CERTIFIED PEER SPECIALIST TRAINING COURSE CURRICULUM Facilitator Guide

The integrated curriculum for supporting foundational competency and practice for effective, professional peer support
Authors

Wisconsin Department of Health Services
Scott Caldwell
Cory Flynn
Joann Stephens

Access to Independence
Brittyn Calyx
Tim Saubers

P-02884 (03/2021)
# Table of Contents

**Introduction** ................................................................................................................................. 4

**Section 1** ........................................................................................................................................ 6
  Curriculum Guide ............................................................................................................................... 7
  Introductions, Group Guidelines, and Course Overview ................................................................. 8
  Wisconsin Peer Specialist Employment Initiative Overview ......................................................... 12
  Certified Peer Specialist Practice Overview ...................................................................................... 22
  Practicing Self-Care ............................................................................................................................ 30
  Assign Homework .............................................................................................................................. 32

**Section 2** ........................................................................................................................................ 36
  Curriculum Guide ............................................................................................................................... 37
  Review Homework ............................................................................................................................... 38
  Ethics, Confidentiality, and Professional Boundaries ........................................................................ 39
  Resilience and Trauma ......................................................................................................................... 44
  Practicing Self-Care ............................................................................................................................ 52
  Assign Homework .............................................................................................................................. 59

**Section 3** ........................................................................................................................................ 62
  Curriculum Guide ............................................................................................................................... 63
  Review Homework ............................................................................................................................... 64
  OARS Communication Skills Overview ............................................................................................ 65
  Open Questions ..................................................................................................................................... 67
  Affirmation ........................................................................................................................................ 70
  Reflective Listening ............................................................................................................................. 74
  Summary ........................................................................................................................................... 91
  Assign Homework .............................................................................................................................. 93

**Section 4** ........................................................................................................................................ 94
  Curriculum Guide ............................................................................................................................... 95
  Review Homework ............................................................................................................................... 96
  The Connecting Process ....................................................................................................................... 98
  Practicing Self-Care ............................................................................................................................ 110
  Assign Homework .............................................................................................................................. 111

**Section 5** ......................................................................................................................................... 114
  Curriculum Guide ............................................................................................................................... 115
  Review Homework ............................................................................................................................... 116
  The Exploring Process ....................................................................................................................... 117
  Listening, Revisited ............................................................................................................................ 124
  Assign Homework .............................................................................................................................. 130

**Section 6** ......................................................................................................................................... 144
  Curriculum Guide ............................................................................................................................... 145
  Review Homework ............................................................................................................................... 146
  The Supporting Process ..................................................................................................................... 147
  Setting Boundaries and Gentle Refusal ............................................................................................ 157
  Assign Homework .............................................................................................................................. 167
Introduction

Thank you for acting as a certified peer specialist training course facilitator. Here is an overview of the curriculum’s design, the supplies needed to facilitate a class, and general facilitation tips.

CURRICULUM DESIGN

• **Formats.** Many learning formats are used.
  o Solitary writing. Participants respond to questions with a brief written response.
  o Pair and share or turn to a neighbor.
  o Small group activities.
  o Large group share out. At the end of a small group activity, participants from the small groups share their learning to the large group.
  o Large group activities or discussions. All participants are involved in an activity.
  o Reading. There is content that must be covered through reading.
  o Skill practice. Opportunities to practice, reflect, and receive supportive feedback based on peer observation.
  o Demonstration. Opportunities for facilitators to demonstrate briefly a procedure, process, or skill.
  o Debrief. Opportunities to highlight key learning moments following skill practice or demonstration.

• **Layering.** Fundamental processes, key concepts, and skills of peer support are introduced within initial sections and continually layered into subsequent sections for specific application and practice. The goal is for participants to develop, refine, and continually practice the skills that are critical for effective peer support.

• **Modeling.** Modeling the communication skills being taught is a powerful form of learning. However, modeling is challenging when the many details of facilitation demand attention. It is important for facilitators to learn the skills quickly. There are reminders throughout the curriculum to support this learning.

• **Parallel process.** The curriculum is designed in parallel to the practice of peer support. For example, there is an emphasis on participant engagement through connection, exploration in person-centered ways, support, and empowerment of participants. It can be useful to make explicit the parallel process of what is happening in the training room with the practice of peer support.
SUPPLIES NEEDED

- 3x5 index cards.
- Sticky notes.
- Easel paper pad/flip chart paper pad with sticky back or use painter’s tape to stick paper to a wall.

FACILITATION TIPS

Effective facilitation is a key to participant engagement and learning.

- Speak at a volume in which all participants can hear you.
- Each learning activity is designed for a specific purpose. Be sure you know the purpose and “bottom line” of what you hope the learners experience.
- Because activities are designed with a specific purpose, provide clear instructions to ensure that learners understand what is expected. It is recommended to spend time practicing prior to class, providing clear and concise instructions.
- The debrief of a learning activity is where learning happens because participants can make sense of what was experienced and learned. Skillful facilitation is important to draw out learning. Invite sharing with an open question (example: “What was your experience like?”) and pause to give people a moment to collect their thoughts. When people share, listen carefully and respond with a concise reflective listening statement to reinforce the learning. Draw out more sharing with “What else?” Wrap up debrief with “Anything else?”
- There is a lot to accomplish in this course with a relatively short amount of time to do it in. Each section is about 3 ½ hours in duration, including a 15-minute break. The sequence of activities is provided in each section. Timing is provided for each activity, including when to take the 15-minute break. Facilitators have flexibility as to when to take the break. However, because there is a lot of content to cover and learning activities to facilitate (the time will go very quickly), it is highly recommended that facilitators stick to the recommended time guidelines for each activity. That means facilitation needs to be focused on keeping the group moving. Avoid lingering on a single discussion or taking tangents.
- When not facilitating an activity, observe. It can be useful to plant yourself with a group for a few minutes to observe. Be available to address questions and provide guidance when it is requested.
Section 1

This section sets the foundation for the training course. Participants take part in an introduction exercise. Group guidelines are developed. The Wisconsin Peer Specialist Employment Initiative and the role of the certified peer specialist is introduced. The principles of recovery are explored and strengths-based recovery is presented. Participants are asked to review the certified peer specialist core documents as a homework assignment.
Curriculum Guide

SECTION 1

70 minutes   Introductions, Group Guidelines, and Course Overview
40 minutes   Wisconsin Peer Specialist Employment Initiative Overview
15 minutes   Break
60 minutes   Certified Peer Specialist Practice Overview
25 minutes   Practicing Self-Care
10 minutes   Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Believes in and respects people’s rights to make informed decisions about their lives</td>
</tr>
<tr>
<td>1.3</td>
<td>Believes that personal growth and change are possible</td>
</tr>
<tr>
<td>1.7</td>
<td>Believes in lifelong learning and personal development</td>
</tr>
<tr>
<td>1.10</td>
<td>Believes in the healing power of healthy relationships</td>
</tr>
<tr>
<td>2.1</td>
<td>Knowledge of Substance Abuse and Mental Health Services Administration’s definition of recovery: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”</td>
</tr>
<tr>
<td>3.2</td>
<td>Knowledge of ethics and boundaries</td>
</tr>
<tr>
<td>3.3</td>
<td>Knowledge of scope of practice</td>
</tr>
<tr>
<td>4.1</td>
<td>Ability to bring an outlook on peer support that inspires hope and recovery</td>
</tr>
<tr>
<td>4.2</td>
<td>Ability to be self-aware and embrace and support own recovery</td>
</tr>
<tr>
<td>4.9</td>
<td>Ability to recognize and affirm a person’s strengths</td>
</tr>
</tbody>
</table>
**Introductions, Group Guidelines, and Course Overview**

(70 minutes)

**OBJECTIVE**

To foster initial connections, come to agreement on group guidelines, and provide course overview with discussion.

**METHOD**

1. Complete introductions.
   a. Pair and share. Ask participants to find someone they do not already know. Take turns listening to each other and complete the *Introductions* worksheet.
   b. Large group share out. Facilitate participant introductions. Ask that participants introduce themselves with name, preferred pronouns, and one thing to share with the group (unfortunately, there is not enough time for everyone to share their entire introduction). Facilitators should introduce themselves as well.

2. Complete group guidelines. Large group activity. Ask participants to suggest group guidelines. Note these on a flip chart page labeled “Group Guidelines.” Facilitate this discussion in a way that participants can come to a general agreement about group guidelines to follow for the duration of the course. The key is to be inclusive of multiple perspectives, but also to be efficient because there is a lot of material to cover in this section. Review *Group Guidelines* and add these to the group’s input.

3. Provide a course overview.
   a. Direct participants’ attention to the table of contents for a quick look at the sections and topics of this course.
   b. Review *Course Overview*.
   c. Large group discussion. Ask participants: “What are your initial thoughts, concerns, or questions about the course?” Create a parking lot flip chart and carefully note all concerns and questions. It will be important to return periodically to the parking lot to ensure these have been addressed. Concerns and questions can be added to the parking lot and addressed during the course.
Introductions

With a partner, discuss the following questions. Prepare a brief introduction to the group.

• What is your name? (If comfortable sharing: What are your pronouns?)

• What is your greatest accomplishment?

• What made you want to take this course?

• What do you like to do in your spare time (interests, activities, hobbies, etc.)?

• What are guidelines that the group should consider in order to build a trusting, safe group environment? Try to be as specific as possible. In other words, what does the group behavior look like?
Group Guidelines

- **Attend regularly.** To receive a completion certificate, only one absence (based on emergency or prior approval) is acceptable. Please inform a facilitator if you cannot attend a class or if you decide to withdraw from the course.

- **Practice punctuality.** The class will start and finish on time.

- **Respect confidentiality.** What is said in class stays in class.

- **Participate and be mindful of everyone’s airtime.** As people take more responsibility for their airtime, you can do less management.

- **Take risks.** The practice of peer support may involve new ways of being and communicating which at first may be awkward or uncomfortable.

- **Take care of yourself.** There will be regularly scheduled breaks each day, but feel free to take a break as needed.

- **Complete assigned homework.** The homework should be completed before the beginning of the next class.

- **Relax.** Enjoy your journey through this course with your classmates.
Course Overview

This course introduces you to the profession of peer support, including scope of practice; core competencies; ethics and boundaries; and the processes, key concepts, skills, and tools of the practice. This course provides an introductory, entry-level understanding of peer support as practiced across a wide range of services and programs. Upon completion, many participants will go on to pass the required exam to become a certified peer specialist. Upon gaining employment in the field, an agency may provide training that is more specialized.

Drawing upon best practices in adult learning, this course features a wide range of learning activities such as: sharing in pairs; small group and large group discussions; self-reflection and brief writing activities; round-robin readings; demonstrations; and most importantly, activities focused on developing, practicing, and refining the skills of peer support. Fundamental processes and skills are introduced early in the course, and then continually layered into subsequent sections for specific application and practice.

You are encouraged to take notes. Note taking is useful because it allows you, the learner, to reference important learning moments later, which can inform your practice in the field.

Learning also happens outside of the classroom. You are expected to engage in readings, access resources, and complete homework assignments as part of the learning process.
Wisconsin Peer Specialist Employment Initiative Overview

(40 minutes)

OBJECTIVE

To provide an overview of the Wisconsin Peer Specialist Employment Initiative.

METHOD

1. Read *Wisconsin Certified Peer Specialist Employment Initiative Overview*. Invite participants to ask questions and share concerns during this reading.

   a. When discussing the certification exam, let participants know that you will give them a sample practice exam for homework at the end of this section.

   b. When introducing the Wisconsin Certified Peer Specialist Employment Initiative website, go to [https://www.wicps.org/](https://www.wicps.org/). Display the website to participants, if possible, or encourage participants to go to the website on their mobile device, if available, during the discussion. Show participants how to:

      i. Identify the exam date most relevant to the participants taking the course, including application deadlines (found on "Exams" page).

      ii. Learn how to find and fill out a reasonable accommodations request for the exam (found on "Exams" page).

      iii. Look for certified peer specialist jobs (found on "Jobs" page).

      iv. Learn more about the team members associated with the Wisconsin Peer Specialist Employment Initiative (found at the bottom of the "About WICPS" page).

      v. Find resources and core documents for Wisconsin Certified Peer Specialists (found on "Resources" page – filter for certified peer specialist).

      vi. Plan for meeting recertification and continuing education requirements (found on "Recertification" page).

      vii. Get answers to frequently asked questions (found on FAQ page).

      viii. Access the social media accounts for the Wisconsin Peer Specialist Employment Initiative (found in the upper right-hand corner of the page when viewed in a desktop browser).

      1. The Facebook account provides all program updates and resources.
2. The LinkedIn account provides information on continuing education and job opportunities.

3. The Instagram account provides images relevant to the program and workforce.

ix. Sign up for the email contact list (found near the bottom of the home page, as well as other pages).

2. Facilitate a large group discussion: After reading the Wisconsin Certified Peer Specialist Employment Initiative Overview, ask participants: “What do you hope to gain (goals) personally and professionally from participating in this course?”
Wisconsin Peer Specialist Employment Initiative Overview

BACKGROUND

Wisconsin has a long history of engaging with and supporting peer inclusion, including:

- Involving peers in state policy decisions and program development.
- Setting the expectation for peer involvement at all levels.
  - Statewide peer advisory committees:
    - Recovery Implementation Task Force
      [https://www.dhs.wisconsin.gov/ritf/home.htm](https://www.dhs.wisconsin.gov/ritf/home.htm)
    - Certified Peer Specialist Advisory Committee
      [https://www.dhs.wisconsin.gov/peer-specialist/advisory-committee.htm](https://www.dhs.wisconsin.gov/peer-specialist/advisory-committee.htm)
    - Peer-Run Respite Advisory Committee
    - Wisconsin Voices for Recovery
      [https://wisconsinvoicesforrecovery.org/](https://wisconsinvoicesforrecovery.org/)
    - Office of Children’s Mental Health Collective Impact Partners
      [https://children.wi.gov](https://children.wi.gov)
  - Local program coordinating committees, peer satisfaction surveys, and access to peer services.
  - Requiring services be delivered with a strengths-based approach that is person-centered, recovery-oriented, and trauma-informed, which empowers peers to engage in their own treatment.
- Modeling peer inclusion in the workforce by hiring peer positions at the Department of Health Services.
  - Consumer affairs coordinator, Bureau of Prevention Treatment and Recovery
  - Peer services coordinator, Bureau of Prevention Treatment and Recovery
  - Certified peer specialists at Winnebago Mental Health Institute, Mendota Mental Health Institute, and Wisconsin Resource Center
- Investing in peer-run services as a valuable resource within the substance use and mental health systems.
  - ED2Recovery
  - Peer recovery centers
The Wisconsin Peer Specialist Employment Initiative is a result of this engagement and embodies the understanding that peer support is valuable to individual healing, that embedding peer services enriches the quality of the service systems, and that including peers in the workforce ensures systems change.

For certified peer specialists, the Recovery Implementation Task Force’s Peer Specialist Committee, Department of Health Services, Access to Independence, and other stakeholders developed core competencies, a job description, ethics and boundaries, and related documents. With these documents in place, these groups worked together to establish a training protocol and a statewide competency-based examination process. This work culminated with the first people earning the certified peer specialist title in 2010.

For certified parent peer specialists—caregivers who have experience supporting young people with mental health and substance use challenges—a committee of leaders in the parent support community, the Department of Health Services, and Access to Independence developed core competencies, ethics and boundaries, and related documents. With these documents in place, these groups worked together to establish a training protocol and a statewide competency-based examination process. This work culminated with the first people earning the certified parent peer specialist title in 2019.

A Certified Peer Specialist Advisory Committee was established by the Department of Health Services in 2019 to advise the Department of Health Services in its support and oversight of certified peer specialists and certified parent peer specialists.

**GENERAL INFORMATION**

- The Department of Health Services provides oversight of the certification of peer specialists in Wisconsin.
- Wisconsin residents who have experienced mental health and substance use challenges who take this training course and who pass an exam earn a certification giving them the ability to work for agencies and programs to provide peer support.
- The only peer support service that can be reimbursed by Wisconsin Medicaid is that of certified peer specialists.
- Wisconsin Medicaid only recognizes Wisconsin’s peer specialist certification.
- Other states may recognize Wisconsin’s peer specialist certification at their discretion.
- Wisconsin’s certification is valid for two years, at which time certified peer specialists must recertify.
- Wisconsin’s certification does not certify participants as mandated reporters.
There are over 1,500 certified peer specialists in Wisconsin.

CERTIFICATION EXAM

- People who score at least 85% on the Wisconsin Certified Peer Specialist Certification Exam earn the peer specialist certification.
- The exam is proctored and managed by the University of Wisconsin-Milwaukee through a contract with Access to Independence.
- The exam is offered four or five times a year.
- Exam dates are listed on the Wisconsin Certified Peer Specialist Employment Initiative website (https://www.wicps.org/).
- The exam is a series of 62 weighted, multiple-choice questions, with participants given up to three hours to answer the questions.
- Upon completion of the exam, the test taker receives their score immediately. (Note: When the exam is taken in a public setting, please do not react to your exam results in a way that may be disruptive to the other exam takers.) Those who pass the exam will receive a certification certificate issued by the Department of Health Services within six weeks.

EXAM REGISTRATION PROCESS

- Registration for the Wisconsin Certified Peer Specialist Certification Exam is managed by the University of Wisconsin-Milwaukee through a contract with Access to Independence.
- To register for the exam, complete an application through the UW-Milwaukee School of Continuing Education (https://uwm.edu/sce/peerspecialist).
- There is a $50 exam registration fee.
- Mail a copy of your Certified Peer Specialist Training Certificate of Completion and payment (check or money order) to:

  UWM School of Continuing Education
  ATTN: Gloria Lane
  161 W. Wisconsin Ave., STE 6000
  Milwaukee, WI 53203

All application materials must be postmarked no later than three weeks in advance of the exam.

Staff from the UW-Milwaukee School of Continuing Education will email people who have submitted all the required materials and payment the time and location for their exam approximately one week in advance of the exam.
EXAM PREPARATION

- A study guide and practice test can be found on the Wisconsin Certified Peer Specialist employment initiative website (https://www.wicps.org/).
- Facilitators or participants can host a study group.
- Participants can contact the certified peer specialist program manager at Access to Independence to discuss what to expect when taking the exam.
- Participants interested in requesting accommodations for the exam must complete the “Reasonable Accommodations Application for the Wisconsin Certified Peer Specialist Certification Exam,” which can be found on the Wisconsin Certified Peer Specialist Employment Initiative website: https://www.wicps.org/reasonable-accommodations-requests/. Submit requests to the certified peer specialist program manager at Access to Independence no later than two weeks in advance of the exam.

RECERTIFICATION PROCESS

Every two years a certified peer specialist must recertify to maintain the state certification.

- Certified peer specialists must complete 20 continuing education hours in these categories:
  - Cultural humility
  - Ethics and boundaries
  - Substance use specific
  - Mental health specific
  - Trauma-informed care
  - Peer specialist specific
- Certified peer specialists must complete 1.5 hours of continuing education hours in each of the six categories and may complete the remaining 11 continuing education hours in the categories of their choice.
- Acceptable continuing education opportunities for recertification purposes provide certified peer specialists a certificate or document that lists the number of continuing education hours they have received. Webinars, conference sessions or breakouts, in-person and virtual trainings, as well as the community of practice gatherings hosted by the Wisconsin Peer Specialist Employment Initiative that relate to the continuing education categories are appropriate options for meeting continuing education requirements.
Books or videos (examples: YouTube content, TED Talks) related to the continuing education categories do not qualify for recertification purposes.

College courses related to the continuing education categories do not qualify for recertification purposes.

- When participating in continuing education opportunities, certified peer specialists are encouraged to keep in mind the guiding ethical principles of certified peer specialists, as well as how material presented may relate to or conflict with the role of a certified peer specialist.

- All continuing education hours must be documented using the “Wisconsin Certified Peer Specialist Recertification Continuing Education Requirements” form that is available on the Wisconsin Certified Peer Specialist Employment Initiative website: https://www.wicps.org/.

- Upon completion of all continuing education hours, submit the “Wisconsin Certified Peer Specialist Recertification Continuing Education Requirements” document and the $50 recertification fee (check or money order) to the University of Wisconsin-Milwaukee School of Continuing Education, which manages this process through a contract with Access to Independence.

  UWM School of Continuing Education
  ATTN: Gloria Lane
  161 W. Wisconsin Ave., STE 6000
  Milwaukee, WI 53203

The records and documentation regarding continuing education hours maintained by certified peer specialists may be audited by the Wisconsin Certified Peer Specialist Employment Initiative. Keep your records and documentation for two years.

**VISIT THE WEBSITE**

The Wisconsin Peer Specialist Employment Initiative website is home to the following important information.

- Upcoming trainings: https://www.wicps.org/trainings/
- Upcoming exams: https://www.wicps.org/exams/
- Recertification information: https://www.wicps.org/recertification/
- Continuing education guidelines: https://www.wicps.org/continuing-education/
- Employment opportunities https://www.wicps.org/jobs/
- State and national resources: https://www.wicps.org/resources/
• Support for employers and supervision: https://www.wicps.org/resource_cat/employer-resources/?post_types=resource

• Information on certified peer specialists: https://www.wicps.org/certified-peer-specialist/

• Information on the certified parent peer specialists: https://www.wicps.org/parent-peer-specialist/

• Links to the Wisconsin Peer Specialist Employment Initiative social media accounts
  o Instagram: https://www.instagram.com/wicps/
  o Facebook: https://facebook.com/wicps.org
  o LinkedIn: https://linkedin.com/company/wicps

JOIN THE EMAIL CONTACT LIST

The Wisconsin Peer Specialist Employment Initiative encourages aspiring and current certified peer specialists to sign up for the Wisconsin Peer Specialist Employment Initiative’s email list. Bulletins are sent regularly on continuing education opportunities, professional development and networking opportunities, employment opportunities, and upcoming training courses and certification exams. Sign up for the email list at: https://www.wicps.org/contact/

OPPORTUNITIES FOR EMPLOYMENT

Opportunities for employment include:

• Advocacy organizations.

• Community mental health and substance use programs in which certified peer specialists can perform an array of tasks within their scope of practice.
  o Community Support Programs
  o Crisis services

• Community mental health and substance use programs that offer peer support services within their service array.
  o Comprehensive Community Services
  o Community Recovery Services
  o ED2Recovery

• County jails.

• Hospitals.

• Independent living centers.
• Nonprofit organizations.
• Peer recovery centers.
• Peer-run respites.
• Prisons and treatment facilities operated by the Wisconsin Department of Corrections.
• School-based mental health programs sponsored by the Wisconsin Department of Public Instruction.
• Treatment alternative programs and treatment alternative diversion court programs supported by the Wisconsin Department of Justice.

FUNDING FOR PEER SUPPORT SERVICES

Funding for peer support services comes from a variety of sources. Wisconsin Medicaid provides reimbursement for services delivered by certified peer specialists within the service arrays of Comprehensive Community Services and Community Recovery Services. Other funding sources include Wisconsin’s share of two federal block grants (Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant), and grants to community-based organizations from state agencies supported by federal tax dollars, state tax dollars, and/or state program revenue. Tribal, county, and municipal governments may provide funding for services. Private funding and donations also support services.

SUPERVISION OF CERTIFIED PEER SPECIALISTS

When certified peer specialists work within an agency or program that receives Medicaid reimbursement for peer support services, the certified peer specialist must receive supervision by a mental health professional. The supervision must be coordinated within the context of service plans and provide opportunities for continuing education.

When certified peer specialists work in an agency that does not receive Medicaid reimbursement for peer support services (examples: a peer-run respite, peer-run organizations), the certified peer specialist must receive regular supervision by a professional who understands the role of the certified peer specialist, ideally from first-hand experience working within that role. Supervisors should focus on not only employment, but also the certified peer specialist’s work and skills in working with individuals with mental health and substance use challenges. Certified peer specialists and employers should be aware if the program or agency’s funding sources have supervision requirements and abide by those.
DOCUMENTATION

Documentation of peer support services provided is required for county-operated programs (examples: Comprehensive Community Services, Community Recovery Services, Community Support Programs, and crisis services). Documentation is important because it provides a record of the provided services and a mechanism through which the program can bill Medicaid for reimbursement.

While the documentation format will vary from program to program, in general, documentation includes the following elements: date, the amount of time, the name of the individual receiving the services, the name of the certified peer specialist providing the services, and a brief description of the peer support provided by the certified peer specialist. The certified peer specialist should work with their supervisor to understand the type and content of the documentation that is needed. For example, some certified peer specialists prefer to use collaborative documentation as a way to include the peer in the process of documentation. Such documentation is done with the peer present to include them in the documentation process. This empowers the peer to know what is being documented and gives them the ability to comment on the documentation so those comments can be included in the progress and case notes.

Certified peer specialists may be concerned that some information shared by the person they are supporting was confidential and the person requested that it not be included in their case notes. When this occurs, it is essential that certified peer specialists strive to ensure that the confidentiality and privacy of their peer is respected. If employer policy dictates it is necessary to include specific information that is disclosed, for instance, if a person is considering suicide, the certified peer specialist will make sure that the peer is informed of this policy at the start of services. When such a scenario is encountered, the certified peer specialist will inform the peer that the information must be documented, and they will discuss with the peer how they would like the note to reflect their experience.

Certified peer specialists should ensure that their documentation is strengths-based, person-centered, and recovery-oriented whenever possible. Their notes need to reflect the lens through which they are providing support and, at times, may be in conflict with the requirements set by employers or funding sources. When this situation arises, certified peer specialists need to discuss how to balance both requirements with their supervisor. Additional training may be available around this area.

It is recommended that upon starting employment that the certified peer specialist discuss all program requirements with their supervisor, including requirements for documentation, if any.
Certified Peer Specialist Practice Overview

(60 MINUTES)

OBJECTIVE

To define the role and practice of the certified peer specialist and consider the concept of recovery.

METHOD

1. Read Exploring the Certified Peer Specialist Practice. Facilitate a large group discussion. Ask participants: “What gets you excited about becoming a certified peer specialist?”

2. Distribute Wisconsin Certified Peer Specialist Scope of Practice and Wisconsin Certified Peer Specialist Core Competencies documents and provide a brief overview to each.
   a. Wisconsin Certified Peer Specialist Scope of Practice
   b. Wisconsin Certified Peer Specialist Core Competencies

3. Before reviewing Defining Recovery, facilitate a solitary writing activity to introduce the topic of recovery. Distribute five sticky notes to each participant with these instructions: “Think for a moment about your own experiences with recovery. From your perspective, what are some of the most important aspects of recovery? On each sticky note, please write one important aspect of recovery using a word or a phrase. You don’t have to use all the notes but try to identify at least two or three.” Place 10 flip charts on walls around the room during the solitary writing activity. At the top of each flip chart, write a Substance Abuse and Mental Health Services Administration domain of recovery: hope, person-driven, many pathways, holistic, peer support, relational, culture, addressing trauma, strengths/responsibility, or respect.

4. Read Defining Recovery.

5. Facilitate Activity: Defining Recovery.
   a. Provide these instructions: “With the 10 domains of recovery around the room on flip charts, please find the domain that best fits with each of your important aspects of recovery and post your sticky note under that domain.”
   b. Note flip charts and domains that have many sticky notes and ask the participants: “How does our collective understanding of recovery seem to fit with these domains?”
c. Note flip chart pages that have few or no sticky notes and ask the participants: "How does our collective understanding of recovery seem to differ from these domains?"

Participants bring a wealth of understanding and experiences with recovery. Recognize and affirm the wisdom in the room, even for those who do not find meaning or value in the term for themselves. Emphasize the point that recovery is a deeply personal process. There is no one right way to define it. However, the certified peer specialist can consider principles of recovery that can inform effective peer support, including how various definitions of recovery can support a life of wellness, meaning, and purpose.

6. Read *Principles of Strengths-Based Recovery*.

7. Facilitate an activity based on *Principles of Strengths-Based Recovery*.
   a. Pair and share. Ask participants to choose a partner. Take turns discussing what principle of recovery most resonates with their personal experience and why.
   b. Large group share-out. Bring participants back together. Have a few participants briefly identify the recovery principle that most resonates with their personal experience and why.
Exploring the Certified Peer Specialist Practice

- The certified peer specialist and peer build a relationship that promotes respect, trust and connection, and empowers individuals to make changes and decisions to enhance their lives.

- The certified peer specialist practice is grounded in four fundamental processes: connecting, exploring, supporting, and planning. These processes are ongoing, flexible, dynamic, and intersect in interesting ways. These processes also guide the practice of peer support. For example, connecting is first because it is the process through which the peer relationship is developed.

- The certified peer specialist approach is based on a belief that individuals with lived experience have the right to make informed decisions about their lives and build meaning.

- The certified peer specialist focuses on peer strengths.

- The certified peer specialist supports peers to connect with resources in the community.

- The certified peer specialist connects with peers who have lived experience with mental health and substance use challenges. Support happens through careful
listening, curiosity and exploration, inspiring hope, and examining supports and resources for recovery.

- The certified peer specialist is a nonclinical professional who offers valuable support to those with lived experience.

- The certified peer specialist is a person who has lived experience with mental health and/or substance use challenges, who has had formal training in the peer specialist practice of mental health and/or substance use recovery, and who has passed the certified peer specialist exam.

- The certified peer specialist is an active member of the peer’s treatment and recovery team. During team meetings, the certified peer specialist integrates the values, perspectives, and practices of peer support into interactions with other team members.

- The certified peer specialist engages in advocacy on three levels. They advocate with their peer to address the peer’s individual needs, for themselves as a peer specialist within their role in the service delivery system as well as within their employment, and they approach advocacy more generally at the team, agency, and systems levels.
Defining Recovery

Many definitions of recovery exist because recovery is a deeply personal process. In an effort to provide a general perspective, the Substance Abuse and Mental Health Services Administration, a federal agency, defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

According to the Substance Abuse and Mental Health Services Administration, there are ten domains of recovery: person-driven, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/responsibility, respect, and hope.

---

**TEN DOMAINS OF RECOVERY**

- Person-driven
- Many pathways
- Holistic
- Peer support
- Relational
- Culture
- Addresses trauma
- Strengths/responsibility
- Respect
- Hope
Activity: Defining Recovery

Grab the sticky notes you completed during the solitary writing activity. Look around the room. Find the domain that best fits with each of your important aspects of recovery and post your sticky note under that domain.

The following questions will be discussed during a large group debrief.

- How does our collective understanding of recovery seem to fit with these domains?

- How does our understanding of recovery seem to differ from these domains?

- In what ways does the Substance Abuse and Mental Health Services Administration’s model of recovery relate to wellness? How does a relationship between recovery and wellness vary when considering personal definitions of recovery?
Principles of Strengths-Based Recovery

Traditional mental health and substance use delivery systems are highly influenced by the medical model. The basic approach is diagnosis and treatment in order to maintain an individual’s stability. The focus is on examining an individual’s deficits, assessing symptoms, making a diagnosis, and then treating symptoms; it is a disease-centered approach.

In recent years, a movement has emerged to challenge the medical model approach to care. The new approach focuses on person-centered care with an emphasis on an individual’s strengths and the possibilities of recovery. This approach allows treatment providers and certified peer specialists to acknowledge that people are not their symptoms and that each individual has a unique set of strengths and abilities that can foster recovery, health, and wellness.

The certified peer specialist profession is firmly rooted in the person-centered, strengths-based, and recovery-oriented approach to care. The following recovery principles guide the process of providing effective peer support.

- **The focus is on the person’s strengths—not pathology, symptoms, weaknesses, problems, or deficits.** At best, focusing on problems restores a person to the status quo. The certified peer specialist and peer work together to identify strengths in order for the peer to work towards achieving their hopes and dreams. This focus is person-centered and positive.

- **Community engagement and relationships are viewed as a source of support, not as obstacles to a person’s recovery.** The certified peer specialist believes that healing happens in relationships. People benefit when connected to natural supports and resources in their community. Communities are rich with resources that benefit everyone, including those who have lived experience. Acknowledging the importance of these supports also helps certified peer specialists engage peers in a way that honors their unique cultures.

- **Support is based on the principle of a person’s self-determination.** Nothing should be done without the peer’s input and approval. A certified peer specialist believes in the right of every person to make their own informed decisions about how to navigate their lives. The freedom to take risks and self-direct a person’s own life is a cornerstone of peer support.

- **The peer relationship is unique and essential.** The certified peer specialist is able to be there with the person they are supporting when life becomes tough or they are in crisis. Having a trusted professional and supportive relationship with another person with lived experience is important. It provides a unique benefit in navigating particularly intense times.
• **It is preferable to meet with a peer in the community.** Meeting at a park, a peer’s home, library, or café goes a long way in developing a genuine peer relationship. The certified peer specialist will learn more about the person they are supporting when they connect in the context of their environment and community.

• **People continue to grow, learn, and change no matter the challenges they may face.** The strengths-based recovery approach is oriented around building on the peer’s existing strengths to work towards the goals they would like to achieve in their lives.

The person-centered, strengths-based, and recovery-oriented care approach is relatively new to human service systems. It may be a new experience for people to have their voices heard, their strengths seen, and their personal decisions supported.
Practicing Self-Care

(25 minutes)

OBJECTIVE

To introduce the concept of self-care and how it relates to providing effective peer support.

METHOD

1. Read *Practicing Self-Care*.
2. Allow time for solitary writing activity.
3. Facilitate large group discussion. Note participant responses on flip charts titled:
   a. Regular/daily self-care strategies
   b. Class time self-care strategies
4. Inform participants that self-care will be a theme throughout the course. Remind participants that a group guideline is "take care of yourself" and that people should feel free to take a break as needed. Keep the flip charts created during this section visible throughout course as a reminder of self-care activities.
Practicing Self-Care

Providing peer support can be stressful, draining, and depleting. Practicing self-care is critical for providing peer support. In order to be effective, you must be able to show up present and attentive to another's needs. This means you must recognize your own needs and seek to take care of yourself.

This is a solitary writing activity.

List ways that you practice self-care. How do you take care of yourself on a regular or daily basis in your life? Please be specific.

In this course, real, sensitive, and delicate topics will be addressed that can arouse strong emotions. What are some ways that you can take care of yourself while remaining engaged in learning?
Assign Homework

(10 MINUTES)

OBJECTIVE

To consider the benefits of peer support from the peer and certified peer specialist perspectives and review information relevant to becoming a certified peer specialist.

METHOD

1. Assign Why Peer Support?
2. Assign Readings and Response.
3. Assign Wisconsin Certified Peer Specialist Certification Exam Practice. (Note: Email the link you received to the sample exam for the class to all course participants.)
**Why Peer Support?**

Take a few minutes to reflect on why peer support is important. First, consider the benefits that peers may receive. Then, consider the benefits that you may receive in the certified peer specialist role. In the space below, write out the anticipated benefits from each perspective.

<table>
<thead>
<tr>
<th>Benefits to Peers</th>
<th>Benefits to Certified Peer Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Readings and Response

Review the contents of each document, and then respond to the questions below.

- Wisconsin Certified Peer Specialist Scope of Practice

- Wisconsin Certified Peer Specialist Core Competencies

- Wisconsin Certified Peer Specialist Code of Ethics

1. What were your top two or three takeaways from reviewing the information?

2. What questions or concerns came up?

3. How does what you learned get you thinking about the practice of providing peer support?
Wisconsin Certified Peer Specialist Certification Exam Practice

The Wisconsin Certified Peer Specialist Certification Exam is based on four core competencies, grouped into four domains: values, in-depth knowledge of recovery, roles and responsibilities of a certified peer specialist, and skills. Questions may integrate knowledge of all core competencies.

To understand the core competencies of the certified peer specialist profession, refer to the following documents.

- Wisconsin Certified Peer Specialist Scope of Practice
- Wisconsin Certified Peer Specialist Core Competencies
- Wisconsin Certified Peer Specialist Code of Ethics

SAMPLE EXAM

Check your email for a link to the sample exam.

Allow at least 30 minutes to take the sample exam.

You may not know the answer to all of the questions on the sample exam. Try your best at answering each question. The purpose of this exercise is to help you understand the content and structure of the Wisconsin Certified Peer Specialist Certification Exam.
Section 2

This section begins with ethics, confidentiality, and professional boundaries. To promote a better understanding of ethics, a small group activity is completed. Then, resiliency and trauma is covered. Participants have the opportunity to take the resiliency questionnaire and the adverse childhood experiences quiz, allowing better understanding how their lives may be affected by protective factors and trauma. This section concludes with the effects of disrupted neurodevelopment, trauma triggers, and reactions. A homework assignment is introduced, with a focus on solidifying learning from this section.
Curriculum Guide

SECTION 2

15 minutes  Review Homework
60 minutes  Ethics, Confidentiality, and Professional Boundaries
70 minutes  Resiliency and Trauma
10 minutes  Practicing Self-Care
15 minutes  Break
45 minutes  Resiliency and Trauma (continued)
5 minutes  Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>Believes that personal growth and change are possible</td>
</tr>
<tr>
<td>1.6</td>
<td>Believes in the importance of self-awareness and self-care</td>
</tr>
<tr>
<td>1.7</td>
<td>Believes in lifelong learning and personal development</td>
</tr>
<tr>
<td>1.10</td>
<td>Believes in the healing power of healthy relationships</td>
</tr>
<tr>
<td>2.3</td>
<td>Knowledge of the basic neuroscience of mental health and addiction</td>
</tr>
<tr>
<td>2.5</td>
<td>Knowledge that recovery and wellness involves the integration of the whole person, including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community</td>
</tr>
<tr>
<td>2.6</td>
<td>Knowledge of trauma and its impact on the recovery process</td>
</tr>
<tr>
<td>2.9</td>
<td>Knowledge of the impact of discrimination, marginalization, and oppression</td>
</tr>
<tr>
<td>3.2</td>
<td>Knowledge of ethics and boundaries</td>
</tr>
<tr>
<td>3.4</td>
<td>Knowledge of confidentiality standards</td>
</tr>
<tr>
<td>3.5</td>
<td>Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions</td>
</tr>
<tr>
<td>4.1</td>
<td>Ability to bring an outlook on peer support that inspires hope and recovery</td>
</tr>
<tr>
<td>4.9</td>
<td>Ability to recognize and affirm a person’s strengths</td>
</tr>
<tr>
<td>4.14</td>
<td>Ability to know when to ask for assistance and/or seek supervision</td>
</tr>
<tr>
<td>4.15</td>
<td>Ability to set, communicate, and respect personal boundaries of self and others</td>
</tr>
<tr>
<td>4.19</td>
<td>Ability to advocate for self in the role of a certified peer specialist</td>
</tr>
</tbody>
</table>
Review Homework

(15 minutes)

OBJECTIVE
To explore learning results from the assignments.

METHOD
1. Ask participants: “What are some reasons why peer support is important?”

2. Encourage participants to share some of their responses from reviewing the Wisconsin Certified Peer Specialist Scope of Practice and Wisconsin Certified Peer Specialist Core Competencies documents.

3. Ask participants: “How did you do on the practice exam?”
   a. Read the correct answers aloud and write on flip chart.
   b. Discuss briefly the concerns and questions from the participants related to the content and structure of the exam.
Ethics, Confidentiality, and Professional Boundaries

(60 minutes)

OBJECTIVE

To review and discuss the ethical, legal, and practice obligations of the certified peer specialist.

METHOD

1. Encourage participants to share some of their responses from reviewing the Wisconsin Certified Peer Specialist Code of Ethics document.

2. Facilitate Activity: Ethics Practice.
   a. Work through the first scenario as a large group to demonstrate the process, and then launch the small group work.
   b. Small group work.
      i. Have participants get into groups of three or four.
      ii. Assign each group one of the scenarios on the Activity: Ethics Practice with the exception of the first scenario.
      iii. Ask the group to review the scenario, identify the ethical dilemma, and reference the relevant code that relates to the dilemma in the Wisconsin Certified Peer Specialist Code of Ethics. They should discuss how to ethically navigate the situation and be ready to share out to the large group.
   c. Large group share out. Facilitate discussion by having each small group report to the large group the results of discussion.
   d. Remind participants that certified peer specialists practice peer support in ways that are consistent with the Wisconsin Certified Peer Specialist Code of Ethics.

3. Read Confidentiality.

4. Read Professional Boundaries.

5. Note that the key documents governing the certified peer specialist profession, such as the Wisconsin Certified Peer Specialist Code of Ethics, may seem bureaucratic and boring. However, understanding these key documents is important for being able to establish and assert professional boundaries of the certified peer specialist profession.
Activity: Ethics Practice

1. Mary has been an exceptional certified peer specialist for the past two years and is currently going through a very difficult divorce. The strain of the divorce has resulted in sleep difficulties, significant weight loss, and concern by Mary about her sobriety and mental wellness. What would be an ethical practice for Mary?

2. Ricardo, who has worked as a certified peer specialist for more than a year, experienced a short relapse while attending an out-of-town wedding. Because the lapse was of such short duration, Ricardo plans not to disclose the relapse to the organization through which he provides peer support services. What ethical issues are raised by this situation? What should Ricardo do?

3. Zia has many assets that would qualify her as an excellent certified peer specialist, but in interviewing her for a certified peer specialist position, you are concerned about one potential problem. Zia passionately believes that the 12-step program of Alcoholics Anonymous is the only viable framework of long-term addiction recovery, and she expresses considerable disdain for alternatives to Alcoholics Anonymous. What ethical issues could arise if Zia brought her biases in this area into her work as a peer specialist?

4. Barry’s supervisor has assigned a new person for Barry to visit in his role as a peer specialist. Barry recognizes the name as a person to whom Barry once sold drugs in the past. Does Barry have a responsibility to report this to his supervisor? Why or why not?

5. Gina has been working as a certified peer specialist for three years and has developed a close relationship with Julie. Julie has worked through some big issues and leans in to give Gina a hug at the end of their session. Is this an ethical issue? Why or why not? Now, change Julie to James and answer the same questions.

6. Carrie is a new certified peer specialist at a mental health center at which she does not receive services. Their supervisor is constantly asking her about her “mental health issues,” what medication she is on, and what she wants from the supervisor if she gets “symptomatic” at work. The supervisor has asked Carrie to go over her Wellness Recovery Action Plan with her. Carrie does not want to discuss these issues with her supervisor. What ethical issues come into play in this scenario?
7. Ahmed has been going to the Middletown Mental Health Center for four years. He has developed many skills and has connected with resources and supports to aid him in his recovery. Over the past four years, he has developed many strong relationships with other peers at Middletown. Currently, the only service he receives from Middletown is a monthly meeting with his psychiatrist. The agency has decided to hire a certified peer specialist on the Comprehensive Community Services team, and Ahmed has applied for the position. What ethical considerations come into play?

8. Janice has been receiving peer support services from your agency for years. While you are grocery shopping, you run into Janice’s mom and she begins to ask how Janice is doing. What ethics or boundaries apply in this situation?

9. Tim is a peer with whom you have been working for several months. He has sent you a friend request on social media and asked why you have not accepted it. How would you answer and what ethical considerations need to be taken?
Confidentiality

Through the process of peer support, peers open up about their life and disclose personal, intimate details about relationships, concerns, struggles, and challenges. This disclosure to the certified peer specialist is sacred. What the peer shares in confidence must remain confidential. Confidentiality inspires trust and is critical for establishing and maintaining a good working peer relationship.

It is your responsibility to understand:

- Federal law and the Health Insurance Portability and Accountability Act (HIPAA).
- Wisconsin statutes and Wis. Admin. Code ch. DHS 94.
- The *Wisconsin Certified Peer Specialist Code of Ethics*.
- The employing agency's policies and procedures. For example, the certified peer specialist is able to share relevant information about a peer within the treatment team. In addition, each agency will have guidelines for how to report danger and safety risks.

According to the above regulations and policies, there are also limitations to confidentiality that can arise during the process of providing peer support. It is important to discuss these limitations of confidentiality during the initial meeting with a peer. Certified peer specialists have to disclose when:

- A peer expresses intention of doing serious harm to themselves or others. Talk with the agency supervisor in these situations. It is not your role to assess for safety. This will be discussed more in later sections of this course.
- A peer discloses abuse from a caregiver.
- A court orders testimony or records.

Although confidentiality regulations, policies, and limitations are clear, sometimes the rules in practice are less clear. For example, consider the following questions:

- How do you talk with other members of the treatment team about your work with a peer?
- What do you document about your conversations with a peer?
- How do you decide if/when confidentiality should be broken?
- If the decision is made to break confidentiality, how do you maintain peer support?
- What happens if you mistakenly provide identifying information about a peer?

There is complexity in these questions. The bottom line is that it is okay to reach out and ask for assistance in navigating situations of confidentiality and disclosure.
Professional Boundaries

Certified peer specialists are expected to understand and follow the employing agency's policies, procedures, and performance expectations. However, there may be times that the certified peer specialist's work conflicts with agency expectations. The nature of conflict may be due to differing service delivery philosophies, values, and approaches. For example, the certified peer specialist approach is grounded in a person-centered, strengths-based, recovery orientation while most human services agencies follow a medical model approach.

Conflict is an opportunity to educate. Because the certified peer specialist role is relatively new to the field, clarifying professional boundaries will sometimes be necessary. The certified peer specialist can initiate an ongoing conversation within the agency in several ways:

- **Discussions with leadership.** Ask leadership to review the employer toolkit provided on the Wisconsin Certified Peer Specialist Employment Initiative website. This toolkit provides information about the role of a certified peer specialist. Schedule time to meet, review, and discuss.

- **Discussions with a supervisor.** Share the following documents: *Wisconsin Certified Peer Specialist Scope of Practice*, *Wisconsin Certified Peer Specialist Core Competencies*, or *Wisconsin Certified Peer Specialist Code of Ethics*. Schedule time to meet, review, and discuss.

