don't try to "outsmart" the quiz by answering how you *think* you should answer. There are no wrong answers here, only more knowledge about yourself.

5 = **very typical** of how I act in conflict

4 = **frequently typical** of how I act

3 = **sometimes typical** of how I act

2 = **seldom typical**

1 = **never typical**

Section 1

1. I try to walkway around a potential conflict before I get sucked in
2. I bite my tongue before things get out of hand if it's starting to heat up between me and my adversary
3. I'll join the battle, but at some point, I'll retreat so that I get to go back to the battle later on
4. I stay away from people who openly disagree with me, who like to pick fights, or who like to debate
5. I do what I can to avoid quarrelsome people. They only make my life miserable
6. The best way I have of handling conflicts is to avoid them to begin with
7. When there's a conflict, I just figure there's nothing so important you have to fight over it. I just drop it.

Total questions 1-7

Section 2

8. I lean firmly on my opponent to get my needs met one way or the other.
9. I'll make a power play when necessary and to heck with the principles at stake
10. I like to intimidate my opponent into backing off or running away
11. I like to take the bull by the horns if it looks like a conflict is brewing. I get good results that way
12. When I hold my ground firmly in an argument, I find it makes the other person back off
13. I like to draw a line in the sand and then defend my territory
14. There are two kinds of people—winners and losers. I like to be a winner.

Total questions 8-14

Section 3

15. I like to speak gently and quietly in order to soften my opponent's heart
16. I try to de-escalate the conflict with my choice of words so that things can be smoothed out
17. I prefer to be so nice and sweet that my opponent is disarmed and confused, and I ultimately win
18. I find that speaking kindly is the best way to go when I'm in a conflict. It doesn't cost me much at all
19. I ensure harmonious relationships by using soft words when I find myself in touchy situations
20. I find that when I'm in a dispute, gentleness triumphs over anger
21. If someone deals me a low blow, I just strike that person back with a feather, if you know what I mean

Total questions 15-21

Section 4

- 22. I like to approach my adversary with an offer to find ways that we can scratch each other's backs
 - 23. I'd rather get half my case won than risk losing the whole thing
 - 24. If I can fight on a level playing field and meet my opponent with equal force, I can accept whatever outcome
 - 25. I follow through on doing to others as they have done unto me. It's a law of life and it's fair
 - 26. I find that I make friends and not enemies by doing favors for people who have done favors for me
 - 27. I'm happy with getting part of what I wanted when I'm in a conflict. It's better than not getting anything at all
 - 28. When I and the other person manage to give in halfway, I find that a fair settlement has been reached
- Total questions 22-28

Section 5

- 29. I try to draw my opponent into some kind of rational dialogue
 - 30. When in conflict, I like to get to the facts and deal from that basis even when they go against popular opinion
 - 31. I like to keep an open mind when I go into conflict because I realize that every person has a piece of "the truth"
 - 32. I have a habit of opening up my mind when I'm in a conflict so that I'm able to hear and learn from my opponent
 - 33. I try to bring smoldering conflicts into the open and face them directly. The best solutions seem to occur that way
 - 34. I aim at being frank, honest and trusting when I'm part of a conflict. I find acting this way moves mountains
 - 35. I try to dig and dig for the truth. That's the way I like to arrive at resolution of conflicts I'm involved in
- Total questions 29-35

Scoring

Enter the totals for each section. Your highest score indicates your preferred style. Your next highest score indicates your backup style.

Section 1 = Avoid

Section 2 = Compete

Section 3 = Accommodate

Section 4 = Compromise

Section 5 = Collaborate

Appendix H: Going home checklist

Who will do the following tasks?

Care for children

Care for pets

Water plants

Pick up and sort mail

Speak to our employer

Pay bills

Speak to our landlord

Negotiate late payment of rent or utilities

Arrange for food upon return home

Clean home (including throwing out spoiled food)

Pick up new prescriptions

Stay with us for first few hours or evening

Make follow-up appointments for health care

Other (specific to peer). List tasks and who will take care of them.

Appendix I: Activities

Crisis Awareness and Communication in Peer Support

Learning and Assessment Activities

These activities are recommended for use with the module assigned; however, please feel free to revise and adapt activities to meet the varied needs of both learners and facilitators.

