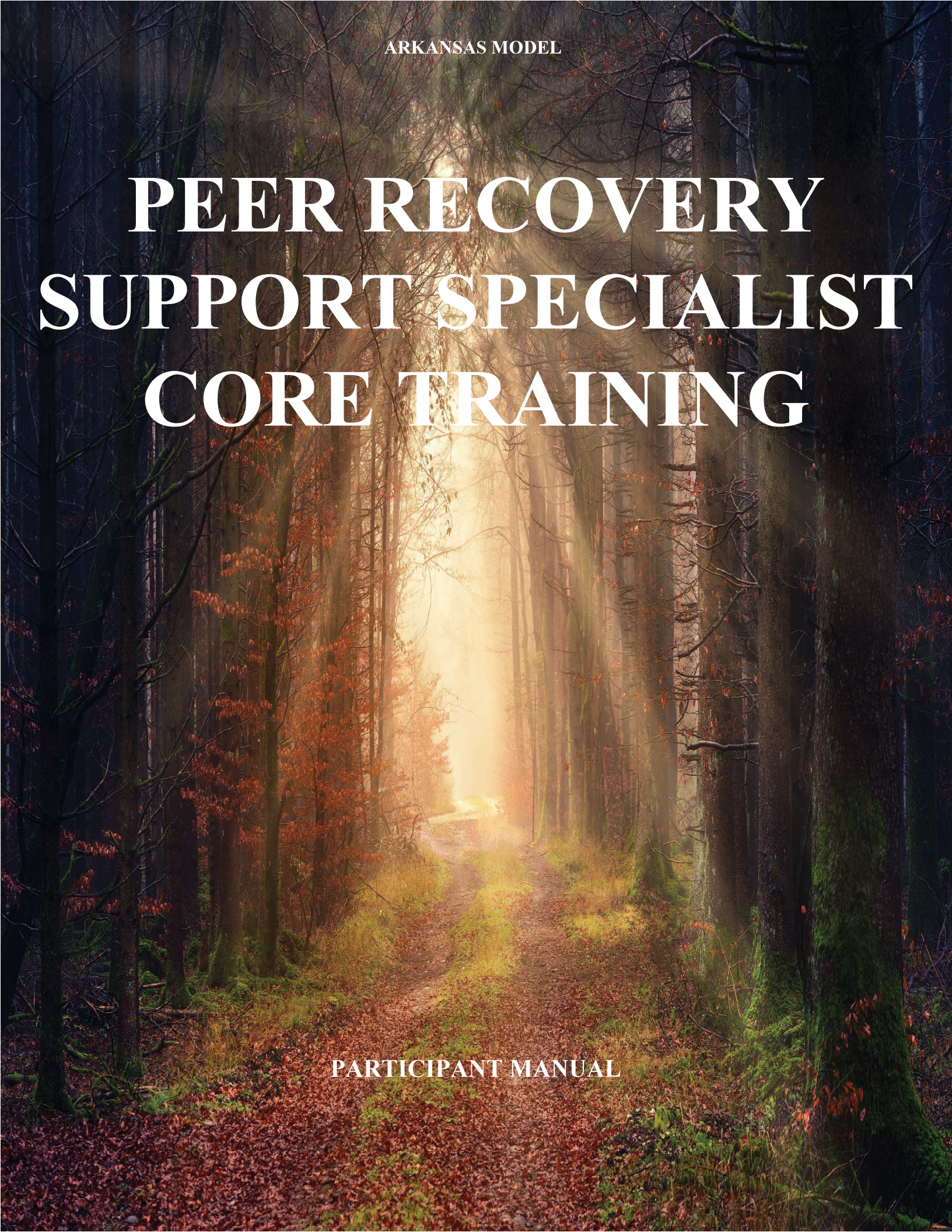


ARKANSAS MODEL

PEER RECOVERY SUPPORT SPECIALIST CORE TRAINING

PARTICIPANT MANUAL

Peer Recovery Specialist Core Training
Participant Guide
Contents

Session 1
Introductions & Overview of the Training

People in recovery have a very important role to play in system transformation by using their experience with recovery.

Welcome to the Arkansas Peer Recovery Specialist Certification training program.

This training is NOT about substance use, mental illness, symptoms, diagnosis and medication. It is about the impact that substance use or mental health challenges can have on a life. Often the greatest impact of the onset of substance use or mental health challenges is a sense of loss and disconnection.

Name three things you have lost because of your substance use or mental health challenges.

1.

2.

3.

The behavioral health system has traditionally focused its treatment plans on reducing the symptoms of the illness, controlling the substance use and disruptive behavior associated with both. Treatment plans have seldom focused on overcoming this sense of loss and disconnection, which is at the heart of the recovery process. Peer Recovery Specialists are in the best position to help people overcome these losses and sense of disconnection. Your role in doing this will be a major focus of this training.

As a Peer Recovery Specialist, you will not be hired because of your clinical education, but because of your lived experience. Therefore, this training is designed to enhance your recovery experience, not educate you about substance use or mental illness.

Training is designed to:

- Prepare you to pass the certification exam.
- Give you some of the skills needed to work as a peer specialist.
- Affirm your experience with what is called "substance use/mental illness and recovery" as a gift in working with your peers.

Session 1 Overview

This session has six parts:

1. Welcome, Introductions and Housekeeping
2. The Role of a Peer Recovery Specialist
3. Fundamental Beliefs Underlying the Training
4. 20-Session Agenda and Intents
5. Comfort Contract
6. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain the difference in focusing on the illness/substance use and misuse/disruptive behavior and focusing on the sense of loss and disconnection that is the result of substance use or mental health challenges.
- Explain the role of a Peer Recovery Specialist.
- Explain the definitions of recovery and hope as used in this training.
- Explain and agree to follow the Comfort Contract.

Part 2 – The Role of a Peer Recovery Specialist

The role of Peer Recovery Specialists is to use their lived experience to support and promote the recovery of their peers.

This will:

- Help peers set goals they believe improve the quality of their lives and will motivate them.
- Help peers gain skills, resources, and support needed to accomplish their goals.
- Get peers' goals into the agency's treatment plans so they have the full support of all agency resources.

This training will:

- Clarify how this role differs from and complements the role of traditional behavioral health staff.
- Explore how this is done within the traditional behavioral health provider agency and identify challenges.
- Give participants the tools to meet these challenges.

Our training is based on the following definitions of recovery and hope:

RECOVERY is the process of change that comes through hope and empowerment that promotes a healthy way of life, regaining things once lost, while often gaining things that one has never had.

HOPE is the belief that one has both the ability and the opportunity to engage in the recovery process.

Part 3 – Fundamental Beliefs Underlying the Training

Our training program is based on the following five fundamental beliefs about life.

Beliefs	Within a recovery context
Everyone has the ability to learn and grow.	Having substance use or mental health challenges does not take away the ability to learn and grow. People can recover and move on with their lives.
People's beliefs determine their behavior.	What a person believes about themself because they have substance use and mental health challenges is the most important determinant of their success in creating the life they want.
People think their way through life.	Having substance use or mental health challenges does not take away the ability to think strategically and creatively.
Whatever people focus on, they give power to.	While symptoms and "disability" bring people in for services, the focus needs to shift to wellness and strengths as soon as possible.
Life's experiences are the best teacher.	Your recovery experience is your greatest gift to your peers.

Part 4 – The 21-Session Agenda and Intents

Day 1

Session 1	Introductions & Overview of the Training
Session 2	The State System, Peer Recovery Specialists, & the Role of the Training
Session 3	The Shift to Recovery
Session 4	The Role of Peer Recovery Specialists, Part 1
Session 5	Five Stages In the Recovery Process
Session 6	Using Your Recovery Experience as a Recovery Tool

Day 2

Session 7	Creating Recovery Cultures
Session 8	Pathways to Support Healing and Recovery
Session 9	Problem-Solving With Individuals
Session 10	Facing One's Fears
Session 11	Combating Negative Self-Talk
Session 12	Shared Decision Making

Day 3

Session 13	Trauma-Informed Care
Session 14	Facilitating Recovery Dialogues
Session 15	Effective Listening & the Art of Asking Questions

Day 4

Session 16	Recovery Goal Setting
Session 17	Peer Specialist Ethics & Professional Boundaries
Session 18	Power, Conflict, & Integrity in the Workplace

Day 5

Session 19	The Role of Peer Recovery Specialists, Part 2
Session 20	Self-Care
Session 21	Final Reflections, Evaluations & Next Steps

Creating recovery partnerships with the people you serve…

- They are your peers in this recovery process.
- The state or organization sponsoring this training supports you in your training.
- The behavioral health system is shifting toward embracing recovery, and Peer Recovery Specialists can play a major role in increasing that shift.
- Your peers want to move on with their lives. Your role is to help them help identify strengths and to believe in their abilities to create the life that they want.
- They are possibly in one of the five stages in the recovery process. Try to figure out which one. This will help you use your recovery experience to understand what is going on with them and avoid any dangers at that stage.
- Non-diagnosed staff may be experts in treating addiction or mental illness. You are an expert in living with substance use or mental health challenges. Demonstrating recovery is a major part of your job.
- Remember that they have heard a lot of negative messages about their abilities and potential for creating the life that they want. This reinforces their negative self-image. Surround them with the possibility of recovery.
- Recovery pathways are highly personalized, building on the strengths, talents, coping abilities, and resources of each individual. Individuals have unique needs, strengths, preferences, goals, cultures, and backgrounds that affect their pathways to recovery.
- They may be overwhelmed with problems. Teach them a problem-solving method to help overcome some of those problems.
- They may know what they want but are afraid to move out of their comfort zone. Help them face the fear and move through it to the life that they want.
- They may know what they want but talk themselves out of it. Help them combat their negative self-talk and get the life that they want.
- They may not be comfortable talking to professional and clinical staff about their concerns. Teach them strategies that they can use to advocate for themselves.
- They may have had a lot of trauma in their lives. Show concern about what has happened in their lives, not what's "wrong" with them.

- They may not be in an environment that encourages them to talk about their recovery struggles. Move them into some recovery dialogues.

- They have their own answers deep inside. Listen to them and ask questions that help get them in touch with their own inner wisdom.

- A person needs to have something they look forward to in order to motivate and sustain their recovery process.

- They will look to you as a Peer Recovery Specialist who acts ethically and professionally.

- As you advocate for peers with staff who may not believe they have the potential to create the life that they want, remember to affirm the roles that these staff have played. Share how staff helped you move on and create a recovery-focused partnership with these staff. They want the same thing for the people they serve that you want.

- Peer Recovery Specialists need to be placed in positions in the agency so that they can use their lived experience to promote and support the recovery of their peers.

- Self-care is a way we can take control of our lives and ease the impact when we face events that are beyond our control.

- Moving from hopelessness to hope is what recovery is about. Helping one another do this is what peer support is about. This training covers how this is done in the behavioral health system.

Part 5 – Comfort Contract

- Respect the confidentiality of those you serve. When talking about or using examples from your place of employment, do not use the actual names of any individuals at any time.
- What is said in this room stays in this room. Always respect the confidentiality of classmates.
- No cell phones or computers during class time.
- Please smoke in the designated areas, pick up the butts, and discard them appropriately.
- Speak from your own experience.
- Nothing about me without me!
- Go easy on aftershave and perfume (some of your classmates may be allergic to these).
- No personal attacks. Listen for what the person is trying to say, or what they are saying their experience has been so far.
- Mistakes are ok.
- The question you think you are supposed to already know the answer to (but don't!) is the very question you should ask.
- Speak even if your voice shakes!
- Keep side conversations to a minimum.
- This Comfort Contract can be changed at any time based on group needs and consensus.
- Feel free to add or change as your group feels is right for them.

Part 6 – Review Questions

1. What is the difference in focusing on substance use and misuse or the symptoms of a mental illness and focusing on the losses and sense of disconnection usually associated with substance use or mental health challenges?

2. What are the definitions of recovery and hope as used in the training?

3. What is the basic role of a Peer Recovery Specialist?

4. What is the function of a Comfort Contract and name some of the elements that are usually a part of a Comfort Contract?

Session 2

The State System, Peer Recovery Specialists, & The Role of the Training

The behavioral health system is making a shift toward recovery and peers have a key role to play in supporting this shift in the state.

Session 2 will explain why you are at this training, and how it fits into what is happening in the state.

Peer Recovery Specialist Description

Job Scope

Peer Recovery Specialists (PR) **CAN** and should assist the clinical process by performing such duties as:

- Identifying goals
- Assisting with treatment planning
- Coaching life skills
- Referring resources
- Conducting recovery groups
- Assisting with discharge planning
- Conducting individual sessions (one-on-one coaching)
- Transporting to the doctor's office/pharmacy/appointments/etc.

Peer Recovery Specialists **CANNOT** provide clinical services such as:

- Therapy
- Medication management
- Psychosocial evaluations
- Diagnostic assessment
- Psychiatry services
- Therapy groups

How It Works

Peer Recovery Specialists use knowledge, skills and experience to help others work toward meaningful recovery from mental illness or substance-use challenges. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose and social connections in their lives.

Facilitating and Leading Recovery Groups

In addition to conducting one-on-one coaching, mentoring and resource-connecting activities, many PR's facilitate or lead recovery-oriented group activities. Some of these activities are structured as support groups, while others have educational purposes within scope of experience. Many have components of both.

The group activities structured as support groups typically involve the sharing of personal stories and some degree of collective problem solving. Many of these groups are formed around shared identity. This could include belonging to a common cultural or religious group. Or it could include a shared experience related to the substance use disorder. Examples include re-entering the community following incarceration, being HIV positive or facing similar parenting challenges. Many, but not all, group activities conducted by PR's have a spiritual component.

The group educational activities tend to focus on a specific subject or skill set. They may involve the participation of an expert as well as the PR. Typical topics and activities include training in job skills, budgeting, managing credit, group processing, recovery concepts, triggers, high-risk situations and relapse prevention. Additional topics and activities could

include courses targeted to people in recovery, such as conflict resolution grounded in recovery skills.

Building Community

A person in early recovery is often faced with the need to abandon friends or social networks that promote and help sustain a substance use disorder. However, they may not have alternatives that support recovery. PR's can help these peers make new friends and begin to build alternative social networks. They often encourage recovery-oriented activities that range from opportunities to participate in team sports, to family-centered holiday celebrations and alcohol- and drug-free payday get-togethers. These activities provide a sense of acceptance and belonging to a group and opportunities to practice new social skills.

Peer Recovery Certification

NAADAC, the Association for Addiction Professionals - Arkansas Peer Specialist Program – Peer Certification

For the first time in the State of Arkansas, individuals with lived experience have direct involvement in the development and administration of a peer support credentialing program. The Arkansas Peer Specialist Program (APSP) is a collaborative effort between NAADAC, the Association for Addiction Professionals, and the State of Arkansas that streamlines each step of the credentialing process, producing highly trained and knowledgeable peer specialists and creating a one-stop shop for all peer credentialing needs.

APSP is an innovative three-tiered credentialing process developed with involvement of peer specialists at every level of the application and certification process that provides an individual the opportunity to progress through the core, advanced, and supervisory levels of the Arkansas Model. Through this model, peers can climb the career ladder, to hold the Arkansas Core Peer Recovery Specialist (PR) credential, the Arkansas Advanced Peer Recovery Specialist (APR) credential, and the Arkansas Peer Recovery Peer Supervisor (PRPS) credential. Each level of this career ladder has its own training, education, experience, and supervisory requirements designed to produce highly trained and knowledgeable Peer Recovery Specialists.

The Arkansas Model has three levels allowing peer specialists to advance in their profession:

1. Arkansas Core Peer Recovery Specialist (PR)
2. Arkansas Advanced Peer Recovery Specialist (APR)
3. Arkansas Peer Recovery Peer Supervisor (PRPS)

Arkansas Core Peer Recovery Specialist (PR)

Eligibility Requirements: To be eligible to become an Arkansas Core Peer Recovery Specialist (PR), you must:

- have a GED or have graduated from high school
- be at least 18 years of age
- have a minimum of 2 years of recovery from substance use disorder and/or mental health disorder
- have a minimum of 2 years of abstinence from illicit drugs and alcohol
- have not committed a sexual offense or murder or have any active warrants

How to become an Arkansas Core Peer Recovery Specialist (PR):

STEP 1: Apply to the APSP PR Program

- Meet the PR eligibility requirements
- Apply to begin Core PR training by submitting:
  a) a completed and signed PR application
  b) all supporting documentation
  c) a $50 non-refundable application fee
  d) Applicant must email completed and signed application, all supporting documentation, with payment of the non-refundable $50 application fee to Kyle Brewer, Peer Specialist Program Manager, at kbrewer@naadac.org.

STEP 2: Become a Peer in Training (PIT)

- Once accepted into the program, complete the 30-hour core training and submit the training certificate to the APSP Manager
- Be paired with a Peer Recovery Peer Supervisor (PRPS) and begin peer supervision
- Receive PIT confirmation letter from APSP Manager

STEP 3: As a PIT, complete the remaining required education and experience.

- Complete an additional 16 education hours
- Complete 500 experience hours, including 100 hours of domain-specific experience to be comprised of:
  a) 25 hours of advocacy experience
  b) 25 hours of ethical responsibility experience
  c) 25 hours of mentoring/education experience
  d) 25 hours or recovery/wellness experience
- Complete 25 hours of domain-specific peer supervision (individual/group)

STEP 4: Pass the PR credentialing exam

Arkansas Advanced Peer Recovery Specialist (APR)

Eligibility Requirements: To be eligible to become an Arkansas Advanced Peer Recovery Specialist (APR), you must have:

- a current Arkansas Core Peer Recovery Specialist (PR) state credential
- have a minimum of 2 years of recovery from a substance use disorder and/or mental health disorder
- have a minimum of 2 years of abstinence from illicit drugs and alcohol

How to become an Arkansas Advanced Peer Recovery Specialist (APR):

- Hold a current Arkansas Core Peer Recovery Specialist (PR) state credential
- Apply to begin APR training by submitting
  a) a completed and signed APR application
  b) Attest to having a minimum of 2 years of abstinence-based recovery from lived experience with substance use disorders and/or mental health disorder (page. 9 of application);
  c) Attest that you have read, understand, and will adhere to the Arkansas Peer Recovery Code of Ethics (page. 9 of application)
  d) Submit a completed and signed reference evaluation from your Peer Supervisor (page 6 of application)
  e) Submit a completed and signed personal/professional reference evaluation (page 7 of application)
  f) a $75 non-refundable application fee
  g) Applicant must email completed and signed application, all supporting documentation, with payment of the non-refundable $75 application fee to Kyle Brewer, Peer Specialist Program Manager, at kbrewer@naadac.org.
- Complete 35 education hours (including the 18-hour Advanced training);
- Complete 500 experience hours (including 100 hours of domain-specific experience to be comprised of:
  a) 25 hours of advocacy experience
  b) 25 hours of ethical responsibility experience
  c) 25 hours of mentoring/education experience
  d) 25 hours or recovery/wellness experience
- 25 hours of domain-specific peer supervision (individual/group)
- Pass the APR credentialing exam.

Arkansas Peer Recovery Peer Supervisor (PRPS)

Eligibility Requirements: To be eligible to become an Arkansas Peer Recovery Peer Supervisor (PRPS), you must:

- hold a current Arkansas Advanced Peer Recovery Specialist (APR) state credential
- be currently employed as an PR or APR
- have a minimum of 1-2 years of consistent employment as an PR or APR
- have a minimum of 3 years of recovery from a substance use disorder and/or mental health disorder
- have a minimum of thr3ee years of abstinence from illicit drugs and alcohol

How to become an Arkansas Peer Recovery Peer Supervisor (PRPS):

- Hold a current Arkansas Advanced Peer Recovery Specialist (APR) state credential
- Apply to start your PRPS training by submitting:
  a) a completed and signed PRPS application
  b) Attest to having a minimum of 3 years of abstinence-based recovery from lived experience with substance use disorders and/or mental health disorder (page 10 of application)
  c) Attest that you have read, understand, and will adhere to the Arkansas Peer Recovery Code of Ethics (page 10 of application)
  d) Submit 2 completed and signed reference evaluations, one by professional and one by the PRPS assigned to you by the APSP (pages 7-8 of application)
  e) Submit a copy of a background check completed in the last 60 days
  f) a $100 non-refundable application fee
  g) Applicant must email completed and signed application and all supporting documentation with payment of the non-refundable $100 application fee to Michael Little, Peer Specialist Program Manager, at mlittle@naadac.org.
- Complete 40 education hours (including the 24-hour Supervisor training);
- Complete 500 experience hours including
  a) 250 hours of supervised work experience
  b) 250 hours of providing supervision
  c) 50 hours of which must take place under the supervision of a more experienced peer supervisor
- Complete 25 hours of peer supervision hours provided by NAADAC's Peer Specialist Program Manager and the Arkansas Peer Advisory Committee
- Pass the PRPS state credentialing exam.

Steps to Renew Certification for PR, APR, or PRPS
Every 2 years

1. Complete PR, APR or PRPS renewal application
2. 20 continuing education hours (6 hours must be ethics) at all three levels
3. Peer supervision hours
   - For **PR:** 20 hours
   - For **APR:** 15 hours
4. Sign statement to adhere to Arkansas Peer Recovery or Peer Supervisor Code of Ethics
5. Self-attest to ongoing abstinence and recovery
6. Pay $150 renewal fee at all three levels

To learn more about the Arkansas Peer Specialist Program, including eligibility requirements and details about the application process, please visit
www.naadac.org/arkansas-peer-specialist-program
or contact Michael Little at mlittle@naadac.org.

Declaration of Peer Roles

Origins: This document originated with the Western Massachusetts Peer Network in 2013 and grew from there to encompass many voices. It was adopted by other states including Arkansas.

Our Objective: Peer-to-peer support is well-established in many contexts from cancer survivor groups and bereavement groups to twelve-step groups and beyond. Our objective in producing this document is to clarify the concept of the peer role in relation to the substance use and mental health field. It is a support tool to guide practice and explain activities and values of peer roles. It was created with the contribution of many voices. Our goal is to see these concepts and values integrated into all peer roles and ultimately to filter into all aspects of the substance use and mental health system.

Definition of Peer: According to Merriam-Webster, a 'peer' is one that is of equal standing with another. We each have many 'peer' groups based on our age, work, hobbies and other facets of our identity. In the mental health system, peer support is offered by an individual who identifies as having lived experience with trauma, psychiatric diagnosis and/or extreme emotional states. The term 'peer' does not simply refer to someone who has had a particular experience. Peer-to-peer support is primarily about how people connect to and interact with one another in a mutual relationship.

Peer-to-peer roles are different from traditional roles that happen to be filled by someone with lived experience. Someone working in a traditional role, such as a clinician or nurse, may have had similar experiences as those who are using their services (e.g., a nurse may also be a cancer survivor). This still does not make that person a 'peer' in the sense that we are discussing here. They may share their personal experience, but they are still operating within their primary role as a clinician or nurse. There remains a substantive difference between peer and non-peer roles, although both have value. The definition of the peer role within the context of the substance use or mental health system is further clarified by the values and actions that follow.

There are three essential areas of focus for peer-to-peer support:

- **Mutual peer support:** Here, mutuality refers to operating from as equal of a playing field as possible where the connection is the focal point and no one person is the 'fixer.'

- **Change agent:** Based on wisdom gained from personal experience, people in peer roles advocate for growth and facilitate learning within the system and beyond.

- **Remaining 'in' but not 'of' the system**: This refers to working in the substance use or mental health system while holding values that are specific to the peer role and not taking on responsibilities that dilute purpose.

Our Values: Our experiences are diverse. While some people receive positive support from the substance use and mental health systems, there are many others who feel the need to heal from the impact of how they've been treated.

Historically speaking, many of us have been labeled as 'client' or 'consumer' or a diagnosis that represents only what people see as our 'sick' or 'broken' parts. We have commonly been approached for assessment and evaluation, while few people have asked to hear our own stories or ways of making meaning. Often, we've been taught that others are the experts, that there is a professional who has 'the answer' and knows what is best, and that there are only rigid versions of truth.

Additionally, problems have typically been regarded as the result of our faulty brains, rather than, at least in some instances, due to the ways we've been impacted by trauma or other environmental factors. People around us have frequently operated from a sense of responsibility and fear of liability that have driven decisions and limited tolerance of risk taking, sometimes eliminating choice entirely. All too often, we've been taught to have low expectations and focus on maintenance rather than the prospect of a full life. These experiences (as lived by us and/or those around us) have driven the creation of the values below.

- **Human Potential and Vision:** We believe in the probability that all of us can and will heal. Our focus is on the vision of a full and meaningful life for all, not just day-to-day survival.

- **Prioritize Self-Determination and Choice:** We put a high value on the healing power of simply having choices and refuse any participation in force or coercion.

- **Dignity of Being a Whole Person:** We are the experts of our own experience. We regard each person as whole, with many strengths and contributions to make.

- **Easy-to-Understand Language:** We value clear, human, non-clinical language that creates space for each person to explore and find their own meaning in life and their experiences.

- **Mutuality:** We are committed to reciprocity and being honest and real in our connections. We recognize the fluidity of human experience and our various roles and the ability of each of us to learn from one another.

- **Approach Each Other with Genuine Curiosity:** We seek to understand each person's worldview. We are dedicated to learning about people from them and not from files or meetings where they are not present.

- **Honesty, Truth and Transparency:** We believe in people's fundamental resiliency and are upfront with them about limitations, concerns and conflicts. We are never complicit in decisions about people without them.

- **See Challenges as Growth and Learning Opportunity, not as a Crisis:** We choose to regard our times of greatest distress as a potential sign of change to come and as an

opportunity for growth. This is not intended to deny the deep pain that people may experience, but rather to value and have faith in what can emerge from that place.

- **Recognize the Need for Transformation in the Substance Use and Mental Health System and Society:** We believe that, for change and healing to be sustainable and real, it must happen throughout our communities and systems. It is not solely the responsibility of each individual seeking help.

- **Focus on Moving Forward:** We seek the development of something better and healthier than the power structures and approaches that have harmed many of us in the past. We will consciously avoid compromising our values or replicating past wrongs.

- **Recognize Our Connectivity and Our Part in a Movement:** Our work is a part of a civil rights movement. We strive to have our fundamental connectedness to a history of oppression and fight for human rights recognized and understood.

- **The Importance of Community Involvement:** We believe in the importance of human connection in healing. A person in a peer role can support someone to find resources within and from the community to meet this need and make sustained change.

Our Actions: We see this as an ongoing process and are aware that there are peer roles (as of this writing) that are not currently consistent with what is written here. We recognize that our roles are also influenced by the systems and programs within which we work. We do not wish to leave behind anyone who is committed to working toward these shared values and actions, even if there is a long way to go.

The following are the actions we strive to include in our daily practice.

1. We actively advocate and support people to find and use their own voice.

2. We share our experiences, strengths and wisdom without giving unsolicited advice.

3. Our primary responsibility is to those we support.

4. We avoid speaking in diagnoses and pathologizing language and will not refer to people using words like 'client,' 'consumer' or other systematized terms.

5. We respect the power of simply 'being with' (though it may appear to others that we are doing very little) and are flexible in spending time with people in this way.

6. We consider the support of others in peer roles central to our work, including reaching out to people working in isolated environments.

7. We stay connected to one another and our work by participating in meetings, events and gatherings geared toward learning and new ideas. We consider this an essential responsibility.

8. We treat each other (and ourselves) with compassion, but not as fragile. We demonstrate this through a commitment to honesty, transparency and a willingness to work through conflict.

9. We act as change agents within the system, sharing new ideas, challenging the status quo and inviting others to join us.

10. We support a culture of questioning and asking 'why' to help both ourselves and those around us understand and be well informed about how practices and beliefs have been shaped.

11. We are committed to being aware of and transparent about our own power and privilege in our roles and to examine that on an ongoing basis.

12. We do not consider it consistent with our values to participate in activities that run the risk of further increasing power imbalances.
    This includes (but is not limited to):
    - Involvement in medication administration
    - Acting in the role of Representative Payee
    - Routinely talking about people without them present in individual or team meetings
    - Participating in traditional clinical documentation, we do not document in front of the person who receives our services (e.g., charting, medical notes, etc.)
    - Reading files on people we serve
    - Participating in drug testing
    - Giving advice
    - Assessing, diagnosing or writing treatment plans
    - Any actions that make us complicit in force or coercion

13. We are also aware of our environment and how it may impact our ability to engage in mutual connections. We give input about elements of the environment not in our control e.g., 'staff only' signs, institutional looking furniture, etc.).

We avoid the following wherever possible:

- Wearing name tags or badges
- Meeting with desks between us
- Having individual/staff-only areas when not necessary
- Visibly carrying around lots of keys (especially where there are lots of locked doors)

An invitation to all: We invite those of you who are working in provider roles to join us. Many of the values and actions contained herein do not need to be specific to 'peer' roles. We invite all organizations to make space for this work to be done in a real way. Change does not happen overnight, and tension can be a natural and positive sign of progress. In the end, a truly healing system will lead us all to be humbler and human with one another.

Review Questions

1. What are the main requirements to become a Peer Recovery Specialist?

2. Do Peer Recovery Specialists need to be certified in the State of Arkansas?

3. What are some of the duties expected of a Peer Recovery Specialist?

Session 3
The Shift to Recovery

Over the past 10-15 years, major shifts have occurred in the behavioral health system to support recovery.

Session 3 will explain the shift from stabilization and maintenance to recovery and resiliency and the implications of this shift on the delivery of services.

Session Overview

This session has four parts:

1. The Meaning of "Recovery" in Relation to Substance Use and Mental Health Challenges
2. The Shift from Stabilization and Maintenance to Recovery and Resiliency
3. The Stress Response and the Relaxation Response
4. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain the shift from stabilization and maintenance to recovery and resiliency.
- Explain how the focus of the system impacts the delivery of services.
- Explain the Stress Response.
- Explain the steps involved in eliciting the Relaxation Response.

Part 1 – What is Meant by Recovery in Relation to Substance Use and Mental Health Challenges

SAMHSA (Substance Abuse and Mental Health Services Administration)
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

The President's New Freedom Commission Report on Mental Health
Recovery refers to the process in which people are able to live, work, learn, and fully participate in their communities.

PRA (Psychiatric Rehabilitation Association)
Recovery involves learning the skills, developing the supports, and accessing the resources to increase one's capacity to be successful and satisfied in living, working, learning, and social environments of one's choice.

Arkansas Training Curriculum
Recovery is a process of change that comes through hope and empowerment that promotes a healthy way of life, often regaining things that one has lost and gaining things one has never had.

Appalachian Consulting Group
Recovery is the process of gaining control over one's life and the direction one wants that life to go—on the other side of an addiction and/or psychiatric diagnosis and all of the losses usually associated with that addiction and/or diagnosis.

What are some of the common elements of the above definitions?

Write your definition of recovery.

