Wisconsin Peer Specialists

CERTIFIED PEER SPECIALIST TRAINING COURSE

Participant Guide

WISCONSIN DEPARTMENT of HEALTH SERVICES

P-02884ALP (08/2023)

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Section 1

This section sets the foundation for the training course. You take part in an introduction exercise and explore community learning considerations to support a sense of safety. A course overview is provided. The section also includes an exploration of the importance of self-care and community care.

Course Guide: Section 1 (3 hours 30 minutes)

105 minutes	Grounding and Acknowledgements, Introductions, Community Learning Considerations, and Practicing Self-Care and Community Care
15 minutes	Break
15 minutes	Course Overview
65 minutes	Practicing Self-Care and Community Care
10 minutes	Homework Assignment

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.2	Believes in and respects people's rights to make informed decisions about their lives
1.3	Believes that personal growth and change are possible
1.4	Believes in the importance of empathy and listening to others
1.5	Believes in and respects all forms of diversity
1.6	Believes in the importance of self-awareness and self-care
1.7	Believes in lifelong learning and personal development
1.10	Believes in the healing power of healthy relationships
1.11	Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery
2.5	Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.9	Knowledge of the impact of discrimination, marginalization, and oppression
3.3	Knowledge of scope of practice of a certified peer specialist
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
3.7	Knowledge of cultural competency
4.1	Ability to bring an outlook on peer support that inspires hope and recovery
4.2	Ability to be self-aware and embrace and support own recovery
4.3	Ability to problem-solve

Domain	Item Description
4.6	Ability to listen and understand with accuracy the person's perspective and experience
4.8	Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.10	Ability to foster engagement in recovery
4.11	Ability to locate appropriate recovery resources, including basic needs, medical, mental health, and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.12	Ability to facilitate and support a person to find and utilize resources
4.15	Ability to set, communicate, and respect personal boundaries of self and others
4.16	Ability to utilize own recovery experience and skillfully share to benefit others
4.17	Ability to balance own recovery while supporting someone else's

Grounding and Acknowledgments

(Core Competencies: 1.5; 2.5; 3.7)

The State of Wisconsin was founded in 1848 as the 30th state in the United States of America on the land of the Ojibwe, Potawatomi, Oneida, Mohegan, Ho-Chunk, Menominee, and Brothertown. Each of these sovereign nations has their own government, traditions, ceremonies, and culture. They survived with the principles of peer values, including the Grandfather Teachings: humility, honesty, truth, wisdom, respect, bravery, and love. These teachings cross cultural lines and are exhibits of community practices that have mentored several generations. It is in this spirit that we celebrate the diversity of our state and work for the opportunity for all to receive peer support.

Introductions

(Core Competencies: 1.4; 1.6; 1.10; 3.5; 4.2; 4.8)

- Who are you? (If comfortable sharing: What are your pronouns?)

- What does this course mean to you?

- How will participation in this course impact your community?

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

- Describe a safe environment that would enable you to go beyond your comfort zone. What does the group culture look like?

Course Overview

(Core Competencies: 1.7; 1.11; 3.3)

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 layered continually into subsequent sections for specific application and practice.

You are encouraged to take notes. Note taking is useful because it allows you to reference important learning moments later that 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.

Scope of the course

Peer support is a broad practice rooted in various communities, settings, and cultures. Peer support is also not a new practice. Peer support has existed as long as humans have been in community with one another, supporting each other through adversity while relating over common experiences.

Not every approach to peer support is professional in nature. Some people or communities engaging in peer support seek certification or professionalization of relational ways of being with and supporting others. This course presents the practice of peer support as it is recognized for the purpose of state certification in Wisconsin. It does not seek to invalidate other approaches or forms of peer support, even when those approaches go by other names.

Practicing Self-Care

(Core Competencies: 1.2; 1.6; 1.7; 2.5; 3.5; 3.7; 4.2; 4.6; 4.15; 4.17)

Providing peer support in a professional role can be emotionally complex and stressful. At times, it can be draining and depleting. Practicing self-care or nurturing community connection is critical for those offering peer support. To be effective, you must be able to show up present and attentive to another's need. 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 or nurture your community connection. How do you take care of yourself or connect with your community on a regular or daily basis? Please be specific.

Leaning into discomfort and brave space

In this course, real, sensitive, and delicate topics will be explored that can arouse strong emotions or present challenges. Various topics that will be explored include historical and collective trauma, supporting people considering suicide, diagnosis, the effects of stigma, systemic marginalization and oppression, and involuntary commitment.

If some of these terms are unfamiliar to you, an excellent glossary of terms related to equity is found at Racial Equity Tools: https://www.racialequitytools.org/glossary.

It will be important for participants and facilitators alike to actively lean into uncomfortable conversations and new perspectives. This part of the co-learning process is important in peer support. Earlier in this section, community learning considerations were explored to support a safer learning space. Now, it's time to ask the question, "Why do we want to support a sense of safety?" A physical sense of safety is vital to supporting participants and facilitators in taking risks, sharing with honesty and vulnerability, speaking up for their own and the group's collective needs, as well as courageously addressing missteps or conflict. This is called a brave space.

What are some ways that you can take care of yourself or intentionally connect with community while remaining actively engaged in learning through full participation?

Practicing Self-Care and Community Care

(Core Competencies: 1.3; 1.4; 1.6; 1.10; 2.5; 2.9; 3.5; 3.7; 4.1; 4.2; 4.3; 4.11; 4.12; 4.16; 4.17)

For certified peer specialists, self-care and community care help cultivate the ability to bring one's full presence and strengths to peer relationships in order to deliver highly effective professional services. Self-care and community care is a skill. Like any skill, develops through an ongoing learning process of self-reflection and engagement in community. Part of practicing is developing awareness of both self and others through listening, identifying feelings, and considering needs and unmet needs.

Exploring the importance of both self-care and community care

Certified peer specialists have long advocated for strengthening self-care in peer support work. All people benefit from taking responsibility for their own well-being in a variety of ways. Self-care can both feel pleasurable and like difficult work, as it is composed of a variety of components as diverse as people. Though self-care is important, the exclusive focus put on the importance of self-care has also contributed to feelings of isolation for certified peer specialists and a sense of alienation for those who are rooted in more collectivist cultures. Self-care alone tends to place the sole responsibility for one's well-being and resilience on the individual. Oftentimes, self-care is talked about in terms of activities, especially feel-good activities that can be part of the work of self-care. This approach ignores that much of what is described as self-care requires effort, time, and resources. In this context, it is also important to validate that self-care can even feel burdensome. On top of that, many people who

are systemically marginalized face barriers to traditional self-care approaches. Many are busy caring for others. People experiencing poverty may not have the resources to participate in self-care rituals. Those working multiple jobs don't have as much time available. Systemically marginalized communities are inundated with work, news, trauma, and activism. For these reasons, when we consider the central focus and value of full community participation for those with lived experience in peer support history, a shift to community care in certified peer specialist practice becomes necessary. Recovery and meaningful living happen in the context of community. For this reason, the following sections and activities will explore community care, and introduce a variety of skills and practices important for the peer support work ahead.

Importance of community

Community care recognizes that we don't all have equal access to time and money, which are the main resources required for care. It reminds us that as human beings, are interdependent. The third level of Maslow's Hierarchy of Needs is "a sense of belonging and love." We have a psychological need for intimate relationships and, for many of us, we depend on those relationships to meet our physiological needs. If you're able to practice self-care, that's great. Just don't forget about the people around you. No matter how privileged we are, we still need human connection. We still need to give and receive love. Here are five ways to shift your thinking to community care, considering the needs of your family members, friends, co-workers, neighbors, group members, and others you interact with on a regular basis.

- **Check-in regularly:** In many cultures, it's a norm to open conversations and even transactions with "How are you?". It's a question asked quickly and automatically, often without waiting for an answer. Instead of asking people how they're doing, clearly state that you're checking in with them. One way to do this is by saying, "Hi, I wanted to check in with you. How are you feeling?". If you know the person is particularly overwhelmed or having a difficult time, you may want to be specific. You can say: "Hey, I know you're working from home and taking care of your grandmother. How are you managing?" You can also ask people if they're finding time to do anything other than work. If you can't help, you can show moral support. If you're able to help, you can make an offer.
- **Empathize:** We sometimes experience similar circumstances. While socioeconomic status and demographics change the way we navigate these circumstances, there are universal elements to every challenge. Working with the same difficult co-worker, having no help with childcare, or being in quarantine, are all frustrating issues you may not be able to change—but you can talk about it. Empathy is not the same as dwelling on an issue, and it's not about feeling bad for someone. Empathy is understanding and feeling what someone else is feeling. It's a way to validate someone's thoughts and feelings and to let them know they're seen. Part of being in a community is acknowledging difficulties as much as we celebrate achievements. This makes it okay to experience both the ups and downs of being human.
- **Make a specific offer:** We can often intuit when other people are having a difficult time. When we're able, most of us like to

help. One of the failings of self-care is that it's difficult to pinpoint what you need when you need it the most. When someone says, "Let me know how I can help," we understand it as a kind gesture. Still, it often ends there because we're burdened with the self-assessment and solution-building process. A part of community care is assessing what others may need, offering to provide it, and following through when the offer is accepted. Instead of vaguely telling someone you're willing to help, anticipate their needs and make an offer. Ask if you can deliver a meal for their family, do their grocery shopping, fix the leaking sink, draft the email they're struggling to send, or create a playlist with feel-good music. If you're checking in regularly or you've spent time empathizing, you'll know what to do.

- **Prioritize rest:** It's easy to glorify busyness and celebrate accomplishments, but this often leads to imbalance. We need to be able to balance work with the rest of our lives and not use work as a distraction or escape from the challenges we face. Some stressed individuals may shift their attention to work, try to increase productivity, and seek a higher sense of self-worth through endless to-do lists. Communities can help prioritize well-being. Productivity, whether at work, in volunteerism, or at home, is often valued more than health and well-being. We unintentionally communicate that productivity is better than, and in competition with, rest. People need permission to take time off. That permission comes from their community. If you know someone is working 60 hours per week and they're showing up to volunteer for 10 hours, remind them that rest is not only possible, but necessary. Appreciate

their commitment but prioritize their well-being. You just might help prevent burnout. Employers can encourage staff to use personal time off, offer mental health days, and implement company-wide days of rest. Take a cue from the Astraea Lesbian Foundation for Justice. In response to the impact of COVID-19, they enacted a 15-day organization-wide pause. Similarly, the Equality Fund took two months of rest.

- **Socialize:** With so much going on in the world, we forget to just relax and enjoy each other's company. This is separate from checking in, empathizing, or doing acts of service for each other. It's important to have time together free from thoughts and conversations about the things that aren't going well. Watch great movies, check out the new restaurant in the neighborhood, choreograph a dance to the latest hip-hop hit, play a raucous game of Taboo, or take a class together. Much of this can be done virtually, too. Do something to keep you from watching or talking about the news. You may find a self-massage is just what you need to combat touch starvation. Use this time to be together as a community that's not bound together only by the struggles you share, but by your common humanity. Connection itself is reason enough.

We're responsible for each other

Even as we become more attuned to the needs of people in our communities and try to respond to them, self-care will continue to be necessary. We will still need to clean, feed, and clothe ourselves, make dental appointments, organize our kitchen pantries, see therapists (if that is part of our support system), drink water, and try to move our bodies more. Doing these things together and for each other creates a sense of belonging and builds the intimacy that's one of our basic needs. It reminds us that we weren't meant to walk these paths alone, but to learn from and care for one another as we find better ways to live together. The challenges will keep coming, but our communities have the resources to get us all through.