- **Discussions with co-workers.** There are many opportunities for informal discussions with co-workers as well as formal discussions during team meetings about the philosophies, values, and approaches of peer support.

In all of these discussions, you can demonstrate skillful communication to model the practice. Use your OARS skills (Open Questions, Affirmations, Reflections, and Summary) to draw out various perspectives, affirm willingness and interest to engage discussion, and listen carefully with reflection (see Section 3). Provide information in a skillful manner (see Section 5). Use advocacy strategies (see Section 11).

You are never alone in these conversations. Please reach out to others in the certified peer specialist community to prepare for these discussions. You or your agency leadership can reach out to the certified peer specialist program manager at Access to Independence for questions or support.
Resiliency and Trauma

(115 minutes)

**OBJECTIVE**

To understand the importance of resiliency and trauma in providing effective peer support and consider the topics from personal experience through completion of brief self-assessments and discussion.

**METHOD**

1. Read *Resiliency*.
   a. Facilitate a large group discussion by asking participants these questions:
      i. How might peer support create and foster some of these protective factors?
      ii. How might you challenge yourself to think about ways cultural identity can cause trauma?

2. Ask participants to complete the *Resilience Questionnaire*.

3. Read *Understanding Developmental Trauma*.
   a. Provide an example of developmental trauma after reading the opening section of this document.
      i. Use a personal example or the following: A man was in a car accident. He was ejected from his vehicle and immediately rendered unconscious. When he was ejected, he skidded across the dirt and laid there until help arrived. The medical helicopter came and transported him to the hospital. He remained in critical care for weeks. After several months and countless surgeries, he was released from the hospital. For years afterward every time he heard a helicopter, he would taste soil in his mouth. Even though he was not conscious during the event, his body remembered the taste of soil in his mouth when the helicopter came for him that day.
      ii. Ask an open question to engage the participants in a large group discussion.
   b. Ask participants after the large group discussion and before moving on to the “Acute Trauma Versus Complex Trauma” section: “What do you already know about trauma?” Allow participants to discuss briefly their trauma knowledge and experience.
   c. Continue to read.
      i. Pause to ask open questions (Why might this be? How might this create difficulty in developing and maintaining relationships?)
ii. Allow participants to ask questions throughout the reading.

d. Remind participants of the resilience questions they explored before this reading at the end of the “Types of Trauma” section. Each person’s experience is uniquely their own. Understanding the balance of protective factors and adversity is a completely individual experience. A trauma-informed approach is to assume that people are doing the best they can with what they have experienced.

e. Instruct participants to examine the Finding Your Adverse Childhood Experience Score. Allow five minutes for participants to complete the questionnaire if they choose. Allow five minutes for participants to discuss their findings in a large group discussion. Read the needs of your group. If people are triggered by the questions or discussion, it may be appropriate to take a short break or do a self-care activity before moving on.

f. Watch video: “Hand Model of the Brain.” Facilitate a large group discussion. Ask participants: “Have you ever ‘flipped your lid’?” “Have you ever seen another person ‘flip their lid’?” “What assumptions do you think people make when they see others ‘flip their lids’?”

g. Ask participants at the end of the “Understanding Disrupted Neurodevelopment” section: “What are some things you’ve experienced in times of heightened stress?” Facilitate a large group discussion.

h. Facilitate a large group discussion after the “Triggers” section.

i. Present the following to the participants: Think about a peer who experiences a lot of dysregulation, who “flips their lid” easily, who does not have access to self-soothing tools, who has a very negative view of the world, or who struggles with a mixture of different negative aspects of trauma. Facilitate a large group discussion using the following prompts. If their response was seen as willful, intentional, bad behavior: How have they typically been responded to? What do you think people’s assumptions were of the behavior? How might they have been held accountable, or “taught a lesson” about their behavior? How might responses like this impact a peer’s view of themselves in the world? In the certified peer specialist role, how can these harmful perspectives and responses be avoided?
Resiliency

The Wisconsin Children’s Mental Health Collective Impact Coalition-Resiliency Workgroup defines resiliency as the ability to overcome challenges of all kinds and to bounce back stronger, wiser, and more powerful. People bounce back in two ways: they draw upon their own internal resources and/or they encounter people, organizations, and activities that provide them with the conditions that support resilience.

The Substance Abuse and Mental Health Services Administration says that protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor’s impact. Protective factors may be seen as positive countering events. Many protective factors exist within these internal and external conditions.

Caring relationships/building community. Caring relationships are grounded in listening with established safety and trust. This is conveyed through compassion, understanding, respect, and curiosity. Positive peer relationships are based on similar values. A sense of belonging to the larger community is intentionally cultivated.

Meaningful participation. People are involved in decisions that directly affect their lives. They are recognized as a valuable contributor; people have what they need to reach their goals and can seek out and advocate for the resources they need.

Positive and high expectations with support. Positive and high expectations convey belief in people’s innate resilience. Look for strengths versus deficits.

Mastery. People require experiences that allow them to develop skills and mastery with something in order to develop self-efficacy and self-confidence.

Real talk. People want honest and open conversations about recovery and the issues important to them.

Creative expression. This is about having the opportunity to express one's imagination, to tell one's story, and to connect one's inner experience, drive, call, and feelings to the outer world.

Service to others. People benefit from opportunities to utilize their strengths and skills to help others and to connect to the community in ways that are meaningful to them.

Families (as defined by the peer) as partners in building resilience. Families provide the strongest influence for resilience and promoting protective factors. Actively explore with peers how they can connect with and include the individuals they feel closest to.

Cultural identity. Cultural identity and affiliation can be a source of resiliency. It is important to honor how peers define the role that culture plays in their lives.
Parent and adult resilience. For youth and young adults, the parents and adults who are connected to the young person promote their own resilience through staying connected to their sense of purpose and modeling resilience for young people.

Peer support matters. A recent study of adult resilience showed that supportive relationships, opportunities to engage with community, and people to look up to during childhood (among other protective factors) reduced by half—from 29% to 14%—the adult prevalence rate of mental illness. Certified peer specialists are in an ideal position to create and foster some of the protective factors that increase a person’s resilience.

For more information

Centers for Disease Control and Prevention: Adverse Childhood Experiences
https://www.cdc.gov/violenceprevention/aces/index.html

ACEs Connection: Got Your ACE, Resilience Scores?
https://www.acesconnection.com/blog/got-your-ace-resilience-scores

The Philadelphia ACE Project: Philadelphia ACE Survey
https://www.philadelphiaaces.org/philadelphia-ace-survey

Wisconsin Department of Health Services: Resilient Wisconsin
https://www.dhs.wisconsin.gov/resilient/index.htm

Wisconsin Office of Children’s Mental Health
https://children.wi.gov/
RESILIENCE QUESTIONNAIRE

Using the following 0-4 response scale, circle the number that best fits with your experience.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Definitely not true</td>
<td>Probably not true</td>
<td>Not sure</td>
<td>Probably true</td>
<td>Definitely true</td>
</tr>
</tbody>
</table>

1. I believe my mother loved me when I was little. 0 1 2 3 4
2. I believe that my father loved me when I was little. 0 1 2 3 4
3. When I was little, other people helped my parents take care of me and they seemed to love me. 0 1 2 3 4
4. I’ve heard that when I was an infant, someone in my family enjoyed playing with me and I enjoyed it too. 0 1 2 3 4
5. When I was a child, there were relatives in my family who helped me feel better when I was sad or worried. 0 1 2 3 4
6. When I was a child, neighbors or my friends’ parents seemed to like me. 0 1 2 3 4
7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me. 0 1 2 3 4
8. Someone in my family cared about how I was doing in school. 0 1 2 3 4
9. My family, friends, and neighbors talked about making our lives better. 0 1 2 3 4
10. We had rules in our house and were expected to keep them. 0 1 2 3 4
11. When I felt really bad, I could almost always find someone I trusted to talk to. 0 1 2 3 4
12. As a youth, people noticed that I was capable and could get things done. 0 1 2 3 4
13. I was independent and a go-getter. 0 1 2 3 4
14. I believe that life is what you make it. 0 1 2 3 4
15. There are people I can count on now in my life. 0 1 2 3 4

How many of these protective factors did I have as a child and youth?
(How many of the first 14 were circled “Definitely True-4” or “Probably True-3”)

__________

Of those circled, how many are still true for me?

__________
Understanding Developmental Trauma

Trauma-informed care is changing the way human services are provided. Consumer activism, emerging science about brain development, and prevalence data showing widespread psychological trauma in our society are all propelling transformation efforts. Services become much more effective when they are provided in a trauma-informed way and our perspectives are shifted to see behaviors as adaptations. Just as it is important for service providers to shift their perspective, it is much more hopeful for a person with trauma to understand themselves through a trauma-informed lens. This means that the root of their behavior is due to changes in their physiological response system and does not mean they are just a bad person.

For purposes of this training course, this is how trauma will be defined: Trauma refers to extreme stress like a threat to life or bodily harm, which overwhelms a person’s ability to cope. It is important to note that trauma is very subjective. What is traumatic to one person may not be traumatic to another, even if both experienced the same event.

Trauma often leaves people feeling vulnerable and helpless and may result in significant fear. It interferes with relationships and beliefs that a person has about themselves and their place in the world. It affects neurodevelopment, resulting in physiological dysregulation and heightened stress responses.

Trauma is universal and it happens regardless of age, culture, gender, socioeconomic class, and so on. It lives in the body whether a person is consciously aware of it or not. Trauma changes people on a cellular level.

ACUTE TRAUMA VERSUS COMPLEX TRAUMA

People with acute trauma often struggle with re-experiencing the situation. They may have disturbing memories and thoughts, dreams, and flashbacks, with intense psychological (relating to a mental or emotional state) or physiological (relating to the physical state) distress. This includes hyperarousal in which the body stays in high alert. Hyperarousal often causes difficulty going to or staying asleep, paying attention, and having an exaggerated startle response. Being in this hypervigilant mode is stressful on a person’s body and can cause them to seem angry and irritable. People also may experience avoidance and seem detached, numb, or disengaged from the real world. They may seem to be daydreaming or spacing out and appear to be uncaring or unmotivated.

Complex trauma is trauma that happens early in life while the brain is still developing. This extreme or toxic stress can occur when a child experiences strong, frequent, and/or prolonged adversity without adequate adult support and can create an engrained response in the person’s physiological system. There is a significant amount of stigma associated with it and individuals often experience tremendous vulnerability. When
people experience trauma in early life, they may have the same struggles associated with posttraumatic stress disorder (re-experiencing, hyperarousal, and avoidance), along with a myriad of other issues caused by disrupted neurodevelopment because of dysregulation.

Dysregulation affects a person’s emotions, making it difficult to manage feelings. The person may have low frustration tolerance and few self-soothing strategies. They often have problems using words to express needs, thoughts, and concerns. Many people struggle with feeling chronic emptiness and shame.

Cognitively a person might be catastrophizing (thoughts like: “my life sucks,” “nothing ever works right,” “I mess everything up,” and so on). People may struggle with very concrete, all or nothing thinking. They may have difficulty maintaining focus and often struggle with memory impairments.

In their interpersonal relationships, people may have difficulty assessing social cues. There may be a person who is not aware of the emotions and feelings of those around them. They may not react when people around them express their emotions. Alternatively, a person may be hyperaware of emotions and feelings of people around them. They may overreact to other people’s facial expressions or body movement and misread social cues because of it.

People may also have difficulty seeking attention in appropriate ways and have challenges in seeing another’s point of view that causes much difficulty in maintaining relationships. Additionally, they frequently experience challenges related to managing transitions, unpredictability, and change. All of this can create an unstable self-image.

A person’s behavior may be impacted by traumatic experiences. Their behavior may be impulsive. They may be at higher risk for suicide. They may engage in self-harming behavior and turn to substance use to mitigate the physiological response in their body.

Some providers are still not fully knowledgeable about complex trauma because it is not a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*. Therefore, people with trauma may be misdiagnosed. National trauma expert Sandra Bloom says, “Our labels don’t describe the complex interrelated, physical, psychological, social, and moral impacts of trauma…and they rarely help us know what to do to help.”

**CATEGORIES OF TRAUMA**

There are many categories of trauma. Here is an overview of some of the categories.

**Psychological trauma** is trauma that includes observing or experiencing a life-threatening event or being violated by people on whom you depend on for your well-being. Examples of psychological trauma include abrupt changes in health or employment, abuse of any kind, bullying, experiencing food insecurity, exploitation, disasters (natural or human-caused), violence, and war.
Sanctuary trauma is trauma that occurs in settings that are socially sanctioned as safe. Sanctuary trauma involves actions of providers or systems that bring up feelings of vulnerability, helplessness, fear, shame, etc. This can occur within the medical system, the substance use and mental health services system, justice system, foster care, child protective services, school, and faith communities. Provider bias is a part of sanctuary trauma. It refers to attitudes and behaviors by service providers that unnecessarily restrict client access and choice. These biases are often a result of a provider’s culture, religious beliefs, or lack of knowledge. Provider bias can be explicit (conscious and intentional) or implicit (unconscious and unintentional).

Historical trauma or generational trauma or intergenerational trauma is trauma that refers to the cumulative or collective emotional harm experienced by an individual or a group across generations that are still suffering the effects. Examples include racial and ethnic discrimination and violence. This type of trauma can result in people being hesitant to enter systems of care that have historically oppressed specific racial or ethnic groups. It is important that certified peer specialists support members of communities impacted by this category of trauma in the context of their individual and collective culture.

Racial trauma or race-based traumatic stress is trauma that results from race-related experiences that involve discrimination, prejudice, racism. Posttraumatic slave syndrome is a consequence of the multigenerational oppression of Africans and their descendants resulting from centuries of slavery.

Vicarious trauma is trauma that appears when an individual experiences trauma-related symptoms in response to helping others who have experienced traumatic events. Certified peer specialists may be impacted by this category of trauma. If this happens to you, validate the impact of the trauma on the peer and recognize the impact it has you. Address the distress you are experiencing. Recognize that the trauma shared does not belong to you. Practice self-care to avoid compassion fatigue or burnout.

Collective trauma is trauma that refers to a traumatic event that shared is by a group of people. It may involve a small group, like a family, or it may involve an entire society. Examples of a collective trauma include famines, mass shootings, a natural disaster, a pandemic, a plane crash, and war. People do not necessarily need to have experienced the event first-hand in order to be changed by it. Watching the events unfold on the news can be traumatic, for example.

It is important to note that trauma is a personal experience. There is still a lot more to be learned about why people are more or less impacted by traumatic events. Certified peer specialists should avoid comparing people’s experiences and responses to trauma.
Practicing Self-Care

(10 minutes)

OBJECTIVE

To acknowledge that discussing trauma is heavy work and that practicing self-care is important.

METHOD

1. Refer back to the practicing self-care flip charts from Section 1 and briefly review the identified activities.

2. Ask participants what self-care activities should be added to the list.

3. Invite participants to select and engage with a self-care activity during the break.
ADVERSE CHILDHOOD EXPERIENCES

It is important to understand the developmental roots of trauma. In a groundbreaking study, researchers Dr. Vince Felliti and Dr. Rob Anda examined 10 categories of adverse experiences during childhood including: living in a household with substance use, untreated mental illness, parental separation or divorce, domestic violence, or an imprisoned household member. They also accounted for different types of abuses including psychological, physical, and sexual, as well as physical or emotional neglect. Although the original study focused on household dysfunction, it is now known that there are many situations that can have the same impact on a person, including living in an area where there is neighborhood violence, the death of a parent or other family member, being bullied in school, and even being born prematurely or with health issues.

It is also important to understand that adverse childhood experiences or ACEs are a classification, not a measure of chronicity or severity. In other words, if a person experienced sexual abuse once in their life, this equals one adverse childhood experience. If they experienced sexual abuse twice a week for two years in their life, this still equals one adverse childhood experience.

At the University of Wisconsin-Madison, Dr. Seth Pollak researched the effects of poverty on a child’s brain development. He found that living in poverty, the very experience of a person not knowing if their basic needs will be met, can cause the same developmental changes in the brain as if the child were suffering severe abuse and neglect, even if they have a supportive family structure.

In the adverse childhood experiences research, Dr. Felliti and Dr. Anda saw a consistent relationship between adverse childhood experiences scores and percentages of health issues. They examined the correlation between adverse childhood experiences and smoking, drug and alcohol use, obesity, mental health diagnosis, life satisfaction, and illnesses like cancer, heart disease, and autoimmune diseases. What they found was that the higher a person’s adverse childhood experiences score, the more likely they are to experience health issues later in life.

Also important to recognize is the fact that various marginalized communities may experience higher average adverse childhood experiences scores. This is not due to failures of any kind by members of that community, but rather indicative of systemic oppression and historical trauma that these communities face. Certified peer specialists need to be aware of the systemic elements at play and not assign blame to individual families or communities.
FINDING YOUR ADVERSE CHILDHOOD EXPERIENCES SCORE

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often... Yes  No
   swear at you, insult you, put you down, or humiliate you?
   OR
   Act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household often or very often... Yes  No
   push, grab, slap, or throw something at you?
   OR
   Ever hit you so hard that you had marks or were injured?

3. Did an adult or person at least five years older than you ever... Yes  No
   touch or fondle you or have you touch their body in a sexual way?
   OR
   attempt or actually have oral, anal, or vaginal intercourse with you?

4. Did you often or very often feel that... Yes  No
   no one in your family loved you or thought you were important or special?
   OR
   your family didn't look out for each other, feel close to each other, or support each other?

5. Did you often or very often feel that... Yes  No
   you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   OR
   your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents ever separated or divorced? Yes  No

7. Was your mother or stepmother: Yes  No
   often or very often pushed, grabbed, slapped, or had something thrown at her?
   OR
   sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   OR
   ever repeatedly hit at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes  No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? Yes  No
10. Did a household member go to prison? Yes  No

11. Did you experience repeated bullying as a child? Yes  No

12. Did you repeatedly experience discrimination based on ethnicity, skin color, or sexual orientation? Yes  No

13. Did you live in a neighborhood that experienced gang related violence? Yes  No

14. Did you ever live in a foster home or group home? Yes  No

The Philadelphia Adverse Childhood Experiences Survey expands the questions and asks the following:

15. Did you feel safe in your neighborhood? Yes  No

16. Did people in your neighborhood look out for each other, stand up for each other, and can be trusted? Yes  No

17. Did you see or hear someone being beaten up, stabbed, or shot in real life? Yes  No

Add up your “yes” answers, this is your adverse childhood experiences score:  

For more information

ACEs Connection: Got Your ACE, Resilience Scores?  
https://www.acesconnection.com/blog/got-your-ace-resilience-scores

The Philadelphia ACE Project: Philadelphia ACE Survey  
https://www.philadelphiaaces.org/philadelphia-ace-survey
UNDERSTANDING DISRUPTED NEURODEVELOPMENT

Exploring the way human brains develop is helpful in understanding why adversity has such a long-lasting impact on a person.

"Hand Model of the Brain" - Dr. Dan Siegel
https://youtu.be/gm9CIJ74Oxw

Human brains develop from the bottom up.

The base of the brain is the reptilian brain that connects with the spinal cord and is called the basal ganglia. It includes the brainstem and cerebellum. This part of the brain is equated with animal instincts. It tells our heart to beat and our lungs to breathe. It also controls reflex behaviors, muscles, balance, and other bodily functions. This brain structure is very reactive to direct stimulation.

The limbic system is the midbrain, the center of emotion, motivation, and learning. It is unique to mammals. Everything in the limbic system is agreeable (pleasurable) or disagreeable (pain, distress). Survival is based upon avoidance of pain and reoccurrence of pleasure. During periods of stress or trauma, the limbic system can default to previous levels of response. Essentially the limbic system may not be responding to danger in the moment. The response may have been imbedded in the person’s physiological system.

The top part of the brain is the neocortex or the thinking brain. It is unique to primates. Humans have a highly evolved neocortex. This part of the brain includes the pre-frontal lobes that regulate so much of what makes a human a human: executive functioning, higher-order thinking skills, moral reasoning, speech, meaning making, and will power.

In situations where the person’s life is in danger, the limbic region is activated to help the person survive. This is the fight, flight, or freeze response. Every being is instilled with this response system in order to survive. When a being experiences the fight, flight, or freeze response, over 1,400 physiological changes happen in its body.
Fight, flight, and freeze are responses that a person is expected to have when faced with a bear threatening their life. A person’s body is wired to become activated to save them from that bear. Once the bear (or threat) is gone, human bodies are meant to return to a place of calm. However, when the stressors are continuous, when a person experiences ongoing abuses or neglect, this response keeps activating and does not allow the body to come back to a place of calm. It causes significant changes in the way their brains and bodies develop.

Researchers are starting to connect many health issues to early toxic stress and abuse based on the changes that happen in a person’s system when they are activated. Research now shows that a person with four or more adverse childhood experiences dies approximately 20 years younger than a person with no adverse childhood experiences. It is important to remember that the brain is malleable and that a person’s resilience factors can play a role in mitigating the outcomes associated with higher adverse childhood experiences scores, specifically the many long-term health implications that can be linked to shorter life expectancy.

**TRIGGERS**

Once it is understood how a person’s response system may be rewired because of trauma, there is a responsibility to think about things that may elicit a stress response in that person. People may be triggered by actions that make them feel vulnerable,
helpless, afraid, oppressed, or not in control. Other triggers include: threats or feeling threatened; isolation; interacting with authority figures; lack of information; being told what to do; being touched, watched, or ignored; and having someone ask intrusive or personal questions. Like trauma, triggers are very subjective and unique for each person.

Just about any sensory experience can be a trigger. Any sight, sound, taste, smell, or touch that reminds the person of a trauma can lead to a physiological response. It can be difficult to identify a person’s trigger without connecting with that person and supporting them as they reflect and name the trigger for themselves. Changes in body language and physiology may be important signifiers that a person is triggered. Certified peer specialists must recognize that each person’s response to a trigger is different.

Most behaviors make a lot more sense when they are put in the context of the person’s experiences. When time is taken to hear, validate, and understand that person’s story, it is possible to see the behavior from a new perspective, a trauma-informed perspective.
Assign Homework

(5 minutes)

**OBJECTIVE**

To solidify learning in this section.

**METHOD**


Review Questions

1. What role does resilience play in the peer relationship?

2. How might you support the peer in a trauma-informed way if you had to break confidentiality and disclose something the peer shared with you in confidence (example: serious thoughts of self-harm)?
Section 3

This section focuses on the core skills of the certified peer specialist. Referred to as OARS (Open questions, Affirmation, Reflective listening, Summary), these skills provide the basis of effective communication. First, an overview is provided. Then, each skill is highlighted with opportunities for discussion and practice. This section concludes with a practice assignment for homework. Because regular use of OARS skills is essential for effective peer support, practice opportunities are layered throughout the course.
Curriculum Guide

SECTION 3

10 minutes    Review Homework
15 minutes    OARS Communication Skills overview
20 minutes    Open Questions
40 minutes    Affirmation
15 minutes    Break
95 minutes    Reflection
20 minutes    Summary
5 minutes     Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Believes in and respects people’s rights to make informed decisions about their lives</td>
</tr>
<tr>
<td>1.4</td>
<td>Believes in the importance of empathy and listening to others</td>
</tr>
<tr>
<td>4.4</td>
<td>Ability to assist people in exploring life choices and the outcomes of those choices</td>
</tr>
<tr>
<td>4.6</td>
<td>Ability to listen and understand with accuracy to the person’s perspective and experience</td>
</tr>
<tr>
<td>4.7</td>
<td>Effective written and verbal communication skills</td>
</tr>
<tr>
<td>4.8</td>
<td>Ability to draw out a person’s perspective, experiences, goals, dreams, and challenges</td>
</tr>
<tr>
<td>4.9</td>
<td>Ability to recognize and affirm a person’s strengths</td>
</tr>
</tbody>
</table>
Review Homework

(10 minutes)

OBJECTIVE

To provide an opportunity to discuss the homework questions.

METHOD

1. Ask participants: “What role does resilience play in the peer relationship?”

2. Ask participants: “How might you support a peer in a trauma-informed way if you had to break confidentiality?”
OARS Communication Skills Overview

(15 minutes)

OBJECTIVE

To provide an overview of OARS (Open questions, Affirmation, Reflective listening, Summary) communication skills and engage in initial skill practice.

METHOD

1. Facilitate a large group discussion regarding the what and the why of effective communication. Start this activity by stating that skillful communication is central to providing peer support.
   a. Assign half of the participants to each discussion topic.
      i. Group 1: What does effective communication look like? What are some of the skills of effective communication?
      ii. Group 2: Why is effective communication important for providing effective peer support?
   b. Have participants turn to one another and discuss the assigned topic.
   c. Have people share out to the larger group.
      i. Ask participants to share out on topic 1 and note responses on flip chart.
      ii. Ask participants to share out on topic 2 and note responses on flip chart.

2. Write the OARS acronym on another flip chart and label each skill (Open questions, Affirmation, Reflective listening, Summary). Facilitate large group discussion. Ask participants: “How does what we just discussed about effective communication fit with OARS communication skills?”

3. Read OARS Communication Skills Description.

4. Offer this bottom line: The OARS skills are deceptively simple. Developing these skills will take time and practice. This course is designed to give you many opportunities to practice these communication skills in the certified peer specialist role. Most importantly, please be open and willing to try new ways of communicating because using these skills is different from our everyday communication.
OARS Communication Skills Description

OARS skills are simple. Developing these skills will take time and practice. Be open and willing to try new ways of communicating with these skills.

O – OPEN QUESTIONS

Open questions draw out the peer’s perspectives, experiences, thoughts, feelings, ideas, dreams, concerns, and challenges. In other words, open questions are designed to invite people to share and explore. This fosters a good connection. The opposite of open questions is closed questions. Closed questions tend to gather facts (who, what, where, when) or specific information with short or one-word responses (yes or no) and this can limit connection and exploration.

A – AFFIRMATION

Actively look for and affirm peer strengths, positive attributes, and prior successes with recovery and change. Affirmation specifically identifies strengths, positive attributes, and successes. Affirmation is about a peer’s specific strengths, not about your praise or cheerleading.

R – REFLECTIVE LISTENING

Reflective listening or reflection is the skillful expression of empathy. Whereas empathy is a way of being with people, reflection is what the listener does. Reflection involves careful listening with genuine interest and curiosity to understand the peer’s perspectives and experiences—then, like a mirror—reflecting back the meaning of what the peer shared. Reflective listening is the most important communication skill in the process of providing peer support.

S – SUMMARY

After a period of conversation, a summary ties together what the peer shared. A summary can provide a transition to the next topic or can bring closure to a meeting. Like reflection, a summary demonstrates careful listening and understanding of what the peer said.

For more information

Open Questions

(20 minutes)

OBJECTIVE
To learn more about open questions (OARS) and engage in initial practice.

METHOD
1. Provide Open Questions Skills Description.
2. Complete Activity: Open Questions. Facilitate a large group discussion to debrief the activity by discussing each item.
Open Questions (OARS) Skill Description

Open questions draw out the peer’s perspectives, experiences, thoughts, feelings, ideas, dreams, concerns, and challenges. In other words, open questions are designed to invite people to share and explore, and this fosters a good connection. The opposite of open questions is closed questions. Closed questions tend to gather facts (who, what, where, when) or specific information with short or one-word responses (yes or no) and this can limit connection.

How do you know if a question is open or closed? It is the first word that determines the type of question. Questions that start with “Can you…”, “Do you…”, “Are you…”, ‘Is there…”, and “Has there…” will always be closed questions.

Open question starters:

- What...
- How...
- Tell me about...
- Describe...
Activity: Open Questions

In groups of two or three, review the following questions and decide whether the question is open or closed (place a check box in the appropriate column). If the question is closed, turn it into an open question by writing it out in the space provided using an open question starter.

<table>
<thead>
<tr>
<th>Question</th>
<th>Open</th>
<th>Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How are you doing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are you having a good day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How can I support you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do you have some stresses in your life right now?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Can you tell me about your life?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. What concerns do you have at this time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Is there some stress happening for you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Tell me about your social supports.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you ever feel lonely?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Can you tell me where you are at in your recovery?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Now, construct two open questions that are about connecting with a peer during the initial meeting.

Connecting open question 1:

Connecting open question 2:
Affirmation

(40 minutes)

OBJECTIVE

To learn more about affirmation (OARS) and engage in initial practice.

METHOD

1. Review Affirmation Skill Description.

   a. Large group brainstorm. Ask participants: “What are some of the strengths peers have in life, community, and recovery?” Each strength should be a word or a brief phrase. Note each strength on a flip chart. Invite continued participant sharing with the open question ”What else?” (Not the closed question ”Anything else?”). Continue until about 20 strengths are noted on the flip chart.
   b. Small group work. Divide participants into groups of four or five. Assign each group about four strengths from the list and ask the group to select only one strength for the activity. Provide instructions: “Once you select the strength, brainstorm the two discussion questions. Have someone take notes to share out to the large group. Then construct two affirmations using best practices.”
   c. Large group share-out. Each group should share their selected strength, the results of the brainstorms, and their favorite affirmation of the two. Facilitator should note each affirmation, word-for-word, on a flip chart for later reference.

Affirmation (OARS) Skill Description

Certified peer specialists are strengths-based, which means certified peer specialists actively look for the strengths, positive attributes, and prior successes with recovery and change that peers present.

Affirmation best practices:

- Affirmation is specific about a peer’s strength, positive attribute, or prior success. The certified peer specialist must identify the specific strength, attribute, or success.
- Affirmation is genuine and comes from the heart.
- Affirmation is about the peer and therefore is expressed as a “you” statement (not “I”).

Examples of skillful affirmation:

- Thank you for your honesty.
- Thank you for taking a risk and sharing.
- You are being very thoughtful in the way you are handling this situation.
- With all that you have been through, you have such strong determination.
- You are a courageous person in your recovery.
- You are a resilient person to have overcome so many of life's obstacles.

Affirmation is **not** expressing approval, agreement, cheerleading, or providing nonspecific praise. The following statements may sound nice, but each falls short of a skillful affirmation. What does each statement lack? (See best practices above.)

- That is great.
- That is wonderful.
- Great job!
- I knew you could do it!
- Keep up the good work.
- I am really proud of you.

While there is good intention behind each of these statements, skillful affirmation goes beyond intention to have positive impact on peer support. Positive impact is more likely to happen when an affirmation is specific, genuine, and meaningful.
Activity: Affirmation 1
What are some strengths that peers have in life, community, and recovery?

STRENGTHS WITHIN MY PEERS
Strength: ______________________________
How do people express this strength?

How does this strength help people?

CONSTRUCT AFFIRMATIONS USING BEST PRACTICES
Affirmation 1:

Affirmation 2:
Activity: Affirmation 2

Sometimes, it is easier to see strengths in others than in ourselves. For this activity, consider strengths within yourself. What are some strengths you bring to your life, community, and recovery? Which ones do you see in yourself, or which ones might others who know you, see in you? Review the list of strengths and identify four to six strengths that you or others see. Note strengths in the space provided below.

Adventurous  Focused  Peaceful
Analytical    Friendly   Perseverant
Appreciative  Generous  Persistent
Artistic      Grateful  Practical
Assertive     Helpful   Precise
Authentic     Honest   Problem-solver
Caring        Hopeful  Quick-witted
Compassionate Humble  Resourceful
Communicative Humorous Respectful
Considerate   Independent Responsible
Courageous    Inquisitive Self-controlled
Creative      Inspirational Spiritual
Curious       Intelligent Spontaneous
Decisive      Kind    Strategic
Dedicated     Knowledgeable Team-oriented
Deliberate    Motivated Thoughtful
Detail-oriented Observant Trustworthy
Determined    Optimistic Versatile
Empathetic    Open-minded Warm
Energetic     Orderly    Wise
Enthusiastic  Organized
Fair          Outgoing
Flexible      Patient

Strengths within myself:

__________________  ___________________  ________________
__________________  ___________________  ________________

73
Reflective Listening

(95 minutes)

OBJECTIVE

Learn more about reflective listening (OARS) and engage in initial practice.

METHOD

1. Review *Reflection Skills Description*.

2. Complete activities.

   a. *Activity: Reflection 1 – Listening Roadblocks.* Provide the instructions as written. Allow participants time to complete 1-10. When it appears all participants have completed 1-10, review the text after number 10. Watch the video. As a large group, answer the questions listed. Remind participants that the *Listening Roadblocks Cheat Sheet* is a quick reference guide on listening roadblocks.

   b. *Activity: Reflection 2 – Strategies for Listening.* Participants complete the first half of this activity in pairs. Once the participants have noted some strategies bring everyone back together for a large group share out. Begin the large group share out by asking participants to share their most useful, careful listening strategy. Collect these strategies by noting each on a flip chart. After all of the strategies have been noted, offer a summary. At the bottom of the flip chart, draw a bold line and share the “bottom line.” State the following: “Each of these strategies has one thing in common and that is that a decision to listen was made. Deciding to listen is the “bottom line.” Keep the flip chart created as part of this activity for later reference.

   c. *Activity: Reflection 3 – Nonverbal Listening.* Read the instructions for each role. Ask participants not to switch until you call time. Set the timer for two minutes. This activity is awkward for most people. Allow participants to struggle through the two minutes, and then call time. Have participants switch roles, provide the same instructions again for the new roles. Set the timer for two minutes and launch the activity. Call time. Facilitate a large group discussion to debrief. Start the debrief with an affirmation. (That was a challenging activity and thank you for hanging in there through the awkwardness.) Next, ask an open question to draw out experiences for participants. (Listeners: What was nonverbal listening like for you? What else was it like? Speakers: How could you tell the person was listening to you?) Model reflective listening when responding to participant sharing.

   d. *Activity: Reflection 4 – Educated Guesses.* Provide the following instructions to set up activity: “Speakers you will begin this activity by sharing one thing that
you like about yourself. Then, no matter what happens, speakers, you will only respond yes or no. This is not a conversation. It is a training activity. Now, listeners, once you find out what the speaker likes about themselves, I want you to make an educated guess about the underlying meaning. Use the starter ‘you mean that you…’ then make your guess. Speakers, remember, you can only respond yes, the guess is in the ballpark, or no, the guess is a little bit off. Listeners, regardless of whether you get a yes or no, offer a total of four guesses. When you are done with this sequence, go ahead and switch roles and do the same sequence again.” Demonstrate the activity. Be prepared to demonstrate the speaker-listener sequence with four educated guesses. Launch the activity after your demonstration. After everyone has had a chance in the speaker and listener roles, facilitate a large group debrief to help participants make sense of this activity. The most important role in this activity was the listener role. Listeners had to make educated guesses and that required high-level cognition and thinking. Ask listeners to share what it was like in this activity. (Listeners, what was it like for you in this activity from a thinking point of view?) If you hear responses such as, “It was hard,” “It was challenging,” “I ran out of guesses,” reflect back to reinforce these experiences. (You had to listen carefully; listening in this way is challenging.) It is important to validate that listening is a deep skill that requires lots of practice to improve. Another set of responses you may hear is how listeners received immediate feedback from the speaker. This is an important insight about reflective listening worth highlighting. In conversations with peers when you hold up the mirror and reflect, you get immediate feedback on whether your guess is accurate. If your guess is accurate, people tend to light up and continue sharing; if your guess is off a bit that is okay because peers see that you are trying to understand their experience and perspective. There will be no penalty for having a guess that is off a bit.

e. **Activity: Reflection 5 – Educated Guesses (continued).** Participants complete this activity in the same pairs as the previous activity. After participants have guesses for each item, facilitate a large group share out. Read each item, one at a time, and invite pairs to share one of their guesses. Invite three to four guesses for each item. When participants share a guess, encourage the guess to be shared as a statement, not a question, because this sets up the next activity. Generate a brief discussion about why each guess seemed educated. The bottom line here is that making educated guesses about a peer's underlying meaning feels risky because of the fear that the guess may be off or inaccurate. Being a skilled listener requires people to listen carefully not just to the words the person is saying, but also the meaning underneath the words. The risk may be worth it because the benefit is that with understanding, strong connections with peers are formed very quickly.
f. **Activity: Reflection 6 – Why Statements, Not Questions For Reflection.** Start with a pair and share or turn to neighbor for discussion on why statements, not questions, are key for reflective listening. Next, facilitate a large group discussion. Draw out ideas and perspectives on the question. It is all right that participants struggle to answer this question. In fact, the struggle will deepen understanding of this important aspect of reflective listening. At the same time, you will want to have a response at the ready. This is a description from William R. Miller: "It usually feels strange at first to be making a statement rather than asking a question. After all, you know that what you are saying is a guess, so shouldn't you be asking instead of telling? Here is one reason why. Linguistically, a question places a demand on the person for an answer. It is a subtle pressure, a micro-interrogation... What happens when you offer a reflective listening statement? Typically, the speaker keeps right on talking, moving along the same road without having to dodge a roadblock. Sharing reflective listening as statements allows people to express and explore their own experience without interference." The bottom line is that we are not used to listening in this way and, for many, offering reflections as a statement will feel awkward and uncomfortable. That is all right, and it is the reason why the course is designed to offer opportunities to practice developing this critically important skill.

g. **Activity: Reflection 7 – Reflection as Statements.** Read each question. Make sure your voice goes up at the end for a question. Participants all together aloud should turn the question into a statement. Use the same words, but change the voice inflection. Make sure your voice goes down at the end for a statement.

3. Remind participants that the *Reflective Listening Cheat Sheet* is quick reference guide to reflective listening. Review this document in a large group discussion. The review should cover all aspects of reflective listening, including levels and types of reflection within the examples, reflection starters, and reflection best practices.

4. Complete **Activity: Reflective 8.** Provide the instructions as written.
Reflection (OARS) Skill Description

In this course, skillful listening is referred to as reflective listening or simply reflection. Reflection is the expression of empathy. Empathy is a way of being with people that is nonjudgmental, accepting, and curious about another’s feelings, perspectives, and experiences. Empathy is like putting yourself in another person’s shoes while remaining in your own shoes.

Whereas empathy is a way of being with people, reflection is what the listener does. Reflection involves careful listening with genuine interest and curiosity to understand the peer’s perspectives and experiences—then, like a mirror—reflecting back the meaning of what the peer shared. Reflective listening is the most important communication skill in the process of providing peer support.

STEPS TO FORMING A REFLECTION

There are three steps to forming a reflection.

- Step 1: Listen carefully and hear what the peer is saying.
- Step 2: Make an educated guess about the peer’s underlying meaning.
- Step 3: Share your educated guess as a concise listening statement.

For more information

Activity: Reflection 1 – Listening
Roadblocks

Step 1 in forming a reflection is to carefully listen and hear what the peer is saying. Good listening starts here, but immediately challenges arise because many roadblocks exist. Review the list below and identify the top two or three roadblocks that challenge your good listening.

1. **Directing**: telling people what they need to do
   a. You have to face up to reality.
   b. You have to do something about this situation.

2. **Warning**: pointing out the risks or dangers of what a person is doing
   a. If you do, you will regret it.
   b. You have to stop, or else!

3. **Advising**: making suggestions, providing solutions
   a. Here is what I would do if I were you...
   b. Have you thought about...

4. **Persuading**: providing reasons or attempting to convince with logic
   a. It is the right thing to do and here is why...
   b. Now let’s think this through. The facts are...

5. ** Agreeing**: taking the person’s side, approving, praising
   a. Yes, you are absolutely right.
   b. That is exactly what I would do.
   c. Good for you!

6. **Analyzing**: explaining what the person is doing or saying
   a. Do you know what the real problem is?

7. **Probing**: asking questions to get information or to gather facts
   a. When did you first realize that?
   b. What makes you feel that way?
8. **Reassuring**: consoling people
   a. Everything will be okay.
   b. This will work out.

9. **Sympathizing**: feeling pity or sorrow for people
   a. I am so sorry to hear this.
   b. I am really sad about your situation.
   c. Well, at least it is not as bad as ________.

10. **Distracting**: using humor, changing the subject, or withdrawing
   a. That reminds me of this joke...
   b. Let’s talk about something else.

It is not to say that these responses are wrong. Indeed, there are times, situations, and circumstances in which some of these responses may be necessary or appropriate. The point is these responses are **not listening**.

Sometimes empathy is confused with sympathy. Empathy is a way of being with people that is nonjudgmental, accepting, and curious about another’s feelings, perspectives, and experiences. Sympathy is our feeling pity and sorrow for another’s misfortune. Sympathy usually comes from a place of care or concern. However, expressing sympathy is actually a roadblock to listening.

After watching the video, answer the following questions.

- What stood out for you in the video?
- How does sympathy present a roadblock to listening and understanding another’s feelings, perspectives, or experiences?
Listening Roadblocks Cheat Sheet

These are the roadblocks to listening.

- Directing: telling people what they need to do
  - You have to face up to reality.
  - You have to do something about this situation.
- Warning: pointing out the risks or dangers of what a person is doing
  - If you do, you will regret it.
  - You have to stop, or else!
- Advising: making suggestions, providing solutions
  - Here is what I would do if I were you...
  - Have you thought about...
- Persuading: providing reasons or attempting to convince with logic
  - It is the right thing to do and here’s why...
  - Now let’s think this through. The facts are...
- Agreeing: taking the person’s side, approving, praising
  - Yes, you are absolutely right.
  - That is exactly what I would do.
  - Good for you!
- Analyzing: explaining what the person is doing or saying
  - Do you know what the real problem is?
- Probing: asking questions to get information or to gather facts
  - When did you first realize that?
  - What makes you feel that way?
- Reassuring: consoling people
  - Everything will be okay.
  - This will work out.
- Sympathizing: feeling pity or sorrow for people
  - I am so sorry to hear this.
  - I am really sad about your situation.
  - Well, at least it is not as bad as _________.
- Distracting: using humor, changing the subject, or withdrawing
  - That reminds me of this joke...
  - Let’s talk about something else.

For more information

Activity: Reflection 2 – Strategies for Listening

The challenge, as Dr. Brown noted, is that empathy requires us to be curious about another's feelings, perspectives, and experiences. Considering a peer’s perspective can be challenging when we are invested in our own perspectives and points of view. The good news is that empathy and reflective listening is a skill that can be learned, practiced, developed, nurtured, and refined.

Activity in pairs: Turn to your neighbor and briefly share with each other your top two or three listening roadblocks. Do you ever find yourself offering sympathy? Then, brainstorm with each other ways you might be able to overcome or get around your listening roadblocks. What are some strategies for how you could be a fully present, attentive listener? Try to be as specific as possible and note your strategies here:

Bottom line on being a fully present, attentive listener:
Activity: Reflection 3 – Nonverbal Listening

Activity in pairs: Find someone who you have not worked with yet and decide who will start in the speaker role and who will start in the listener role.

- Instructions for speaker: Please talk about why you believe listening is important. What might you need to do in order to be a fully present, attentive listener in providing peer support?

- Instructions for listener: Make a decision to listen. Avoid your listening roadblocks. Try one or two of your listening strategies. Listen carefully with interest and curiosity; listen with your eyes, ears, and heart. Nonverbal listening! That means do not make a sound during this activity.
Activity: Reflection 4 – Educated Guesses

Step 2 in forming a reflection is to make an educated guess about the person’s underlying meaning. A peer’s spoken words in any moment rarely communicate the richness of their life experiences. Thus, understanding a person’s experience and perspective requires some educated guess work.

Activity in pairs: Find another person who you have not worked with yet and decide who will start as the speaker and who will start as the listener.

- Speaker: “One thing I like about myself is...”
- Listener: “You mean that you...”
- Speaker: Only respond yes or no.
- Listener: Make three more guesses.
Activity: Reflection 5 – Educated Guesses (continued)

Making educated guesses as the listener is not making assumptions because of the first step in forming a reflection: you have listened carefully to understand the person’s experiences and perspectives. However, making educated guesses can feel risky because your guess may not accurately reflect the meaning or emotion of what the person said. To increase comfortability in offering educated guesses, let’s continue practicing the second step of forming a reflection.

In the same pairs from the previous activity, read each peer item below and work together to generate and note three guesses about the possible underlying meaning or emotion using “you” statements. Here is an example:

**I am not sure I can participate in these services anymore.**
- You are struggling to find reliable transportation.
- You have a schedule conflict.
- You are not having a good experience here.

**I am feeling so depressed this week.**

**I do not like taking this medication.**

**I am having strong urges to use drugs.**
Activity: Reflection 6 – Why Statements, Not Questions For Reflection

Let’s review the steps to forming a reflection.

- In Step 1, we made a decision to listen, got around our listening roadblocks, and were able to listen carefully to the peer.

- In Step 2, we listened beyond the peer’s spoken words to consider the peer’s underlying meaning and emotion and we began formulating an educated guess about it.

- Now, in Step 3, the educated guess we formulated will be shared as a concise listening statement. Reflective listening is always shared as a statement, not a question.

Why do you think listening is best expressed as a statement instead of a question?
Activity: Reflection 7 – Reflection as Statements

Sharing your reflection as a statement requires getting rid of the question mark at the end. The key is to inflect your voice down at the end. When your voice inflects up at the end, it sounds like a question. When your voice inflects down at the end, it will be a statement.

Large group activity: Change each question to a statement.

- Life has gotten stressful for you? Example: Life has gotten stressful for you. (Notice the same spoken words, but voice inflection goes down at the end for a statement.)

- You are really struggling?

- You are confident you can get through the stress?

- The meeting really helped?

- You do not like the medication?

- You want to see the doctor for a medication adjustment?
Reflective Listening Cheat Sheet

REFLECTION LEVELS

- **Simple reflection**: Repeat (same words) or rephrase (slight change of words). This is useful for clarifying what a peer said.

- **Complex reflection**: Paraphrase (restatement) which brings in an educated guess or inference about the person’s underlying meaning or emotion. If the guess about a person’s deeper meaning or emotion is accurate, this is a powerful expression of empathy.