Part 2 – The Shift in Mental Health from Stabilization and Maintenance to Recovery-Based Services

People cannot recover

Up until around 1980, the belief that dominated the mental health system was that people diagnosed with a mental illness and/or substance use would not recover. More than likely the illness would get progressively worse. The best you could expect was to get people stabilized. Then you would maintain them as best you could in supervised environments where they would not harm themselves or others and would not cause too many problems. This usually involved high doses of medication, long stays in secure institutions, and years in "day treatment programs." These programs were designed to entertain with TV, table games, recreation, trips, outings, and other "low-stress" activities.

It is important that we understand the mindset and beliefs of what is called "the old system." Many of these beliefs have been hard to dismiss and are still found in many agencies and organizations today.

People can and do recover

Around 1980, this began to change. Dr. William Anthony, director of the Center for Psychiatric Rehabilitation at Boston University, states that three things played a key role in enabling this change:

- The writings of peers like Judi Chamberlain and Patricia Deegan, who were moving on with their lives.
- The longitudinal research of people like Dr. Courtney Harding.
- The emergence of the philosophy of psychosocial rehabilitation.

By 1990, the concept of recovery had gained a foothold in many programs across the country. Anthony calls the 90's the "Decade of Recovery." Individual peers and staff were beginning to believe in the possibility of recovery, but as they began to creatively bring the concept of recovery into a variety of environments and program settings, they continued to run up against the constraints of the old system.

The system can support recovery

In 2003, the President's New Freedom Commission Report on Mental Health was issued. The report promotes the concept of recovery in its vision statement by saying, "We envision a time when everyone diagnosed with a mental illness will recover." It goes on to state that the major focus of the current mental health system is not recovery. The system is currently oriented to meet the requirements of the bureaucracy (system) and NOT the peer. It focuses mainly on increasing the peer's ability to "manage symptoms" and NOT on managing life's challenges. If recovery is to take hold, staff alone cannot do the job. The system itself will have to become more supportive. As a sign of this shift, funding agencies began to seek out proposals that were focused on system transformation.

Recovery initiatives involve the whole person
In 2006, the National Association of State Mental Health Program Directors (NASMHPD) issued a report, "Morbidity and Mortality in People with Serious Mental Illness." It states, "People with serious mental illness served by the public mental health system die, on average, 25 years earlier than the general population." This report has caused a major shift in the field of mental health. In 2009, three of the 11 Technology Transfer Initiative (TTI) grants given by SAMHSA were given to states implementing programs that involved using peer specialists to help a peer set and achieve whole health goals. The states were Michigan, Georgia, and New Jersey. Also, Georgia has recently created a Medicaid-approved billing code for peer specialist Wellness Coaches.

Part 2 – The Shift in Substance Use from Stabilization and Maintenance to Recovery-Based Services

People cannot recover
For centuries, drug and alcohol users were looked at as "weak" individuals who did not possess enough willpower to simply abstain from using. The notion that a person cannot change their ways is a generalization often applied to those with a substance use disorder. In the 1930's a prominent doctor described alcoholism as "an obsession of the mind that condemns one to drink and an allergy of the body that condemns one to die."

People can and do recover
In the 1990s, there was a resurgence in grassroots recovery advocacy. Renewed and new local advocacy organizations were springing up across the United States to pursue the functions of policy advocacy and public and professional education. The battle cry of this New Recovery Movement was not that substance use disorder was a disease or that treatment worked, but that recovery was a reality in the lives of hundreds of thousands of individuals and families all across America. This new movement called recovering people to offer themselves as living proof of the hope for sustained recovery from using. This movement attacked stigma by challenging portrayals that misrepresent, dehumanize, and stigmatize using and recovering people.

Systems can support recovery
On October 4, 2015, tens of thousands of people attended the UNITE to Face Addiction rally in Washington, D.C. The event was one of many signs that a new movement was emerging in America. People in recovery, their family members, and other supporters were banding together to decrease the discrimination associated with substance use disorders and spread the message that people do recover. Much of the success of the event hinged on the growing network of Recovery Community Organizations (RCOs) that proliferated across the country creating cultures of recovery and advancing recovery-positive attitudes, programs, and prevention strategies.

Recovery advocates have created a once-unimagined vocal and visible recovery presence. They are living proof that long-term recovery exists in the millions of individuals who have attained degrees of health and wellness. They are now leading productive lives and making valuable contributions

to society. Meanwhile, policymakers and healthcare system leaders are beginning to embrace recovery as an organizing framework for approaching using as a chronic disorder. And individuals can recover from this chronic disorder, so long as they have access to evidence-based treatments and responsive long-term supports.

Recovery initiatives involve the whole person

The history of substance use disorder treatment and recovery in the United States contains a rich "wounded healer" tradition. For more than 275 years, individuals and families recovering from severe alcohol and drug problems have provided peer-based recovery support to sustain one another and to help those still suffering. Formal peer-based recovery support services are now being delivered through diverse organizations and roles.

The Behavioral Health System is in the process of making a shift …	
From focusing only on…	**To focusing also on…**
Stabilization and Maintenance	Recovery and Resiliency
Disease/Disability	Wellness/Strengths
What's Wrong?	What's Strong?
Staff Driven	Peer Driven
Staff-Peer Hierarchy	Staff-Peer Partnership
Behavioral Health	Whole Health
Social Separation	Social Integration
Compliance to a Plan	Engagement in a Process
Dependence	Interdependence
If you were to visit an agency focused on the above areas, what would you see going on?	If you were to visit an agency focused on the above areas, what would you see going on?
How have you experienced the above?	How have you experienced the above?
Notes on discussion:	**Notes on discussion:**

Part 4 – Review Questions

1. What are some of the programs and activities of a system that focuses on stabilization and maintenance?

2. What are some of the programs and activities of a system that focuses on recovery and resiliency?

Session 4

The Role of Peer Recovery Specialists, Part 1

Peer Specialists have a very special and unique role to play in promoting and supporting the recovery process.

Session Overview

This session has six parts:

1. The Difference in Peer Support, Peer Recovery Specialists, and Peer Recovery Support Services
2. The Role of a Peer Recovery Specialist
3. The Gifts of a Peer Recovery Specialist
4. The Abilities of a Peer Recovery Specialist
5. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain the meaning and role of the peer recovery specialist within peer recovery support services.
- Give examples of the peer recovery specialist's role as a connector.

Part 1 – The Difference in Peer Support, Peer Recovery Specialists, and Peer Recovery Support Services

What is peer support in the field of behavioral health?

Peer Support is the act of people who have had similar experiences with substance use and mental health challenges. They give each other encouragement, hope, assistance, guidance, and understanding that aids in recovery. This support can be done anytime or anywhere when two or more peers are in a mutual, supportive relationship.

What is a peer recovery specialist?

Peer Recovery Specialists are people who have substance use or mental illness diagnosis and work as providers of behavioral health services. They are trained and have the ability to use their recovery experience to help their peers recover.

What are peer recovery support services in the behavioral health system?

Peer Recovery Support Services are programs, discussions, events, and groups within the behavioral health system that are led by peer support/recovery specialists and based on the philosophy of peer support. They take place within the structure of an agency or organization. A trained peer specialist provides the service.

Explain why the following statement from Recovery Innovations, a large provider agency in Arizona, is true.

> "When peers begin to work in the behavioral health system as peer recovery specialists, recovery is accelerated in three ways:
>
> The Peer Specialist's recovery is strengthened.
>
> Peer Specialists help others recover.
>
> Peer Specialists help the agency and/or the system recover."

Part 2 – The Role of a Peer Recovery Specialist

The role of peer recovery specialists is to use their lived experience to support and promote the recovery of their peers by connecting with the peer and creating a relationship of trust, in order to –

1) connect the peer to recovery;
2) connect the peer to clinical staff;
3) connect the peer to treatment services;
4) connect the peer to community resources;
5) and to support and promote recovery across the agency.

SAMHAS Core Competencies

Principles of Core Competencies
Core competencies for peer workers reflect certain foundational principles identified by members of the mental health consumer and substance use disorder recovery communities. These are:

Recovery-oriented: Peer workers hold out hope to those they serve, partnering with them to envision and achieve a meaningful and purposeful life. Peer workers help those they serve to identify and build on strengths and empower them to choose for themselves, recognizing that there are multiple pathways to recovery.

Person-centered: Peer recovery support services are always directed by the person participating in services. Peer recovery support is personalized to align with the specific hopes, goals, and preferences of the people served and to respond to specific needs the people have identified with the peer worker.

Voluntary: Peer workers are partners or consultants to those they serve. They do not dictate the types of services provided or the elements of recovery plans that will guide their work with peers. Participation in peer recovery support services is always contingent on peer choice.

Relationship-focused: The relationship between the peer worker and the peer is the foundation on which peer recovery support services and support are provided. The relationship between the peer worker and peer is respectful, trusting, empathetic, collaborative, and mutual.

Trauma-informed: Peer recovery support utilizes a strength-based framework that emphasizes physical, psychological, and emotional safety and creates opportunities for survivors to rebuild a sense of control and empowerment.

Part 3 – The Gifts of a Peer Recovery Specialist

Here are gifts that represent the fruit of a lived experience.

First, there is a sense of gratitude and a desire to give back that is manifested in compassion and commitment.

Second, there is insight into the experience of internalized stigma.

Third, peer recovery specialists take away the "you do not know what it's like" feeling.

Fourth, they have experienced moving from hopelessness to hope.

Fifth, they are in a unique position to develop a relationship of trust with their peers.

Sixth, they have developed the gift of monitoring their substance use and mental health challenges and managing their lives holistically, including both mind and body.

Notes:

Part 4 – The Abilities of a Peer Recovery Specialist

What unique abilities do peer recovery specialists bring as providers?

In addition to these gifts, or maybe because of them, peer recovery specialists are hired because they bring unique abilities that non-peer staff do not have. They can use these abilities no matter what their job description or position is in the agency. These unique abilities include *peer change agent, peer bridge builder, peer mentor, peer supporter, and peer recovery advocate.*

Peer Change Agent – *Changes Beliefs*
A change agent within an agency or system enables others to look at beliefs underlying behavior. They are aware that changing beliefs is a major part of system transformation. This helps move the agency toward creating a recovery culture.

Peer Bridge Builder – *Promotes Understanding*
A bridge connects two entities that are separated. Because of the peer recovery specialists' experiences as both "peer" and "staff," they have the ability to provide a bridge between the two.

Peer Mentor – *Teaches Skills*
A mentor is a person who has experience in a given area and uses that experience to help another person advance in a particular area of life. A peer mentor uses his recovery experience to help a peer learn the needed skills to move beyond the disabling power of his substance use or mental illness and create the life the peer wants.

Peer Supporter – *Supports Goals*
A supporter is a person who does what is necessary to enable another person to do what she feels she wants or needs to do. In the behavioral health system, a peer supporter is a person who has the ability to help a peer set and achieve the goals that will move the peer's life in the direction the peer wants to go.

Peer Recovery Advocate – *Promotes Another's Concerns*
An advocate is a person who speaks for or pleads for the cause of another. A recovery advocate is a person who believes in a peer's potential for recovery even when that potential might not be so obvious to others and advocates for what that peer wants.

Notes:

Part 6 – Review Questions

1. What is the difference between peer support and peer recovery support services?

2. Explain why the following statement from Recovery Innovations is true.
   "When peers begin to work in the mental health system as peer specialists, recovery is accelerated in three ways. The Peer Specialist's recovery is strengthened. Peer Specialists help others recover. Peer Specialists help the agency/system recover."

3. Give an example of each of the following roles:

   Peer Change Agent

   Peer Bridge Builder

   Peer Mentor

   Peer Supporter

   Peer Recovery Advocate

Session 5
Five Stages In the Recovery Process

Creating a common image and language for discussing recovery is key to the transformation of the behavioral health system.

Session Overview

This session has five parts:

1. Deegan Paper
2. Reflection on the Deegan Paper
3. Introduction of the Five Stages
4. Pull-Together of the Stages, Dangers and Services
5. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Name and describe the five stages of recovery.
- Describe the dangers and role of services at each stage.
- Give examples of peer support at each stage

Part 1 – Story Told by Patricia Deegan

1. At a recent conference that brought together persons with diverse disabilities, I had the pleasure of talking with a man who was paraplegic. We shared our stories of recovery.

2. At a young age, we had both experienced a catastrophic shattering of our world, hopes and dreams. He had broken his neck and was paralyzed, and I was diagnosed as being schizophrenic. We recalled the impact of those first days following the onset of our disabilities. He was an athlete and dreamed of becoming a professional in the sports world. I was a high school athlete and had applied to college to become a gym teacher. Just days earlier we knew ourselves as young people with exciting futures, and then everything collapsed around us. As teenagers, we were told that we had an incurable malady and that we would be "sick" or "disabled" for the rest of our lives. We were told if we continued with recommended treatments and therapies, we could learn to "adjust" and "cope" from day to day.

3. Needless to say, we didn't believe our doctors and social workers. In fact, we adamantly denied and raged against these bleak prophesies for our lives. We felt it was all just a mistake, a bad dream, a temporary setback in our lives. We just knew that in a week or two, things would get back to normal again. We felt our teenage world was still there, just waiting for us to return to it. Our denial was an important stage in our recovery. It was a normal reaction to an overwhelming situation. It was our way of surviving those first awful months.

4. The weeks passed us by, but we did not get better. It became harder and harder to believe we would ever be the same again. What initially had seemed like a fleeting bad dream transformed into a deepening nightmare from which we could not awake. We felt like ships floating on a black sea with no course or bearings. We found ourselves drifting farther and farther away from the young, carefree people we had been. He lay horizontal and in traction while his friends selected to play ball at very prestigious colleges. I stood drugged and still in the hallways of a mental hospital while my classmates went off to their first year of college.

5. We experienced time as a betrayer. Time did not heal us. Our pasts deserted us, and we could not return to who we had been. Our futures appeared to be barren, lifeless places in which no dream could be planted and grow into a reality. As for the present, it was a numbing succession of meaningless days and nights in a world in which we had no place, no use, and no reason to be. Boredom and wishfulness became our only refuge.

6. Our denial gave way to despair and anguish. We both gave up. Giving up was a solution for us. It numbed the pain of our despair because we stopped asking, "Why and how will I go on?" Giving up meant that for 14 years he sat in rooms of institutions gazing at soap operas, watching others live their lives. For months I sat in a chair in my family's living room, smoking cigarettes and waiting until it was 8:00 PM so I could go back to bed. At this time even the simplest tasks were overwhelming. I remember being asked to come into the kitchen to help knead some bread dough. I got up, went into the kitchen, and looked at the dough for what seemed an eternity. Then I walked back to my chair and wept. The task seemed overwhelming

to me. Later I learned the reason for this: when one lives without hope (when one has given up) the willingness to "do" is paralyzed as well.

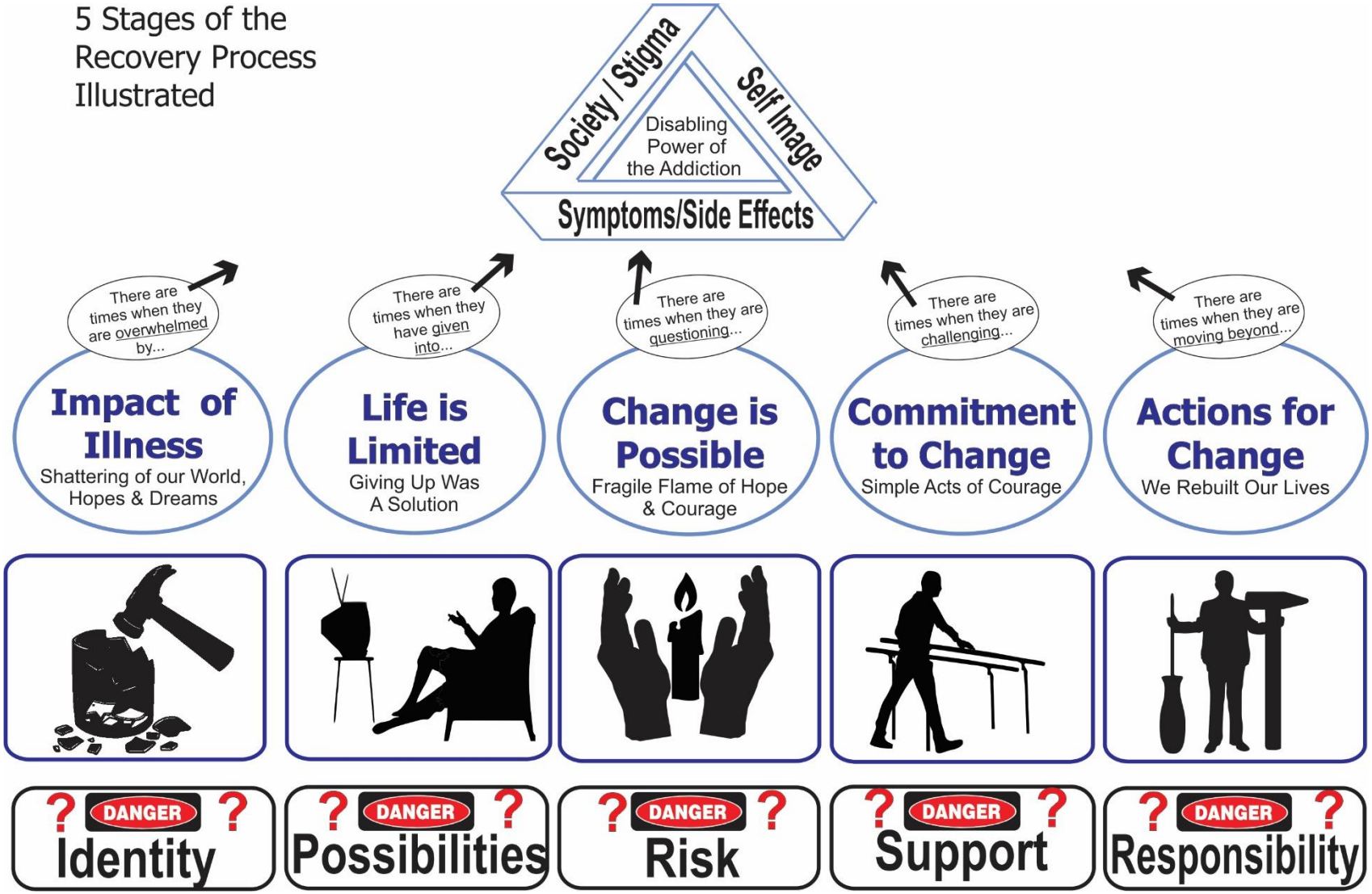
7. All of us who have experienced catastrophic illness and disability know this experience of anguish and despair. It is living in darkness without hope, without a past or a future. It is self-pity. It is hatred of everything that is good and life-giving. It is rage turned inward. It is a wound with no mouth, a wound that is so deep that no cry can emanate from it. Anguish is a death from which there appears to be no resurrection. It is inertia that paralyzes the will to do and to accomplish because there is no hope. It is being truly disabled, not by disease or injury, but by despair. This part of the recovery process is a dark night in which even God was felt to have abandoned us. For some of us, this dark night lasts moments, days, or months. For others of us, it lasts for years. For others, the despair and anguish may never go away.

8. Neither the paralyzed man nor I could remember a specific moment when the small and fragile flame of hope and courage illuminated the darkness of our despair. We do remember that even when we had given up, there were those who loved us and did not give up. They did not abandon us. They were powerless to change us, and they could not make us better. They could not climb this mountain for us, but they were willing to suffer with us. They did not overwhelm us with optimistic plans for our futures, but they remained hopeful despite the odds. Their love for us was like a constant invitation, calling us forth to be something more than all of this self-pity and despair. The miracle was that gradually the paralyzed man and I began to hear and respond to this loving invitation.

9. For 14 years the paralyzed man slouched in front of the television in the hell of his own despair and anguish. For months I sat and smoked cigarettes until it was time to collapse back into a drugged and dreamless sleep. But one day something changed for us. A tiny, fragile spark of hope appeared and promised that there could be something more than all of this darkness. This is the third phase of recovery. This is the mystery. This is the grace. This is the birth of hope called forth by the possibility of being loved. All of the polemic (which means "verbal attack on a belief") and technology of psychiatry, psychology, social work, and science cannot account for this phenomenon of hope. But those of us who have recovered know that this grace is real. We lived it. It is our shared secret.

10. It is important to understand that for most of us, recovery is not a sudden conversion experience. Hope does not come to us as a sudden bolt of lightning that jolts us into a whole new way of being. Hope is the turning point that must quickly be followed by the willingness to act. The paralyzed man and I began in little ways with small triumphs and simple acts of courage. He shaved, he attempted to read a book and he talked to a counselor. I rode in the car, I shopped on Wednesdays and I talked to a friend for a few minutes. He applied for benefits. He got a van and learned to drive. I took responsibility for my medications, took a part-time job, and had my own money. He went to college so he could work professionally with other disabled people. I went to school to become a psychologist so I could work with disabled people. One day at a time, with multiple setbacks, we rebuilt our lives. We rebuilt our lives on three cornerstones of recovery—hope, willingness, and responsible action.

Notes for Discussion:


5 Stages of the Recovery Process Illustrated
Society / Stigma
Self Image
Disabling Power of the Addiction
Symptoms/Side Effects
There are times when they are overwhelmed by...
Impact of Illness
Shattering of our World, Hopes & Dreams
There are times when they have given into...
Life is Limited
Giving Up Was A Solution
There are times when they are questioning...
Change is Possible
Fragile Flame of Hope & Courage
There are times when they are challenging...
Commitment to Change
Simple Acts of Courage
There are times when they are moving beyond...
Actions for Change
We Rebuilt Our Lives
DANGER
Identity
DANGER
Possibilities
DANGER
Risk
DANGER
Support
DANGER
Responsibility

Five Stages in the Recovery Process

Appalachian Consulting Group, Inc. (with quotations from Patricia Deegan)

Impact of Illness

"The shattering of one's world, hopes and dreams."

***There are times when the person is* <u>overwhelmed by</u>** the disabling power of the illness. The impact of the illness is the dominant experience in a person's life and the person is having difficulty functioning.

The **<u>danger</u>** is that the person will redefine her <u>identity</u> in mental illness terminology that will automatically limit her future.

The **<u>role of services</u>** is to decrease the emotional distress by reducing the symptoms and communicating that there is life after diagnosis.

Life is Limited

"We both gave up. Giving up was a solution."

***There are times when the person has* <u>given into</u>** the disabling power of the illness. He doesn't like the way his life is but believes that this is the best he will ever be. He is not ready/able to make a commitment to change

The **<u>danger</u>** is that the person will have identified so strongly with the negative stigma of the illness that he cannot see any <u>possibility</u>.

The **<u>role of services</u>** is to instill hope, a sense of possibility, and rebuild a positive self-image by helping the person review and evaluate his options.

Change is Possible

"The fragile flame of hope and courage."

***There are times when the person is* <u>questioning</u>** the disabling power of the illness. She believes that there may be more to life than she is currently experiencing and is beginning to believe her life can be different.

The **<u>danger</u>** is that she will be afraid to take the necessary <u>risks</u>, or be discouraged to do so, and remain in the 'life is limited' stage.

The **<u>role of services</u>** is to help her see that she is not so limited by the illness, and in order to move on she will need to take some risks.

Commitment to Change

"I began in little ways with small triumphs and simple acts of courage."

***There are times when the person is* <u>challenging</u>** the disabling power of the illness. He believes that there are some possibilities, but he is not sure what they are. He is willing to explore what it will take to make some changes.

The **<u>danger</u>** is that he will not get the skills, resources, and <u>supports</u> that he needs to do what he wants to do and will become frustrated and give up.

The **<u>role of services</u>** is to help the person take the initial steps by helping him identify his strengths and needs in terms of skills, resources, and supports.

Actions for Change

"We rebuilt our lives on three cornerstones of recovery - hope, willingness, and responsible action."

***There are times when the person is* <u>moving beyond</u>** the disabling power of the illness. She knows the direction she wants to go but is not sure that she can do it. Yet she is willing to begin to take more responsibility for her life.

The **<u>danger</u>** is that she will begin to doubt her ability to function on her own and to take <u>responsibility</u> for her own actions.

The **<u>role of services</u>** is to equip her with the necessary skills, resources, and supports so that she can trust in her own decision-making ability and take more responsibility for her life

Part 5 – Review Questions

1. What are the five stages in the recovery process as defined in this training?

2. What are ways people often relate to the disabling power of a mental health or substance use challenges at each of these?

3. What is the danger at each stage that may cause a person to get stuck or side-tracked?

4. What can a peer recovery specialist do at each stage to help prevent a person from getting caught up in this danger?

Session 6

Using Your Recovery Experience as a Recovery Tool

One of the major “recovery tools” that peers bring to the behavioral health system is their own lived experience and recovery story.

Session 6 explores the difference between an “illness story” and a “recovery story”. This session will help you experience the power and potential of your own recovery story to inspire others.

Session Overview

This session has five parts:

1. Opening Conversation
2. Instructions and Individual Work
3. Sharing in Small Groups
4. Sharing About the Small Group Experience
5. Listening to a Recovery Story
6. Review Questions

Learning Objectives

By the end of this session, you should be able to:

- Explain the difference between an illness story and a recovery story.
- Give at least two examples of ways your recovery story can help another person.

Part 1 – Opening Conversation

Let's talk briefly about our own recovery stories.

- How many of you have told your recovery story to another peer?
- How many of you have told your recovery story to a group of people?
- What is the power of telling your recovery story for yourself? …for the listeners?
- What is the difference between telling your recovery story and your substance use or illness story?

Part 2 – Telling Your Recovery Story

1. What were some of the early indications that you were beginning to have difficulties?

2. Briefly describe yourself and your situation when you were at your worst.

3. What helped you move from where you were to where you are now? What did you do? What did others do?

4. What have you overcome to get to where you are today?

5. What have you learned about yourself? What have you learned about moving on with your life?

6. What are some strengths you have developed?

7. What are some things that you do to stay on the right path?

Part 3 – Sharing in Small Groups

In Part 2 of this session, you wrote about your recovery story, talking about where you started on your journey, how things were for you at your lowest point, and your movement from illness to recovery.

For this part, you will ask these same open-ended questions to a peer as you work together in pairs.

Each peer will share for 10 minutes. Listen for similarities in each other's story. Listen for the peer's strength and hope. Listening is a powerful tool for building support and trust.

Even as you share your story again, you may feel your confidence and hope growing stronger. You may even share a part of your story this time, that you had forgotten in Part 2 of this session.

1. What were some of the early signs that you were beginning to have trouble?

2. Briefly describe yourself and your situation when you were at your worst.

3. What helped you move from where you were then to where you are now? What did you do? What did others do?

4. What have you overcome to get to where you are today?

5. What have you learned about yourself? What have you learned about moving on with your life? How do others respond to you differently?

6. What are some strengths you have developed?

7. What are some things that you do to stay on the right path?

8. Who can you count on when you need extra support?

9. What does "recovery" mean to you?

Part 4 – Sharing About Small Group Experience

What was that like?

What did you learn?

What is the power of that exercise?

Why would we include an activity like this early in the training?

Part 5 – Review Questions

1. What is the difference between a “recovery story” and a “illness story?”

2. Give two examples of using your recovery experience to help another person.

Session 7

Creating Recovery Cultures

Staff do not have control over the community and home environments. But they do have control over program environments. It is important that these environments promote recovery.

Session 7 explains how negative messages keep people from moving forward with their lives and how to create program environments that promote recovery.

Session Overview

This session has six parts:

1. How Negative Messages Are Sent
2. The Power of Negative Messages
3. Changing Negative Attitudes and Beliefs
4. Program Environments that Promote Recovery
5. Language that Promotes Recovery
6. Group Activity
7. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain how negative messages are sent.
- Explain the power of negative messages.
- Explain how negative attitudes and beliefs change.
- Describe program environments that promote recovery.

Part 1 – How Negative Messages Are Sent

Negative messages are things that people say and do that put down another person.
Negative messages communicate that a person is incapable of doing very much with their life.

Scenario

Some of us have worked with the Arkansas Office of Behavioral Health. We have identified two to four programs with staff and peers who do not believe in the possibility of recovery. They may say they believe in recovery. However, when we went with case managers to staff meetings, read charts and treatment plans, and attended peer groups, we saw and heard things indicating they don't believe peers can get better.

What did we see and hear on our visits with staff and peers that let us know they do not believe in the possibility of recovery? In other words, how were negative messages sent about an individual's ability and potential for growth?

Individually list three to five answers to the above question.

1.

2.

3.

4.

5.

Examples of Negative Messages About Peers' Abilities and Potential for Growth

1	Progress reports show no change	18	Lecturing peers like they are children	35	Progress notes reflect negative behavior
2	Staff tell peers what to do	19	Condescending language	36	Impatience on the part of the staff
3	Unsupportive of peer's goals	20	Not permitting failure	37	Treatment talk vs. recovery talk
4	No peers on advisory councils	21	No shared eating or recreational activities	38	Too many demands to be in the program
5	Cookie-cutter treatment plans	22	Minimalizing peer feelings and ideas	39	Treating the chart, not the peer
6	Doing things for peers they can do for themselves	23	Catering to the needs and wants of attractive few	40	Telling peers they will never complete treatment
7	Staff leading all groups	24	Patronizing behavior	41	Giving up on peers
8	"Always" and "never" statements from staff and peers	25	Loud, impatient, frustrated voices (staff and peers)	42	"Recovery for these people is just not possible."
9	Passive peer; not active in treatment	26	Goal= stay out of the hospital, stay on meds	43	"We do the treatment plan and they sign it."
10	Decisions are made without peer present, and the peer doesn't question	27	Peers allowed /encouraged to remain in maintenance mode	44	Peer unable to identify current goals
11	Run-down buildings and facilities	28	Inappropriate comments by staff	45	Peers always asking for permission
12	Peer doesn't know their goals	29	Low attendance in programs	46	Telling people that they are not ready
13	Jokes/complaints/derogatory remarks about peer	30	"You will never be able to function in the community."	47	Everyone doing the same thing all the time
14	Peers appears hopeless	31	Repeated materials in groups	48	Goals are not recovery-based
15	Problem-focused talk	32	No shared eating or recreational activities	49	Us/ them mindset
16	Peers embarrassed into compliance	33	Not letting peers make their own decisions	50	Staff tell another staff that a peer will never change
17	No respect for peer wishes	34	No recognition of achievements	51	"You can't even take care of yourself."