Work-life balance

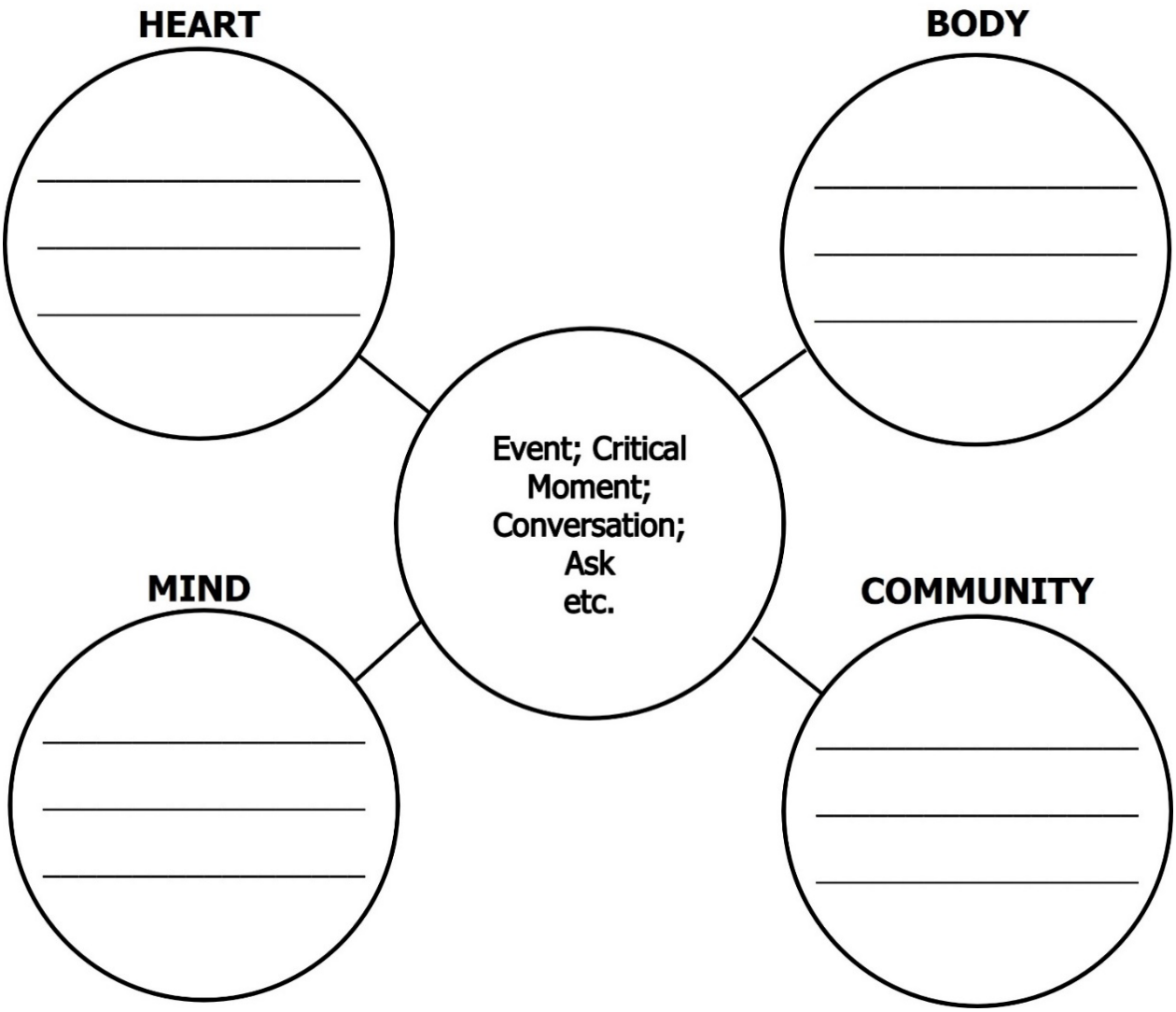
Finding a balance between the demands of work and personal life can be challenging. Certified peer specialists strive to be empathic people and care deeply for the people they support; leaving work behind may be difficult. However, an important aspect of self-care is finding a way to strike that balance, and self-care can include community spaces to decompress and find safety in. With hopes to show up fully in this work, caring for ourselves and finding people who we can find safety in allows a certified peer specialist to return to work more present, engaged, and effective in providing peer support.

Activity: Planning Around Self-Care and Community Care

Planning for self-care and community care can look however you want it to, but the point is to name your current or anticipated needs and who can support you in getting your needs met. Be sure to communicate your needs to the people who will support you. If your community is a web-based one, maybe create a private online shareable spreadsheet that folks can contribute to and edit. If your community isn't online, maybe set up an in-person group meeting, a conference call, or make individual calls or meetings.

When folks ask you for support, remember to listen and follow their lead in lifting their own self-determination. This is about the person requesting support, so don't make it about you. If you feel you can't meet a need, be clear and honest about that, and help strategize another way to meet that need. Folks experiencing or dealing with their own triggers, crisis, or trauma may or may not be able to support. Ask. Don't assume anyone is or isn't able to provide support. If you do commit to supporting the needs of community, you may also need support in meeting those needs, so consider creating a wellness plan for yourself.

FURTHER READING: "Breaking Isolation: Self-Care and Community Care Tools for our People", The Audre Lorde Project, https://alp.org/breaking-isolation-self-care-and-community-care-tools-our-people)


HEART
BODY
Event; Critical Moment; Conversation; Ask etc.
MIND
COMMUNITY

1. **Needs** - What are the needs you can anticipate. Body - biological needs, physical needs Mind - emotional needs, needs for your thought process Heart - motivational needs, spiritual needs, how you stay grounded Community - needs from your social relationships, interpersonal needs, community support	2. Who can support these needs?

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.

Benefits to Peers	Benefits to Certified Peer Specialist

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 homework assignment examines the privileges we hold.

Instructions

Read 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 feel like it is not true, draw one mark signifying that you do not identify with that privilege. There will be a brief large group debrief during homework review.

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 must 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?

Review the Racial Equity Tools Glossary found at:
https://www.racialequitytools.org/glossary

Section 2

This section continues focusing on self-care and community 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 also includes information on culturally informed approaches to trauma, as well as trauma-informed care.

Course Guide: Section 2 (3 hours 35 minutes)

45 minutes	Homework Review
100 minutes	Stigma and Cultural Competency
15 minutes	Break
50 minutes	Trauma-Informed Peer Support
5 minutes	Homework Assignment

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.1	Believes that recovery is an individual journey with many paths and is possible for all
1.3	Believes that personal growth and change are possible
1.4	Believes in the importance of empathy and listening to others
1.5	Believes in and respects all forms of diversity
1.6	Believes in the importance of self-awareness and self-care
1.7	Believes in lifelong learning and personal development
1.10	Believes in the healing power of healthy relationships
1.11	Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery
2.2	Knowledge of mental health and substance use disorders and their impact on recovery
2.5	Knowledge that recovery and wellness involves the integrations of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.6	Knowledge of trauma and its impact on the recovery process
2.7	Knowledge of person-centered care principles
2.9	Knowledge of the impact of discrimination, marginalization, and oppression
2.10	Knowledge of the impact of internalized stigma and shame
3.3	Knowledge of the scope of practice of a certified peer specialist

Domain	Item Description
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interaction
3.7	Knowledge of cultural competency
4.6	Ability to listen and understand with accuracy the person's perspective and experience
4.11	Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.18	Ability to foster the person's self-advocacy and provide advocacy when requested by the person

Stigma and Marginalization Connected to Lived Experience

(Core Competencies: 1.1; 1.5; 1.11; 2.5; 2.6; 2.9; 2.10; 3.7; 4.6; 4.11)

The Merriam-Webster Dictionary defines stigma as a mark of shame or discredit. The definition offered for marginalization is to relegate to an unimportant or powerless position within a society or group.

Many people with lived experience of mental health or substance use challenges describe the negative and sometimes compounding effects of stigma and marginalization in relation to seeking wellness, recovery, and a sense of safety. The historical causes of such stigma and marginalization are debated widely among those who practice peer support in professional roles.

Alongside the lived experiences with stigma and marginalization related to mental health and substance use, the intersectionality of people's identities can add weight to carry as people navigate through health systems. When more than one part of a person's identity molds their experiences with obstacles and barriers, the path to recovery must include a wholesome look at all the pieces of a person that are impacted by stigma and marginalization, such as race, ethnicity, gender identity, sexual orientation, socioeconomic status, immigration status, etc.

As a certified peer specialist engages in their work and offers peer support, they center the humanity, validity, agency, and autonomy of the people they support. An empathic and compassionate approach, with mindfulness to a person's intersectional identities, can open a deeper understanding of another and solidify the immense value of sharing and listening to

one another's stories and experiences. This connection can aid a certified peer specialist in addressing the corrosive effects of stigma and marginalization connected to lived experience and the many components that contribute to these experiences.

Wisconsin efforts to address stigma

- Wisconsin Initiative for Stigma Elimination (WISE)
  - WISE is a coalition of individuals and organizations promoting inclusion and support for all affected by mental health and substance use challenges that 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.
  - To learn more about WISE, visit wisewisconsin.org.
- Wisconsin Voices for Recovery
  - 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.
  - To learn more about Wisconsin Voices for Recovery, visit wisconsinvoicesforrecovery.org.

Peer-based efforts to address stigma and marginalization connected to lived experience

The resources listed below are some examples of peer-based organizations that address stigma and marginalization connected to lived experience.

- Project LETS
  - Project LETS builds peer support collectives; leads political education; develops new knowledge and language around mental distress; organizes and advocates for the liberation of people with lived experience globally; and create innovative, peer-led alternatives to the current mental health system.
  - To learn more about Project LETS, visit projectlets.org.
- Wildflower Alliance
  - The Wildflower Alliance supports healing and empowerment for people and communities impacted by psychiatric diagnosis, trauma, extreme states, homelessness, problems with substances, and other life-interrupting challenges.
  - To learn more about Wildflower Alliance, visit wildfloweralliance.org

Culture, Power, Privilege, and Peer Support

(Core Competencies: 1.3; 1.5; 1.6; 1.11; 2.6; 2.9; 2.10; 3.5; 3.7; 4.6; 4.18)

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 mental health and substance use challenges are experienced, understood, and expressed.

What is power?

Power is often understood as the ability to affect change and control or direct others.

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.

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. These roles include intentionality with unpacking personal implicit biases and advocating for culturally relevant resources.

When certified peer specialists provide peer support, they must recognize that each person's intersectional identities are unique to themselves, even among people who may come from similar backgrounds. The assumption that people of similar backgrounds are a monolith is harmful, and the intention to educate oneself of this experience is critical to reducing harm in the peer relationship. Additionally, education on the systemic barriers a peer experiences is needed to fully grasp the hindrance a peer has endured when receiving resources or individualized support. This deeper understanding provides a certified peer specialist an awareness to truly meet a peer where they are at in their journey.

An effective certified peer specialist will approach each person they support with as much education as empathy to create true mutuality. Taking this into consideration, any information shared by the peer must be reflected in the adjustments made to the support provided.

Exploring culture

Certified peer specialists will support people who have different cultural identities, worldviews, norms, beliefs, and values. The mental health and substance use services system, including certified peer specialists, are working toward providing services in a manner that take everyone's own culture into account. This is advocacy and accountability.

Certified peer specialists must be familiar with how areas in the cultural iceberg (below) interact within and among individuals.

CULTURAL ICEBERG

Surface culture

Food, flags, festivals, fashion, music, art, games, dance, crafts, performance, literature, celebrations, language

Deep culture

Communication styles and rules…facial expressions, gestures, eye contact, touching, personal space, tone of voice, body language, handling and displaying emotion, conversational patterns in different social situations

Notions of…courtesy and manners, friendship, leadership, cleanliness, modesty, beauty

Approaches to…religion, courtship, marriage, raising children, decision-making, problem-solving

Attitude toward…elders, adolescents, dependents, rule expectations, work authority, cooperation vs. competition, relationships with animals, age, sin, death

Concepts of…self, time, past and future, fairness and justice, roles related to age, class, family

An important aspect of understanding how these cultural elements may impact providing peer support is for certified peer specialists to understand 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, also known as systemic racism, refers to the systems in place that create and maintain racial inequality.

VIDEO: "Feeling Critically to Understand Social Justice"
– Suthakaran Veerasamy, TEDxUWLaCrosse
https://www.youtube.com/watch?v=dHxUb2oXtEo

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.

FURTHER READING: "Healing Ethno-Racial Trauma in Latinx Immigrant Communities: Cultivating Hope, Resistance, and Action"
https://psycnet.apa.org/fulltext/2019-01033-005.html

Systemic oppression in mental health and substance use services

In addition to understanding culture and the ability to explore the lived experiences of the people who 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 systemically marginalized communities have experienced oppression due to the design of the mental health and substance use services system and the population for which they were created. This is not to say that each individual member of a systemically marginalized community has been personally harmed by service systems. The systems have led to oppression of

communities at large. When working with people who are members of systemically marginalized communities, certified peer specialists must recognize and understand how this oppression comes into play when navigating through the service systems.

The systemic oppression at play in the mental health and substance use services system can have an impact on systemically marginalized community members in many ways, for example:

- Invalidation and denial of the accuracy of one's insight and lived experience in service systems to a higher degree than their counterparts, also known as gaslighting.
- Misdiagnoses occur 3-4 times more in Black, Indigenous and People of Color (BIPOC) communities.
- People who are incarcerated have limited access to services of any kind, including proven effective approaches to care and treatment.
- The expectation that transgender people will thrive in therapeutic environments when sorted into services for a gender with which they do not identify.
- Indigenous communities being denied equal access to culturally specific and relevant supports.
- Lack of accessibility of services for communities experiencing disability, resulting in far fewer support and treatment options due to disability.
- The real and sometimes perceived threat of being deported if attempting to access services while undocumented.

Culturally Informed Approaches to Trauma

(Core Competencies: 1.4; 1.5; 1.7; 1.11; 2.2; 2.6; 2.7; 2.9; 2.10; 3.5; 3.7; 4.6; 4.11; 4.18)

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 various levels of systemic 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 Indigenous communities have experienced an adverse childhood experience.
- 76% of multiracial and Black individuals have experienced an adverse childhood experience.
- 66% of Hispanic and Latino individuals experienced an adverse childhood experience.
- 55% of white individuals experienced an adverse childhood experience.
- 39% of Asian individuals experienced an 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 systemically

marginalized identities in addition to 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.

Below is a chart showing some of the most common cultural mistakes about trauma 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.

Common Cultural Mistakes About Trauma	**More Culturally Sensitive Approach**
Assuming everyone who has experienced violence needs professional help.	Not assuming anything about a person and holding space for them to share their story. Educating oneself about the identities of a peer to better understand the intersections of their experiences.
Focusing on the most extreme instances of violence as the most damaging.	Allowing each person to define what aspects of their experience have been most traumatic and recognizing that this may change over time.
Assuming that violence is unusual, an aberration, and generally perpetrated by individuals.	Recognizing that violence is perpetrated by groups and institutions, not only individuals, and may be so common that people become desensitized to it.
Applying norms and standards of behavior without considering political and social context.	Recognizing that political and social oppression impacts a person's experience, and it affects priorities and values.