1. Iceberg

After Day 1, during module 2, ask participants to draw an iceberg showing 10% of the object above the waterline and 90% of it below. Ask participants to attach at least five (5) characteristics to the top that they think are easily noticed about themselves by others in a first impression or glance. Then ask them to look at themselves below the surface and identify the features that others would not be able to understand just from visual markers- introduce us to the things that make them who they are.

2. After Crisis Skit

After Day 5 in small groups, practice “peering” a warm hand-off after crisis. Determine who is involved besides the CPC and peer. What formal and natural supports will be involved and how?

3. Perfect Crisis Response Team

After Day 2, ask participants in groups to identify who they’d like to show up on the perfect crisis response team. Use white paper puzzle pieces to create the picture-perfect community response. Ask attendees to discuss as a whole why they chose the care-givers that they did.

4. Self-care Aware

During Days 1 & 5, as well as throughout the course you will touch on self-care. To illustrate the impact of responsibilities and stress, ask students to write one each on as many balloons as they need. Then when everyone is done, ask students to practice walking around the room carrying all their balloons.

5. CPC and Peer Crisis Role-Play

After Day 3 students will practice role-playing in pairs. Ask the pairs of students to pick a scenario from the appendix that they will role play in front of the class

6. Introductory Activity

Prior to the course starting, write each participant’s name on a balloon then ask the students to find their balloon in the bunch. As they are looking for their own they will come across others’ names. When they have a hold of someone else’s balloon they will be able to ask this person to tell them about themselves. In this way the class is meeting one another.

7. Walk the Line

During Day 4, loosen up the class with an activity to promote students’ ability to make room for or notice the other story. In a demonstration of DEI, and in complete silence, start participants on a horizontal line taped to the floor. Tell them that if they would respond affirmatively to the questions given, they step forward (if not then they step backwards) from the line in attempt to notice the similarities and differences they have with one another.

8. Two Truths and One Lie

Once gathered, have everyone come up with two things that are true about themselves and another thing that’s false. Then each person presents what they came up with and everyone tries to guess the right answer, which leads to stories about past life experiences and facilitates engaging and enjoyable conversation.

9. Introductions

Ask participants to share name, pronouns, land acknowledgment, the work they do, one interesting thing, and what they are hoping to take from this course. Facilitators use flip-chart to keep inventory of the participants’ goals for taking the course.

10. Stretch Agreement

Have folks list what they need from each other in order to take risks- feel safe in the stretch zone.

11. Modified Grounding Techniques

This activity will be useful in Day 1 especially. Ask the students to think about what they can feel right now. What surface do their fingers touch? Is the surface smooth or rough? Cold or warm? Flat or lumpy? Ask what their feet feel. Can they feel the firmness of the floor beneath their feet? Can they feel the texture of their socks? How their legs feel against the chair? How does their back feel? What else can you feel? -clothing? -air? A fan?

12. Crisis Discussion Topics for Day 1

- What is it about crisis work that interests me?
- If I have had a personal experience of crisis, what was helpful for me?
- What kinds of things have I found not to be helpful in crisis?
- In small groups, discuss how you define crisis and how you think about “help.” How are these ideas shaped by your culture? Why is this knowledge important to our work?
- Work in small groups. Thinking about these partnering skills, which you learned in CPC class and have been practicing, how does culture impact the use of these skills? Have you seen cultural variations? Are there cultural variations you would suggest to your group?
- In small groups, following an overview of SAMHSA’s 10 Guiding Recovery Principles, ask which two do you think are most important in crisis settings? What would it look like to implement these principles in a crisis?

13. Six Principles of TI Approaches

In Module 2, a small group discuss the assigned trauma-informed approach principle. Consider how the approaches are evident in your work and what that looks like.

14. Language Matters Discussion

Use as much time as needed in Module 2 to talk about the importance of language, especially since it creates structures and systems. Use the short table and a flip-chart of paper.

15. Post Traumatic Growth

During Module 2, in small groups, discuss your most important post-traumatic growth experiences. You can use the five factors on the PTGI, or you can simply talk about the growth experience however it feels meaningful. You will be asked to share with the learning community when you return. How did you get from “crisis” to “growth”?

16. PTG Plan

Ask participants to create their own post-traumatic growth plans in Module 2, using the following information:

Five Factors of Post Traumatic Growth:

1. Relating to others
2. New Possibilities
3. Personal Strength
4. Spiritual Enhancement
5. Appreciation of Life

Ask if there are any goals they would like to set that relate to the five factors?