Part 2 – The Power of Negative Messages & and Creating Recovery Environments

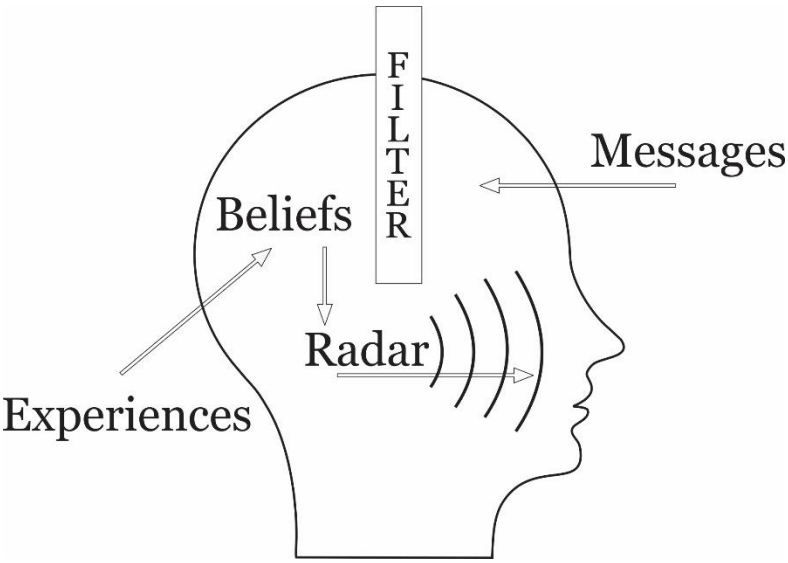
By the end of this session, you should be able to say why the following statements are true.

1. Negative messages reinforce a negative self-image. Therefore, avoid negative messages to create a presence of positive messages.

2. If people are not taking responsibility for their own recovery, it is often because they are receiving negative messages about their own abilities and potential for growth.

3. The greatest barrier to recovery is often the negative messages that reinforce a person's negative self-image and negative self-talk.

This image is a simple presentation of a complex mental process that helps us understand why changing beliefs is so difficult.



Main Points of the Presentation: The Power of Negative Messages

- Life is a lot of experiences and in order to make sense of these experiences, we create beliefs.

- We protect these beliefs because they are who we are.

- We protect these beliefs by filtering out messages and information that contradict them and letting in messages and information that support them.

- Also, we seek out information that will support our beliefs.

- There are at least five ways that beliefs change:
  a) The right thing happening at the right time.
  b) There is a crack in the filter.
  c) Over-powering the filter system.
  d) New awareness of options and possible benefits.
  e) The power of a peer.

  The first two cannot be consciously catalyzed by another person or group. The last three CAN be consciously catalyzed by another person or group.

Notes:

Key Points from the Presentation:

- *Life is one experience after another.*

- *As conscious, reflective human beings we learn by trying to make sense out of these experiences by asking questions like:*
  What does this encounter mean?
  What was the significance of that comment?
  What have I learned that can help me function?

- *In answering these questions, we create a set of beliefs about who we are, how the world operates, what is expected of us, and what we can expect of others.*

- *These beliefs determine our behavior. Everything we do is based on what we have learned or what we believe to be true.*

- *Our beliefs about our current situation determine how we relate to that situation.*

- *Many of these beliefs lead to actions that become habits. We do something without thinking about it.*

- *These beliefs are who we are. They determine everything we do. They form our identity.*

- *If these beliefs change, we change. Change is usually very uncomfortable, so we resist.*

- *We resist change by protecting our beliefs. When we receive information that contradicts these beliefs, our first response is to avoid change. We want to protect the belief by disproving the information. We don't initially question the beliefs behind the actions.*

- *It is as if we have a filter system. This filter protects and strengthens our beliefs by filtering out information that does not support our beliefs. And we let in the information that does.*

- *Also, it is as if we have a radar system that seeks out information that supports our beliefs.*

- *If we did not have this "filter" and "radar" system, our lives would be very chaotic.*

If I tend to filter out information that challenges my negative beliefs about myself, let in information, or seek out information supporting those beliefs, then how are my beliefs going to change?

1. Beliefs sometimes change because the right thing happens at the right time. **(Conversion experience – PROVIDE EXAMPLE)**

2. Beliefs sometimes change because there is a crack in the filter. **("When the student is ready, the teacher will appear." PROVIDE EXAMPLE)**

3. Beliefs sometimes change because the filter system is overloaded. It cannot filter out all of the contradictory messages. **(Brainwashing – PROVIDE EXAMPLE)**

4. Beliefs sometimes change because the person decides to make some changes in order to have the kind of life that she wants. (**New awareness of options and possible benefits – PROVIDE EXAMPLE**)

5. Beliefs sometimes change because the messenger is believable. (**The power of a peer – PROVIDE EXAMPLE**)

1 & 2 **cannot be consciously** created by another person or group of people in order to cause change in a person.

3, 4 & 5 **can be consciously** created by another person or group of people. How you do this is where we will spend a lot of time this week.

Notes on the Discussion:

Part 3 – Changing Negative Attitudes and Beliefs

Scenario

As you leave this training you go to an agency or situation where most of the staff and peers do not believe in recovery. Your only assignment is to CHANGE staff and peer attitudes and beliefs by surrounding them with possibilities of recovery. You cannot fire anyone.

Focus Question

What would you do over the next six months to surround both staff and peers with the possibility of recovery? Be specific about what actions or activities you would introduce.

Individual List

1.

2.

3.

4.

Part 4 – Program Environments that Promote Recovery

Recovery Program Environments are those in which people involved make a constant and consistent effort to. . .

1. Eliminate negative messages about a person's abilities and potential for growth.
2. Bring in program graduates to tell their success stories.
3. Provide peer mentors in specific areas of a person's life.
4. Make available peer role models who are comfortable with and articulate their own recovery.
5. Offer training in stress reduction and stress management skills.
6. Create opportunities for staff and peers to share their success stories with one another.
7. Set up an awards system ranging from verbal praise to completion certificates to small prizes.
8. Celebrate peer and staff victories.
9. Coordinate ongoing wellness support groups.
10. Set up ongoing goals support group.
11. Provide recovery stories on reception room TV.
12. Train peers to write their own progress notes.
13. Educate staff and peers on the definition and dynamics of recovery.
14. Educate staff and peers on the philosophy and value of psychosocial rehabilitation.
15. Focus on the strengths of the peers rather than the illness.
16. Create opportunities in group settings for peers and staff to learn and talk about recovery.
17. Teach peers problem-solving skills.
18. Engage peers in solving program problems.
19. Enable staff to focus time on skills teaching, support development and resource coordination.
20. Ensure that everyone has input into program development and evaluation.
21. Ensure that the overriding theme throughout is that a person can get better.

Part 5 – Language that Promotes Recovery

Words are so important!

If you want to care for something, you call it a "flower;" if you want to kill something, you call it a "weed."

In "The Language of Recovery Advocacy," William White writes:

> *It is time people in recovery rejected imposed language and laid claim to words that adequately convey the nature of our experience, strength, and hope. We must forge a new vocabulary that humanizes (behavioral health) problems and widens the doorways of entry into recovery. . .We must counter the clinical language that reduces human beings to diagnostic labels that pigeon-hole our pathologies while ignoring our strengths and resiliencies. . .We need language that is hope-infused, recovery-focused, and family-centered. We need a new language that reflects and conveys diverse pathways and styles of recovery.*

In this passage, what words and phrases caught your attention?

What do you think White means by "imposed language" that talks about the experience of those with behavioral health challenges? Provide two or three examples.

1.

2.

3.

What does the author mean by "lay claim to words that adequately convey the nature of our experience, strength, and hope?" Provide two or three examples of those words.

1.

2.

3.

List two or three examples of clinical language "that reduces human beings to diagnostic labels that pigeon-hole our pathologies while ignoring our strengths and resiliencies."

1.

2.

3.

Language both reflects and creates culture.

The following are words and phrases that are **barriers** to creating a culture of recovery.

Current Word or Phrase	What culture or beliefs are being reflected?	What are more recovery-focused words we could use?	What is the emerging culture or belief?
You will be on medication for the rest of your life.			
I can't be working her recovery harder than she is.			
Only 10% of people will succeed in this program.			
He continues to be non-compliant with treatment.			
She is too sick to ever live independently.			
They are just attention-seeking.			
He is just a chronic relapser.			
They don't know how to set their own goals.			
Medication to assist recovery is just a crutch.			
They want to be homeless.			
She is a frequent flyer.			
He is just trying to be manipulative.			

What are some other words or phrases you have heard that create or define a culture that doesn't support recovery?

Part 6 – Review Questions

1. What is meant by the term “negative messages?”

2. Give three examples of negative messages in behavioral health program environments.

3. Why do negative messages have so much power in behavioral health program environments?

4. Name four kinds of group or one-on-one activities that recovery-based programs could include.

5. If you were in charge of a program that did not promote recovery, what would you do to change the focus of the program?

6. If you were to visit a program at another mental health center, what would you look for to see if the program was or was not promoting recovery?

7. What are four examples of words or phrases that are used in clinical settings that do not support a recovery environment?

Session 8

Pathways to Support Healing and Recovery

Every person in recovery has a unique story about their path to recovery and the twists and turns that that path has taken.

Session 8 will examine some of the multiple pathways to recovery for both mental health and substance use issues.

Session Overview

This session has seven parts.

1. The Importance of Offering Multiple Pathways
2. Multiple Steps to Recovery but One Goal
3. Commonly used pathways to recovery
4. Multiple Pathways Worksheet
5. Peer Recovery Specialist Support Multiple Pathways
6. Review Questions

Learning Objectives

- Explain the principle of multiple pathways to recovery.
- Give examples of different pathways.

Part 1 - The Importance of Offering Multiple Pathways to Recovery from Holistic Practices to Recovery Support

Recovery pathways are highly personalized, building on the strengths, talents, coping abilities, and resources of each individual. Individuals have unique needs, strengths, preferences, goals, cultures, and backgrounds— including trauma experience — that affect their pathways to recovery. When peer recovery specialists and entire organizations recognize and affirm those unique aspects, they are better able to deliver support for people to initiate or maintain recovery and enhance the quality of life of peers in long-term recovery.

Peer recovery specialists adopt an approach that accepts and supports many paths to recovery in order to reach more people with recovery supports, enhance services, and reduce stigma.

It is important to recognize that there is not just one pathway to recovery. Every person is different and as such everyone's recovery is different, too.

Many find their best Recovery pathway is a well-trod path. While for others, the road less traveled suits their individual needs. There are multiple pathways to Recovery, some more well-known than others, but that doesn't make any single option superior. Each pathway is a tool that you can draw on as needed.

Pathways may include clinical treatment, faith-based approaches, medications, peer support, family support, self-care, and/or holistic practices to heal the body and the mind.

Asking for help is the first step in a lifelong journey of healing physically, and growing mentally, emotionally, and spiritually from mental health and substance abuse challenges. Any pathway that works for you can offer a healthier and more productive life.
Many in the midst of recovery begin with one method and then switch. While some find that a combination of ideas and approaches brings lasting change in their lives. The variety of approaches gives those struggling with addiction multiple avenues at their disposal.

People tend to develop strong feelings when a recovery pathway saves them from a painful life. Recovery should be by any means necessary under any circumstances. Regardless of how we achieved recovery, it is our responsibility as members of the recovery community to better inform ourselves (and others) of the other options out there rather than suggesting that our way is the only way

Part 2 - Multiple Steps to Recovery but One Goal

We agreed on the following definition of recovery earlier in the training:

RECOVERY is the process of change that comes through hope and empowerment that promotes a healthy way of life, regaining things once lost, while often gaining things that one has never had.

People use many different words to describe recovery.

- Self-worth
- Okay
- Wellness
- Self-aware
- Balance
- Connected
- Healed
- Sober
- Happy
- Peace
- Control
- Proud
- Enlightened
- Recovered
- Goal-oriented
- Clean and dry
- Healing
- Calm
- Great
- Mature
- Resilient
- Changed
- Free
- Growth

Just like the many different words to describe recovery, there are also many ways to get there. Recovery is always our overriding goal.

Different Pathways of Recovery

There is no right or wrong way to approach recovery; your path may be different than other peoples'. Your needs may change with time making different types of recovery more effective at different stages of life

To build the strongest possible foundation of recovery, it's vital that you choose the pathway to recovery that fits best with your belief system(s), physical health, peer support needs, interests, and lifestyle. We will walk through some of the more common pathways of recovery but bear in mind that any pathway that allows the person to remain thoughtful and fulfilled is the right one for them, and it may include elements from a variety of different recovery approaches.

Please list the pathways that you have used to support your recovery.

How would you describe your recovery pathway?

What were some of the components?

Part 3 - Commonly used pathways to recovery

There are many paths to recovery. People will choose their recovery pathway based on cultural values, socioeconomic status, and psychological and behavioral needs. With such a personal and varied stake it is impossible to categorize every single type of recovery. However, there are several large areas that recovery falls into. Most people use more than one pathway to support their recovery.

Natural recovery – does not include any formal treatment or support programs. Sometimes a major life change leads to recovery.

Mutual aid groups, 12-step based programs - includes AA, NA, CA, and other 12-step groups including Emotions, Gamblers, Overeaters Anonymous, and others. This is a very commonly used pathway.

Mutual aid groups, non-12-step based programs - include a diverse range of support groups. Examples include Women for Sobriety, SMART Recovery, Depression Bipolar Support Alliance, Hearing Voices Network, Self-Injury Recovery, Survivors of Suicide (SOS support group), and others.

Medication-assisted treatment - involves using a prescribed medication to manage a condition. This includes medications for mental health and/or substance use conditions.

Faith-based recovery - includes a wide variety of practices. It may involve formal church-based recovery programs or personal spiritual practices.

Cultural recovery - involves a person embracing cultural practices that support recovery. Examples may include traditional Native American sweat lodges or traditional Chinese medicine.

Criminal justice - recovery may be initiated in drug court or while incarcerated.

Outpatient treatment - may include group and individual counseling. Outpatient treatment might focus on mental health, substance use, or both.

Inpatient treatment - involves a period(s) of time in a hospital-like environment. This is usually reserved for the most acute health issues. Again, the treatment might focus on mental health, substance use issues, or both.

Bodywork - promotes recovery through the movement of the physical body or energy and includes such popular activities as yoga, Tai Chi, and Reiki.

Artistic pursuits - involves following creative passions such as music, dance, and art as a recovery tool.

Giving back - may involve a person doing community services within or outside of recovery communities as a strategy that supports their recovery. It could also involve giving back to family and friends as well.

Harm Reduction - a set of practical, public health strategies designed to reduce the negative consequences and behaviors of drug use and promote healthy individual lifestyles and communities.

Part 4 - Multiple Pathways Worksheet

Please rate your knowledge and beliefs about the following pathways to recovery. Circle or place a checkmark next to the ones that you use or have used to promote your own recovery.

Mutual aid groups, 12-step based programs (e.g., AA, NA)

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Natural recovery-life events changed leading from problem use to abstinence.

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Mutual aid groups not based on 12-steps (e.g., SMART Recovery, Women for Sobriety)

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Harm Reduction

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Faith-based recovery

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Cultural recovery (e.g., traditional Native American sweat lodges)

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Criminal justice programs (e.g., incarceration, drug court)

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Outpatient treatment (e.g., counseling, groups, family therapy, mental health care)

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Inpatient treatment, rehab, mental health treatment

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Bodywork (e.g., yoga, Tai Chi, energy healing work)

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Artistic pursuits or art therapy

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Medication-assisted treatment, methadone, buprenorphine, naltrexone

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

Service work, giving back, inside or outside a recovery program

Knowledge:	Know a Lot	Know Something	Know a Little	Know Nothing
Opinion:	Very Positive	Somewhat Positive	Somewhat Negative	Very Negative

We think we "know" what people need to recover but even for individuals with a substance abuse condition the Substance Use Disorders Institute says that 46.1 % of individuals with a diagnosable substance use condition are recovering without specific interventions. Statistics for mental health conditions are much more difficult to pin down. We need more diversity in our approach, recommendations, and language surrounding recovery.

Are there pathways with which you feel uncomfortable?

How would you feel about working with a person who is following a pathway different from your own?

How do you set aside your own bias?

How can you educate yourself about a pathway that you know little about?

Part 5 - Peer Recovery Specialist Support Multiple Pathways.

There are many paths to recovery, but the question remains: which path is best? It would be great if there was one solution that worked for every person 100% of the time.

Instead, different pathways will work better for different people. Typically, one path isn't enough. A person may need to try out several different recovery pathways before you find the combination that works for them. People usually mix two or more of the pathways to create a solution that works for them and their unique circumstances.

The likelihood of success in recovery is increased and the recovery process is shortened if the pathway(s) are individualized. Many individuals try the wrong pathway one, two, three, four, or more times before achieving a state of long-term recovery. Different avenues work for different people depending on their challenges, the supports they need, the barriers they face, where they are in their lives, and other factors.

Ways to support a person to find their recovery path.

Support the person to discover their why.

- Supporting the person to identify why they are seeking recovery in the first place can be a good guidepost. That "why" will be the motivation to continue to seek a recovery path that fits.

Reflect on personal passions and ultimate life goals.

- Recovery involves having a life worth living. Reflecting on passions, interests, and goals can build a life worth living.

Help them build a solid support system for your recovery.

- No one recovers alone. Many people have lost healthy supports and don't know how to build healthy ones.

Integrate and investigate multiple methods.

- Support the person to research and investigate multiple methods. Recognizing that most recovery pathways include multiple tools, processes, and interventions. If it still doesn't feel right, try something else.

How can you as a peer recovery specialist support a person to find a recovery path that works for them?

Part 6 – Review Questions

1. Explain why supporting a person to examine multiple pathways is important.

2. Give 3 examples of different pathways.

Session 9

Problem-Solving With Individuals

There is a belief that a person needs to be "fixed" by someone else. This is because the individual does not have the ability to solve his or her own problems.

Session 9 shares a problem-solving process. When applied to problems this process is helpful in finding solutions.

Session Overview

This session has seven parts:

1. Definition of a Problem
2. Explain the PICBA Problem-Solving Process
3. Demonstrate the PICBA Problem-Solving Process
4. Reflection on the Demonstration
5. Practicing the PICBA Problem-Solving Process
6. Reflection on the Practice Session
7. Problem-Solving with Individuals
8. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain the PICBA problem-solving process.
- Use the PICBA problem-solving process with a peer.

Part 1 – Definition of a Problem

A problem clearly stated is a problem half-solved.

The way we state the problem determines where we look for solutions. If I tell you my problem is a flat tire, then the only solution is to fix the tire. What if I say I have a flat tire, but my problem is I plan to use my car to go to the doctor? Then I have multiple solutions to get to the doctor's appointment.

Most people tend to see their situation (flat tire) as the problem. This causes them to focus on changing the situation (fixing the tire). If you focus on changing your situation, then you focus on what you don't want (a flat tire). Shift your thinking that **the problem is the situation preventing you from doing what you want to do** (get to your doctor's appointment). Focus on what you want to create instead of what you want to change.

Remember, a problem is a situation that is preventing you from doing something. So, in order to clearly state a problem, describe the situation and identify what it prevents you from doing.

The key to problem-solving is:

- The ability to stand outside the problem and to view it with objectivity.
- The willingness to never make a major decision until you are clear that there are at least two options or choices.
- The awareness that there are always multiple ways of coming to a solution.

Part 2 – The PICBA Problem-Solving Process

The first three steps fully state the problem. The next two steps move you toward a solution.

STEP 1 - Problem
State the problem as clearly as possible. Ask the individuals questions about their current situation. What parts of the situation can they change? What is outside of their control? How does the situation keep them from doing what they would like to do?

STEP 2 - Impact
Identify how the individual impacts the situation. Ask what he or she might do that negatively impacts the situation or helps create the problem. Often there isn't time to deal with the impact the person has on the situation. However, making the individual aware can create an opportunity to deal with it later.

STEP 3 - Cost/Benefits
Explore the cost and benefits. If the problem is not resolved, ask the cost. If the problem is resolved, ask about the benefits.

STEP 4 - Brainstorm
Identify five to seven possible options that might solve this problem.

STEP 5 - Actions
Select the one or two best options from the above list. Determine the actions needed to work on the options selected.

* Use your story to make a connection, build trust, and provide hope during this process. Remember to only use your story to encourage the person to share.

Part 3 –Role play Demonstration of the PICBA Problem-Solving Process

P – the peer
PR – the peer recovery specialist

P – I have a big problem!

PR – What's going on?

P – When I tried to start my car just now, I realized the battery was dead. (States the situation.)

PR – Why is that a problem? (Clarifying that the dead battery is the situation, not the problem - what the situation is preventing the peer from doing is the problem.)

P – I have a doctor's appointment, and now I can't use my car.

PR – When is your appointment? (Still clarifying the situation.)

P - In an hour.

PR – Seems like the dead battery is not the real problem. The real problem is you need to get to your doctor's appointment. (Moving from the situation to what the situation is preventing the peer from doing or why the situation is a problem.)

P – Maybe I left the lights on. I haven't had this car that long. I keep forgetting that the lights don't automatically turn off like my other car did.

PR – I know, I had that same thing with a car once. (sharing story) Maybe something you need to keep in mind next time, but for right now let's focus on getting to the doctor's appointment. (Confirmed the Impact the peer had on the situation – didn't realize he had not turned off the lights.)

P – Right. "Should haves" don't help now but have to remember so it doesn't happen again.

PR - What's going to happen if you don't make the appointment? (Looking at the Cost/Benefits in order to have the peer state how important it is to find a solution.)

P – I won't be able to get my meds. I really don't do well when I don't take my meds.

PR – So, making the appointment gets you your meds, and that is pretty important for you.

P – Yes, very important.

PRS – So, let's quickly look at how you can get there. You can't use your car. So, what can you do? (Beginning the brainstorming process.)

P – I guess I could call a taxi, but I am not sure I have enough money to get there and back.

PR – Let's just get out some options before you decide what you can and can't do. (Continuing the brainstorming,)

P – I could call and change the appointment and then try to get the battery charged.

PR – That may work. But what else? (Continuing the brainstorming,)

P – Maybe I could call someone to give me a ride.

PR – What else?

P – I could just not go.

PR – That is always an option but what else could you do? You could walk or ride your bike. (PS makes a suggestion)

P – I could walk to the bus stop and maybe catch a bus.

PR – Anything else?

P – I could see if I could call someone for a ride.

PR – You mention, calling a taxi, changing the appointment, not going, taking the bus, and calling someone. Which of these sounds the best to you? (Moving from brainstorming to actions.)

P – I don't want to change the appointment. I really need my meds. I don't know the bus route or schedule. It's too far to walk. Not sure I have enough money for a taxi. I think I need to call someone.

PR – I understand, I take meds and I know how important they are to me. (sharing story)Who could you call?

P – Jimmy lives close by, and he is off work today. I guess could call him.

PR – Who is your backup if he is not able to give you a ride?

P – I don't know. Maybe I could reschedule.

PR – Would you like to try calling Jimmy?

P – Yes, because I would really like to get there today.

Part 4 - Reflection on the Demonstration

Notes on group discussion:

Part 5 – Problem-Solving with Individuals

As you work through the PICBA example, you learn how to look at the problem from different perspectives and brainstorm to find solutions.

Below are more examples for you to practice the PICBA process. One peer can role-play the person with the problem and the other peer.

We will walk through the first scenario together before we break into pairs. Use the worksheet on page 9.9 and 9.10 to take notes as we go.

You may be amazed at how your own experiences will come into play in this exercise even if the scenario itself is not one that you have gone through.

Scenario #1

Joyce has three young children and was recently evicted from her apartment because she did not pay rent. She is staying at a shelter and can only stay there for five more days. Her rental history has been eviction due to failure to pay rent.

Use Steps 1-3 to fully identify the problem.

Step 1. Clearly Define the Problem

State Joyce's PROBLEM as clearly as possible.

Ask questions to help clearly identify the problem.

- How did Joyce get into the situation of being evicted?
- What are parts of the situation that Joyce may be able to change?
- What are issues that may be outside of Joyce's control?
- How might the situation keep Joyce from doing what she would like to do?

Step 2. How the Person Has Impacted the Problem

What has Joyce done that may have negatively impacted the situation or helped create her problem?

-

-

Step 3. Costs/Benefits

If Joyce does not resolve the problem, what are some possible COSTS/BENEFITS to her in the short-term and long-term?

- Costs

- Benefits

Use Steps 4 and 5 to move toward the solution.

Step 4 - Brainstorming

What are 5 possible ways that Joyce may solve this problem? These are big steps. Anything can go on this list.

1.

2.

3.

4.

5.

Step 5. Actions

Now select 1 or 2 best solutions from brainstorming. What are the possible pros and cons of each best solution?

Pick one of the two possible best solutions. What are a couple of **ACTIONS** or small steps that Joyce can take now to begin working on the solution? Ask Joyce to set a timeline for her small steps. What can she do today or tomorrow?

Possible Best Solution #1 –

Pros –

Cons –

Possible Best Solution #2 –

Pros –

Cons –

Below are more examples for you to practice the PICBA process. Practice these scenarios in groups or in pairs.

One peer can role-play the individual with the problem and the other peer specialist.

Scenario 2

Troy has a chance to work for a company despite his criminal background. The job is located just outside the city and there is no bus route. Troy's driver's license is suspended.

Step 1. Clearly Define the Problem
State Troy's PROBLEM as clearly as possible.
Ask questions to help clearly identify the problem.

- How did Troy get into the situation where his driver's license was suspended?
- What are parts of the situation that Troy may be able to change?
- What are issues that may be outside of Troy's control?
- How might the situation keep Troy from doing what he would like to do?

Step 2. How the Person Has Impacted the Problem
What has Troy done that may have negatively impacted the situation or helped create his problem? (Great time to use your story)

-

-

Step 3. Costs/Benefits

If Troy does not resolve the problem, what are some possible COSTS/BENEFITS to him in the short-term and long-term?

- Costs

- Benefits

Use Steps 4 and 5 to move toward the solution.

Step 4 - Brainstorming

What are 5 possible ways that Troy may solve this problem? These are big steps. Anything can go on this list.

1.

2.

3.

4.

5.

Step 5. Actions

Now select 1 or 2 best solutions from brainstorming. What are the possible pros and cons of each best solution?

Pick one of the two possible best solutions. What are a couple of **ACTIONS** or small steps that Troy can take now to begin working on the solution? Ask Troy to set a timeline for his steps. What can he do today or tomorrow?

Possible Best Solution #1 –

Pros –

Cons –

Possible Best Solution #2 –

Pros –

Cons –

Scenario 3

In this scenario, the person playing the peer with the problem will make up their own problem. The person playing the peer specialist will start off the conversation by saying –

You sound kind of stressed out. What's up?

Step 1 – Problem. State the problem as clearly as possible.

Step 2 – Impact. Identify how the situation impacts the individual.

Step 3 – Cost/Benefits. Explore the cost and benefits of not resolving the issue.

Step 4 – Brainstorm. Identify 3-5 possible options that might solve this problem.

Step 5 – Actions. Select one of the options and create a plan taking small steps toward change.

Part 8 – Review Questions

1. What are the five basic steps to problem-solving with individuals?

Session 10

Facing One's Fears

Often people know what they want but many things keep them from believing they can create the life they want. Fear is one barrier to creating the life a person wants.

Session 10 provides a safe environment for discussing uncomfortable feelings and thoughts. This session will also explore what is involved in handling fears.

Session Overview

This session has six parts:

1. Conversation on Fear
2. Discussion of Comfort Zones
3. Facing Your Fear Worksheet
4. Moving Through the Facing Your Fears Worksheet
5. Moving Through Your Fear
6. Personal Reflection
7. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain the difference between fears that protect us from physical harm and fears that keep us from growing.
- Explain the statement, "What we are really afraid of is that we will not be able to handle the uncomfortable feelings.
- Share some examples of what you have learned about dealing with uncomfortable feelings.

Part 1 – Conversation on Fear

Fear is…

…the feeling of alarm or agitation caused by the expectation or realization of danger. Fear is basically good. It protects us from real or perceived danger. Fear often keeps us from doing something that may cause us physical harm.

BUT some fears can limit our growth. They can be from another time in our life. This could be a time when we needed to protect ourselves. Now, we no longer need that protection. We may think we do! The fear now is inappropriate and may prevent us from growing and creating the life we want.

Think about this question.
What would you really like to do but are afraid to do?

Part 2 – Discussion of Comfort Zones

Complete the following statement. "If I were not afraid, I would…"

Why would I like to do this? In other words, how do I think my life would be different?

What are you getting by staying in your comfort zone? What are the benefits?

1.

2.

3.

4.

5.

What are the biggest benefits you receive by staying in your comfort zone?

What are you giving up by staying in your comfort zone? What is it costing you?

1.

2.

3.

4.

5.

What is the biggest cost you pay by staying in your comfort zone?

What have I learned about successfully dealing with the feelings that arise when I move out of my comfort zone?

What have I learned about living in the “discomfort” or “growth zone?”

If you were able to move through this fear and do what you want to do, what would be the greatest benefit?

Part 3 – Facing Your Fear Worksheet

Complete the following statement: "If I were not afraid, I would…"

What is the fear that keeps me from doing what I want to do? Complete the following statement: "I am afraid of…"

Part 4 – Moving Through Your Fear Worksheet

How does experiencing that fear make me feel? What are the feelings (physical and emotional sensations) that I experience? Be as specific as possible.

What are the thoughts that come to my mind in that situation?

What have I learned from past experiences about how to successfully deal with these feelings and thoughts?

What are some small steps that may help me deal with these feelings and negative thoughts?

What kind of support would I like to help me face and move through this fear?

Who do I think could support me?

Part 5 – Moving Through Your Fear

Everyone has fears at different times and about different things. Our fears can protect us or paralyze us. We generally know the difference. Even if we are not always willing to admit it.

But we can easily allow the unhealthy fears to stop us from making changes and moving outside our comfort zones. We allow these unhealthy fears to block us from growing and maturing.

Some common unhealthy fears are:

- Fear of failure
- Fear of losing control
- Fear of losing a friend
- Fear of being alone
- Fear of someone knowing the truth
- Fear of being judged

Points to remember:

- While working with a peer in this exercise, be willing to step outside your comfort zone (either in telling your story or listening to the peer share their story).

- Create a safe environment for the peer to share a fear that has prevented them from growing, maturing, and creating a new or better life.

- Naming the fear is thought to give the fear less power over your life.

- Keep in mind that some people can be so afraid of being vulnerable that they can't even say that they are afraid of anything. Use your effective listening skills.

- Sometimes people express their fear through behavior. This they do or do not do. This is another way you can listen for a persons fears.

Ask the open-ended questions. Remember, open-ended questions are good ways to hear more of the other person's story.

These questions also help the peer to focus on their strengths, dreams, and values. All of these can help build hope and move away from the fear that may be paralyzing them or creating a roadblock.

The following worksheet can be used with at person you are working with. Feel free to make copies.

Peer-to-Peer Activity – Moving Through the Fear

- If you were not afraid, what would you do?
- What is the fear that keeps you from doing what you want to do?
- How does that fear you feel physically or emotionally?
- What are some thoughts that come to mind in that situation?
- What have you learned from past experiences about how to deal with these thoughts or feelings?
- How can you use what you learned from past experiences to help you with this fear?
- What are small steps that you can take to help you deal with these feelings and negative thoughts?
- What kind of support do you need to help you face and move through the fear?
- Who do you think would support you?