Common Cultural Mistakes About Trauma	More Culturally Sensitive Approach
Relying on DSM diagnoses or lists of trauma symptoms.	Recognizing that historical and racial trauma are not considered in the DSM but do contribute to the various responses that individuals do to express grief and loss.
Assuming one person's story represents the typical story for the group.	Recognizing that one person's story is just one person's story.
Inadvertently highlighting the stories of people that fit cultural stereotypes.	Providing opportunities for many people to share their stories and noticing what is unique; making sure many points of view are represented.
Assuming if people speak English, you do not need an interpreter or translated documents.	Recognizing that some topics are very difficult to talk about in anything other than a person's first language. Provide accessible resources for people to receive information.
Assume.	Approach with curiosity, avoiding assumptions.

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 outlook and experiences around power and privilege.
- Validating a person's experience with transparency, do not challenge their lived experience.
- Taking time to learn about a person's culture and background.
- Exploring all resources, including natural and culturally appropriate supports within the peer's community that are accessible for them to support their recovery.
- Staying accountable. Respond 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 with.

The Need for Trauma-Informed Care

(Core competencies: 1.10; 1.11; 2.6; 2.9; 3.3; 4.6)

Trauma is a near universal experience for people living with mental health and substance use challenges. 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. According to the U.S. Department of Health and Human Services Office on Women's Health, 85% to 95% 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. Certified peer specialists can reasonably expect that when working with a peer, lived experience will include trauma and the intersectional experiences of trauma.

Why care?

Certified peer specialists care deeply. Working alongside peers, certified peer specialists continue to grieve, cope, and heal with one another. To do so, certified peer specialists must bring their full selves to the work of peer support. This means holding great capacity for compassion and empathy; mindfulness to advocacy; and seeking to support recovery, health, and wellness. People with unhealed trauma and people who continue to experience systemic trauma regularly experience:

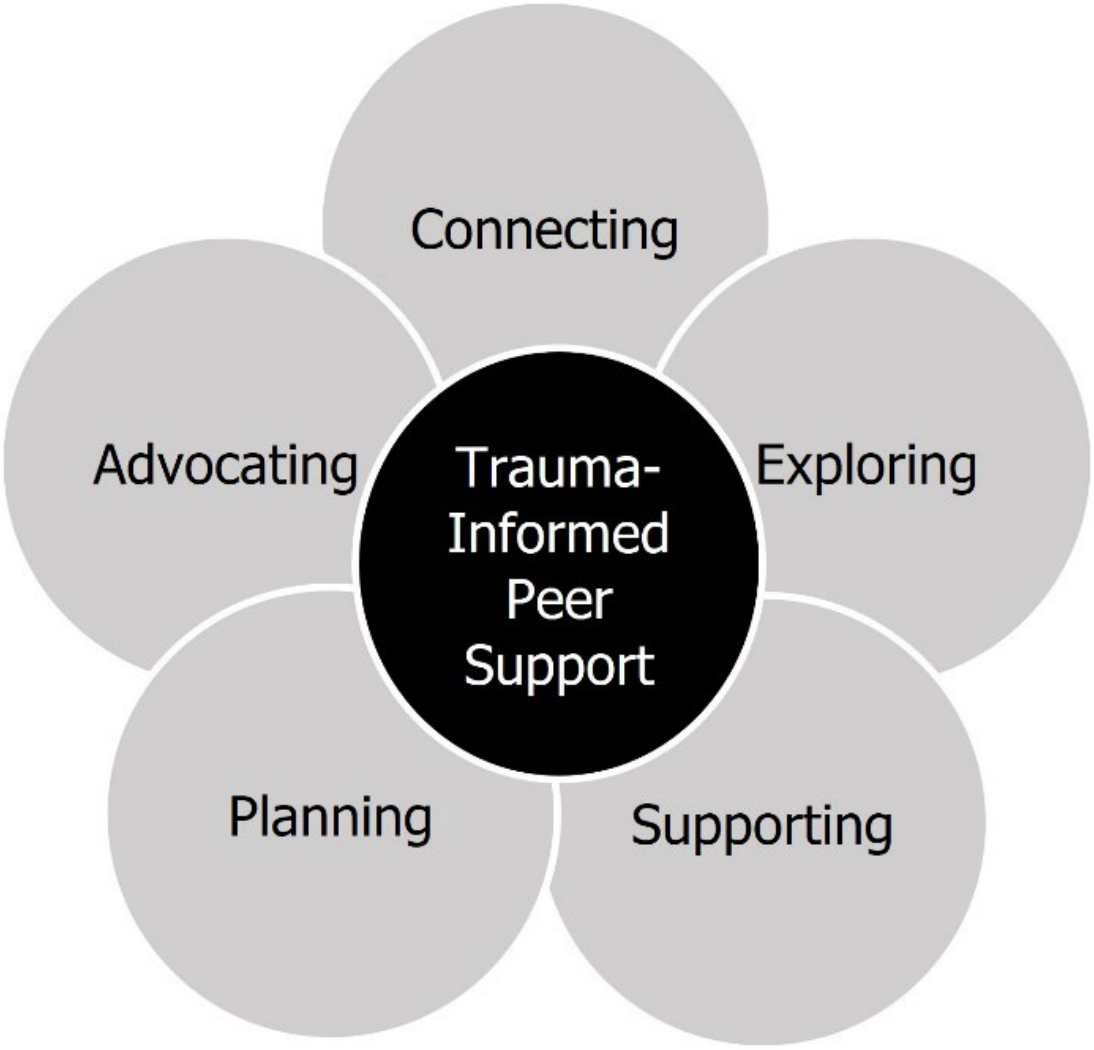
- A wide range of physical health challenges, disabilities, and chronic pain.
- Barriers to finding and keeping a job; living in stable housing.
- Urges to use substances to sedate, numb, and cope with the emotional pain of the past.
- Interpersonal relationships.

- Continuation of grieving and coping within systemic systems that are embedded with injustices.
- 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. **O**pen Questions, **A**ffirmations, **R**eflections, and **S**ummary (OARS) skills and self-disclosure are tools for effective communication in a trauma-informed approach.



These are the six key principles of a trauma-informed approach, according to the Substance Abuse and Mental Health Services Administration.

Safety

Trustworthiness and transparency

Peer support

Collaboration and mutuality

Empowerment, voice, and choice

Cultural, historical, and gender issues

VIDEO: "5 Tips for Being an Ally"
– Chescaleigh
https://www.youtube.com/watch?v=_dg86g-QlM0

Activity: Moving Toward Trauma-Informed Peer Support and Advocacy

This is a small group (two to four people per group) brainstorm activity. Work together to identify how trauma-informed processes, skills, and allyship can be applied to advocacy in peer support. 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

Review Questions

1. How does self-care and community care show up in your life? In what ways are they separate and in what ways do they connect? List examples.

2. Give examples of stigma and its impact on recovery. How can an awareness of stigma allow certified peer specialist to provide adequate support?

3. What have you learned about cultural humility? How can this be reflected in the support we provide as certified peer specialists?

Self-Survey – Part 1

Reflect on your skill level of these behaviors. This self-survey will not be collected.

Certified peer specialist has the ability and willingness to…	Not Skilled	Slightly Skilled	Pretty Skilled	Very Skilled
Recognize when one is feeling tired, angry, sad, etc.				
Be mindful of nonverbal emotional cues with an awareness that these can also be misunderstood (eye contact, facial expression, tone of voice, body posture, movement and gestures, rate of voice, etc.).				
Keep calm and stay present in situations of stress.				
Talk about personal history.				
Receive constructive feedback.				
Communicate without inducing fear, guilt, and shame.				
Set boundaries and articulate when they have been violated or invaded.				
Practice self-care and community care.				

Certified peer specialist has the ability and willingness to…	Not Skilled	Slightly Skilled	Pretty Skilled	Very Skilled
Discuss emotions while at work.				
Take time away from work to connect with people and activities.				
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.

Certified peer specialist has the ability and willingness to…	Not Skilled	Slightly Skilled	Pretty Skilled	Very Skilled
Identify, verbalize, and validate other's emotions.				
Engage with those experiencing overwhelming feelings.				
Think about behavior through the lens of curiosity ("how does this behavior make sense?" *or* 'what might have happened to this person that has led to this behavior?").				
Listen effectively while peers share emotionally painful events.				
Use nonjudgmental language when referring to peers.				
Point out strengths of others - what they do well, how they are resilient.				
Use of person-centered language, including language preferred by peer.				
Vent about feelings towards a peer by focusing on reactions vs. the peer behavior.				

Certified peer specialist has the ability and willingness to…	Not Skilled	Slightly Skilled	Pretty Skilled	Very Skilled
Understand why peers may not want to share information.				
Which skills do you wish to develop further? What is your first step to develop these skills?				

Section 3

This section begins with reviewing the "Wisconsin Certified Peer Specialist Code of Ethics" and an activity to allow you to practice navigating the certified peer specialist role. Resiliency and trauma are covered to provide a better understanding of protective factors and trauma. This section also includes information on the effects of disrupted neurodevelopment, trauma triggers, and reactions.

Course Guide: Section 3 (3 hours 30 minutes)

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

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.3	Believes that personal growth and change are possible
1.5	Believes in and respects all forms of diversity
1.6	Believes in the importance of self-awareness and self-care
1.9	Believes that recovery is a process
1.10	Believes in the healing power of healthy relationships
1.11	Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery
2.1	Knowledge of SAMHSA's definition of recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."
2.2	Knowledge of mental health and substance use disorders and their impact on recovery
2.3	Knowledge of the basic neuroscience of mental health and addiction
2.5	Knowledge that recovery and wellness involves the integration of the whole person, including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.6	Knowledge of trauma and its impact on the recovery process
2.9	Knowledge of the impact of discrimination, marginalization, and oppression
3.2	Knowledge of ethics and boundaries
3.4	Knowledge of confidentiality standards
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
3.7	Knowledge of cultural competency

Domain	Item Description
4.3	Ability to problem-solve
4.4	Ability to assist people in exploring life choices, and the outcomes of those choices
4.5	Ability to identify and support a person in crisis and know when to facilitate referrals
4.6	Ability to listen and understand with accuracy the person's perspective and experience
4.7	Effective written and verbal communication skills
4.10	Ability to foster engagement in recovery
4.13	Ability to work collaboratively and participate on a team
4.14	Ability to know when to ask for assistance and/or seek supervision
4.19	Ability to advocate for self in the role of a certified peer specialist

Activity: Ethics Practice

1. Fatima is currently going through a very difficult divorce. The strain of the divorce has resulted in sleep difficulties and significant weight loss. She is now concerned about her sobriety and mental wellness. What pieces of the code of ethics should be considered when supporting Fatima? What led you to choose this ethical practice?
2. Ricardo has worked as a certified peer specialist for more than a year and experienced a short relapse while attending a family event. Because the relapse 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, a veteran, has many assets that would qualify them as an excellent certified peer specialist. In interviewing them 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. They express considerable disdain for alternatives to Alcoholics Anonymous. What ethical issues could arise if Zia brought their biases in this area into their work as a peer specialist?
4. John's supervisor assigned a new person for him to visit in his role as a peer specialist. John recognizes the name as a person to whom he once bought drugs from in the past. Does John have a responsibility to report this to his supervisor? Why or why not?

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

6. Tasha, a Black woman, is a new certified peer specialist at a mental health center at which she has not received services. Tasha brought up concerns about some policies and practices. Her supervisor felt she was being aggressive and disrespectful by criticizing the way things are done. Tasha's supervisor proceeds to ask about her mental health issues and what medication she is on. The supervisor has asked Tasha to go over her Wellness Recovery Action Plan with her. Tasha does not feel this is relevant to discuss with her supervisor. What ethical issues come into play in this scenario?

7. Jin has been receiving peer support services from your agency for years. While you are grocery shopping, you see Jin's mom. She begins to ask how Jin is doing. What ethics or boundaries apply in this situation?

8. Dante is a formerly incarcerated peer being supported by a reentry certified peer specialist. During Dante's incarceration, he became deaf because of violence. Dante is working with his certified peer specialist to access supports around substance use. The team is saying only one recovery group will be appropriate for him because the agency finds it would be too expensive to add in American Sign Language interpretation services to the other addiction support groups. What ethical considerations are at play here?
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? What ethical considerations need to be taken?

Confidentiality

(Core Competencies: 1.11; 3.4; 4.5; 4.14)

Through the process of peer support, peers share 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 can 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 must 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

(Core Competencies: 1.11; 3.2; 3.5; 4.3; 4.7; 4.13; 4.14; 4.15; 4.19)

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. This provides an opportunity to advocate for peer values. 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, collective recovery orientation, while most human services agencies follow a medical model approach.

Conflict is an opportunity to educate and grow both professionally and personally. Because the certified peer specialist role is relatively new to the field, clarifying professional boundaries will 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. Through these discussions, challenging perceptions of the world also is critical to moving in a collective direction with co-workers.

In all these discussions, you can demonstrate skillful communication to model the practice. Use **O**pen Questions, **A**ffirmations, **R**eflections, and **S**ummary (OARS) skills to draw out various perspectives, affirm willingness and interest to engage discussion, and listen carefully with reflection (see Section 4). Provide information in a skillful manner (see Section 7). Use advocacy strategies (see Section 12).