TYPES OF COMPLEX REFLECTION

- **Double-sided**: Both sides of ambivalence about change (advantages/disadvantages) are contained in a single reflection.
  - Peer: I am so much more open when I drink, but the next morning can be rough.
  - Certified peer specialist: On one hand, you like drinking, and on the other hand, you do not like the consequences.

- **Feeling**: Reflection of implied feeling or emotion. Name it.
  - Peer: I might test positive for marijuana on the drug test.
  - Certified peer specialist: You are worried about this.

- **Metaphor**: This is “picture language” or statements that evoke images.
  - It is as if a dam broke and emotion is flooding out.
  - For you, recovery is like climbing a mountain and you are trying to get to a peak for a nice view.
  - You hit a wall on trying to figure this out.

- **Coming alongside**: Take up and reflect the side of the struggle or challenge; this is empathy in action.
  - Peer: I cannot take these meds anymore.
  - Certified peer specialist: The side effects have become unbearable.

- **Continuing the paragraph**: Anticipate the next statement that has not yet been expressed by the peer in the direction of change. Starts with And... or Because...
  - Peer: I need to attend more therapy sessions.
  - Certified peer specialist: ... Because recovery is a priority for you right now.
REFLECTION STARTERS

• What I hear you saying is... (get the "I" out of reflection)
• It sounds like you...
• From your point of view...
• For you, it is a matter of...
• You mean that...
• You are feeling...
• You must be...
• So you...

REFLECTION BEST PRACTICES

• Voice inflection down for statement.
• "You" statement (get the "I" out of it).
• Keep it concise.
• Take a risk and make an educated guess about the peer's underlying meaning.
Activity: Reflection 8 – Practice

Small group work (three or four participants). The following narrative is about a peer discussing life in an initial meeting with a certified peer specialist. Read each peer item, then work together to construct a reflective listening statement using best practices.

1. Life has been hard lately. It seems like everything that could go wrong is going wrong.

   Reflection:

2. My partner got laid off from work and it is causing a lot of stress at home. He is always fighting with our teenage son. Sometimes I have to get in the middle.

   Reflection:

3. It does not seem like I have a minute for myself because, if I do not hold everything together, I worry that my family will fall apart.

   Reflection:

4. Times like this have caused me to break down in the past. I can manage some stress, but I do not do well with a lot of it all the time. I feel like I am heading into crisis mode.

   Reflection:

5. I have had a therapist off-and-on over the years. I guess it has been a little helpful, but I have not been able to stick with it.

   Reflection:
6. What is it that you do as a certified peer specialist?
   Reflection:

7. You seem nice and all, but I am not sure I can meet regularly. With everything going on, I am not sure I can commit to anything.
   Reflection:
Summary

(20 minutes)

OBJECTIVE

To learn more about summary (OARS) and engage in initial practice.

METHOD

1. Provide *Summary Skill Description*.
2. Facilitate small group activity.
3. Facilitate large group share out.
Summary (OARS) Skill Description

After a period of conversation, a summary can be useful in several ways: tying together what the peer has said, providing a transition to the next topic, or bringing closure to a meeting. Like skillful reflection, a summary demonstrates careful listening and understanding of what the peer said.

Summary best practices:

- Begin with “To summarize...” or other starter.
- Accurately describe what was discussed.
- It is all right to affirm a specific strength as part of a summary.
- Conclude with an open question that moves the conversation forward.

Summary Activity

In your same group of three or four, review Activity: Reflection 8, then construct a summary in the space below using best practices. There will be a large group share out after this activity.
Assign Homework

(5 minutes)

OBJECTIVE

To solidify learning in this section.

METHOD

Provide the following instructions: Between now and the next class, use any of the OARS skills in conversations with friends, family, or acquaintances. Notice what you do and how people respond.
Section 4

This section begins with an overview of certified peer specialist practices. Concentrating on the initial connecting process/meeting, with an emphasis on building strong relationships. There is also a focus on connecting OARS and how it can be applied to this topic. Participants have the opportunity to practice their skills along with self-reflection. The homework contains review questions to help solidify the understanding of these topics.
Curriculum Guide

SECTION 4

10 minutes  Homework Review
5 minutes   Overview of Certified Peer Specialist Practice
100 minutes  The Connecting Process
15 minutes  Break
75 minutes  Connecting with OARS Activity
10 minutes  Practicing Self-Care
5 minutes  Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>Believes that personal growth and change are possible</td>
</tr>
<tr>
<td>1.7</td>
<td>Believes in lifelong learning and personal development</td>
</tr>
<tr>
<td>1.10</td>
<td>Believes in the healing power of healthy relationships</td>
</tr>
<tr>
<td>2.3</td>
<td>Knowledge of the basic neuroscience of mental health and addiction</td>
</tr>
<tr>
<td>2.5</td>
<td>Knowledge that recovery and wellness involves the integration of the whole person, including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community</td>
</tr>
<tr>
<td>2.6</td>
<td>Knowledge of trauma and its impact on the recovery process</td>
</tr>
<tr>
<td>3.2</td>
<td>Knowledge of ethics and boundaries</td>
</tr>
<tr>
<td>3.4</td>
<td>Knowledge of confidentiality standards</td>
</tr>
<tr>
<td>3.5</td>
<td>Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions</td>
</tr>
<tr>
<td>4.1</td>
<td>Ability to bring an outlook on peer support that inspires hope and recovery</td>
</tr>
<tr>
<td>4.9</td>
<td>Ability to recognize and affirm a person’s strengths</td>
</tr>
</tbody>
</table>
Review Homework

(10 minutes)

OBJECTIVE

To provide an opportunity to discuss the homework assignment.

METHOD

1. Ask participants: “What did you notice about how people responded when you practiced your OARS skills in conversations?”

2. Ask participants: “Did any questions or concerns come up?”
## Overview of Certified Peer Specialist Practice

These fundamental processes, key concepts, and tools inform the certified peer specialist practice.

<table>
<thead>
<tr>
<th>Fundamental Process</th>
<th>Description</th>
<th>Key Concepts</th>
<th>Tools and Resources</th>
</tr>
</thead>
</table>
| **Connecting**      | Connecting is task number one in every meeting. Establish the peer relationship, and then maintain a good working relationship. | • Self-awareness  
• Benefits of the peer relationship  
• Strengths-based recovery principles  
• Trauma-informed care  
• Confidentiality | • Practicing self-care  
• Connecting open questions  
• Look for strengths and affirm  
• Reflective Listening Cheat Sheet  
• Initial Meeting Checklist |
| **Exploring**       | Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future. | • Exploring lived experience  
• Substance use and mental health challenges  
• Resilience and protective factors  
• Ambivalence  
• Multiple pathways to recovery | • OARS skills  
• Exploring open questions  
• Look for strengths and affirm  
• Advantages and Disadvantages Worksheet  
• Personal values card sort  
• Listening, revisited |
| **Supporting**      | Powerful support is provided peer-to-peer to address a range of potential concerns. Support is provided based on the foundation of connection and exploration. There are professional boundaries and ethics that guide the practice of peer support. | • Supporting lived experience  
• Multiple pathways to recovery  
• Difficult conversations (suicide, self-harm, responding to anger)  
• Setting healthy boundaries  
• Stigma, culture, power, privilege | • OARS skills  
• Providing information (Ask-Share-Ask)  
• Sharing recovery story (Ask-Share-Ask)  
• Preparing Response to Anger worksheet  
• Gentle refusal 3 steps  
• Advocacy |
| **Planning**        | Planning is based on the peer’s desires, hopes, goals, and needs in recovery. Planning unfolds and evolves over time for ongoing peer support. | • Multiple pathways to recovery  
• Planning pitfalls and possibilities  
• Natural supports | • OARS skills  
• Planning possibilities  
• Brainstorming  
• Sharing information and resources (Ask-Share-Ask)  
• Best practices for concluding the relationship |
The Connecting Process

(100 minutes)

OBJECTIVE

Learn about connecting as a fundamental process of peer support and engage initial practice.

METHOD

1. Set up initial brainstorm activity. Attach three flip charts to walls around the room. At the top of each flip chart, write question a, b, and c. There should be plenty of room on each flip chart for participants to note responses. Key questions:
   a. In your experience, what does connecting mean?
   b. From your perspective, how does connecting happen? (Imagine you were a peer meeting with a certified peer specialist for the first time. What things would help establish a sense of connection? Be specific.)
   c. Why is connecting peer-to-peer so important?

2. Facilitate initial brainstorm activity. Preview the key questions and inform participants that they will be engaged in a brief brainstorm for each question. Divide the room into thirds and ask each group to visit a flip chart. From there, provide a marker to each group and ask participants to spend a couple of minutes considering the key question, and then have someone note group responses to the flip chart. This is a rapid brainstorm (five minutes). Call time and ask the groups to rotate to the next flip chart/key question with a similar discussion process to add to what the earlier group noted. Time for another five minutes, and then ask the groups to rotate for the final key question with a similar process.

3. Large group discussion. Bring the groups back together and review collective responses on each flip chart. Any participant may elaborate on a particular response. Look for and reinforce when participants connect earlier ideas of resiliency and trauma into the discussion. For example, connecting is incredibly important because it fosters resiliency and heals trauma.

4. Read The Connecting Process. Facilitate solitary writing on each question listed in the reading and a large group share out of OARS skill application. For each application of OARS, have two or three participants provide input. There is no need to note what is shared on a flip chart. Participants can take notes.

5. Read Connection for Health. Facilitate a large group discussion. Start by asking participants: “Connection helps to heal the negative impacts of trauma. Why do you think this is so?”
6. Review *Initial Meeting*. During the confidentiality section, ask participants to recall the three limits of confidentiality discussed in Section 2.

7. Review *Initial Meeting Checklist*. Emphasize that connecting is task one. State the following: “The exploring and supporting processes and practices will be covered later in the course. For now, we are focusing on the connecting process.”

8. Complete *Activity: Connecting with OARS Skills*. This is a small group activity. Explain the activity using the instructions provided. When the groups are ready, start everyone together. Set a timer for 15 minutes. When the timer goes off, provide a one-minute warning and encourage the certified peer specialist role to wrap up with the summary. During this activity, walk around the room and observe each group. Notice the extent to which the observer is tracking the conversation. Notice the extent to which the certified peer specialist is sticking with the connecting process. If participants seem a little off track, it is okay to gently interrupt, find out how things are going, and encourage engagement in the activity for the remaining few minutes. Once the 15 minutes is completed, have each group debrief within their group. Here is a suggested way to structure the small group debrief after each round: Have the certified peer specialist share first about what they liked and what seemed to go well. People tend to be hard on themselves and this debrief should highlight the positive. The observer should go next by sharing some specific observations of demonstrated skill. Finally, the peer should share what was useful; what did the peer like about the conversation? Give groups about five minutes for the debrief, and then have participants rotate roles within the group for the same process. Set timer again for 15 minutes and start all groups together. Same debrief. Repeat the process for one more round.

9. Facilitate a large group discussion on the *Activity: Connecting with OARS Skills*. Ask participants: “What did you learn about the connecting process?” “What did you learn about yourself?” Draw out and encourage participant sharing by asking open questions (“What else?”) and refrain from shutting down sharing with closed questions (“Is there anything else?”). Note responses on a flip chart because these will be useful lessons to return to throughout the course.

10. Review *OARS Measures and Calculations*. This document is a companion to the *OARS Skills Observer Sheet*. OARS can be readily observed and assessed in practice with gentle feedback provided as part of participant communication skill development. Observation using the *OARS Skills Observer Sheet* is integrated into several practice activities throughout the training course. Know how to use the *OARS Skills Observer Sheet* to count skills during practice, then how to calculate accurately and note results in the *OARS Measures and Calculations*. These learning tools can provide powerful feedback to participants as part of the ongoing learning process. Direct observation with practice-based feedback can also create performance anxiety. In the first observed practice activity (*Activity: Connecting with
There is no need to have participants calculate OARS skills results. However, as the course progresses, consider teaching participants how to use *OARS Measures and Calculations* to note practice results with comparison to what to strive toward. After participants are more comfortable with the direct observation of practice, you should ensure opportunities for the detailed OARS skills feedback that is possible from using these learning tools.
The Connecting Process

Connection promotes resilience and heals trauma. Connecting with peers is a fundamental process of peer support. Through this process, the peer relationship is initially established, and then a good working relationship is maintained. Connecting is task number one in the initial meeting with a peer and in every meeting thereafter. With some peers, connecting will happen very quickly upon meeting. With other peers, connecting will take weeks or months. There is no timeline for connecting, however, a good working relationship must be established as the foundation for future exploring, supporting, and planning.

Rapid and powerful connection is possible through skillful communication. Consider application of OARS skills:

- Ask open questions that are person-centered and strengths-based. Seek to draw out the peer’s general life experiences and perspectives. Avoid fact-gathering questions (who, what, where, when) because these can limit connection. What are some examples of connecting open questions?
• Look for and specifically **affirm** the peer’s strengths and positive attributes. Strengths are a foundation of recovery and resilience. What are some strengths that you are likely to see in people in the initial meeting?

• Make the decision to listen. Avoid listening roadblocks. What is a good strategy you can use to be a fully present, attentive listener?

• **Reflective listening** is the most powerful way to connect with people. Offer more reflective listening statements than asking questions. Take risks and make educated guesses about the peer’s underlying meaning and emotion. When your reflections accurately convey understanding the peer’s experiences and perspective, there will be a powerful moment in which the peer feels heard and understood. What types of reflection may be particularly powerful during the connecting process?

• After a period of time, offer a **summary** of the conversation before transitioning into tasks of the initial meeting.
## Connection for Healing

Historical, developmental, and complex trauma have profound impacts on a person’s worldview, perspectives, and life experiences. The connecting process of peer support can be a source of healing for the negative impacts of trauma.

<table>
<thead>
<tr>
<th>Trauma Impacts on Worldview, Perspectives, and Life Experiences</th>
<th>Connecting Process of Peer Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mistrust, no one is safe, no place is safe. Expect danger and crisis.</td>
<td>Connection is the basis of peer support. A certified peer specialist spends purposeful time in the connecting process. Careful listening, empathy, and reflection demonstrate understanding. This builds a sense of safety and trust.</td>
</tr>
<tr>
<td>Negative self-talk, negative self-worth, experience of fear, pessimism about the future.</td>
<td>The connecting process builds the peer relationship through continually looking for strengths. A certified peer specialist finds strengths and offers specific, genuine affirmations. Affirmation gently challenges negative self-talk and invites new perspectives of self-understanding. Open questions are used to explore values, life goals, and dreams that can build hope for the future. A certified peer specialist sharing an aspect of their recovery story can inspire hope as well.</td>
</tr>
<tr>
<td>Experience of hopelessness, powerlessness, lack of confidence, and difficulties initiating change.</td>
<td>A certified peer specialist’s acceptance and support of the peer’s choice of pathway to recovery is empowering. Relevant recovery resources are provided—only with permission—and this contributes to empowerment as well. Ongoing peer support builds momentum for positive change. Small steps and accomplishments are affirmed and celebrated; small steps lead to more steps and accomplishments.</td>
</tr>
</tbody>
</table>
Initial Meeting

Consider the following elements of an initial meeting with a new peer.

**INTRODUCTION**

There is only one chance to make a first impression. Be ready with an introduction of yourself and your role as a certified peer specialist in a way that fosters connection. In the space below, write what you might say. Consider including the following elements in your introduction:

- A little about yourself.
- Your interest and curiosity in the peer’s perspectives and lived experiences.
- Your role in peer support to listen, collaborate, and empower.

**USE YOUR OARS SKILLS**

Use your OARS skills for rapid and powerful connection by asking connecting open questions, looking for strengths to affirm, and offering reflective listening statements to demonstrate understanding. There is a tendency to want to start with chat and small talk. While there is good intention for starting this way, it can have the unintended effect of promoting some initial disconnection.

**MENTION ANY LIMITATIONS OF SERVICE DURATION**

The employing agency may have guidelines governing the duration of time that a person may be enrolled in services. For example, some crisis services programs limit service duration to six months. It is useful to discuss any limitations to services in the initial meeting.

**CONFIDENTIALITY DISCUSSION**

Bring up the topic of confidentiality by saying “everything we discuss is confidential.” Then, ask the peer what is their understanding of confidential? Peers often have an excellent understanding of what confidential means and that can be affirmed. However, be ready to supplement the peer’s understanding with the limits of confidentiality.
Initial Meeting Checklist

The process of peer support begins in the initial meeting. Consider the following tasks within each process.

**CONNECTING**

- Provide a brief introduction of yourself and the certified peer specialist role; any limitations of service duration.
- Make the decision to listen carefully; avoid listening roadblocks.
- Ask two to three connecting open questions. Draw out the peer's perspectives and lived experiences. For example:
  - What is going on in your life that brought us together today?
  - Tell me about yourself.
  - What are some important relationships in your life?
  - What is the coolest thing about you?
- Look for strengths and affirm.
- Listen carefully and offer many reflective listening statements. Try to offer twice as many reflections as questions.
- Confidentiality discussion: Everything we discuss is confidential.
  - What is your understanding of confidentiality?
  - Identify the limitations of confidentiality.
- Summarize the conversation to this point.

**EXPLORING**

- Explore support areas of interest.
- Explore peer's expectations of working with a certified peer specialist.
- Identify peer's immediate and short-term needs.
- What does the certified peer specialist need in order to support the peer? (certified peer specialist’s boundaries)
- How do we build the mutual peer relationship (peer’s boundaries)?
SUPPORTING

- With permission, share an aspect of recovery story (only necessary details, focused on peer needs and the wellness story).
- Continue careful listening and regular reflection.
- Provide resources, if requested.
  - Use Ask-Share-Ask to provide information (Section 6).
  - Focus on peer needs.
  - If needed, use warm hand-off procedure where the peer specialist facilitates the contact to the referral with the peer present to support the peer in the initial contact.
- Summarize meeting.
Activity: Connecting with OARS Skills

In this small group activity, you will have an opportunity to practice connecting with a peer using OARS communication skills.

There will be three roles in this activity: peer, certified peer specialist, and observer. Get into groups of three with people you have not yet worked with. Decide who will start in each role.

Instructions for each role:

- **Peer:** This is a role-playing of showing up for an initial meeting with a certified peer specialist. You have experienced recent difficulties and challenges related to mental health and/or substance use; you are very open to working with a certified peer specialist.

- **Certified peer specialist:** You will have 15 minutes to connect with the peer and begin establishing a good working relationship. The time will go quickly. Please avoid small talk and chat and just jump into the following:
  - Try your introduction script.
  - Be ready with two or three connecting open questions.
  - Look for strengths and offer an affirmation.
  - Listen carefully and offer many reflective listening statements.
  - Discuss confidentiality.
  - At the conclusion, offer a summary to demonstrate your listening.

- **Observer:** Using the *OARS Skills Observer Sheet*, make a hash mark in the appropriate category every time the certified peer specialist demonstrates a skill. Try to track everything the certified peer specialist says and note examples that you can share during the debrief. Consider these guidelines:
  - Listen for voice inflection to differentiate questions from reflective listening statements. If voice inflection goes “up” – mark as a question.
  - Sometime it is hard to tell if a reflection is simple (repeat) or complex (brings in the educated guess). If you are unsure, mark reflection as simple.
  - A summary is counted as a single reflection.
  - To mark an affirmation, the affirmation must identify a specific strength or positive attribute. Do not count comments such as “wow, that’s wonderful” or “good job” as an affirmation.
OARS Skills Observer Sheet

In the observer role, listen carefully to the certified peer specialist and place a hash mark for each OARS skill demonstrated. Try to count and categorize everything the certified peer specialist says. Note examples in each category, including any observed listening roadblocks.

<table>
<thead>
<tr>
<th>Watch for...</th>
<th>Count (hash mark)</th>
<th>Note Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Open question</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tell me about...</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| closed questions   |                   |               |
| Can you...         |                   |               |
| Do you...          |                   |               |
| Are you...         |                   |               |
| Is there...        |                   |               |

| Affirmation        |                   |               |
| *must be specific* |                   |               |

| Reflections (simple)|                   |               |
| Repeat             |                   |               |
| Rephrase           |                   |               |
| *must be statements*|                   |               |
| count a summary as one reflection | | |

| Reflections (complex)|                   |               |
| Paraphrase           |                   |               |
| Double-sided         |                   |               |
| Feeling              |                   |               |
| Metaphor             |                   |               |
| Coming alongside     |                   |               |
| Continuing the ?     |                   |               |

| Listening roadblocks|                   |               |
| Advising            |                   |               |
| Agreeing            |                   |               |
| Reassuring          |                   |               |
| Sympathizing        |                   |               |
OARS Measures and Calculations

Based on the OARS Skills Observer Sheet, communication skills demonstrated in the certified peer specialist role can be readily assessed. The table below identifies how to calculate results of the practice. Count hash marks in each category and use the calculation guidelines below to calculate practice results, and then enter those results for each measure in the space provided.

<table>
<thead>
<tr>
<th>OARS measure</th>
<th>Calculation</th>
<th>Benchmark</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of open questions</td>
<td># Open questions / total # questions</td>
<td>70% or more</td>
<td></td>
</tr>
<tr>
<td>% of complex reflections</td>
<td># Complex reflections / total # reflections</td>
<td>50% or more</td>
<td></td>
</tr>
<tr>
<td>Ratio of reflections to questions</td>
<td>total # reflections / total # questions</td>
<td>1.0 or more</td>
<td></td>
</tr>
<tr>
<td>Number of affirmations</td>
<td># of affirmations</td>
<td>1 or more</td>
<td></td>
</tr>
</tbody>
</table>

What should you strive toward in everyday communication with OARS? Specific benchmarks are identified in the table above that can be compared with practice results. In general, skillful communication with OARS involves:

- Asking mostly open questions to draw out the peer’s perspectives, experiences, and ideas.
- Looking for and affirming at least one peer strength in every encounter.
- Offering just as many reflective listening statements as questions. This ratio of 1.0 means that for every one question there is, on average, one reflection. Advanced practice is a ratio of 2.0, that is, for every one question there are two reflections.
- When you reflect, use complex reflections about half of the time to reflect the peer’s deeper meaning and emotion.

For more information

Practicing Self-Care

(10 minutes)

OBJECTIVE

To continue the practice of self-care as part of effective peer support.

METHOD

1. Refer back to the practicing self-care flip charts from Section 1 and briefly review the identified activities. Ask participants if anyone would like to add an activity to the list.

2. Invite participants to select and engage in a self-care activity during the break.
Assign Homework

(5 minutes)

OBJECTIVE

To solidify learning in this section.

METHOD

Assign Review Questions.
Review Questions

1. How does careful listening, empathy, and reflection demonstrate understanding and build a sense of safety and trust with the peer?

2. What did you learn about using OARS skills during the initial meeting practice? Identify one or two takeaways from the practice activity.
Section 5

This section focuses on the exploration process and how it is fundamental to empowering peers and strengthening the certified peer specialist relationship. The emphasis is then shifted toward the sharing of mental health, substance use, and recovery challenges. The advantages and disadvantages worksheet assists participants in determining the level of sharing they are comfortable with. This section allows for the exploration of personal values. Finally, the topic of listening is revisited with activities to solidify understanding and practice this skill. The homework assignment asks participants to review the history and timelines of the mental health, substance use, and consumer movements.
Curriculum Guide

SECTION 5

10 minutes   Review Homework
120 minutes  The Exploring Process
15 minutes   Break
60 minutes   Listening, Revisited
5 minutes   Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Believes that recovery is an individual journey with many paths and is possible for all</td>
</tr>
<tr>
<td>1.11</td>
<td>Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery</td>
</tr>
<tr>
<td>3.5</td>
<td>Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions</td>
</tr>
<tr>
<td>4.3</td>
<td>Ability to problem solve</td>
</tr>
<tr>
<td>4.4</td>
<td>Ability to assist people in exploring life choices and the outcomes of those choices</td>
</tr>
<tr>
<td>4.7</td>
<td>Effective written and verbal communication skills</td>
</tr>
<tr>
<td>4.8</td>
<td>Ability to draw out a person's perspective, experiences, goals, dreams, and challenges</td>
</tr>
<tr>
<td>4.9</td>
<td>Ability to recognize and affirm a person’s strengths</td>
</tr>
<tr>
<td>4.10</td>
<td>Ability to foster engagement in recovery</td>
</tr>
</tbody>
</table>
Review Homework

(10 minutes)

OBJECTIVE

To provide an opportunity to discuss the homework questions.

METHOD

1. Ask participants: “How do careful listening, empathy, and reflection demonstrate understanding and build a sense of safety and trust with the peer?”

2. Ask participants: “What were your one or two takeaways from using the OARS skills during the initial meeting practice activity?”
The Exploring Process

(120 minutes)

OBJECTIVE

To gain an understanding of exploring as a fundamental process for peer support and consider key concepts of exploring and to engage in practice of OARS communication skills.

METHOD

1. Read the Exploring Process for overview.

2. Read Sharing Mental Health, Substance Use, and Recovery Challenges with Others.

3. Facilitate activity in pairs to practice exploring ambivalence with Advantages and Disadvantages Worksheet. Hand out worksheet and provide these instructions:
   a. Peer role. Be ready to discuss ambivalence you currently have or that you had in the past about sharing an aspect of your story. Pick a person, a group of people, or a setting in which you had this ambivalence.
   b. Certified peer specialist role. Follow the procedure to administer the advantages/disadvantages worksheet.
   c. Call time at about 10 minutes. Have pairs switch roles, restate instructions, and launch round two. Call time again at 10 minutes
   d. Large group debrief. How was it exploring ambivalence and using the advantages/disadvantages worksheet?

4. Read Exploring Values and facilitate group discussions.

5. Complete a demonstration of the Personal Values Card Sort. It is recommended that you practice this activity before demonstrating to the group. The demonstration should be a real play, not a role-playing. Because values are deep and personal, it is difficult for someone to play the role of another person. Ask for a participant who is willing to explore their values in front of the group. Complete the Personal Values Card Sort with this participant. Facilitate a large group discussion afterwards to debrief the activity.
The Exploring Process

Exploring is a fundamental process of peer support. Through exploration, the certified peer specialist draws out the peer’s beliefs, perspectives, and lived experience on a wide range of topics regarding life and recovery. Exploration can include current and past efforts in recovery, areas of strength and resilience, concerns and challenges, values about what is most important, and hopes and dreams for the future. The exploring process typically occurs once connection and the peer relationship is established. Exploration deepens trust and connection that creates the foundation for providing effective support.

The key OARS skill during the exploration process is use of open questions. Open questions invite the peer to share and explore beliefs, perspectives, values, and lived experiences on a range of topics. Asking about strengths, motivations, ideas about change, and hopes can foster a peer’s resilience. Try to avoid closed-ended and fact gathering questions because these types of questions tend to limit exploration.
Specific topics for exploration with peers that will be covered in this training course:

- Decision-making regarding sharing personal story (Section 5)
- Values and what is most important in life (Section 5)
- Mental health and substance use diagnoses (Section 7)
- Multiple pathways to recovery (Section 7)
- Difficult conversations such as suicide and self-harm (Section 8)
- Stigma, culture, power, and privilege (Section 9)
- Spirituality and religion (Section 10)
- Multiple pathways to recovery (Section 10)

In each of these topic areas, exploration will be considered.
Sharing Mental Health, Substance Use, and Recovery Challenges with Others

A certified peer specialist can explore with the peer whether—and to what extent—to share mental health, substance use, and recovery challenges with others. To share or not to share is a highly personal decision. There may be times when the peer wants to tell others their story and there may be times when the peer does not want to tell their story. At other times, the peer may be unsure what to do.

A key concept here is ambivalence. Ambivalence involves feeling two ways about something. On one hand, there may be reasons to share and, on the other hand, there may be reasons to not share. When reasons for and against are held simultaneously, that is the experience of ambivalence. Ambivalence is a normal experience in the process of coming to a decision. A certified peer specialist can non-judgmentally explore with the peer both sides of ambivalence for the peer to make an informed decision. This exploration process empowers the peer to decide what makes the most sense for sharing (or not sharing) their story.

The Advantages and Disadvantages Worksheet is a useful tool for exploring ambivalence. The advantages are the reasons for making the decision; for example, deciding to share one’s story could have benefits and result in positives. The disadvantages are the reasons against making the decision; for example, deciding to share one’s story could have harmful effects and result in negatives. Consider this procedure for using the worksheet:

1. Briefly introduce the concept of ambivalence as part of a decision-making process.

2. Explore with the peer if there is a particular person, group of people, or situation for considering sharing their story.

3. Use the worksheet to guide exploration and take notes:
   a. Explore the peer’s perspective on ADVANTAGES – What are the advantages or positives for sharing your story? Ask for elaboration on reasons, if useful. Offer reflections to demonstrate listening.
   b. Explore the peer’s perspective on DISADVANTAGES – What are the disadvantages or the negatives for sharing your story? Ask for elaboration on reasons, if useful. Offer reflections to demonstrate listening.
   c. Summarize advantages and disadvantages and draw out the peer’s perspective with final open question: "So where does this leave you?"
   d. Listen carefully and reflect

This exercise was adapted from the WISE Wisconsin Up to Me program.
Advantages and Disadvantages Worksheet

Use this worksheet to explore the advantages and disadvantages of making a decision. The decision under consideration is:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

<table>
<thead>
<tr>
<th>ADVANTAGES – What are the advantages or the positives for making this decision? What else?</th>
<th>DISADVANTAGES – What are the disadvantages or the negatives for making this decision? What else?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summarize advantages and disadvantages.

Exploration question: So where does this leave you?

Listen carefully and reflect.
Exploring Values

Values are deeply held ideas, beliefs, principles, and morals that guide a person’s life and decisions about what is most important. Values are embedded in culture and community. To get to know someone deeply is to understand what the person believes is most important in life. In other words, this means exploring their values. Challenges for the certified peer specialist immediately emerge when a peer’s values about what is most important conflict with a certified peer specialist’s own values.

- When a clash of values occurs, how can that impact peer support?

- How might we be able to overcome any clashes in order to connect with a peer?

- How might we be able to support effectively a peer who has different values or priorities than we do?

- A useful activity for exploring a peer’s values is the Personal Values Card Sort. The activity involves presenting 100 values cards to a peer and guiding an exploration of which values are most important for guiding the peer’s life. Here is the link to this activity: https://www.guilford.com/add/miller2/values.pdf

Consider this procedure for facilitating the Personal Values Card Sort:

1. Hand to the peer the shuffled value cards.

2. Lay out the five categories of importance: “Most Important to Me,” “Very Important to Me,” “Important to Me,” “Somewhat Important to Me,” and “Not Important to Me.”

3. Ask the peer to review each value card and place each into one of the five importance categories.

4. Once all values cards are placed into piles, have the peer examine all value cards in the most important and very important piles. If there are many cards in both piles, perhaps only examine most important. The goal is to have the peer identify about
10 to 15 of the most important values, then rank order those values from least to most important.

5. Have the peer discuss each value card in the rank-ordered pile. Start with least important and end with most important. Draw out and explore why these values are important to the peer. Listen carefully and reflect to demonstrate understanding. This can be the final step of exploring in the spirit of getting to know the peer. However, if it makes sense, the certified peer specialist can take this exploration process one more step.

6. Building from Step 5, the certified peer specialist can bring the values conversation into a recovery context. Values can be a deep source of strength and inner resources for change. Consider these exploratory open questions:

a. How do the values that are most important to you fit into how you think about recovery?

b. How might these values support the changes you are attempting to make in your life right now? Is there a particular value that stands out? What is it about this particular value that supports your change efforts?

c. How do these values fit with your dreams and life goals?
LISTENING, REVISITED

(60 minutes)

OBJECTIVE

To consider listening as a critical skill during the exploration process and continue practicing reflective listening skills.

METHOD

1. Read Listening, Revisited and Listen poem. Facilitate large group discussion. Start with asking participants: “What do you hear from the Listen poem?”

2. Facilitate Activity: Circle Listening Practice. This is a complex activity with many moving parts. Read the steps listed carefully in order to provide clear instructions to participants. Knowing how this activity works and being able to provide clear instructions will ensure a successful practice activity.

3. Read The Benefits of Listening Well.
Listening, Revisited

Thus far, the exploration process has featured the skill of open questions for drawing out the peer’s thoughts, perspectives, experiences, and values. Indeed, a purposeful open question invites people to share about their life.

Upon hearing a peer’s story, there can be a tendency to want to gather facts about a problem (who, when, where), engage in analysis and problem solving, or offer advice and solutions. While such responses may be appropriate, the challenge for a certified peer specialist is to stay curious as a listener. The desire to problem-solve can unintentionally limit the peer’s willingness to continue sharing.

Reflective listening is a powerful way to avoid these potential roadblocks during exploration. Reflective listening fosters peer sharing because when a peer feels listened to, heard, and understood, safety and trust is developed. As safety and trust develop, the peer is more likely to become vulnerable, open up, and discuss the difficult challenges. Skillful reflective listening by a certified peer specialist sends the message: I want to understand your experience because I trust that you have what you need within yourself.

This sentiment is expressed in the poem on the following page.
**Listen**

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

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

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

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

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

But, when you accept as a simple fact that I do feel, no
matter how irrational, then I can quit trying to convince
you and get about the business of understanding what’s
behind the irrational feeling.

And when that’s clear the answers are
obvious and I don’t need advice. Irrational
feelings make sense when you understand
what’s behind them.

Perhaps that’s why prayer works,
sometimes, for some people, because God
is mute, and doesn’t give advice or try to
fix things.

God listens and lets you work it out for yourself.

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

–ANONYMOUS
Activity: Circle Listening Practice

This activity will provide an opportunity to practice reflective listening.

INSTRUCTIONS

1. Distribute a 3x5 index card to each participant with these instructions: “During the exploration process, you will hear peers discuss difficulties and challenges in their lives. Think about what a peer might say regarding a specific difficulty or challenge about mental health or substance use. Write one or two sentences about the difficulty or challenge that you might hear.”

2. After participants have a short time to write their index card, provide the following instructions: “All you will need for this activity is your index card with the peer statement. However, because we are going to do a lot of reflective listening practice, feel free to bring your Reflective Listening Cheat Sheet. When I say go, everyone is going to get up and move to the perimeter of the room. Please form two circles facing each other so that each person has a partner and is spread out so that you’re at least an arm’s length away from the next pair.”

3. After participants have formed the circles, provide the following instructions “Those of you standing on the outside circle looking into the room, you will be in the listener role to start. Those of you standing on the inside circle looking out; you will be in the speaker role to start. Speaker, your job is to read the peer statement. Because this is a practice activity, speakers, I want you to share your peer statement twice. So those of you on the outside in the listener role, you are going to hear the peer statement two times. The first time you hear the statement offer a simple reflection, just repeat or rephrase what you are hearing. The second time you hear the statement, now is your chance to go a little deeper and make an educated guess about the peer’s underlying meaning. Try a complex reflection. Listeners, please keep in mind that your reflections should be statements, not questions—let me say that again, this activity is for practicing listening statements not question asking. Try to make your reflective listening statements as concise as possible. Once you have completed this exchange, pause and I will give you further instructions. Any questions? Okay, please begin.

4. [Note: This speaker-listener exchange is considered a round. Each round takes about one minute to complete. This activity does not simulate a conversation but a brief exchange to enable participants to practice reflective listening statements.] Provide these instructions after each round: “Okay everyone, you’re going to stay in your exact same roles. Listeners, I would like you to move one person to your left. Introduce yourself to your new partner and begin the exact same sequence as before.”
5. After about one minute, ask listeners to move again one person to the left. This continues for a total of eight rounds.

6. After eight rounds, provide the following instructions: “Now, we’re going to switch roles. For those of you who have been listening and reflecting, you are going to be in the speaker role, so get your index card ready. For those of you who have been in the speaker role, you will now be the listener. You will have two opportunities to reflect the peer statement. First pass, start with a simple reflection, then second pass deepen it, make a guess about the underlying meaning, and try different complex reflections. Okay, go ahead and begin.”

7. Same process as before. Ask the new listener to move one person to the left after each one-minute round. This continues for a total of eight rounds.

8. After the 16 rounds, facilitate a large group debrief while everyone is still standing [focus on participant experiences in the listening role]. Ask the “listeners:” “How did that go in the listening role?” “How were you able to develop your reflective listening skills?” “What did you learn about your listening in this activity?” “What do you want to continue to work on as a listener?”
Benefits of Listening Well

Even though there are many challenges of showing up as an attentive listener, there are many benefits to listening well.

• Listening well fosters connection with peers.

• Peers are more likely to engage in services delivered by a certified peer specialist when they experience acceptance and the lack of judgment that comes with skillful reflection.

• Peers who are quiet, shy, and introverted can feel strong levels of support through a certified peer specialist who carefully listens and skillfully reflects.

• A certified peer specialist can offer more relevant support through better understanding a peer’s experiences, perspectives, priorities, and feelings.

• Listening well fosters exploration because when feeling listened to, heard, and understood, people tend to open up and share more deeply.

• Listening well saves time because the certified peer specialist can more quickly grasp the essence of what the peer is attempting to communicate.

• Listening well can foster insights for people that they may not have otherwise experienced without a careful listener to reflect back underlying meaning.

• Listening well helps people to regulate strong emotion and to resolve conflict.

• Listening well helps people to identify their inner strengths and resources.
Assign Homework

(5 minutes)

OBJECTIVE

To explain the history and timeline of the mental health and consumer involvement in systems change.

METHOD

1. Assign the following readings. Explain that these readings offer insights on the ways in which trends in society, advances in science and treatment, and cultural understanding influence national policy and attitudes toward these issues.

   a. “Significant Events in the History of Addiction Treatment and Recovery in America,” which can be found online: https://www.williamwhitepapers.com/pr/AddictionTreatment&RecoveryInAmerica.pdf

   b. “The History and Evolution of Mental Health Treatment,” which can be found online: https://sunrisehouse.com/research/history-evolution-mental-health-treatment/

   c. Historical Context for Certified Peer Specialists

   d. Timeline of Systems Transformation and Consumer Involvement

Historical Context for Certified Peer Specialists

Many cultures have viewed the various human experiences that now are described as mental health challenges as a form of religious punishment or demonic possession. In ancient Egyptian, Indian, Greek, and Roman writings, these experiences were often categorized as a religious or personal problem. In the fifth century B.C., Hippocrates was a pioneer in treating people with these experiences with techniques not rooted in religion or superstition; instead, he focused on changing a patient’s environment or occupation, or administering certain substances as medication. During the Middle Ages, people with experiences that today would be viewed as mental health challenges were believed to be possessed by evil entities or in need of religious solutions. Negative attitudes towards people with these experiences persisted into the 18th century in the United States, leading to stigmatization of people with mental health challenges, and unhygienic (and often degrading) confinement of individuals.

Throughout history, psychoactive substances have been used by priests in religious ceremonies, by healers for medicinal purposes, or by the general population in a socially approved way. The issue of loss of control of the substance or today’s concept of problem substance use was already being discussed in the 17th century. Through the years there have been opposing attitudes on issues such as: whether harmful substance use is a sin or a disease; whether treatment be moral or medical; whether problem substance use is caused by the substance; whether harmful substance use is caused from the individual’s vulnerability, psychology, or social factors; and whether substances should be regulated or freely available.

A harsh reality is that people with mental health and substance use issues have been persecuted through time. In the early 1900s, there were waves of laws passed in the United States calling for the mandatory sterilization of defectives: the mentally ill, the developmentally disabled, alcoholics, and people experiencing harmful substance use.

Dr. Samuel Woodward called for the creation of inebriate asylums in the 1930s, according to Alcoholics Anonymous. The idea was to punish these people for their disorders and provide them with a strong reason to stop using and start living their lives in a new way. Interventions for alcoholism involved yelling and even physical abuse. The treatment that followed used many of the same tactics. Many inebriate homes were developed around the country. The New York State Inebriate Asylum in Binghamton was the first inebriate asylum in the country. Inebriate asylums initially treated only alcoholism. Many of these homes quickly expanded to treat other problem substance use, including the use of opium, morphine, cocaine, chloral, ether, and chloroform. The Martha Washington Home in Chicago was the first institution in the country that specialized in the treatment of inebriate women.
Dorothea Dix lobbied for better living conditions for those termed insane after witnessing the dangerous and unhealthy conditions in which many patients lived. Her work began in the 1840s. Over the next 40 years, she successfully persuaded the U.S. government to fund the building of 32 state psychiatric hospitals in an effort to end the practice of criminalizing what was known as madness.

This model—patients living in hospitals and treated by professional staff—was considered the most effective model of care at the time. Families struggling to care for their relatives welcomed institutionalization. Although institutionalized care increased access to mental health and substance use services, the state hospitals were often underfunded and understaffed. The institutional care system drew harsh criticism following a number of high-profile reports of poor living conditions and human rights violations. Patients rarely had say in their care and treatment.

A push to develop an outpatient system of care began in the mid-1950s. This push was spurred by the development of a variety of antipsychotic drugs and treatments for problem substance use.

At this time, it was believed that patients would receive better treatment and have a higher quality of life if treated in their communities rather than in large hospitals.

The promotion of outpatient services over inpatient services became known as the deinstitutionalization movement. Many state psychiatric hospitals closed as a result of this movement. The Community Mental Health Act of 1963 set strict standards for care and treatment at state psychiatric hospitals. With the enactment of this law, only individuals who posed an imminent danger to themselves or someone else could be committed to state psychiatric hospitals.

Within a few years of the enactment of the Community Mental Health Act, people diagnosed with bipolar disorder, schizophrenia, and/or personality disorders were moved from state psychiatric hospitals to community-based mental health homes or similar facilities. Nationally, the number of patients in state psychiatric hospitals fell from its peak of 560,000 in the 1950s to 130,000 by 1980. By 2000, the number of state psychiatric hospital beds per 100,000 people was 22, down from 339 in 1955. In place of institutionalized care, community-based mental health and problem substance use care were developed to include a range of treatment options, including community clinics, smaller supervised residential homes, and community-based psychiatric teams.

The stated goal of deinstitutionalization—improving treatment and quality of life for people with mental health and substance use challenges—is not controversial. However, the reality and consequences of poorly funded and coordinated deinstitutionalization efforts has made it a highly polarizing issue. Many studies have reported positive outcomes from community-based mental health care programs, including improvements in adaptive behaviors, friendships, and patient satisfaction, other studies have found that individuals in community living settings face significant challenges to important
aspects of health care, including vaccinations, cancer screenings, and routine medical checks. Other studies report that “loneliness, poverty, bad living conditions, and poor physical health” are prevalent among people with mental health and substance use challenges living in their communities. However, there are studies that conclude that community-based programs that have proper management and sufficient funding may deliver better outcomes than institutionalized care, and are “not inherently costlier than institutions.”

Critics of the deinstitutionalization movement say many patients have been moved from inpatient psychiatric hospitals to nursing or residential homes, which are not always staffed or equipped to meet the needs of people with mental health and substance use challenges. In many cases, deinstitutionalization has also shifted the burden of care to the families of patients. Families often lack the financial resources and training to provide proper care.

Many say deinstitutionalization has simply become transinstitutionalization or a situation in which state psychiatric hospitals and criminal justice systems are functionally interdependent. In other words, deinstitutionalization combined with inadequate and underfunded community-based mental health and substance use programs has forced the criminal justice system to provide the highly structured and supervised environment some believe is required for some people to be safe and healthy.

Others say transinstitutionalization applies to a small fraction of people with mental health and substance use challenges. They say most people would benefit from improved access to community-based treatment programs, rather than expansion of state psychiatric hospitals. They believe the reduced availability of inpatient beds is not the cause of the high rates of incarceration among people with mental health and substance use challenges, arguing that deinstitutionalized patients and incarcerated individuals with serious mental illnesses and/or substance use disorders are clinically and demographically distinct populations. Instead, they suggest that other factors such as the high arrest rate for drug offenses, lack of affordable housing, and underfunded community treatment are responsible for the high rates of incarceration.

Though the deinstitutionalization debate continues, many health professionals, families, and advocates for individuals with mental health and substance use challenges have called for a combination of more community treatment programs (including the utilization of peer support professionals and those with lived experience acting as systems navigators) and increased availability of intermediate and long-term psychiatric inpatient care for patients in need of a more structured care environment. Many hope that by improving community-based programs and expanding inpatient care to fulfill the needs of severely ill patients, the United States will achieve improved treatment outcomes, increased access to mental health and substance use care, and better quality of life for individuals with substance use and mental health challenges.
For more information


Timeline of Systems Transformation and Consumer Involvement

1860: What is now known as Mendota Mental Health Institute opens in Madison. It is the first state-run psychiatric hospital in Wisconsin.

1873: What is now known as Winnebago Mental Health Institute opens near Oshkosh. It is the second state-run psychiatric hospital in Wisconsin.

1935: Alcoholics Anonymous begins as the outcome of a meeting between Bill W., a stockbroker from New York, and Dr. Bob S., a surgeon from Akron. Both had been “hopeless alcoholics.”

1963: The Mental Health Centers Act is signed into law by President Kennedy. Several Community Mental Health Centers are funded in Wisconsin.

1967: Training in Community Living, now known as the Program of Assertive Community Treatment or PACT, evolved out of research work led by Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D., on an inpatient research unit of what is now known as Mendota Mental Health Institute in Madison. Noting that gains made by clients in the hospital were often lost when they moved back into the community, the researchers hypothesized that the hospital’s 24/7 supports alleviated the symptoms of clients and that ongoing treatment and support was important.

1970: The State Council on Alcohol and Other Drug Abuse is created to provide leadership and coordination regarding alcohol and other drug abuse issues confronting Wisconsin. Members are appointed by the governor.

1972: PACT moves from a hospital ward to an office in the community. PACT was the basis for what became Community Support Programs in Wisconsin.