- If you moved through this fear and did what you want, what would be the greatest benefit to you?
- What have I learned about successfully dealing with the feelings that arise when I move out of my comfort zone?
- What have I learned about living in the "discomfort" or "growth zone?"

Part 6 - Personal Reflection Sheet

(This is for your own use and will not be shared.)

What do I need to do to follow up on this workshop experience to more effectively face my fears and expand my comfort zone?

Part 7 – Review Questions

1. Explain the difference between fears that protect us from physical harm and fears that keep us from growing.

2. Explain the statement, "We are really afraid of the uncomfortable feelings we will not be able to handle."

3. What are some examples of what you have learned about dealing with uncomfortable feelings?

Session 11

Combating Negative Self-Talk

Negative self-talk is another major barrier to creating the life that one wants.

Session 11 explores a variety of way to catch, check and change negative self-talk to prevent frustration, depression an despair.

Session Overview

1. This session has four parts:
2. Carol's Story and Reflection 2. Catch it! Check it! Change it!
3. Small Group Sharing
4. Review Questions

Learning Objectives

By the end of this session, you should be able to:

- Explain the "Catch it! Check it! Change it!" process.
- Share some ways that you have been able to combat your own negative self-talk.

Part 1 – Carol's Story and Reflection

Carol's Story

Carol awoke and realized she had overslept. "Oh! No! I am going be late for work! I said I wanted to get up every morning and go for a walk. I should have known that I wasn't serious. I always have great plans, but I never follow through. When am I going to grow up and start taking some responsibility for my life? I am such a failure!"

As Carol went to the kitchen, she caught a glimpse of herself in the hall mirror. "I shouldn't wear this skirt. It is tight across my butt. If I bend over, I will bust the seams. I have really put on a lot of weight lately. I am so fat and ugly."

As Carol was opening the door of the fridge, she said to herself, "What am I doing? I shouldn't eat breakfast…I really need to skip a few meals; then my clothes may fit a little better. I probably need to not eat for a week! No, I've changed my mind. Why don't I eat everything in the fridge? I am a great example of a person who doesn't care how fat and ugly she gets. I am really hopeless."

Carol left the house almost in tears. She got on the bus for work. When she sat in her seat she looked at her reflection in the window. She realized that she had forgotten to comb her hair. "My hair looks horrible. I am so ugly. I ought to shave my head and wear a wig. Nobody could ever like a person who looks like me!"

When Carol got to work, she remembered that she had not finished a report that was due that day. As she sat at her computer and got to work, her boss walked by. Carol said to herself, "He is going to think that I just started working on this report, and it is due today. He won't expect it to be very good. I am sure that he will give it to someone more capable to rewrite it. I am probably not going to have this job much longer. He will probably fire me soon. What will I do then? I am such a fat, ugly failure that no one could ever like. I wish I was dead!"

Reflection on Carol's Story

Our self-talk usually starts by something happening. There are four events that "jump-started" Carol's negative self-talk.

1. She overslept.
2. She saw that her skirt was tight.
3. She forgot to comb her hair.
4. She had not finished a report that was due that day.

Each time her self-talk quickly moved from stating the facts to telling herself a story that was not based on facts.

"I overslept…I am such a failure."

"My skirt is too tight…I am fat and ugly."

"I forgot to comb my hair…Nobody could ever like a person who looks like me."

"I haven't finished the report…I will be fired soon."

In each paragraph, when does her self-talk shift from fact to story?

Part 2 – Catch it! Check it! Change it!

- Everyone has negative thoughts/negative self-talk.
- Negative thoughts/self-talk is not the problem.
- The problem is when negative thoughts spiral downward and we end up defining ourselves in absolute/permanent negative language it becomes what we believe about ourselves.

What can we do?

Catch it! Check it! Change it!

- Learn to **Catch It** early on. This involves knowing when you are moving from fact to story.
- **Check It** against what is actually going on. Stick with the facts.
- **Change It** to more appropriately reflect reality.

How would life be different if you learn to catch your negative thinking in the early stages, check it against the actual situation and change it to something more in line with the facts? What would you do that you can't do now?

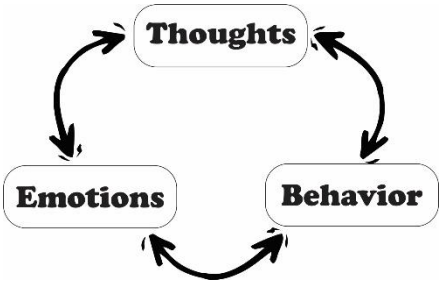
Notes:

Part 3 – Small Group Sharing

Catch It
Check It
CHANGE IT

Our negative thinking and self-talk has become a habit. Changing that habit or behavior doesn't happen automatically. It takes practice in thinking about what you are thinking. By not allowing your thought to overtake you and crash your efforts toward a healthier life.

How we think about something – accurate or inaccurate - will impact how we feel and how we act.



What do you notice about this figure?

Our thoughts impact our emotions, which impact our behavior. It is a cycle where each part impacts the other.

Thoughts are not facts; they are thoughts and can range from being totally false to totally true.

You are not the only one who has these type of thoughts, we all do. The key is what we do with these thoughts and our self-conversations.

Do we change them? Do we allow them to control our lives?

If you could learn to catch your negative thinking in the early stages, check it against the actual situation, and change it to something more in line with the facts, how would your life be different? What would you be able to do that you can't do now?

1.

2.

3.

4.

5.

Activity #1 – Carol's Story Revisited

There are numerous "thinking errors" that a person can make about something that happened or something that did not happen. Let's take a look at some of these common errors, also known as "stinking thinking," or distorted thinking.

Common Thinking Errors (AKA "Stinking Thinking")

- Thinking or assuming the worst.
- Jumping to conclusions – interpreting things negatively without facts to support your conclusion.
- Mind-reading – without facts, you decide that someone is thinking badly about you.
- Magnifying – exaggerating the importance of your problem or minimizing the importance of your better qualities.
- Black or White Thinking (the "all or nothing" principle).
- Labeling – attaching labels to experiences, people. Example: If someone makes a mistake, instead of saying "She made a mistake," you label her saying "She's such a loser."
- Fortune-telling – making statements about the future. Example: "I know I'm going to fail this test!" or "He told me that he would call me tomorrow but he won't."
- Discounting the positive experiences with thoughts that "those don't count."
- "Should" ("must, ought to and have to") statements – telling yourself that things "should" have turned out a certain way because you wanted or expected them to.

Catch it, Check it, Change it is a skill that gets easier with practice.

Go back to Carol's story.

Which of these distorted thinking errors do you notice?

Discussion notes for Activity #1.

Activity #2 – Practice Session

Work through this activity on your own or with a peer.

Learning how to break this bad habit of negative thinking we must:

- Recognizing our automatic thoughts. Our "stinking thinking"?
- Noticing our feelings. Feelings are not facts.
- Identifying our usual automatic actions
- Look at how we can change those automatic responses to take actions based on facts.

Situation	Automatic Thoughts	Feelings	Actions	Change it!
You are in the grocery store, and see Brad, a coworker. You call out to him and wave. Brad does not wave or answer back.	He doesn't like me.	Rejected	Avoid being around Brad at work. Don't speak to him. (withdraw)	
	He is mad at me.	Hurt	Confront Brad about why he didn't speak to you at the store. (lash out)	
	He probably didn't hear or see me.	Neutral	Speak to Brad at work and treat as you treated him before.	

Activity #3 – Practice Session

Using this worksheet, think about a time when you let one unhealthy thought spiral downward to unhealthier thoughts, hurt feelings, and then unhealthy behavior. Next brainstorm how you might have other more positive helpful thoughts.

<table>
<tr><td colspan="2">Situation</td></tr>
<tr><td colspan="2">What was the situation – what happened?</td></tr>
<tr><td colspan="2">Catch It</td></tr>
<tr><td colspan="2">What automatic thought did you have?

What story did you tell yourself?

Was the thought - Reality based? or Emotional based?</td></tr>
<tr><td colspan="2">Check it</td></tr>
<tr><td colspan="2">Was the thought healthy, helpful, and realistic?

How did the thought make you feel? (Name the emotion – anger, jealousy, humiliation, sadness, hatred, grief, anxiety, worthlessness)

How did the thought help or hurt your current situation or choices?

Was the thought realistic or a mistake in thinking?</td></tr>
<tr><td colspan="2">Change it</td></tr>
<tr><td>Brainstorm some alternative thoughts:
#1 –

#2 –

#3 –</td><td>Is this thought….

• Healthy – how does it make me feel?
• Helpful – how will it affect my current situation?
• Realistic – is it always true or a mistake in thinking?</td></tr>
</table>

Part 4 – Review Questions

1. Explain the Catch it! Check it! Change it! process.

2. What are some of the things you have found helpful in catching, checking and changing negative self-talk?

Session 12

Shared Decision Making

Meeting with a psychiatrist in the public behavioral health system has become a “medication appointment”. This can be a powerless experience.

Session 12 explores the traditional 15-20 minute “med check” meeting with the psychiatrist and a variety of strategies to better prepare for the meeting.

Session Overview

This session has five parts:

1. Context for this Session
2. Conversation about Visits to the Psychiatrist
3. Demonstrate the Role-Playing Preparation and Visit
4. Role-Plays
5. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain the concept of "shared decision making."
- Explain the steps involved in helping a peer prepare for a meeting with his or her psychiatrist or other persons in a "power position."

Part 1 – Context for this Session

Shared Decision Making is a concept developed by Patricia Deegan that deals with self-advocacy in situations of a peer with a professional. Often there is a sense of imbalance of power in these relationships and the peer has difficulty communicating their needs. While this concept was developed to deal with the peer-psychiatrist relationship during medication appointments, the skills taught can be helpful in any relationship in which there seems to be an imbalance of power and the peer is having difficulty communicating their concerns.

First, we will reflect on and demonstrate the concept as it was originally designed related to meeting with a psychiatrist. Then we will explore how the concept can be used by peers in multiple settings.

Part 2 - Conversation About Visits to the Psychiatrist

This is a passage from an article by Patricia Deegan, "Reclaiming Your Power During Medication Appointments with Your Psychiatrist."

> *Meeting with a psychiatrist during "medication appointments" is usually a very disempowering experience. The meetings usually last for 15-20 minutes. During the meeting you are expected to answer a few perfunctory questions and to leave with prescriptions for powerful drugs that can dramatically alter the quality of your life. In these meetings the psychiatrist assumes a position of power, and you usually fulfill the expected role of being quiet, unquestioning, passive patient. Subsequently, you will be praised for merely being compliant or scolded/punished if you fail to comply with prescribed medications.*

Over the years, Deegan developed a number of strategies for changing the power imbalance during medication meetings with psychiatrists. Later she developed this approach further and called it "Shared Decision Making." The idea is that when the doctor and peer meet, there are two experts in the room.

What do you think she means by "Shared Decision Making" and there are "two experts in the room?"

Part 3 – Demonstrate the Role-Playing Preparation and Visit

Role-Play #1

Ken is concerned about his weight gain over the past three months. He has not changed his life style or eating habits. He has gained about 25 pounds. He thinks the weight gain may be related to a new medication his psychiatrist prescribed three and a half months ago. He has tried to talk to his psychiatrist about this. His psychiatrist doesn't seem interested in discussing the side-effects. He wants to talk about whether or not the new medication is lessening his symptoms. He has come to you, his peer specialist, to discuss this concern.

Notes on Role-Play:

Role-Playing Preparation and Visits

In preparation for a visit, use the worksheet below.
Remember: find a way in the conversation to explore the issues and concerns mentioned.

- **Clarify the peer's concerns.**
  What are the major concerns you want to discuss with the psychiatrist?

- **Explore how previous visits have gone.**
  Have you tried to discuss these concerns in previous visits? If so, how did it go? If not, why not?

- **Discuss what the peer would like to achieve in the next visit.**
  What would you like to accomplish in the next visit?

- **Explore what difficulties she might have in accomplishing this and what she might do differently to better advocate for herself. (Role-playing can give the peer the opportunity to practice the conversation).**
  What do you think some of the difficulties might be? What can you do differently at the next visit?

- **Clarify what the peer needs to do to prepare for the next visit.**
  What can you do to prepare for your next visit?

Part 4 – Role-Plays

Role-Play #2
Sally is concerned about having knee surgery in two months. She is worried about taking pain medication after the surgery. She has tried to discuss this with her doctor but feels he isn't interested in developing a plan of action. Sally wants a plan to support her recovery from surgery and to sustain her personal recovery. The doctor only wants to discuss the need for her to have the surgery. Sally has come to you, her peer specialist, to discuss this concern.

How might you support Sally?

- **Clarify the peer's concerns.**

What is the major concern that you want to discuss with your doctor?

- **Explore how previous visits have gone.**

How did you try to discuss this concern during your previous visit? What prevented you from discussing your concern?

- **Discuss what the peer would like to achieve in the next visit.**

What would you like to accomplish in the next visit?

- **Explore what difficulties he may have in accomplishing this and what she might do differently to better advocate for herself.**

What do you think some of the difficulties might be? What can you do differently during the next visit?

- **Clarify what the peer needs to do to prepare for the next visit.**

What can you do to prepare for your next visit?

Role-Play #3

Scenario:
Lisa is renting a house and was temporarily laid off from her job. She has no savings and cannot pay her rent. Her caseworker keeps encouraging Lisa to find a different job and a different place to live. Lisa does not want to move herself and her three kids and thinks she will be called back to work soon. Lisa wants her caseworker to help her apply for the rental assistance program. Lisa gets upset with her caseworker and has a difficult time talking about it. She has come to you, her peer specialist, to discuss her concern.

How might you support Lisa?

- **Clarify the peer's concerns.**

What is the major concern that you want to discuss with your case worker?

- **Explore how previous visits have gone.**

How did you try to discuss this concern during your previous visit? What prevented you from discussing your concern?

- **Discuss what the peer would like to achieve in the next visit.**

What would you like to accomplish in the next visit?

- **Explore what difficulties he may have in accomplishing this and what she might do differently to better advocate for herself.**

What do you think some of the difficulties might be? What can you do differently during the next visit?

- **Clarify what the peer needs to do to prepare for the next visit.**

What can you do to prepare for your next visit?

Role-Play #4

Scenario:
Phil is concerned about what he the thinks are memory lapses. He is on several medications and thinks these medications are causing the lapses that started six months after he was placed on medication. For the past four visits to his primary care doctor, he has tried to talk about this. The doctor either ignores his concerns or says that no medication that Phil is taking will cause memory problems. He tells you that he stopped taking all the medications that the doctor prescribed. He has come to you, his peer specialist, to discuss the concern.

How might you support Phil?

- **Clarify the peer's concerns.**

What is the major concern that you want to discuss with your primary care doctor?

- **Explore how previous visits have gone.**

How did you try to discuss this concern during your previous visit? What prevented you from discussing your concern?

- **Discuss what the peer would like to achieve in the next visit.**

What would you like to accomplish in the next visit?

- **Explore what difficulties he may have in accomplishing this and what he might do differently to better advocate for himself.**

What do you think some of the difficulties might be? What can you do differently during the next visit?

- **Clarify what the peer needs to do to prepare for the next visit.**

What can you do to prepare for your next visit?

Part 5 – Review Questions

1. Explain the concept of "shared decision making."

2. Explain the steps involved in helping a peer prepare for a meeting with a person in a "power position."

Session 13

Trauma-Informed Care

Trauma is a universal experience among people receiving behavioral health services.

Session 13 recognizes the prevalence and impact of trauma. This session discusses how trauma shapes a person's view of the world and relationships.

Session Overview

This session has five parts:

1. What Is Trauma?
2. Why Does Trauma Matter?
3. What Does Trauma-Informed Care Mean?
4. What Is the Role of Peer Support in Trauma-Informed Services?
5. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Define the term "trauma."
- Explain the impact that trauma has on a person.
- Explain why trauma-informed care is important.
- Describe some of the elements of trauma-informed care.

Part 1 – What Is Trauma?

Trauma occurs when an external threat overwhelms a person's coping resources. It can result in specific signs of psychological or emotional distress. Trauma can affect many aspects of a person's life over a period of time. Sometimes challenges that individuals face are a result of trauma that occurred earlier in life. Trauma is unique to each individual—the most violent events are not always those with the deepest impact. Trauma can happen to anyone. But these groups are particularly vulnerable: women and children, people with disabilities, homeless, or those living in institutions including the foster care system, corrections, and psychiatric institutions.

Trauma = the event + the experience of the event + the effect on the individual.

Other important aspects of trauma

- Trauma results from both the event and how the individual experiences that event. (The story the individual tells him or herself about the event)

- Trauma that is intentionally caused (for example, domestic violence or child abuse) rather than caused by natural disasters can often have the most profound impact.

- Interpersonal violence, that is, violence experienced as a result of trusted relationships is especially damaging.

- And finally, interpersonal violence is more common for women, though men also experience violence in their relationships. Statistically, men are more likely to experience trauma from strangers.

- The experience of trauma can negatively impact every area of human functioning physical, mental, behavioral, social, and spiritual.

What is the impact of trauma on individuals and relationships?

- Shatters trust
- Destroys feelings of safety
- Violates personal boundaries
- Induces feelings of hopelessness and helplessness
- Takes away personal power and choice
- Produces feelings of shame, guilt, rage and self-hatred
- Results in isolation & disconnection from self, others, and the world

What would you add?

What are stories people may live out who have experienced trauma?

- "No one tried to protect me, so I must not be worth protecting."
- "Everyone is out to hurt me, so I will hurt them first."
- "People I trusted betrayed me, so I won't trust anyone."

What are stories people tell themselves?

How might the impact of trauma and self-stories create challenges in building relationships, including peer relationships?

Some seemingly safe situations can trigger the feelings and physical sensations of the actual traumatic events. What are examples of "safe" situations triggering trauma?

Notes:

Part 2 – Why Does Trauma Matter?

Reports on the number of people in the mental health system who have experienced trauma can vary. Many things can influence these statistics. Often people do not feel safe enough to report past trauma. For some, trauma was a daily occurrence. In other words, it was the backdrop to their home and community life. But for others, they may feel too ashamed or embarrassed to tell anyone, even when asked. Or in some cases, they may feel it was their fault, never report it, or deny that they are survivors.

Reported statistics include:

- 80% of individuals in psychiatric hospitals have experienced physical or sexual abuse, most of them as children.
- 81% of adults diagnosed with Borderline Personality Disorder were abused as children.
- Up to two-thirds of both men and women in substance use treatment report childhood abuse or neglect.
- Although trauma does not mean that a person will develop substance use challenges, research suggests that trauma is a major underlying factor.
- 75% of individuals who survive abuse and/or violent trauma develop issues related to substance use.
- 33% of those involved in serious accidents, illnesses, and natural disasters report alcohol misuse.
- PTSD increases the risk of substance misuse.
- Sexual abuse survivors have a higher rate of substance use disorder.

Trauma may impact people over their lifetime. Trauma can result in many of the health risk behaviors that cause early mortality rates. Let's take a look at why.

Adverse Childhood Experiences Study

Beginning in 1995 the Centers for Disease Control and Prevention (CDC) funded a study titled "Adverse Childhood Experiences Study" (ACE Study). This was the largest study of its kind. Researchers looked at the lifelong impact of certain adverse events for 17,400 participants. They asked people coming in for a routine checkup in a primary care clinic to fill out a questionnaire. The questionnaire asked whether or not they had experienced certain adverse events before the age of 18. The ACEs studied in this research are:

Ace Study

- Recurrent physical abuse.
- Recurrent emotional abuse.
- Contact sexual abuse.
- Emotional neglect.
- Physical neglect.
- Mother treated violently.
- Household member misused substances.
- Household member was depressed, mentally ill, or attempted suicide.
- Parental separation or loss of a parent or other through death.
- Incarcerated household member.

Exposure to one category of ACE equals one point. If an individual experienced emotional neglect and a household member abused substances, the ACE score is 2.

Individuals with an ACE score of 4 or more were:

- Nearly **two times** more likely to smoke, have heart disease, and/or cancer
- **Two times** more likely to have a gambling addiction
- **Seven times** more likely to suffer from chronic alcoholism
- **Eleven times** more likely to engage in IV drug use
- **Nineteen times** more likely to attempt suicide
- Men with an ACE score of 6 or more were **4600%** more likely to use IV drugs.

Combating the Negative Impact of Early Childhood Experiences

The following are some healthy practices to combat the negative impact of trauma. Write what you are currently doing or could do for each activity.

- Evaluate sources of persistent stress and change what you can.

- Become more self-compassionate.

- Be more compassionate to others. Engage in community service projects.

- Get involved in an activity or hobby that you enjoy.

- Practice meditation—thought awareness and thought control.

- Develop a ritual and practice that helps you sleep restfully.

- Eat healthy foods such as fruits, vegetables, and omega-3s. Skip fatty and processed foods.

- Disconnect from screens for part of the day and connect with people.

- Cultivate a few good, close relationships.

- Spend time in nature.

Part 3 – What Does Trauma-Informed Care Mean?

Trauma-informed care refers to services and supports that look at how common (prevalent) trauma is and the impact of trauma. Trauma-informed services and supports are guided by these principles:

- Choice
- Safety
- Trust
- Empowerment
- Collaboration

Why are these principles important in guiding the development and implementation of trauma-informed services and supports?

There are three components to the definition of trauma-informed care.

Component 1: Recognize just how common trauma is.

Component 2: Understand the impact (in terms of the development of coping strategies and adaptations).

Component 3: Change policies, procedures, and practices to reflect this information. Reduce/eliminate practices that could create or re-create trauma experience.

Other qualities of a trauma-informed system:

- Trauma-informed services strive to reduce or eliminate any interventions that can re-traumatize people or cause first-time trauma.
- Trauma-specific services deal directly with the impact of trauma.
- Trauma-informed services recognize that many of the behaviors once viewed as symptoms of illness are actually the person's best attempt to cope and adapt to trauma.
- Trauma-informed services practice universal precautions.
- Trauma-informed services are aware that punishing misbehavior is akin to piling on even more trauma.
- Trauma-informed services shift the focus from "What's wrong with you?" to "What happened to you?"
- Trauma-informed services help peers build resilience by mastering a skill, building a sense of belonging, and feeling a part of a larger purpose.

Part 4 – What is the Role of Peer Support in Trauma-Informed Services?

Trauma-informed peer support means paying attention to what is going on in a person's life. Understand that many of a peer's current challenges are responses to adverse situations and events. This could be trauma from the distant past or from the present. Trauma-informed peer support changes the question from "What's wrong with you (illness)?" to "What happened to you (event)?"

How might this change what we do in peer support?

- **Common or Shared Experience** - Instead of basing relationships on the idea of illness and coping with illness, trauma-informed peer support is different. It recognizes that adverse life events powerfully shape us as adults. Thus, a common or shared experience is not assumed. It is discovered in the process of learning about each other.

- **Human Experience Language** - Since the focus is on what has taken place in our lives, the language we use is based on human experience rather than on illness terminology or clinical language.

- **Sensitivity to Power** - Since traumatic events are often events in which people experience powerlessness, trauma-informed peer support pays close attention to the issue of power and privilege in peer relationships.

- **Focus on Connection** - Emphasis shifts from problem-solving, goal setting, and resource coordination to building healing relationships. Why? It is hard to support people in achieving their wants and needs if you have not been able to establish trust and a sense of safety with them. People cannot be honest if they fear that revealing their hopes and dreams will result in betrayal, again. Interpersonal violence, especially betrayal of trust and violation of personal safety, compromises a person's ability to trust others, to connect, and to feel safe. Thus, the task of peer support is to un-do what trauma has done. In other words, engage in ways to support an individual's right to be heard, to make meaningful choices and to experience trust and safety in all relationships.

Navigating difficult subjects

A common challenge in peer support is how to navigate the relationship when difficult material comes up. Below are some suggestions to help guide you:

- Be caring and respectful while staying honest and open about your own needs.

I'm glad you feel like you can tell me about these things that have happened to you. I need to be honest with you, though, and let you know that it is bringing up some of my own stuff. Would it be ok if we took a breather? It sure would help me a lot.

- Make sure you and those you support understand the difference between peer support and clinical support. Clinical support tends to be based on what one person in the relationship needs—usually the peer.

I'm wondering what you know about peer support and in what way our relationship might be different from the kinds of relationships you have had in the past with a therapist or counselor?

- Keep the focus on what your relationship needs in order for the two of you to stay connected rather than on what one of you in the relationship needs. Peer support is a two-way relationship where the needs, wants, and perspectives of both matter.

I need to be honest with you. I'm having a hard time staying present. I wonder if we could figure out a way to talk about this hard stuff that lets us both feel connected?"

- Identify staff members in your agency, other peer supporters, and resources in your community that can support survivors in their journey—especially if you feel overwhelmed.

- Finally, self-care is important to overall health and well-being.

Notes:

Part 5 – Review Questions

1. Can you define the term “trauma?”

2. How does repeated trauma impact a person’s view of the world and relationships with other people?

3. What is the ACE Study?

4. Why is Trauma-Informed Care in the mental health system important?

5. Can you describe some of the elements of Trauma-Informed Care?

Session 14

Facilitating Recovery Dialogues

Many peer recovery specialists have to spend a lot of time leading groups in their programs.

Session 14 presents guidelines and procedures for facilitating Recovery Dialogues that can be used in behavioral health programs.

Session Overview

1. This session has eight parts:
2. Introducing the Recovery Dialogue
3. Demonstrating a Recovery Dialogue
4. Reflecting on the Demonstration
5. A Walk Through the Manual
6. Assignments for Session 14
7. Participant Practice Facilitation and Reflection
8. Closing Reflection
9. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain what a Recovery Dialogue is and how it differs from a Mutual Support Group.
- Explain the structure of a Recovery Dialogue.
- Explain the role of the facilitator in the Recovery Dialogue

LET'S TALK ABOUT RECOVERY MANUAL

Guidelines for Facilitating Recovery Dialogues

Facilitating Recovery Groups that Promote Recovery

Context: *While Recovery Dialogues we used re initially created for people with mental health challenges, most of them can be used with people with substance use challenges. Often the Recovery Dialogues, revised for this training curriculum, will have the statement – "peers with mental health or substance use challenges". If using the Recovery Dialogues with just one of the groups, be sure to limit the references to that group.*

Why do we need Recovery Dialogues?

1) Peers you work with have been through a lot and have a lot of 'recovery wisdom'.
2) We learn best from people who have had similar experiences, who understand and who are not judgmental.
3) We all need opportunities to share and learn.

This training manual is for people who facilitate groups designed to help people with mental health and substance use challenges further what we generally think of as recovery. The meaning of the word 'recovery', as it is used in this manual, is:

Recovery is the process of gaining control over one's life - and the direction one wants that life to go - on the other side of a mental illness or substance use diagnosis and all of the losses usually associated with those diagnoses.

Recovery often has to do with becoming aware of or realizing that you can take more control of your life. Then build on that awareness and grow in self-confidence.

Recovery Dialogues are designed to help people achieve that awareness and increase their self confidence. They are designed to cut across that belief that *'there is nothing I can do that is going to make my life better.'* This is done by enabling depth sharing in a safe environment in order for people to identify and reflect on those times in their lives when they were able to act on their own behalf and affect their lives in a positive manner.

Recovery Dialogues are different from the more traditional self-help/mutual support groups. While both involve sharing experiences, *Recovery Dialogues* do this by initially focusing the discussion on a topic. Most often, this is a printed handout to be read or a story to be told. This allows the individuals in the group to initially focus their attention on something other than themselves. The questions about the printed material or story begin to move the participants' attention away from the objective material toward their

own lives. The questions follow a process that 1) enables individual participation, 2) keeps the group focused on the topic, 3) honors individual perspectives, and 4) moves the sharing to a depth level.

You can either teach people how to handle negative feelings from your own experience or you can help them look at what they have learned about handling negative feelings in the past, clarify and strengthen those learnings and help her apply what they know to their current situation. This manual uses the second approach.

The facilitator needs to understand that there is a 'flow' or structure (process) to the question they ask in the *Recovery Dialogues*. The structure is basically the same for every *Recovery Dialogue*. Even though the questions may differ, the function of the questions at each stage of the discussion is the same. First, the facilitator needs to introduce the topic. This is done in the form of a short article, story, quotation, etc. Whenever possible and appropriate, participants are given a copy of the 'topic' as a handout. Once the topic is introduced, the facilitator asks questions that get people discussing the topic without necessarily sharing their own experiences. This is important because many people are hesitant to share their own experiences. Initially focusing on something other than their own experiences gets the group participating without having to expose any of their own life experiences. Once the group is involved in discussing the topic, the facilitator begins to ask questions that move the group toward their own experiences of the topic being discussed. Finally, the facilitator asks questions that help people relate the topic and their experiences to their own recovery.

The biggest mistake most people make when facilitating *Recovery Dialogues* is that they try to teach people something. They talk too much and do not trust the group. The basic assumption of the teacher is that they know something that the people in the group do not know. The facilitator needs to remember that most people have experienced, at some level, whatever it is that they will be discussing. Everybody with a psychiatric diagnosis knows something about the struggle to recover. The basic assumption of the facilitator is that the group has experienced everything they will be discussing. The facilitator needs to help them know what they know.

Four Examples of Recovery Dialogues

The first four Recovery Dialogues explain the flow and function of the questions in Recovery Dialogues. They include detailed instructional information as to the role and function of the questions. After the examples, the Recovery Dialogues do not have as much instructional detail. The **basic guidelines** follow throughout:

- You introduce the topic.
- Try to get everyone participating in the first question.
- Move from the topic to people's experience with the topic.
- Then discuss how this helps in their recovery.
- Finally ask how we can improve the program.

In the first, "Being Disabled by Despair," the topic is held in a short quotation. In the second, "Signs of Recovery," the topic is presented in a series of statements about the topic. In the third, "I Want My Life Back," the topic is introduced in three short stories. In the fourth, "Good Days – Bad Days," the topic is held in a phrase. In the first two, copies of the quotation and the statements can be given to the participants. They can also be put on the wall as décor.

It is very important to the participatory nature of the dialogue that everyone be given an opportunity to talk very early in the group process. Since it is assumed that everyone knows each other, there will not be a need for introductions. The first question in the dialogues usually allows for everybody to have the opportunity to respond.

Toward the end of each dialogue, the group's attention is moved away from their experiences and is focused on how their participation in the dialogue may help them in their recovery and be used to improve the program they are all in. You end the dialogue by thanking people for their participation.

Each Recovery Dialogue has a section called "Guidelines for the Facilitator." This is for the facilitator's benefit and is not shared with the group. Also, words in *italics* are instructions to the facilitator and are not shared with the group. Words in **bold print** are the questions the facilitator asks or comments he makes. The asterisks * are where you want to spend most of your time.