You are never alone in these advocating conversations. Advocating for systemic or organizational change is inherently disruptive. It challenges current processes. Yet, this is necessary disruption to better meet people where they are at in their journey. Creating a community of system disruptors or challengers who understand and value our existence can prepare peers for these discussions. The certified peer specialist community is a space to begin building these connections. Your agency leadership can also reach out to the certified peer specialist program manager at the Wisconsin Peer Specialist Employment Initiative for questions or support.

Resiliency

(Core Competencies: 1.3; 1.9; 1.10; 2.1; 2.5; 2.6; 3.7; 4.4; 4.10)

Resiliency can be defined 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.

- **In relationships**: risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision. In this context, parental involvement is an example of a protective factor.
- **In communities**: risk factors include neighborhood poverty and violence. Here, protective factors could include the availability of faith-based resources and after-school activities.
- **In society**: risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity. Protective factors in this context would include hate crime laws or policies limiting the availability of alcohol.

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.

VIDEO: "How Childhood Trauma Affects Health Across a Lifetime"
- Nadine Burke Harris
https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en

FURTHER READING:

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

Understanding Developmental Trauma

(Core Competencies: 1.5; 1.6; 2.2; 2.3; 2.9; 3.5; 3.7; 4.6; 4.10)

Consumer activism and emerging science about brain development have contributed to a shift in how human services are provided. Services are much more effective when they are provided in a trauma-informed way or a way in which 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.

On the other hand, with the many injustices embedded into systems and repeated throughout American history, a person's survival can be rooted in behavior that protects them. They may be more passive, or they may be more expressive with their words and actions. They may engage in self-harming behavior or

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 and community 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 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 impacted by traumatic events. Certified peer specialists should avoid comparing people's experiences and responses to trauma.

Understanding Disrupted Neurodevelopment

Exploring the way human brains develop clarifies why adversity has such a long-lasting impact on a person.

VIDEO: "How Trauma Impacts the Brain: Reducing Stigma Around Addiction and Substance Use"
- Carleton University
https://www.youtube.com/watch?v=LNVShudqsTI

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,

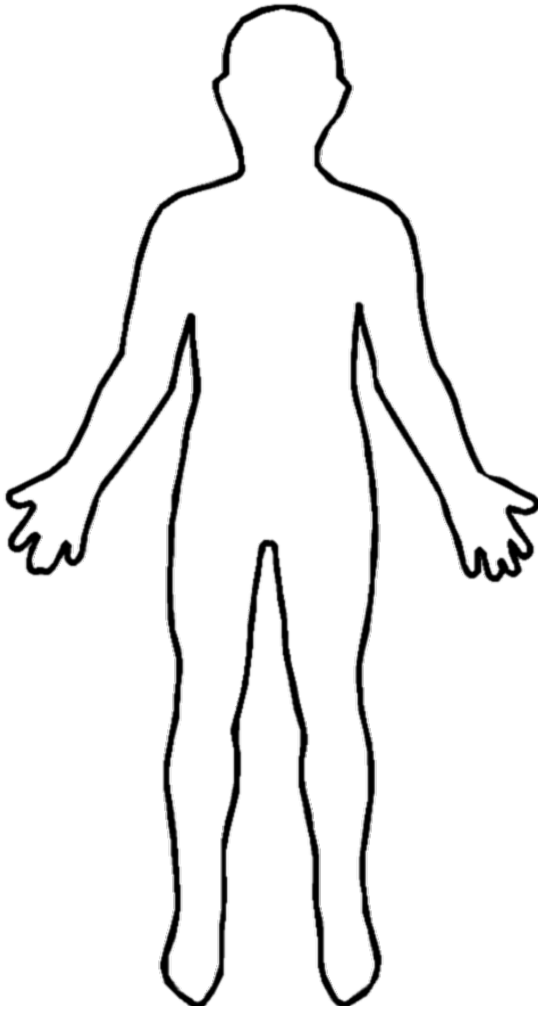
higher-order thinking skills, moral reasoning, speech, meaning making, and will power.

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 to survive. When a being experiences the fight, flight, or freeze response, over 1,400 physiological changes happen in its body.

FIGHT, FLIGHT, FREEZE RESPONSE

Noticeable effects

- Breathing fast and shallow
- Chest pains
- Heart pumps faster
- Hyperventilation
- Mouth goes dry
- Neck and shoulder muscles tense
- Pupils dilate



Hidden effects

- Adrenaline released
- Blood pressure rises
- Brain gets body ready for action
- Cortisol released
- Digestion slows or ceases
- Liver releases glucose

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. 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 a person's brain and body develops.

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 (law enforcement, social work systems, school systems, etc.); 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.

Review Questions

1. How does resilience show up in your story? Did you experience this as resiliency or a means of survival?

2. What are your protective factors?

3. How do you address your triggers? Do these behaviors still serve you?

4. How does resiliency play a role in the peer relationship?

5. How does your experience with resiliency guide your connection with peers?

Section 4

This section focuses on the core skills of the certified peer specialist. Referred to as OARS (**O**pen questions, **A**ffirmation, **R**eflective listening, **S**ummary), these skills provide the basis of an effective and non-violent communication style. These skills open space to support peers as they lead their life journey. This section first provides an overview of the skills. Next, each skill is highlighted with opportunities for discussion and practice.

Course Guide: Section 4 (3 hours 40 minutes)

10 minutes	Homework Review
15 minutes	OARS Communication Skills overview
20 minutes	Open Questions
40 minutes	Affirmation
15 minutes	Break
95 minutes	Reflective Listening
20 minutes	Summary
5 minutes	Homework Assignment

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.1	Believes in that recovery is an individual journey with many paths and is possible for all
1.3	Believes that personal growth and change are possible
1.4	Believes in the importance of empathy and listening to others
2.7	Knowledge of person-centered care principles
2.8	Knowledge of strengths-based planning for recovery
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
4.1	Ability to bring an outlook on peer support that inspires hope and recovery
4.4	Ability to assist people in exploring life choices and the outcomes of those choices
4.6	Ability to listen and understand with accuracy to the person's perspective and experience
4.7	Effective written and verbal communication skills
4.8	Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.9	Ability to recognize and affirm a person's strengths
4.10	Ability to foster engagement in recovery

OARS Communication Skills Description

(Core Competencies: 1.4; 2.7; 2.8; 4.1; 4.4; 4.6; 4.7; 4.8; 4.9)

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 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.

FURTHER READING: Miller W.R., & Rollnick, S. (2013). *Motivational Interviewing: Helping people change* (3rd edition). New York, NY: Guilford Press.

Open Questions (OARS) Skill Description

(Core Competencies: 2.7; 4.4; 4.6; 4.7; 4.8)

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.

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

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 (OARS) Skill Description

(Core Competencies: 1.3; 2.7; 2.8; 4.1; 4.6; 4.7; 4.9)

Certified peer specialists are strengths-based. This means certified peer specialists actively look for the strengths, positive attributes, and prior successes with recovery.

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. It is expressed as a "you" statement (not "I" statement).

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 incredibly brave for continuing to show up.
- 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 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	Determined	Inspirational
Analytical	Empathetic	Intelligent
Appreciative	Energetic	Kind
Artistic	Enthusiastic	Knowledgeable
Assertive	Fair	Motivated
Authentic	Flexible	Observant
Caring	Focused	Optimistic
Compassionate	Friendly	Open-minded
Communicative	Generous	Orderly
Considerate	Grateful	Organized
Courageous	Helpful	Outgoing
Creative	Honest	Patient
Curious	Hopeful	Peaceful
Decisive	Humble	Perseverant
Dedicated	Humorous	Persistent
Deliberate	Independent	Practical
Detail-oriented	Inquisitive	Precise

Problem-solver	Spiritual	Thoughtful
Quick-witted	Spontaneous	Trustworthy
Resourceful	Straightforward	Versatile
Respectful	Strategic	Warm
Responsible	Tactful	Welcoming
Self-controlled	Team-oriented	Wise

Strengths within myself:

_____ _____

_____ _____

_____ _____

Reflection (OA**R**S) Skill Description

(Core Competencies: 1.1; 1.4; 2.7; 4.1; 4.4; 4.6; 4.7; 4.8; 4.9)

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 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.

1. Listen carefully and hear what the peer is saying.

2. Make an educated guess about the peer's underlying meaning.

3. Share your educated guess as a concise listening statement.

FURTHER READING: Miller W.R. (2018). *Listening well: The art of empathic understanding*. Eugene, OR: Wipf & Stock.

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
    - You must face up to reality.
    - You must do something about this situation.
2. **Warning**: pointing out the risks or dangers of what a person is doing
    - If you do, you will regret it.
    - You must stop or else!
3. **Advising**: making suggestions, providing solutions
    - Here is what I would do if I were you…
    - Have you thought about…
4. **Persuading**: providing reasons or attempting to convince with logic
    - It is the right thing to do and here is why…
    - Now let's think this through. The facts are…

5. **Agreeing**: taking the person's side, approving, praising
    - Yes, you are right.
    - That is exactly what I would do.
    - Good for you!
6. **Analyzing**: explaining what the person is doing or saying
    - Do you know what the real problem is?
7. **Probing**: asking questions to get information or to gather facts
    - When did you first realize that?
    - What makes you feel that way?
8. **Reassuring**: consoling people
    - Everything will be okay.
    - This will work out.
9. **Sympathizing**: feeling pity or sorrow for people
    - I am so sorry to hear this.
    - I am sad about your situation.
    - Well, at least it is not as bad as _____.
10. **Distracting**: using humor, changing the subject, or withdrawing
    - That reminds me of this joke…
    - 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 a roadblock to listening.

VIDEO: "Empathy"
- Dr. Brené Brown
https://www.youtube.com/watch?v=1Evwgu369Jw&t

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 must face up to reality.
  - You must 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 must 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 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 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.

FURTHER READING: Miller W.R. (2018). *Listening well: The art of empathic understanding*. Eugene, OR: Wipf & Stock.

Activity: Reflection 2 – Strategies for Listening

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: Facilitators will pair participants with someone they not worked with yet and participants will 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 to be a fully present, attentive listener in providing peer support?
- Instructions for listener: Decide 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: you have listened carefully to understand the person's experiences and perspectives. Still, 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 decided 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 refection 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. You will never understand me.
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. I am so angry about everything that I must do to protect myself.
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 (OARS) Skill Description

(Core Competencies: 1.4; 2.7; 2.8; 3.5; 4.1; 4.4; 4.6; 4.7; 4.8; 4.9; 4.10)

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 another 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.

Activity: Summary

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.

Review Questions

1. What did you learn about yourself in these conversations?

2. Were you able to feel with or did you feel for?

Section 5

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 OARS and how it can be applied to this topic. There are practice exercises for OARS skills along with self-reflection.

Course Guide: Section 5 (4 hours 15 minutes)

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

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.1	Believes that recovery is an individual journey with many paths and is possible for all
1.2	Believes in and respects people's rights to make informed decisions about their lives
1.3	Believes that personal growth and change are possible
1.4	Believes in the importance of empathy and listening to others
1.6	Believes in the importance of self-awareness and self-care
1.7	Believes in lifelong learning and personal development
1.10	Believes in the healing power of healthy relationships
2.3	Knowledge of the basic neuroscience of mental health and addiction
2.5	Knowledge that recovery and wellness involves the integration of the whole person, including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.6	Knowledge of trauma and its impact on the recovery process
2.7	Knowledge of person-centered care principles
2.8	Knowledge of strengths-based planning for recovery
2.10	Knowledge of the impact of internalized stigma and shame
3.2	Knowledge of ethics and boundaries
3.3	Knowledge of the scope of practice of a certified peer specialist
3.4	Knowledge of confidentiality standards
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions

Domain	Item Description
3.6	Knowledge of appropriate use of self-disclosure
4.1	Ability to bring an outlook on peer support that inspires hope and recovery
4.7	Effective written and verbal communication skills
4.8	Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.9	Ability to recognize and affirm a person's strengths
4.10	Ability to foster engagement in recovery
4.12	Ability to facilitate and support a person to find and utilize resources
4.15	Ability to set, communicate, and respect personal boundaries of self and others
4.16	Ability to utilize own recovery experience and skillfully share to benefit others
4.18	Ability to foster the person's self-advocacy and provide advocacy when requested by the person

Overview of Certified Peer Specialist Practice

(Core Competency: 3.3)

On the next pages is a chart that provides an overview of the fundamental processes, key concepts, and tools that inform the certified peer specialist practice.