1973: The Vocational Rehabilitation Act is passed. The rules implementing this law required recipients of federal funds to “administer programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”

1976: Major revisions of Wisconsin’s Mental Health Act include a bill of rights for people receiving services for mental health, developmental disabilities, or alcohol and other drug use. This bill of rights (Wis. Stat. § 51.61) is known as Wisconsin’s Client Rights Law.

1977: Three mothers in Madison founded the Dane County Alliance for the Mentally Ill. This organization grew to become NAMI or the National Alliance for the Mentally Ill, known today as the National Alliance on Mental Illness.

1980: Lighthouse, a small consumer group, is allocated space at a state office in Madison with access to mail, copying, and phone services. They publish a newsletter.
1981: NAMI Wisconsin is created.

1983: The Wisconsin Council on Mental Health is established as the mental health planning council for the state. Members are appointed by the governor. At least half of the members are consumers or family members of consumers.

1987: American Medical Association calls all drug addictions diseases.

1988: Wisconsin Coalition for Advocacy (now known as Disability Rights Wisconsin) hires two consumers to plan a consumer conference.

1988: Wisconsin Family Ties, an advocacy organization for families of children with severe emotional disturbance, is established.

1988: The Wisconsin Network of Mental Health Consumers is organized with an office in Madison.

1988: The Wisconsin Department of Health and Social Services awards federal block grant funds to the AIDS Resource Center of Wisconsin (now Vivent Health) to begin outreach programs to people who inject drugs in an effort to help reduce and stop the risk of HIV, HCV, and the harms associated with injection drug use. Peers provide the outreach service and help refer people to services including syringe exchange, HIV and HCV testing and counseling, and treatment and recovery services for substance use.

1989: The state administrative code creating Community Support Programs in Wisconsin is published.

Late 1980s: The Community Support Programs Conference begins to involve consumers through the conference planning committee and consumer roundtables at the conference. County programs are encouraged to bring consumers to the conference.

1990s: Online recovery support groups and services form, creating a virtual recovery community without geographic boundaries.

1990: The first Children Come First Conference is held by Wisconsin Family Ties.

1992: The Wisconsin Department of Health and Social Services begins to allocate $480,000 each year in federal block grant funds for consumer and family self-help and peer support programs.

1993: Eighteen consumer and family self-help and peer support programs in Wisconsin are funded with mental health block grant money.


1994: SMART Recovery is founded as a non-12-step program focused on self-empowerment.
1994: Larry Schomer is the first consumer to be elected as chair of the Wisconsin Council on Mental Health.

1995: Grassroots Empowerment Project is established under the umbrella of NAMI Wisconsin as the first statewide organization in Wisconsin run by consumers.

1995: Crossroads Conference on Trauma is held in Milwaukee, with consumers planning the conference and presenting workshops.

1995: Wraparound Milwaukee program is established with federal funds.

1996: Winnebago Mental Health Institute hires a consumer to run peer support groups.

1996: In Wisconsin, the Governor’s Blue Ribbon Commission on Mental Health convenes, with only a few consumers at the table. More consumers are added to this group after consumers requested more representation.

1996: Kathleen Crowley, a mental health consumer, writes the chapter on the actions and mindset associated with optimizing the healing process, known as Procovery, for the Governor’s Blue Ribbon Commission on Mental Health report. Crowley later publishes a book on Procovery and establishes the Procovery Institute in California, which works to implement the Procovery methodology.

1997: The Governor’s Blue Ribbon Commission on Mental Health publishes its final report that emphasized recovery and consumer involvement.

1997: The Milwaukee County Mental Health Division creates a Consumer Affairs Office.


2001: Grassroots Empowerment Project becomes its own nonprofit organization with a board of directors made up primarily of consumers.


2002: Grassroots Empowerment Project begins convening annual Consumer Empowerment Days in Madison. Leadership academy training is provided.

2002: Wisconsin United for Mental Health is established. It is a public-private partnership to eradicate stigma through education and information.
**2004:** The federal government advises states to move toward a recovery-oriented care model for mental health. The state administrative code governing what became known as Comprehensive Community Services is published.

**2004:** The consumer affairs liaison at the Department of Health and Family Services works with a group of peers to develop the Recovery-Oriented Systems Assessment Tool to define what a recovery-oriented system looks like. Over 250 peers around the state are interviewed by peers to collect the data that informed the tool’s development.


**2004:** The Milwaukee Mental Health Task Force is established to identify issues faced by people affected by mental illness, facilitate improvements, give a voice to consumers and families, reduce stigma, and implement recovery principles.

**2004:** Over 26 consumer self-help/peer support groups exist in the state.

**2005:** The Department of Health and Family Services contracts with David Loveland to develop a recovery coach training manual.

**2005:** With the help of the Recovery Implementation Task Force and the consumer affairs liaison at the state Department of Health and Family Services, Wisconsin developed Comprehensive Community Services, a recovery-oriented program that provides both mental health and substance use services across the lifespan. Counties providing Comprehensive Community Services are required to have coordinating committees that include consumers.

**2005:** The consumer affairs liaison at the Wisconsin Department of Health and Family Services organizes a team of peer leaders from around the state to develop the Recovery Basics Training, which was used to train counties that wanted to provide Comprehensive Community Services. Peers receiving services were invited to attend the trainings along with the providers. It is notable that the trainings were delivered to county providers with peers alongside state staff.

**2006:** The Wisconsin Department of Health and Family Services begins discussions to develop a certified peer specialist program.

**2007:** The consumer affairs liaison at the Wisconsin Department of Health and Family Services partners with peer leaders to develop trainings for peers on person-centered planning to help peers understand their role in shared decision-making within the services they obtain.

**2007-2009:** Wisconsin creates the certification process for certified peer specialists. The Department of Health Services partners with the Recovery Implementation Task Force and Access to Independence on this project. Training courses from the Depression and Bipolar Support Alliance, Kansas Consumers as Providers, the Arizona...
META model, and the National Association of Peer Specialists (NAPS) are approved for use in Wisconsin.

2008: A trauma-informed care coordinator is hired by the Wisconsin Department of Health Services. The trauma-informed care coordinator partners with peer leaders from around the state to develop and deliver a Trauma-Informed Care 101 Training to county service providers, calling these peers “Trauma-Informed Care Consumer Champions.”

2008: The consumer affairs liaison at the Wisconsin Department of Health Services and a team of peers creates a speakers bureau and trains 36 peers from around the state to deliver the Recovery Basics Training to Comprehensive Community Service providers throughout the state.

2009: Over 430 people attend a statewide conference focused on trauma-informed care. Consumers are involved in planning and presenting the conference.

2009: The Opening Avenues to Re-entry Success Program is established to promote the successful transition of people with mental illness from prison to community.

2010: 2009 Wisconsin Act 218 is enacted. It is known as Wisconsin’s Mental Health Parity Law.

2010: The first Wisconsin certified peer specialist certification exam is proctored. Nearly 100 people pass the exam in its first year.

2010: Grassroots Empowerment Project partners with Optum Health, Options for Independent Living, NAMI Greater Milwaukee, and NAMI Racine to implement the PeerLink program, which provides peer support to Optum members in an effort to decrease emergency room visits and hospitalizations and increase access to community services.

2011-2014: The Wisconsin Department of Health Services partners with the national group “The Pillars of Peer Support” to develop the national standards for peer support.

2013: A more than $26 million investment in Wisconsin’s public behavioral health system includes the expansion of Coordinated Services Teams Initiatives and Comprehensive Community Services. Funding is provided for the creation of peer-run respites. The Office of Children’s Mental Health is created.

2013: A group of 13 Wisconsin residents interested in building a recovery advocacy organization form Wisconsin Voices for Recovery with support from the Wisconsin Department of Health Services. They develop an advisory committee with a diverse group of stakeholders to guide their work.

2014: The Office of Children’s Mental Health creates a family relations coordinator position.
2014: The Children’s Mental Health Collective Impact Coalition convenes, with a quarter of the membership being parents of children with mental illness and young adult peers.

2014: The consumer movement in Wisconsin identifies that the four different certified peer specialist training models approved for use in Wisconsin are not equal and none of the trainings include information on supporting a peer with substance use concerns.

2014: Forward Health Update No. 2014-42 states that a Comprehensive Community Services program must provide all services covered under the benefit that a member needs as determined by an assessment, including peer support.

2014: The Wisconsin Department of Health Services convenes a group of stakeholders to advise work on developing a model for peer-run respites in Wisconsin. Three organizations receive funding to develop and operate peer-run respites.

2014: Wisconsin Voices for Recovery holds its first Recovery Rally at the state Capitol.

2015: The Wisconsin Department of Health Services decides to move toward an integrated training model for certified peer specialists, a model that includes the area of substance use, a first of its kind approach for the United States.

2016: Peers from the Wisconsin Department of Health Services and Access to Independence develop a pilot integrated training model for certified peer specialists.

2016: The Wisconsin Department of Health Services partners with Wisconsin Voices for Recovery to develop ED2Recovery, a program that connects people taken to an emergency department for an opioid overdose with a recovery coach.

2017: Wisconsin Voices for Recovery develops Recovery U, a free online resource for peer support providers.

2018: The Wisconsin Department of Health Services creates the Certified Peer Specialist Advisory Committee to advise its work on certified peer specialist and certified parent peer specialists.

2018: Wisconsin Voices for Recovery hosts trainings for recovery coaches who identify as people with lived experience to become certified peer specialists.

2018: Certified peer specialist trainings are delivered in institutions throughout the Wisconsin Department of Corrections. People who are incarcerated are able to become certified peer specialists and begin providing services within the institutions.

2019: Using the data from the pilot project and information and feedback from trainers, a team of peers from the Wisconsin Department of Health Services and Access to Independence work together to revise the pilot integrated training model for certified peer specialists.
2019: The Wisconsin Department of Health Services awards funding for the nation’s first peer-run respite for veterans.

2020: Western Technical College offers a certified peer specialist training as a 15-week course.

2020: The Wisconsin Peer Specialist Employment Initiative launches a community of practice to foster professional growth, skill-sharing and learning, and the development of a broader community of people working as certified peer specialists.

2021: Madison College offers a certified peer specialist training as a three-week course through its continuing education program.

2021: The revised integrated certified peer specialist training curriculum is released.
Review Questions

1. What are some of the significant views on substance use and mental health presented in the history homework?

2. What are your two or three most important takeaways that you learned from the exploring process?
Section 6

This section covers the supporting process and information sharing. Activities are focused on skillful sharing of information and self-disclosure. The topic is then shifted to setting boundaries and gentle refusals. Boundaries are defined along with how and why they are imperative. Exercises allow for self-reflection and practice using gentle refusal. This section concludes with a homework assignment geared towards a review of the content covered.
Curriculum Guide

SECTION 6

10 minutes  Homework Review
105 minutes  The Supporting Process (Sharing Information, Self-Disclosure)
15 minutes  Break
85 minutes  Setting Boundaries and Gentle Refusal
5 minutes  Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

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

(10 minutes)

OBJECTIVE

To review and briefly discuss the homework assignment.

METHOD

1. Ask participants: “What are some of the significant views on mental health presented in the history homework?”

2. Ask participants: “What are your two or three biggest takeaways that you learned from the exploring process?”
The Supporting Process

(105 minutes)

OBJECTIVE

To introduce the supporting process and identify elements of peer support and gain initial practice in providing peer support.

METHOD

1. Read The Supporting Process.
2. Read Sharing Information.
3. Facilitate sharing information practice activity. Divide participants into groups of three. There are three roles in each group: peer, certified peer specialist, and observer. Provide the following instructions. The peer role identifies a recovery topic that you do not know much about but would like to know more. The certified peer specialist role uses the Ask-Share-Ask procedure to share relevant information on the topic. Be sure to listen carefully to the peer and reflect to ensure understanding. The observer role listens to the certified peer specialist and uses the Sharing Information Observer Sheet provided to track the Ask-Share-Ask procedure. Note examples of what the certified peer specialist said and did. This activity should take about five minutes. After five minutes, encourage the small groups to debrief within their group. Ask observers to lead debrief by sharing some observation. To practice, observers should use the Ask-Share-Ask procedure to share observations. The debrief should take about five minutes. Switch roles for one more round following same procedure as above. Complete another debrief in small groups. After the second round bring everyone back together for a large group debrief. Ask the participants: “Where does this practice activity leave you regarding sharing information in a skillful way?”

4. Read Self-Disclosure. Facilitate large group discussion. Ask participants: “What makes self-disclosure such a special and unique aspect of providing peer support?”

5. Facilitate self-disclosure activities.
   a. Activity: Self-Disclosure (Part 1) is a solitary writing activity.
   b. Activity: Self-Disclosure (Part 2) is an activity done in pairs.
   c. Hold a large group debrief. Ask participants: “What was it like in the certified peer specialist role sharing a purposefully focused aspect of the recovery story?” “What was it like hearing this aspect of the recovery story in the peer role?”
The Supporting Process

The supporting process rests upon a foundation of connecting and exploring. Powerful support is provided peer-to-peer to address a range of concerns and challenges that a peer could present. There are professional boundaries and ethics that guide the certified peer specialist practice of peer support.

Using OARS skills is a powerful form of support. Consider OARS application:

- As a starting point in the supporting process, it may be useful to draw out the peer’s own understanding, definition, and notions of what “support” means. Ask open questions to draw out the peer’s ideas. For example:
  - What does support mean to you?
  - What supports have you found useful in the past?
  - What has not been useful?
  - How can I support you?
• Peers often begin services with a certified peer specialist during periods of increased struggle and stress. Here are some open questions to consider when supporting someone experiencing struggle and stress. Note that some questions are exploring and some are supporting.
  o What areas of your life are particularly stressful right now? [Exploring]
  o What might be some of the causes or sources of the stress? [Exploring]
  o What sorts of supports might be useful for addressing the stress? [Supporting]
  o What is needed to get through this and how can I support you? [Supporting]

• Strengths have been noticed and affirmed since the initial meeting, through the connecting and exploring processes, and now this will continue into the supporting process. Specifically affirming the peer’s strengths creates a foundation of recovery and resilience. Noticing and affirming a peer’s strength is a powerful form of support.

• When exploring ways to support the peer, a certified peer specialist may have a strong tendency to want to fix the situation, problem solve, or jump to an action step. Recall that these are listening roadblocks. Roadblocks can limit the ability of the certified peer specialist to provide effective support because the peer may not be ready for action. It is best practice to make the decision to listen, and then listen carefully to understand the peer’s lived experience.

• Offer many reflective listening statements during the supporting process. Advanced certified peer specialist practice is this: for every one question asked, there are two reflective listening statements offered. This ratio is a powerful marker of effective support because it indicates that the certified peer specialist is doing more listening than asking; it is listening with accurate empathy where powerful healing occurs. In other words, healing happens when people feel accepted, heard, and understood; not as much when there are 20 questions that the peer feels obligated to answer.

• Periodically offer a summary to consolidate understanding and reinforce the peer’s ideas.

• Sharing an aspect of the recovery story is another powerful skill for supporting.
Sharing Information

Sharing information is an important part of the peer support process. Peers may have limited information about pathways to recovery, recovery resources, and ways to navigate complex human service systems. Knowing when and how to share information is an important certified peer specialist skill.

PRINCIPLES OF EFFECTIVE INFORMATION SHARING

Peers are the experts on themselves. Peers bring a wealth of experience, knowledge, and wisdom. A certified peer specialist takes time to find out what the peer already knows because sharing information that a peer already possesses may be perceived as redundant or unhelpful. Affirmation can be used to highlight the peer’s existing knowledge and wisdom.

A certified peer specialist is curious. Sharing information is a collaborative search to understand the peer’s challenges, strengths, and information needs. To ensure that information is helpful, a certified peer specialist asks the peer what information might be valuable. In other words, curiosity drives the effort to understand the peer’s information needs. Approaching with curiosity and asking the peer what they find valuable are two examples of the skill of exploration. Understanding what is important to the peer minimizes any biases about what the certified peer specialist believes is important. A certified peer specialist uses open questions to draw out the peer’s information needs and uses reflective listening to ensure accurate understanding.

Information is shared in a way that enhances peer autonomy. Once a certified peer specialist knows what information the peer would find helpful, information is shared in a neutral and respectful manner. It is up to the peer to decide how the information may be relevant to their situation. Information from a certified peer specialist is offered in the spirit of acceptance that the peer has the right to use (or not use) the information as the peer sees fit. In other words, information is only shared after first obtaining the peer’s interest or permission. Obtaining permission before sharing information enhances peer autonomy and the right to self-determination.

Power differentials are recognized and acknowledged. Certified peer specialists understand that they are in a position of power over the person they are supporting due to their professional standing and experience. They strive to ensure that they do not use their position of power to exert undue influence on the peer, to provide advice disguised as information, or to censor information that may be relevant.

SKILLFUL SHARING OF INFORMATION: ASK-SHARE-ASK

As the above principles suggest, information can be shared in a highly skillful, collaborative way. The Ask-Share-Ask procedure is a skillful way to ensure that relevant,
useful information is provided. In this procedure, a certified peer specialist shares information sandwiched between two useful questions.

**Ask.** The first step is to ask. Find out what the peer may already know about the topic, issue, or situation. Draw out the person’s knowledge, experience, and wisdom. Here are some examples of open questions:

- “What do you already know about...?”
- “What has been your experience with...?”
- “In your experience with this situation, what lessons have you learned?”

Then, find out what information might be useful about the topic, issue, or situation or ask for permission to share information. Here are some examples:

- “What would you like to know about?”
- “What information can I share that might be useful?” or “I have some information that might be relevant. Would you be interested?”
- “Would it be okay if I shared a perspective on this situation?”

**Share.** Once there is peer permission, the second step is to share the information. Consider these guidelines for ensuring the information is useful:

- Share information concisely. The peer will be able to better process information that is shared in small, manageable chunks rather than extensive information shared with many details.
- Share information clearly. Avoid jargon, labels, and clinical terms. Instead, use everyday language.
- Share information in a neutral tone of voice. It is up to the peer how the information may or may not be used. Taking a stance of neutrality (versus influence) helps support peer autonomy and their right to self-determination.

**Ask.** The final step is to ask for the peer’s understanding, interpretation, or response to the information just shared. This crucial step allows the peer to make meaning of the information and to consider its relevance for an actionable next step. Here are some example open questions:

- “What is your opinion on this?”
- “What are your thoughts on this?”
- “I wonder what this all means to you.”
- “How might you use this information?”
- “What might be a next step?”
Once the peer responds, a certified peer specialist listens carefully, holds up the mirror, and reflects back to ensure understanding. In summary, when certified peer specialists share information, it can be done in a highly skillful, relevant way that deepens collaboration.

This section was adapted from "Motivational Interview: Helping People Change, 3rd Edition," a book by William R. Miller and Stephen Rollnick.
# Sharing Information Observer Sheet

Listen to the certified peer specialist. Track the Ask-Share-Ask procedure. Note examples of what the certified peer specialist said and did.

<table>
<thead>
<tr>
<th>Informing Skill</th>
<th>Note Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask</strong></td>
<td>☐ Certified peer specialist asked about what peer already knows on the topic</td>
</tr>
<tr>
<td></td>
<td>☐ Certified peer specialist asked what peer would like to know OR asked permission to share information</td>
</tr>
<tr>
<td><strong>Share</strong></td>
<td>Information shared was...</td>
</tr>
<tr>
<td></td>
<td>☐ brief</td>
</tr>
<tr>
<td></td>
<td>☐ clear</td>
</tr>
<tr>
<td></td>
<td>☐ in neutral tone</td>
</tr>
<tr>
<td><strong>Ask</strong></td>
<td>☐ Certified peer specialist asked for peer’s understanding, interpretation, or response</td>
</tr>
<tr>
<td><strong>Listen</strong></td>
<td>☐ Certified peer specialist offered reflective listening statement</td>
</tr>
<tr>
<td></td>
<td>☐ Reflection seemed accurate</td>
</tr>
</tbody>
</table>
Self-Disclosure

Self-disclosure is another important part of the peer support process. A certified peer specialist’s willingness to share about their own recovery is a hallmark of the unique peer-to-peer relationship. A certified peer specialist’s recovery story can be powerful because it offers truth, hope, and possibilities to a peer who may be struggling.

ETHICS OF SELF-DISCLOSURE

- **Is my self-disclosure in the best interest of the peer as determined by the peer?** Under some circumstances, self-disclosure could be harmful. To be ethical, self-disclosure must be in the best interest of the peer as determined by the peer.

- **Is there a clear reason why my self-disclosure would be helpful?** Important questions to consider: Why do I believe that self-disclosure in this moment will benefit the peer? What it is about this part of my story that I believe will be helpful? How might self-disclosure support the peer relationship? Am I sharing to benefit the peer or to unburden myself?

- **Am I sharing my illness story or my recovery story?** An illness story focuses on the disabling impacts of illness, promotes reliving difficult times, and features suffering and trauma which can lead to a sense of hopelessness and despair. Conversely, a recovery story focuses on opportunities, overcoming barriers, strengths, resilience, health, and wellness that can promote hope and possibilities of change. While each certified peer specialist gets to decide what part of their story to share, it is important to be mindful of sharing aspects of the recovery story.

SKILLFUL SELF-DISCLOSURE

Skillful self-disclosure can be accomplished using the Ask-Share-Ask procedure:

- **Ask.** What the peer would like to know about your recovery story? What about your recovery story might be particularly helpful, relevant, and relatable to the peer? Ask permission to share your story to ensure peer openness and interest.

- **Share.** Disclose an aspect of your recovery story. Keep the details purposeful, focused, and brief. Remember, self-disclosure is a form of peer support. Sharing too much risks turning attention to your life. Keep the focus on the peer relationship.

- **Ask.** Pose a follow-up question to explore what the peer found helpful, relevant, or relatable.

This section was adapted from “Motivational Interview: Helping People Change, 3rd Edition,” a book by William R. Miller and Stephen Rollnick, and “Making Effective Use of Your Recovery Story in Peer Support Relationships,” a presentation by Mark Parker and Michael Uraine.
Activity: Self-Disclosure (Part 1)

This is a solitary writing activity. Prepare for self-disclosure of your own recovery story by reflecting on the following questions. Write a brief response to each question.

- What have you had to overcome to get to where you are today?

- What are some of the strengths you have developed and used to advance your recovery? Try to be specific. Refer back to the list of strengths in Section 2, if needed.

- What types of supports and strategies have you developed and used?

- What are some of the things you do today to support your health, wellness, and recovery?

- What are the top two to three things you have learned about yourself through recovery that could inspire others on their journey?
Activity: Self-Disclosure (Part 2)

Find a person who you have not yet worked with and decide roles: peer and certified peer specialist. Use the following procedure for this practice activity.

1. Peer: **Ask** the certified peer specialist to share one aspect of their recovery story. Specify an aspect that you believe would be helpful to you.

2. Certified peer specialist: **Share** that aspect of your recovery story. Keep the details purposeful, focused, and brief.

3. Certified peer specialist: **Ask** the peer what was helpful, relevant, or relatable about what you just shared.

4. Peer: Respond in any way that feels natural.

5. Certified peer specialist: Offer a reflective listening statement to demonstrate understanding.

This conversation should take no more than five minutes. Switch roles after five minutes and repeat the steps above.
Setting Boundaries and Gentle Refusal

(85 minutes)

OBJECTIVE

To introduce the concepts of boundaries and gentle refusal as a critical part of providing effective peer support.

METHOD

1. Direct participants to Setting Boundaries. Divide participants into two groups. Assign one question to one group. Assign the other question to the other group. Launch brainstorming. During the brainstorming, create two flip charts: one labeled “What are boundaries?” and one labeled “Why are boundaries important?” After a few minutes, ask groups to share responses with the large group. Draw out and document responses for each flip chart question.

2. Read Understanding Boundaries. Facilitate a brief large group discussion. Ask participants to compare how the information in the reading is similar to what the group already knew as documented in the flip charts created during the earlier brainstorm.

3. Read Setting Healthy Boundaries. After the reading, show the Dr. Brené Brown video. Facilitate a large group discussion after the video. Ask the participants: “What stood out for you in the video?” “How might you be thinking a little differently about boundaries right now?”

4. Read How to Set Healthy Boundaries.

5. Facilitate Activity: Self-Reflection. Explain the activity using the instructions provided. After providing the instructions, give participants time to complete the activity. When it looks like most people have responded to most questions, set up the next activity. Tell participants that they will now have an opportunity to practice peer support. This is an activity done in pairs. Each pair should decide who will be in the speaker role and who will be in the listener role. Ask speakers to take a few minutes and discuss their responses. The listeners should focus on careful listening and ONLY offer reflective listening statements. Describe this activity as an opportunity for participants to provide peer support through listening. Set a timer for six minutes and provide a one-minute warning before ending the activity. In the final minute, the listener should offer a summary. Have participants switch roles and reiterate instructions. After all participants have experienced both roles, facilitate a large group debrief. Ask the participants: “How did this activity go?” “What was it like for speakers to get a little vulnerable and to be listened to?” “What was it like for listeners to focus only on reflective listening?”
6. Read *Gentle Refusal*. There are two situations in the reading. For each situation, ask two participants to volunteer. One will play the peer. The other will play the certified peers specialist. After they have read the narrative aloud, ask each participant their thoughts on the use of OARS skills and gentle refusal.

7. Facilitate *Activity: Gentle Refusal Practice*. This is an activity done in pairs. Assign each pair one scenario. Provide instructions as written for the activity. After providing instructions for the activity, give participants time to develop their scripts and to practice role-playing. The role-playing should take no more than three to four minutes. When it looks like most pairs have completed the role play, invite two or three pairs to share their role play with the large group; starting with identifying the assigned situation. Unfortunately, there is not enough time for more than three pairs to demonstrate. After each pair demonstrates their role-play, acknowledge the sharing with applause. Affirm the participants’ willingness to take a risk in front of the large group. After all the demonstrations, complete the activity with large group debrief. Ask the participants: “What did you learn about yourselves in this activity?”
Setting Boundaries

The what, why, and how of boundaries will be discussed in this section.

Small group brainstorm:

- What do you already know about boundaries? Provide examples of boundary setting.

- In general, why might setting boundaries be important? Why might boundaries in the peer relationship be especially important?

For more information

Recovery Education Network: Setting Healthy Personal Boundaries
Understanding Boundaries

A boundary can be the:

- Emotional and physical space between you and another person.
- Demarcation of where you end and another begins and where you begin and another ends.
- Limit or line over which you will not allow anyone to cross because of the negative impact of it being crossed in the past.
- Established set of limits over your physical and emotional well-being that you expect others to respect in their relationship with you.
- Emotional and physical space you need in order to be the real you without the pressure from others to be something that you are not.
- Healthy emotional and physical distance you can maintain between you and another so that you do not become overly enmeshed and/or dependent.
- Appropriate amount of emotional and physical closeness you need to maintain so that you and another do not become too detached and/or overly independent.
- Balanced emotional and physical limits set on interacting with another so that you can achieve an interdependent relationship and do not lose your personal identity, uniqueness, and autonomy in the process.
- Set of parameters that make you a unique, autonomous, and free individual who has the freedom to be a creative, original, and dynamic problem solver.

In addition, boundaries can be self-defined, mutually identified, flexible or firm, specific to each unique relationship, and can adjust over time as relationships and roles change.
Setting Healthy Boundaries

There are several reasons to consider setting healthy boundaries.

- **Compassionate people set boundaries.** Setting boundaries can foster safer relationships. People know where they stand with you and this can create some safety. Setting boundaries also promotes self-care and provides greater capacity for empathy with others.

- **Generous people set boundaries.** If you do not set boundaries, you could be overextending yourself and you might be at risk for burnout. Boundaries allow us to have more sustainable relationships that means you can afford to be generous to and connect with more people over a longer period of time.

- **Boundaries allow growth.** Boundary setting communicates to others what is important to you and what you need to stay in a relationship. It models setting healthy limits without rejection. It also makes others aware of the impact of their behavior. Healthy boundaries garner respect from people.

- **Boundaries allow you to get more of what you want, and less of what you do not.** Boundaries help protect from unwanted, harmful behavior; boundaries also foster the behavior that you want to see in others.

- **Effective people set boundaries.** Doing so keeps you in control of your time and efforts and makes you feel better about yourself. This leads to increased self-esteem, confidence, and self-respect.

- **Practice makes perfect.** If this is not familiar behavior it will feel awkward and unnatural at first; developing or changing habits takes time. Pushback is natural; people may not like it at first. However, setting boundaries provides opportunities to practice honest, direct communication. With practice comes skills and with skills comes a sense of accomplishment and personal/professional growth.

WATCH VIDEO

“Boundaries” – Dr. Brené Brown

[https://www.vimeo.com/274228723](https://www.vimeo.com/274228723)
How to Set Healthy Boundaries

As a first step, consider examining your own beliefs about setting boundaries in relationships. What you tell yourself about setting boundaries is directly related to your ability to set boundaries. Identifying the beliefs that may limit your ability to set boundaries can create opportunities to challenge in gentle way those beliefs. The following provides some examples of limiting beliefs and gentle challenges.

<table>
<thead>
<tr>
<th>Limiting Belief</th>
<th>Gentle Challenge / Self-Affirmation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I cannot say “no” to others.</td>
<td>I have a right to say “no” to others if it is an invasion of my space or a violation of my rights.</td>
</tr>
<tr>
<td>I have to be available to my peer no matter what.</td>
<td>I have a right to take care of myself.</td>
</tr>
<tr>
<td>I can never trust anyone again.</td>
<td>I have a right to take the risk to grow in my relationships with others. If I feel my boundaries are being violated or ignored, I can assertively protect myself to ensure I am not hurt.</td>
</tr>
<tr>
<td>I would feel guilty if I did something on my own.</td>
<td>I have the right and need to do things that are uniquely mine so that I do not lose my identity.</td>
</tr>
<tr>
<td>It does not matter what they are doing to me. As long as I keep quiet and do not complain, they will eventually leave me alone.</td>
<td>I will stand up for myself and assert my rights to be respected and not hurt or violated. If they choose to ignore me, then I have the right to disengage from the situation.</td>
</tr>
<tr>
<td>As long as I am not seen or heard, I will not be violated or hurt.</td>
<td>I have a right to be visible and to be seen and heard. I will stand up for myself so that others can learn to respect my rights, my needs, and not violate my space.</td>
</tr>
<tr>
<td>I would rather not pay attention to what is happening to me in this relationship that is overly intrusive, smothering, and violating my privacy. In this way, I do not have to feel the pain and hurt that comes from such a violation.</td>
<td>I choose to stay present with my feelings when I am being treated in a negative way so that I can be aware of what is happening to me and assertively protect myself from further violation or hurt.</td>
</tr>
<tr>
<td>I have been hurt badly in the past and I will never let anyone in close enough to hurt me again.</td>
<td>I choose to open myself to others and trust that I will be assertive to protect my rights and privacy from being violated.</td>
</tr>
<tr>
<td>I can never tell where to draw the line with others.</td>
<td>This line ensures my uniqueness, autonomy, and privacy. I am able to be me the way I am rather than the way people want me to be by drawing this line.</td>
</tr>
</tbody>
</table>
Activity: Self-Reflection

Below are situations a certified peer specialist may encounter in their role (or in life, more generally). Select one situation and work through the questions below. Be ready to share responses with a neighbor.

Select a situation:

- Peer shows up to an appointment angry and begins yelling at you.
- Peer makes a derogatory comment in your direction.
- Peer asks you to make an important decision, the answer to which you do not know.
- Peer asks you to make an extra commitment for support and you do not have the capacity to make the commitment.
- Peer asks you for money.

In this situation, which limiting belief(s) is present for you?

How can you gently challenge that belief? Which self-affirmations most resonate for you? Feel free to create your own self-affirmation.

What might you do and say to set a healthy boundary? Try to be as specific as possible.
Gentle Refusal

Gentle refusal is a form of boundary setting and involves respectfully responding “no” to a peer’s request. Gentle refusal is done in a manner that validates the person’s request while also suggesting alternative means of support. Saying “no” may be difficult, especially after establishing a close and supportive peer relationship. However, setting healthy boundaries is crucial for nurturing and sustaining a good working relationship.

Gentle refusal can benefit the certified peer specialist and the peer in several ways. For the certified peer specialist, gentle refusal can reduce burnout, reduce resentment, promote job satisfaction, and be a source of personal and professional growth. For the peer, experiencing gentle refusal can present an opportunity to witness self-determination in action, to explore resources collaboratively, and to navigate emotions brought about by the gentle refusal.

STEPS TO GENTLE REFUSAL

- **Step 1**: Listen to what the peer is requesting. Listen especially for the underlying meaning and emotion in the peer's request. Offer a reflective listening statement that demonstrates understanding.

- **Step 2**: Refuse peer request. In your own words, respectfully and gently respond “no.”

- **Step 3**: Invite an alternative. Share with the peer what you are willing to do as an alternative.

In the hypothetical situations below, note how the certified peer specialist uses steps of gentle refusal in response to a peer request.

Situation: Peer asks for money.

- Peer: Hey, I am wondering if I can borrow a little money from you. I am really stretched this month. I will pay you back next month.

- Certified peer specialist: You are really stressing about money right now. You're wondering how you're going to make it. [Step 1, listening and reflection of underlying meaning.]

- Peer: Yeah. It is really embarrassing to ask for assistance, but this has been a bad month. You probably cannot loan me money anyway.

- Certified peer specialist: You are taking a big risk with me and I really appreciate that [Affirmation skill]. You are right that I cannot lend you money [Step 2, gentle refusal] and I am wondering what other resources we might be able to tap into to see you through [Step 3, invitation].
• Peer: I am not really sure what things might be available.

• Certified peer specialist: If you are interested, I have some ideas that we could explore for accessing emergency resources [Asking permission, Informing skill].

Situation: Peer asks to meet on the weekend and you are off.

• Peer: Thanks so much for meeting with me. You have been so supportive during this difficult time I am going through. Things are so stressful, especially on the weekends. I am wondering if we could meet next weekend.

• Certified peer specialist: You could really use the extra support on the weekend [Step 1, listening and reflection].

• Peer: Yeah. My teenage stepson is around on the weekends—that is the time we have placement with him—and it is just so stressful when he is there because he does not treat me with any respect.

• Certified peer specialist: It is a stressful situation with him there [Reflection]. Unfortunately, my schedule does not allow me to meet on the weekends [Step 2, gentle refusal]. What are your thoughts about exploring supports to get you through the weekend? Also, we could definitely check in first thing on Monday to see how things went [Step 3, invitation].
Activity: Gentle Refusal Practice

Instructions: Work in pairs with your assigned situation to create a brief role-playing of gentle refusal. Be sure that your role-playing demonstrates each step. Use the outline below to script your role-playing.

Situation #1. A person you are working with wants to take you to their favorite hangout, “Doc’s Brats and Curds.” You have been there before and found it so loud from the music and large number of people that you could not hear a thing and left with a migraine.

Situation #2. The peer outreach coordinator calls you at the last minute and asks if you will go to the inpatient psychiatric unit as soon as possible to meet with a new peer. Other certified peer specialists are not available. The coordinator is in a bind, but you were on this unit once, did not have a good experience, and told yourself you would never want to return.

Situation #3. A colleague and fellow certified peer specialist calls you at night and says he needs to talk because he had an awful day. You really like this person and he has been a source of support for you, but you also had an awful day and do not feel like you can be much support for him. The idea of listening carefully to anyone right now seems very challenging.

Situation #4. A peer asks if he can borrow money and says he will pay you back when you meet next month. He usually manages his money well, but this month his car required unexpected repair work. He has never asked for money before, but you are uncomfortable loaning any money.

Outline the role-playing

Step 1. Identify the request being asked by the peer. What might be the underlying meaning or emotion involved in this request? Make an educated guess and write out your reflective listening statement:

Step 2. Identify your boundary in this situation. What will you say “no” to? Write out what you might say:

Step 3. What could you offer instead? What could the peer be invited to do as an alternative? Write that out here:

Now, based on your situation and scripted outline above, practice steps to gentle refusal in a role-playing with your partner.
Assign Homework

(5 minutes)

OBJECTIVE

To solidify learning in this section.

METHOD

Assign Review Questions.
Review Questions

1. How do your boundaries differ between personal and professional relationships?

2. How would you use “gentle refusal” in a situation in your life right now?

3. How can self-disclosure be used to foster engagement in recovery.
Section 7

This section explains mental health and substance use diagnoses. It begins with background information on this topic and a brief overview of the different diagnoses. Exploring and supporting lived experience is then covered. The misunderstanding of these experiences is discussed and examples are given to solidify understanding. The section concludes with a homework assignment based on the idea of multiple pathways of recovery and the process of change.
## Curriculum Guide

### SECTION 7

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Homework Review</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Mental Health and Substance Use Diagnosis Background</td>
</tr>
<tr>
<td>90 minutes</td>
<td>Exploring and Supporting Lived Experience</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Break</td>
</tr>
<tr>
<td>50 minutes</td>
<td>Multiple Pathways to Recovery</td>
</tr>
<tr>
<td>25 minutes</td>
<td>Exploring Ambivalence: Taking Prescription Medication</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Assign Homework</td>
</tr>
</tbody>
</table>

### CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.9</td>
<td>Believes that recovery is a process</td>
</tr>
<tr>
<td>1.11</td>
<td>Believes and understands there are a range of views regarding mental health and substance use disorder and their treatment, services, supports, and recovery</td>
</tr>
<tr>
<td>2.2</td>
<td>Knowledge of mental health and substance use disorders and their impact on recovery</td>
</tr>
<tr>
<td>2.3</td>
<td>Knowledge of the basic neuroscience of mental health and addiction</td>
</tr>
<tr>
<td>2.4</td>
<td>Knowledge of stages of change and recovery</td>
</tr>
<tr>
<td>2.5</td>
<td>Knowledge that recovery and wellness involve the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community</td>
</tr>
<tr>
<td>2.7</td>
<td>Knowledge of person-centered care principles</td>
</tr>
<tr>
<td>3.5</td>
<td>Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions</td>
</tr>
<tr>
<td>4.11</td>
<td>Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals</td>
</tr>
<tr>
<td>4.12</td>
<td>Ability to facilitate and support a person to find and utilize resources</td>
</tr>
</tbody>
</table>
Review Homework

(5 minutes)

OBJECTIVE

To solidify learning in the previous section.

METHOD

1. Ask the participants: “How do your boundaries differ between personal and professional relationships?”

2. Ask the participants: “How would you use “gentle refusal” in a situation in your life right now?”

3. Ask the participants: “How can self-disclosure be used to foster engagement in recovery?”
Mental Health and Substance Use Diagnosis Background

(30 minutes)

OBJECTIVE

To familiarize participants with mental health and substance use diagnostic criteria and compare and contrast medical model and peer support approaches.

METHOD

1. Read Mental Health and Substance Use Diagnosis Background. Facilitate large group discussion questions.
2. Review Mental Health and Substance Use Diagnoses.
   a. Break participants into small groups.
   b. Assign two or three diagnoses to each small group so that all diagnoses have been assigned to a small group.
   c. Give the small groups 10 minutes to review their assigned diagnoses.
   d. Facilitate a large group discussion.
      i. Ask participants: “As you look at these diagnostic criteria, how do any of these criteria fit with your lived experience? How do they not fit with your lived experience?”
      ii. Ask participants: “The borderline personality disorder description incorporates language such as, ‘inappropriate,’ ‘paranoid,’ ‘self-mutilating,’ ‘imagined abandonment,’ ‘unstable,’ and so on. How do you think having such language used to describe a person might impact their self-perception and ability to identify personal strengths or empowered self-determination?”
      iii. Ask participants: “How can we as certified peer specialists foster connection with a peer who finds value or helpfulness in diagnosis language?”
      iv. Ask participants: “In what ways do you think certified peer specialists can offer support to discovering strengths and making meaning of one’s experiences?”
      v. Ask participants: “What were some of the questions that came up for you while reviewing these descriptions?”
This section can bring up mixed feelings and strong opinions. Some may find the clinical language triggering. Others may find it validating. Participants may even see aspects of themselves in the symptoms listed, bringing up a variety of potential roadblocks or detours. Strive to keep the conversation focused on how to explore the differences between a medical model approach and a peer support approach.
Mental Health and Substance Use Diagnosis

Background

Certified peer specialists support people with a wide range of lived experience. Because many peers have received a mental health or substance use diagnosis, a Wisconsin certified peer specialist core competency is to have “knowledge of mental health and substance use disorders and their impact on recovery.” The purpose of this background is to prepare certified peer specialists to provide peer support within health care systems that are often based on the medical model. It is important to be able to compare and contrast the medical model and peer support approaches. After the background, the implications for peer support are discussed.

The medical model features assessment, diagnosis, and treatment to reduce symptoms. Diagnosis serves to categorize human experiences of distress that can then be treated. Diagnosis is often required for treatment service reimbursement. Diagnostic categories are created by the American Psychiatric Association and published in the “Diagnostic and Statistical Manual of Mental Disorders.” Currently in its fifth edition (DSM-5), the manual is used by psychiatrists and mental health clinicians to make a diagnosis based on an assessment of problem symptoms.

Large group discussion:

- As you compare and contrast medical model and peer support approaches to diagnosis, what stands out for you?

- How does the peer support approach resonate with your beliefs and values?
Consider the following perspectives on diagnosis from the medical model and peer support:

<table>
<thead>
<tr>
<th>Differing perspectives on diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical model approach</strong></td>
</tr>
<tr>
<td>Assess problem symptoms and apply diagnostic criteria to categorize human experience.</td>
</tr>
<tr>
<td>Mental health clinician is the expert based on the possession of technical knowledge about human experience.</td>
</tr>
<tr>
<td>Diagnosis leads to reimbursement for treatment. Goal of treatment is to reduce problem symptoms.</td>
</tr>
<tr>
<td>Diagnosis is focused on pathology and deficits. Treatment includes the peer’s acceptance of diagnosis.</td>
</tr>
<tr>
<td>Diagnosis is fixed and tenacious. Diagnosis tends to follow people.</td>
</tr>
<tr>
<td>Many people can have the exact same diagnosis.</td>
</tr>
<tr>
<td>Rejection of diagnosis by peer is viewed negatively by the clinician as resistance, difficult patient, in denial, or other negative view.</td>
</tr>
</tbody>
</table>
Mental Health and Substance Use Diagnoses

The diagnoses presented below are a small sample of the list in the DSM-5. Each diagnosis is presented with symptoms and the diagnostic criteria needed in order to receive the diagnosis.

Certified peer specialists engage in a strengths-based, person-centered approach to peer support, so some may question why the following samples are included in this manual. This information is included primarily to support a basic understanding of how diagnoses are structured, the kind of language used, and to spark discussion to explore the distinctions of a medical model approach and a peer support approach, especially when it comes to more common diagnoses or diagnoses that relate to commonly misunderstood lived experiences.

When reading these selections of various diagnoses, please take the opportunity to notice patterns or themes in how they are presented. What questions come up for you?

MAJOR DEPRESSIVE DISORDER

The DSM-5 gives the following criteria for assisting clinicians in making a diagnosis of major depressive disorder.

1. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure.
   - Depressed mood most of the day, nearly every day, as indicated by either subjective report (examples: feels sad, empty, hopeless) or observation made by others (example: appears tearful).
   - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
   - Significant weight loss when not dieting or weight gain (example: a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
   - Insomnia or hypersomnia nearly every day.
   - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
   - Fatigue or loss of energy nearly every day.


Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

2. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

3. The episode is not attributable to the physiological effects of a substance or to another medical condition.

4. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

5. There has never been a manic episode or a hypomanic episode.

**GENERALIZED ANXIETY DISORDER**

The DSM-5 gives the following criteria for assisting clinicians in making a diagnosis of generalized anxiety disorder.

1. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least six months, about a number of events or activities (such as work or school performance).

2. The individual finds it difficult to control the worry.

3. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past six months):

   - Restlessness or feeling keyed up or on edge.
   - Being easily fatigued.
   - Difficulty concentrating or mind going blank.
   - Irritability.
   - Muscle tension.
   - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
4. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

5. The disturbance is not attributable to the physiological effects of a substance (examples: a drug of abuse, a medication) or another medical condition (example: hyperthyroidism).

6. The disturbance is not better explained by another mental disorder (examples: anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

**MOOD DISORDERS**

The DSM-5 describes bipolar I disorder and bipolar II disorder as diagnoses that are composed of varying combinations of mania or hypomania along with major depressive episodes. If a person has experienced any number of major depressive episodes in their life and have also experienced at least one manic or hypomanic episode, a diagnosis of either bipolar I disorder (having experienced mania) or bipolar II disorder (having experienced hypomania but never mania) is considered warranted. Outlined below are the varying criteria associated with manic episodes and hypomanic episodes as described in the DSM-5.

**Manic episode**

1. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

2. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
   - Inflated self-esteem or grandiosity.
   - Decreased need for sleep (example: feels rested after only three hours of sleep).
   - More talkative than usual or pressure to keep talking.
   - Flight of ideas or subjective experience that thoughts are racing.
   - Distractibility (attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
• Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (purposeless non-goal-directed activity).

• Excessive involvement in activities that have a high potential for painful consequences (example: engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

3. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

4. The episode is not attributable to the physiological effects of a substance (examples: a drug of abuse, a medication, other treatment) or to another medical condition.

**Hypomanic episode**

1. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity and energy, lasting at least four consecutive days and present most of the day, nearly every day.

2. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
   - Inflated self-esteem or grandiosity.
   - Decreased need for sleep (example: feels rested after only three hours of sleep).
   - More talkative than usual or pressure to keep talking.
   - Flight of ideas or subjective experience that thoughts are racing.
   - Distractibility (attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
   - Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
   - Excessive involvement in activities that have a high potential for painful consequences (examples: engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

3. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

4. The disturbance in mood and the change in functioning are observable by others.
5. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

6. The episode is not attributable to the physiological effects of a substance (examples: a drug of abuse, a medication, other treatment).