*Instructors don’t actually read this very personal document.

17. Wellness Planning

During Module 3, review the 8 Dimensions of Wellness. Ask the class to pick two of them to incorporate into each of their Post-Traumatic Growth Plans. Review the plans together on the last day of class.

18. Telling Your Story

Get into pairs during Module 3 and discuss how you know when to tell or not to tell your story to someone experiencing a behavioral health crisis. What skills and principles will you rely on?

19. Cultural Expressions of Help

In Module 4 we discuss that an ask for help is often culturally determined. Some common behaviors in crisis have been described. In small groups, discuss how expression of help might look in a culture other than your own. How can we learn to recognize asking for help from other cultures?

20. Cultural Implications of Detention

In small groups during Module 4, discuss how involuntary detention might impact various communities. How will it impact veterans? Native Americans? Seniors? People with disabilities? People experiencing homelessness? LGBTQ folx? Families? Other communities? What kind of conversation might be had with a peer about the possibility of being detained?

21. Mental Health Advance Directive

In Module 5, ask for participants to get into small groups to review the Mental Health Advance Directive form. Groups will discuss how they might use this form to work with peers. How will they support peers in developing their own MHAD?

22. Advocacy Activity

In pairs during Module 5, each person will take a turn talking about a need they have. Ask them to make a brief advocacy plan to pursue their goal and to be prepared to share it with the learning community.

23. Wellness Plan for Work

Ask each student to independently develop a rough outline of a wellness plan for work in Module 5. Include both routine wellness tasks and anything they might want to do when things get challenging. Are there any new wellness strategies they want to try? Ask them to share one or two with the learning community.

24. Advocacy Scenario

While in Module 5 ask participants to imagine themselves in the following scenario:

You are working with a peer who has relapsed and has asked you to advocate for them to go to inpatient treatment. They have insurance and their families' support. The team is hesitant to refer the peer to inpatient treatment because this will be the individual's 3rd time in (2) yrs. You feel the peer you are supporting is sincere and they have expressed their recovery goals to you. What steps will you take to advocate with them?

25. Identifying Supports

Once in small groups, ask each student in Module 6 to make a list of people in their life that they'd ask for help in an emergency. Ask them to think about what kinds of things people would take care of for you if you are away from home for an extended time.

Consider the peers with whom you are working:

- How many of those things will they need?
- What supports will they need?
- What contacts do they have to support their needs?
- How can they develop additional resources?

26. Define Brave Space

During Day 1, you may want to ask what "brave/safe space" means to you. In small groups ask students to discuss what that means as the person in services and as the Certified Peer Counselor.

- How do you create a "safe space" for peers in crisis? Sometimes we invite people into a "brave space" because we may not know exactly what's safe for them, but we invite them to be brave in the face of this fear.
- Ask what partnering skills would you use to find out what "safe space" means to the peer?

27. Role Play Peer in Crisis and CPC

Ask students to partner up to work through the challenging scenario provided. One person will play the peer in crisis and the other will play the CPC. While in the role of the Certified Peer Counselor, remain calm; use CPC partnering skills; be aware of body language; and keep the person engaged. Consider culture. Remember the CPI tips!

When the role play feels complete, ask partners for feedback. Start with what worked well. Each person should have an opportunity to play the role of the CPC.

Bonus Practice: In small groups, discuss the "untold story" of a person who comes in and says to you, "I'm so tired of everything, I just want to be done!" What might be the person's untold story? How might you find out?

28. Conflict Resolution Activity

In Module 7 ask students to talk about a recent conflict they had with someone other than a peer (a coworker, friend, family member, etc.).

- How did you resolve the conflict, or did you?
- Are you satisfied with the resolution?
- Does the conflict need more work for a resolution?

29. Suicide Prevention Discussion

Ask participants during Module 8 in what communities or cultures do you think suicide is especially prevalent right now? What factors work to make it more prevalent in those communities? What resources and supports are available for people in those communities?

30. Prevention Poster Activity

In Module 8, ask students in small groups to use flipchart paper (or whiteboard on Zoom?) to make a poster. The poster will be used to inspire hope and prevent suicide(s) in one or more of the vulnerable communities identified earlier. Share poster/whiteboard with the rest of the class.