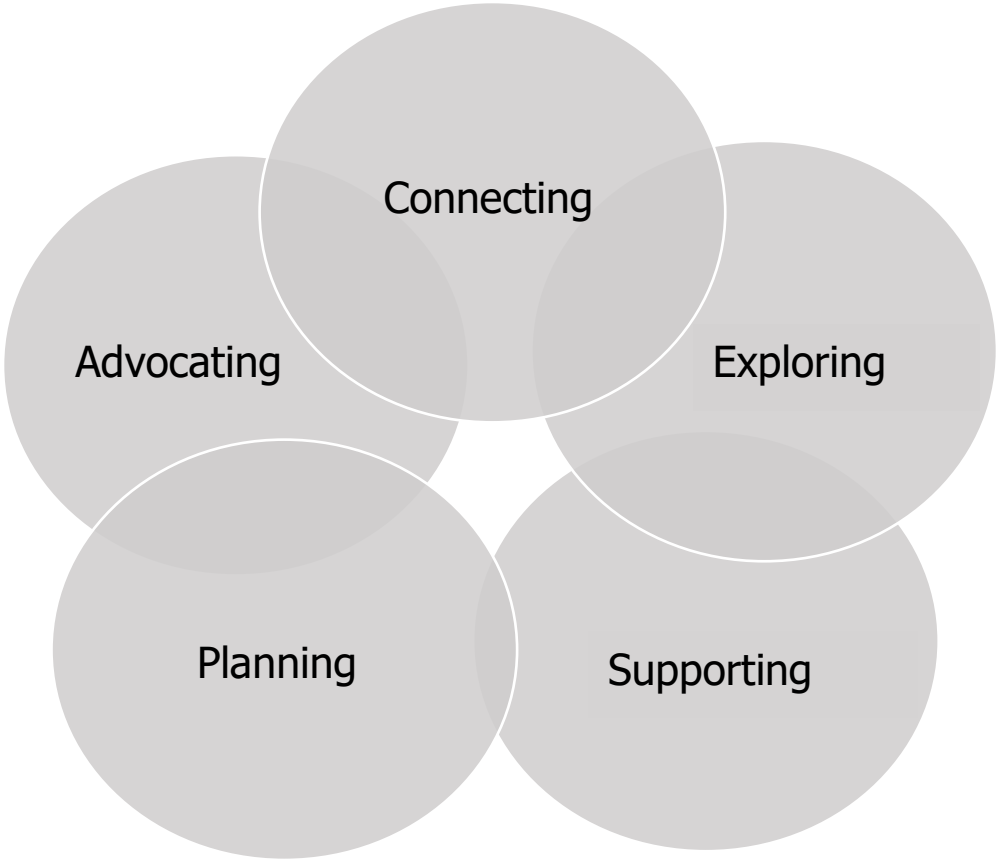
Fundamental Process	Description	Key Concepts	Tools and Resources
Connecting	Connecting is task number one in every meeting. Establish the peer relationship. Maintain a good working relationship.	• Self-awareness • Benefits of the peer relationship • Strengths-based recovery principles • Trauma-informed care • Confidentiality	• Practicing self-care and community 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* • Exploring values • Listening, revisited

Fundamental Process	Description	Key Concepts	Tools and Resources
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

Fundamental Process	Description	Key Concepts	Tools and Resources
Advocating	Advocating is done with peers for change in workplace and change in service systems. Advocacy honors the value of certified peer specialists, the wishes of peers, and centers the supports needed for harm reduction.	• Advocate with peer • Advocate for professional needs in workplace • Advocate for certified peer specialist role and supports • Advocate for systemic change • Advocate for intentionality in integrating diversity, equity, and inclusion in all spaces	• OARS skills • Connect with resources and others with shared values • Applying understandings of culture, power, and privilege • Exploring values • Brainstorming • Collaboration and fostering connections through organizing advocacy efforts

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 informed changes and decisions to enhance their lives.
- Certified peer specialist practice is grounded in four fundamental processes: connecting, exploring, supporting, and planning. These processes are ongoing, flexible, dynamic, and intersect in many 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 people 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 with formal training in the peer specialist practice of mental health and/or substance use recovery who has passed the certified peer specialist exam.
- The certified peer specialist is an active member of the peer's treatment and recovery team, when working in clinical settings. 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 the process of advocating on five unique levels. They advocate for peer's individual needs in a collaborative fashion led by the peer, for professional needs in the workplace, for clear understanding

and support for the certified peer specialist role, and for systemic change.

Principles of Strengths-Based Recovery

(Core Competencies: 1.1; 1.3; 1.7; 1.8; 1.9; 1.10; 1.11; 2.5; 2.7; 2.8; 2.10; 3.3; 4.1; 4.9; 4.10)

The traditional mental health and substance use services system is highly influenced by the medical model. The medical model focuses on diagnosis and treatment in order to maintain an individual's stability. The approach examines an individual's deficits, assesses symptoms, makes a diagnosis, and treats 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 everyone 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.** The certified peer specialist and peer work together to identify strengths for the peer to work towards achieving their hopes and dreams.
- **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. Cultures and communities are rich with resources and supports that benefit people seeking meaningful living, recovery, and connection. Acknowledging the embedded support systems in communities 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 difficult, or they express 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 place that is comfortable for the peer 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.

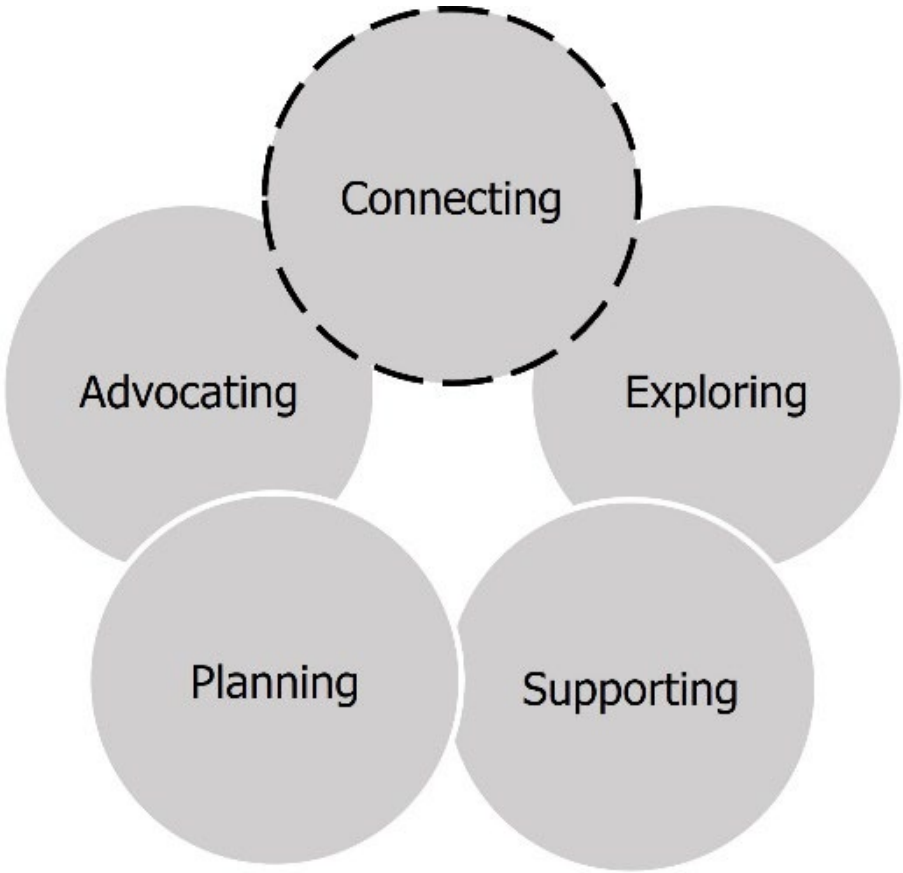
- **People continue to grow, learn, and change no matter the challenges they may face.** The strengths-based recovery approach is oriented around building on the peer's existing strengths to work towards the goals they would like to achieve in their lives.

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.

The Connecting Process

(Core Competencies: 1.1; 1.3; 1.7; 1.8; 1.9; 1.10; 1.11; 2.5; 2.7; 2.8; 2.10; 3.3; 4.1; 4.9; 4.10)

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 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 some peers. With other peers, connecting will take weeks or months. There is no timeline for connecting. A good working relationship must be established as the foundation for future exploring, supporting, planning, and advocating.



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 to 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

(Core Competencies: 1.3; 1.4; 1.9; 1.10; 2.6; 2.7; 2.8; 2.10; 3.5; 4.12; 4.16)

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.

Potential Trauma Impacts on Worldview, Perspectives, and Life Experiences	**Connecting Process of Peer Support**
Mistrust, no one is safe, no place is safe. Expect danger and crisis.	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.
Negative self-talk, negative self-worth, experience of fear, pessimism about the future.	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.

Potential Trauma Impacts on Worldview, Perspectives, and Life Experiences	Connecting Process of Peer Support
Experience of hopelessness, powerlessness, lack of confidence, and difficulties initiating change.	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. This contributes to empowerment. Ongoing peer support builds momentum for positive change. Small steps and accomplishments are affirmed and celebrated. Small steps lead to more steps and accomplishments.

Initial Meeting

(Core Competencies: 1.2; 3.2; 3.3; 3.4; 3.5; 4.8)

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 OARS skills

Use 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. This approach may have its advantages at times and in various settings. However, opening with casual chat and small talk can at times have the unintended effect of promoting some initial disconnection. Remember, the first part of listening is making the decision to listen. Listen to the peer, reflect understanding, and let them guide the nature of the initial conversation.

Mention any limitations or service duration

Your 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, outlining what is held in confidence and the limits of confidentiality informed by the *Wisconsin Certified Peer Specialist Code of Ethics* and your employer's policies and procedures. Ask the peer what they understand about confidentiality. 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

(Core Competencies: 1.2; 1.10; 2.5; 2.7; 2.8; 3.2; 3.3; 3.4; 3.5; 3.6; 4.8; 4.9; 4.10; 4.12; 4.15; 4.16; 4.18)

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

Connecting

- Provide a brief introduction of yourself, the certified peer specialist role, and any limitations of service duration.
- Make the decision to listen carefully; notice any 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. Confidentiality discussion: Explore confidentiality in the peer relationship.
    - 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 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 your 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 7).
    - 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.

Advocating

- Engage in information-gathering, research, and exploring with open questions to understand the situations where advocacy is needed more fully.
- Advocate alongside the peer rather than taking the lead as the certified peer specialist (co-advocacy).
- Center an informed-consent approach when co-advocating (exploring advantages and disadvantages of advocacy strategies).
- Explore the impacts of culture, power, and privilege as well as influential people or decision-makers who may impact advocacy efforts.
- Continue to connect with the peer throughout the advocating process (connecting is the first process of certified peer specialist practice and advocating can strengthen this connection).
- Explore the barriers the person faces and what they want to see changed.
- Expand on the planning process to also address those barriers through advocating.

OARS Skills Observer Sheet

(Core Competency: 4.7)

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.

Watch for…	**Count (hash mark)**	**Note examples**
Open question What… How… Describe… Tell me about…		
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*		

Watch for…	Count (hash mark)	Note examples
Reflections (complex) Paraphrase Double-sided Feeling Metaphor Coming alongside Continuing the paragraph		
Listening roadblocks Advising Agreeing Reassuring Sympathizing		

OARS Measures and Calculations

(Core Competency: 1.7)

Based on the *OARS Skills Observer Sheet*, OARS communication skills demonstrated in the certified peer specialist role can be readily assessed. Some certified peer specialists using OARS may find a more structured support useful in their practice. The table below identifies how to calculate OARS practice in conversations. Count hash marks in each category and use the calculation guidelines below to calculate practice results, then enter those results for each measure in the space provided.

OARS measure	Calculation	Benchmark	Result
% of open questions	# Open questions / total # questions	70% or more	
% of complex reflections	# Complex reflections / total # reflections	50% or more	
Ratio of reflections to questions	total # reflections / total # questions	1.0 or more	
Number of affirmations	# of affirmations	1 or more	

When using this tool, it is important to remember that it will take time and practice to use these skills to a level that feels natural. During this process, continuing to connect and communicate with peers. Make the active decision to listen during interactions. Specific benchmarks are provided 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 question there is, on average, one reflection. Advanced practice is a ratio of 2.0, that is, for every 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.

FURTHER READING: Miller W.R. (2018). *Listening well: The art of empathic understanding*. Eugene, OR: Wipf & Stock

Review Questions

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

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

Section 6

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.