**POSTTRAUMATIC STRESS DISORDER**

1. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   - Directly experiencing the traumatic event(s).
   - Witnessing, in person, the event(s) as it occurred to others.
   - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

2. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   - Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
   - Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s).
   - Dissociative reactions (example: flashbacks) in which the individual feels or acts as if the traumatic event(s) are/were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.
   - Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic events(s).
   - Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

3. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   - Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic events(s).
• Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

4. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

• Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

• Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (examples: “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

• Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

• Persistent negative emotional state (examples: fear, horror, anger, guilt, or shame).

• Markedly diminished interest or participation in significant activities.

• Feelings of detachment or estrangement from others.

• Persistent inability to experience positive emotions (examples: inability to experience happiness, satisfaction, or loving feelings).

5. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

• Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

• Reckless or self-destructive behavior.

• Hypervigilance.

• Exaggerated startle response.

• Problems with concentration.

• Sleep disturbance (difficulty falling or staying asleep or restless sleep).

6. Duration of the disturbance is more than one month.

7. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
8. The disturbance is not attributable to the physiological effects of a substance (examples: medication, alcohol) or another medical condition.

**BORDERLINE PERSONALITY DISORDER**

The DSM-5 outlines borderline personality disorder as composed of the following list of criteria.

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (examples: spending, sex, substance use, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (examples: intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (examples: frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

**SCHIZOPHRENIA**

The DSM-5 describes schizophrenia as composed of the following criteria.

1. Two (or more) of the following, each present for a significant portion of time during a one-month period (or less if successfully treated). At least one of these must be one of the first three mentioned:
   - Delusions.
   - Hallucinations.
   - Disorganized speech (frequent derailment or incoherence).
   - Grossly disorganized or catatonic behavior.
Negative symptoms (diminished emotional expression or avolition).

2. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

3. Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion 1 (active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion 1 present in an attenuated form (examples: odd beliefs, unusual perceptual experiences).

4. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or (2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

5. The disturbance is not attributable to the physiological effects of a substance (examples: a drug of abuse, a medication) or another medical condition.

6. If there is a history of autism spectrum disorder or a communication disorder of a childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least one month (or less if successfully treated).

**BINGE-EATING DISORDER**

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   - Eating, in a discrete period of time (example: within any two-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
   - A sense of lack of control over eating during the episode (examples: a feeling that one cannot stop eating or control what or how much one is eating).

2. The binge-eating episodes are associated with three (or more) of the following:
   - Eating much more rapidly than normal.
• Eating until feeling uncomfortably full.
• Eating large amounts of food when not feeling physically hungry.
• Eating alone because of feeling embarrassed by how much one is eating.
• Feeling disgusted with oneself, depressed, or very guilty afterward.

3. Marked distress regarding binge eating is present.

4. The binge eating occurs, on average, at least once a week for three months.

5. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

ANOREXIA NERVOSA

1. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or for children and adolescents, less than that minimally expected.

2. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

3. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

ALCOHOL USE DISORDER

A problematic pattern of alcohol use leading to clinically significant impairment of distress, as manifested by at least two of the following, occurring within a 12-month period:

• Alcohol is often taken in larger amounts or over a longer period than was intended.
• There is persistent desire or unsuccessful efforts to cut down or control alcohol use.
• A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
• Craving, or a strong desire or urge to use alcohol.
• Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
- Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
- Recurrent alcohol use in situations in which it is physically hazardous.
- Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of alcohol.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for alcohol.
  - Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

**STIMULANT USE DISORDER**

A pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- The stimulant is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control stimulant use.
- A great amount of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects.
- Craving, or a strong desire or urge to use the stimulant.
- Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant.
• Important social, occupational, or recreational activities are given up or reduced because of stimulant use.

• Recurrent stimulant use in situations in which it is physically hazardous.

• Stimulant use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the stimulant.

• Tolerance, as defined by either of the following:
  o A need for markedly increased amounts of the stimulant to achieve intoxication or desired effect.
  o A markedly diminished effect with continued use of the same amount of the stimulant.

  a. Withdrawal, as manifested by either of the following:
     o The characteristic withdrawal syndrome for the stimulant.
     o The stimulant (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

**OPIOID USE DISORDER**

A problematic pattern of opioid use leading to clinically significant impairment or distress as manifested by at least two of the following, occurring within a 12-month period:

• Opioids are often taken in larger amounts or over a longer period than was intended.

• There is a persistent desire or unsuccessful efforts to cut down or control opioid use.

• A great amount of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.

• Craving, or a strong desire or urge to use opioids.

• Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.

• Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.

• Important social, occupational, or recreational activities are given up or reduced because of opioid use.
• Recurrent opioid use in situations in which it is physically hazardous.
• Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
• Tolerance, as defined by either of the following:
  o A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
  o A markedly diminished effect with continued use of the same amount of an opioid.

b. Withdrawal, as manifested by either of the following:
  o The characteristic opioid withdrawal syndrome.
  o Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms
Exploring and Supporting Lived Experience

(90 minutes)

OBJECTIVE

To explore the role of peer support in lived experience and the exploring and supporting processes.

METHOD

1. Read opening to Exploring and Supporting Lived Experience. Divide the group into two halves. Assign one-half of the group the exploring discussion questions. Assign the other half of the group the supporting discussion questions. Within each half, small groups of two to four participants can work together. The goal is for each group to brainstorm ideas to share out to the large group.

2. Facilitate large group share out.

   a. Start with the exploring discussion questions. To be inclusive of the small group work, have each group initially share only one response from the brainstorm. Go around to each group until all responses are exhausted, and then continue to next question. Reinforce the following points in the discussion:

      i. It is crucial that certified peer specialists do not fall into the trap of assuming they understand a person’s experiences just because they are familiar with the diagnosis that person has received.

      ii. If a peer is upset about a diagnosis, the role of the certified peer specialist is to honor and explore this perspective, remain nonjudgmental, and keep any bias in check (examples: pro-medical model, anti-psychiatry stance).

      iii. Certified peer specialists must strive to draw out and understand what a peer’s diagnosis or lived experience means to the peer. This involves asking good exploring open questions. Ask the following questions if the groups struggle with this concept: “What does that word or label mean to you?” “How do you understand what is going on for you?” “What language or labels resonate with you in terms of your challenges and experiences?”

   b. Repeat the same process for the supporting questions. Reinforce the following points in the discussion:

      i. Certified peer specialists view the peer as the expert of their own experience.

      ii. Certified peer specialists do not seek to save people or steer peers on a certain path to recovery.
iii. OARS skills can be used in powerful ways to support a peer, regardless of lived experience—especially affirmation of strengths and careful listening with reflection.

3. Introduce *Commonly Misunderstood Lived Experiences.*
   a. Read *Hearing Voices Experiences.*
      i. Introduce video. Note that this video is from the Hearing Voices Network. It feels like a promotional video at times, but it highlights powerful points that will be discussed after the video. Assign small groups to one or two questions prior to showing the video so that participants can be ready for an efficient discussion after the video.
      ii. Show video.
      iii. Facilitate a large group discussion of the questions.
   b. Read *Eating or Body-Image Related Challenges.*
      i. Show video.
      ii. Facilitate discussion. Ask participants: “What were one or two takeaways from the video?”
   c. Read *Substance Use Challenges.* Facilitate discussion by asking participants the following questions: “What are your thoughts about providing peer support with people who present with substance use challenges?” “How might your own biases or beliefs be potential roadblocks for connecting and supporting a peer with this challenge?”
   d. Read *Psychiatric Medication Side Effects.* Facilitate discussion by asking participants the following question: “What can a certified peer specialist do to be supportive when a peer discusses medication side effects?”
Exploring and Supporting Lived Experience

The medical model features assessment of problem symptoms and application of criteria to diagnose peoples’ experiences. Peer support takes a person-centered, strengths-based, and recovery-oriented approach to understanding a person’s lived experience. The intersection of exploring and supporting processes is considered here.

EXPLORING

- What can be some roadblocks to being open and curious about a peer’s lived experience regarding a diagnosis?

- How can we be open and curious to a peer whose experience may be:
  - Different than our own experience
  - Similar to our experience (example: same diagnosis received)

- If a peer brings up the topic and seems upset about having been given a diagnosis, how can we help the peer make meaning of it? What might be some useful open questions to explore?
• If a peer brings up the topic and **seems relieved** about having been given a diagnosis, how can we help the peer make meaning of it? What might be some useful open questions to explore?

**SUPPORTING**

• How to support people who have never received a mental health or substance use diagnosis?

• Professional boundaries issue: It is not the certified peer specialist role to get people assessed and diagnosed. Why do you think this is so?

• When a peer is discussing their experience with a particular diagnosis, how can we have the conversation using person-first language? (This is language that avoids labels, jargon, and categories to describe the experiences.)

• How to support and respect a peer’s self-determination to make meaning of their own experiences in the face of having been diagnosed? Be specific.

• Is there a difference in how we might go about supporting a person who has lived experience with a substance use challenge versus a person who has lived experience with a mental health challenge? What about a person who experiences both?
Commonly Misunderstood Lived Experiences

In order to provide effective peer support services, it is important to examine our beliefs about commonly misunderstood lived experiences. Examining and gently challenging our beliefs about certain people or groups of people may increase our capacity for providing peer support to all people.

Let’s consider four commonly misunderstood lived experiences: hearing voices, eating or body image-related challenges, substance use, and psychiatric medication side effects.

HEARING VOICES EXPERIENCES

Why is this a commonly misunderstood lived experience? What is the nature of the misunderstanding?

• Hearing voices, seeing visions, or having unusual beliefs about the world are commonly feared, judged, and misunderstood because these experiences are not readily observable. In fact, an estimated 1 in 10 people worldwide have such experiences.

• In the mental health and substance use service systems, such experiences are often ascribed to the diagnostic label of schizophrenia or other psychotic disorders.

What can go wrong through misunderstanding? What are the negative impacts on people?

• Many hold biases toward voice hearers through negative portrayals in media, news, and popular culture. People often link people who hear voices or who have a diagnosis of schizophrenia with violence. In reality, voice hearers and people with schizophrenia are more likely to be the victims—not the perpetrators—of violence.

• Within the substance use and mental health service system, there is an assumption that certified peer specialists can only offer peer support to people with relatively mild or moderate challenges but that some people, the so-called severely mentally ill, cannot benefit from peer support. This is a myth.

What can be done? What does this mean for certified peer specialists?

• Many who have these experiences have formed communities of mutual and peer support throughout the world, such as the organizations Intervoice and the Hearing Voices Network.

• It is entirely within the role and scope of practice of a certified peer specialist to offer peer support to people who experience hearing voices or people who have
been understood to have “psychotic symptoms.” There is no diagnosis, level of severity, or lived experience that would contraindicate peer support. All peers can potentially benefit from the healing of peer support.

"Beyond Possible: How the Hearing Voices Approach Transforms Lives” – Open Excellence
https://youtu.be/Qk5juEqi1oY

After watching the video, answer the following questions.

1. What key concepts, skills, or processes of peer support were illustrated that have been central to this course?

2. The facilitator, Caroline, stated: “What’s worked well is to address [voices] from a place of strength, but it’s really hard to get things like strength, purpose, meaning, and connection from a prescription.” What are your thoughts about this statement?

3. Who was featured in this video? From what backgrounds or cultures did they belong?

4. What sort of shifts will be required to understand the experience of hearing voices as a normal, human experience rather than a dangerous, scary, negative experience?
EATING OR BODY IMAGE-RELATED CHALLENGES

Why is this a commonly misunderstood lived experience?

Many people assume that eating disorders only affect young women, white people, or people from a relatively privileged economic class. These are myths based on misinformation from media and popular cultural portrayals.

What can go wrong through misunderstanding? What are the negative impacts on people?

- Though women are more likely to be diagnosed with an eating disorder and gain access to treatment, many factors create bias in who gets support around eating or body image-related challenges.

- Assumptions people can make, such as all eating disorders mean someone is unusually thin or that they constantly throw up their food, erases the very real challenges many others face relating to food and body image that may not result in significant weight loss or more obvious signs of struggle.

- Many barriers exist regarding access to support around these challenges. Most supports exist only in the medical model. Treatment options are often limited to intensive outpatient, residential, or inpatient care. Many insurance companies refuse to cover expensive residential programs. Additionally, many mental health clinicians will not see someone with eating concerns until completion of such a program. Many end up without any support; others are hospitalized and endure forced tube feeding and coercive strategies for meal plan compliance.

What can be done? What does this mean for certified peer specialists?

- Those who struggle with eating and body image-related concerns can sometimes be driven by a need to take back or assert control in their lives. Sometimes this takes the form of establishing a system of food rules which becomes reliable and comforting, even if only temporarily. Such efforts toward personal control, agency, and autonomy can be seen as strengths and inner resources.

- As always, certified peer specialists should refrain from a one-size-fits-all approach to support. What seems important to one person struggling with eating or body image concerns, may feel completely irrelevant to another.

"Things Not To Say To Someone With An Eating Disorder" – BBC Three
https://youtu.be/sxvFwHOBETQ
SUBSTANCE USE CHALLENGES

Why is this a commonly misunderstood lived experience? What is the nature of the misunderstanding?

There is a widespread stigma associated with struggles related to substances. Many people attribute these challenges to moral failing, personal weakness, or lack of will power. Policymakers have misunderstood the nature of substance use challenges, criminalizing behavior related to a health issue.

What can go wrong through misunderstanding? What are the negative impacts on people?

- Without a full understanding of the nature of substance use challenges, many people believe the solution to the challenges are a moral or spiritual directive or “pull yourself up by the bootstraps” advice.
- Some communities are disproportionately impacted by the criminalization of behaviors related to substance use, resulting in vastly different outcomes. One person may be supported on a path to recovery wellness, while another person faces harsh sentencing and incarceration.
- Due to its prevalence and longevity, the 12-step recovery model has become synonymous with recovery and intertwined with the traditional substance use service system, sometimes to the exclusion of other support options. Many people have been funneled into the 12-step recovery model by the court system without the chance to explore other recovery pathways. Some have found 12-step recovery to be an alienating experience and this can limit self-determination and future help seeking.

What can be done? What does this mean for certified peer specialists?

- Wisconsin is a national leader in creating a peer specialist certification that recognizes peer support for mental health and substance use challenges. Having this integrated knowledge prepares a certified peer specialist to support people with a multitude of experiences.
- The role of the certified peer specialist is to explore with their peers how they make meaning of their own experiences and to support them in making decisions about their own paths towards recovery. Trauma-informed approaches, ethics guided by the principle of self-determination, connecting through careful listening, and recognizing the important roles of culture and community, power and privilege in people’s lives can all aid in better supporting people with substance use challenges. Certified peer specialists are uniquely well-suited to offer these supports.
PSYCHIATRIC MEDICATION SIDE EFFECTS

Why is this a commonly misunderstood lived experience? What is the nature of the misunderstanding?

Medications to treat behavioral health challenges have existed since the 1950s. Today, medications to treat depression, anxiety, and attention challenges are commonplace with millions of prescriptions filled annually. Recent pharmaceutical research and development efforts have attempted to target more specific neurochemistry and other biological markers presumed to cause behavioral health challenges.

In a statement prior to the publication of the American Psychiatric Association’s DSM-5 (May 2013), Dr. David Kupfer noted that, “The promise of the science of mental disorders is great. In the future, we hope to be able to identify disorders using biological and genetic markers that provide precise diagnoses that can be delivered with complete reliability and validity. Yet this promise, which we have anticipated since the 1970s, remains disappointingly distant. We have been telling patients for several decades that we are waiting for biomarkers. We’re still waiting.”

What can go wrong through misunderstanding? What are the negative impacts on peers?

- Those prescribing medications may encounter barriers to providing fully informed consent to the peer.

- All medications come with risks and side effects. The following is a selected list of side effects from commonly prescribed types of medications: nausea, diarrhea, sexual dysfunction, insomnia, fatigue (antidepressants); drowsiness, impaired coordination, memory impairment, dry mouth (antianxiety); loss of appetite, sleep problems, and mood swings (stimulants); dry mouth, blurred vision, constipation, dizziness, lightheadedness, weight gain, problems sleeping, extreme tiredness and weakness, and (more rare) tardive dyskinesia characterized by involuntary movements in the mouth, lips, tongue, and extremities (atypical antipsychotics).

- Taking medication for behavioral health challenges has resulted in significant harm for many people.

What can be done? What does this mean for certified peer specialists?

- The role of a certified peer specialist is to validate a peer’s experience with medications and be ready to explore any ambivalence that might arise, always centering the peer’s personal agency and remaining mindful of one’s own bias.

- A certified peer specialist can support the peer to advocate for their needs with their prescriber if they feel that they are not being heard, if asked by the peer.
Multiple Pathways to Recovery

(50 minutes)

OBJECTIVE

To consider perspectives on multiple pathways of recovery and the process of change.

METHOD

1. Facilitate Activity: Where Do We Stand.
   a. The purpose of this large group activity is get participants exploring their perspectives on pathways to recovery. Emphasize that there is no right or wrong answer. Model no judgment behavior.
   b. Prepare for this activity by placing a flip chart on one wall labeled “Strongly Agree.” On the opposite wall, place a flip chart labeled “Strongly Disagree.”
   c. Launch the activity by reading the instructions provided. Explain that if participants “strongly agree” with the statement you read, they should stand by the “strongly agree” flip chart. Likewise, if participants “strongly disagree” with the statement you read, they should stand by the “strongly disagree” flip chart. Read each statement. Pause after each statement to give participants a moment to indicate where they stand.
   d. Invite two or three participants to share why they “strongly agree” or “strongly disagree” with the statement after participants have selected where they stand for each statement. Draw out multiple perspectives. Be curious. Offer reflective listening statements to demonstrate nonjudgmental understanding of the perspectives and opinions offered. Move quickly. There is no need to linger on any one discussion.
   e. Facilitate a large group debrief after all statements have been covered. Ask participants: “What does this activity tell us about multiple pathways to recovery?” “What did we learn?” “What might this learning mean for providing effective peer support?”

2. Read Multiple Pathways Identified. Facilitate a large group discussion during the reading.
   a. Ask participants: “What pathways were helpful to you in your recovery journey?”
   b. Ask participants: “What pathways are missing from this outline?”
   c. Identify settings and programs in which certified peer specialists can provide services.
3. Read *Stages of Change*.

4. Facilitate *Activity: Exploring Ambivalence-Taking a Prescription Medicine*

   a. Read the context, preparation, and instructions as provided.

   b. Set a timer for eight minutes and provide a one-minute warning before time expires. At eight minutes, call time and provide these instructions for a five-minute debrief in the groups:

      i. Ask certified peer specialists to start with what they liked and what they could have done a little differently.

      ii. Ask the observer to share two or three observations using the Ask-Share-Ask procedure that was learned earlier.

   c. Tell the groups to switch roles for one more round. Repeat the process above.
Activity: Where Do We Stand

The Substance Abuse and Mental Health Services Administration defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” Certified peer specialists identify as people with lived experience and have navigated their own personal pathway to recovery. Because peers’ lived experiences are based on a unique set of perspectives, beliefs, values, culture, sense of community, and resources, each person’s path to recovery will be unique as well. There is no right way to enter recovery. Multiple pathways to recovery exist. The role of the certified peer specialist is to understand, accept, and support each peer’s unique path in order to walk alongside the peer.

Where do you stand on multiple pathways to recovery? In this activity, share your opinion on the following statements indicating where you stand from “Strongly Agree” to “Strongly Disagree.” For each statement below, indicate your perspective by standing in the spot that best reflects your level of (dis)agreement. Please know that there is no "right" or "wrong" answer. Your opinions and perspectives are what matter.

- Medication is an important and effective part of substance use disorder treatment.
- Medication is an important and effective part of mental health treatment.
- For people addressing opiate use, residential or inpatient treatment is the best path into early recovery.
- Good outpatient treatment programs are, on average, about as effective as inpatient programs for long-term outcomes.
- Most people get into recovery on their own using their natural supports.
- Most people who attend a 12-step self-help group become regulars.
- Most people who regularly attend 12-step self-help groups enter and stay in recovery.
- For people participating in clinical treatment services, only evidence-based practices such as motivational interviewing, cognitive behavioral therapy, or dialectical behavioral therapy are effective in helping people get into recovery.
- Peer support is a powerful way to help people enter and stay in recovery.
Multiple Pathways Identified

There exists a wide range of available recovery services and supports for people with mental health and substance use challenges. Certified peer specialists need general knowledge of what exists in order to provide relevant information, resources, and advocacy to meet a peer’s needs. Various supports for recovery, wellness, and a life of meaning are briefly described. Pathways within those routes are explored with the peer.

PRIVATE HEALTH CARE SYSTEM

Services provided within the private health care system are typically linked to reimbursement for medically necessary services that are covered by health insurance. Services are most often provided within the walls of a formal clinic or hospital linked to a specific insurance system. Private insurance is obtained either through a person’s employer, purchased through the marketplace exchange, or through Medicare. Services are most frequently provided by psychiatrists, psychologists, and other licensed medical clinicians.

- Outpatient treatment services are provided in both substance use and mental health and represent the most widely accessed and utilized treatment level. These services are provided in weekly, biweekly, or monthly sessions with individual, group, or family treatment modalities.

- Intensive outpatient programs for mental health or substance use involve at least 12 hours of weekly services in group and individual sessions.

- Day treatment/partial hospitalization programs are provided for both substance use and mental health treatment.

- Residential treatment programs exist within medical facilities and are generally targeted toward specific diagnoses (substance use disorders, eating disorders, mood disorders, trauma disorders, etc.). Residential treatment programs are generally a more restrictive setting than outpatient services, intensive outpatient programs, and day treatment or partial hospitalization, but less restrictive than inpatient hospitalization.

- Inpatient hospitalization are highly intensive treatment experiences that last from days to several weeks. Inpatient hospitalization can be costly and difficult to access.

Treatments within the health care system

- Evidence-based practices are psychologically and socially based services that research shows are repeatedly effective. Evidence-based practices can be provided within an individual or group setting as well as with couples and families. Examples include: motivational interviewing, cognitive behavioral therapy, dialectical
behavioral therapy, Matrix Model, behavioral couples’ therapy, and the community reinforcement approach.

- Medication-assisted treatment complements psychosocial treatment by addressing the underlying biological basis of opioid addiction. Medications such as buprenorphine products, methadone, and naltrexone are highly effective in reducing or eliminating drug cravings or withdrawal symptoms, thus providing a critical support in early recovery.

- Psychiatric medications also complement services and are used to address depression, anxiety, attention, and other mental health challenges. While psychiatric medication has helped many people to reduce or manage difficult symptoms, there are also significant risks and side effects.

PUBLIC MENTAL HEALTH AND SUBSTANCE USE SYSTEM

Medicaid and tribal, federal, state, county, and municipal governments fund services provided within Wisconsin’s public mental health and substance use services system. Professionals employed across hundreds of agencies provide a continuum of services for people needing all levels of care.

The public system combines all the services provided by the private system and expands the definition of medically necessary services, recognizing the value of community and natural supports in a person’s recovery.

In Wisconsin, counties are required by state law (Wis. Stat. § 51.42) to provide a system of community-based services for individuals "dependent on alcohol and other drugs" or having "serious and persistent mental illness."

The human services workforce comprises a wide range of professionals who help people address substance use and mental health challenges. Each discipline has its own regulations, scope of practice, and licensing requirements. There are two general types of professionals who provide these services: specialists and non-specialists.

- Specialist providers have specific education and training in substance use and mental health in order to provide treatment services as licensed or certified professionals. Licenses are discipline-specific (examples: licensed professional counselor or licensed clinical social worker). Health care professionals such as physicians or psychiatrists may have an additional credential to prescribe medication-assisted treatment for opioid use disorder. A human services professional may obtain a certificate to become a clinical substance abuse counselor. Specialist providers are able to provide reimbursable treatment services in a range of clinical settings.

- Non-specialist providers also are an essential part of the workforce. General health care workers may provide support services to people with substance use and mental
health challenges. Physicians can provide psychiatric medication prescriptions and monitoring. Other human services professionals (case managers and crisis workers) provide a range of support services.

**Medicaid-funded programs**

These programs are offered by tribal and county agencies or contracted providers. Medicaid-funded programs means that allowable services may be reimbursed for individuals enrolled in Medicaid.

- Crisis services assist individuals by addressing emergencies related to substance use and mental health challenges. Crisis workers seek to assist individuals in de-escalating the person’s crisis, with linkage to follow-up services, as needed. Crisis services tend to be relatively brief encounters.

- Comprehensive Community Services provides coordinated services for individuals with substance use and mental health challenges across the lifespan (from children to older adults). Comprehensive Community Services assists individuals who may have short-term intensive or ongoing needs by providing person-centered and trauma-informed individualized services. Information can be found at [https://www.dhs.wisconsin.gov/ccs/index.htm](https://www.dhs.wisconsin.gov/ccs/index.htm)

- Community Support Programs are for adults living with serious and persistent mental health challenges. Community Support Programs provide team-based intensive treatment that includes a broad range of services to meet an individual's unique needs. Community Support Programs assist individuals who might otherwise need an institutional level of care to live independently in the community. Information can be found at [https://www.dhs.wisconsin.gov/csp/index.htm](https://www.dhs.wisconsin.gov/csp/index.htm)

- Community Recovery Services assist people with mental health challenges to improve their quality of life in the community through an outcomes-based planning and support process focused on the individual's unique recovery needs. Comprising three sets of services (Community Living Support, Peer Support, and Supported Employment), Community Recovery Services is Wisconsin’s most intensive community-based program for people with mental health challenges. Individuals who receive Community Recovery Services mostly reside in group home or adult family home settings. Information can be found at [https://www.dhs.wisconsin.gov/crs/index.htm](https://www.dhs.wisconsin.gov/crs/index.htm)

**OTHER COMMUNITY-BASED OR PROFESSIONAL SERVICES**

- Certified peer specialists offer peer support to people navigating substance use and mental health challenges. Whether a certified peer specialist works in a peer-run organization with a team entirely composed of other peer support professionals or as part of a treatment or recovery team including clinicians and other service providers, they are active participants and colleagues who bring their own valuable
expertise and skill sets.

A certified peer specialist is a person who has their own lived experience of mental health and substance use challenges and has completed formal training and certification in the peer specialist model of mental health and substance use peer support. They use their unique set of experiences and recovery in combination with skills training, including continuing education, to support people living with mental health and substance use challenges.

- Certified parent peer specialists are people who have lived experience raising youth experiencing mental health and substance use challenges. This person combines their lived experience with formal skills training to support others in a parenting role.

Certified parent peer specialists use their own family’s experience as a tool for support and connection. They support the families they serve in recognizing and fostering their own resiliency and provide information about resources relevant to the family’s needs. At the heart of the work of certified parent peer specialists is facilitating family-directed services, including goal setting and fostering strong communication networks between families and service providers.

- A network of peer-run recovery centers in Wisconsin provide a variety of recovery supports. Most offer opportunities for one-on-one peer support as well as group support. Information about the peer-run centers funded by the Department of Health Services can be found at: https://www.dhs.wisconsin.gov/recovery/peer-run-recovery-centers.htm

- Peer-run respites offer a supportive, home-like environment during times of increased stress or symptoms and opportunities for support from people who have experienced similar mental health and substance use challenges. Information on the peer-run respites funded by the Department of Health Services can be found at: https://www.dhs.wisconsin.gov/peer-run-respite/index.htm

- Alternative therapies and practices are primarily found outside of the substance use and mental health service systems. Some of these may be included in service arrays for Medicaid benefit programs (example: Comprehensive Community Services). Some resources that may be considered alternative therapies and practices include yoga, equine therapy, acupuncture, and life coaching.

- The independent living specialists at independent living centers are responsible for advocating and delivering the core services of independent living centers including independent living skills training, peer counseling, information and referral services, individual and systems advocacy, and deinstitutionalization. They also are expected to possess knowledge of disability issues, the independent living philosophy, and accessibility resources. Find your local independent living center here: https://www.dhs.wisconsin.gov/disabilities/physical/ilcs.htm
SELF-HELP

- Support groups (examples: 12-step programs, SMART Recovery, Celebrate Recovery, Secular Organizations for Sobriety, LGBTQ+ Support Groups, Hearing Voices Network, Alternatives to Suicide, Elder Support Groups) - Many support groups exist to aid people in accessing help and support related to a variety of lived experiences and life challenges. Many of these support groups focus on the benefit of connecting over shared lived experience and have a peer support component. Though peer support can be found in these groups, it is different from the services offered by a certified peer specialist.

- Self-help books, media, and trainings – Many people start their research into how to support themselves while navigating life’s challenges by accessing various types of self-help media. These can include recorded presentations, as well as, books that guide readers through clinical models presented in a self-study fashion.

- Lifestyle changes – Many find that making adjustments to their lifestyle, including the food they eat, how they engage with physical activity, attending to balanced sleep, and so on make significant positive impact upon their wellness and recovery efforts. Though some people choose to make these changes on their own, sometimes service providers recommend such changes.

NATURAL SUPPORTS

Natural supports that aid people in their recovery are numerous, diverse, and sometimes specific to different cultures. Natural supports also do not always take the form of people or organizations, but also include activities, animals, and so on. A simple list of natural supports is provided here:

- Family (of origin or chosen)
- Friendships
- Community groups and social or cultural organizations
- Religious or spiritual supports
- Political or advocacy groups and organizations
- Recreational pursuits
- Artistic expression
- Educational or mentoring involvement
- Natural world and animal supports
Natural supports are in and of themselves valid recovery pathways. Some people with lived experience do not seek a pathway to wellness that lies within formal services or feel comfortable even defining their journey in the language of recovery. This is okay.

Certified peer specialists provide support to people with diverse experiences, and support the meaning people make of their own experiences and struggles. This allows peers to self-determine the most accurate language to describe their experiences, as well as how to navigate them.
Stages of Change

A peer’s unique pathway to recovery typically leads through stages of change. The Stages of Change model was developed by behavioral health researchers, Carlo C. DiClemente and J. O. Prochaska, to understand the process of change relating to substance use. This model can be applied to a range of substances as well as to specific mental health challenges. Five descriptive stages offer a way for certified peer specialists to consider where a peer is at in the process of change.

STAGES OF CHANGE DESCRIBED

This stage model is not prescriptive nor should it be used as an assessment. It simply offers a general description of where a peer may be in the change process. There are five stages:

- **Pre-contemplation.** In this stage, the peer is not considering making a change regarding a specific substance or mental health challenge. The status quo is fine. There is no perception that a problem exists.
• **Contemplation.** Here, the peer begins thinking about change. There may be some perception that a problem exists. The hallmark of this stage is that the peer may experience ambivalence or feel two ways about change: on one hand, there are some benefits to the current status quo (advantages), and on the other hand, there are some downsides (disadvantages). The peer’s ambivalence may be resolved on the side of no change (return to pre-contemplation) or on the side of change (progress to preparation).

• **Preparation.** In this stage, the peer has resolved ambivalence and a decision is made to move forward. Planning for change has begun which can involve identifying supports, recovery resources, coping strategies, and other recovery-oriented activities.

• **Action.** Preparation and planning sets the stage for action. Here the initiation of change happens. For substance use, change could mean reducing use (example: cutting down on the frequency or quantity), stopping use (example: taking a break), changing another aspect of substance use.

• **Maintenance.** Change is initiated in action, and during this stage, the peer stays the course. Maintenance involves settling into new routines of recovery. The successful coping strategies and supports developed earlier are refined.

**STAGES OF CHANGE INSIGHTS**

The stages of change offer several insights into providing effective peer support:

• Pre-contemplation or not thinking about change is a valid stage in the change process. There should not be an implication of deficits for a peer who is not considering change. Moreover, contemplating change and experiencing ambivalence is a normal, expected part of the change process.

• Stages of change are not linear. They are cyclical. People can cycle through from one stage to another, return to earlier stages, then continue forward in an ongoing learning process.

• Relapse or return to the status quo is a normal part of the change process. From this perspective, relapse is simply a temporary setback. The peer may need to return to an earlier stage of change to complete tasks that may not have been fully completed previously. For example, ambivalence may need to be explored again (contemplation stage) or more supports may need to be put into place (preparation stage).

• Action for change is one of the last stages (not one of the first). The insight here is not to get ahead of peoples' readiness for change. When a peer is contemplating change, it is okay to stay in the exploration process. Jumping ahead to plan before the peer is ready can be counter-productive.
Here are some ways to consider peer support informed by a peer’s general stage of change:

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Peer Support</th>
</tr>
</thead>
</table>
| **Pre-contemplation.**  
No recognition of need to change. | • Connect and build the relationship.  
• Avoid listening roadblocks, especially refrain from giving advice.  
• Listen carefully and offer many reflections; come alongside, side with no change, reflect feeling.  
• Look for strengths and affirm.  
• With permission, share one relevant aspect of the recovery story. |
| **Contemplation.**  
Ambivalent about change. | • Continue to connect and build the relationship.  
• Explore ambivalence (*Advantages and Disadvantages Worksheet*).  
• Listen carefully and offer many reflections; double-sided reflection to reflect ambivalence.  
• With permission, share one relevant aspect of the recovery story. |
| **Preparation.**  
Getting ready for change. | • Explore multiple pathways to recovery.  
• Explore how values fit with the change (*Personal Values Card Sort*).  
• Look for strengths and affirm.  
• Identify potential barriers to change.  
• Brainstorm strategies for change.  
• Offer assistance in developing a recovery plan.  
• Explore natural supports. |
| **Action.**  
Initiate change. | • Look for strengths of initial change efforts, affirm, and celebrate.  
• Express support and acceptance of harm reduction changes.  
• Continue to listen carefully and reflect.  
• Continue to explore natural supports.  
• Continue to brainstorm strategies for change.  
• Offer assistance in making adjustments to the recovery plan.  
• Express optimism for recovery. |
| **Maintenance.**  
Keep change going. | • Continue to listen carefully and reflect.  
• Continue to look for strengths and affirm.  
• Ask open questions that draw out lessons learned.  
• Continue to offer assistance in making adjustments to the change plan.  
• Continue to express optimism for recovery. |
| **Relapse.**  
Temporary setback. | • Continue to connect and build the relationship. Listen carefully, come alongside, and reflect feeling.  
• Frame relapse as a setback or a “bump along the road.”  
• Consider returning to an earlier stage of change. For example, explore advantages and disadvantages of change OR explore multiple pathways to recovery OR explore how values fit with the change.  
• With permission, share one relevant aspect of the recovery story.  
• Provide advocacy, as needed. |
**Activity: Exploring Ambivalence—Taking a Prescription Medication**

**Context:** Ambivalence about change—that is, feeling two ways about something—is a normal part of the change process. Peer ambivalence reflects the contemplation stage of change and provides certified peer specialists an opportunity to explore both sides with no judgment. The goal is to facilitate a useful exploration process so that the peer can come to their own decision about whether to move forward with a change.

**Preparation:** Listening well is a key to exploring a peer’s ambivalence. To prepare, recall your listening strategies for overcoming listening roadblocks. Get ready to make a decision to listen and to offer many reflective listening statements. Also, please find the *Advantages and Disadvantages Worksheet.* This worksheet will guide the exploration process with key open questions and other prompts.

**Activity:** Get into groups of three with participants you have not worked with yet during the course. In each group, decide these roles:

- **Peer.** You may present a role-playing or a real play based on prior lived experience with taking a prescription medication. Get ready to discuss some benefits of the medication (advantages), as well as the downsides or risks (disadvantages). In other words, you are ambivalent about taking this medication.

- **Certified peer specialist.** Your role is to explore the peer’s ambivalence. Use the *Advantages and Disadvantages Worksheet* to guide the conversation. Please follow the worksheet procedure and prompts. Be sure to listen carefully and offer many reflective listening statements to demonstrate understanding. You will have eight minutes for this and a one-minute warning will be called so that you can offer a summary.

- **Observer.** Using the *OARS Observer Sheet,* carefully observe the certified peer specialist and make a hash mark for each skill that is demonstrated. Try to make a mark for each thing the certified peer specialist communicates in terms of OARS skills (watch for listening roadblocks, too).
Advantages and Disadvantages Worksheet

Use this worksheet to explore the advantages and disadvantages of making a decision. The decision under consideration is:

______________________________________________________________________________

<table>
<thead>
<tr>
<th>ADVANTAGES – What are the advantages or the positives for making this decision? What else?</th>
<th>DISADVANTAGES – What are the disadvantages or the negatives for making this decision? What else?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summarize, advantages and disadvantages.

Exploration question: So where does this leave you?

Listen carefully and reflect.
Assign Homework

(5 minutes)

OBJECTIVE

To answer questions regarding the information on the Stages of Change and prepare for the next section.

METHOD

Assign *Review Questions and Reading*. 
Review Questions and Reading

1. How do the peer support processes of connecting, exploring, and supporting seem relevant across the Stages of Change?

2. What are some of the key concepts, skills (OARS skills, self-disclosure), and tools of peer support embedded within each stage? Provide some examples. How do these concepts, skills, and tools seem particularly relevant within a given stage?

Read the “Are We Anti?” article by Western Mass Recovery Learning Community. Be prepared to bring thoughts, questions, and reflections to the next class. The article can be found online here: https://www.westernmassrlc.org/rlc-articles/213-are-we-anti
Section 8

This section begins by exploring ambivalence and how it applies to the peer support process. An advantages and disadvantages activity helps solidify this topic. This section then shifts focus toward suicide and self-harm. Various aspects of suicide are discussed, such as warning signs, attitudes, beliefs, and supporting peers considering suicide. The concept of self-harm is defined and discussed concerning harm reduction. Self-care is also revisited in this section. To conclude, a homework assignment is given that focuses on the self-harm bill of rights.
Curriculum Guide

SECTION 8

40 minutes    Homework Review
100 minutes   Difficult Conversations: Suicide
10 minutes    Practicing Self-Care
15 minutes    Break
50 minutes    Difficult Conversations: Self-Harm
5 minutes     Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Believes in and respects people’s rights to make informed decisions about their lives</td>
</tr>
<tr>
<td>1.6</td>
<td>Believes in the importance of self-awareness and self-care</td>
</tr>
<tr>
<td>2.4</td>
<td>Knowledge of the stages of change and recovery</td>
</tr>
<tr>
<td>3.3</td>
<td>Knowledge of the scope of practice of a certified peer specialist</td>
</tr>
<tr>
<td>3.4</td>
<td>Knowledge of confidentiality standards</td>
</tr>
<tr>
<td>4.5</td>
<td>Ability to identify and support a person in crisis and know when to facilitate referrals</td>
</tr>
<tr>
<td>4.6</td>
<td>Ability to listen and understand with accuracy the person’s perspective and experience</td>
</tr>
<tr>
<td>4.7</td>
<td>Effective written and verbal communication skills</td>
</tr>
<tr>
<td>4.12</td>
<td>Ability to facilitate and support a person as they find and utilize resources</td>
</tr>
<tr>
<td>4.14</td>
<td>Ability to know when to ask for assistance and/or seek supervision</td>
</tr>
<tr>
<td>4.16</td>
<td>Ability to utilize own recovery experience and skillfully share to benefit others</td>
</tr>
<tr>
<td>4.18</td>
<td>Ability to foster the person’s self-advocacy and provide advocacy when requested by the person</td>
</tr>
<tr>
<td>4.19</td>
<td>Ability to advocate for self in the role of a certified peer specialist</td>
</tr>
</tbody>
</table>
Review Homework

(40 minutes)

OBJECTIVE

To review the questions about Stages of Change assigned as homework and discuss the “Are We Anti?” article.

METHOD

1. Ask the participants: “How do the peer support processes of connecting, exploring, and supporting seem relevant across the Stages of Change?”

2. Ask the participants: “What are some of the key concepts, skills (OARS skills, self-disclosure) and tools of peer support embedded within each stage? How do these concepts, skills, and tools seem particularly relevant within a given stage?”

3. Discuss the “Are We Anti?” article.
Difficult Conversations: Suicide

(100 minutes)

OBJECTIVE

To explore beliefs and attitudes towards suicide and consider peer support.

METHOD

1. Read Suicide Overview and Suicide Warning Signs.

2. Facilitate Activity: Exploring Attitudes and Beliefs About Suicide.
   a. The purpose of this large group activity is to get participants to explore their perspectives on suicide. Emphasize that there is no right or wrong answer. Model no judgment behavior.
   b. Prepare for this activity by placing a flip chart on one wall labeled “Strongly Agree.” On the opposite wall, place a flip chart labeled “Strongly Disagree.”
   c. Launch the activity by reading the instructions provided. Explain that if participants “strongly agree” with the statement you read, they should stand by the “strongly agree” flip chart. Likewise, if participants “strongly disagree” with the statement you read, they should stand by the “strongly disagree” flip chart. Read each statement. Pause after each statement to give participants a moment to indicate where they stand.
   d. Invite two or three participants to share why they “strongly agree” or “strongly disagree” with the statement after participants have selected where they stand for each statement. Draw out multiple perspectives. Be curious. Offer reflective listening statements to demonstrate nonjudgmental understanding of the perspectives and opinions offered. Move quickly. There is no need to linger on any one discussion.
   e. Facilitate a large group debrief after all statements have been covered. Ask participants: “What did you learn?” “How might our attitudes and beliefs about suicide impact our abilities to provide effective peer support services?”


4. Review Discussing Suicide for Peer Support.
5. Facilitate *Activity: Discussing Suicide.*

a. This is small group activity. Divide participants into groups of four.

b. Read the description of each role as provided. Direct each group to decide on roles in the first round.

c. Explain that there will be four rounds of this activity so that each participant can play each role. Each round is 10 minutes, followed by a five-minute debrief among group members.

d. Set a timer for 10 minutes and launch the activity.

e. During the activity, circulate, observe, and answer questions.

f. Provide a one-minute warning at nine minutes.

g. Call time and direct the groups to the debrief instructions on a flip chart.

i. Certified peer specialist goes first. Consider the following questions: “What did you like about what you did?” “We have a tendency to be hard on ourselves, so try to resist that and start with what you liked.” Discuss what could have been a little different.

ii. Observers go second. For practice, observers should use the Ask-Share-Ask procedure to share just two to three brief observations. Observers should emphasize what went well, and then provide the OARS observer sheet and checklist to certified peer specialist.

h. Tell groups to rotate roles. Follow the same process as above for a total of four rounds.

i. Facilitate a large group debrief after four rounds. Ask participants: “What did you get out of that practice activity?” “What did you learn about yourself in the certified peer specialist role?” Be sure to affirm the willingness to be vulnerable, the courage to take risks, and the efforts to experiment with new ways of working.
Suicide

Suicide is a difficult and emotional topic. Most people, particularly those with lived-experience, have a deeply personal connection to the topic of suicide and may find it challenging to stay present and supportive of a peer who may be perceived as being at risk for suicide. It is important that certified peer specialists are aware of their own feelings and perspectives surrounding suicide and understand how to navigate them before beginning work.

When a peer expresses thoughts or feelings about suicide, a certified peer specialist must understand that this expression does not inherently mean the peer is experiencing a crisis. Even when supporting a peer through an emotionally intense experience it is crucial that certified peer specialists allow the peer to define crisis in their own terms. Many people live with ongoing, active, or recurrent thoughts of suicide and have found ways to navigate and live alongside the experience with or without treatment, medication, and other services.

SUICIDE WARNING SIGNS

Standardized checklists and tools exist for assessing a person’s suicide risk. While formal assessment may be useful for people in clinical roles, it is important to understand that the personal and individualized nature of risk makes standardized assessment highly limited in fully understanding a person’s experience. A certified peer specialist should not be doing a complete risk assessment, as it falls outside of their role. However, peers should be aware of suicide warning signs.

The following list is an example of suicide warning signs that comes from Befrienders Worldwide and covers situational, physical, behavioral, and psychological warning signs of suicide:

At-risk situations

- Personal history of suicidal behavior
- Family history of suicide or violence
- Sexual or physical abuse
- Death of a close friend or family member
- Suffering a major loss or life change
- Divorce or separation, ending a relationship
- Failing academic performance, impending exams, exam results
- Job loss, problems at work
• Impending legal action
• Recent imprisonment or upcoming release

**Physical changes**
• Lack of energy
• Disturbed sleep patterns—sleeping too much or too little
• Loss of appetite
• Sudden weight gains or loss
• Increase in minor illnesses
• Change of sexual interest
• Sudden change in appearance

**Behaviors**
• Becoming withdrawn
• Behaving recklessly
• Getting affairs in order and giving away valued possessions
• Showing a marked change in behavior, attitudes, or appearance
• Using drugs or alcohol

**Thoughts and emotions**
• Thoughts of suicide
• Loneliness—lack of support from family and friends
• Rejection, feeling marginalized
• Deep sadness, depression, or guilt
• Unable to see beyond a narrow focus
• Anxiety and stress
• Helplessness
• Loss of self-worth
• Intense psychological and physiological distress

How to make sense of this list? Three facts should be considered: 1) most people at some point in their life have shown a warning sign because these signs are highly
prevalent in the population; 2) the presence of warning signs does not necessarily imply a person is at-risk for suicide; and 3) the more warning signs that a person presents does suggest more risk for suicide.

When a certified peer specialist notices or observes what they perceive to be warning signs or risk for suicide they must understand these within the context of the person’s experience and explore their meaning. If, in your exploration with the peer, you and the peer determine there is an inherent crisis, the certified peer specialist should inform the peer of the protocols set forth by their agency. The first step would be for the certified peer specialist to seek supervision in reporting the crisis. The certified peer specialist could invite the peer to meet with their supervisor.
Activity: Exploring Attitudes and Beliefs about Suicide

In this activity, we will explore our attitudes and beliefs about suicide. You will notice “Strongly Agree” and “Strongly Disagree” on opposite walls. For each statement below, please indicate your perspective by standing in the spot that best reflects your level of agreement or disagreement. Please know that there is no “right” or “wrong” answer. What matters is your perspective.