31. Interpretations of Distress

Ask students in Module 9 to consider various viewpoints and meanings of distress. Around the world, there are many ways to think about the experiences we call "distress." We know that psychiatry's perspective on behavioral health challenges is that psychiatry treats organic disease. Share your perspectives with the rest of the class.

Spirituality, Mythology, Culture, Sociology, Race, Economics, Nutrition, and Trauma may be interesting to consider as well.

32. Discuss Grounding Strategies

Ask participants to move their bodies and stretch. If possible ask that they move away from their chair briefly. In small groups, talk about the strategies use to stay grounded when discussing difficult topics.

33. Review Cultural Needs

During Module 9, review in small groups the cultures in the area that you live and work. Participants will tell how they have learned about those cultures, and what specific needs are anticipated for them in crisis settings.

34. Role Play Post-Crisis Care

In small groups, discuss how you will support peers in the post-crisis period. Specifically imagine that you are having a conversation with the peer about the aftermath of a behavioral health emergency. What communication tools will you use, and how? Improvise a role play to show the whole class.

35. Regional Resources

During Module 10, we want to explore what kinds of crisis prevention services are available in our communities. In some communities, unique resources serve small communities or special needs. For example, in one state participants in 12-Step programs erected a sweat lodge on agency property for use in healing ceremonies.

- Do you know of unique, specialized resources through an agency or a private entity?
- Make a list.
- Share it with the rest of the class.

36. Appreciation, Apology, Aha

At the end of the day, each person may give an appreciation, an apology, or share an aha moment.

37. Rose and Thorn

Open or close with this activity. Ask students to reveal one good thing about their day and one not so good thing, or maybe ask what they're looking forward to or not.

38. A-Z

Open or close using a flip-chart and challenge small groups to identify a word for each letter of whatever category you assign, e.g. flavors of ice cream.

Appendix J: Crisis Mental Health Services (WAC 246-341-0900)

(Effective until May 1, 2023) **WAC 246-341-0900 Crisis mental health services—General.**

Crisis mental health services are intended to stabilize an individual in crisis to prevent further deterioration, provide immediate treatment and intervention in a location best suited to meet the needs of the individual, and provide treatment services in the least restrictive environment available.

1. Crisis services include:
 - a. Crisis telephone support;
 - b. Crisis outreach services; and
 - c. Crisis stabilization services.
2. An agency providing crisis mental health services does not need to meet the requirements in WAC 246-341-0640.
3. An agency providing any crisis mental health service must:
 - a. Require that trained staff remain, in person or on the phone, with the individual in crisis in order to provide stabilization and support until the crisis is resolved or referral to another service is accomplished;
 - b. Determine if an individual has a crisis plan and request a copy if available;
 - c. As appropriate, refer individuals to voluntary or involuntary treatment facilities for admission on a seven-day-a-week, twenty-four hour-a-day basis, including arrangements for contacting the designated crisis responder;
 - d. Transport or arrange for transport of an individual in a safe and timely manner, when necessary;
 - e. Be available twenty-four hours a day, seven days a week, unless providing only crisis stabilization services; and
 - f. Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the individual in crisis.
4. When services are provided in a private home or nonpublic setting the agency must:
 - a. Have a written plan for training, staff back-up, information sharing, and communication for staff members who respond to a crisis in an individual's personal residence or in a nonpublic setting;
 - b. Ensure that a staff member responding to a crisis is able to be accompanied by a second trained individual when services are provided in the individual's personal residence or other nonpublic location;
 - c. Ensure that any staff member who engages in home visits is provided access, by their employer, to a wireless telephone or comparable device for the purpose of emergency communication as described in RCW 71.05.710;
 - d. Provide staff members who are sent to a private home or other private location to evaluate an individual in crisis prompt access to information about any history of dangerousness or potential dangerousness on the individual they are being sent to evaluate that is documented in a crisis plan(s) or commitment record(s). This information must be made available without unduly delaying the crisis response.
5. Documentation of a crisis service must include the following, as applicable to the crisis service provided:
 - a. A brief summary of each crisis service encounter, including the date, time, and duration of the encounter;
 - b. The names of the participants; Certified on 2/20/2023 WAC 246-341-0900 Page 1
 - c. A follow-up plan or disposition, including any referrals for services, including emergency medical services;
 - d. Whether the individual has a crisis plan and any request to obtain the crisis plan; and
 - e. The name and credential of the staff person providing the service.