Course Guide: Section 6 (3 hours 30 minutes)

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

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

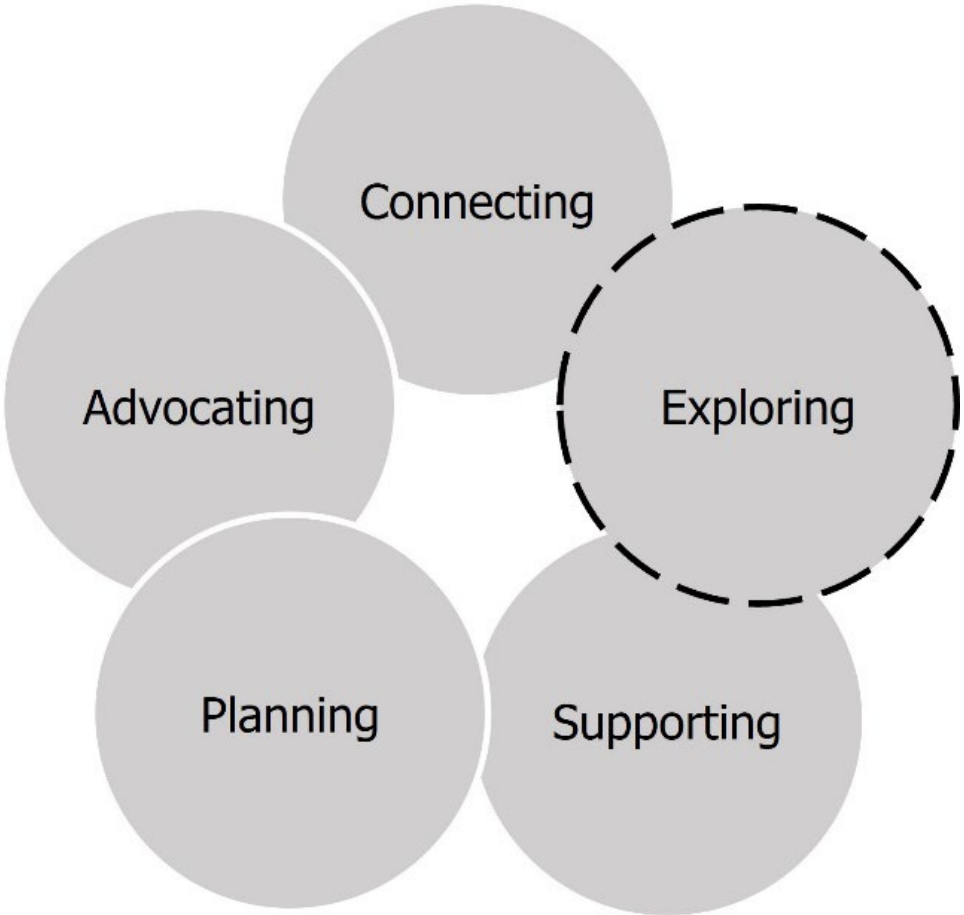
Domain	Item Description
1.1	Believes that recovery is an individual journey with many paths and is possible for all
1.2	Believes in and respects people's rights to make informed decisions about their lives
1.4	Believes in the importance of empathy and listening to others
1.5	Believes in and respects all forms of diversity
1.11	Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery
2.5	Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality, gender identity; and community
2.7	Knowledge of person-centered care principles
2.9	Knowledge of the impact of discrimination, marginalization, and oppression
2.10	Knowledge of the impact of internalized stigma and shame
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
3.6	Knowledge of appropriate use of self-disclosure
3.7	Knowledge of cultural competency
4.3	Ability to problem solve
4.4	Ability to assist people in exploring life choices and the outcomes of those choices
4.6	Ability to listen and understand with accuracy the person's perspective and experience

Domain	Item Description
4.8	Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.9	Ability to recognize and affirm a person’s strengths
4.19	Ability to advocate for self in the role of a certified peer specialist

The Exploring Process

(Core Competencies: 2.5; 2.7; 4.8)

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, community connections, cultural identity, and hopes and dreams for the future. The exploring process typically occurs once connection and the peer relationship are established. Exploration deepens trust and connection that creates the foundation for providing effective support.



The key OARS skill during the exploration process is the 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 course include:

- Decision-making regarding sharing personal story (Section 6)
- Values and what is most important in life (Section 6)
- Mental health and substance use lived experience (Section 8)
- Multiple pathways to recovery (Section 8)
- Natural supports (Section 8)
- Difficult conversations such as suicide and self-harm (Section 9)
- Stigma, culture, power, and privilege (Section 2)
- Spirituality and religion (Section 10)
- Advocating with the peer (Section 12)

In each of these topic areas, exploration will be considered.

Sharing Mental Health, Substance Use, and Recovery Challenges with Others

(Core Competencies: 1.2; 2.10; 3.5; 3.6; 4.3; 4.4; 4.8)

A certified peer specialist can explore with the peer whether 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.

The key concept here is ambivalence. Ambivalence is feeling two ways about something. On one hand, there may be reasons to share their mental health, substance use, and recovery challenges with others. On the other hand, there may be reasons to not share. When reasons for and against are held at the same time, this is the experience of ambivalence. Ambivalence is a normal experience, particularly, 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 offer the benefit of having others in the peer's life better understand their challenges and what might be helpful. The disadvantages are the reasons against making the decision. For example, deciding to share one's story could result in people

responding negatively after the peer has disclosed their struggles. 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

(Core Competency: 4.4)

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

_____

_____

_____

ADVANTAGES – What are the advantages or the positives for making this decision? What else?	**DISADVANTAGES –** What are the disadvantages or the negatives for making this decision? What else?

Summarize advantages and disadvantages.

Exploration question: So where does this leave you?

Listen carefully and reflect.

Exploring Values

(Core Competencies: 1.5; 2.5; 2.7; 4.6; 4.19)

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 navigate any clashes to deepen mutual understanding and connect with a peer?

- How might we be able to effectively support 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. https://sakai.ohsu.edu/access/content/group/Kathlynn_Tutorials/public/Value%20Card%20Sort%20Exercise%20-%20Storyline%20output/story_html5.html

Listening, Revisited

(Core Competencies: 1.1; 1.4; 1.11; 4.6)

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 in different roles or settings, the challenge for a certified peer specialist is to stay curious as a listener and to center connection in the peer relationship. The desire to problem-solve can unintentionally limit the peer's willingness to continue sharing or place the certified peer specialist in a perceived expert role.

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."

Activity: Circle Listening Practice

Instructions

The following activity designed will provide an opportunity to practice reflective listening. Time will be spent on practicing reflective listening only, and the *Reflective Listening Cheat Sheet* is available for reference. By the end of the activity, all participants will have offered reflective listening statements, practiced reflective listening only while avoiding listening roadblocks. Remember, this is not a role play or conversation. This is practicing a simple reflection followed by a complex reflection.

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 down 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. Those of you on the outside are 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 question. 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 for 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, 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

(Core Competencies: 4.1; 4.6; 4.9)

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 offered 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 from 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 to a peer fosters exploration because when feeling listened to, heard, and understood, people tend to open up and share more deeply.
- Listening well to a peer saves time because the certified peer specialist can more quickly grasp the essence of what the peer is attempting to communicate.
- Listening well to a peer can foster insights for them that they may not have otherwise experienced without a careful listener to reflect back potential underlying meaning.
- Listening well to a peer can help them to regulate strong emotions and to resolve conflict.

- Listening well to peer can help them to identify their inner strengths and resources.

Historical Context for Certified Peer Specialists

(Core Competencies: 1.5; 2.5; 2.9; 3.7; 4.19)

Prior to reviewing the timeline of *Systems Transformation and Western Consumer Involvement*, it is important to be grounded in what came before the timeline begins.

The skills and practice of peer support have been present in the Black, Indigenous, and people of color (BIPOC) communities long before the Wisconsin Peer Specialist Employment Initiative formed. The root of this initiative reflects the community care and collective support that has long existed as part of the culture of BIPOC communities.

Many cultures have found truth, safety, and courage in peer skills and support. Though embedded into their identities as people, the innate instinct to lean on community became a means to survive the systemic injustices being faced in the Western world. These injustices include the colonization of Indigenous land, the dehumanizing of Black and Brown bodies as slaves in the United States, and the near-wholesale abandonment of Indigenous people who were used as political and social leverage.

Additionally, other communities who have faced systemic marginalization or alienation have turned to community care and collective support, including mutual aid and peer support, as a means of survival long before the Wisconsin Peer Specialist Employment Initiative came into being. Some examples include survivors of institutionalization with lived experience of mental health and substance use challenges, LGBTQ+ communities in response to the AIDS crisis and widespread homophobia and

transphobia, as well as migrant communities and those facing visa insecurity or threat of deportation to name a few. In these examples, the systemic marginalization or neglect caused situations to arise where shared lived experience was the driving force of community connection, resilience, and emotional, as well as material, support.

Historical context for Wisconsin

The Wisconsin Department of Health Services (DHS) values diversity and recognizes a responsibility to support and meet the needs of people who have been systemically marginalized. Peer support is a way of providing care that is strongly rooted in diverse communities where individuals often face barriers to accessing services due to stigma, racism, and bias.

Peer support has grown from natural support systems (family and friends), into grassroots community systems. Today, it is a formal part of the mental health and substance use services system. It is also part of other systems of care.

Wisconsin has been a national leader in training and certifying peer specialists and parent peer specialists. Currently, there are two types of certified peer specialists in Wisconsin:

- A certified peer specialist or CPS is a professional who uses their personal lived experience of mental health and/or substance use to provide support to others and demonstrate that recovery is possible. A Wisconsin certified peer specialist has taken a state-endorsed training course and passed a state-approved exam.
- A certified parent peer specialist or CPPS combines knowledge gained from being a caregiver for a child with social, emotional,

behavioral, mental health and/or substance use challenges and training to increase their skills to support other caregivers of children with similar life experiences. A Wisconsin certified parent peer specialist has taken a state-endorsed training course and passed a state-approved exam.

DHS has long recognized the benefit of peer support.

- As of January 2023, there is a network of 11 state-funded peer recovery drop-in centers with eight locations focused on mental health and three locations focused on substance use.
- As of January 2023, there are six state-funded peer-run respites, including the only one in the nation that serves veterans.

State supported peer-run organizations work with people on ways to increase independence, employment options, and educational opportunities.

Timeline of Systems Transformation and Western 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: In Wisconsin, Training in Community Living, now known as the Program of Assertive Community Treatment (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 Wisconsin 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 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 Wisconsin administrative code that created Community Support Programs 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: 1993 Wisconsin Act 445 takes effect, with changes to client rights, mental health program certification, and the composition of community human service boards.

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: The Wraparound Milwaukee program is established with federal funds.

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

1996: 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.

1998: The Wisconsin Department of Health and Family Services develops the Recovery Implementation Task Force to advise work on implementing recovery-oriented services.

1998: The Wisconsin Department of Health and Family Services creates a consumer relations coordinator position.

1999: Larry Schomer, Barry Blackwell, and Joann O'Connor publish, "Consumer Staff in Psychiatric Inpatient Facilities."

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

2001: The Recovery Implementation Task Force publishes, "Recovery and Mental Health Consumer Movement in Wisconsin."

2002: Grassroots Empowerment Project begins to host its 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.

2004: 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 a recovery-oriented system of care. Over 250 peers around the state are interviewed by peers to collect the data that informed the tool's development.

2004: Nora Jacobson publishes, "In Recovery, The Making of Mental Health Policy," which highlights the Recovery Implementation Task Force.

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: More than 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 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 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 Department of Health and Family Services begins discussions to develop a certified peer specialist program.

2007: The consumer affairs liaison at the 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 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 Department of Health Services and a team of peers creates a speaker's 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 400 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 in Wisconsin 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 to decrease emergency room visits and hospitalizations and increase access to community services.

2011-2014: The 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, Comprehensive Community Services, and 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 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 Department of Health Services convenes a group of partners 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 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 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 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 Department of Corrections. People who are incarcerated can 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 Department of Health Services and Access to Independence work together to

revise the pilot integrated training model for certified peer specialists.

2019: The Department of Health Services awards funding for the nation's first peer-run respite for veterans.

2020: Wisconsin 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 Wisconsin 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 7

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 it is imperative to allow peers to define these for themselves. Exercises allow for self-reflection and practice using gentle refusal.

Course Guide: Section 7 (3 hours 40 minutes)

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	Homework Assignment

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

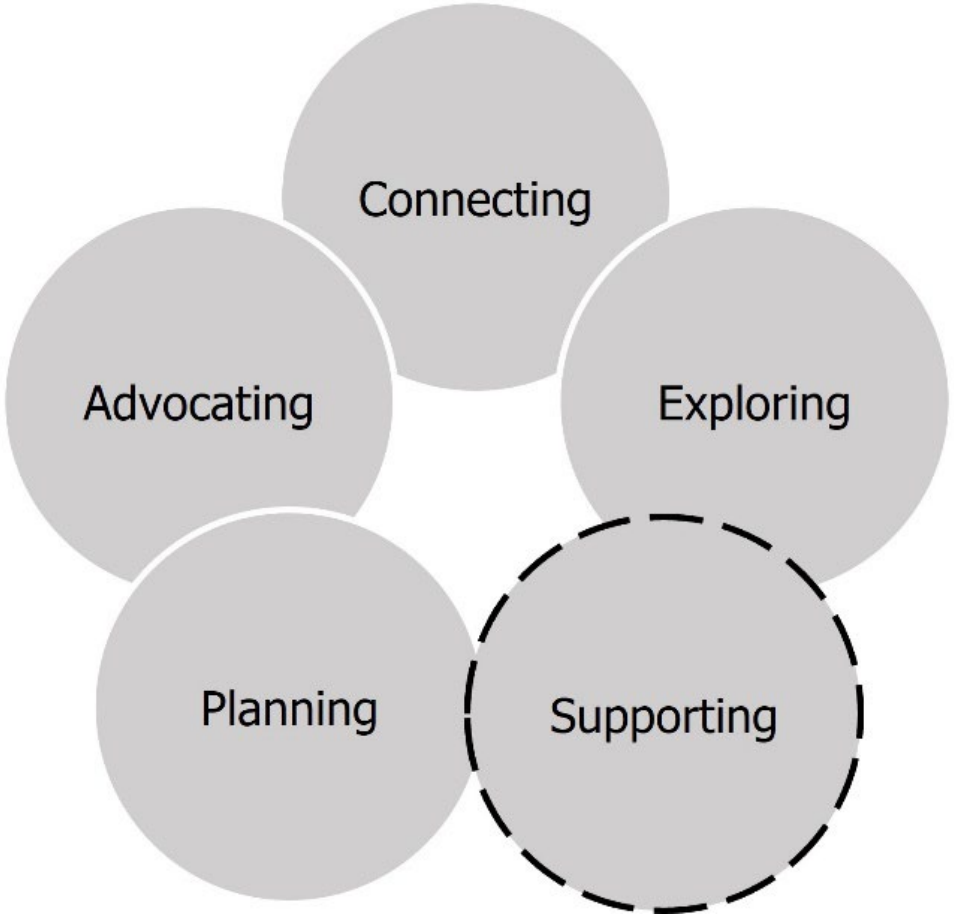
Domain	Item Description
1.2	Believes in and respects people's rights to make informed decisions about their lives
1.4	Believes in the importance of empathy and listening to others
1.6	Believes in the importance of self-awareness and self-care
1.10	Believes in the healing power of healthy relationships
2.6	Knowledge of trauma and its impact on the recovery process
2.7	Knowledge of person-centered care principles
2.8	Knowledge of strengths-based planning for recovery
3.2	Knowledge of ethics and boundaries
3.3	Knowledge of the scope of practice of a certified peer specialist
3.4	Knowledge of confidentiality standards
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
3.6	Knowledge of appropriate use of self-disclosure
3.7	Knowledge of cultural competency
4.1	Ability to bring an outlook on peer support that inspires hope and recovery
4.2	Ability to be self-aware and embrace and support own recovery
4.4	Ability to assist people in exploring life choices and the outcomes of those choices
4.5	Ability to identify and support a person in crisis and know when to facilitate referrals
4.9	Ability to recognize and affirm a person's strengths
4.10	Ability to foster engagement in recovery