- Suicide should be illegal.
- Suicide is wrong.
- Suicide is selfish.
- A person attempting suicide should be stopped by any means necessary.
- It is my responsibility in my job to stop people.
- Suicide is okay in some situations, like when a person is terminally ill.
- Certain thoughts and feelings always predict suicide.
- Suicide is linked to mental illness for most people.
- Self-injury or self-harm is always a first step toward suicide.
Supporting Peer Considering Suicide

It is crucial that certified peer specialists consciously choose to approach conversations about suicide with curiosity, empathy, and compassion rather than fear. It is normal and understandable to experience fear or concern in the face of conversations about suicide. However, a certified peer specialist centers hope and the peer relationship over acting or reacting from a place of fear. This hope and curiosity-based approach supports empowerment and resilience as well as the ethical principle of self-determination.

Supporting a peer through a conversation about suicide can deepen a trusting relationship. Listening for understanding is the key. What is the person’s lived experience in the moment? What is the meaning that the person is making right now? Only a careful listener will be able to understand the peer’s perspectives and experiences in that moment.

Small group brainstorm: Supporting a peer who is considering suicide involves the fundamental processes of peer support and OARS skills. In your small group, you will be assigned a specific process (connecting, exploring, or supporting). Work together, brainstorm the following questions, and take notes for a large group share out.

- Why is this process important for effective peer support? Be specific.
  - Connecting:

  - Exploring:

  - Supporting:

- What might the application of OARS look like within that specific process of peer support? Provide specific examples, if possible.
  - O
  - A
  - R
  - S

When understanding is reached, a certified peer specialist can better mutually explore relevant and timely resources and supports, as needed. If, in your exploration with the peer, you and the peer determine there is an inherent crisis, the certified peer specialist should inform the peer of the protocols set forth by their agency. The first step would be for the certified peer specialist to seek supervision in reporting the crisis. The certified peer specialist could invite the peer to meet with their supervisor. Each
employing agency will have policies and procedures guiding how to respond to peers who are at risk of suicide and the certified peer specialist must be familiar with these guidelines.
Discussing Suicide for Peer Support

Connecting

- Avoid listening roadblocks such as sympathy, giving advice, offering reassurance, or asking closed-ended, fact gathering, and assessment-oriented questions.
- The goal is to connect and understand the person’s experience. This requires making the decision to listen. Express empathy and offer many reflective listening statements. Listen for underlying meaning and emotion. Come alongside, reflect feeling, and reflect ambivalence with double-sided reflection.
- Look for strengths and affirm. Strengths could include help seeking—thank you for taking a risk to share this, courage —your vulnerability to share is real strength.

Exploring

- Ask open questions to explore the person’s experience:
  - What does “feeling suicidal” mean to you?
  - What has your experience with suicide been in the past?
  - What is happening in your life that is contributing to how you are feeling right now?
- Explore ambivalence – what are the advantages and disadvantages of suicide? Use Advantages and Disadvantages Worksheet.
- Explore the possibilities of alternatives to suicide.

Supporting

- Identify your role; convey involvement: “I’m here to listen and I care.”
- Ask open questions: How can I best support you right now? What does your support system look like?
- Support the person in leading the conversation, do not pursue a personal agenda or assess for safety.

Discuss supports for pursuing alternatives to suicide. Encourage peer to seek out the identified supports.

- If the person is in an immediately life-threatening situation, call for assistance. Keep the peer informed and provide information about what to expect. Inform the peer that you will continue to be available for support.
- A peer expressing a desire to die or the fact they are struggling with suicidal feelings does not necessarily constitute a reason in itself to pursue emergency services intervention.
Activity: Discussing Suicide

The purpose of this activity is to practice skillful communication and peer support with someone considering suicide.

This activity will be completed in groups of four. Each member of the group will have one of the following roles.

- **Peer.** Act as a person who is strongly considering suicide with the means complete this act within their grasp. However, there is a glimmer of hope for life somewhere inside. Be realistic. It is not useful in a practice activity to be purposefully difficult in a role. Draw upon prior personal experience for the peer role, if you wish.

- **Certified peer specialist.** Start with connecting. Avoid your listening roadblocks. Select two to three open questions to ask, then be ready to carefully listen and reflect. Strive to provide at least two reflective listening statements per one question asked. Avoid roadblocks such as assessment and planning. You will have 10 minutes. You will get a one-minute warning before time is called to offer a brief summary.

- **Observer of OARS skills.** Use the *OARS Skills Observer Sheet* to note skills. Try and mark every skill you hear and note some examples.

- **Observer of processes.** Use the *Discussing Suicide for Peer Support* checklist to note each element the certified peer specialist uses in the conversation.

There will be four rounds of this activity to allow each member of the group to play each role. Each round is 10 minutes, followed by a five-minute debrief in the group.
Practicing Self-Care

(10 minutes)

OBJECTIVE

To remind participants of the importance of self-care and allow time for the participants to practice self-care.

METHOD

1. Refer to flip chart that lists self-care activities identified in an earlier section. Discuss with participants which self-care activity makes sense right now following an intense experience.

2. Move from this group discussion into the scheduled break and encourage participants to practice self-care.
Difficult Conversations: Self-Harm

(50 minutes)

OBJECTIVE

To explore beliefs and attitudes toward self-harm and consider peer support.

METHOD

1. Read Self-Harm.

2. Facilitate Activity: Perspective Taking on Self-Harm.
   a. Model the qualities of an effective peer specialist: curiosity, openness, and careful listening (reflective listening) to demonstrate understanding because this topic has many perspectives. Facilitate from a stance of neutrality.
   b. Divide the room in half.
      i. In groups of four to five, half of the participants will take the peer perspective.
      ii. In groups of four to five, the other half of the participants will take the certified peer specialist perspective.
   c. Set a time for 15 minutes and instruct all of the groups to brainstorm responses to their three questions. Give the groups a two-minute warning before time expires.
   d. Facilitate a large group share out.
      i. Draw out group responses for each peer perspective discussion question in order.
      ii. Draw out group responses for each certified peer specialist discussion question in order.
         1. Note that these questions are parallel to the peer perspective.
         2. Note similarities and differences in responses from the perspective.
      iii. Ask all participants: “What did we learn from this activity?”
      iv. Ask all participants to make connections between the peer and the certified peer specialist perspectives.
      v. Ask all participants to notice how there was overlap with ideas of support, but maybe there were differences, too.
Self-Harm

Self-harm is a difficult topic of conversation. Self-harm includes behaviors such as using substances, cutting, burning, hitting, as well as over-exercising, bingeing, or purging food. Self-harming behaviors do not necessarily indicate a crisis or suicide risk. For many, self-harm is a coping tool that has been developed to manage intense emotions or experiences.

Similarly, to the difficult conversation of suicide, it is important that certified peer specialists are aware of their own attitudes and beliefs about peers who engage in self-harming behaviors. The role of the certified peer specialist is not to attempt to stop people. It is to explore what the behavior means to the peer, what purpose the behavior serves, and to offer useful support for developing alternatives if welcome.

HARM REDUCTION AND SELF-HARM

Harm reduction is the practice of mitigating some of the risk for people who engage in self-harming behavior without setting the expectation that they will stop. Many people who engage in self-harming behavior may have been told that recovery can only be achieved by completely stopping the behavior, but that is not true. Shifting the focus from complete cessation to harm reduction allows for a more engaging conversation and connection within the peer relationship. A certified peer specialist needs to be able to hold space for the peer to determine when or if they are ready to engage in harm reduction or cessation and to what degree.

Supporting a person who is working on harm reduction can be an intimidating and uncomfortable experience for a certified peer specialist who has been trained in an abstinence model of recovery. There is a common misconception that validating someone who is engaged in harm reduction is the same thing as supporting and encouraging the self-harming behavior, but that is not the case. There are many ways for a certified peer specialist to support someone who is working on harm reduction, including:

- Exploring with that person what the self-harming behavior means to them.
- Exploring if the person knows the signs and has a plan for if they reach a point where they need medical intervention. For example:
  - If a person has used too much of a substance, can they recognize the signs of overdose?
  - If a person cuts themselves too deep, do they know the signs of shock and have a plan for aftercare?
  - If a person has an eating disorder, can they recognize when it is having a serious effect on their body and know when to get help?
• Supporting the peer in obtaining sterile, new equipment to decrease the risk of serious harm and spreading disease.

• Understanding that people engage in less common self-harming behaviors.

• Recognizing the strength people display by choosing to engage in harm reduction and not viewing it as a step on the path to complete cessation.

For many people the idea of supporting someone in obtaining equipment that will be used for self-harming behavior or to continue using a substance, can feel jarring, counterintuitive, and unethical. The role of a certified peer specialist is to support people on their individual path to recovery that can encompass harm reduction, complete cessation, or both over a period of time. Certified peer specialists must have a comprehensive understanding of their own beliefs and negotiating boundaries with their peer as well understanding their employer’s policies surrounding supporting someone engaging in harm reduction.

ADVOCATING FOR IMPLEMENTATION OF HARM REDUCTION POLICIES

Not all agencies recognize harm reduction as a viable path to recovery. For many employers these types of policies can present a unique and challenging shift in the approach they have utilized for many years. As the support for multiple pathways to recovery is a core tenet of being a certified peer specialist, it is crucial that they advocate for the recognition of harm reduction as a valid recovery choice while receiving services of any kind through their agency. Certified peer specialists are uniquely positioned, as agents of change, to educate and advocate for the implementation of harm reduction policies at their place of employment.
Activity: Perspective Taking on Self-Harm

The purpose of this activity is to explore multiple perspectives on self-harm.

In groups of four or five, briefly consider three questions either from the peer perspective or from the certified peer specialist perspective. Have someone document your group responses. Be prepared to share out to the large group.

**Taking the peer perspective, put yourself in a peer’s shoes or draw upon your own personal experience to consider these questions:**

- What might be going on in this person’s life on the inside and outside?
- What might this person find beneficial, helpful, or supportive? What could a peer support person do and say that would be useful?
- What might not be useful? What should people refrain from doing and saying?

**Taking the certified peer specialist perspective, consider these questions:**

- What might be our initial responses on the inside (thoughts, feelings) when a peer presents thoughts of wanting to self-harm?
- What might be some effective ways of responding as a certified peer specialist? What could we do and say to be supportive? Consider OARS communication skills and provide specific examples of application.
- What should we be sure to refrain from doing and saying? What listening roadblocks should we be sure to avoid?
Assign Homework

(5 minutes)

OBJECTIVE

To continue perspective taking and learning on the difficult topic of self-harm and prepare for next section.

METHOD


3. Direct participants to take the Race Implicit Association Test (IAT) in preparation for the discussion in Section 9.
   a. Explain that this test is available online at: https://implicit.harvard.edu/implicit/takeatest.html
   b. Tell participants they must select “I wish to proceed” at the bottom of the first webpage that appears.
   c. Tell participants they must select “Race IAT” from the list of test topics to take the test.
Review Questions

1. What are the two or three most important takeaways from this section?

2. What is one thing I did during the course of this section to take care of myself?
Section 9

This section continues focusing on self-care and its significance within the peer support process, a self-evaluation is provided. Next, stigma and the role of culture in peer support are addressed, including marginalization and how it is connected to lived experience. Culture, power, and privilege are defined and discussed in relation to peer support. The section concludes with information on culturally informed approaches to trauma as well as trauma-informed care. The homework assignment asks participants to continue looking at culture and stigma, along with an anger questionnaire.
Curriculum Guide

SECTION 9

5 minutes  Homework Review
40 minutes  Practicing Self-Care
100 minutes  Stigma and Cultural Competency
15 minutes  Break
50 minutes  Trauma-Informed Peer Support
5 minutes  Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Believes that recovery is an individual journey with many paths and is possible for all</td>
</tr>
<tr>
<td>1.2</td>
<td>Believes in and respects people’s rights to make informed decisions about their lives</td>
</tr>
<tr>
<td>1.4</td>
<td>Believes in the importance of empathy and listening to others</td>
</tr>
<tr>
<td>1.5</td>
<td>Believes in and respects all forms of diversity</td>
</tr>
<tr>
<td>1.6</td>
<td>Believes in the importance of self-awareness and self-care</td>
</tr>
<tr>
<td>1.11</td>
<td>Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery</td>
</tr>
<tr>
<td>2.3</td>
<td>Knowledge of the basic neuroscience of mental health and addiction</td>
</tr>
<tr>
<td>2.5</td>
<td>Knowledge that recovery and wellness involves the integrations of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community</td>
</tr>
<tr>
<td>2.6</td>
<td>Knowledge of trauma and its impact on the recovery process</td>
</tr>
<tr>
<td>2.7</td>
<td>Knowledge of person-centered care principles</td>
</tr>
<tr>
<td>2.9</td>
<td>Knowledge of the impact of discrimination, marginalization, and oppression</td>
</tr>
<tr>
<td>2.10</td>
<td>Knowledge of the impact of internalized stigma and shame</td>
</tr>
<tr>
<td>3.5</td>
<td>Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interaction</td>
</tr>
<tr>
<td>3.7</td>
<td>Knowledge of cultural competency</td>
</tr>
<tr>
<td>4.6</td>
<td>Ability to listen and understand with accuracy the person’s perspective and experience</td>
</tr>
<tr>
<td>4.8</td>
<td>Ability to draw out a person’s perspective, experiences, goals, dreams, and challenges</td>
</tr>
</tbody>
</table>
Review Homework

(5 minutes)

OBJECTIVE

To discuss homework from the previous section.

METHOD

1. Ask participants: “What are the two or three most important takeaways from the previous section?

2. Review experience with the Race Implicit Association Test (IAT).
   a. Ask participants: “How did the implicit bias test challenge or validate your assumptions about your own biases?”
   b. Ask participants: “What do you think a certified peer specialist should do in regards to their biases?”

3. Ask participants: “What is one thing you did during the course of this section to take care of yourselves? (write answers on flip chart)
Practicing Self-Care

(40 minutes)

OBJECTIVE
To continue developing the practice of self-care.

METHOD
1. Read *Practicing Self-Care.*
   a. Review the examples of moral injury.
   b. Ask participants: “How could these situations be considered moral injury and how can they set boundaries to navigate them?”

2. Encourage participants to complete the self-care assessment.
   a. Provide the instructions as listed on the self-care assessment.
   b. State that participants can share their results with another participant after everyone has completed the self-care assessment.
Practicing Self-Care

Self-care by the certified peer specialist is defined as cultivating the ability to bring one’s full self, presence, resilience, and strengths to peer relationships—and to relationships in life more generally—in order to deliver highly effective professional services. Self-care is a skill and, like any skill, develops through an ongoing learning process of self-reflection and practice. Part of practice is developing self-awareness in order to listen to oneself, identify feelings, consider needs, and recognize when needs are not being met.

THE ROLE OF BOUNDARIES

Boundaries are defined as “what is okay and what is not okay” (from Boundaries with Brené Brown video). Recall from an earlier discussion that self-care through setting boundaries is central to effective peer support. Why?

• To have more capacity for compassion and empathy.
• To have more equitable relationships which means more capacity for generosity.
• To have more self-confidence, self-esteem, and self-respect.
• To get more respect from others.
• To get more of what is desirable and to get less of what is undesirable.
• To get more control over our time, efforts, and life.

Another reason to set boundaries about what is and is not okay is to lessen the potential impacts of moral injury to the certified peer specialist. Moral injury is a concept that emerged from mutual support among military veterans. Through this work, it was discovered that, for some veterans, the pain and trauma experienced in combat was related to profound injuries to one’s moral code and values. For instance, if someone had entered a war with a desire to be of service to others—but was expected to carry out orders that directly contradicted this value—a moral injury could then occur.

The concept of moral injury can be generalized beyond the experience of war veterans to include anyone who is pressured to betray their moral compass or values system. The mental health and substance use systems and the agencies within them are continuously learning, growing, and changing to meet the needs of individuals. That being said, a certified peer specialist may find that the system’s response may be at odds with their core beliefs. Certified peer specialists have reported the following difficult situations within their work settings. Consider how these might be examples of moral injury:
• A certified peer specialist who values seeing the peer through a strengths-based lens is required to use deficit-based language in documentation.

• A certified peer specialist is required by the employing agency to involve police and call 911 when the person they support does not identify as being in crisis or consent to their involvement.

• A certified peer specialist is asked to connect a person they are supporting to a recovery pathway that the certified peer specialist feels is harmful.

• A certified peer specialist who is expected to participate in developing a treatment plan for their peer when they are not present or involved in any way.

• A certified peer specialist is required to turn away a person seeking support because they do not have a permanent address.

WORK-LIFE BALANCE

Finding a balance between the demands of work and personal life can be challenging. Certified peer specialists strive to be empathic people and care deeply for the people they support; leaving work behind may be difficult. However, an important aspect of self-care is finding a way to strike that balance. Setting boundaries around work allows more opportunities to engage in activities that promote health, wellness, and personal growth. Again, through boundaries, the certified peer specialist is able to return to work more present, engaged, and effective in providing peer support.
SELF-CARE ASSESSMENT

When certified peer specialists have their boundaries crossed, experience moral injury, or have difficulty managing work-life balance, the practice of self-care becomes particularly important. Consider taking the opportunity now to check-in with yourself on where you are at with self-care.

The following information is adapted from “Transforming the Pain: A Workbook on Vicarious Traumatization” by Karen W. Saakvittne and Laurie Anne Pealman.

Rate each self-care item by circling the number that best reflects how often it happens.

0 = Never, 1 = Rarely, 2 = Occasionally, 3 = Frequently

Physical Self-Care
- Eat regularly (examples: breakfast, lunch, and dinner). 0 1 2 3
- Eat healthy. 0 1 2 3
- Exercise. 0 1 2 3
- Get regular medical care for prevention. 0 1 2 3
- Get medical care when needed. 0 1 2 3
- Take time off when needed. 0 1 2 3
- Get massages. 0 1 2 3
- Dance, swim, walk, run, play sports, sing, or engage another fun activity. 0 1 2 3
- Take time to be sexual—with yourself, with a partner. 0 1 2 3
- Get enough sleep. 0 1 2 3
- Wear clothes you like. 0 1 2 3
- Take vacations. 0 1 2 3
- Take day trips or mini-vacations. 0 1 2 3
- Make time away from cellphones. 0 1 2 3
- Other: _______________________________ 0 1 2 3

Psychological Self-Care
- Make time for self-reflection. 0 1 2 3
- Have your own personal psychotherapy. 0 1 2 3
- Write in a journal. 0 1 2 3
- Read literature that is unrelated to work. 0 1 2 3
- Do something at which you are not expert or in charge. 0 1 2 3
- Decrease stress in your life. 0 1 2 3
- Let others know different aspects of you. 0 1 2 3
- Notice your inner experience such as thoughts, attitudes, and feelings. 0 1 2 3
- Engage your intelligence in a new area (examples: go to an art museum history exhibit, sports event, auction, theater performance). 0 1 2 3
- Practice receiving from others. 0 1 2 3
- Be curious. 0 1 2 3
- Say “no” to extra responsibilities. 0 1 2 3
- Other: _______________________________ 0 1 2 3
**Emotional Self-Care**
- Spend time with others whose company you enjoy.
- Stay in contact with important people in your life.
- Give yourself affirmations, praise yourself.
- Love yourself.
- Re-read favorite books, re-view favorite movies.
- Identify comforting activities, objects, people, relationships, places and seek them out.
- Allow yourself to cry.
- Find things that make you laugh.
- Express your outrage through social action, letters and donations, marches, protests.
- Play with children.
- Other: ___________________________________________

**Spiritual Self-Care**
- Make time for reflection.
- Spend time with nature.
- Find a spiritual connection or community.
- Be open to inspiration.
- Cherish your optimism and hope.
- Be aware of nonmaterial aspects of life.
- Try at times not to be in charge or the expert.
- Be open to not knowing.
- Identify what is meaningful to you and notice its place in your life.
- Meditate.
- Pray.
- Sing.
- Spend time with children.
- Have experiences of awe.
- Contribute to causes in which you believe.
- Read inspirational literature.
- Watch inspirational documentaries, films, discussions, etc.
- Other: ___________________________________________
Review your responses. For each component, identify two to four activities that have become a routine part of your self-care practice (the 3s) that you would like to continue. Then consider one activity that never (0s) or rarely (1s) occurs that you believe would be useful to start practicing.

**Physical self-care practices**
*Routine activities to continue are:*

- 
- 
- 

*Activity to start is:*

**Psychological self-care**
*Routine activities to continue are:*

- 
- 
- 

*Activity to start is:*

**Emotional self-care**
*Routine activities to continue are:*

- 
- 
- 

*Activity to start is:*

**Spiritual self-care**
*Routine activities to continue are:*

- 
- 
- 

*Activity to start is:*
Stigma and Cultural Competency

(100 minutes)

OBJECTIVE

To develop an understanding associated with stigma, marginalization, and oppression in mental health and substance use services.

METHOD

1. Read *Stigma and Marginalization Connected to Lived Experience.*
   a. Facilitate large group discussion focused on the understanding or personal experience of stigma and marginalization related to lived experience of mental health and substance use challenges.
   b. Ask open questions.
   c. Link to material learned so far (connection, exploring, and supporting) and how what has been learned can help a certified peer specialist in combatting the impacts of stigma and marginalization upon a peer. How might self-stigma or internalized marginalization impact a certified peer specialist in the workplace?
   d. Ask the large group to image how stigma might be different for the following:
      i. Woman to man
      ii. Man to woman
      iii. Transwoman to cisgender woman
      iv. Black man to black woman
      v. Impoverished black family to impoverished white family

2. Read *Cultural, Power, Privilege, and Peer Support.*

   a. Follow the instructions provide.
   b. Ask participants the following questions after the activity is complete: “How does the term intersectionality apply to your own lived experience?”

4. Read *Culturally Informed Approaches to Trauma.*
Stigma and Marginalization Connected to Lived Experience

The Merriam-Webster Dictionary defines stigma as "a mark of shame or discredit." The definition offered for marginalization is as follows: "to relegate to an unimportant or powerless position within a society or group."

Many people with lived experience of substance use or mental health challenges describe the negative and sometimes compounding effects of stigma and marginalization in relation to seeking wellness, recovery, and a sense of resilience. The historical causes of such stigma and marginalization are debated widely among those who practice peer support in professional roles. There are debates that are even more heated when it comes to the perceived helpfulness or potential harmful roles of anti-stigma campaigns.

Anti-stigma campaigns usually center around a medical model understanding of lived experience, with a focus on promoting theories of biogenetic causes for mental health challenges (example: genetic factors, chemical imbalances). This is often the focus, in part, because many people believe that if substance use or mental health challenges are seen as no different as someone dealing with a physical illness or condition, blame will not be placed on a person experiencing a mental health or substance use challenge. Rather, they would be supported with no judgment and have greater access to treatment.

Others more critical of traditional anti-stigma campaigns point to the fact that social and political factors, as well as trauma, are often absent from anti-stigma messaging. Additionally, there is a long history of human rights abuses against people with lived experience in the context of treatment settings. Though forced lobotomies reside in the past, many advocates and activists with lived experience continue a struggle against practices they see as human rights abuses today. Many point to involuntary outpatient commitment, emergency detention, restraint and seclusion, coercion, and lack of informed consent around treatment options, as well as electroconvulsive therapy and the overprescribing or incorrect prescribing of psychiatric medications as concerning byproducts of anti-stigma campaigns that focus on treatment as the end goal.

A certified peer specialist may find themselves personally drawn to one side of this debate or the other. However, as a certified peer specialist engages in their work and offers peer support, they must center the humanity, validity, agency, and autonomy of the people they support. This, alongside an empathic and compassionate approach, as well as understanding the immense value of sharing and listening to each other's stories and experiences, will aid a certified peer specialist in combatting the corrosive effects of stigma and marginalization connected to lived experience.
WISCONSIN EFFORTS TO COMBAT STIGMA

In Wisconsin, WISE (Wisconsin Initiative for Stigma Elimination), a statewide coalition of organizations and individuals promoting inclusion and support for all affected by substance use and mental health challenges, promotes evidence-based practices for stigma reduction efforts. For WISE, stigma reduction is driven by the power of the story of someone’s recovery. Their campaign focuses on individuals strategically sharing their story to educate others on mental health challenges and the reality that recovery is possible. https://wisewisconsin.org/resources/wise-basics-stigma-reduction/

Wisconsin Voices for Recovery has developed a training to help people understand what stigma is and how it can affect a person in or seeking recovery, understand what recovery messaging is, learn how to share their recovery story in a way that is not stigmatizing, and learn ways to advocate and reduce stigma. The “Ending Stigma with Recovery Messaging: How to Share Your Story to Reduce the Stigma of Addiction and Recovery” training module is part of the Wisconsin Voices for Recovery online RecoveryU resources. http://wisconsinvoicesforrecovery.org/resources-and-training/
Culture, Power, Privilege, and Peer Support

WHAT IS CULTURE?

Culture may be defined as the behaviors, values, and beliefs shared by a group of people, such as an ethnic, racial, geographical, religious, gender, class, or age group. Everyone belongs to multiple cultural groups. Each person is a blend of many influences. Culture affects every aspect of a person’s life, including how substance use and mental health challenges are experienced, understood, and expressed.

WHAT IS POWER?

Power is often understood as the ability to affect change and control or direct others. Frequently, people feel that they do not have power because they are not in positions of power such as legislators, CEOs, doctors, nonprofit executive director, boss or supervisor, contract monitors, and grant distributors. It is important to remember that everyone should have power over their own life and have the ability to make decisions for themselves in one way or another.

WHAT IS PRIVILEGE?

Privilege is a type of inherent power that affords people benefits, access, and support, frequently without realizing it and often without having earned it. Everyone has privilege of some kind, regardless of race, gender, class, sexual orientation, and so on. Privilege can be used in a variety of ways, including getting ahead in life, continuing the oppression of marginalized communities, or using a position of privilege to give voice to those communities.

HOW DO CULTURE, POWER, AND PRIVILEGE INTERSECT WITH PEER SUPPORT?

Certified peer specialists have a variety of roles to play when it comes to the intersection of culture, power, privilege, and peer support. Some are related to the people they are supporting and others are related to their own experiences.

When certified peer specialists provide peer support, they must recognize that each person’s cultural identity is unique to themselves, even among people who may come from similar backgrounds. An effective certified peer specialist will approach each person they support with empathy, meeting each person where they are, taking into consideration any information shared by the peer, and making adjustments to the support they are providing as needed.
EXPLORING CULTURE

Certified peer specialists will find themselves supporting people who have different cultural experiences, backgrounds, and values than themselves. It is important to recognize that this is a common occurrence. Over time, the mental health and substance use service systems, including certified peer specialists, have started working toward providing services in a manner that takes each individual’s own culture into account. This is often referred to as cultural competency, cultural intelligence, or cultural humility.

Certified peer specialists should be familiar with how areas in the cultural iceberg (below) may interact within and among individuals.

CULTURAL ICEBERG

Surface culture

Deep culture

Communication styles and rules
facial expressions  gestures  eye contact  touching  personal space  tone of voice  body language  handling and displaying of emotion  conversational patterns in different social situations

Approaches to...
religion  courtship  marriage  raising children  decision-making  problem-solving

Attitudes toward...
elders  adolescents  dependents  rule expectations  work authority  cooperation vs. competition  Relationships with animals  age, sin, death

Notions of...
courtesy and manners  friendship  leadership  cleanliness  modesty  beauty

Concepts of...
self, time, past and future  fairness and justice  roles related to age, class, family, etc.

Food
Flags  Festivals
Fashion  Music  Art
Games  Dance  Crafts
Performances  Literature
Celebrations  Language
An important aspect of understanding how these cultural elements may impact providing peer support is for certified peer specialists to have an understanding of their own views on these topics and their own biases, implicit or otherwise. By continually checking in with themselves regarding bias, certified peer specialists set themselves up to mitigate potential harm they may cause when working with people from different cultures or who hold different values or beliefs.

**SYSTEMIC OPPRESSION**

Systemic oppression refers to the mistreatment of people within a social identity group, supported and enforced by society, solely based on the person’s membership in the social identity group. It is driven by institutions of the society, including the education system, health care system, housing system, and financial system, through laws, customs, or practices.

According to the National Equity Project, the lens of systemic oppression assumes that:

- All negative forms of prejudice and/or bias are learned and therefore can be unlearned.
- Oppression and injustice are human creations and phenomena and therefore can be undone.
- Systemic oppression exists at the level of institutions (harmful policies and practices) and across structures (education, health, transportation, economy, etc.) that are interconnected and reinforcing over time.
- Oppression and systematic mistreatment (such as racism, classism, sexism, or homophobia) is more than just the sum of individual prejudices.
- Systemic oppression is systematic and has historical antecedents; it is the intentional disadvantaging of groups of people based on their identity while advantaging members of the dominant group (gender, race, class, sexual orientation, language, etc.).
- Systemic oppression manifests in economic, social, political, and cultural systems.
- Systemic oppression and its effects can be undone through recognition of inequitable patterns and intentional action to interrupt inequity and create more
democratic processes and systems supported by multiethnic, multicultural, and multilingual alliances and partnerships.

- Discussing and addressing oppression and bias will usually be accompanied by strong emotions.

**SYSTEMIC OPPRESSION IN SUBSTANCE USE AND MENTAL HEALTH SERVICES**

In addition to having an understanding of culture and the ability to explore the lived experiences of the people whom certified peer specialists support, they must also be able to recognize the connection between a person’s culture and background and the role that plays in deciding which supports they would like to connect with.

All marginalized communities have experienced systemic oppression due to the design of the mental health and substance use service systems and the population for which they were created. This is not to say that each individual member of a marginalized community has been personally harmed by service systems. The systems as a whole have led to oppression of communities at large. When working with people who are members of marginalized communities, certified peer specialists must recognize and have an understanding of how this oppression comes into play when navigating through the service systems.

The systemic oppression at play in the substance use and mental health service systems can have an impact on marginalized community members in many ways, for example:

- Being blamed and shamed when interacting with service systems to a higher degree than their counterparts.

- Certain diagnoses being disproportionately assigned to various communities.

- People who are incarcerated having less access to services of any kind including evidence-based approaches (person-centered, trauma-informed, strengths-based, and so on).

- The expectation that transgender people will thrive in therapeutic environments, when sorted into services for a gender with which they do not identify.

- Black women being labeled as angry or aggressive when they advocate for themselves or their loved ones.

- Indigenous communities being denied equal access to culturally specific and relevant supports within the mental health and substance use service system.
Activity: Understanding Privilege

Privilege is a key element in perpetuating oppressive systems. According to Webster’s Dictionary, privilege is “a right, favor, or immunity, granted to one individual or group and withheld from another.”

This activity examines the privileges we hold.

Instructions

You will be given a tally sheet. Listen to each of the privilege statements. If you identify with the statement and feel that it is true, do nothing. If you do not identify with the statement or feels like it is not true, draw one mark signifying that they do not identify with that particular privilege. There will be a brief large group debrief after this activity.

Privilege statements

1. The leader of my country is also a person of my racial group. (RACE)
2. When going shopping, I can easily find clothes that fit my size and shape. (SIZE)
3. In public, I can kiss and hold hands with the person I am dating without fear of name-calling or violence. (SEXUALITY)
4. When I go shopping, I can be fairly certain that sales or security people will not follow me. (RACE/APPEARANCE)
5. Most of the religious and cultural holidays celebrated by my family are recognized with days off from work or school. (RELIGION/CULTURE)
6. When someone is trying to describe me, they do not mention my race. (RACE)
7. When I am angry or emotional, people do not dismiss my opinions as symptoms of “that time of the month.” (GENDER)
8. When expressing my opinion, I am not automatically assumed to be a spokesperson of my race. (RACE)
9. I can easily buy greeting cards that represent my relationship with my significant other. (SEXUALITY)
10. I can easily find hair products and people who know how to style my hair. (RACE)
11. In my family, it is seen as normal to obtain a college degree. (CLASS)
12. If I am going out to dinner with friends, I do not worry if the building will be accessible to me. (ABILITY)
13. I can be certain that when I attend an event there will be people of my race there. (RACE)
14. People do not make assumptions about my work ethic or intelligence based upon the size of my body. (SIZE)
15. When I strongly state my opinion, people see it as assertive rather than aggressive. (RACE/GENDER)
16. When I am with others of my race, people do not think that we are segregating ourselves. (RACE)
17. I can feel comfortable speaking about my culture without feeling that I will be judged. (RACE/ETHNICITY)
18. I can usually afford (without much hardship) to do the things that my friends want to do for entertainment. (CLASS)
19. When filling out forms for school or work, I easily identify with the box that I have to check. (GENDER/RACE)
20. I can choose the style of dress that I feel comfortable in and most reflects my identity, and I know that I will not be stared at in public. (GENDER/APPEARANCE)
21. If pulled over by a police officer, I can be sure that I have not been singled out because of my race. (RACE)
22. My professionalism is never questioned because of my age. (AGE)
23. I do not worry about walking alone at night. (GENDER)
24. People do not make assumptions about my intelligence based upon my style of speech. (RACE)
25. When attending class or other events, I do not have to worry about having an interpreter present to understand or to participate. (ABILITY/LANGUAGE)
26. I can book an airline flight, go to a movie, ride in a car and not worry about whether there will be a seat that can accommodate me. (SIZE/ABILITY)
27. People assume I was admitted to school or hired based upon my credentials, rather than my race or gender. (RACE/GENDER)
28. As a child, I could use the “flesh-colored” crayons to color my family and have it match our skin color. (RACE)

**Process questions**

- How did you feel doing this activity?
- How was it to consider the number of tally marks you had on your paper?
- How was it to notice the tally marks of others around while you were or were not making marks on your page?
- What does it feel like to have or not to have certain privileges?
- What is privilege? How would you define it?

Intersectionality is the acknowledgement that everyone has their own unique experiences of discrimination and oppression. We must consider everything and anything that can marginalize people (gender, race, class, sexual orientation, physical ability, etc.). Intersectionality is the concept that all oppression is linked.
Culturally Informed Approaches to Trauma

The original adverse childhood experiences study relies on data predominantly collected from white people classified as middle class or upper middle class, with a focus on experiences within the home. It falls short in understanding the depth and breadth of the impact of trauma on communities of people who experience marginalization and multiple marginalization.

According to the Behavioral Risk Factor Surveillance System, individuals of different races in Wisconsin experienced adverse childhood experiences from 2011 to 2016 as follows:

- 77% of American Indians have experienced any adverse childhood experience.
- 76% of multiracial and Black individuals have experienced any adverse childhood experience.
- 66% of Hispanic and Latino individuals experienced any adverse childhood experience.
- 55% of white individuals experienced any adverse childhood experience.
- 39% of Asian individuals experienced any adverse childhood experience.

The 2019 Wisconsin Behavioral Health System Gaps Report, a report compiled by the UW Population Health Institute at the request of the Wisconsin Department of Health Services, identified the impact of historical and emergent community-level trauma on those who live at the intersection of many marginalized identities as well as the barriers that individuals face when engaging in mental health or substance use treatment.

"As one respondent articulated, "People fear the system. They fear losing their jobs, children, and their integrity. They fear the 'state' or the 'system' will lock them up, or chapter them for using services. They may have always been involved within the system therefore will not seek help for treatment due to retaliation from law enforcement/court systems."

The 2019 Wisconsin Behavioral Health System Gaps Report is available on the UW Population Health Institute’s website: https://uwphi.pophealth.wisc.edu/publications-2/evaluation-reports-2/
Below is a chart showing some of the most common cultural mistakes and alternative responses to the same situation. Read the chart and consider how certified peer specialists can make their peer relationships more culturally and trauma sensitive. Notice that using these alternative responses can lead to more trauma-informed interactions with all the people certified peer specialists work with, not just those from other cultures.

<table>
<thead>
<tr>
<th>Common Cultural Mistakes About Trauma</th>
<th>More Culturally Sensitive Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assuming everyone who has experienced violence needs professional help.</td>
<td>Assuming people are resilient and holding space for them to express if they need help.</td>
</tr>
<tr>
<td>Focusing on the most extreme instances of violence as the most damaging.</td>
<td>Allowing each person to define what aspects of their experience have been most traumatic and recognizing that this may change over time.</td>
</tr>
<tr>
<td>Assuming that violence is unusual, an aberration, and generally perpetrated by individuals.</td>
<td>Recognizing that violence is perpetrated by groups and institutions, not only individuals, and may be so common that people become desensitized to it.</td>
</tr>
<tr>
<td>Applying norms and standards of behavior without considering political and social context.</td>
<td>Recognizing that political and social oppression may affect priorities and values; allowing each person to define the meaning of what they have experienced.</td>
</tr>
<tr>
<td>Relying on DSM diagnoses or lists of trauma symptoms.</td>
<td>Recognizing that trauma responses are varied and that different cultures express grief and loss and understand trauma differently; learning how each person and their culture expresses distress.</td>
</tr>
<tr>
<td>Assuming that one person’s story represents the “typical” story for the group.</td>
<td>Recognizing that “one person’s story is just one person’s story.”</td>
</tr>
<tr>
<td>Inadvertently highlighting the stories of people that fit cultural stereotypes.</td>
<td>Providing opportunities for many people to share their stories, and noticing what is unique; making sure many points of view are represented.</td>
</tr>
<tr>
<td>Assuming that if people speak English, you do not have to worry about an interpreter or translated documents.</td>
<td>Recognizing that some topics are very difficult to talk about in anything other than a person’s first language; knowing and acting within the law about provision of language assistance services.</td>
</tr>
<tr>
<td>Assuming that people always (or never) want to tell their stories and that if people want help they will ask for it.</td>
<td>Being aware that self-disclosure and help seeking vary widely across cultures and may be dependent upon whether someone feels safe.</td>
</tr>
</tbody>
</table>
Some populations are more likely to experience a traumatic event or a specific type of trauma.

- Rates of traumatic stress are high across all diverse populations and cultures that face military action and political violence.
- Culture influences not only whether certain events are traumatic, but also how an individual interprets and assigns meaning to the trauma.
- Some traumas may have greater impact on a given culture because those traumas represent something significant for that culture or disrupt cultural practices or ways of life.
- Culture determines acceptable responses to trauma and shapes the expression of distress. It significantly influences how people convey traumatic stress through behavior, emotions, and thinking immediately following a trauma and well after the traumatic experience has ceased.
- How traumatic stress is expressed varies according to the type of trauma within the culture.
- Culture affects what qualifies as a legitimate health concern and what warrants help.
- In addition to shaping beliefs about acceptable forms of help-seeking behavior and healing practices, culture can provide a source of strength, unique coping strategies, and specific resources.

**CULTURALLY INFORMED PEER SUPPORT**

Providing peer support that is culturally informed will be unique to each person with whom the certified peer specialist is working. Some general guidelines for providing effective, culturally informed peer support include:

- Meeting each person where they are at, challenging your own assumptions and biases.
- Using open questions to explore each person’s unique cultural outlook and experiences around power and privilege.
- Validating a person’s experience, do not challenge their lived experience.
- Exploring and promoting each person’s unique resilience factors through the lens of that person’s individual culture and background.
- Exploring all resources, including natural and culturally appropriate supports within the peer’s community that will support them in their recovery.
• Responding with validation, a genuine apology, and making changes when called out for engaging in hurtful behavior, whether intentional or unintentional.

• Advocating for inclusive, culturally informed policies at places of employment and holding both employers, other service providers, and themselves accountable for implementing change.

• Recognizing that the intent behind what a certified peer specialist says or does may not match with the impact it has on to the person with whom they are interacting.
Trauma-Informed Peer Support

(50 minutes)

OBJECTIVE

To consider the importance and the practice of trauma-informed peer support.

METHOD

1. Read *The Need for Trauma-Informed Care*. Ask participants after the “Why Care?” section: “What else would you add to this short, incomplete list for why we care about trauma?”

2. Facilitate *Activity: Moving Toward Trauma-Informed Peer Support*.
   a. Divide participants in small groups of two to four people.
   b. Assign a trauma-informed care principle to each group.
   c. Instruct the groups to work together to identify the trauma-informed processes and skills that can be applied in peer support practice.
   d. Allow the small groups to work for a short time.
   e. Bring participants back together for a large group share out in which each group will lead the discussion for their assigned trauma-informed care principle. Encourage all participants to offer comments. Document results of this share out on a flip chart. One flip chart for each trauma-informed care principle.
   f. Leave the flip charts visible for the remainder of the training course.
   g. Reference the flip charts as often as possible (examples: Section 10 when discussing anger and Section 12 when discussing advocacy).
3. Discuss The *Choice is Yours*...

a. Emphasize that it is clear how important OARS skills and effective communication is to trauma-informed peer support.

b. Explain that you understand that at this point in the course, participants have had many opportunities to brainstorm, discuss, practice, and receive peer feedback on the use of OARS. There still may be some peers who are still struggling with asking open questions, forming reflections as statements, or moving beyond simple reflection to make educated guesses about underlying meaning. These are not easy skills to learn. The point is that trauma-informed care is directly related to the skill level of the certified peer specialist.

c. Ask participants where they believe their OARS skills are at right now. How might they want to spend the remainder of the course in terms of honing in on some communication skill challenges? Framing skillful communication as a way to be trauma-informed could be a source of motivation for some participants who have otherwise not been interested in making changes to communication.
The Need for Trauma-Informed Care

As covered in Section 2, trauma is a near universal experience for people living with mental health and substance use challenges. According to the U.S. Department of Health and Human Services Office on Women’s Health, 55% to 99% of women in substance use treatment and 85% to 95% percent of women in the public mental health system report a history of trauma, including sexual, emotional, and psychological abuse—most commonly having occurred in childhood. In the National Council for Behavioral Health’s report on “Training for Trauma-Informed Peers,” over 90% of individuals in treatment were identified with a history of trauma. Certified peer specialists can reasonably expect that when working with a peer, lived experience will include trauma.

WHY CARE?

Certified peer specialists care deeply: bringing their full selves to the work of peer support; holding great capacity for compassion and empathy; and seeking to support recovery, health, and wellness. People with unhealed trauma regularly experience:

- Difficulties finding and keeping a job; living in stable housing.
- Difficulties in relationships.
- Urges to use substances to sedate, numb, and cope with the emotional pain of the past.
- A sense of despair, hopelessness, and powerlessness.

This understanding—coupled with what is now known about systemic oppression, power, and privilege—creates a sense of ethical obligation and call to action for certified peer specialists.
WHAT CAN A CERTIFIED PEER SPECIALIST DO?

The bottom line is that a certified peer specialist can adopt and fully integrate a trauma-informed approach to maximize the healing impacts of peer support. Let’s begin thinking about how this might be accomplished. Here are the fundamental processes of peer support. If a trauma-informed approach is fully integrated, it will be at the center of the work. The OARS skills and self-disclosure are tools for effective communication.

These are the six key principles of a trauma-informed approach, according to the Substance Abuse and Mental Health Services Administration.
Activity: Moving Toward Trauma-Informed Peer Support

This is a small group (two to four people per group) brainstorm activity. Work together to identify how trauma-informed processes and skills can be applied in peer support practice. Try to be as specific as possible.

1. Safety

2. Trustworthiness and transparency

3. Peer support

4. Collaboration and mutuality

5. Empowerment, voice, and choice

6. Cultural, historical, and gender issues
The Choice is Yours...

<table>
<thead>
<tr>
<th>Peer Support Not Trauma-Informed</th>
<th>Trauma-Informed Peer Support</th>
</tr>
</thead>
</table>
| Peer shares...  
“ I am hearing voices.”  
“I want to hurt myself.”  
“I’m depressed/can’t stop crying.”  
“I feel like dying.”  
“I feel like hurting someone.”  
“I can’t manage my anger. I’m in trouble with the law.”  
“I keep using even though I can’t pay my rent next.” |  |
| Certified peer specialist response:  
What is wrong?  
Do you... have you... are you...? | Certified peer specialist response:  
What happened?  
Tell me about.... |
| Certified peer specialist is worried and concerned about peer. | Certified peer specialist looks for strengths; offers a specific and genuine affirmation. |
| Certified peer specialist has only vague, superficial understanding of trauma-informed care. | Certified peer specialist is fluent in complex developmental trauma, adverse childhood experiences, and impacts on worldview, perspective, and lived experience. |
| Certified peer specialist has listening roadblocks in place. | Certified peer specialist makes the decision to listen. |
| Certified peer specialist responds with sympathy.  
Oh, I am so sorry. | Certified peer specialist responds with empathy  
Sounds like you...  
You are feeling... |
| Certified peer specialist moves to problem-solving and solutions. | Certified peer specialist stays with connecting or exploring. |
| Certified peer specialist has resources to point to for a specific path to recovery and provides information without permission. | Certified peer specialist explores what might be helpful from the peer’s point of view, sharing multiple pathways ways to recovery are possible and holds off on providing information to continue exploring. |
Assign Homework

(5 minutes)

OBJECTIVE

To continue perspective taking and learning on the topics of stigma, culture, and trauma-informed peer support and complete the Anger Questionnaire in preparation for Section 10.

METHOD

1. Ask participants to bring in one example of a recent event, public statement, or news article that demonstrates stigma and lack of understanding of mental health and substance use disorders.


3. Assign Self-Survey Part 1 and Part 2

4. Assign Anger Questionnaire.
Review Questions

1. List three things you can do for better balance and self-care.

2. Give some examples of stigma and its impact on recovery.

3. What is cultural competency and why is it important?

4. Is being curious about the role of religion and spirituality in the peer’s life a part of cultural competency?
**Self-Survey – Part 1**

Reflect on your skill level of these behaviors. This self-survey will not be collected.