It is very important that the facilitator read through the material and answer all of the questions in his or her own mind before facilitating the dialogue with a group.

Index of Dialogues

Example 1 – Being Disabled by Despair

Handout:
"When one lives without hope, the willingness to do is paralyzed…It is being disabled, not by illness or disease, but by despair."

Guidelines for the Facilitator:
The purpose of this discussion is to help people see that much of what we call apathy, lack of motivation, etc. is really despair that comes from the loss of hope. The discussion enables them to share what has helped when they felt hopeless. This is where you spend the most time and push the group for depth answers.

Today, we are going to have a discussion on hope and despair and how despair can disable a person. In order to get started, I want to share with you a statement by Patricia Deegan, who was diagnosed with schizophrenia at 17.

> **"…for months I sat in a chair in my family's living room, smoking cigarettes and waiting until it was 8:00 PM so I could go back to bed. At this time even the simplest of tasks were overwhelming. I remember being asked to come into the kitchen to help knead some bread dough. I got up, went into the kitchen, and looked at the dough for what seemed an eternity. Then I walked back to my chair and wept. The task seemed overwhelming to me. Later, I learned the reason for this: when one lives without hope, the willingness to do is paralyzed as well…It is being disabled, not by disease or injury, but by despair."**

Put the quotation, "When one lives without hope, the willingness to do is paralyzed…It is being disabled, not by illness or disease, but by despair," on the wall in front of the group so that it becomes a visual image. Read the quotation again to begin to narrow and focus the topic.

What do you think people are like when they have lost all hope?

What do they think about? What is going on in their mind? What are they feeling?

The purpose of these early questions is to get the group thinking about what it is like to live without hope without having to talk about their own lives. Even the questions in this part of the discussion have a flow—"look like"—"think about"—"feel." It is often easier to talk about someone else's pain than our own. They are, more than likely, thinking about times in their own lives when they had no hope, but they do not have to share those experiences right off the bat when they may still feel uncomfortable or a little hesitant.

What do you think might cause people to lose all hope?

We are still talking about "people," but it is easier to describe a person who is in despair, than to talk about our own despair. When we move to "cause" we move more into our own experience and what may have caused our own hopelessness. But, in theory, we are still talking about other people.

How does "not having hope" paralyze a person's will to do?

We are still talking about people in general, which includes everyone in the group.

When people have lost hope, what is helpful in moving them out of that darkness and despair?

We are still talking about "people."

***What was not helpful when you felt hopeless?**

***What was helpful when you felt hopeless?**

These questions move directly into the participants' experiences of hopelessness, but do not focus on the darkness and despair. They focus on what helped or did not help them move through it. This is where you want to spend most of your time.

How can you use what we have been discussing to help you further your own recovery?

What could we do to make this program more helpful for people when they do not feel very hopeful—when they are in darkness and despair?

You may want to make a list of the group's suggestions for further discussion at a later date.

When one lives without hope, the willingness to do is paralyzed.... It is being disabled, not by illness or disease, but by despair.

- Patricia Deegan

Example 2 – Signs of Recovery – "I Know I Am Moving Forward When…"

Handout: A series of statements about the "Signs of Recovery."

Guidelines for the Facilitator: The purpose of this discussion is to help people look at their own recovery, how they know when they are doing well and what they do to keep themselves doing well.

In order to begin our dialogue, I want everyone to give a word or phrase that comes to your mind when you hear the word "recovery."

Hand out the "Signs of Recovery" worksheets.

This sheet contains what I call "signs of recovery." These statements came from a workshop with a group of about 20 peers. They are real life experiences that peers used to describe "recovery" in their own lives. I want us to read these statements aloud—one at a time. I will read the opening statement, and you will follow with the first statement. Then I will repeat my statement, and you will read the second statement, and so on until we have read all of the statements. "I know that I am moving forward in my recovery when…"

Which of these statements spoke the most to you?

The purpose of these early questions is to relate the group to the statements. At this level, you are not interested in why that statement spoke to someone nor commenting on it. Quickly get answers from one-third to one-half of the group. They have thought about their own experiences, but you don't want them to share those thoughts yet.

We have been talking about statements from other peers. What would you add?

I know that I am moving forward in my own recovery when…

You are asking the group to share examples of when that happened. When a person adds a statement, ask them, "Why that statement? Why is that an important sign for you? How does that let you know that you are doing well?"

Let's look at the first two words in each of the statements.

Quickly read or have someone or the group read these words. I find…I become…I know…etc. until you read all 18.

***What do you know about recovery? What has your experience taught you?**

Now you are ready for the participants to start sharing more of their own experiences. This is where you want to spend most of your time. Here you can begin to push people to think deeper about what they know with questions like, "How did you learn that? How does that affect your life?"

How can you use what we have been discussing to help you further your own recovery?

What are some things we could do to make this program more helpful in people's recovery?

You may want to make a list of the group's suggestions for further discussion at a later date.

I know that I am moving forward in my recovery when…

I find myself questioning people who say I will not recover.

I become more aware of those things that I am good at.

I know what I can handle and what I need to share with the professionals.

I am able to set up safeguards for myself.

I learn from my peers and get support from them.

I see trouble coming before it arrives.

I think I may have a chance.

I know who and what's not good for me.

I realize what sets me off and stresses me out.

I know how to work the system.

I know when my behavior is appropriate and inappropriate.

I am able to hear "hope" from my peers. "Hang in there, it's not forever."

I know the difference between symptoms and stigma and am developing coping skills for each.

I believe I can recover.

I know when to leave a situation because it has given me all it can.

I realize that my past life has value.

I know when I need a special kind of help and seek it out.

I know that sharing with peers helps put things in perspective.

Example 3 - I Want My Life Back

Handout:
There is no handout. The topic is presented in three short stories.

Guidelines for the Facilitator:
The purpose of this discussion is to help people think about what it means to "lose one's life" with the onset of a psychiatric diagnosis and to think creatively about the kind of program activities that people would find helpful in "getting back their lives."

I want to share with you three stories that someone told me.

He was facilitating a training course in Brooklyn. A young man came up to him and said, "I have been coming to this clinic for six years. I take my meds. I talk to my counselor. I see my doctor. And I still don't have a life. What more do I need to do?"

The second story involved a woman from Vermont who had been leading a "normal," productive life. Then her life began to fall apart. She was diagnosed with manicdepression. Many of the things she had been able to do, she could no longer do. In the midst of her anger she said, "I want my life back!"

The third story was about a young man whose college education had been interrupted by alcohol and drugs. Over the past two to three years, he had been in and out of residential treatment programs, out-patient treatment programs and sober houses. In the midst of his frustration, he said, "I just want to get on with my life."

The next questions focus the group on the stories.

What caught your attention in those three stories?

All three people said, in one way or another, that they wanted their lives back. What do you think that meant for them? What did they want?

The next two questions move the group away from the stories to what they think. They are beginning to consider their own experiences.

What does it mean to have a life?

What is it like to feel you don't have a life?

The next question relates to what they have learned from their own experience.

What works against a person with mental health or substance use challenges "getting a life, or getting back her life, or getting on with his life?"

The next question asks the group to share their own experiences and what has helped them. This is where you want to spend your time and push the group to articulate deeply what they know about getting back or getting on with their lives.

When you felt like you did not have a life, what has helped you get your life back?

You want to get four or five people to answer the next question in detail. Push them on how their suggestions would really help people.

***If you had 12-15 people in a program who did not feel that they had a life, what kind of activities would you set up in the program that might help them?**

Pull the discussion toward the end by asking the following questions.

Which of these suggestions could we begin to implement in our program?

What would be involved in implementing them?

How can you use what we have been discussing to help you further your own recovery?

Example 4 - Good Days, Bad Days

Handout: There is no handout.

Guidelines for the Facilitator:
The purpose of this conversation is to enable people to realize that they already know some ways of taking care of themselves. They need to become more aware and disciplined. While this conversation can be used as a stand-alone conversation, it is a good conversation to use to begin to get people thinking about creating their own wellness program. It can be followed up with Mary Ellen Copeland's Wellness Recovery Action Plan (WRAP) © and a WRAP support group.

Today we want to talk about good days and bad days.

How many of you have good days?

How many of you have bad days?

Some days we feel good. Some days we feel bad. Good days and bad days don't just happen. There is something going on that causes us to feel the way we do.

Now you are going to ask people to share their experiences of what it is like to have good days and bad days. They are relating the topic to their own lives.

How do you know when you are doing well…having a good day? What are you like physically, mentally and emotionally?

How do you know when you are not doing well…having a bad day? What are some of the physical, mental and emotional indications?

The next questions begin to push people to think more deeply about their own experiences.

What are some of the things you do that help you have good days? (Example: Whenever I _____, I seem to have pretty good days.)

What are some of the things that cause you not to do well? (Example: Whenever I _____, I seem not to do so well.)

The next area is where you want to spend most of your time. It is here that people begin to see that they can do things that have a positive effect on their lives.

***When you are not doing well, what are some of the things you have found helpful for getting you back on track…back to doing well…having a good day?**

A different way to ask the same question.

***What do you do to turn a bad day around and make it a good day?**

It is interesting that we all seem to know what to do to have more good days and how to turn a bad day into a good day, we just don't always do what we know is best for us.

How can you use what we have been discussing to help you further your own recovery?

What do we need to do to help more of us take what we know and begin to create our own wellness programs?

Or you could use this discussion to introduce a Wellness Recovery Action Plan (WRAP) group that you hope to start in the next week. You would then use this time to announce this to the group and have a short discussion of when it may start, etc.

Example 5 - Hope as the Beginning of Recovery

Handout: "In my darkest moments, hope emerged when…."

Guidelines for the Facilitator:
The purpose of this discussion is to help people look at the role hope plays in recovery and how they sustain hope in their lives.

In order to begin our dialogue on "Hope as the Beginning of Recovery," I want everyone to give a word or phrase that comes to your mind when you hear the word "hope." What are some of the songs, poems, or sayings that speak of hope?

Be sure to have a few of your own that you can use to "prime the pump" if the group can't immediately think of any.

How would you define "hope?"

Dictionary definition: "expectation of something desired."

Pass out worksheet on "Hope Emerges When…"

This sheet contains statements from a workshop with about 20 peers. They were asked to think of a very dark and difficult time in their own lives when they had lost all hope, when life seems to have lost all meaning. What happened to give them hope? I want us to read aloud these statements, one at a time. I will read the opening statement, and you will follow with the statements listed below, one at a time in the order in which they are written. "In my darkest moments, hope emerged when…"

Repeat this process until all statements are read.

Which of these statements spoke the most to you?

We have been talking about statements from other peers, what statements would you add to the list?

What has your experience taught you about when hope emerges?

***We all know that once you begin to slide into "darkness and despair," it is difficult to pull yourself out. The key is to not begin the slide. What are some of the things you do to sustain hope in your life?**

How can you use what we have been discussing to help you further your own recovery?

What are some things we could do to make this program even more helpful to keep hope alive?

In my darkest moments, hope emerged when…

…I was distracted by another tragedy.

…I realized that so many people do care about me.

…Someone consoled me.

…I realized that I had fought so hard to survive that I shouldn't give up now.

…I heard a voice that said "no way".

…I realized that I could make a million mistakes and it doesn't matter.

…I realized that there was something beautiful I could see.

…I realized someone needed me.

…Someone enabled me to participate in the normal activities of life.

…I realized that I was afraid of dying.

…I realized there were people worse off than me.

…I turned to my faith that it would get better.

…The hate I was feeling was overcome by love.

…I realized that I was not alone.

…Someone noticed how bad it was and really listened.

…I realized I had a belief in myself that couldn't be taken away.

…I was able to forgive someone else.

Example 6 - Feeling Disempowered

Handout:
A series of statements made by peers entitled, "I feel disempowered when…"

Guidelines for the Facilitator:
The purpose of this dialogue is to engage the participants in a discussion about how they deal with potentially disempowering situations in their lives.

Today we want to talk about empowerment by first looking at disempowerment. I want everyone to give a word or phrase that comes to mind when you hear the word "empowerment." If all of these things have to do with "empowerment," what does disempowerment mean?

Pass out the worksheet, "I feel disempowered when…"

This sheet contains statements from a research project conducted by Judy Chamberlain. Peers were asked to define the word "empowerment." The following statements are the opposite of what they saw as empowerment. I want us to read aloud these statements, one at a time. I will read the opening statement and you will follow with the statements listed below, one at a time in the order in which they are written. "I feel disempowered when…"

Repeat the process until they are all read.

Which of these statements spoke the most to you?

Get answers from about one-third to one-half of the group.

We have been discussing what other people have said. What statements would you add? What kind of experiences do you associate with disempowerment (not feeling good about yourself)?

Get two or three answers to each question.

Does anyone have a particular disempowering experience you would like to share?

The next question is where you want to spend time and push people for clear, in-depth answers.

***How do you care for yourself when things like that happen? What's helpful? What's not helpful?**

How can you use what we have been discussing to help you further your own recovery?

What do we need to do to make our programs and environment here less disempowering?

I feel disempowered when…

…I am not allowed to make my own decisions.

…Other people question my abilities.

…I can't get information and resources that I feel I need.

…I am told that this is my only option or choice.

…Others tell me I will never get better.

…I am told that I will never amount to anything.

…Others talk about me as if I were not there.

…I am criticized for asserting myself.

…I am labeled as "chronic" or "incurable" or "a drunk."

…I am seen as a "case history."

…Other people do not listen to me.

…I get angry and am told that I am "decompensating" or "out of control."

…My rights are abused or taken away.

…People refer to me as a "mental patient" or "crazy" or other labels.

…I am told that I will never be able to do anything worthwhile.

…I am forced into activities that I feel are not helpful.

…Other people label me as incompetent.

…I am never given a chance to do what I want to do.

Example 7 - Beyond Just Treatment Services

Handout:
A one-page sheet on the differences between Treatment Services and Rehabilitation Services.

Guidelines for the Facilitator:
The purpose of this discussion is to help people understand the difference between Treatment Services and Rehabilitation Services and to understand how they complement one another.

We want to look at the difference between Treatment Services and Rehabilitation Services.

Use the sheet on Treatment Services and Rehabilitation Services as the basis for a talk or hand out the sheet to the participants and read through it with the group while asking for examples. Present the Treatment Services first. Then read the sentence:

"A person with severe mental illness wants more than just symptoms relief."

What more do people want than just symptom relief?

After a brief discussion, present the Rehabilitation Services. Then ask the following questions:

What are some of the consequences of mental illness?

Assume there were two doors leading out of this room. One has a sign: "Enter here and get some medication and therapy to help reduce your symptoms." The other door has a sign: "Enter here and get the skills, resources and supports to reach your goals."

What do you think might be going on in each room?

First look at the Treatment Services room; then look at the Rehabilitation Services room.

Which door would you want to enter? Why?

If it does not come from the group, the facilitator needs to remind the group that both kinds of services are necessary. A good quotation is from a person who said, "Treatment Services saved my life. Rehabilitation Services gave me back my life." Usually the shortcoming is on the side of the Rehabilitation Services.

Which of those rooms is more like the programs you are currently going to? (Or for staff, the programs you are currently offering?)

How can you use what we have been discussing to help you further your own recovery?

What would have to happen in our current programs to make them more like what is the "best in both rooms?"

When physical illness has a catastrophic effect on one's ability to function—for example, a stroke—treatment is most often followed by rehabilitation. This enables the person to "recover" as much of her life as possible. Until recently, this rehabilitation dynamic has been missing from the mental health service delivery system.

	Focus	**Purpose**	**Activities**
Treatment Services	The illness and reduction of symptoms	Decrease of emotional distress	Psychiatric diagnosis Medications Psychotherapy
A person with severe mental illness wants more than just symptom relief.			
Rehabilitation Services	The consequences of the illness and the rebuilding of a positive self-image	Provide skills, resources and supports to maintain and sustain independence	Goal setting Skills teaching Resource coordination Supports development

Notes:

Example 8 - I'm Not as Sick as I Have Been Led to Believe

Handout: There is no handout. The topic is presented in a story.

Guidelines for the Facilitator: The purpose of this discussion is to enable people to realize that many of their "limitations" are not from their diagnosis, but from believing what others have told them about people with their diagnosis.

I want to share a story with you that a peer recently shared with me.

Read or share in your own words the following statement to the group and then ask the questions that follow.

> **"A few years ago, my doctor told me that I was pretty much stabilized. My medication seemed to be working. I basically had my symptoms under control. I was able to work a couple of hours a day, and I spent some time each day going to program. He said that it was now up to me to accept the limitations of my illness and stop feeling sorry for myself."**

Why would a doctor tell someone this?

What do you think it meant for this person to "accept the limitations of her illness?"

Let's continue the story.

> **"Then something happened and I realized that I was not as sick, as disabled, as I had been led to believe. I sensed that I could do more than work a couple of hours a day and spent some time each day going to program."**

What does that statement mean? "...that I was not as sick, as disabled, as I had been led to believe."

What do you think might have happened?

What helped this person to see her abilities and potential for growth in a new light?

What changed for this person?

***Someone share a time in your life when you realized that you were not as "disabled as you had been led to believe," and that you could do more with your life.**

**As people share these stories, ask questions that help them to articulate what it was that catalyzed the new realization and how that changed their life.*

How can you use what we have been discussing to help you further your own recovery?

What do we need to do in our programs that would help people here continue to explore what are "real" limits and what are "perceived" limits of their illness?

Example 9 - Taking Care of Oneself

Handout:
A one-page sheet called "Taking Care of Oneself – Fourteen Ways"

Guidelines for the Facilitator:
The purpose of this discussion is to help participants think through ways that they can and do take care of themselves.

Today we want to talk about how we can take better care of ourselves.

Hand out the list "Taking Care of Oneself– Fourteen Ways." After everyone has had time to read through the list, ask the following questions.

Which one caught your attention?

Did any of them surprise you?

Someone pick one of the ways of caring for yourself that you use. Tell us what you do and what it does for you.

Try to get most of the group to share.

What works against your taking care of yourself? What makes it difficult to take care of yourself?

What have you learned about taking care of yourself?

***How do you get yourself to do those things that take care of you when you don't feel like doing them?**

How can you use what we have been discussing to help you further your own recovery?

What do we need to do in our programs to help people take better care of themselves?

Taking Care of Oneself – Fourteen Ways

Do something special for yourself. Have your hair done, go out for dinner or a movie, buy yourself a gift.

Do something that gives you space from the tensions and chaos of life. Go for a ride, take a walk, window shop.

Do something that engages your creativity or talents. Work in a garden, play the piano, write a poem.

Do something that you enjoy or relaxes you. Listen to music, take a hot bath, read a book.

Do something that takes some of the chaos out of your life and gives you a sense of control. Organize your day, create a to-do list, clean your house.

Do something that cuts over old negative self-talk. Practice reality checks, create a Wall of Accomplishments, re-state the actual situation.

Do something that connects you with other people. Go to a support group, phone a friend, join a club.

Do something that connects you with your Higher Power. Go to church, meditate, pray.

Do something that symbolizes a new decision you have made about how you are going to live. Shower and shave each morning, dress for the day, cut out junk food.

Do something that enables you to give of yourself to someone else. Help in a soup kitchen, share with another person how you deal with difficulties, visit a shut-in.

Do something that prevents old patterns from setting in (for example, isolating). Schedule things you need to do, force yourself to make commitments, keep busy.

Do something that challenges your thinking. Read a good book, go to a seminar, take a course.

Do something that helps you reflect regularly on your life. Write in a journal, keep a daily gratitude list, note your week's accomplishments.

Do something that keeps you healthy. Exercise at least 30 minutes a day, maintain a healthy diet, get adequate sleep.

Example 10 – Surrounded by Possibilities

Handout:
A question, "When people are having difficulty seeing 'recovery' as a part of their lives, they need to be surrounded by the possibilities of recovery."

Guidelines for the Facilitator:
This dialogue requires that people spend some time writing their answers. If some people have difficulty writing, the group can work in small groups and report back. The purpose of this discussion is to examine how you change negative self-images when people tend to filter out messages that contradict what they believe about themselves and let in messages that reinforce the existing negative self-image. It is best done after you've done the session on "Creating Program Environments that Promote Recovery."

Today we want to talk about how you change negative self-images.

Put the quote on the wall. Read it or have someone in the group read it.

How would you know if a person was having difficulty seeing recovery as part of his or her life?

What would that person be talking about or not talking about?

How would you know if a staff person was having difficulty seeing recovery as part of the lives of peers they work with?

What would that staff person be doing or not doing?

**Hand out the worksheet and ask people to take a few minutes to individually write five to seven things that could be done. Get individuals to share what they have written. Reflect on which ones may be the most difficult, the easiest, most catalytic, etc.*

How can you use what we have been discussing to help you further your own recovery?

What could we do in our programs here to better "surround everyone with the possibilities of recovery?"

When people are having difficulty seeing recovery as part of their lives, they need to be surrounded with the possibility of recovery.

Participant Worksheet

"When people are having difficulty seeing 'recovery' as part of their lives, they need to be surrounded by the possibilities of recovery."

List 5-7 things you would do to surround staff with the possibility of recovery.	List 5-7 things you would do to surround peers with the possibility of recovery.
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.

Example 11 – Definitions of Recovery and Hope

Handout:
There is no handout. The topic is held in the definitions. The definitions could be written on a large piece of paper and put on the wall, but it is not necessary.

Guidelines to the Facilitator:
There are no special instructions.

We want to spend some time talking about "recovery" and "hope." First, I would like to share a definition of recovery. Recovery is the process of gaining control over one's life—and the direction one wants that life to go—on the other side of a mental illness or substance use diagnosis and all of the losses associated with that diagnosis.

What, for you, are key words or phrases in the definition? Why?

What about a mental illness or substance use diagnosis works against people "gaining control over their lives?"

What has been helpful for you in gaining control?

Now let's look at a definition of "hope."

> **Hope is the belief that one has both the ability and the opportunity to engage the recovery process.**

What are some things that people with a mental illness or substance use diagnosis often do not believe they have the ability to do?

What are some things that people with a mental illness or substance use diagnosis often do not believe they have either the ability or the opportunity to do?

What's the difference in believing you have the ability, but not the opportunity, and believing you have the ability AND the opportunity?

***When you felt like you did not have the ability or opportunity to do what you wanted to do, what helped you move beyond that?**

***What is going on in this program or behavioral health center that works against people believing in themselves?**

How can you use what we have been discussing to help you further your own recovery?

What could we do in this program to increase people's belief that they have both the ability and the opportunity to gain more control over their lives?

Example 12 – Becoming the Person You Want to Be

Handout:
There is no handout. The topic is held in the conversation between Aunt Sophie and Kat.

Guidelines for the Facilitator:
There are no special instructions.

Today we want to talk about "becoming the person you want to be."

The following is an excerpt from a conversation between Aunt Sophie and Kat in Sidney Sheldon's novel, "Nothing Lasts Forever."

> **Aunt Sophie: "...from now on, you are going to stop running away. You know that song they sing on Sesame Street? 'It's not easy being green?' Well, honey, it's not easy being black, either. You have two choices. You can keep running and hiding and blaming the world for your problems, or you can stand up for yourself and decide to be somebody important."**
>
> **Kat: "How do I do that?"**
>
> **Aunt Sophie: "By knowing that you are important. First, you get an image in your mind of who you want to be, child, and what you want to be. And then you go to work, becoming that person.**

What words, phrases or images caught your attention?

What do you think Kat was running away from? What was she hiding from? What was she blaming the world for?

Aunt Sophie substituted "being black" for "being green." What if we substituted "having a mental illness or substance use diagnosis" for "being green?"

Re-read the story.

> **Aunt Sophie: "...from now on, you are going to stop running away. You know that song they sing on Sesame Street? 'It's not easy being green?' Well, honey, it's not easy having a mental illness or substance use diagnosis either. You have two choices. You can keep running and hiding and blaming the world for your problems, or you can stand up for yourself and decide to be somebody important."**
>
> **Kat: "How do I do that?"**

Aunt Sophie: "By knowing that you are important. First, you get an image in your mind of who you want to be, child, and what you want to be. And then you go to work, becoming that person."

Why is that not easy?

What might a person run from, hide from or blame the world for if that person has a psychiatric diagnosis?

Aunt Sophie gave four pieces of advice to Kat.

- **Stand up for yourself.**
- **Decide to be somebody important.**
- **Get an image in your mind of who and what you want to be.**
- **Go to work becoming that person.**

Which of those do you think is the most important?

Which is the hardest?

Get three or four people to answer the next questions.

***Someone share with the group who and what you want to be.**

***What is the work you have to do to become that person?**

Then close with the following question.

How can you use what we have been discussing to help you further your own recovery?

What could we do in this program to help each other become the people we want to be?

Example 13 - Anxiety – A Natural Experience or a Symptom of My Diagnosis?

Handout: There is no handout.

Guidelines for the Facilitator:
The purpose of this dialogue is to help people understand that seeing all emotions as symptoms can possibly intensify the experience. This may be a difficult discussion to get people involved in, but it could be very beneficial.

Today we want to talk about anxiety. Let's start with a dictionary definition.

> **"Anxiety is a state of being uneasy, apprehensive, or worried about what may happen; concern about a possible future event; an abnormal state, characterized by a feeling of being powerless and unable to cope with threatening events."**

What are some of the feelings, physical sensations and emotions that people experience and call "anxiety?"

Let's create a situation to work with.

You suddenly remember that you have a major report due tomorrow. You realize that there is a real possibility that you will not have the report done. You begin to feel very anxious. How do you experience that anxiety? ...Emotionally? ...Physically? ...Mentally?

Try to get the group to be as specific as possible.

Why does the body/mind create these moods, feelings, emotions and physical sensations?

Let the group share their answers around the questions for five or six minutes. If no one mentions it, share with the group that what we call anxiety is the body and mind's "call to examination." Everyone experiences what we call anxiety in situations like the one we discussed.

What is the difference in saying to yourself, "I am being called to examine what is going on in my life," and, "I am beginning to get symptomatic?

Let the group play with this question for a few minutes.

Let's look at some possible scenarios.

> **First scenario:**
> **You believe that your experience of anxiety is the early experience of the symptoms of your psychiatric diagnosis. You suddenly remember that you have a major report due tomorrow. You realize that there is a real possibility that you will not have the report done. You begin to feel very anxious.**

Remember that you believe that your experience of anxiety is the early experience of the symptoms of your psychiatric diagnosis.

How do you experience that anxiety? ...Emotionally? ...Physically? ...Mentally?

The anxiety begins to increase.

What do you begin to think? What is your self-talk? What do you begin to do?

Where is this taking you? What is a responsible action for you at this point?

Second scenario:

> **You believe that your experience of anxiety is the body and mind's "call to examination."**
>
> **You suddenly remember that you have a major report due tomorrow. You realize that there is a real possibility that you will not have the report done. You begin to feel very anxious.**

Remember you believe that your experience of anxiety is the body and mind's "call to examination."

How do you experience that anxiety? ...Emotionally? ...Physically? ...Mentally?

The anxiety begins to increase.

What do you begin to think? What is your self-talk? What do you begin to do?

Where is this taking you? What is a responsible action for you at this point?

What have you learned about the difference in "early warning signs" and the "call to examination?"

What is the value of knowing this?

What might be some of the dangers?

How can you use what we have been discussing to help you further your own recovery?

What could we do in this program to help people better understand and cope with anxiety?

Example 14 - Entitlements

Handout: There is no handout.

Guidelines for the Facilitator:
There are no special instructions.

Today we want to talk about "entitlements."

I want to share with you a statement I overheard someone say.

"I'm entitled to the entitlements that the system owes me."

What are some of the entitlements that this person might believe she is owed by the system?

Where do you think that belief comes from? Why would a person believe that the system owes her something?

What role or function do you believe entitlements play in recovery?

When a person says, "I'm entitled to the entitlements that the system owes me." What role does that belief play in that person's recovery?

What do you believe the system owes you? Why do you believe it owes you that?

How can you use what we have been discussing to help you further your own recovery?

What could we do in this program to help people better understand both the positive and negative roles of entitlements in the recovery process?

Example 15 - I Am More Than My Diagnosis

Handout:
There is no handout.

Guidelines for the Facilitator:
There are no special instructions.

I want to share with you a statement that someone shared with me. A lady made this comment at a behavioral health conference.

> **"For 37 years I knew my diagnosis, but I did not know me. I was afraid if I gave up my diagnosis, I would not know who I was."**

What was this person saying?

What might have happened to cause her to feel that way?

What do you think her life was like for those 37 years?

Would someone share what it is like to see yourself as your diagnosis?

What have you found helpful in seeing that you are more than your diagnosis?

How has that changed your life?

How can you use what we have been discussing to help you further your own recovery?

What could we do in this program to help people see that they are more than their diagnosis?

Example 16 - Learning About One's Diagnosis

Handout:
There is no handout. The topic is held in the book excerpt.

Guidelines for the Facilitator:
There are no special instructions.

We want to talk today about educating oneself about one's diagnosis.

In Vanessa Sawyer's book, "Journey from Madness to Sanity," she writes:

> **"Until I was hospitalized for the second time, I never really believed that mental illnesses were, in fact, serious disorders... Since I had survived two major episodes, I began to take time to learn about this thing called Bipolar Affective Disorder. I read up on the medications, the illness, and different therapeutic alternatives. I also studied the symptoms and outcomes of several cases. I learned that I was not alone, and I could still have a productive life. I studied all I could, because I wanted to be able to effectively live with this illness."**

What caught your attention about her statements?

What do you think caused her to want more knowledge?

***When have you found yourself wanting to know more about your diagnosis?**

***What have you learned and how has that helped you?**

How can you use what we have been discussing to help you further your own recovery?

How could we use this program to help people learn more about their diagnosis?

Example 17 - Impact of Illness

Handout: There is no handout.

Guidelines for the Facilitator:
This dialogue is the first of five dialogues on the Five Stages in the Recovery Process. The dialogues are designed to help people understand the Five Stages and the danger at each stage. They help the group begin to build a common framework, language and imagery for talking about the recovery experience.

We want to spend some time today talking about one of the Five Stages in the Recovery Process.

We want to talk about the "Impact of Illness/Substance Misuse" stage.

You may want to write this statement on a flip chart.

We will talk about the other stages in our next sessions together.

The impact that a mental illness/Substance Misuse can have on a person's life can be very devastating. Patricia Deegan describes the onset of a mental illness as "a catastrophic shattering of one's hopes, dreams and expectations." This shattering can also apply to substance use. If you think of this time as the time from when a person first begins to experience what we call psychiatric symptoms or the time when drinking or drugging has taken over a person's life through the time of getting a diagnosis and some relief, what words or phrase would you use to describe this time in a person's life?

Why does a person often give up or reduce his hopes, dreams and expectations after getting a mental illness/substance use diagnosis?

The greatest danger is that a person begins to see himself differently, in a negative way. His identity gets tied up in his diagnosis? Why does this happen?