Domain	Item Description
4.11	Ability to locate appropriate recovery resources, including basic needs, medical, mental health, and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.12	Ability to facilitate and support a person to find and utilize resources
4.14	Ability to know when to ask for assistance and/or seek supervision
4.15	Ability to set, communicate, and respect personal boundaries of self and others
4.16	Ability to utilize own recovery experience and skillfully share to benefit others
4.17	Ability to balance own recovery while supporting someone else's
4.18	Ability to foster the person's self-advocacy and provide advocacy when requested by the person
4.19	Ability to advocate for self in the role of a certified peer specialist

The Supporting Process

(Core Competencies: 1.4; 1.10; 2.6; 2.7; 3.4; 3.5; 3.6; 4.2; 4.4; 4.10; 4.16)

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.
    - What areas of your life are particularly stressful right now? [Exploring]
    - What might be some of the causes or sources of the stress? [Exploring]
    - What sorts of supports might be useful for addressing the stress? [Supporting]
    - 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 while acknowledging the impacts of social injustice 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 to 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. 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 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 heard, understood, and accepted.
- 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

(Core Competencies: 1.4; 1.10; 2.7; 2.8; 3.5; 3.6; 4.2; 4.4; 4.9; 4.10; 4.16)

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 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.** Information should be 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. Additionally, a certified peer specialist must always acknowledge the power dynamics of race, ethnicity, gender, sexuality, ability, etc., that shows up in the peer relationship.

Skillful sharing of information: Ask-Share-Ask

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 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.

Informing Skill		Note Example
Ask	□ Certified peer specialist asked about what peer already knows on the topic □ Certified peer specialist asked what peer would like to know OR asked permission to share information	
Share	Information shared was… □ brief □ clear □ in neutral tone	

Informing Skill		Note Example
Ask	□ Certified peer specialist asked for peer's understanding, interpretation, or response	
Listen	□ Certified peer specialist offered reflective listening statement □ Reflection seemed accurate	

Self-Disclosure

(Core Competencies: 1.10; 2.7; 3.2; 3.3; 3.5; 3.6; 4.1; 4.2; 4.10; 4.16; 4.17)

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?
- **Where does hope and connection appear in my recovery story?** A recovery story focuses on opportunities, overcoming barriers, strengths, resilience, health, and wellness that can promote hope and connection with the 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 would the peer 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 experiences and connections have had the most impact in your life?

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

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

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

(Core Competencies: 1.4; 1.6; 1.10; 2.6; 2.7; 3.2; 3.5; 3.7; 4.2; 4.5; 4.10; 4.14; 4.15; 4.17; 4.19)

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

Small group brainstorm:

- What do you already know about boundaries? How might it feel when you set them? How has it felt when others set them with you?

- Why might setting boundaries be important in a peer relationship? How can mutuality show up when you set these boundaries?

Understanding Boundaries

(Core Competencies: 1.2; 1.3; 1.4; 1.6; 2.6; 2.7; 3.2; 3.5; 3.7; 4.2; 4.10; 4.14; 4.15; 4.17)

A boundary can be the:

- Emotional and physical space between you and another person.
    - Emotional and physical space you need to be the real you without the pressure from others to be something that you are not.
    - 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.
- Clear sense of where you end, and another begins or where you begin and another ends.
    - 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.
- Limit or a 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.
- 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.

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

(Core Competencies: 1.4; 1.6; 1.10; 2.6; 2.7; 3.2; 3.5; 3.7; 4.2; 4.5; 4.10; 4.14; 4.15; 4.17; 4.19)

There are several reasons to consider setting healthy boundaries.

- **Compassionate people set boundaries.** Nurturing peer relationships where it is okay to set boundaries can foster safer relationships. People know where they stand. This can create some sense of transparency and safety. Setting boundaries also demonstrates self-care and allows greater capacity for empathy with others.
- **Boundaries help us to be present with our whole self**. If you do not set boundaries, you could be overextending yourself. You might be at risk for burnout. Boundaries allow us to have more sustainable and mutual relationships that mean you can 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 mutual relationship. It models setting healthy limits without rejection. It also makes others aware of the impact of their behavior. Healthy boundaries remind us of the respect we deserve, as well as the respect we must give others.

VIDEO: "Genograms – Boundaries & Collectivism (Bowen Family Systems)"
– Boontarika Sripom
https://www.youtube.com/watch?v=VN4tLMtQ9cE

How to Set Healthy Boundaries

(Core Competencies: 1.4; 1.6; 1.10; 2.6; 3.2; 3.5; 3.7; 4.2; 4.10; 4.15; 4.17; 4.19)

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 a gentle way those beliefs. The following provides some examples of limiting beliefs and gentle challenges.

Limiting Belief	Gentle Challenge/Self-Affirmation
I cannot say "no" to others.	I have a right to say "no" to others when harm is being done or disrespect for a person's or community's existence is perpetuated.
I have to be available to my peer no matter what.	I have a right to communicate boundaries to take care of myself.
I can never trust anyone again.	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 reduce any harm I may experience.
I would feel guilty if I did something on my own.	I know it is important to respect that I am part of a community and to do things that are uniquely mine so that I do not lose sense of my whole self.

Limiting Belief	Gentle Challenge/Self-Affirmation
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.	I deserve mutual respect and bodily autonomy. I have the right to address violations and injustices.
As long as I am not seen or heard, I will not be violated or hurt.	I have a right to be visible and to be seen and heard.
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.	I choose to stay present with my feelings when I am being treated in a harmful way so that I can be aware of what is happening to me and assertively protect myself from further violation or hurt. In this way, I show respect to myself and communicate what connection feels good to me.
I have been hurt badly in the past and I will never let anyone in close enough to hurt me again.	I choose to open myself to others in ways that feel nurturing, and I have the right to communicate my needs and boundaries.
I can never tell where to draw the line with others.	I make a commitment to listen with curiosity to myself and others, knowing that boundaries may change over time or throughout a relationship.

Boundaries and moral injury

Practicing self-care and community care as a certified peer specialist through setting boundaries (whether individually in one's own life or mutually with a peer) is central to effective peer support. This is necessary:

- To have capacity for compassion and empathy.
- To have equitable relationships which means more capacity for generosity.
- To have self-confidence, self-esteem, and self-respect.
- To attain mutuality in relationships.
- To get more of what is desirable and to get less of what is undesirable.
- To get control over our time, efforts, and life.
- To recognize when community with other certified peer specialists can be a resource.

Another reason for the certified peer specialist to set boundaries about what is and is not okay is to lessen the potential impacts of moral injury. 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. 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 the peer is 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.

Activity: Self-Reflection

Below are situations a certified peer specialist may encounter in their role (or in life, more generally). Select one situation and individually work through the questions below. Facilitators will give a one-minute notice before a large group debrief. Be ready to share responses with the group.

Select a situation:

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

(Core Competencies: 1.2; 1.4; 1.6; 2.7; 3.2; 3.3; 3.5; 4.5; 4.11; 4.12; 4.15; 4.18)

Gentle refusal is a form of boundary setting. It 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. Offer a reflective listening statement, if necessary, that demonstrates understanding. This will be important if you are unclear about the specific request.
- **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: Wow, I am really struggling financially right now. My paycheck was late. I don't know how I'm going to pay this utility bill. I need some help with this. I can pay you back.
- Certified peer specialist: You're really in a bind right now and are asking for a loan from me. [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. I know I'll be able to pay you back next month.
- Certified peer specialist: You are taking a big risk with me and it's hard to ask for help [Affirmation skill]. Unfortunately, I'm not comfortable lending money in my role [Step 2, gentle refusal]. I'd love to explore other resources with you that may be able to help [Step 3, invitation].
- Peer: I have no idea where to start.
- Certified peer specialist: I have some ideas that we could explore for accessing emergency resources. Are you interested in exploring this with me now? [Asking permission, Informing skill].

Activity: Gentle Refusal Practice

Each participant will have an opportunity to do a role-play with one of the facilitators by choosing a scenario below or a new scenario. The facilitators will play the role of the certified peer specialist while the participant will play the role of the peer.

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 one of the facilitators as your partner.

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. You were on this unit once and did not have a good experience. You told yourself you would never want to return.

Situation #3. A colleague and fellow certified peer specialist calls you at night. He says he needs to talk because he had an awful day. You really like this person. He has been a source of support for you, but you also had an awful day. You 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 they can borrow money because they are hungry. They usually bring a lunch, but they didn't today. They have never asked for money before.

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?

4. Think of a time that you were in a pre-contemplative or contemplative stage of change in your life. Write it down, we will be using it for real plays tomorrow.

Section 8

This section begins with background information on mental health and substance use diagnoses. It transitions to defining recovery then covers exploring and supporting lived experience. The misunderstanding of these experiences is discussed. Examples are given to solidify understanding. The section continues with activities that cover multiple pathways to recovery, ambivalence, and the stages of change.

Course Guide – Section 8
(4 hours 25 minutes)

5 minutes	Homework Review
30 minutes	Mental Health and Substance Use Diagnosis Background
45 minutes	Person-Centered Recovery
90 minutes	Exploring and Supporting Lived Experience
15 minutes	Break
50 minutes	Multiple Pathways to Recovery
25 minutes	Exploring Ambivalence
5 minutes	Homework Assignment

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.1	Believes that recovery is an individual journey with many paths and is possible for all
1.2	Believes in and respects people's rights to make informed decisions about their lives
1.5	Believes in and respects all forms of diversity
1.7	Believes in lifelong learning and personal development
1.8	Believes that recovery is a foundation of well-being
1.9	Believes that recovery is a process
1.11	Believes and understands there are a range of views regarding mental health and substance use disorder and their treatment, services, supports, and recovery
2.1	Knowledge of SAMHSA's definition of recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."
2.2	Knowledge of mental health and substance use disorders and their impact on recovery
2.4	Knowledge of stages of change and recovery
2.5	Knowledge that recovery and wellness involve the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.6	Knowledge of trauma and its impact on the recovery process
2.7	Knowledge of person-centered care principles
2.8	Knowledge of strengths-based planning for recovery
2.9	Knowledge of the impact of discrimination, marginalization, and oppression

Domain	Item Description
2.10	Knowledge of the impact of internalized stigma and shame
3.1	Knowledge of the rights of peers seeking support, such as state and federal law regarding client rights, civil rights, and the Americans with Disabilities Act (ADA)
3.3	Knowledge of the scope of practice of a certified peer specialist
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
3.7	Knowledge of cultural competency
4.4	Ability to assist people in exploring life choices, and the outcomes of those choices
4.6	Ability to listen and understand with accuracy the person's perspective and experience
4.8	Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.10	Ability to foster engagement in recovery
4.11	Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.12	Ability to facilitate and support a person to find and utilize resources
4.17	Ability to balance own recovery while supporting someone else's
4.18	Ability to foster the person's self-advocacy and provide advocacy when requested by the person
4.19	Ability to advocate for self in the role of a certified peer specialist

Mental Health and Substance Use Diagnosis Background

(Core Competencies: 1.1; 1.11; 2.2; 2.9; 2.10; 3.7)

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 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 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." This manual is used by psychiatrists and mental health clinicians to make a diagnosis based on an assessment of problem symptoms.

Consider the following perspectives on diagnosis from the medical model and peer support:

Differing perspectives on diagnosis

Medical model approach	Peer support approach
Assess problem symptoms and apply diagnostic criteria to categorize human experience.	Look for strengths and affirm. Listen to understand the peer's lived experience. Each person is unique.
Mental health clinician is the expert based on the possession of technical knowledge about human experience.	Peer is the expert on their own lived experience based on a lifetime of experience.
Diagnosis leads to reimbursement for treatment. Goal of treatment is to reduce symptoms, as well as support recovery, health, and wellness.	Lived experience informs both personal choices, as well as access to various options. The goal is to foster trust and mutual relationships to support recovery, health, and wellness.
Diagnosis is focused on assessment of pathology and experiences of distress. Treatment is understood to be aided by the patient's acceptance of diagnosis and following a given treatment plan.	Lived experience includes life lessons, wisdom, values, and strengths, as well as struggles and traumas. Drawing upon a strengths-based approach can have empowering effects. Supporting self-determination and honoring the perspectives of peers relating to their own lived experience, whatever they may be, is essential to recovery.