<table>
<thead>
<tr>
<th>Certified peer specialist has the ability and willingness to...</th>
<th>Not Skilled</th>
<th>Slightly Skilled</th>
<th>Pretty Skilled</th>
<th>Very Skilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognize when one is feeling tired, angry, sad, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read nonverbal emotional cues. (eye contact, facial expression, tone of voice, body posture, movement and gestures, rate of voice, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keep calm and stay present in situations of stress.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk about personal history.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receive constructive feedback.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communicate without inducing fear, guilt, and shame.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Set boundaries and articulate when they have been violated or invaded.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice self-care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss emotions while at work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take time away from work to connect with people and activities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Which skills do you wish to develop further?**

**What is your first step to develop these skills?**
Self-Survey – Part 2

Reflect on your skill level of these behaviors. This self-survey will not be collected.

<table>
<thead>
<tr>
<th>Certified peer specialist has the ability and willingness to...</th>
<th>Not Skilled</th>
<th>Slightly Skilled</th>
<th>Pretty Skilled</th>
<th>Very Skilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify, verbalize, and validate other’s emotions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engage with those experiencing overwhelming feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Think about troubling behavior through the lens of curiosity [&quot;how does this behavior make sense?&quot; or what might have happened to this person that has led to this behavior?].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hear others talk about emotionally painful events without becoming overwhelmed with own feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use nonjudgmental language when referring to peers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point out strengths of others - what they do well, how they are resilient.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use person first language [person who is homeless vs. a homeless person].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Vent’ about feelings towards a peer by focusing on reactions vs. the peer behavior.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understand why peers may not want to share information.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Which skills do you wish to develop further?**

**What is your first step to develop these skills?**
Anger Questionnaire

To prepare for Section 10, take a few minutes to reflect on your thoughts and experiences with anger by responding to the questions below.

- What does anger mean to you? Complete this sentence: Anger is...

- What did you learn about anger as a child?

- In Section 10, there will be a discussion about the anger iceberg, a metaphor that is useful for considering anger. Most of an iceberg is hidden under the waterline. This is true for our deep emotions, too. In general, what emotions are hidden under the surface when you are angry?

- In general, how do you handle your own experience of anger? Note three ways:
  1. 
  2. 
  3. 

- In general, how do you handle others’ experience of anger?

- What might be some of the “advantages” or benefits of anger? What might be some of the “disadvantages” or detriments of anger?

<table>
<thead>
<tr>
<th>ADVANTAGES of anger</th>
<th>DISADVANTAGES of anger</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This exercise was adapted from the Canadian Mental Association’s “Peer Support Training Manual.”
Section 10

This section discusses spirituality, religion, and ethical considerations. An activity is provided to help participants discuss these topics. The section then moves on to cover anger and how to prepare and respond to anger within a peer support relationship. Activities and examples are given to solidify understanding. Section 10 concludes with homework based on self-reflection and communication approaches.
Curriculum Guide

SECTION 10

70 minutes  Read Discussing Spirituality and Religion
30 minutes  Discussing Spiritual and Religion Practice Activity
15 minutes  Break
20 minutes  Anger: Preparing and Responding in Peer Support
60 minutes  Preparing to Respond to Anger
20 minutes  Responding to Anger
5 minutes  Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>Believes in and respects all forms of diversity</td>
</tr>
<tr>
<td>1.6</td>
<td>Believes in the importance of self-awareness and self-care</td>
</tr>
<tr>
<td>2.5</td>
<td>Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community</td>
</tr>
<tr>
<td>2.10</td>
<td>Knowledge of the impact of internalized stigma and shame</td>
</tr>
<tr>
<td>3.5</td>
<td>Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interaction</td>
</tr>
<tr>
<td>3.7</td>
<td>Knowledge of cultural competency</td>
</tr>
<tr>
<td>4.7</td>
<td>Effective written and verbal communication skills</td>
</tr>
</tbody>
</table>
Review Homework

(10 minutes)

OBJECTIVE

To recognize stigma, discriminatory behavior, and lack of understanding of mental health and substance use disorders.

METHOD

1. Encourage participants to share their examples of stigma on discrimination.

2. Ask participants to provide examples of things they can do for better balance and self-care.

3. Ask participants: “What is cultural competency and why is it important?”

4. Ask participants: “Is being curious about the role of religion and spirituality in the peer’s life a part of cultural competency?”
Discussing Spirituality and Religion

(75 minutes)

OBJECTIVE

To discuss topics about spirituality and religion in peer support.

METHOD

1. Read *Discussing Spirituality and Religion*.
   
   a. Facilitate a pair and share after the “Background: Spiritual Versus Religious” section.
   
      i. There is a speaker role and listener role.
      
         1. Ask speakers to discuss this question: How would you describe the role of spirituality or religion in your life and recovery?
         
         2. Ask listeners to listen carefully and offer reflective listening statements to demonstrate understanding.
      
      ii. Set a timer for five minutes. Launch activity.
      
      iii. Call time and have the pairs switch roles following the same instructions as the first round.
      
      iv. There is no time for a large group debrief.
   
   b. Facilitate a large group discussion after the “Spirituality, Religion, and Recovery” section.
      
      i. Ask participants: “How would you approach differences of beliefs and values in the peer relationship?”

   c. Facilitate a large group discussion after watching the video focused on participant thoughts and reactions to the most recent reading and video. As you listen to participants share, reflect the depth and complexity that these topics present. State there is no right way to think about these topics. Multiple perspectives are to be expected.

2. Facilitate *Activity: Discussing Spirituality and Religion*
   
   a. Follow the instructions provided.
   
   b. Note seven to eight questions neatly on a flip chart during the first large group brainstorm for later use.
c. During the large group debrief after the pair and share, ask participants: “What was that conversation like in the certified peer specialist role?” “What was the conservation like in the peer role?” “What are your final takeaways from thinking about peer support practice on the topics of spirituality and religion?”
Discussing Spirituality and Religion

The topic of spirituality and religion is important for a certified peer specialist to consider because of the possible impacts on a peer’s life (examples: positive, negative) and the role that these lived experiences can play in recovery (examples: helpful, hindering). First, some general background is offered. Then, the topic is discussed in the context of recovery and ethics. Finally, implications for peer support are discussed with an opportunity for practice.

BACKGROUND: SPIRITUAL VERSUS RELIGIOUS

People often unconsciously link the concepts of spirituality and religion, but spirituality does not always need to be defined through the lens of religion. Some may feel like they have a sense of or practice spirituality even though they are not affiliated with a specific religion. Those who practice a religion often find the religion serves as a suitable framework from which to get their spiritual needs met.

Some find it helpful to think of religion as rules, practices, or traditions agreed to by a number of people, whereas spirituality is more related to a person’s individual experience and connections.

Though no one definition of spirituality will resonate with everyone, a more inclusive definition is provided by Christina Puchalski, “Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.”

Spirituality means different things to different people and individuals express their spirituality in varied ways. It may be:

- Their religion or faith tradition.
- Meditation or mindfulness.
- Meaning and direction in their life, sometimes described as their journey.
- A way of understanding the world and their place in it.
- A belief in a higher power or a force greater than any individual.
- A core part of their identity and essential humanity.
- A feeling of belonging or connectedness.
- A quest for wholeness, hope, resilience, or harmony.
SPIRITUALITY, RELIGION, AND RECOVERY

Many people find immense value in cultivating their spirituality to strengthen recovery. There can be many reasons for this. Engaging in spirituality can sometimes bring a feeling of connectedness to something bigger than oneself. It can provide a way of coping in addition to personal emotional resilience. Spirituality can also provide a sense of direction, purpose, and meaning. Such an experience can be a source of motivation for navigating recovery.

Another positive aspect of many faith traditions is a sense of community. While the stated focus in most faith traditions tends to be a specific deity or deities, this connection to community can be a valuable source of social support. This sense of community is powerful. Those who have found aspects of 12-step recovery programs to be unhelpful still often describe the sense of community and increased social supports as positive.

Just as people may have experienced benefits from spirituality and religion in their recovery, many also have experienced harm, traumas, and abuses from spiritual frameworks and religious institutions that can present significant barriers to recovery. For example:

- Dismissive or invalidating experiences with spiritual or religious authority figures regarding mental health or substance use concerns.
- Messages about worth, good and evil, and sin and salvation can foster feelings of shame, alienation, and fear of judgment.
- Experience of unethical treatment practices.
- Isolation and breaking ties with social supports not approved by the framework or institution.
- Only one right way approaches to recovery or salvation.
- Hierarchical power structure in which leaders promote powerlessness in followers.
- Punishment or shunning for non-adherence to doctrine.
- No redress, restoration, or healing from inflicted harms and abuse.

It is important to understand that a person’s relationship to spirituality and religion is highly personal and varied. Just as it is critical for the certified peer specialist to provide validation and affirmation for people who benefit from a spiritual or religious framework, it is equally necessary for certified peer specialists to validate and affirm those who have experienced harm or trauma as a result of such frameworks or institutions.
ETHICAL CONSIDERATIONS

The support certified peer specialists offer must be viewed and understood in the larger context of the culture in which it takes place. Recognizing the culture in both Wisconsin and the larger peer or recovery movement is important because culture has a way of shaping and influencing the services and supports provided. Likewise, examining various aspects of culture relating to spirituality can highlight common ethical concerns encountered in peer support. The following paragraphs detail some of the most prevalent roadblocks faced and how certified peer specialists should navigate them.

Assumption of Christian faith tradition

According to the Pew Research Center, a 2014 survey found that in terms of faith tradition 71% of Wisconsinites identify with some form of Christianity, 4% identify with non-Christian faiths, and 25% identify as unaffiliated (atheist, agnostic, or nothing in particular).

Although more than a quarter of the state does not follow a Christian faith tradition, the dominant culture in Wisconsin—and the United States more broadly—assumes Christianity as the major spiritual framework. Though it is true that the majority of people in Wisconsin are Christian, assumptions about people’s worldviews, spiritual frameworks, and interpretation of a specific faith tradition have no place in effective peer support.

Like in discussing any aspect of a peer’s experience, the role of a certified peer specialist is to listen without judgment, approach with curiosity, ask open questions, and support self-determination. By doing these things, certified peer specialists are more likely to understand the person they are supporting, earn their trust, and avoid making hurtful or unfair assumptions.

The impact and influence of 12-step groups

As stated previously, there are aspects of the 12-step recovery model that many people find beneficial, particularly as they are just beginning to explore recovery. These may include connecting with people with similar experiences, a sense of community and safety, support from a sponsor, accountability, and a clear guide to one way of navigating recovery.

The 12-step recovery model’s core beliefs of powerlessness over addiction and dependence on a higher power can have a large impact on how certified peer specialists, who have chosen this recovery path, engage with the people they are supporting. These beliefs can come into conflict with tenets of peer support including empowering people to navigate recovery and their life in a way that works best for them, and engaging with spirituality in a person-centered manner.
Viewing intense spiritual experiences through a cultural lens

Within the medical model, there has been a history of categorizing intense spiritual experiences that many people go through as delusions, psychosis, or symptoms of a larger mental health condition. Although some people may choose to view their experiences through the lens of these terms and find meaning within them, many others feel that their experiences are just as meaningful despite having a label of psychosis put upon them.

Certified peer specialists must be able to recognize that each person has the right to make meaning of their experiences in their own way and that the role of a certified peer specialist is never to invalidate someone’s religious or spiritual experience. Likewise, a certified peer specialist is not in a position to attempt to change how a person perceives or values their spiritual experiences and needs to take steps to ensure that they do not try to convince a person that their experiences are symptoms of a diagnosis if the person does not view them that way.

"Negotiating Reality Role Play from Intentional Peer Support” – Steven Morgan
https://youtube.com/watch?v=1eCJTfmMF3M&t=231s

IMPLICATIONS FOR PEER SUPPORT

Because spirituality and religion can have profound influences on a person’s lived experience and recovery, it is important for a certified peer specialist to be prepared for this topic. Here are some ideas:

- These topics are deeply personal. As a starting point, it is important that certified peer specialists reflect on their own beliefs and potential biases; anticipate how to manage potential clashes in values and beliefs, and how to ensure that practice aligns with the principles of effective peer support. Hopefully, the earlier group discussions began this process.

- Explore the role that spirituality or religion plays in the peer’s life and recovery. Ask exploring open questions to draw out the peer’s perspectives and experiences.

- Self-disclosure, with permission, about your own experiences with spirituality and religion. Be sure the story is focused on recovery, delivered in a neutral tone, and shared with only relevant details.

- Gather information to learn more about a peer’s spiritual and faith traditions. This demonstrates interest and involvement.
• Listen carefully to understand the peer’s experiences, perspectives, beliefs, values, and lived experiences surrounding spirituality, religion, and recovery.

• For many people it can be hard to understand how people can find meaning and value in their life outside of spirituality or religion; it is important to be aware that many people do just that. The concept of cultural humility is relevant here. Cultural humility requires certified peer specialists to be open to and genuinely curious about a peer’s experience, seeking to understand and listen rather than make assumptions or presume to know what is true or right.
Activity: Discussing Spirituality and Religion

The purpose of this activity is to practice the process of exploration on the topic of spirituality and religion.

The topic of spirituality and religion is very personal. It can also be provocative because multiple perspectives exist. Multiple perspectives can surface conflict and tension that must be navigated for effective peer support. This activity will feature the exploring process. When you are in the role of the certified peer specialist, your job will be to explore, listen, and reflect the peer’s perspectives and experiences. Therefore, it is the O and R of OARS skills.

**Large group brainstorm:** What are good open questions to ask to explore the topic of spirituality and religion? The goal is to draw out experiences, perspectives, and opinions of the peer. Focus on open questions.

**Large group brainstorm:** Consider how you might approach listening and reflection. Look at the Reflective Listening Cheat Sheet. How are you thinking you could approach the listening in this activity?

**Pair and share.** Pair up with someone you have not worked with yet or have not worked with recently. Decide who will start in peer role and who will start in certified peer specialist role.

**a.** Peer – You have about 10 minutes to talk about this topic. Feel free to speak from your lived experience or you can do a role-playing.

**b.** Certified peer specialist – Your job is to ask exploring open questions, but more importantly, listen carefully and offer reflective listening statements. This is an opportunity to listen carefully for underlying meaning. Take risks to make educated guesses. Offer more reflections than you ask questions.

You will get a one-minute warning in the certified peer specialist should offer a summary.

You will switch roles after 10 minutes and repeat the activity.
Anger: Preparing and Responding in Peer Support

(100 minutes)

OBJECTIVE

To discuss and strategize ways to respond to anger while providing peer support.

METHOD

1. Read What is Anger? Facilitate a brief large group discussion. Participants should have the Anger Questionnaire assigned for homework in Section 9 available for reference.

2. Read Preparing Response to Anger. Based on your lived experience, offer a demonstration of how to think through the four steps of responding to anger. After the demonstration, ask for thoughts and questions from participants. The demonstration and debrief will set up participants to effectively complete the Preparing Response to Anger Worksheet.

3. Complete Preparing Response to Anger Worksheet. This is a solitary writing activity. Provide the instructions as written on the worksheet. When it looks like most participants have completed most of the worksheet, ask participants to pair up and take turns sharing their work. After a short time, bring the participants back together for a large group share out. Ask participants: “What was this activity like? Is this a useful tool to prepare yourself for difficult encounters?” “Where does this activity leave you?”

4. Review the Responding to Anger in Peer Support tool. Provide an overview of responding to anger in peer support. Next, organize participants into groups of three or four. Provide instructions for small group brainstorm. Ask each group to turn to the Responding to Anger in Peer Support tool and compare and contrast. Ask participants to respond to the following questions in their small groups: “What was similar?” “What was different?” Facilitate a brief large group share out.
What is Anger?

Anger is a complex, normal human experience comprising a range of physiological, psychological, and behavioral responses. For example:

- Increased heartbeat, respirations, and adrenaline; blood flow increases to muscles in arms and legs to prepare the body for fight (or flight).
- Thoughts and perceptions trigger emotions along a continuum of irritation and annoyance to rage.
- Behavior can range from agitated to assertive, aggressive, and threatening.

While these experiences may be uncomfortable for a person experiencing or responding to anger, anger always has a purpose. Sometimes, the purpose can be adaptive, for example to:

- Alert to the possibility that something is wrong.
- Defend against criticism or judgment.
- Self-protect when experiencing vulnerability.
- Build energy and motivation for positive action.

How do these understandings of anger fit with your understanding? What would you add?
WHAT IS UNDERNEATH?

The iceberg metaphor is useful for considering anger. Above the waterline is where the expressions of anger can be readily observed. However, most of the iceberg is hidden under the waterline and this is where unobserved, deeper emotion can reside.

During times that you have experienced anger, what have been some underlying emotions?

How might the concept of an educated guess in listening be relevant when responding to another’s anger with reflection?
PREPARING RESPONSE TO ANGER

Certified peer specialists are uniquely positioned to support people who express anger. However, in order to respond, thoughtful preparation is required. Why? Because if certified peer specialists understand and manage their own experiences with anger, a powerful presence can be provided to hold space for a peer’s anger. Describing this as compassionate communication, Lindsey Dickenson notes in an article published on ExperienceLife.com that, “When we’re able to pay attention to core needs—our own and others’—we’re motivated to act out of compassion instead of out of guilt, fear, or shame. And, when we are motivated by compassion, we do not rely on defensive or blaming language—language that stalls and sometimes completely derails effective communication—in difficult situations. Instead, we approach others with more kindness and understanding—and, in turn, we’re more likely to be able to both give and receive what’s most needed.”

There are several steps that certified peer specialists can practice to prepare for the eventual encounter of a peer’s anger. The good news is that these steps have been central themes in this course: self-awareness, self-care, and setting healthy boundaries.

1. Observe the situation.

2. Identify your feelings.

3. Identify your needs.

4. Make request.
Preparing Response to Anger Worksheet

Consider a situation in which someone is expressing anger toward you and respond to each step below (observation, feelings, needs, request). Think of this activity as your part of a conversation.

1. What are you telling yourself about the situation? Identify any judgments, and then set aside. Now, note an observation about this situation without judgments. I see that...

2. Identify your feelings in the situation (see Feelings Inventory). I feel...

3. Now, identify your needs (see Needs Inventory). Because I need...

4. Make a request (not demand) that will get the need met. I request...

*The exercise was adapted from the Center for Nonviolent Communication.*
FEELINGS INVENTORY (from Center for Nonviolent Communication)

<table>
<thead>
<tr>
<th>AFRAID</th>
<th>EMBARRASSED</th>
<th>FATIGUED</th>
</tr>
</thead>
<tbody>
<tr>
<td>apprehensive</td>
<td>ashamed</td>
<td>beat</td>
</tr>
<tr>
<td>dread</td>
<td>chagrined</td>
<td>burnt out</td>
</tr>
<tr>
<td>foreboding</td>
<td>flustered</td>
<td>depleted</td>
</tr>
<tr>
<td>frightened</td>
<td>guilty</td>
<td>depleted</td>
</tr>
<tr>
<td>mistrustful</td>
<td>mortified</td>
<td>lethargic</td>
</tr>
<tr>
<td>panicked</td>
<td>self-conscious</td>
<td>listless</td>
</tr>
<tr>
<td>petrified</td>
<td></td>
<td>sleepy</td>
</tr>
<tr>
<td>scared</td>
<td></td>
<td>tired</td>
</tr>
<tr>
<td>suspicious</td>
<td></td>
<td>weary</td>
</tr>
<tr>
<td>terrified</td>
<td></td>
<td>worn out</td>
</tr>
<tr>
<td>wary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>worried</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANNOYED</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>aggravated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dismayed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disgruntled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>displeased</td>
<td></td>
<td></td>
</tr>
<tr>
<td>exasperated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>frustrated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>impatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>irritated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>irked</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANGRY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>enraged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>furious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>incensed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>indignant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>irate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>livid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>outraged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>resentful</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AVERTION</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>animosity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>appalled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>contempt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disgusted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dislike</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>horrified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hostile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>repulsed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISCONNECTED</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>alienated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>aloof</td>
<td></td>
<td></td>
</tr>
<tr>
<td>apathetic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bored</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>detached</td>
<td></td>
<td></td>
</tr>
<tr>
<td>distant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>distracted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>indifferent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>numb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>removed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>uninterested</td>
<td></td>
<td></td>
</tr>
<tr>
<td>withdrawn</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISQUIET</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>agitated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>alarmed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>discombobulated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disconcerted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disturbed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>perturbed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>rattled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>restless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>shocked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>startled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surprised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>troubled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>turbulent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>turmoil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>uncomfortable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>uneasy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>unnerved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>unsettled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>upset</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAIN</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>agony</td>
<td></td>
<td></td>
</tr>
<tr>
<td>anguished</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bereaved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>devastated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>heartbroken</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hurt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lonely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>miserable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>regretful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>remorseful</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TENSE</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>anxious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cranky</td>
<td></td>
<td></td>
</tr>
<tr>
<td>distressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>distraught</td>
<td></td>
<td></td>
</tr>
<tr>
<td>edgy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fidgety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>frazzled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>irritable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>jittery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>nervous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>overwhelmed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>restless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stressed out</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SAD</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>depressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dejected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>despair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>despondent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disappointed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>discouraged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disheartened</td>
<td></td>
<td></td>
</tr>
<tr>
<td>forlorn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>gloomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>heavy hearted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hopeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>melancholy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>unhappy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>wretched</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONFUSED</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ambivalent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>baffled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bewildered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dazed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hesitant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mystified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>perplexed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>puzzled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>torn</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VULNERABLE</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>fragile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>guarded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>helpless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>insecure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>leery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>reserved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sensitive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>shaky</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YEARNING</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>envious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>jealous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>longing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>nostalgic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pining</td>
<td></td>
<td></td>
</tr>
<tr>
<td>wistful</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### NEEDS INVENTORY (from Center for Nonviolent Communication)

<table>
<thead>
<tr>
<th>CONNECTION</th>
<th>PHYSICAL WELL-BEING</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>acceptance</td>
<td>air</td>
<td>awareness</td>
</tr>
<tr>
<td>affection</td>
<td>food</td>
<td>celebration of life</td>
</tr>
<tr>
<td>appreciation</td>
<td>movement / exercise</td>
<td>challenge</td>
</tr>
<tr>
<td>belonging</td>
<td>rest/sleep</td>
<td>clarity</td>
</tr>
<tr>
<td>cooperation</td>
<td>sexual expression</td>
<td>competence</td>
</tr>
<tr>
<td>communication</td>
<td>safety</td>
<td>consciousness</td>
</tr>
<tr>
<td>closeness</td>
<td>shelter</td>
<td>contribution</td>
</tr>
<tr>
<td>community</td>
<td>touch</td>
<td>creativity</td>
</tr>
<tr>
<td>companionship</td>
<td>water</td>
<td>discovery</td>
</tr>
<tr>
<td>compassion</td>
<td></td>
<td>efficacy</td>
</tr>
<tr>
<td>consideration</td>
<td></td>
<td>effectiveness</td>
</tr>
<tr>
<td>consistency</td>
<td></td>
<td>growth</td>
</tr>
<tr>
<td>empathy</td>
<td></td>
<td>hope</td>
</tr>
<tr>
<td>inclusion</td>
<td></td>
<td>learning</td>
</tr>
<tr>
<td>intimacy</td>
<td></td>
<td>mourning</td>
</tr>
<tr>
<td>love</td>
<td></td>
<td>participation</td>
</tr>
<tr>
<td>mutuality</td>
<td></td>
<td>purpose</td>
</tr>
<tr>
<td>nurturing</td>
<td></td>
<td>self-expression</td>
</tr>
<tr>
<td>respect / self-respect</td>
<td></td>
<td>stimulation</td>
</tr>
<tr>
<td>safety</td>
<td></td>
<td>to matter</td>
</tr>
<tr>
<td>security</td>
<td></td>
<td>understanding</td>
</tr>
<tr>
<td>stability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to know and be known</td>
<td></td>
<td></td>
</tr>
<tr>
<td>see and be seen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to understand and be understood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>warmth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICAL WELL-BEING</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>air</td>
<td>awareness</td>
</tr>
<tr>
<td>food</td>
<td>celebration of life</td>
</tr>
<tr>
<td>movement / exercise</td>
<td>challenge</td>
</tr>
<tr>
<td>rest/sleep</td>
<td>clarity</td>
</tr>
<tr>
<td>sexual expression</td>
<td>competence</td>
</tr>
<tr>
<td>safety</td>
<td>consciousness</td>
</tr>
<tr>
<td>shelter</td>
<td>contribution</td>
</tr>
<tr>
<td>touch</td>
<td>creativity</td>
</tr>
<tr>
<td>water</td>
<td>discovery</td>
</tr>
<tr>
<td></td>
<td>efficacy</td>
</tr>
<tr>
<td></td>
<td>effectiveness</td>
</tr>
<tr>
<td></td>
<td>growth</td>
</tr>
<tr>
<td></td>
<td>hope</td>
</tr>
<tr>
<td></td>
<td>learning</td>
</tr>
<tr>
<td></td>
<td>mourning</td>
</tr>
<tr>
<td></td>
<td>participation</td>
</tr>
<tr>
<td></td>
<td>purpose</td>
</tr>
<tr>
<td></td>
<td>self-expression</td>
</tr>
<tr>
<td></td>
<td>stimulation</td>
</tr>
<tr>
<td></td>
<td>to matter</td>
</tr>
<tr>
<td></td>
<td>understanding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEANING</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>awareness</td>
<td></td>
</tr>
<tr>
<td>celebration of life</td>
<td></td>
</tr>
<tr>
<td>challenge</td>
<td></td>
</tr>
<tr>
<td>clarity</td>
<td></td>
</tr>
<tr>
<td>competence</td>
<td></td>
</tr>
<tr>
<td>consciousness</td>
<td></td>
</tr>
<tr>
<td>contribution</td>
<td></td>
</tr>
<tr>
<td>creativity</td>
<td></td>
</tr>
<tr>
<td>discovery</td>
<td></td>
</tr>
<tr>
<td>efficacy</td>
<td></td>
</tr>
<tr>
<td>effectiveness</td>
<td></td>
</tr>
<tr>
<td>growth</td>
<td></td>
</tr>
<tr>
<td>hope</td>
<td></td>
</tr>
<tr>
<td>learning</td>
<td></td>
</tr>
<tr>
<td>mourning</td>
<td></td>
</tr>
<tr>
<td>participation</td>
<td></td>
</tr>
<tr>
<td>purpose</td>
<td></td>
</tr>
<tr>
<td>self-expression</td>
<td></td>
</tr>
<tr>
<td>stimulation</td>
<td></td>
</tr>
<tr>
<td>to matter</td>
<td></td>
</tr>
<tr>
<td>understanding</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEANING</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>choice</td>
<td></td>
</tr>
<tr>
<td>freedom</td>
<td></td>
</tr>
<tr>
<td>independence</td>
<td></td>
</tr>
<tr>
<td>space</td>
<td></td>
</tr>
<tr>
<td>spontaneity</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HONESTY</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>authenticity</td>
<td></td>
</tr>
<tr>
<td>integrity</td>
<td></td>
</tr>
<tr>
<td>presence</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HONESTY</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>authenticity</td>
<td></td>
</tr>
<tr>
<td>integrity</td>
<td></td>
</tr>
<tr>
<td>presence</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAY</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>joy</td>
<td></td>
</tr>
<tr>
<td>humor</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAY</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>joy</td>
<td></td>
</tr>
<tr>
<td>humor</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEACE</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>beauty</td>
<td></td>
</tr>
<tr>
<td>communion</td>
<td></td>
</tr>
<tr>
<td>ease</td>
<td></td>
</tr>
<tr>
<td>equality</td>
<td></td>
</tr>
<tr>
<td>harmony</td>
<td></td>
</tr>
<tr>
<td>inspiration</td>
<td></td>
</tr>
<tr>
<td>order</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PEACE</th>
<th>MEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td>beauty</td>
<td></td>
</tr>
<tr>
<td>communion</td>
<td></td>
</tr>
<tr>
<td>ease</td>
<td></td>
</tr>
<tr>
<td>equality</td>
<td></td>
</tr>
<tr>
<td>harmony</td>
<td></td>
</tr>
<tr>
<td>inspiration</td>
<td></td>
</tr>
<tr>
<td>order</td>
<td></td>
</tr>
</tbody>
</table>
RESPONDING TO ANGER IN PEER SUPPORT

Once you have prepared yourself to respond to a person’s anger, now you are ready to provide effective peer support. Certified peer specialists are uniquely positioned to support people who express anger because of the person-centered, strengths-based, and recovery-oriented approach of peer support. How to respond? At this point in the course, you have many ideas. Take a few minutes to note your ideas in the following elements of peer support. Try to provide specific examples for each element.

• Practicing self-care in the moment:

• OARS skills for connecting:

• OARS skills for exploring:

• Setting healthy boundaries:

• Other ideas:
Responding to Anger in Peer Support

Consider these elements of providing peer support in response to a peer’s expression of anger.

- **Stay calm and be present.**
  - Practice deep breathing or sensory strategies.
  - Use nonthreatening nonverbal.
  - Speak calmly with neutral tone.
  - Practice self-affirmation: Do not take the person's anger personally.

- **Deepen connection**
  - Listen carefully for understanding and offer many reflections: come alongside, validate, and reflect the feeling of anger.
  - Consider underlying meaning: what might be under the tip of the iceberg? Make educated guesses about underlying meaning and emotions.
  - Allow pause and silence for the peer to respond.
  - Share a relevant aspect of your recovery, with permission, that the peer may find relatable.

- **Deepen exploration.**
  - Reframe anger as an opportunity to explore.
  - Look for and affirm the peer's strengths that underlie the expression of anger.

- **Model the practice of healthy boundary setting.**
  - Be aware of personal space and boundaries.
  - Recognize when a boundary is crossed.
  - Practice healthy boundary setting.
Assign Homework

(5 minutes)

OBJECTIVE

To self-reflect on communication approaches.

METHOD

1. Direct participants to review *Communication Styles*.
## Communication Styles

<table>
<thead>
<tr>
<th></th>
<th>PASSIVE</th>
<th>AGGRESSIVE</th>
<th>PASSIVE-AGGRESSIVE</th>
<th>ASSERTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEHAVIOR</strong></td>
<td>Keep quiet. Do not say what you feel, need, or want. Apologize when you express yourself. Deny that you disagree with others or feel differently.</td>
<td>Express your feelings and wants as though any other view is unreasonable or stupid. Dismiss, ignore, or insult the needs, wants, and opinions of others.</td>
<td>Failure to meet the expectations of others through “deniable” means; forgetting being delayed, and so on. Deny personal responsibility for your actions.</td>
<td>Express your needs, wants, and feelings directly and honestly. Do not assume you are correct or that everyone will feel the same way. Allow others to hold other views without dismissing or insulting them.</td>
</tr>
<tr>
<td><strong>NONVERBAL</strong></td>
<td>Make yourself small. Look down, hunch your shoulders, and avoid eye contact. Speak softly.</td>
<td>Make yourself large and threatening. Eye contact is fixed and penetrating voice is loud, perhaps shouting.</td>
<td>Usually mimics the passive style.</td>
<td>Body is relaxed, movements are casual. Eye contact is frequent, but not glaring.</td>
</tr>
<tr>
<td><strong>BELIEFS</strong></td>
<td>Others’ needs are more important than yours. They have rights; you do not. Their contributions are valuable. Yours are worthless.</td>
<td>Your needs are more important and more justified than theirs. You have rights; they do not. Your contributions are valuable. Theirs are silly, wrong, or worthless.</td>
<td>You are entitled to get your own way, even after making commitments to others. You are not responsible for your actions.</td>
<td>Your needs and those of others are equally important. You have equal rights to express yourselves. You both have something valuable to contribute. You are responsible for your behavior.</td>
</tr>
<tr>
<td><strong>EMOTIONS</strong></td>
<td>Fear of rejection. Helplessness, frustration, and anger. Resentment toward others who “use” you. Reduced self-respect.</td>
<td>Angry or powerful at the time, and victorious when you “win.” Afterward: remorse, guilt, or self-hatred for hurting others.</td>
<td>Fear that you would be rejected if you were more assertive. Resentment at the demands of others. Fear of being confronted.</td>
<td>You feel positive about yourself and the way you treat others. Self-esteem rises.</td>
</tr>
<tr>
<td><strong>GOALS</strong></td>
<td>Avoid conflict. Please others at any expense to yourself. Give others control over you.</td>
<td>Win at any expense to others. Gain control over them.</td>
<td>Get your own way without having to take responsibility.</td>
<td>Both you and others keep your self-respect. Express yourself without having to win all the time. No one controls anyone else.</td>
</tr>
</tbody>
</table>
Review Questions

1. Provide an example of each style of communication that you have witnessed in the past few months.

2. How would you describe your communication style? Feel free to break it down by behavior, nonverbal, beliefs, etc. (in other words, you may use all of these communication styles).

3. Self-care and setting boundaries have been themes during this course. Which communication style best reflects your current practice of self-care? For setting boundaries?

4. Are you happy with your current results of self-care and boundary setting? Are there adjustments to your communication approach you would like to consider? If so, what might communication adjustments look like?
Section 11

This section covers the planning process. The elements of a plan are discussed along with the pitfalls and possibilities. It then moves on to a more in-depth look at the different elements in the process of planning. These include brainstorming, use of language, and possibilities. This is followed by a group activity using conversation. There is no homework assignment given this section.
Curriculum Guide

SECTION 11

10 minutes  Homework Review
130 minutes  The Planning Process
15 minutes  Break
60 minutes  Planning Possibilities
5 minutes  Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Believes in and respects people’s rights to make informed decisions about their lives</td>
</tr>
<tr>
<td>1.3</td>
<td>Believes that personal growth and change are possible</td>
</tr>
<tr>
<td>1.9</td>
<td>Believes that recovery is a process</td>
</tr>
<tr>
<td>1.11</td>
<td>Believes and understands there are a range of views regarding mental health and substance use disorder and their treatment, services, supports, and recovery</td>
</tr>
<tr>
<td>2.1</td>
<td>Knowledge of Substance Abuse and Mental Health Services Administration’s definition of recovery: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”</td>
</tr>
<tr>
<td>2.2</td>
<td>Knowledge of mental health and substance use disorders and their impact on recovery</td>
</tr>
<tr>
<td>2.4</td>
<td>Knowledge of stages of change and recovery</td>
</tr>
<tr>
<td>2.5</td>
<td>Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community</td>
</tr>
<tr>
<td>2.7</td>
<td>Knowledge of person-centered care principles</td>
</tr>
<tr>
<td>2.8</td>
<td>Knowledge of strengths-based planning for recovery</td>
</tr>
<tr>
<td>4.3</td>
<td>Ability to problem-solve</td>
</tr>
<tr>
<td>4.7</td>
<td>Effective written and verbal communication skills</td>
</tr>
<tr>
<td>4.13</td>
<td>Ability to work collaboratively and participate on a team</td>
</tr>
</tbody>
</table>
Review Homework

(10 minutes)

OBJECTIVE

To review homework on communication styles and briefly discuss review questions.

METHOD

1. Ask participants to provide an example of each style of communication that they have witnessed in the past few months.

2. Ask participants: “How would you describe your communication style?”

3. Ask participants: “Which communication style best reflects your current practice of self-care? For setting boundaries?”

4. Ask participants: “Are you happy with your current results of self-care and boundary setting? Are there adjustments to your communication approach you would like to consider? If so, what might communication adjustments look like?”
The Planning Process

(130 minutes)

OBJECTIVE
To learn about the planning process of peer support and engage practice.

METHOD
1. Read *The Planning Process*.
   a. After the “Pitfalls and Possibilities of Planning” section:
      i. Ask participants: “During planning conversations, which pitfall(s) do you see yourself most easily falling into?”
      ii. Ask participants: “Which two or three planning possibilities most resonate with you? Why?”

2. Facilitate *Activity: The Process of Planning*
   a. Divide participants into small groups.
   b. Assign one of the basic planning questions to each question and ask the groups to construct two or three open questions to further explore and draw out the peer’s ideas.
   c. Bring the participants back together for a large group share out after it appears all of the small groups have constructed at least two questions.
   d. Use the information provided on the activity sheet to talk about the OARS skills that should be used in the planning process.

3. Read *Brainstorming*.
   a. Brainstorm activity 1: Demonstration. Facilitator provides demonstration of brainstorming with a participant who offers a specific challenge. Large group debrief.
   b. Brainstorm activity 2: In pairs, what are natural supports? Large group debrief.

4. Read *Language Matters*.
   a. Launch solitary writing activity.
   b. Facilitate large group share out. Ask participants to share their answers to the self-reflection activity.
5. Facilitate *Activity: Planning Possibilities*.
   a. Divide participants into groups of three.
   b. Instruct groups to assign roles.
   c. Instruct groups to follow the directions provided.
   d. Allow time for a debrief in the groups before starting the large group debrief.
   e. The certified peer specialist role should start the small group debrief by stating what they liked and what they could have done a little differently.
   f. The observers should share one or two supportive observations using the Ask-Share-Ask procedure.
   g. Ask all participants as part of the large group debrief: “Where does this practice activity leave us for having planning conversations with peers?”
The final fundamental process of peer support is planning. The planning process rests upon a foundation of the prior processes of peer support: connecting and the establishment of a good working relationship; exploring to understand the peer's lived experiences, perspectives, values, concerns, and challenges; and experiencing the mutuality of peer support. Planning provides a road map for where the peer wants to go in their recovery journey and how to get there.
# PITFALLS AND POSSIBILITIES OF PLANNING

The planning process presents pitfalls and possibilities to certified peer specialists.

<table>
<thead>
<tr>
<th>Pitfalls</th>
<th>Possibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting ahead of the peer’s readiness and jumping to a solution, plan, or action step before the peer is ready.</td>
<td>It is okay to stay in the exploration process indefinitely as a source of useful support. Contemplation is a valid stage of change.</td>
</tr>
<tr>
<td>Staying in exploration when the peer is ready to plan.</td>
<td>There are signals of readiness that can indicate a peer is ready for planning. For example, expressing resolve about a change, asking questions about change, envisioning a new future, or stating a desire to plan. It is useful to check the peer’s readiness by “testing the water” for planning.</td>
</tr>
<tr>
<td>Judging a peer’s goal to be unrealistic or certain to fail.</td>
<td>Conveying acceptance and honoring of a peer’s self-determination to set their own course is a powerful form of peer support.</td>
</tr>
<tr>
<td>Being personally or professionally invested in a particular plan outcome and viewing the outcome as a reflection of one’s peer support competency.</td>
<td>Being able to let go of a peer’s outcome is to set a healthy boundary. Boundaries increase capacity of empathy and compassion if/when a peer does not achieve a desired outcome. To engage a peer in planning is an opportunity to (later) practice self-care.</td>
</tr>
<tr>
<td>Not recognizing multiple pathways to recovery. For example, emphasizing an abstinence approach to a substance use challenge rather than exploring harm reduction options in addition to abstinence.</td>
<td>Person-centered planning requires exploration of many options with careful listening to understand the peer’s desires, goals, and needs.</td>
</tr>
<tr>
<td>Seeing a plan as a formal, written document that must be revisited.</td>
<td>There are many ways to plan. One way is to create a formal, written document. Another way is to have a one-time informal discussion. Another way is to have an ongoing discussion about a plan.</td>
</tr>
<tr>
<td>Viewing planning as a technical problem-solving activity to search for and find solutions and resources.</td>
<td>The greatest solutions and resources lie within each peer. There is a wealth of lived experience, expertise, strengths, prior successes, values, motivations, and inner resources to identify, explore, and cultivate during the planning process. The certified peer specialist can offer an idea or solution, but please remember to use the Ask-Share-Ask procedure.</td>
</tr>
</tbody>
</table>
ELEMENTS OF A PLAN

Although many recovery plan formats exist, here are the most basic elements of a plan.

- What is the peer moving toward? (concept taken from Intentional Peer Support: https://www.otrtw.org/intentional-peer-support/)
  - Desires, goals, dreams, hopes, interests, needs, and preferences...
    - Regarding something (examples: participate in community, increase self-control, develop a specific skill, make a change with substance use, address a mental health challenge)
    - In a particular timeframe (examples: today, this week, this month, the next six months, this year, across a lifetime)
- What will likely get in the way? (Identify barriers, roadblocks, triggers)
- How can these be addressed or overcome? (Strategies, brainstormed ideas)
- What supports does the peer have access to? (Peer’s strengths, natural supports, services, resources)

Creating a written or discussed road map allows the peer and certified peer specialist to revisit the plan and continue exploring and supporting. Planning can be an ongoing process.

Here are some well-established plan formats:

- Wellness Recovery Action Plan
  https://www.mentalhealthrecovery.com/wrap-is/
- Trauma Addictions Mental Health and Recovery
  https://www.nasmhpd.org/content/trauma-addictions-mental-health-and-recovery-tamar-treatment-manual-and-modules
- Substance Abuse and Mental Health Services Administration
- Mental Health.gov Develop a Recovery Plan
  https://www.mentalhealth.gov/basics/recovery-possible
- Recovery.org
  https://www.recovery.org/pro/articles/developing-your-personal-recovery-plan-template-included/
Activity: The Process of Planning

This is a small group activity to demonstrate how the OARS skills are applied during the planning process in specific ways.

Ask open questions to draw out the peer’s expertise, lived experiences, and wisdom about what has worked, what has not worked, and what might work for a recovery plan. By tapping into and drawing out the peer’s wealth of experience, the eventual plan will be highly individualized, relevant, and meaningful.

In small groups, using the basic planning question as a starting point, construct two or three more open questions to further explore and draw out a peer's ideas.

- What are you moving toward?
  - 
  - 
  -

- What will likely get in the way?
  - 
  - 
  -

- How can these barriers be addressed or overcome?
  - 
  - 
  -

- What are some supports for moving forward?
  - 
  - 
  -
Look for strengths and **affirm**. The strengths-based approach to recovery planning identifies and affirms inherent strengths of the peer, prior successes with change, positive attributes, and motivations to cultivate and build upon. Affirmation of strengths provides (potentially for the first time in the person’s experience) building blocks for change.

Offer frequent **reflection listening statements**. The key to planning is to understand the peer’s perspectives and this requires careful listening. Avoid listening roadblocks.

**Summarize** the planning process. Once the conversation is coming to a close, briefly summarize the plan. End the summary with an open question that moves the conversation forward.
Brainstorming

Brainstorming is a collaborative way for peers to generate ideas for addressing any planning challenge. Planning challenges typically include identifying multiple options for what to move toward, addressing a barrier to recovery, and identifying supports for change. Here are five steps in the brainstorming process:

**Step 1.** Peer identifies a challenge. The challenge could include a barrier to change, lack of supports or resources, or considering how to address a difficult problem. The more specific and concrete the challenge can be identified, the more effective the brainstorm will be.

**Step 2.** Certified peer specialist sets the stage for the brainstorm by providing these instructions: "We are going to work together to identify all possible ideas regarding this challenge. All ideas are valid. We are going to think out of the box. You are the expert here but my job is to encourage your ideas. Ready?"

**Step 3.** Begin the brainstorm. Ask for the peer's ideas and note these in a list. Encourage ideas by asking the open question "What else?" (not the closed question "Anything else?"). Be patient and give the peer time to think. Refrain from jumping in with your good ideas. Ask for elaboration ("Tell me more about that idea.") to encourage sharing. In this step, be sure to affirm the peer's expertise and lived experience. Also, be sure to demonstrate listening with frequent reflective listening statements. Once the peer seems to be running out of ideas, feel free to contribute to the brainstorm using the Ask-Share-Ask procedure.

**Step 4.** Once all ideas have been exhausted, have the peer review. "There are a lot of really creative, solid ideas here. Given that you know yourself the best, which ideas might be the most useful for you to put into action?" Try to have the peer narrow down to the top one or two actionable ideas.

**Step 5.** Document the results of the brainstorm and the one or two ideas on the recovery plan for future reference. It will be useful to return to these ideas as the plan unfolds to revise, adjust, or brainstorm another list.

*This exercise was adapted from the Canadian Mental Health Association’s “Peer Support Teaching Manual.”*
Language Matters

Some employing agencies require certified peer specialists to document peer support services as part of a confidential record. Language matters in how people, behavior, and service activities are described. Within the medical model approach, human services have a long history of referring to people as their diagnosis, using stigmatizing labels, speaking in pejorative terms, and embracing deficit-based descriptions. Language matters and we all need to work hard to use person first language. That means we must change how we think and talk about people, behavior, and services.

The following tables contrast deficit-based language from strengths-based, person-first language when describing people, behavior, and services.