What does it mean to begin to see yourself as your diagnosis? What is that like?

What does the following statement mean? "Re-defining oneself in mental illness or substance misuse terminology automatically limits one's beliefs as to what he can or will be able to do."

You may want to use this quotation as a handout or have it written in big block letters so you can put it on the wall.

Would someone who has experienced what we've been talking about share what this time was like for you?

The next question is where you want to spend most of your time. Get as many people to share as possible. Push for what other people actually did and how it helped.

***What helped or would have helped you begin to see yourself in a more positive manner?**

How can you use what we have been discussing to help you further your own recovery?

What could we do in this program/at this agency to help reduce the negative impact of a mental illness/substance use and help people see that there is life after diagnosis?

Example 18 - Life Is Limited

Handout:
There is no handout.

Guidelines for the Facilitator:
This dialogue is the second of five dialogues on the Five Stages in the Recovery Process. The dialogues are designed to help people understand the Five Stages and the danger at each stage. They help the group begin to build a common framework, language and imagery for talking about the recovery experience.

We want to spend some time today talking about another one of the Five Stages in the Recovery Process.

Last time we talked about the "Impact of Illness/Substance Misuse" stage. Today we want to talk about the "Life Is Limited" stage.

You may want to write this statement on a flip chart.

This is that time when a person has resigned herself to a life without possibility of anything ever changing. She has at some level decided that her life as she has known it is over. She has no future. She gives into a "limited life" of living on benefit checks, going to program, watching TV, etc. She may believe that she will never be able to work, get an education, live on her own, have significant relationships or have a lot of friends.

She has the tendency to think of herself as a "mental patient or hopeless addict" without a real future.

Why does a person often live for years in the behavioral health system without seeing any possibility for having a different life? What is going on that would cause this?

The danger is that she begins to resign herself to the belief that this is her life. She becomes very negative about her future. Patricia Deegan says, "When one lives without hope—when one has given up—the willingness to 'do' is paralyzed as well."

You may want to use this quotation as a handout or have it written in big block letters so you can put it on the wall.

What is it like to live without hope, to not see any possibility for your life?

Would someone who has experienced what we've been talking about share what this time was like for you?

The next question is where you want to spend most of your time. Get as many people to share as possible. Push for what other people actually did and how it helped.

***What helped or would have helped you begin to see your future in a more positive manner?**

How can you use what we have been discussing to help you further your own recovery?

What could we do in this program/at this agency to help people see their life is not so limited, that there is possibility for them?

Example 19 - Change Is Possible

Handout: There is no handout.

Guidelines for the Facilitator:
This dialogue is the third of five dialogues on the Five Stages in the Recovery Process. The dialogues are designed to help people understand the Five Stages and the danger at each stage. They help the group begin to build a common framework, language and imagery for talking about the recovery experience.

We want to spend some time today talking about another one of the Five Stages in the Recovery Process.

We have talked about the "Impact of Illness/Substance Use" stage and the "Life Is Limited" stage. Today we want to talk about the "Change Is Possible" stage.

You may want to write this statement on a flip chart.

This is the time when a person who has been stuck in the behavioral health system for years begins to realize that her life doesn't have to be this way. Something happens that causes her to see that her life can be more than she thought it could be. It is the realization that "I am not as sick, as disabled, as everyone has told me I was. "Maybe I could get sober or clean. Maybe I could go back to school. Maybe I could work part-time. Maybe I could live in my own apartment. Maybe I could have a life.

What is that awareness like? What was it like for you?

The danger is that when a person sees that she will need to take some risks and move out of her "comfort zone," she begins to question her ability to do this.

Why does a person often talk herself out of doing what she says that she wants to do? What is going on that would cause this?

Would someone who has experienced what we've been talking about share what this time was like for you?

The next question is where you want to spend most of your time. Get as many people to share as possible. Push for what other people actually did and how it helped.

***What helped or would have helped you decide to take some risks?**

How can you use what we have been discussing to help you further your own recovery?

What could we do in this program/at this agency to encourage people to move out of their comfort zones and take more risks?

Example 20 – Commitment to Change

Handout:
There is no handout.

Guidelines for the Facilitator:
This dialogue is the fourth of five dialogues on the Five Stages in the Recovery Process. The dialogues are designed to help people understand the Five Stages and the danger at each stage. They help the group begin to build a common framework, language and imagery for talking about the recovery experience.

We want to spend some time today talking about another one of what we call the Five Stages in the Recovery Process.

We have talked about the "Impact of Illness/Substance Misuse" stage, the "Life Is Limited" stage and the "Change Is Possible" stage. Today we want to talk about the "Commitment to Change" stage.

You may want to write this statement on a flip chart.

This is the time when a person decides to take a risk and move out of his comfort zone. Often this can be a very scary time, especially if you have been sitting in your comfort zone for a long time - doing nothing to improve or change your life.

What is it like when a person first begins to move out of his comfort zone – to decide to make some changes?

Often this involves taking steps or doing things that don't necessarily "move you toward a goal," but they do break the pattern of doing nothing. Patricia Deegan talks about this as a time of "small triumphs and simple acts of courage." What were some of your small triumphs and simple acts of courage?

The danger is that a person will not know all of the supports he will need to have to be successful. He will move out too quickly, he will not succeed and will retreat back into his comfort zone within the system.

Why does a person often not know what supports are needed or not get the support from others that he feels he needs? What is going on that would cause this?

Would someone who has experienced what we've been talking about share what this time was like for you?

The next question is where you want to spend most of your time. Get as many people to share as possible. Push for what someone else actually did and how it actually helped.

***What helped or would have helped you understand and get the support that you needed to succeed?**

How can you use what we have been discussing to help you further your own recovery?

What could we do in this program/at this agency to help people get the support they need to succeed at whatever they want to do?

Example 21 – Actions for Change

Handout:
There is no handout.

Guidelines for the Facilitator:
This dialogue is the fifth of five dialogues on the Five Stages in the Recovery Process. The dialogues are designed to help people understand the Five Stages and the danger at each stage. They help the group begin to build a common framework, language and imagery for talking about the recovery experience.

We want to spend some time today talking about the last of what we call the Five Stages in the Recovery Process.

We have talked about the "Impact of Illness/Substance Use" stage, the "Life Is Limited" stage, the "Change Is Possible" stage and the "Commitment to Change" stage. Today we want to talk about the "Actions for Change" stage.

You may want to write this statement on a flip chart.

This is the time when a person decides to make a major change in his life. Often this involves creating relationships and getting involved in activities outside of the behavioral health system so that his "mental illness" is not the central focus of his life. As he moves more of his life outside of the mental health system, he has to take more and more responsibility for his own decisions.

What is it like to decide that you are finally responsible for your own life, to move away from the comfort of and dependency on the behavioral health system?

What are some of the issues and concerns that people have when they do this?

The danger at this stage is that he will begin to doubt his own decision-making abilities and his ability to function on his own. Then he may decide he can't function without the supports of the mental health system and revert back to a life lived within the confines of the mental health system.

Why does a person often begin to seriously question his ability to make major changes that involve letting go of the system, creating relationships and getting involved in activities outside of the behavioral health system? What is going on that would cause this?

Would someone who has experienced what we've been talking about share what this time was like for you?

The next question is where you want to spend most of your time. Get as many people to share as possible. Push for what someone else actually did and how it actually helped.

How can you use what we have been discussing to help you further your own recovery? *What helped or would have helped you create a life outside of all of the "supports" of the behavioral health system?

What could we do in this program/at this agency to help people lessen their dependency on the behavioral health system and get more involved in the community at large?

Example 22 – Moving on with One's Life

Handout: A list of 13 things that help people move on with their lives.

Guidelines for the Facilitator:
This dialogue uses 13 skills/abilities that many people have found helpful in their recovery. The purpose of this dialogue is to provide an opportunity for people to share what they have found helpful and where they need to move next to strengthen their recovery. Remember the asterisk is when you want to spend the most time. You can move through the first four questions rather quickly – getting responses from 2-3 people for each question. The fifth question sets up the asterisk question and you can get a few more people to respond. When someone answers the first question of the three-part asterisk question, ask that person the next two questions.

Introduction: Today we want to talk about how you move on with your life after being diagnosed with a mental illness.

Pass out the handout for this dialogue. Have someone(s) read the list or have the group read the list in unison or give the group time to read the list individually.

Questions:

Which one caught your attention?

Which do you believe have to be in place for a person to be in recovery? Why those?

Which do you believe do not necessarily have be in place for a person to be in recovery? Why those?

Which, in general, are the most difficult to get into place? Why?

Which, in general, have been the most important for you to get into place? Why?

***If you were to prioritize them for yourself, which 2-3 do you need to work on or strengthen? Why? What might that look like?**

We have been discussing what is helpful in moving on with one's life for the past 1520 minutes, what are 2-3 things you will take from this discussion that will help you in your own recovery?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to help people see it's possible to move on with their lives?

Moving on with One's Life

The ability to move on with one's life on the other side of receiving a mental health diagnosis is strengthened when a person…

…has a means of controlling the intensity of their symptoms. (SYMPTOM CONTROL)

…has a good understanding of their diagnosis. (KNOWLEDGE)

…has a plan for monitoring and managing their wellness. (WELLNESS PLAN)

…has a belief that they can move on with their life. (HOPE)

…has a sense of meaning, purpose and connection in their life. (SPIRITUALITY)

…sees themselves as more than their diagnosis. (POSITIVE SELF-IMAGE)

…has a strong network of support. (SUPPORT NETWORK)

…is in touch with their hopes and dreams. (PERSONAL GOALS)

…has their basic needs met. (ECONOMIC STABILITY)

…takes responsibility for their decisions and actions. (PERSONAL RESPONSIBILITY)

…is able to effectively manage their physical health conditions. (PHYSICAL HEALTH)

…has opportunities to make choices about their daily activities. (CHOICES)

…has the ability to clearly communicate their needs and wishes. (SELF-ADVOCACY)

Example 23 -The Power of Words

Handout: There is no handout

Guidelines for the Facilitator:
The purpose of this Recovery Dialogue in to talk about the positive power of words to motivate and sustain people in the recovery process. The focus is on the power of words as they show up in affirmations, inspirational quotations and help individuals decide which one(s) they choice to prioritize in their own life. ***It is very important as the facilitator to have a number of examples to share with the group at appropriate times.***

Today we want to talk about the power of words as they show up in affirmations, quotations and famous sayings.

<u>Questions:</u>

What are some saying you remember from childhood? A couple for me are… *(The facilitator needs to have a couple of examples to share with the group to get the discussion started.)*

What are some you remember? *(Get out examples from about ½ of the group.)*

What are some of your favorite sayings of quotations? I like… *(The facilitator needs to have a couple of examples to share with the group to get the discussion started.)*

What are some affirmations or quotations that have been helpful in motivating and sustaining you on your recovery journey? *(Again, the facilitator needs to have a couple of examples to share with the group to get the discussion started if it is needed.)*

* **If you could pick one affirmation or quotation to put in a prominent place in your living or work space so that you saw it every day - maybe even multiple times – what would that quotation or affirmation be?** *(The facilitator needs to have a couple of examples to share with the group to get the discussion started. After each person shares, ask one or more of the following questions.)* **Why that one? Why is that statement important to you at this time? What do you hope would be the benefit?**

How can you use what we have been discussing to strengthen your own recovery? What is something you take away from this discussion?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to help people surround themselves with positive messages?

Example 24 -Assessing Community Resources

Handout: There is no handout

Guidelines for the Facilitator:
Many people have found that being able to access community resources has helped them get back or move on with their life. Yet this is often not easy to do. This Recovery Dialogue explores some of the challenges people face in accessing community resources and what people have found helpful.

Introduction:

Welcome. Today we want to talk about accessing community resources.

Questions:

What do you think of when you hear the term 'community resources'?

What are some examples of community resources? *(Take a few minutes to get out a list of some of the most common. Make sure you get out some that are common to everyone, not just people in the behavioral health system – churches, libraries, etc.)*

What are some community resources that you have found helpful in your recovery? *(Get out examples from about ½ of the group? When a person shares a resource they found helpful, ask…* **What did that community resource help you do? What role did it play in your recovery?**

***What are some of the challenges people face in accessing community resources?**

***What have you found helpful in dealing with these challenges?**

We have been talking about accessing community resources for the past 15-20 minutes. What has been helpful? What will you take away from this discussion?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to help people access the community resources they need?

Example 25 -Self-Advocacy

Handout: Quotation – Write on flip chart.

"Be strong enough to stand alone; Smart enough to know when you need help; and Brave enough to ask for it." (Source unknown)

Guidelines for the Facilitator:
Often people do not get what they want or think they need because they do not know how to advocate for themselves. The purpose of this Recovery Dialogue is to explore the concept of self-advocacy and have people share how and when they were successful at doing this.

Introduction:

Welcome. Today we want to talk about self-advocacy

Questions:

What does the term 'self-advocacy' mean? *(Work with the group until you feel they have a clear understanding of the term. This may happen quickly or it may take a few minutes.)*

We hear a lot about important issues in our communities and around the world. Can you think of an event or issue where advocacy by one person or many has helped bring about a positive outcome? *(Get out 2-3 events or issues. Examples – climate change – Al Gore, specific types of health exams – Katy Couric. If someone mentions an event or issue that others in the group do not know about, ask them to explain the event and who was doing the advocacy and what was they outcome.)*

Let's take a minute to think about self-advocacy and how it can and does impact our lives. Was there ever a time when you needed something or needed help and did not get it because you did not let your need be known? Take a few seconds to think about that time. How did it make you feel? *(Get out responses from about ½ of the group.)*

Can a few people share a time when you advocated for yourself and your needs were met? What was the situation and what did you do? (Try to get out 45 examples.)*

How can you use what we have discussed today to help you advocate more for yourself?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to support people in learning to advocate for themselves?

Example 26 -Gratitude

Quotation: – **"It is not happiness that brings us gratitude. It is gratitude that brings us happiness."** (Author Unknown)

Guidelines for the Facilitator

The purpose of this Recovery Dialogue to talk about the power of gratitude in the recovery process. It is designed to help individuals to recognize the positives and how gratitude can re-direct our focus when we are becoming negative. As the facilitator, you need to have examples to share with the group at appropriate times.

Introduction:

Welcome. Today we want to talk about gratitude. *(Read the quotation – You may want to have a printed copy as a handout or have it written on a flip chart.)*

"It is not happiness that brings us gratitude. It is gratitude that brings us happiness."

Questions:

What does it mean to be grateful?

What is something you are grateful for from your past? *(Get out examples from about ½ of the group. The facilitator may use an example of their own to spur the discussion.)*

What is something you are grateful for today? *(Get out examples from about ½ of the group.)*

What impact does being grateful have on you?

* **What are some challenges that stand in the way of you being grateful?**

* **What have you learned that helps you stay in an attitude of gratitude? What are ways you remind yourself to be grateful?**

What are ways being more grateful can further your own recovery? What is something you can take away from this discussion?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to support people is seeing the power of gratitude and to be more grateful?

Example 27 -Negative Self-Talk

Handout: One page of negative self-talk statements and negative messages that reinforce negative self-talk

Guidelines for the Facilitator:

*Everyone has negative thoughts about themselves. Many people receive negative messages that reinforce their negative self-talk. Negative thoughts are not the problem. The problem is when they continue to the point that we believe them and they have a negative impact on our recovery. The purpose of the Recovery Dialogue is to help people recall what they have learned about reducing the negative impact. Remember you want to spend most of your tie on the *question.*

Introduction:

Welcome. Today we want to talk about negative self-talk.

Questions:

(Hand out the one-page of negative messages from other people and the negative selftalk statements.) **What are some of the statements on the flyer reflect negative self-talk? Which one's are negative messages from the outside? What is the difference in the two?** *(Make sure the group sees the difference.)*

The two definitely impact each other, but we want to focus this discussion on the negative self-talk. How have you seen negative self-talk effect a person's recovery? *(Get responses from about ½ of the group.)*

How or when has your negative self-talk kept you from achieving your goals? How has it worked against your recovery?

What have you learned about handling or reducing the impact of your negative self-talk on your recovery? (This is where you want to spend most of your time. When people answer this question, ask additional questions like – "How does this help?" "Give me an example of when and how you do this."*

How has our discussion helped you in dealing with your own negative selftalk? What is one thing you will take away from this discussion?

(If everyone is in the same program, you may close by asking the following question.)

What could we do in this at this agency to help people with their negative self-talk?

Handout for Negative Self-Talk Recovery Dialogue

I will never be able to do that.

She won't be able to live outside of the hospital.

Recovery for these people is just not possible.

You can't even shop for yourself.

You will never be able to function in the community.

I will never be able to hold down a real job.

You will never be able to live independently.

I don't want to try, because I know I will fail.

My mother was right. I will never amount to anything.

Nobody will hire me. I have two felons and have been in prison.

I am just a drunk, and will always be a drunk.

She is lazy, unmotivated and doesn't want to lose her check.

I am so stupid!

He is schizophrenic. He will never be able to live alone.

Personality disorders are worse than schizophrenics!!

Frequent Flyer!! She will be back here in less than a week.

I never can do anything right!

Example 28 -The Power of Words

Handout: Story about the Thai boys' soccer team trapped in the Thailand cave.

Guidelines for the Facilitator:
The purpose of this Recovery Dialogue in to talk about how feeling trapped can affect everything we do. Focus on how we can all feel trapped at times and that we have experiences and skills to handle situations that seem out of our control.

Introduction:

Welcome. Today we want to talk about self-care. *Pass out the article for everyone to read, ask someone from the group to read or read it aloud as the facilitator. Don't get caught up in arguing about the facts of the story. Stick with the part of the story that they were trapped. They did not know if anyone even knew where they were. They did not know anything they could do to get out or to make contact with anyone outside the cave.*

Questions:

First, I want us to focus our discussion on the first 10 days before they were discovered. What do you think it felt like for the boys and their coach to be trapped in the cave?

You may have never been trapped in a cave, but have you ever felt trapped or in a situation that was out of your control? *(Not looking for details at this point. You are only looking at how this relates to the experience of the boys.)* **What were some of the feelings you experienced?**

***What actions have you taken to care for yourself in situations where you felt trapped or not in control?**

***What have you learned about yourself in handling these situations?**

What are ways you could prepare to handle a future situation?

How can you use this wisdom in your own recovery?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to support people in taking care of themselves?

Example 29 -Triggers

Handout: There is no handout

Guidelines for the Facilitator:
*The purpose of this Recovery Dialogue is to talk about our awareness of and the actions we take to address our triggers and not as much about the triggers themselves. Try to keep the discussion focused on the actions. Remember that the focus of the Recovery Dialogue with be on the *question.*

Introduction:

Welcome. Today we want to talk about triggers. The dictionary defines triggers as – "Something that causes an intensive and usually negative emotional reaction."

Questions:

What is meant by the term triggers as used in the behavioral health system *(You want to be sure everyone understands what we are talking about.)*

What are some common triggers? *(You are looking for general answers here. You could also phrase it as "what are some things that could trigger a person? Have some examples ready to share if the group isn't able to give some answers.)*

It seems that everyone has experienced being triggered by something.

* **What are some ways you have learned to cope with situations that may trigger you? What ways have you learned to handle your triggers?**

How has talking about triggers today helped you realize ways to handle future triggers?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to help people deal with situations that might trigger them?

Example 30 -The Power of Thoughts

Handout: List of Quotations on the Power of Thought

Guidelines for the Facilitator:
The purpose of this Recovery Dialogue is to enable reflection on

Introduction:

Welcome. Today we want to talk about the power of our thoughts. *(Hand out the one-page list of quotations and read or have someone read them.)*

Questions:

Which one or ones have you heard before?

Which one especially caught your attention?

Is there one that you would add?

What are some examples of 'stinking thinking' or thinking that is not helpful?

When has your thinking got you in trouble?

***What have you learned about controlling your thoughts that has been helpful in your recovery?**

How can you use what we have been discussing to strengthen your own recovery?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to help people get better control of their thoughts?

Handout - List of Quotations on the Power of Thought

The mind takes what you focus it on as an invitation to bring it into being. (Bill Harris)

Your worst enemy cannot harm you as much as your own unguarded thoughts. (Buddha)

Your situation may endanger your life and limbs, but only your thoughts can endanger your happiness. (Martha Beck)

Whether you think you can or can't, you are probably right. (Henry Ford)

What you focus your energies on, you give power to. (Ike Powell)

Stinking thinking. (Alcoholics Anonymous)

As a man thinketh, so he is. (Proverbs)

Thought is the ancestor of every action. (Author Unknown)

Your thoughts determine your behavior. (Author Unknown)

Your thoughts are the birthplace of your actions. (Author Unknown)

We become what we contemplate. (Author Unknown)

There is a magnetic force in thoughts. (Author Unknown)

What you think about, you bring about. (Author Unknown)

Change your thoughts, change your life. (Author Unknown)

Example 31 'Failures' – Road Blocks or Stepping Stones?

Handout: There is no handout

Guidelines for the Facilitator:
The purpose of this Recovery Dialogue is to explore why some people see small defeats and a challenge and others see to be devastated by them and what they have found helpful in moving through small road blocks.

Introduction to the Dialogue:

I want to share with you an experience that comes a peer specialist at a behavioral health center. One of the clinical staff said to the peer specialist, "You have struggled with a mental illness. I hope you can help me understand what is going on with one of my clients. I have a client that is currently willing to try some new things, but at the least little set-back, he says "See, I told you I couldn't do that. I am such a failure!" Then he would become very depressed for a few days. Soon he would come around and try again. But the same thing happens."

The staff member added, "I don't understand what's going on. He takes every little set-back so seriously. I am afraid he is going to just stop trying and crawl back into his hole. Why does he let such little things get him down?"

Questions:

What caught your attention in that story?

What was going on with the staff person?

What was going on with the peer?

Why is it that some people – when things go wrong, seem to bounce back while others quickly start seeing themselves as big failures?

***From your experience, what would be helpful to break this cycle of taking a small step, not succeeding, seeing oneself as a failure and crawling back into your comfort zone?**

How can you use what we have been discussing to strengthen your own recovery?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to help people see possible failures as stepping stones and not road blocks?

Example 32 - Consumed by the System

Handout: There is no handout

Guidelines for the Facilitator:
The purpose of this Recovery Dialogue how the behavioral health system is different from most health systems and the power of that system to take over peoples' life so they have no life outside of the system and the services they are receiving.

Introduction:

Today we want to talk about the power of the behavioral health system to take over your life.

I want to share with you a conversation between two consumers. It went something like this. One said that she 'entered the mental health system' five years ago when she was diagnosed with bi-polar illness. The other said that she had been a part of the mental health system since she was 17.

Questions:

What were they saying? What does it mean to 'enter the mental health system' or 'be a part of the mental health system'?

Have you ever heard anyone say "I entered the heart system 5 years ago when I had my first heart attack" or "I have been in the diabetes system since I was a teenager"?

What's the difference? Why do we talk about the mental health system this way, but don't talk about other health systems like this? What is the difference?

What is it about the mental health system that seems to suck you in so that it seems to take over your life?

***Why is it so difficult to move parts of your life out of the system? What have you found helpful in doing so?**

How can we use what you have been talking about to strengthen your own recovery?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to support people in not letting the system take over their lives?

Example 33 - Taking Control

Handout: There is no handout

Guidelines for the Facilitator:
This Recovery Dialogue can be used to set up a WRAP training or for people who are not familiar with WRAP.

Today we want to talk about taking control of your health and wellness.

Recovery involves learning to monitor and manage those factors that impact your health and wellness.

What does it mean to monitor something?

What does it mean to manage something?

What is the difference?

Think of the dashboard of a car.... What are some of the gauges that are monitor the system?

What are some of the actions you can take to manage?

What happens when you ignore the gauges or warning signs?

What are some of the gauges on your health and wellness dashboard?

***What are some things you monitor relative to your health and wellness?**

***What are some of the actions you take to manage?**

What happens when you ignore the gauges or warning signs relative to your health and wellness?

How can you use what we have been discussing to strengthen your own recovery?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to help people begin to monitor and manage their health and wellness better?

Example 34 – The Power of Connection

Handout: Two quotations – write them on a flip chart

Guidelines for the Facilitator:
This Recovery Dialogue gives people an opportunity to talk about those times in their lives when then have really felt connected to another person, the benefits of that connection and what they have found helpful in making connection.

<u>Introduction</u>:

Today we want to talk about connecting with another person. In order to start I want to share with you two statements. One is a general statement about connection. And the other is a definition of connection.

The first – "There is a deep yearning in the human heart for connection." I don't know who first said that, but I think it is true.

Second – the best definition of connection that I have heard comes from the researcher/writer, Brene Brown.

"I define connection as the energy that exists between people when they feel seen, heard, and valued; when they can give and receive without judgement; and when they derive sustenance and strength from the relationship."

<u>Questions:</u>

What words or phrases caught your attention in either of those statements?

What helps people make the kind of connection that Brene Brown talks about?

What is the benefit of that kind of connection?

I want a few people to share a time when you experienced that kind of connection?

What works against really connecting?

***Finish this statement – If you want to be able to connect with another person, be sure not to -**

***If you want to connect with another person, you need to------**

How can you use what we have been discussing to strengthen your own recovery?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to help people have relationships that sustain and strengthen them?

Example 35 – Beginning to Dream Again

Handout: Quotation

Guidelines for the Facilitator:
This Recovery Dialogue focuses on what seems to happen when a person is first diagnosed with a mental illness. They believe that their life is over as they had known it and they have to give up their hopes and dreams and may even give up their ability to dream. This dialogue is used in this training because it is the assumption that it also applies to a person when they first realize that drugs or alcohol has taken over their life.

Introduction: *Share the following quotation as a handout or writing it on a flip chart.*

Today we want to talk about moving on with one's life. First, I want to share a statement made by a woman who was living with a mental illness. She said, "When I was first diagnosed with a mental illness, I gave up my hopes and dreams. Eventually I gave up my ability - and even my willingness - to dream." (This also applies to a person when they first realize that drugs or alcohol has taken over their life.)

Questions:

What did this person mean by this statement? What might be some of the 'hopes and dreams' that she gave up?

What are some of the hopes and dreams that you gave up when you were first diagnosed with a mental illness?

What's the difference in giving up your hopes and dreams and giving up your ability and/or willingness to dream?

***When you had given up the ability and/or the willingness to dream, what helped you dream again?**

How can you use what we have been discussing to strengthen your own recovery?

(If everyone is in the same program, you may want to close by asking the following question.)

What could we do in this program/at this agency to help people begin to dream again?

Part 7 – Closing Reflection

Give the group an opportunity to ask questions and make any necessary comments. Then go over the review questions.

Part 8 – Review Questions

1. What is a Recovery Dialogue and how does it differ from a mutual support group?

2. What is the structure of a Recovery Dialogue?

3. What is the role of the facilitator in the Recovery Dialogue?

Session 15

Effective Listening & the Art of Asking Questions

It is important to listen and help people who have been “disabled” by the old system. Help them get in touch with their passion and potential for creating the life they want.

Session 15 demonstrates effective listening and the art of asking questions. The session will focus on helpful questions so a person can connect with their own inner wisdom.

Session Overview

This session has seven parts:

1. Definition of Effective Listening
2. The Art of Asking Questions/Activity
3. Roadblocks to Listening/Activity
4. Five Stages in the Recovery Process Exercises
5. Igniting the Spark of Hope
6. Guidelines for Using Your Lived Experience
7. Demonstration Role-Play
8. Practice Role-Play
9. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain what is meant by "effective listening."
- Explain the six steps in "Igniting the Spark of Hope" process.

Part 1 – Definition of Effective Listening

Quotation 1

If you listen to the person long enough, not only will they tell you the diagnosis, but you will also learn the best way to deal with the problem.

Quotation 2

When someone truly listens to me and does not interrupt with judgments, criticisms, stories of their own, or even good advice, I feel better and often figure out what I need to do for myself.

If listening is so important, why is it hard to really listen to another person?

What is "Effective Listening?"

There is a difference between listening and what we define as "effective listening." Effective listening has to do with knowing what we are listening for.

If I am going to help someone make positive changes, I need to understand that person's self-story. In recovery work, we listen for what a person believes about himself and his current situation (self-talk), what he believes would make his life better (goals), and why he believes he can't have that life (barriers). You are listening for how the person talks about his situation and what they see as the options. This is the person's self-story.
Change the story, change the person.

What you are listening for is what you often hear. Questions are an important way to help the other person share his story.

Part 2 – The Art of Asking Questions

Quotation 3
by Parker J. Palmer

I am convinced that we shut down communication and destroy trust more often by trying to "help" the person with a problem than by any other means…We all know that for life's most difficult problems, the only real answers come from within. We want only one thing from others—simply to be heard. I insist on a simple ground rule in the small groups: in response to what you hear from each other, give each other the gift of honest, open questions; questions that come from deep attentiveness, questions that have no other purpose than helping the speaker listen more deeply to his or her inner truth.

He identifies 3 helpful kinds of questions:

- Honest and open questions.
- Come from deep attentiveness.
- Have no other purpose than helping the speaker listen more deeply to his or her inner truth.

What is an honest question?

What is a question that comes from deep attentiveness?

What is a question that will help a person listen to their inner truth?

Practice Activity – Changing Closed-Ended Questions to Open-Ended Questions

This activity focuses on the importance and benefit of using open-ended questions during peer interactions. With open-ended questions, peers are not limited to "yes" or "no" answers.

The open-ended questions encourage the peer to give more detailed and genuine answers. Open-ended questions allow you to learn more about the peer and to evoke change talk.

Using the worksheet, change the closed-ended questions into open-ended questions.

Closed-Ended Questions	**Open-Ended Questions**
"Are you feeling better today?	What have you been doing that has helped you manage your anxiety this week?
Did you miss your last appointment?	
Do you think that is a good idea?	
Do you ever want to come off probation?	
Are you taking your meds?	
Do you have a support network?	

Part 3 – Roadblocks to Listening

When talking with someone most people have this almost irresistible urge to want to tell them how to fix it or what they need to do, or to try and make them feel better by telling them that "it will all be OK."

The title of this session is Effective Listening and the Art of **ASKING QUESTIONS**, not the art of having answers. It is not our job as peer specialists to have the answers but instead to ask questions.

Our intention may be to help, but these actions create barriers or roadblocks that can interrupt their process of working through the situation. Major roadblocks include:

Fixing

- People are not broken.
- Fixing something for a person only robs them of the opportunity to gain new skills and confidence.
- Any kind of lecturing and/or parenting (real or perceived) represents a power relationship.

Judging

- Understand that resistance is a part of the process.
- Determining that a person's behavior is wrong fails to acknowledge the fact that the individual has some unseen, yet valuable reasons for their behavior.

Words

- Strength robbing phrases include – You should… You need to… You can't…
- One of the most strength-robbing phrases - "My advice to you is."

Statements NOT to use:

- That's not right…"
- You shouldn't feel that way."
- "I know exactly how you feel."

Statements that you should definitely avoid:

- "You should…" Telling someone what to do
- "You are…" Being judgmental
- "You did…" Blaming

What are some roadblock-inducing phrases you have heard?

Activity: What makes a good listener?

In this activity, reflect on a past problem and think about the person that you turned to for help. What qualities and behaviors did that person have?

1. What was it about the person that made you choose them?

2. What specific aspects of their personality or behavior did you find helpful?

3. What did they say or do that may have helped you relax and encouraged you to confide in them?

Think about a recent secret or problem that they shared with another person. We will not be discussing the secret or the person who helped. We only want to reflect on these three questions.

Question – 1:

What was it about the person that made you choose them?

They were:

☐ Open	☐ Sincere	☐ Warm
☐ Honest	☐ Kind	☐ Approachable
☐ Friendly	☐ Patient	☐ Interested
☐ A good listener	☐	☐

Question – 2:

What specific aspects of their personality or behavior did you find helpful?

☐ Open to me and my views.	☐ Interested in me and what I had to say.
☐ Listened to what I had to say.	☐ Treated me seriously.
☐ Gave me their undivided attention.	☐ Respected me.
☐ I knew I could trust them.	☐

Question – 3:

What did they say or do that may have helped you relax and encouraged you to confide in them?

☐ Reassured me that it is not unusual to feel this way.	☐ Asked me questions that helped me clarify the issue.
☐ Listened to me in a focused manner.	☐ Didn't tell me what to do.
☐ Didn't interrupt me.	☐ Gave me lots of reassurance.
☐ Let me make my own decision.	☐

Part 4 – Five Stages in the Recovery Process Exercises

Listening Exercise

Stage - The Impact of the Illness

The role of services is to decrease the emotional distress and communicate that there is life after…

Listening Exercise: Role play working in pairs, with one person as the peer and the other person as the peer support specialist. The "peer" will talk about challenges or difficulties related to the illness.

The peer support specialist will listen and ask open-ended questions, allowing the peer to answer for as long as they see fit until you go to the next open-ended question. Give the peer your full attention. Remember a few things that the peer said so that you can give a reflection or a summary.

NO confronting, correcting, interrupting, fixing, or telling.

LISTEN – with the goal of understanding. No facial, hand, or other body expressions that might be related to judgment. No asking "why" questions unless needed for clarification.

Examples of open-ended questions:

- "What bothers you most about…?"
- "How would you like things to be different?
- "How does this…help (or hurt)?"
- "Where would you like things to go from here?"

What were some of the things that the Peer Specialist heard?

What were some good questions that the Peer Specialist asked?

Reframing Exercise

Stage – Life is Limited

The role of services is to instill hope, develop a sense of possibility, and help rebuild a positive self-image so that the peer can review and evaluate options.

Reframing Exercise: Think about the statements people make about themselves. Statements that help create the shame which can keep the peer from seeing possibilities of change or a better life. The goal of this activity is to "reframe" those statements. Reframe means to see something in a new and less negative way.

Reframe the negative statements people make about themselves. In your role as peer support, help the peer gently move away from negative statements that reinforce the stigma or shame.

Statement 1. "I will never be able to work."
Reframe:

Statement 2. "I am bipolar."
Reframe:

Statement 3. "I'm homeless."
Reframe:

Statement 4. "I'm a loser."
Reframe:

Your turn. Think of one negative statement you have used (or still use) and reframe it.

Statement 5. _____

Reframe 5

Thinking through risk

Stage – Change is Possible!

The role of services is to help a person to see that she is not so limited by the illness. To move forward, she will need to take some risks.

Although the flame of hope and courage may be fragile, and she may be questioning the power of the illness over her – there is more to this story. They just are not sure if they can. The person is not "ready" but thinks just maybe I can… The role of the peer specialist is to help them decide if it is important enough to take the risk and to talk through what it would take to build their confidence.

Exercise
Role play with a peer. Allow them to talk about a big change they would like to make.

Use the importance ruler to find out if they think this change is important enough to put in the effort and take the risks. Often, if the importance level is less than a 4, the person may not be ready. You can also measure readiness by asking follow-up questions.

The Importance Ruler

How IMPORTANT is it to you right now to make this change?

Not important at all Most important

0	1	2	3	4	5	6	7	8	9	10

Follow-up question: Why did you choose a "___" instead of a higher number?

Other follow-up questions:

1.

2.

3.

Next, ask them about their confidence in making the change. Again, ask the follow-up question about their confidence level.

You are allowing your person to "think out loud" while they talk to you. Listen for what resources and support they think they might need to be successful.

The Confidence Ruler

How SURE are you right now that you want to make this change?

Not sure at all Very sure

0	1	2	3	4	5	6	7	8	9	10

Try a follow-up question:

Why did you choose _____?
And not _____?
What would help you be more confident and move from a "__" to a "__"?

Asking this follow-up question helps the person think about lower and higher levels of confidence about the change they are trying to make.

If their confidence level is less than a "5" for this change, consider asking "What else can you do that will help you toward this change?" Remember…small steps can lead to big change.

Other follow-up questions:

1.

2.

3.

Strength Development Strategies

Stage – Commitment to Change

The role of services is to help the person take the initial steps. He will identify his strengths and needs, in terms of skills, resources, and supports.

Building resilience takes small acts or simple acts of courage. Big changes are many small progressive changes. A progressive change is not a straight-line change. This is how we learn new skills, especially complicated skills. Important and meaningful changes involve starts, stops, sometimes moving backward, and then moving forward again.

Commitment to Change: Strength Development Strategies

Strength development must be an active part of working with an individual.

Highlight abilities: both the abilities the person has now and what abilities they desire.

Identify skills and talents: Help the person recognize skills they utilize every day just to get by. People often feel like they are going through the motions and do not see these things as strengths.

Link the person's strengths to the success of their goal: If the person sees they already have some of the skills they will need, it builds confidence.

Demonstrate that learning is a part of the process: Ensure that opportunities for various types and styles of learning are available.

Highlight new skills: Illustrate how these new skills apply to the individual's stated wishes and values. It is important that the person see results and progress from their own perspective.

What questions could you ask?

Action planning

Stage – Actions for Change

The role of services is to equip a person with the necessary skills and support. To help her build a new self-identity, including taking responsibility for her own actions.

Making decisions, sticking with those decisions, and having a plan that is flexible but helps the person stay on track is important. Often when we are doing "well" we can forget that we still need to take care of ourselves, and we forget to use our strengths and supports.

Action for Change Activity: In pairs or groups, complete the following activity with one person as the peer and the other as the peer specialist. Now rotate roles.

The open-ended questions below are examples; you may have some of your own. Try them out!

Open-Ended Questions:

What are some things you do to take care of yourself?

What kinds of activities are you involved in?

How do you know when you are doing well?

What supports do you use to stay well?

How do you know if you are starting to not do well?

What are things you do to get back on track?

Where can you get supports if you need it?

Who are the people in your support network?

What goals do have for yourself today?

Part 5 – Igniting the Spark of Hope

- Interest - Identify an area of interest and ask questions that keep the person talking until you get a feel for what he or she wants.
    - Tell me more.
    - How did you become interested in this?
    - What would this look like?

- Cost/Benefits - Explore the costs and benefits of making a change. The benefits of making a change motivate a person to act. Ask questions that help explore the benefits of making the change.
    - What would be the benefits of doing this?
    - What would be the costs of not doing it?
    - How would your life be different?
    - What would you be able to do that you aren't or can't do now?

- Able to do - Find actions the person is able to do to get started. The person needs to see that they can act on their own behalf to create the life they want. Ask questions that keep the person talking until you find something they can do to help start the change.
    - What would you need to do to get started?
    - What of this could you do?

- Need help with - Look for something that will require new skills. There are always barriers to change or the change would have already happened. Ask questions that help the person explore possible difficulties or barriers.
    - What difficulties might you encounter?
    - What would you need help with?
    - What might get in your way of doing this?

- Supports - Explore the person's support network. No one makes major changes by themselves. Ask questions that help the person explore his support network.
    - Who would support you in making this change?
    - Who would not support you?
    - Is there anyone who might work against you?

    - Use your recovery experience throughout the process to strengthen the relationship. Try to understand what the person is experiencing and relate a time when you had a similar experience. ("I remember how difficult it was when…")

Part 6 – Guidelines for Using Your Lived Experience

It is important to understand when we are sharing our lived experience, our story, that it isn't sharing our life story. We share our story for three reasons:

to make a connection,
build trust and
provide hope.

Anything else and we are only talking about ourselves. Most often sharing our story will consist of 1-2 sentences that apply to the moment.

When you are working with a peer, you are always asking yourself the following questions –

…what do they believe about themselves and their current situation?

…what do they want?

…what do they see as options or possibilities?

How can I use my lived experience to…

…affirm and validate what they are experiencing?

…communicate a sense of hope and possibility?

…help the peer see their situation in a new light?

Part 7 – Practice Role-Plays

We will now have the opportunity to practice the skills and tools we have been discussing in roleplays from real-life situations. Some of the characters in the roleplays have various behavioral health conditions. The first roleplay will be demonstrated by the facilitators and then volunteers will roleplay the other scenarios.

Marge –

Marge is 27 and has been diagnosed with bipolar illness. Her diagnosis came as good news because it helped explain her past, bizarre behavior that she did not understand. She dropped out of college. She lost her part-time job. Her fiancée called off their wedding. Most of her friends no longer talk to her. Her doctor has told her that working or going back to college would be too stressful for her. Her caseworker helped her qualify for benefits. She is grateful that her medication is controlling her symptoms and that she is finally stable. Her doctor recommended she go to the local peer-run drop-in center in order to get out of the house, but told her not to get involved with activities that might cause her to relapse.

She believes that because she is "mentally ill" her life as she has known it might be over. She is trying to figure out what to do with the rest of her life. She is very hesitant to commit to anything other than taking her meds and coming to the drop-in center because she is afraid she will not be able to do it or it will cause her to relapse.

You are a peer specialist at the drop-in center and are talking with her for the first time. Your role is to welcome and orient new people to the activities of the drop-in center. People are not required to get involved in groups or other activities at the drop-in center. People can watch TV, read magazines, or just 'hang out'. You hope to find something that she is interested in doing at the drop-in center and might be willing to see as a goal she can work toward.

Notes:

Jason –

Jason is a 28-year-old male. After graduating from high school, he started using drugs and alcohol. Over the past ten years, he has been in and out of treatment programs. His family and friends have cut ties with him because of his "borrowing' money from them that he never pays back, stealing anything he can sell, and multiple promises that 'this time he is really serious about getting into recovery.

There have been times in the past 2-3 years that Jason has been able to leave a treatment program and stay in recovery for a few months. During those times he says he has no friends, feels his life has no meaning or purpose, and prefers a life on the street with his old buddies, just partying and having fun. He has decided that this recovery stuff is crap and is sick of everyone shoving it down his throat.

He has recently been arrested for shoplifting and is facing jail time or a court-ordered residential treatment program, a program he has been through before. He does not want to go to jail, but he does not think another treatment will be helpful. He has given up on getting and staying in recovery.

Jason knows you as a peer specialist from the treatment center that he could be court-ordered to. You are visiting him in jail (at his request) to help him think through his options.

Notes:

Geraldo –

Geraldo is 23, lives with his mother, and goes to a peer-run, day program. He does hold a High School diploma, even though he attended some Special Education classes. He states that he is getting tired of just coming to the program every day and then going home and watching TV all evening. He thinks that he might want to get a job, go back to school, or just do something different. He is getting tired of the "same old things day after day." He adds that his lifelong dream has always been to become a lawyer. His mother says it is not possible. Geraldo states his mother has become much more controlling since his mental health diagnosis 3 years ago and directs his life for him. He asked his mother about going to work so that he can save money in order to attend a workshop on law at a local technical college. His mother tells him, "Absolutely not! I won't allow it." Geraldo states that he's really tired of everybody telling him what to do.

He has shown interest in leading groups but always has an excuse when asked to do so. He states that he would like to be able to help other people, but is not sure he knows what to do. He heard about the Peer Specialist Training Program and has stated that he wants to go. He tells you that he has been saving money out of his SSI check and that he will have enough to pay for it by the time the next training comes along. He asks you if you think he can do it and if you would help him. This is the first time he has ever shown any interest in doing anything other than coming to the program. Some of the staff think he is not ready to go to an intensive two-week training.

Two weeks ago, Geraldo was complaining of hearing voices that were disturbing to him and it is very hard for him to concentrate.

Geraldo is very shy. It takes him a long time to formulate a sentence and then he usually follows it with some statement to the effect that he is probably wrong, but it is what he thinks. He is constantly looking for yours and others' approval, in spite of his frustration toward others telling him what to do.

Notes:

Shalika –

Shalika is 28 and has been in and out of a peer-run program for people with substance use challenges over the past two years. Recently, she returned from a peer leadership training program. She is excited about her experience. This was a major event in her life. She has never demonstrated so much motivation. She has decided that she wants to become a peer recovery specialist. She feels overwhelmed. She has always struggled with a feeling of low self-esteem and self-doubt. While her anger has caused her problems in the past, she does not believe that she has issues with expressing anger and she refuses to participate in Anger Management groups.

Although this is the most excited staff can remember Shalika ever being about anything, there have been a few times in the past two years that she has indicated interest in various possibilities for herself. Each time she has tried to move in a new direction or take on more responsibility, she has become frustrated and turned to alcohol or drugs. The last time she tried to venture out, she relapsed and had to be admitted to a residential treatment program. This last experience has caused Shalika to be very hesitant to try anything new, but she is very excited about the possibility of becoming a peer recovery specialist. Some people on her treatment team feel that is too big of a move for her at this time. They think that one more failure might destroy the little self-esteem she has left.

Shalika has agreed to come to the peer-run program every day if you will help her reach her goal of becoming a peer recovery specialist. She wants to know if you believe she can do it and what she has to do to get started.

Notes:

Mary -

Mary is 24 and diagnosed with major depression. She has been in the behavioral health system for 6 years. She receives an SSI check, lives in a group home, and goes to a behavioral health day program every day. She has her own WRAP (Wellness Recovery Action Plan), and her medicines and other recovery tools seem to control her symptoms. She feels that she is ready to move on with her life, but is unclear what to do first. She is tired of living at the group home and wants her own apartment, with a roommate of her choice. She feels that there is more to life than going to a day program every day, and would like to work part-time. She has even considered taking some classes in the evening at the local technical college. She says that she is tired of everything in her life having to do with her mental illness. She wants more but is not sure what to do.

She has asked you, a peer specialist at the day program, to meet with her to help her think through her future. She says that she is feeling so well lately and is doing a lot to take care of herself – eating healthy, taking a walk 3-4 times a week, and she has recently started attending a local church that she enjoys very much. She wants to do so much more, but she is afraid that she may take on too much and have a relapse. She says that all she has known as an adult is what she has learned through the behavioral health system.

Notes:

William –

William is 28 years old. He began abusing drugs and alcohol in college. His drinking and drugging became so bad that he began missing classes, failing tests, and finally dropped out of college. After dropping out of college, he moved back in with his parents. He had 3-4 years that he was unemployed and continued to use alcohol and drugs. He received treatment off and on from the public behavioral health clinic in his hometown. Four years ago, he became involved in a peer-run drop-in center and things began to come together for him. He formed close relationships with peers who were well into their recovery, began to develop some of his own recovery tools, took on some leadership roles at the center, was able to get a part-time job, and got off of his benefits.

Six months ago, he moved out of his parent's house and into his own apartment. About the same time, one of his close peer friends was killed in an automobile accident. He took this death very hard and began to slide into deep depression. He began using drugs and alcohol again. Because of some rather bizarre and embarrassing public behavior, his parents had him admitted (with his consent) to a residential treatment program.

You are a peer specialist who works at the peer-run drop-in center where William was involved and have known William for the past four years. A staff at the treatment center contacts you and tells you that William has asked for you to visit him. The staff member also tells you that William is very agitated and depressed, and feels that he has failed in his recovery and will never be able to have a life again. He says that William thought he was doing so well, but now believes he is just too weak to really have the life that he wants. The staff tells you that William has requested for you to visit because he wants you, his peer recovery specialist, to help him get out of his apartment lease and his part-time job. He feels that this is the only option he has.

You are visiting him at the treatment center.

Part 8 – Review Questions

1. What is “effective listening?”

2. Explain the six steps in “Igniting the Spark of Hope” process.

Session 16

Recovery Goal Setting

The word 'goal' often turns off many people receiving services in the behavioral health system.

Session 16 explores the nature of goals and offers a person-centered process to use in helping peers set goals they are motivated to work on.

Session Overview

This session has six parts –

1. The role of a goal and motivated by benefits
2. Developing a person center goal
3. Writing your goal statement
4. Review Questions

Learning Objectives:

By the end of this session, you should be able to –

1. Understand the basic criteria of a person-centered, goal-setting process
2. Use the goal writing process with a peer.

Part 1 – The Role of a Goal

If a peer specialist is going to help a person recover, they need to know how to use a person-centered, recovery-oriented, goal-setting process with the peer.

We all have goals. We may not think of them as goals. We may not call them goals. But all of us want something that we believe will improve the overall quality of our life. This 'want' is what we are pointing to in this training as a goal.

Getting these 'wants' articulated as goals that can be included in a peer's treatment plan is one of the main tasks of a peer support specialist.

Why might someone with behavioral health issues have difficulty sharing what they want?

Person-centered goals activate motivation.

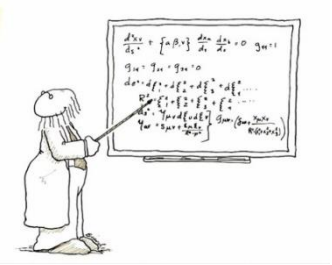
People get involved in the behavioral health system because their lives have been disrupted by the symptoms of a behavioral health illness or they have been court-ordered because of their disruptive behavior. Therefore, the system has traditionally focused its resources on reducing the symptoms, decreasing the emotional distress, and controlling the disruptive behavior. This has involved focusing on diagnosis, medication, therapy, and compliance to a treatment plan – which often results in what we will call 'treatment' goals.

Many people receiving services want more than 'symptom relief'. They want a life of meaning and purpose. They want to be involved in what is called the 'recovery process', which involves working to get something that they believe will improve the quality of their life. Let's call this a person-centered 'recovery' goal.

What are some of the differences between a 'treatment' goal and a 'recovery 'goal?

You often hear about people who are "just not motivated." That happens when the activity does not meet this equation.

Motivation = Involvement + Ownership + Benefits + Support



When a person is -

1) Personally involved in the goal-setting process,
2) Is able to articulate a goal that will improve the quality of their life,
3) Sees the benefits of accomplishing the goal, and
4) Has the support that they need …

… only then will they be motivated to work on that goal.

Part 2 – Developing a Person Center Goal.

We most often measure the quality of our life by what we can and can't do.

A person-centered goal focuses on what is important to the person but sometimes people are unsure of what and how to prioritize their wants and needs.

This can be an excellent tool to use when identifying what areas of recovery are most important to the individual at this moment. The following are skills or abilities that people have found helpful in creating the life they want.

> *"A skill is an ability that can be developed to the point that it can help a person do what they need to do to get the desired results."*

Step 1- Circle the number that best measures how important improving that statement is to you. Additional areas not included in the list can be added at the bottom if you would like.

	I **think I could improve the quality of my life if I could…**	Level of Importance					No Opinion
		Not				Very	
	…reduce the impact of stress on my life	1	2	3	4	5	
	…eat more healthy foods	1	2	3	4	5	
	…engage in more physical activities	1	2	3	4	5	
	…get more restful sleep	1	2	3	4	5	
	…strengthen my support network	1	2	3	4	5	
	…be involved in more service to others	1	2	3	4	5	
	…find ways to reduce my negative self-talk	1	2	3	4	5	
	…feel hopeful about my future	1	2	3	4	5	
	…strengthen my connection with my higher power	1	2	3	4	5	
	…have more meaning and purpose in my life	1	2	3	4	5	
	…have enough money to meet my basic needs	1	2	3	4	5	
	…better access to resources in my community	1	2	3	4	5	
	…better control the symptoms of my mental illness	1	2	3	4	5	
	…change my living situation	1	2	3	4	5	
	…see myself as a more capable person	1	2	3	4	5	
	…learn a way to solve my problems as they arise	1	2	3	4	5	
	…have more clarity about my personal goals	1	2	3	4	5	
	…learn to create action plans to accomplish my goals	1	2	3	4	5	
	…better manage my physical health conditions	1	2	3	4	5	
	…learn to better advocate for myself	1	2	3	4	5	
		1	2	3	4	5	
		1	2	3	4	5	
		1	2	3	4	5	

Step 2 – Looking at your answers above, place a checkmark in the first column of the skills you would like to strengthen.

Step 3 – List the top three skills you would like to strengthen.

1)

2)

3)

Answer the following questions about the skills you chose.

What would be the benefits of strengthening these skills?

How would your life be different?

What would you be able to do, but can't or aren't doing now?

What would be your biggest challenge?

Which one of the three you picked would be the easiest to start working on now?

Which one would be the most difficult?

Which one would bring the most positive changes in your life at this time?

Which one are you most interested in or excited about?

Now, prioritize these skills using the information above, and your intuition, in terms of your willingness to start working on them. (1 being the most willing.)

1)

2)

3)

I think at this time further developing the first skill will improve the quality of my life in the following ways.

1)

2)

3)

and will enable me to do the following:

Taking all of this into consideration my goal is:

Part 3 – Writing the Goal Statement.

From Merriam-Webster's

Full definition of GOAL:

1: the terminal point of a race

2: the end toward which effort is directed :

3: an area or object toward which players in various games attempt to advance a ball or puck and usually through or into which it must go to score points

Not all of these definitions seem to speak to the goals we are talking about today, but they do. They all speak to the endpoint that we want to achieve. We often get distracted and overwhelmed by the steps we need to take to accomplish a goal. Those steps are objectives. The first step in planning a vacation is to decide where you want to go, then you decide how to get there. The same is true for goal setting.

The goal then needs to be written in such a way that it states the benefits, is measurable, clearly calls forth actions that the person can take to reach the goal, and is time-limited.

A good goal statement contains the following four elements –

1) States the benefits,
2) Clearly describes what accomplishing it looks like,
3) Indicates the kinds of actions required, and
4) Gives a timeframe for completion.

What's the difference between the following two goal statements?

- My goal is to get 6 to 7 hours of sleep every night.
- In order to get regular sleep, I will follow a regular "prepare to sleep" routine 6 nights a week by 8 weeks from now.

Write your goal statement in the following format -

In order to (the benefits–why you want this)

Consider the following questions. Why do I want this? What will be the benefit? How will my life be different? What will I be able to do that I can't or am not doing now?

My goal is (what you see yourself being able to do)

Consider the following questions. What could I be doing that might help me attain the benefits above? What is the skill, ability or situation change that I want in my life?

By (example: date)

Consider the following questions. How long will this take me? Is there a date or event I want to accomplish this before?

Some of the things I need to do to accomplish this are –

Some of the possible challenges I might encounter are –

Some of the supports I might need are –

I think this will help me better monitor and manage my behavioral health condition by –

Part 4 - Review Questions

1. What are the key components of motivation?

2. What are the three elements of a good goal statement?

Session 17

Peer Specialist Ethics & Professional Boundaries

Peer Specialists are not clinical professionals, but they must do their jobs professionally and ethically.

Session 17 sets a context for decision-making in situations with ethical implications and offers an opportunity for discussion of a variety of ethical scenarios.

Session Overview

This session has eight parts:

1. What Are Ethics?
2. Possible Ethical Violations
3. Arkansas Peer Recovery Specialist Code of Ethics
4. Professional Boundaries
5. Emerging Peer Recovery Specialist Core Recovery Values
6. Questions to Ask Yourself in Situations with Potential Ethical Implications
7. Demonstration Presentation Scenario
8. Review Questions

Learning Objectives

By the end of this session you should be able to:

- Explain why ethics and boundaries are important concerns.
- Give three examples of work situations with potential ethical and/or boundary implications.
- Give three examples of questions you might ask yourself in situations where your decision and action may cause someone harm.
- List five Emerging Peer Recovery Specialist Core Recovery Values for delivering peer support services.

* This session will introduce and discuss ethical concepts and situations. You will be required to complete additional continuing education hours in ethics prior to certification.

Part 1 – What Are Ethics?

Definitions of ethics:

- Set of moral principles
- Principles of moral conduct governing an individual or group
- Set of moral issues or aspect

Notes on discussion:

What is your definition of ethics?

Part 2 – Possible Ethical Violations

In the report, "Ethical Guidelines for the Delivery of Peer-Based Recovery Support Services," William White states,

> "Aspiring to be ethical at its most primitive level, involves sustained vigilance in preventing harm and injury to those to whom we have pledged our loyalty."

In White's definition, what is the primary value that guides all decisions?

What does it mean to "pledge your loyalty" to someone or something?

The peer specialists have many things to which they have pledged their loyalty –

- the agency,
- the profession,
- the peers being served,
- co-workers
- and self.

Are there possible conflicts between our loyalties? What is an example?

What does it mean as a Peer Recovery Specialist to harm or injure another person? What can we harm?

Part 3 – Arkansas Peer Recovery Specialist Code of Ethics

Part 4 – Professional Boundaries

Boundaries help us to define what is okay and not okay in any relationship. There are personal and professional boundaries that help to protect both the service provider (including peer specialists) and the person who is receiving services.

Professional distance is not what we mean when we refer to professional boundaries. We are talking here about "work" boundaries. As peer specialists, the relationship with the people we serve is different than that of traditional providers. Our role is to be friend "like", with a purpose. We must identify where and how those boundaries are different.

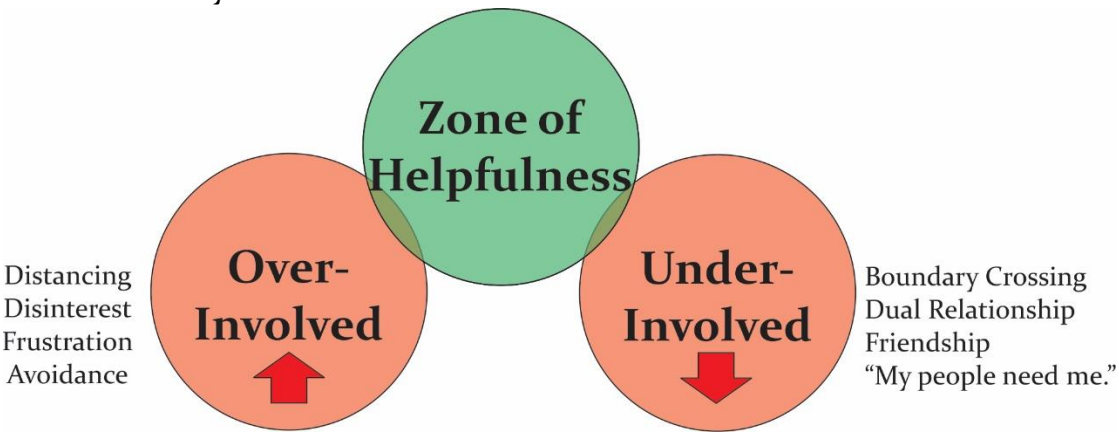
People often think boundaries and ethics are the same thing. They are not. Boundaries are the formal and informal understanding of how people interact with each other. Work boundaries may involve issues of power and control, professional distance, self-disclosure, after-hours involvement, and friendship vs. friendly behavior. On the other hand, ethics are formally stated rules of conduct. Ethics are non-negotiable expectations that all staff must uphold.

In general, all ethical violations would also be boundary violations but not all boundary violations are necessarily ethical violations. But both types of violations are destructive to the recovery of those we serve.

Boundary Violation
- Often ambiguous
- Occurs whenever your actions deviate from your established role as a peer specialist
- Dependent on where you are, who you are with, and the cultural backgrounds of all involved parties
- Decision-making process can be complex

Ethical Violation
- Often clear-cut
- Crossing which creates a reasonable risk of harm or exploitation of a person or people
- Boundary rules apply regardless of where you are, who you are with, or the cultural background of anyone involved
- Decision-making process can be difficult but is usually straightforward regarding what you should do

The relationship between the peer specialist and the people we serve can be plotted on a continuum ranging from over to under-involved. Either extreme of this continuum represents boundary violations.



Signs the peer specialist may not have clear boundaries.

- Feeling chronically taken advantage of, such as emotionally, financially, or physically.
- Saying "yes" to please others at your own expense.
- Often feeling disrespected by others, but not standing up for yourself.
- Engaging in people-pleasing behaviors to be liked and to receive approval.
- Engaging in disrespectful behavior that hurts others.
- Flirting with others.
- Doing whatever you want to get your needs met.
- Only feeling appreciated at work.
- Spending off-duty personal time with a person they provide services.
- Keeping secrets.
- Only reporting negative or positive aspects of a person's behavior.
- Feeling defensive.
- Responding to requests for his/her services differently with different people.

Signs the peers may not have clear boundaries.

- The person idealizes the peer specialists' attributes.
- The person idealizes the peer specialist, romantically,
- The person hopes the peer specialist will rescue them.
- The person considers the peer specialist as a nurturing parent figure.
- The person regards the peer specialist as a savior.
- The person regards the peer specialist as a devoted caretaker.
- The person believes only the peer specialist can support them.
- The person believes the peer specialist knows and understands all.

Part 5 – Emerging Peer Recovery Specialist Core Recovery Values for Delivering Peer Recovery Services

The following Core Recovery Values can help guide both our ethics and boundaries.

The primary responsibility of Peer Recovery Specialists is to support the person to achieve their needs, wants, and goals.

Peer Recovery Specialists strive to…

- Affirm everyone's ability to learn and grow.
- Communicate a sense of hope and possibility.
- Respect the rights and dignity of the individuals they serve.
- Keep the focus on the individual's strengths, assets, and possibilities.
- Accept, affirm, and validate the individuals where they are and honor their decisions.
- Communicate that there are many roads to recovery.
- Keep the individual's well-being as the primary concern.
- Give the individual as many choices and options as possible.
- Help individuals become fully integrated into the community of their choice.
- Maintain confidentiality and do not provide identifying information.
- Communicate that recovery and treatment for one's illness is voluntary.
- Sustain and preserve objective and professional relationships.
- Do not push one's recovery experience onto another individual.
- Keep personal interests from conflicting with the interests of the individual.
- Do not use the unique relationship to unduly persuade or coerce.
- Use recovery stories in a positive and hopeful manner.
- Portray the face of recovery and be a role model.
- Work within the limits of their experience and training.
- Preserve boundaries that promote recovery.
- Maintain and strengthen their own recovery.
- Promote the profession of peer recovery specialists.
- Work in partnership with others to meet the needs of the individuals.
- Show that they take adequate measures to discourage any unethical conduct.
- Communicate that all services should promote a person's recovery.
- Honor agency guidelines, policies, and principles of conduct.