<table>
<thead>
<tr>
<th>Describing a person</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deficit-based language</strong></td>
</tr>
</tbody>
</table>
| Schizophrenic, borderline, bipolar, hoarder | Person diagnosed with...  
Person who experiences the following...  
Person in recovery from...  
Person living with... |
| Addict, junkie, substance abuser | Person who uses substances  
Person living with addiction |
| Consumer, patient, client | Person in recovery  
Person working on recovery  
Person participating in services  
Person with lived experience |
| Frequent flyer, super utilizer, a regular | Frequently uses services and supports  
Is resourceful  
A good self-advocate  
Attempts to get needs met |
### Describing Behavior

<table>
<thead>
<tr>
<th>Deficit-based language</th>
<th>Strengths-based language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good/bad, right/wrong</td>
<td>Different, diverse, unique</td>
</tr>
<tr>
<td>Suffering from</td>
<td>Person is experiencing, living with, working to recover from</td>
</tr>
<tr>
<td>Acting-out, &quot;having behaviors&quot;</td>
<td>Person is experiencing strong emotions</td>
</tr>
<tr>
<td></td>
<td>Person is upset/angry/overwhelmed</td>
</tr>
<tr>
<td>Attention-seeking</td>
<td>Looking for support, looking for connection</td>
</tr>
<tr>
<td></td>
<td>Having a hard time</td>
</tr>
<tr>
<td>Criminal, delinquent, dangerous</td>
<td>Specify unsafe behavior</td>
</tr>
<tr>
<td></td>
<td>Person who has experienced incarceration</td>
</tr>
<tr>
<td>Denial, unable to accept illness, lack of insight</td>
<td>Person disagrees with diagnosis</td>
</tr>
<tr>
<td></td>
<td>Person sees themselves in a strengths-based way</td>
</tr>
<tr>
<td>Manipulative</td>
<td>Resourceful; trying to get help; able to take control in a situation to get needs met;</td>
</tr>
<tr>
<td></td>
<td>boundaries are unclear; trust in relationship has not been established; learned to</td>
</tr>
<tr>
<td></td>
<td>navigate the world differently</td>
</tr>
<tr>
<td>Oppositional, resistant, non-compliant, unmotivated</td>
<td>Constraints of the system don't meet the individual's needs; preferred options are not</td>
</tr>
<tr>
<td></td>
<td>available; services and supports are not a fit</td>
</tr>
<tr>
<td>Danger to others, danger to self, general danger</td>
<td>People should not be reduced to acronyms; describe behaviors that are threatening</td>
</tr>
<tr>
<td>Entitled</td>
<td>Person is aware of their rights, empowered, self-advocate</td>
</tr>
<tr>
<td>Puts self and/or recovery at risk</td>
<td>Person is trying new things that may have risks, exploring recovery pathways</td>
</tr>
<tr>
<td>Weakness, deficits</td>
<td>Barriers, needs, opportunity to develop skills</td>
</tr>
</tbody>
</table>

### Describing service activity

<table>
<thead>
<tr>
<th>Deficit-based language</th>
<th>Strengths-based language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>Self-determined quality of life</td>
</tr>
<tr>
<td>Clinical decompensation, relapse, failure</td>
<td>Challenges, potential setback</td>
</tr>
<tr>
<td>Discharged to aftercare, maintaining</td>
<td>Person is connected to social or community supports</td>
</tr>
<tr>
<td></td>
<td>Person is following up with recovery-oriented supports</td>
</tr>
<tr>
<td>Clinical stability, abstinence</td>
<td>Promoting and sustaining recovery, building resilience, utilizing harm reduction</td>
</tr>
<tr>
<td>Non-compliant with medications, treatment resistant</td>
<td>Person prefers other strategies and pathways</td>
</tr>
<tr>
<td></td>
<td>Person is making their own decisions</td>
</tr>
<tr>
<td></td>
<td>Person's concerns are not being acknowledged by the treatment team</td>
</tr>
<tr>
<td>Enable, learned dependency</td>
<td>Providing support in a person-centered manner, opportunity to clarify boundaries</td>
</tr>
<tr>
<td>Front-line staff, &quot;in the trenches&quot;</td>
<td>Avoid using war metaphors</td>
</tr>
<tr>
<td></td>
<td>Use job title</td>
</tr>
</tbody>
</table>

304
Self-reflection activity instructions: Review the lists of deficit- and strengths-based language and respond to the following.

- What is an example of language that you would like to ***stop*** using:

- What is an example of language that you would like to ***start*** using:

- What is an example of language that you would like to ***continue*** using:
Planning Possibilities

- What are you moving toward?

- What will likely get in the way?

- How can these barriers be addressed or overcome?

- What are some supports for moving forward?
Activity: Planning Possibilities
Complete this activity in groups of three. Assign roles to each person in the group.

- Peer: Talk about something that you would like assistance with planning. This is not a role-playing. It is a real play. Consider discussing moving toward becoming a certified peer specialist

- Certified peer specialist: Have a planning conversation. Use OARS skills and other tools available. There will be 10 minutes for the round with a one-minute warning to offer a summary.

- Observer: Observe the certified peer specialist and use the OARS Skills Observer Sheet to track the conversation.
Assign Homework

(5 minutes)

**OBJECTIVE**

To solidify learning in this section.

**METHOD**

Assign *Review Questions*. 
Review Questions

1. What were your two or three biggest takeaways from this section?

2. How can certified peer specialist best support peers in the planning process?
Section 12

This section focuses on advocacy in the certified peer specialist role. The different areas of advocacy are discussed and promoted. An activity is provided to encourage the exploration of this topic. State and federal regulations are covered along with governmental assistance programs, client rights, the American with Disabilities Act, and involuntary commitment. This section concludes with revisiting the certified peer specialist practice exam.
SECTION 12

10 minutes  Review Homework
90 minutes  Advocacy in the Certified Peer Specialist Role
15 minutes  Break
60 minutes  Federal and State Regulations
45 minutes  Revisiting the Certified Peer Specialist Practice Exam
5 minutes  Assign Homework

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2</td>
<td>Believes in and respects people’s rights to make informed decisions about their lives</td>
</tr>
<tr>
<td>1.7</td>
<td>Believes in lifelong learning and personal development</td>
</tr>
<tr>
<td>2.9</td>
<td>Knowledge of the impact of discrimination, marginalization, and oppression</td>
</tr>
<tr>
<td>2.10</td>
<td>Knowledge of the impact of internalized stigma and shame</td>
</tr>
<tr>
<td>3.1</td>
<td>Knowledge of the rights of peers seeking support, such as state and federal law regarding client rights, civil rights, and the Americans with Disabilities Act (ADA)</td>
</tr>
<tr>
<td>3.5</td>
<td>Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions</td>
</tr>
<tr>
<td>3.7</td>
<td>Knowledge of cultural competency</td>
</tr>
<tr>
<td>4.3</td>
<td>Ability to problem-solve</td>
</tr>
<tr>
<td>4.7</td>
<td>Effective written and verbal communication skills</td>
</tr>
<tr>
<td>4.11</td>
<td>Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals</td>
</tr>
<tr>
<td>4.12</td>
<td>Ability to facilitate and support a person to find and utilize resources</td>
</tr>
<tr>
<td>4.18</td>
<td>Ability to foster the person’s self-advocacy and provide advocacy when requested by the person</td>
</tr>
<tr>
<td>4.19</td>
<td>Ability to advocate for self in the role of a certified peer specialist</td>
</tr>
</tbody>
</table>
Review Homework

(10 minutes)

OBJECTIVE

To discuss answers to the homework questions.

METHOD

1. Ask participants: “What were the biggest takeaways from the last section?”

2. Ask participants: “How can certified peer specialists best support peers in the planning process?” (list answers on flip chart)
Advocacy in the Certified Peer Specialist Role

(90 minutes)

OBJECTIVE

To consider the process, steps, and areas of advocacy that certified peer specialists can advance.

METHOD

1. Read *The Advocating Process*.

2. Facilitate small group activity.
   a. Divide participants into four groups.
   b. Assign one of the four areas from *Areas for Advocacy* to each group with these instructions: “In your group, you will work together to consider steps in the advocating process. Some of this work actually simulates preparing for advocacy. You will have 30 minutes for this so please be thoughtful about how you use your time. Use the *Exploring Advocacy* worksheet to guide your work. It is okay if you want to organize yourselves by having two or three people take a step. In 30 minutes, we will start the large group share out in which your group will share with the rest of us the results of your exploration. You will have up to 10 minutes to present to the large group.”
   c. Call on groups to present in order. In other words, the group focused on advocating with a peer should go first.
   d. Facilitate a five-minute large group discussion on the areas for advocacy after all groups have presented.
The Advocating Process

Connecting, exploring, supporting, and planning are fundamental processes of certified peer specialist practice. Less formal, but nonetheless important, is the advocating process. The purpose of advocating is to bring about change at the team, agency, and system levels to create an environment where the work of peer support can thrive.

There are several important areas of advocacy that certified peer specialists can advance: advocating with a peer, advocating for professional needs, advocating for the certified peer specialist role, and advocating for systems change. The concept of recovery provides a useful parallel for thinking about advocating: it is a process; there are multiple pathways forward; resources are important; self-care is essential. The steps outlined here are not offered as a cookie-cutter plan, but to stimulate thinking and discussion about the certified peer specialist role in an effective advocating process.

**Summarize.** Gather information, do research, and know the facts on the issues. Identify the key stakeholders and understand the multiple perspectives. Clearly summarize the issues and concerns for effective communication.

**Focus.** Issues regarding practices and policies tend to be complex. Narrowing the focus and selecting specific issues can make advocating more manageable. Which issues are the most important? How to collaborate with others about which issues to focus on? This step identifies the what of advocacy.

**Vision.** It is important to have the big picture. Why is advocacy on this issue so important? If positive changes were to occur, what might be some expected benefits? This step addresses the why of advocacy.

**Strategy.** Develop ideas, strategies, and approaches for advocacy. Brainstorming could initially be useful, however, selecting specific strategies will be easier to implement. Who will do what by when? Formulating this step gets at the how of advocacy.

**Preparation.** As discussed throughout this course, preparation is a key to effectiveness. It is useful to think through barriers and risks, as well as self-care, healthy boundaries, responding to anger, natural supports, tools, and resources.

**Reflection.** Once a strategy is implemented or an action is taken, it is important to reflect. What happened? What were the results? Self-awareness is key because this is where learning happens.
Areas for Advocacy

There are several important areas for advocacy that certified peer specialists can advance: advocating with a peer, advocating for professional needs, advocating for the certified peer specialist role, and advocating for systems change.

ADVOCATING WITH A PEER

Because certified peer specialists support self-determination, the certified peer specialist advocates with their peers and not for them. The concept of advocating with is consistent with certified peer specialist practice centered on the peer’s self-defined needs, preferences, and wishes. Examples of advocating with a peer include:

- Exploring with the peer their options and rights without advising them in any particular direction.
- Practicing informed consent, meaning the provision of all resources and context a person may need to make informed decisions for themselves about their path forward.
- Supporting a peer in speaking to their needs and concerns at team meetings or in other settings, including going with them if asked.
- Accompanying a peer to support them in meetings or appointments.
- Holding space for each person to define crisis and recovery on their own terms.
- Validating a peer in the pursuit of their goals, however realistic or unrealistic they may be perceived by others, including by the certified peer specialist.
- Protecting a peer’s confidentiality and privacy particularly when speaking with someone whom the peer has not given consent for information to be shared with (often this can happen in situations involving police).

Advocating with is not sharing with the peer your personal opinion, taking the lead, solving problems, making decisions, or second-guessing a peer’s decision.

ADVOCATING FOR PROFESSIONAL NEEDS

Living with a mental health or substance use challenge can sometimes mean that a peer’s opinions and ideas are not taken seriously. This is why advocacy is required. Unfortunately, a similar dynamic can be replicated for certified peer specialists as professionals within their employing agency. For this reason, certified peer specialists may need to advocate for professional needs in several ways:

- Communicating scheduling needs, including any changes to availability.
• Advocating for employer support around professional development and continuing education (examples: having an employer pay for a conference registration, bringing training opportunities to the entire team, or making sure there is access to training specific to a peer lens).

• Negotiating a living wage reflective of one’s role, experience, training, and other assets to an organization (example: bilingualism).

• Engaging employers in conversation and requesting action when it comes to issues of equity and nondiscrimination.

• Establishing boundaries around one’s personal recovery. The employer’s role is not to oversee its employees’ recovery.

• Requesting accommodations as needed, as guaranteed by the Americans with Disabilities Act.

ADVOCATING FOR THE CERTIFIED PEER SPECIALIST ROLE

The Wisconsin Certified Peer Specialist Scope of Practice identifies many roles for which an employing agency’s leadership or supervisor may not be familiar. Advocacy and education is sometimes needed in these areas:

• General information about the certified peer specialist role, including review of key documents (core competencies, scope of practice, code of ethics).

• Recognition of the contributions and value that the certified peer specialist offers to the agency, team, and participants of services.

• Supervision that is tailored to the unique role of a certified peer specialist—ideally with a person who is an experienced certified peer specialist.

• An adequate number of people with whom to provide support that is reflective of the hours worked and job description.

• Understanding that certified peer specialists are not mandated reporters by virtue of completing this course.

• Understanding that certified peer specialists are not trained to be taxi drivers, administrative assistants, or to engage in menial tasks for the employing agency.

• Recognizing and valuing that certified peer specialists are not funnels for referral to treatment for the people they support.

ADVOCATING FOR SYSTEMS CHANGE

Certified peer specialists practice within the broader mental health and substance use service systems. It is important for certified peer specialists to realize that the employing agency has already taken steps toward change by virtue of having created a
certified peer specialist position. However, change can be slow and incremental in organizations. It could be considered an ethical obligation of the certified peer specialist to continue advocating for systems change. By speaking up and advocating for specific change, the certified peer specialist will be giving voice to many others. Good starting points include:

- Recognizing, validating, and supporting multiple pathways to recovery, including harm reduction and service options outside the medical model.
- Implementing trauma-informed practices based on an ongoing quality improvement process.
- Expecting that a strengths-based approach be taken on an agency-wide level. As a starting point here, advocating that deficit-based language be replaced by strengths-based language in how people, behavior, and service activities are described.
- Providing person-centered and self-directed services that recognize each person as the expert on their own lives and recovery. As a starting point here, replacing cookie-cutter treatment plans with person-centered planning.
- Adopting informed consent practices in multiple ways throughout the agency that truly support peoples’ self-determination.
- Helping the system understand that force, coercion, and restrictive measures are harmful.
- Helping the system understand that discharging people from treatment who experience the very difficulties and challenges that treatment is presumed to address is not helpful.
- Moving toward viewing crisis as an opportunity for growth and connection.
- Supporting organizational diversity and inclusion, as well as ensuring services and the workplace are accessible to all.
Exploring Advocacy

Area of advocacy:

- **Summarize.** Provide a brief summary of this area. What is the general focus of advocacy here? What are the general issues and concerns?

- **Focus.** Select one specific issue to explore. Try to come to consensus on issue selection as quickly as possible.

- **Vision.** Why is advocacy on this issue so important? If positive change were to occur, what might be some expected benefits?

- **Strategy.** What are some ideas and strategies for how to go about effective advocacy on this issue? Try to identify specifics.

- **Preparation.** What would be risky about engaging this advocacy work? How might these risks be mitigated? Consider self-care, supports, tools, and resources.

- **Reflection.** Thinking about these steps and the group discussions, what have you learned about the advocating process? What areas of strength do you believe you bring to advocacy? What areas/Steps may need some work to become more confident or competent?
Federal and State Regulations

(60 minutes)

OBJECTIVE

To gain an overview of the regulatory environment in which the certified peer specialist operates while also looking for opportunities to provide peer support and advocacy.

METHOD

1. Provide context. Certified peer specialists operate within a regulatory environment defined by federal and state laws, administrative codes, and policies.

2. Group activity. Divide participants into five groups. Assign each group to an area of advocacy.
   b. HIPAA.
   c. Americans with Disabilities Act.
   d. Wisconsin Client Rights.
   e. Involuntary Commitment.

Provide the following instructions for the group activity. “In your group, you will work together to skim the assigned document; note the most important points to later summarize to the large group. While you are skimming, consider two questions: What are the opportunities for providing peer support? What might be some opportunities for advocacy? You will have 20 minutes for this activity before we start the large group share out.” Set a timer for 20 minutes. Give people a two-minute warning to begin wrapping up.

3. Provide the following instructions for the large group share out. “Each group should present a brief summary of the document they reviewed. While summarizing, be sure to discuss opportunities for peer support and for advocacy within that particular area. Each group will have eight minutes to present.” Ask a group to volunteer to begin the large group share out.

4. Offer a bottom line after all of the group presentations. The bottom line should relate to how the regulatory environment offers opportunities for peer support and advocacy.
Certified peer specialists may work with people that are receiving benefits from the federal or state government. Individuals may also be receiving disability payments from an employer.

The most common benefits are Social Security, Social Security Disability Insurance, (SSDI), Supplemental Security Income (SSI), Medicare, and Medicaid.

Social Security pays monthly benefits to individuals and certain members of their family if the individual has worked long enough, paid Social Security taxes, and retired at a certain age.

The Social Security Disability Insurance and Supplemental Security Income programs are administered by the Social Security Administration. These two programs are available to individuals who have a disability and meet the medical criteria.

- **Social Security Disability Insurance (SSDI)** pays monthly benefits to individuals and certain members of their family if the individual is insured, meaning that the individual worked long enough and paid Social Security taxes.

- **Supplemental Security Income (SSI)** pays monthly benefits to the individual and certain members of their family with limited income and resources who are disabled, blind, or age 65 or older. Blind or disabled children may also get SSI.

Medicare is a federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease. The different parts of Medicare help cover specific services. Depending on the individual’s circumstance, they may only be entitled to certain benefits.

Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services.
There is a federal law that sets rules for who can look at and receive health information. This law is called the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Entities that must follow the HIPAA regulations are known as covered entities.

Covered entities include:

- **Health plans**, including health insurance companies, HMOs, company health plans, and certain government programs that pay for health care, such as Medicare and Medicaid.

- **Most health care providers**—those that conduct certain business electronically, such as electronically billing health insurance—including most doctors, clinics, hospitals, psychologists, chiropractors, nursing homes, pharmacies, and dentists.

- **Health care clearinghouses** that either process or facilitate the processing of health information received from another entity.

In addition, business associates of covered entities must follow parts of the HIPAA regulations.

Many organizations that have health information are not required to follow HIPPA, including:

- Life insurers
- Employers
- Workers compensation carriers
- Most schools and school districts
- Many state agencies like child protective service agencies
- Most law enforcement agencies
- Many municipal offices

**WHAT INFORMATION IS PROTECTED?**

- Information doctors, nurses, and other health care providers put in a medical record.
- Conversations a doctor has about a patient’s care or treatment with nurses and others.
- Information about a patient in a patient’s health insurer’s computer system.
• Billing information about a patient at the patient’s clinic.
• Most other health information about the patient, held by those who must follow these laws.

HOW THIS INFORMATION IS PROTECTED?
• Covered entities must put in place safeguards to protect health information and ensure they do not use or disclose health information improperly.
• Covered entities must reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose.
• Covered entities must have procedures in place to limit who can view and access a patient’s health information as well as implement training programs for employees about how to protect health information.
• Business associates also must put in place safeguards to protect a patient’s health information and ensure they do not use or disclose health information improperly.

WHAT RIGHTS DOES A PATIENT HAVE OVER THEIR HEALTH INFORMATION?

Patients have the right to:
• Ask to see and get a copy of their health records.
• Have corrections added to their health information.
• Receive a notice that tells the patient how their health information may be used and shared.
• Decide if they want to give their permission before their health information can be used or shared for certain purposes, such as for marketing.
• Get a report on when and why their health information was shared for certain purposes.
• File a complaint with their provider or health insurer, if they believe their rights are being denied or their health information is not being protected.

WHO CAN LOOK AT AND RECEIVE HEALTH INFORMATION?

Health information can be used and shared:
• For the patient’s treatment and care coordination.
• To pay doctors and hospitals for the patient’s health care and to help run their businesses.
• With the patient’s family, relatives, friends, or others the patients identify who are involved with the patient’s health care or the patient’s health care bills, unless the patient objects.

• To make sure doctors give good care and nursing homes are clean and safe.

• To protect the public’s health, such as by reporting when the flu is in a community.

• To make required reports to the police, such as gunshot wounds.

Health information cannot be used or shared without the patient’s written permission unless HIPPA allows it. For example, without the patient’s authorization, the patient’s provider cannot:

• Give the patient’s information to the patient’s employer.

• Use or share the patient’s information for marketing or advertising purposes or sell the patient’s information.

For more information

U.S. Department of Health and Human Services - Your Rights Under HIPAA
The Americans with Disabilities Act

The Americans with Disabilities Act (ADA) became law in 1990. The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as everyone else. The ADA gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications. The ADA is divided into five titles (or sections) that relate to different areas of public life.

In 2008, the Americans with Disabilities Act Amendments Act (ADAAA) was signed into law. The ADAAA became effective on January 1, 2009. The ADAAA made a number of significant changes to the definition of disability. The changes in the definition of disability in the ADAAA apply to all titles of the ADA, including Title I (employment practices of private employers with 15 or more employees, state and local governments, employment agencies, labor unions, agents of the employer and joint management labor committees); Title II (programs and activities of state and local government entities); and Title III (private entities that are considered places of public accommodation).

TITLE I—EQUAL EMPLOYMENT OPPORTUNITY FOR INDIVIDUALS WITH DISABILITIES

Title I is designed to help people with disabilities access the same employment opportunities and benefits available to people without disabilities. Employers must provide reasonable accommodations to qualified applicants or employees. A reasonable accommodation is any modification or adjustment to a job or the work environment that will enable an applicant or employee with a disability to participate in the application process or to perform essential job functions. Employers with 15 or more employees must comply with this law.

TITLE II—NONDISCRIMINATION ON THE BASIS OF DISABILITY IN STATE AND LOCAL GOVERNMENT SERVICES

Title II prohibits discrimination against qualified individuals with disabilities in all programs, activities, and services of public entities. It applies to all state and local governments, their departments and agencies, and any other instrumentalities or special purpose districts of state or local governments. It clarifies the requirements of Section 504 of the Rehabilitation Act of 1973, as amended, for public transportation systems that receive federal financial assistance, and extends coverage to all public
entities that provide public transportation, whether or not they receive federal financial assistance. It establishes detailed standards for the operation of public transit systems, including commuter and intercity rail (example: Amtrak).

**TITLE III—NONDISCRIMINATION ON THE BASIS OF DISABILITY BY PUBLIC ACCOMMODATIONS AND IN COMMERCIAL FACILITIES**

Title III prohibits private places of public accommodation from discriminating against individuals with disabilities. Examples of public accommodations include privately owned, leased, or operated facilities like hotels, restaurants, retail merchants, doctor’s offices, golf courses, private schools, day care centers, health clubs, sports stadiums, movie theaters, and so on. This title sets the minimum standards for accessibility for alterations and new construction of facilities. It also requires public accommodations to remove barriers in existing buildings where it is easy to do so without much difficulty or expense. This title directs businesses to make reasonable modifications to their usual ways of doing things when serving people with disabilities.

**TITLE IV—TELECOMMUNICATIONS**

Title IV requires telephone and Internet companies to provide a nationwide system of interstate and intrastate telecommunications relay services that allow individuals with hearing and speech disabilities to communicate over the telephone. This title also requires closed captioning of federally funded public service announcements.

**TITLE V—MISCELLANEOUS PROVISIONS**

Title V contains a variety of provisions relating to the ADA as a whole, including its relationship to other laws, state immunity, its impact on insurance providers and benefits, prohibition against retaliation and coercion, illegal use of drugs, and attorney’s fees. This title also provides a list of certain conditions that are not to be considered as disabilities.

For more information

ADA National Network – What is the American with Disabilities Act (ADA)?
https://adata.org/learn-about-ada
Wisconsin Client Rights

The Client Rights Office is a unit of the Wisconsin Department of Health Services. It serves individuals receiving services for developmental disability, mental health, and substance use. Individuals may receive these services in a variety of inpatient and outpatient settings, including adult family homes, clinics, community-based residential facilities, facilities operated by the Wisconsin Department of Health Services, and group homes. Inmates, emergency room patients, and single-person provider clinic patients are not served by the Client Rights Office.

The following is a brief summary of the rights of patients under Wisconsin law and administrative code. Patient rights with an asterisk (*) behind them may be limited or denied for certain reasons.

TREATMENT RIGHTS

- Receive prompt and adequate treatment.
- Participate in their treatment planning.
- Be informed of their treatment and care.
- Refuse treatment and medications unless court-ordered.
- Be free from unnecessary or excessive medications.

RECORDS AND PRIVACY ACCESS

- Staff must keep patient information confidential.
- Records cannot be released without patient consent with some exceptions.
- Patients may see their records.
- They can always see records of their medications and health treatments.
- During treatment, access may be limited if the risks outweigh benefits.
- Patients may challenge the accuracy, completeness, timeliness or relevance of entries in their records.

COMMUNICATION RIGHTS

- Have reasonable access to a telephone.*
- See (or refuse to see) visitors daily.*
- Send or receive mail.
- Contact public officials, lawyers or patient advocates.
PERSONAL RIGHTS

- Have the least restrictive environment, except for forensic patients.
- Not be secluded or restrained except in an emergency when necessary to prevent harm to self or others.
- Wear their own clothing and use their own possessions.*
- Have regular and frequent exercise opportunities.
- Have regular and frequent access to the outdoors.
- Have staff make reasonable (non-arbitrary) decisions about them.
- Refuse to work – except for personal housekeeping tasks.
- Be paid for work they agree to do that is of financial benefit to the facility.

PRIVACY RIGHTS

- Not be filmed or taped without his or her consent.
- Have privacy in toileting and bathing.*
- Have a reasonable amount of secure storage space for his or her possessions.*

MISCELLANEOUS RIGHTS

- Be treated with dignity and respect by all staff of the provider.
- Be informed of his or her rights.
- Be informed of any costs of his or her care.
- Refuse electroconvulsive therapy.
- Refuse drastic treatment measures.
- File complaints about violations of his or her rights.
- Be free from any retribution for filing complaints.

The work of the Client Rights Office covers five key areas:

- **Promotion of client rights.** Client Rights Office staff monitor changes in client rights laws and rules and, where appropriate, recommend changes for the benefit of all individuals served by the office.

- **Consultation on client rights.** Client Rights Office staff provide consultation on many topics and questions concerning client rights from individuals receiving services, their families, advocates, service providers, county staff, policymakers, and other interested parties.
• **Community provider grievance process.** The state grievance examiner is a member of the Client Rights Office staff and conducts reviews of grievances from individuals dissatisfied with the outcome of their complaint about services provided in the community. The state grievance examiner also may review any complaints about the community grievance procedure itself.

• **State facility grievance process.** Client Rights Office staff receive and process requests for reviews of grievances from patients of facilities operated by the Wisconsin Department of Health Services dissatisfied with the results of the first two levels of the grievance resolution process.

• **Approval of research.** Client Rights Office staff reviews all research proposals involving anyone who is served by the office. Recommendations on whether to approve a research project are forwarded to the Administrator of the Division of Public Health, who then decides whether the study will receive final approval from the Wisconsin Department of Health Services.

All facilities and programs operating in the community are required to display client rights posters in public view and obtain client rights and informed consent annually. Programs are also required to have an internal client rights officer that assists consumers with grievances before complaints reach the level of the state.

---

**For more information**

Wisconsin Department of Health Services – Client Rights Office  
[https://www.dhs.wisconsin.gov/clientrights/index.htm](https://www.dhs.wisconsin.gov/clientrights/index.htm)
Involuntary Commitment

There are three Wisconsin state statutes that govern the detention and involuntary commitment process: Wis. Stats. §§ 51.15 and 51.20 cover mental health, drug abuse and developmental disability commitments and Wis. Stat. § 51.45 covers alcoholism. Below is a summary of the statutes and processes involved in involuntary commitment.

The first phase of an involuntary commitment is a detention. This is when an individual, who has been diagnosed with a substance use disorder, mental health disorder, or a developmental disability, is taken into custody for the following reasons. The first bullet must exist and at least one condition listed under the second bullet must exist.

- Individuals who are reasonably believed to be unable or unwilling to cooperate with voluntary treatment.
- Individuals who have the probability of one of the following:
  - Physical harm to self
  - Physical harm to other persons
  - Physical impairment or injury to himself or herself due to impaired judgment
  - Unable to satisfy basic needs
  - For individuals with mental illness only: cannot make an informed decision to accept medication or treatment and there is probability that he/she needs treatment to prevent further disability or deterioration

- If these conditions exist, a law enforcement officer detains the individual and takes them to an approved facility that is the least restrictive environment needed.

- Individuals diagnosed with an alcohol use disorder are placed in protective custody and taken to an approved facility. They are subject for commitment based on the following:
  - Person lacks self-control of alcohol
  - Uses alcohol to the extent that health is impaired or endangered and social or economic functioning is disrupted
  - Their condition and conduct is dangerous to the person or others

Once an individual is detained, the situation becomes a civil legal matter and the rest of the process is handled through the county civil court.

- Probable cause hearing occurs within 72 hours of detention and determines if there is probable cause to believe what is alleged in the detention is true.
• Final hearing is set to be within 14 days of probable cause hearing and determines if the person has a mental health disorder, substance use disorder, or developmental disabilities and is a proper subject for a commitment.

• At the final hearing one of the following occurs:
  o Dismissal.
  o A determination whether a protective placement is a better option.
  o A commitment order to the care and custody of the appropriate county department for six months, with potential renewals.
  o An individual with alcoholism is committed to county for 90 days.

An individual can agree to participate in voluntary treatment at any time during the detention or commitment process of an involuntary commitment, which will stop the process.

A certified peer specialist may be on a team providing services to someone on an involuntary commitment. It is beyond the scope of a certified peer specialist to participate in the involuntary commitment process. It is helpful to know the policies and procedures of the agency at which the certified peer specialist is employed.

For more information

Wisconsin State Law Library – Mental Health
https://wilawlibrary.gov/topics/medlaw/mentalhealth.php
Revisiting the Wisconsin Certified Peer Specialist Practice Exam

(45 minutes)

OBJECTIVE

To identify progress in learning and to prepare for the certified peer specialist exam.

METHOD

1. Provide context. Earlier in this course, a practice Wisconsin Certified Peer Specialist Certification Exam was administered. As you may recall, the certification exam is based on four core competencies that are grouped into four domains: values, in-depth knowledge of recovery, roles and responsibilities of a certified peer specialist, and skills. It is time to take the same practice exam again.

2. Administer the practice exam. (Note: Email the link you received to the sample exam for the class to all course participants.)

3. Distribute the exam answer key and have participants self-score. Do not hand out the answer key until after participants complete the practice exam.

4. Debrief. Ask participants how their practice exam score compares to their score on the practice exam at the start of the course. What progress are they seeing? Look for strengths and affirm. Celebrate progress. Ask about areas that need study moving forward.
Assign Homework

(5 minutes)

OBJECTIVE
To solidify learning in this section.

METHOD
Assign Review Questions.
Review Questions

1. List some steps that the certified peer specialist can take in the process of advocating.

2. What are some of the rights of peers seeking support?

3. What are the criteria in Wisconsin for involuntary commitment?
Section 13

This section is the last section of this course. Discussions center on concluding the peer relationship. Participants are given the opportunity to complete a course evaluation. A final wrap up is conducted with each participant given a certificate of completion. A celebration is encouraged which can include refreshments commemorating the success of completing the course.
Curriculum Guide

SECTION 13

10 minutes  Review Homework
90 minutes  Concluding the Peer Relationship
15 minutes  Break
60 minutes  Recap, Review, and Reflection
15 minutes  Course Evaluation
30 minutes  Wrap Up and Celebrate Success

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>Believes that personal growth and change are possible</td>
</tr>
<tr>
<td>1.7</td>
<td>Believes in lifelong learning and personal development</td>
</tr>
<tr>
<td>1.9</td>
<td>Believes that recovery is a process</td>
</tr>
<tr>
<td>1.10</td>
<td>Believes in the healing power of healthy relationships</td>
</tr>
<tr>
<td>4.1</td>
<td>Ability to bring an outlook on peer support that inspires hope and recovery</td>
</tr>
<tr>
<td>4.12</td>
<td>Ability to facilitate and support a person to find and utilize resources</td>
</tr>
</tbody>
</table>
Review Homework

(10 minutes)

OBJECTIVE
To discuss the homework questions.

METHOD
1. Ask participants: “What are some steps that the certified peer specialist can take in the process of advocating?”
2. Ask participants: “What are some of the rights of peers seeking support?”
3. Ask participants: “What are the criteria in Wisconsin for involuntary commitment?”
Concluding the Peer Relationship

(90 minutes)

OBJECTIVE

To prepare for common experiences and emotions during the conclusion of the peer relationship and gain some practice.

METHOD

1. Read Concluding the Peer Relationship.

2. Large group brainstorm. Ask participants: “What might be some best practices for concluding the peer relationship.” Note the responses on a flip chart.

3. Read Best Practices in Concluding the Peer Relationship.

4. Large group discussion. Ask participants: “How do the practices you identified compare to the best practices here? Which ones are similar which ones are different?”

5. Facilitate a practice activity. This activity will be done in pairs. Instruct participants to find a partner. There are two roles for this activity: peer and certified peer specialist. Provide the following instructions.

   a. Peer – This is our last class and now you will have an opportunity to reflect on our time together, your experiences, what you have learned or anything you would like to discuss. This is not a role-playing, but a real play in which you will be yourself.

   b. Certified peer specialist – Your job is to use the identified best practices to practice having a concluding the relationship conversation. Be sure to listen carefully. Try to offer more reflective listening statements than questions. Look for strengths and affirm, in other words, use your OARS skills.

Tell participants: “Do not switch until I call time. We will go for 10 minutes. I will provide a one-minute warning for the certified peer specialist person to offer a concluding summary.” Go 10 minutes. Switch roles. Reiterate instructions. Go for another 10 minutes.

6. Large group debrief of the practice activity. Ask participants: “What was that conversation like for you?” “What came up in the peer role?” “What came up in the certified peer specialist role?”

7. Demonstration. Ask a participant to continue the concluding conversation in front of the group. Demonstrate OARS skills and best practices in having this conversation. Go for no more than 10 minutes, then facilitate a large group debrief.
Concluding the Peer Relationship

Although concluding the peer relationship happens at the end of peer support services, the process begins long before a specific end date. To conclude the peer relationship in a positive and supportive manner, certified peer specialists should consider the following:

- Agencies have guidelines for the duration of peer support services. The approximate duration of services is sometimes known from the start, for example, a few months in a crisis stabilization program or around one week in peer-run respites. It is important that a certified peer specialist clearly communicate guidelines about duration of services.

- If the guidelines are open-ended and flexible, duration of services is an important topic for exploration. The mutual nature of the peer relationship means that the peer's wishes and desires for continuing (or not continuing) in services is the priority; the certified peer specialist also gets to consider their own boundaries and capacity for continuing the relationship.

- Many certified peer specialists are expected to define, monitor, and report service goals and progress as a part of funding requirements. This can present a challenge and an opportunity for advocating with the peer to continue services.

- Sometimes an abrupt end to services can occur, such as a significant life event or change in priorities and time commitments.

Eventually it will be time to say goodbye. Because of the unique relationship created in peer support, saying goodbye can bring forth a range of experiences and emotions for the peer and the certified peer specialist. While every individual will have a unique experience, consider the following:

- Certified peer specialist
  - It can be difficult to conclude a close, good working relationship: you witnessed the peer’s personal growth in an intimate way; the peer may have started or continued in their recovery with your support; you may have learned quite a bit about yourself personally and professionally.
  - Normal emotions include sadness, but also feeling excited, hopeful, and joyful. It is important to be self-aware of emotions.
  - If concluding the relationship is based on a peer’s resurgence of struggles (example: hospitalization), this can be disheartening. Yet, it is important to remember that recovery is a non-linear, ongoing process.
Engage in self-care and turn to your own supports, as needed. It is important to be fully present and emotionally available to the peer during the conclusion of peer support.

- Peers
  - It can be difficult for peers to say goodbye after such an effective and supportive relationship. For some, the certified peer specialist is the first professional in the system who valued their input, worked with no judgment, and honored their voice and choice.
  - Strong emotions can emerge such as grief and loss, abandonment, uncertainty, and anger.
  - There can be a sense of satisfaction, gratitude, and excitement for next steps.
Best Practices for Concluding the Peer Relationship

- **Be proactive.** Raise the topic for discussion weeks before the final meeting.

- **Be curious.** Draw out the peer’s emotions and experiences as the relationship is concluding. Prepare two or three open questions to explore:
  - What is it like having this relationship end? What are your thoughts and feelings?
  - What did you gain from this experience? What did you learn? In what ways did you grow?
  - What are you looking forward to? What are your hopes for the future?

- **Listen for understanding.** Listen carefully to the peer to understand feelings and experiences as the relationship draws to a close. Offer many reflective listening statements.

- **Do not take it personally.** While it is important to listen with empathy, healthy boundaries are also important. Some peers may become upset or shut down during the final meeting. Others may not even show up. The certified peer specialist’s healthy boundaries will help them not take these expressions by a peer personally.

- **Mutuality.** Although the priority is to understand the peer’s experience, it is okay to share your experience and emotions; it is okay to share your own learning and growth in this relationship.

- **Continued support.** Discuss ways that the peer can continue accessing supports such as community resources and natural supports. If another provider is to be involved, consider a warm hand-off for the transition.

- **Acknowledge.** Affirm the work that has transpired, notice changes, and identify strengths you have come to discover in the peer. Genuine, specific affirmations and acknowledgements will have a powerful impact.
Recap, Review, and Reflection

(60 minutes)

OBJECTIVE

To recap, review, and reflect on the course to bring closure and to build momentum for continued learning and next steps toward becoming a certified peer specialist.

METHOD

1. Recap the Wisconsin Certified Peer Specialist Employment Initiative with key points from Section 1. There was a parking lot created in Section 1 to note initial worries, concerns, and questions about the initiative and involvement in it. Revisit the parking lot to ensure that all worries, concerns, and questions are adequately addressed.

2. Ask participants to spend a few minutes reviewing the Overview of Certified Peer Specialist Practice, the processes, concepts, skills, and practice of peer support covered in this course.

3. Facilitate reflection on this training course.
   a. Ask participants to complete Reflection.
   b. Allow time for participants to find another participant to take turns reflecting on the course.
   c. Invite participants to share highlights of learning, key moments in the course, and what they are moving toward in large group discussion.
Next Steps

Congratulations! You have completed the Certified Peer Specialist Training Course, the first step in joining the certified peer specialist profession. Consider these next steps as you prepare to take the Wisconsin Certified Peer Specialist Certification Exam and enter the profession after earning your certification.

- Form individual study groups with some or all of your training peers in preparation for the state-approved certified peer specialist exam.
- Utilize virtually held study group sessions coordinated by the Wisconsin Certified Peer Specialist Employment Initiative.
- Sign up for information on exams, continuing education opportunities, job postings, networking, and other professional development opportunities by joining the Wisconsin Certified Peer Specialist Employment Initiative contact list: https://www.wicps.org/contact/
- Follow the social media accounts associated with the Wisconsin Certified Peer Specialist Employment Initiative for program updates and posts related to peer support as a profession:
  - https://www.facebook.com/wicps.org
  - https://www.linkedin.com/company/wicps
  - https://www.instagram.com/wicps/
- Participate in certified peer specialist communities of practice.
- Encourage your employer, once finding a job as a certified peer specialist, to seek out technical assistance from the Wisconsin Certified Peer Specialist Employment Initiative to improve the implementation of effective certified peer specialist services.
- Engage in skills development useful in the workplace not immediately related to the peer relationship (examples: event coordination, support group and stakeholder facilitation models, Microsoft Office, social media marketing strategy, website maintenance, effective adult education, supervision and leadership courses, implementation science, systems change and advocacy efforts, etc.).
- Learn about peer support projects and initiatives in other states and around the world.
Overview of Certified Peer Specialist Practice

This course has described the certified peer specialist practice in terms of the fundamental processes, key concepts, tools, and resources that inform practice.

<table>
<thead>
<tr>
<th>Fundamental Process</th>
<th>Description</th>
<th>Key Concepts</th>
<th>Tools and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecting</td>
<td>Connecting is task number one in every meeting. Establish the peer relationship, and then maintain a good working relationship.</td>
<td>• Self-awareness</td>
<td>• Practicing self-care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Benefits of the peer Relationship</td>
<td>• Connecting open questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strengths-based Recovery principles</td>
<td>• Look for strengths and affirm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Trauma-informed care</td>
<td>• Reflective Listening Cheat Sheet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Confidentiality</td>
<td>• Initial Meeting Checklist</td>
</tr>
<tr>
<td></td>
<td>Connecting is task number one in every meeting. Establish the peer relationship, and then maintain a good working relationship.</td>
<td>• Practicing self-care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Connecting is task number one in every meeting. Establish the peer relationship, and then maintain a good working relationship.</td>
<td>• Connecting open questions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Connecting is task number one in every meeting. Establish the peer relationship, and then maintain a good working relationship.</td>
<td>• Look for strengths and affirm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Connecting is task number one in every meeting. Establish the peer relationship, and then maintain a good working relationship.</td>
<td>• Reflective Listening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Connecting is task number one in every meeting. Establish the peer relationship, and then maintain a good working relationship.</td>
<td>Cheat Sheet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Connecting is task number one in every meeting. Establish the peer relationship, and then maintain a good working relationship.</td>
<td>Initial Meeting Checklist</td>
<td></td>
</tr>
<tr>
<td>Exploring</td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Exploring lived experience</td>
<td>• OARS skills</td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Substance use challenges and mental health</td>
<td>• Exploring open questions</td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Resilience and protective factors</td>
<td>• Look for strengths and affirm</td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Ambivalence</td>
<td>• Advantages and Disadvantages Worksheet</td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Multiple pathways to recovery</td>
<td>• Personal values card sort</td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• OARS skills</td>
<td>• Listening, revisited</td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Planning possibilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Brainstorming</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Sharing information and resources (Ask-Share-Ask)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Preparing Response to Anger Worksheet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Gentle refusal 3 steps</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explore how the peer experiences life currently, current and past efforts in recovery, areas of strength and resilience, concerns and challenges, and hopes and dreams for the future.</td>
<td>• Advocacy</td>
<td></td>
</tr>
<tr>
<td>Supporting</td>
<td>Powerful support is provided peer-to-peer to address a range of potential concerns. Support is provided based on the foundation of connection and exploration. There are professional boundaries and ethics that guide the practice of peer support.</td>
<td>• Supporting lived experience</td>
<td>• OARS skills</td>
</tr>
<tr>
<td></td>
<td>Powerful support is provided peer-to-peer to address a range of potential concerns. Support is provided based on the foundation of connection and exploration. There are professional boundaries and ethics that guide the practice of peer support.</td>
<td>• Multiple pathways to recovery</td>
<td>• Providing information (Ask-Share-Ask)</td>
</tr>
<tr>
<td></td>
<td>Powerful support is provided peer-to-peer to address a range of potential concerns. Support is provided based on the foundation of connection and exploration. There are professional boundaries and ethics that guide the practice of peer support.</td>
<td>• Difficult conversations (examples: suicide, self-harm, responding to anger)</td>
<td>• Sharing recovery story (Ask-Share-Ask)</td>
</tr>
<tr>
<td></td>
<td>Powerful support is provided peer-to-peer to address a range of potential concerns. Support is provided based on the foundation of connection and exploration. There are professional boundaries and ethics that guide the practice of peer support.</td>
<td>• Setting healthy boundaries</td>
<td>• Preparing Response to Anger Worksheet</td>
</tr>
<tr>
<td></td>
<td>Powerful support is provided peer-to-peer to address a range of potential concerns. Support is provided based on the foundation of connection and exploration. There are professional boundaries and ethics that guide the practice of peer support.</td>
<td>• Stigma, culture, power, privilege</td>
<td>• Gentle refusal 3 steps</td>
</tr>
<tr>
<td></td>
<td>Powerful support is provided peer-to-peer to address a range of potential concerns. Support is provided based on the foundation of connection and exploration. There are professional boundaries and ethics that guide the practice of peer support.</td>
<td>• OARS skills</td>
<td>• Advocacy</td>
</tr>
<tr>
<td>Planning</td>
<td>Planning is based on the peer’s desires, hopes, goals, and needs in recovery. Planning unfolds and evolves over time for ongoing peer support.</td>
<td>• Multiple pathways to recovery</td>
<td>• OARS skills</td>
</tr>
<tr>
<td></td>
<td>Planning is based on the peer’s desires, hopes, goals, and needs in recovery. Planning unfolds and evolves over time for ongoing peer support.</td>
<td>• Planning pitfalls and possibilities</td>
<td>• Planning possibilities</td>
</tr>
<tr>
<td></td>
<td>Planning is based on the peer’s desires, hopes, goals, and needs in recovery. Planning unfolds and evolves over time for ongoing peer support.</td>
<td>• Natural supports</td>
<td>• Brainstorming</td>
</tr>
<tr>
<td></td>
<td>Planning is based on the peer’s desires, hopes, goals, and needs in recovery. Planning unfolds and evolves over time for ongoing peer support.</td>
<td>• Sharing information and resources (Ask-Share-Ask)</td>
<td>• Sharing information and resources (Ask-Share-Ask)</td>
</tr>
<tr>
<td></td>
<td>Planning is based on the peer’s desires, hopes, goals, and needs in recovery. Planning unfolds and evolves over time for ongoing peer support.</td>
<td>• Best practices for concluding the relationship</td>
<td></td>
</tr>
</tbody>
</table>
Reflection

Take a few minutes to review and reflect on your learning experiences and respond to the questions below. You will be invited to share some of these reflections in a closing activity.

• What were your top three or four memorable or “ah ha” moments in this course?

• What were the most important aspects you learned about the practice of peer support? What was a specific process, activity, skill, or tool?

• What did you learn about yourself?

• What would you like to learn more about (personally, professionally)?

• What might be one or two next steps on the path to becoming a certified peer specialist?
Course Evaluation

(15 minutes)

OBJECTIVE

To provide facilitators with feedback on participant experiences in the course.

METHOD

1. Administer course evaluation. Ask participants not to write their name on the evaluation. Inform participants that you are interested in understanding their experience in this course and that you highly value feedback. Encourage participants to be as honest and specific as possible about likes and dislikes in the course and ways to improve it.

2. Collect course evaluations. Place them in an envelope. Submit the envelope to the certified peer specialist program manager at Access to Independence.
Wrap Up and Celebrate Success

(30 minutes)

OBJECTIVE

To encourage closure and celebrate success.

METHOD

1. Talk about celebrating successes as a practice of peer support to encourage people in their recovery.

2. Provide a certificate of course completion to each participant who successfully completed this course.