Part 6 – Questions to Ask Yourself in Situations with Potential Ethical Implications

Individually list five questions that might be helpful to ask yourself in situations where your decision and action may cause someone harm.

1.

2.

3.

4.

5.

Notes on group discussion:

Part 7 – Demonstration Presentation Scenario

The following scenarios raise potential ethical or boundary issues for a Peer Recovery Specialist.

Ethical decision-making involves thinking through the multiple moving parts of a situation. Our first thought or "gut" instinct is not always the "best" choice in a given situation. Sometimes, once we come up with an option we just go with that and do not consider additional options.

Brainstorm five possible actions that could be taken for each scenario. Use the questions listed below to think through each action. Then rank your answers (Best = 1 to Worst = 5).

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Use the following questions to think through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 1

Charlotte is a Peer Recovery Specialist and a co-worker with Mark, a Peer Recovery Specialist in a Peer Recovery program. She passionately believes that WRAP saved her life. And she thinks all peers should have a WRAP and be actively working on it. She feels that it is the only viable tool to sustain recovery over the long haul. Some of the peers in the program are tired of Charlotte always asking them, "Do you have a WRAP? Are you working your WRAP?" They have tried to talk to her, but she continues to say she is sorry but if they really want to stay in recovery, they need to be working their WRAP. Some of the peers have come to Mark for help.

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 2

Anthony, a Peer Recovery Specialist, works for an agency that is beginning to serve more and more Native Americans. Over the past two months, he has developed a close relationship with one of the peers who is deeply grateful for Anthony's support and encouragement. He feels that Anthony helped him get on the road to recovery. One day he brings Anthony a beautiful art piece that he has made. Anthony is aware that the artwork is worth much more than the $10 limit that his agency places on the value of gifts staff may accept from a peer. He is also aware of the role and importance of gifts in the Native American culture. To not accept the gift is to reject his peer.

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 3

Jack is a Peer Recovery Specialist at a residential adult home. He has a good relationship with Norman, a peer who lives at the home. Norman has recently stopped taking his medication. He is becoming agitated and difficult to be around. Some of the staff are concerned about his "mental health." The director of the adult home asks you to use your influence with Norman to get him back on his medication. If Norman doesn't take his medication, the director has threatened to call the police and ask them to take him to the hospital for an "evaluation."

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 4

Cindy is a peer specialist and has been assigned to work with Freda, a female peer who is in a relationship with a man who is probably physically abusing her and is very controlling. Discussing the situation triggers a lot of emotions and past memories for Cindy because of a past relationship where she had been the victim of domestic violence and after a long struggle, had ended the relationship. Cindy is very worried for Freda. She wants to tell Freda about her experience and how at first, she was physically abused and how the violence later accelerated to sexual abuse.

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 5

A peer you serve is struggling financially. He says that he needs toilet paper. You could swipe some from the agency. They wouldn't miss it.

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 6

Aaron is a Peer Recovery Specialist and is in charge of the peer day program at the local mental health center. He is leaving the grocery store with a cart full of groceries when Carl approaches him. He asks for "a loan" so he can buy a burger at McDonald's next door. Carl was a faithful participant in the peer day program until about a month ago. He and Aaron had a good relationship. Aaron has not seen Carl since he stopped coming to the program. He heard that he has relapsed and is homeless. Aaron spent his last dollar on groceries and has no money to give to him. He explains this to him. Carl says that he has food in his cart and offers to go home with him and help him cook them both a good dinner. He says that he hasn't eaten in two days. He really wants the chance to talk with Carl and possibly get him back into services. Aaron sees the potential dangers in this.

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 7

Steve attends a local AA group (the only one in this small community) and realizes that three of the people who are newcomers in the group receive services from the agency where he works. This group has been a vital part of his ongoing recovery.

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 8

A case manager asks you to transport a person to an appointment. This is not a part of your job or something you can justify by making a case note. The case manager tells you to just talk to the person about something on the trip. This way you can document it as a case note.

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 9

You have asked your supervisor to transfer someone off your caseload because they have been acting in a flirting manner with you. The person approaches you and asks why they are being transferred to a new Peer Recovery Specialist.

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Scenario 10

A peer needs to get his ID before he starts his new job tomorrow. Your agency is closed for the day. He approaches you after work because he needs five more dollars. If he doesn't have the ID, he won't get the job. He needs it before your agency opens in the morning.

Ranking: Best = 1 to Worst = 5.

Option A – rank ____

Option B – rank ____

Option C – rank ____

Option D – rank ____

Option E – rank ____

Notes:

Thinking through each action.

- Is there a right or wrong choice?
- Is there an agency policy regarding this situation?
- Does this in any way complicate or negatively impact my relationship with this person?
- Is there an emerging Peer Recovery Specialist core recovery value(s) that addresses this situation?
- What are the possible consequences of each choice?
- Who will be affected by each choice?
- Do I have an obligation or duty to make a certain choice or to report the situation?

Thinking through your number 1 choice.

- Why is this choice ranked number 1?
- Why might someone else not agree with my choice?
- If there are negative consequences for doing the right thing, how can I face them in a strong, positive way?

Part 8 – Review Questions

1. Explain why ethics and boundaries are important concerns for Peer Recovery Specialists.

2. Give three examples of Peer Recovery Specialist work situations with potential ethical or boundary implications.

3. Give three examples of questions you might ask yourself in situations where your decision and action may cause someone harm.

4. List five Emerging Peer Recovery Specialist Core Recovery Values for Delivering Peer Recovery Services.

Session 18

Power, Conflict, & Integrity in the Workplace

Peer Specialists working as providers, as well as the shift to recovery, bring a dynamic to the workplace that can cause interpersonal conflict.

Session 18 explores a variety of potential areas of conflict in the workplace. This session presents techniques of mediation and conflict resolution and offers an opportunity to practice these techniques in group role-play and small-group settings

Session Overview

This session has seven parts:

1. Role-Plays and Discussion
2. The Process of Effective Communication
3. Using the Framing Grid
4. Small Group Work & Role-Plays
5. Review Questions

Learning Objectives

By the end of this session, you should be able to:

- Explain the three steps in the Process of Effective Communication.
- Explain when and how to use the Framing Grid.

Part 1 – Role-Plays and Discussion

Role-Play Negative Communication Skills

CPRS: I'm excited! Roy finally opened up today. He told me he wants to work.

Supervisor: You're kidding. [Flat response—like "You've got to be kidding."]

CPRS: No—said he'd even consider taking his medication. Said he's tired of his symptoms getting in the way of his life.

Supervisor: You can tell him that when he starts taking his meds, we'll start talking about what's next.

CPRS: What?

Supervisor: Look, I can see that you care. However, you are setting him up for failure.

CPRS: No—that's not what I mean!

Supervisor: I've been in this business for 20 years. You walk in the door what—two months ago? You think you're the new peer savior. Let me tell you what your "exuberance" is doing to the peers around here—and that means Roy. You and your "no goal is unrealistic" attitude is setting Roy up for failure and every other peer that we serve in these rooms. It's setting them all up. I find this abusive. I saw Roy when he walked through that door three years ago. We dragged him off the street. He was literally hosed down in the crisis unit. He cried like a baby. He was as scared as a wild animal. Don't talk to me about "Roy is ready to go to work."

CPRS: I didn't say Roy is "ready" to go to work! I said he—Roy—said he wanted to go to work.

Supervisor: Roy doesn't know what he wants yet. And, if you'd been trained clinically, you'd be able to see that he is delusional right now. You CERTIFIED Peer Recovery Specialists are hurting peers.

CPRS: Wait a minute, this isn't about me—I, what do you mean we Certified Peer Recovery Specialists are hurting peers? I am offended by this statement. I, I, I just—I mean, [confused] this—I mean, Roy—You can't say that to me!

Supervisor: This is the opinion of my peers.

CPRS: Wait- wait- wait- wait. What's he doing in services for three years, I mean, doesn't that say you're doing something wrong? I mean, why can't you get it?

Supervisor: Excuse me? Are you calling my work with this peer incompetent?

END

CPRS: I'm excited! Roy finally opened up today. He told me he's anxious about it but wants to work.

Supervisor: You've got to be kidding.

CPRS: No—said he'd even consider taking his medication. Said he's tired of his symptoms getting in the way of his life.

Supervisor: You can tell him when he starts taking his meds, we'll start talking about what's next for him.

CPRS: Don't you think this is Roy's decision?

Supervisor: Roy's decision? I'm afraid Roy doesn't know how to make decisions yet. Roy hasn't decided to take his meds, or take a bath, or wash his clothes. Do you really think someone is going to hire Roy?

CPRS: He wants to work in construction. I never knew this about Roy but he built his own house.

Supervisor: This is pure delusion. And on top of it, you're setting Roy up for failure. I find this completely unprofessional. But whether or not Roy is ready to go to work is not your decision. It will be decided—not by you, not by me, but by a lot of people—led by his psychiatrist, who knows Roy best. Understand?

CPRS: This is an important move on Roy's part. I understand that you see this as a decision Roy can't make for himself. But he has made the decision. Now, we need to find a way to support him so that he has a greater opportunity to succeed. Perhaps we could create a group.

Supervisor: It's <u>not</u> an important move for Roy because it will <u>not</u> be taking place. I've been in this business for 20 years. You walked in the door what—two months ago? You think you're the new peer savior. Let me tell you what your "exuberance" is doing to the peers around here—and that means Roy. You and your "no goal is unrealistic" attitude is setting Roy up for failure and every other peer we serve here. It's setting them all up—all our peers. I find this abusive. I saw Roy when he walked through that door three years ago. We dragged him off the street. He was literally hosed down in the crisis unit. He cried like a baby. He was as scared as a wild animal. Don't talk to me about "Roy is ready to go to work."

CPRS: I hear that you have really been involved in the recovery of all the people we serve here. I am glad to know how far Roy has come because of your commitment. As a peer, I know how important clinical care is. There was a time in my own life when I couldn't make decisions for myself. I was scared, and confused, a lot like how you describe Roy. I needed the kind of care Roy has received from you and the people in this agency. And then, I didn't. It was time for me to get on with my life. I had a peer who supported me and allowed me to challenge old assumptions about my

abilities. Peer support was so very important to me being heard and getting on with my life. My job as a Peer Recovery Specialist is to do for Roy what was once done for me by another CPS. My role is to help Roy get on with his life after treatment.

Supervisor: Yes, I see that. Peer Recovery Specialists happen to be here, and we can't do anything about that.

CPRS: [Ignores the comment] I share your commitment. Your partnership is vital to moving people through the recovery process. Right now, let's stick with what Roy needs.

Supervisor: Besides, you can't bill Medicaid to put someone to work!

CPRS: Let me check that out for you—but I think we can bill Medicaid for helping Roy and other peers who'd like to go back to work but who are really worried about it—to deal with fears and anxiety related to getting a job. We could talk about the real barriers that get in the way and how to…

Supervisor: I am not interested in creating more work for myself.

CPRS: I'll tell you what, how about letting me take this on, with your approval? We can see how it goes with Roy and other peers. We can assess this in, say, one month

END

Notes:

Part 2 – The Process of Effective Communication

The following are the steps involved in the process of effective communication in potential conflict situations:

Steps from the Positive Communication Role-Play

- **Observe and affirm the other's position, values, and concerns.**

  How was that done in the role-play?

  You feel that Roy is not ready to go back to work. I really hear you. You have been involved in the recovery of all peers we serve here. I am glad to know how far Roy has come because of your commitment.

- **Relate the other's position, values, and concerns to your experiences as a peer.**

  How was that done in the role-play?

  As a peer, there was a time in my own life when I couldn't make decisions for myself either. But later a peer helped me challenge old assumptions about my abilities.

- **Offer a "we" statement that promotes partnership in creating another way of doing things.**

  How was that done in the role-play?

  How about letting me take this on with your approval? We can see how it goes with Roy…We can assess it in, say, one month?

Part 3 – Using the Framing Grid

Who was involved in the conversation? **What are their concerns?**	**<u>Administration and management</u>** – always in the room through the agency's policies and procedures. They are concerned about money, billing, risk management, the agency's public image, and peers' well-being. **<u>Co-Worker</u>** (Supervisor) – concerned about the Peer Recovery Specialist not being clinically trained, pushing Roy too fast, being busy, and having no time to take on additional work. **<u>Peer</u>** (Roy) – wants to go to work, sees his symptoms are getting in his way of doing what he wants to do, willing to start taking his meds. **<u>Peer Recovery Specialist</u>** – knows the supervisor questions her abilities but believes in helping people go to work when they say they want to go to work. **Who else?**
Where might these concerns be in conflict? ------ What might the clinician bring up as an excuse not to say "yes?"	• Whether what she is doing with Roy is billable. • Whether she is pushing Roy too quickly. • The supervisor does not like her. • But she needs her support and needs to honor the supervisor relationship. • Strongly advocating for Roy could upset her supervisor and jeopardize her job.
What information from the situation and my life can I use to: ➢ Affirm the other's concerns. ➢ Relate these concerns to my own recovery experience. (How can I use my recovery experience to speak to these concerns?) ➢ Create a plan based on a win-win partnership.	• Research the billability of what you want to do. • The supervisor and the agency have been working with Roy for three years. He has made some progress. The supervisor is concerned about Roy not relapsing. • There was a time when I wasn't doing well, and clinical staff helped me. • Someone saw my potential and believed it was time for me to move on. • The PRS brought a plan that shows that they have thought through everyone's concerns, like getting Roy the kind of support he needs. They are honoring the supervisor role and will keep them informed.

Who is involved? What are their concerns?	
Where might these concerns be in conflict? --- What might the clinician bring up as an excuse not to say "yes?"	
What information from the situation and my life can I use to: ➢ Affirm the other's concerns. ➢ Relate these concerns to my own recovery experience. (How can I use my recovery experience to speak to these concerns?) ➢ Create a plan based on a win-win partnership.	

Part 4 –Power, Conflict, and Integrity Scenarios

Scenario 1

Up until this year, you have been working as a peer on a community support team, where you felt that you were not treated as a full member of the team. You recently got a job at a peer support program in a different agency. You feel good about this new position because you have always felt you worked better with groups than with individuals. Also, you recently passed the Arkansas Peer Recovery Specialist certification exam. You love your new co-workers. Both peers and non-peers treat you like any other staff member. They even invite you to lunch with them and to do things with them and their families on the weekends. You have never been happier in any job.

Last week you found out that the state was sponsoring a three-day conference for peers who are in peer support programs. Your program is to receive three scholarships. The peer support program has its own newly formed advisory council made up of peers in the program. The agency decided to allow the council to oversee and decide program activities including the use of the three scholarships. Your supervisor is aware that the council has discussed this and making their recommendation to the administration. The council chose John, Rosa, and McDonald. While they are not real leaders in the program and sometimes cause problems, the council believes that it is an important "next step" for their recovery.

You set up an appointment with your supervisor to inform her of the council's decision. You need her help to arrange transportation. Before your meeting, you learn through the grapevine that your supervisor is unhappy with the council's decision. She believes that John, Rosa, and McDonald are not the right choices. They should not represent the agency administration. She believes the scholarships should reward those who are "best peers." You don't know why she feels that way, but you believe the council was created to make decisions about the peer support program activities. The council's decisions are important to honor, but you don't want to jeopardize your position with your new supervisor.

You have set up a meeting with the supervisor to discuss the decision and arrange transportation.

Notes:

Scenario 2

Alice is a peer at a newly opened Integrated Health Program. She has a behavioral health condition but also has many physical health problems. She is diabetic, has high blood pressure, and is overweight. She is overwhelmed by all of her health issues and the demands people keep placing on her. She doesn't feel she is able to do anything that she is being demanded to do, so she does nothing. She neglects to take responsibility for managing her diabetes and other health issues. She has difficulty with physical activity because of her weight.

Alice recently attended a Whole Health Action Management (WHAM) program where she will work toward a whole health goal over the next 8 weeks. She was excited about the positive nature of the program and that she could choose her own goal. She liked the weekly action planning process and the peer support she received.

Alice's health goal was to catch, check, and change her negative self-talk at least once a day for five days during the week. She would be able to have this as a regular habit by eight weeks from now.

You are a peer specialist working with Alice and have shared her goal and excitement with her treatment team. Alice's doctor has challenged whether this is the right goal for Alice. He doesn't think working on her negative self-talk is a proper health goal. She needs to start taking responsibility for her diabetes and to lose some weight.

You are meeting with the doctor to discuss Alice's goal.

Notes:

Scenario 3

Kenny has been a resident at a group home for 10 years. You know from his chart that before the onset of his illness, he was a gifted piano player. He even played the organ at his church on Sunday mornings. People used to compliment his playing and tell him how gifted he was. Kenny has been depressed and isolated over the past few years. But recently something changed for him, and he has been feeling much better. He gets up for breakfast, participates in group meetings, and even goes on social outings with other residents on weekends. He has worked with his case manager and other staff members for almost three months on one of the objectives. His goal is to become an active member of his community. Saturday afternoons he goes with some of the group home members to play BINGO at the Elk Lodge. He likes going there because there is a piano. During breaks, he plays a few songs. He has told staff that he enjoys playing music again.

You notice in the weekend newspaper that a retirement home in town wants to hire a piano player for only a few hours on Sunday afternoons. The residents want to participate in a sing-along session. You mention this to Kenny, and he becomes very excited about the opportunity to get involved in his local community. He could earn a few dollars. Kenny, with more enthusiasm than anyone has ever seen in him, approaches his case manager about this opportunity. But the case manager stops him in his tracks and proclaims that he is not ready to do something like that. He tells Kenny that he would have to have a staff member go with him, and there are not any staff available on the weekend. He reminds Kenny that he has been sick for a long time and has only been serious about working on his objective for three months.

The case manager is concerned that you are pushing Kenny to do too much and has asked to meet with you to discuss what's best for Kenny.

Notes:

Scenario 4

Randy has been coming in for services for over a year. At visits, sometimes it is obvious he has been drinking, but he never causes any problems. The policy of the agency is that peers cannot attend the program if they are under the influence. So, Randy is often asked to leave and return when he is sober. The treatment team is meeting tomorrow to discuss Randy. You are aware that many of the team members think Randy's noncompliance with the agency policy is a sign that he is neither ready nor serious about his recovery. Most team members think he should be terminated from the program.

You believe that the agency needs to always keep the door open for peers. Kicking Randy out of the program, you believe, would take away any reason he has not to use. He is coming for services for some reason. You believe he wants something, but doesn't know how to make it happen.

You are meeting with one of the clinicians, a non-peer, on the treatment team to win them over so you will have a person in your camp when you meet with the team tomorrow.

Notes:

Part 5 – Review Questions

1. What are the three steps in the process of effective communication in situations with potential conflict?

2. What are the six questions that you need to think through in preparing to enter a situation in which there is a potential conflict between what you want and what a coworker might want?

Session 19

The Role of Peer Recovery Specialists, Part 2

Peer Specialists have a very special and unique role to play in promoting and supporting the recovery process.

Session 19 explores how to articulate the role to others.

Session Overview

This session has 4 parts:

1. Activity 1 - Preparation
2. Activity 2 - Presentation
3. Activity 3 - Reflection
4. Review Questions

Learning Objective

By the end of this session, you should be able to:

- Explain the benefits of hiring a Peer Recovery Specialist.
- Identify the unique roles of the Peer Recovery Specialist
- Articulate how they would benefit an agency.

Part 1 – Why Hire a Peer Recovery Specialist? Small Group Work

Scenario

The state has recommended that all behavioral health provider agencies hire peer recovery specialists. They have convened a conference for the directors of these agencies to discuss the implementation of this recommendation. Many of the directors are not sure why they should do this. And they are unsure how it will benefit their agency. You are a peer recovery specialist who has been invited to speak at the conference. The title of your talk is "Why behavioral health provider agencies should hire Peer Recovery Specialists."

Directions

Activity 1 - Preparation
Each small group has 15 minutes to create a five-minute presentation.

The small group will choose one person to give the talk to another small group.

For example, the speaker from group 1 will move to group 2 and the speaker from group 2 will move to group 3.

Activity 2 - Presentation

During the presentation, the people in each small group will then assume they are agency directors at the conference. After the 5-minute presentation, they will have 10 minutes to ask questions of the presenter.

Activity 3 – Reflection

After the small group talk and questions, everyone will come back together as a large group and reflect on the process.

The large group reflection will focus on these questions (use a flip chart):

What were some of the most convincing reasons to hire a peer specialist?

What were some of the most challenging questions from the group of directors?

How can we respond to those concerns?

Use the next pages for notes.

Activity 1 – Preparation

– Why Hire a Peer Recovery Specialist? Small Group Worksheet

Individual Work (3-5 minutes). List five reasons why a behavioral health agency should hire a Peer Recovery Specialist.

1.

2.

3.

4.

5.

Share and discuss individual work.

Notes on small group discussion to be used in the presentation:

Activity 2 - Presentation

Presentation observations

What were the major points of the talk?

1.

2.

3.

4.

5.

What were some good points made by the speaker?

What were some good questions asked of the speaker by your group?

Activity 3 – Reflection

What were some of the most convincing reasons to hire a peer specialist?

What were some of the most challenging questions from the group of directors?

How can we respond to those concerns?

Were there any questions you could not answer?

Part – Review Question

1. Give five good reasons a behavioral health provider agency should hire a Peer Recovery Specialist.

Session 20

Self-Care

As peer specialists, we must maintain and manage our self-care.

Session 20 explores the importance of self-care and demonstrates some tools we can use.

Session Overview

This session has six parts –

1. What is self-care
2. Self-care myths
3. Sources of stress
4. Recognizing the lack of self-care
5. Creating self-care habits
6. Review Questions

Learning Objectives:

By the end of this session, you should be able to –

1. Understand what self-care is and is not.
2. Identify personal self-care strategies.

Part 1 - What is Self-care?

"The term self-care refers to activities and practices that we can engage in on a regular basis to reduce stress and maintain and enhance our short- and longer-term health and well-being. Self-care is also necessary for you to be effective and successful in honoring your professional and personal commitments."

Ideally, we all engage in regular self-care in which we do the things that make us feel taken care of mentally, physically, and emotionally. But this doesn't always happen, and we may need to stop and take the time to remind ourselves we are important, too.

Sometimes our feelings become too much, and we need to distract ourselves until we are better able to cope. We can also strategically change how we are feeling when things become too overwhelming.

Self-care is a critical activity because:

- Recovery requires deliberate self-care.
- The key to success is work-life balance.
- Hard work requires intense self-care.
- Self-care teaches us about ourselves.
- Can be tailored to our needs.

What would be the benefit of having good self-care?

Why is it important for peer specialists to practice good self-care?

Part 2 - Self-care Myths

- Self-care isn't selfish.
- Self-care isn't one-size-fits-all.
- Self-care isn't a cop-out.
- Self-care isn't a waste of time.
- Self-care isn't a sign of weakness.

Self-care is all or nothing
We often think if we don't have the whole day or a weeklong vacation why should we bother. Self-care adds up in all the little moments from taking a deep cleansing breath to listening to music or watching the ducks.

Self-care is indulgent and selfish
Making time for ourselves doesn't mean that we don't care about others. It means that we are just as important as anyone else. We need to be scheduling time for ourselves just like we do for all of our other responsibilities. Our self-care is a part of how we serve others. Our self-care gives us room to be more compassionate to others.

You need to spend money to practice self-care
As with most things in life, money can't buy self-care. In fact, throwing money at our stress can only create new stress. Self-care is about rebooting your mind, not your pocketbook.

Self-care is optional.
If we don't take time for our self-care our body will force it on us in ways that can be even more difficult to handle. We can have mental breakdowns or become physically sick. We can seek out destructive coping mechanisms, such as substance use, destructive behaviors, or compulsive behavior. All of which create even more stress.

Self-care is anything that soothes you.
Not everything that soothes you is self-care. Some people seek to manage their stress by binge-watching Netflix, video games, food, or other compulsive, addictive behavior. These habits may feel soothing in the short run but provide no healing.

We have to earn the right to practice self-care.
We tell ourselves that we will do self-care after we finish this project, this class, this task. Putting off our self-care until we feel we have earned it. We don't realize that our self-care will make all of those tasks easier and more efficient if we feed ourselves first.

Practicing self-care means choosing between yourself and others.
Self-care actually means choosing ourselves for others. I cannot care for others if I am not caring for myself. Not practicing self-care can make us more selfish. We get grumpy, we get resentful, we get irritable.

Self-care is only for those times when you are not doing well.
Not doing well can be a symptom of a lack of self-care. Self-care can have a preventive medicine effect and must be practiced regularly, not just when we "need it.

Self-care is just about things that make you feel good
Sometimes self-care is doing things that don't necessarily make you feel good in the moment. Self-care includes things like cleaning the bathroom, going to the dentist, and doing dishes. Putting in the work today will pay as self-care benefits to future you.

Self-care is only about taking care of your mental and emotional health
Humans are not one-dimensional. We don't exist only from the neck up. We are social and spiritual, we have physical and intellectual needs, and we have passions and interests.

I Need to Be Productive All of the Time
Our job isn't to be a human doing, it is to be a human being.

It can feel uncomfortable to slow down because we think we need to run full blast all the time to be valuable. Our bodies and minds need rest for fuel, the only way to be productive is to keep fuel in the tank.

Sometimes the most productive thing we can do is our self-care.

If you practice self-care regularly, you will never have a bad day
Self-care is not a magical cure-all. Life still happens. A hot bath won't wash away the grief of a loss. A deep breath won't fix your car. Self-care is a way we can take control of our lives and ease the impact when we face events that are beyond our control.

Part 3 - Sources of Stress

We must find ways in our own lives to get the same degree of support as we provide to those we serve. People often mention burnout as a part of the experience of being a peer specialist. We face stresses from many fronts.

What are some general life stresses we face? (family, bills, car repairs, etc.)

What are some stresses we face as working people? (hours, pay, evil supervisor)

What are some stresses specific to the type of work we do? (seeing people relapse, listening to people who are in pain)

Which of these lists is longer in your life? We often bundle these stresses together instead of breaking them down. Stress is a normal part of life. We will always have family nagging at us. We will always have days when we hate to hear that alarm go off in the morning for work. We will always have difficult things to face on the job. The question is what do we do about it? The responsibility for our stresses rests not on our life events, having a job, or the work that we do. The responsibility lies on our own shoulders. What are we doing to take care of ourselves? Burnout is an inside job.

Stress	Burnout
Over-engagement	Disengagement
Emotions are over-reactive	Emotions are blunted
Produces urgency or hyperactivity	Produces helplessness or hopelessness
Loss of energy	Loss of motivation or hope
Damage is physical	Damage is emotional

We know that some amount of stress is good and actually productive, but we can also hit a wall: overwhelming stress and burnout

Stress can be characterized as too much:

Too many pressures that demand too much of you physically and mentally
All over the place emotionally
Bouncing from one thing to the other without actually getting anything done

Burnout on the other is about not enough:

Feeling empty
Having a lack of drive and energy
Don't see any hope of positive change
The idea of just giving up

You can think of overwhelming stress as **drowning** and burnout as being all **dried up**.

We need to have insight and awareness of our own triggers, stressors, and tipping points

What is your biggest barrier to practicing self-care?

Part 4 - Recognizing when we are lacking self-care

- Always putting your wants or needs on the back burner
- Becoming impatient
- Believing your work doesn't have meaning
- Persistent, negative, or cynical attitude
- Having racing thoughts
- Becoming short-tempered or frustrated
- Feeling disorganized or overwhelmed
- Physical, emotional, and mental exhaustion
- Feeling nervous or anxious
- Blaming our job /or someone else
- Facing a sense of loneliness or isolation
- Weeping or crying frequently, and not associated with the grieving process
- Feeling anger or resentment

To start, it can be helpful to look back on a situation when you have experienced extreme stress.

What warning signs did you have?

What did you do well during that time?

What didn't you do well?

How can looking back prepare you for future situations?

Part 5 - Creating Self-care Habits

> *"Daring to set boundaries is about having the courage to love ourselves, even when we risk disappointing others."*
>
> Brene Brown

We may not have a "go-to" list of self-care activities. Self-care has to become a habit, so that when we're dealing with stress, we remember that, "Hey, I need to take care of myself in this situation." And, you need a variety of activities to try—if one doesn't work, you can switch to another.

NOW	Current self-care strategies and activities you use to manage stress and stay healthy.
FUTURE	Strategies and activities that you would like to use but are not currently utilizing to enhance self-care.
OBSTACLES	Identify the obstacles keeping you from practicing self-care.
SOLUTIONS	What solutions can you come up with to address the obstacles you listed?

Part 6 - Review Questions

1. Give two reasons why self-care is important.

2. List two healthy self-care strategies.

Session 21

Final Reflections, Evaluations & Next Steps

Evaluating the training is important and looking at the next steps.

Session 21 is the opportunity to evaluate the overall training and to discuss the next steps.

Session Overview

This session has two parts:

9. What was helpful from the training
10. Next steps to continue the certification process

Learning Objectives

By the end of this session you should be able to:

- Explain what you learn during the training.
- Understand the next steps for certification.

Final Reflection, Evaluation, and Next Steps

List the 5-7 parts of the training that you found the most helpful.

1.

2.

3.

4.

5.

6.

7.

What, if any, impact did the training have on you? How are you different?

What is the next step for you – either in your own recovery journey or in using this training to help others?

Arkansas Core Peer Recovery Specialist Credentialing Process (PR)

Eligibility Requirements: To be eligible to become an Arkansas Core Peer Recovery Specialist (PR), you must:

- have a GED or have graduated from high school,
- be at least 18 years of age,
- have a minimum of 2 years of recovery from substance use disorder and/or mental health disorder,
- have a minimum of 2 years of abstinence from illicit drugs and alcohol,
- have not committed a sexual offense or murder or have any active warrants.

How to become an Arkansas Core Peer Recovery Specialist (PR):

STEP 1: Apply to the APSP PR Program

- Meet the PR eligibility requirements.
- Apply to begin Core PR training by submitting:
  a) a completed and signed PR application
  b) all supporting documentation
  c) a $50 non-refundable application fee
  d) applicant must email completed and signed application, all supporting documentation.

STEP 2: Become a Peer in Training (PIT)

Once accepted into the program,

- complete the 30-hour core training. ⬅ YOU ARE HERE
- submit the training certificate to the APSP Manager.
- be paired with a Peer Recovery Peer Supervisor (PRPS) and begin peer supervision.
- Receive PIT confirmation letter from APSP Manager.

STEP 3: As a PIT, complete the remaining required education and experience.

- Complete an additional 16 education hours.
- Complete 500 experience hours, including 100 hours of domain-specific experience to be comprised of:
  a) 25 hours of advocacy experience
  b) 25 hours of ethical responsibility experience
  c) 25 hours of mentoring/education experience
  d) 25 hours or recovery/wellness experience
  e) 25 hours of domain-specific peer supervision (individual/group)

STEP 4: Pass the PR credentialing exam.