Medical model approach	Peer support approach
Diagnosis is shown in charting and billing documentation. Even old or inaccurate diagnoses can stay, impacting how people are treated in various settings.	Lived experience is understood to be dynamic and ever changing. Peer support is not centered in labels or diagnosis and seeks to reduce systemic harm in documentation practices.
Many people can have the exact same diagnosis.	No two people can have the exact same lived experience.
Rejection of diagnosis by a patient is generally viewed negatively by the clinician as resistance, being difficult, or as lacking insight.	Rejection of diagnosis by a peer is accepted without question in peer support because it is a person-centered approach consistent with the principle of self-determination.

Large group discussion:

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

- When people hold lived experience of systemic marginalization or oppression, how do you think they might be impacted by the medical model approach? What about in the peer support approach?

- After discussing the peer support approach to understanding diagnosis, how might this come naturally to you? What challenges might come up?

Defining Recovery

(Core Competencies: 1.1; 2.1; 2.7; 3.3)

Many definitions of recovery exist because recovery is a deeply personal process. Recovery is not only personal, but also impacted and informed by community and culture, as well as historical place and significance. To provide a general perspective, the Substance Abuse and Mental Health Services Administration or SAMHSA, 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
from SAMHSA's Definition of Recovery

Activity: Defining Recovery

Grab the sticky notes you completed during the solitary writing activity. Find the domain that best fits with each of your important aspects of recovery and post your sticky note or written reflection 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?

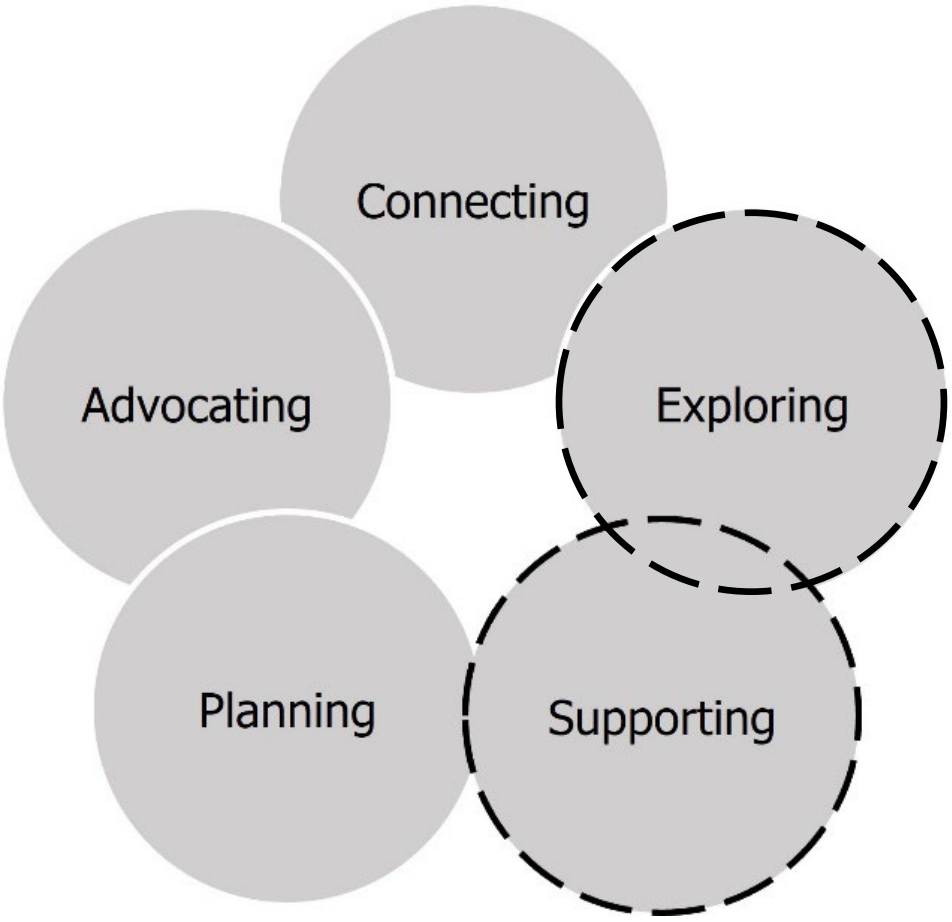
- How does our understanding of recovery seem to differ from these domains?

- 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?

Exploring and Supporting Lived Experience

(Core Competencies: 1.8; 1.11; 2.2; 2.7; 2.8; 2.9; 2.10; 3.3; 4.4; 4.6; 4.8 4.17)

The medical model features assessment of problem symptoms and application of criteria to diagnose a person's 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** from 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 can we better support someone who has never been involved with mental health or substance use services system, or the medical model, and is not interested in those supports? What assumptions might get in our way?
- Professional boundaries issue: It is not the certified peer specialist role to assess symptoms or diagnose. It is also not

the certified peer specialist role to refer peers to treatment unless asked by the peer. Why do you think this is so?

Lived Experience, Bias, and Stigma

(Core Competencies: 1.5; 1.11; 2.2; 2.5; 2.9; 2.10; 3.3; 3.5; 3.7; 4.6; 4.8; 4.18)

To provide effective peer support services, it is important to examine personal beliefs about lived experiences. Examining and challenging our implicit and explicit biases about certain people or groups of people will increase our capacity for providing effective peer support to **all** people.

Let's consider four lived experiences: hearing voices, eating or body image-related challenges, substance use, and psychiatric medication side effects. It's important to be mindful that people in a certified peer specialist course will be navigating some or all the lived experiences explored here.

Hearing voices experiences

What unique biases or stigmas may relate to this lived experience? What is the nature of the potential biases or stigmas?

- Hearing voices, seeing visions, or having what are commonly seen as 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 given the diagnostic label of schizophrenia or other psychotic disorders.

What can go wrong through not challenging or addressing our potential biases? 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 challenge. This is a myth that withholds potentially valuable peer support opportunities from many people.
- When viewing voice hearing as a pathological experience, certified peer specialists also miss an opportunity to better understand peers who may come from a culture or spiritual tradition where these experiences have a spiritual meaning or cultural significance.

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. All peers can potentially benefit from the healing of peer support.

VIDEO: "Beyond Possible: How the Hearing Voices Approach Transforms Lives"
– Open Excellence
https://www.youtube.com/watch?v=Qk5juEgi1oY

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, either internally or within systems, will be required to understand the experience of hearing voices as a normal, human experience rather than a dangerous, scary, negative experience? How will you advocate for those shifts?

Eating or body image-related challenges

What unique biases or stigmas may relate to this lived experience? What is the nature of the potential biases or stigmas?

- Many body-shaming messages often perpetuated through media, communities, and by loved ones result in people navigating eating or body image-related challenges feeling isolated and at fault for their struggles.
- There is an assumption that a certain diagnosis outlines both the nature of eating or body-image related challenges and what would be helpful. In fact, many with such challenges who are diagnosed with an eating disorder either have multiple diagnoses or feel that the diagnosis is insufficient to describe their experiences and what would be helpful.
- Oftentimes, people with these challenges are told to just eat (or not eat), while for many, they find their relationship with nourishment and their bodies to also be impacted by traumas they may have faced.
- 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 not challenging or addressing our potential biases? What are the negative impacts on people?

- Often people seeking support for these challenges are isolated or cut off from supportive community and relationships.

- 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?

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Substance use

What unique biases or stigmas may relate to this lived experience? What is the nature of the potential biases or stigmas?

- There is a widespread stigma associated with people who use certain substances. Some substances may be seen as culturally acceptable. Others are not.
- Many people attribute challenges relating to substance use to moral failing, personal weakness, or lack of will power.
- Many systemically marginalized communities face historical and intergenerational traumas. The stigmas placed upon them related to substance use challenges are informed by a history of colonization.
- Recovery movements have a history of trying to separate people navigating substance use challenges from their communities and connections of importance simply because they are seen as drinking/using friends.

What can go wrong through not challenging or addressing our potential biases? What are the negative impacts on people?

- Black communities as well as other communities of color, 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.
- Certified peer specialists may further perpetuate the pathologizing of substance use and one-size-fits-all approaches

to recovery instead of recognizing a person-centered and culturally relevant importance.

- 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. This can limit self-determination and future help seeking.
- Certified peer specialists may lose sight of historical and cultural context of colonization and intergenerational traumas, while also seeing cultures as a monolith with one experience relating to substances.

What can be done? What does this mean for certified peer specialists?

- 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, connection through careful listening; and recognition of the important roles of culture, community, power, and privilege in people's lives can all aid in better supporting people with substance use challenges. Certified peer specialists are uniquely suited to offer these supports.

VIDEO: "What is the Drug War? With Jay-Z & Molly Crabapple" – Drug Policy Alliance
https://www.youtube.com/watch?v=HSozqaVcOU8

Psychiatric medication side effects

What unique biases or stigmas may relate to this lived experience? What is the nature of the potential biases or stigmas?

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 not challenging or addressing our potential biases? What are the negative impacts on peers?

- Inadvertently projecting our lived experiences onto peers can create listening roadblocks and lead to unintentional advising.

- When those prescribing medications do not provide full information or context when prescribing, it leads to a lack of informed consent options for peers.
- Taking medication for behavioral health challenges may result in significant harm for 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.
- Certified peer specialists will be educated about the risks and side effects of medications. 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).
- Certified peer specialist must not unduly influence peers.
- If asked by the peer, a certified peer specialist must support the peer to advocate for their needs with their prescriber if they feel that they are not being heard.

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 who have navigated their own personal pathway to recovery. Because 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 aligning yourself with the option that best reflects your level of (dis)agreement. Your opinions and perspectives are what matters most in this exploration-based activity.

- Medication is an important and effective part of substance use treatment.
- Medication is an important and effective part of mental health treatment.
- For people addressing opioid use, supervised injection sites will save lives and improve outcomes.
- Good outpatient treatment programs are, on average, about as effective as inpatient programs for long-term outcomes.
- Most people get into recovery and find meaningful living through relying on their natural supports.
- Most Black, Indigenous, and people of color (BIPOC) community members do not seek treatment or system supports for mental health and/or substance use challenges.
- Most people who attend a 12-step groups become regulars.
- Most people who regularly attend 12-step groups enter and stay in recovery.
- Only evidence-based practices such as motivational interviewing and/or cognitive behavioral therapy are effective in helping people get into recovery.
- Peer support should never be offered without parallel clinical supports.

Multiple Pathways Identified

(Core Competencies: 1.1; 1.2; 1.11; 2.2; 2.5; 2.6; 3.1; 3.3; 4.4; 4.11; 4.12; 4.18; 4.19)

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 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 in the context 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, physicians, 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 sometimes in community-based settings, 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.

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 radical healing, motivational interviewing, cognitive behavioral therapy, dialectical behavioral therapy, Matrix Model, Seeking Safety, and the community reinforcement approach.
- A psychological framework of radical healing centers the rich and varied voices and strengths of BIPOC communities, building on each community's traditional cultural healing methods and ancestral wisdom. Those practicing the radical healing framework offer support through understanding that for liberation to occur psychological healing must focus on

systemic conditions contributing to the trauma of racism and colonization. They envision a healing process that acknowledges the pain of oppression while fostering hope for justice and psychopolitical freedom. The proposed framework of radical healing builds on existing theories by arguing that social action is a critical component of radical healing and demands a multisystemic, ecological approach beyond the individual level.

- Medication-assisted recovery complements psychosocial treatment by addressing the underlying biological basis of alcohol use disorder and opioid use disorder. Medications such as buprenorphine (opioid use disorder), methadone (opioid use disorder), and naltrexone (alcohol use disorder/opioid use disorder) 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 nation, 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 is made up of a 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 mental health and substance use to provide treatment services as licensed or certified professionals. Licenses and certifications 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 use counselor. Specialist providers can provide reimbursable treatment services in a range of clinical settings. When working in the public mental health and substance use service system, certified peer specialists are also considered a specialist that offer reimbursable services.

- Non-specialist providers are an essential part of the workforce. General health care workers may provide support services to people with mental health and substance use 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 nation and county agencies or contracted providers. A program that is Medicaid-funded means that allowable services in that program may be reimbursed for people enrolled in Medicaid.

- Crisis services assist individuals by addressing emergencies related to mental health and substance use 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 people with mental health and substance use 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
- 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

- 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 homes or adult family home settings. Information can be found at 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 with 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 caregiver 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.

- Recovery coaches offer a form of strengths-based, healing-centered support for people in or seeking recovery from a substance use concern. Like life and business coaching, recovery coaching is a type of partnership where the person in or seeking recovery self-directs their recovery while the coach provides their expertise in supporting successful change.

  Recovery coaching focuses on achieving any goals important to the individual. The coach asks questions and offers suggestions to help the client begin to take the lead in addressing their

recovery needs. Recovery coaching focuses on honoring values and making principle-based decisions, creating a clear plan of action, and using current strengths to reach future goals. The coach serves as an accountability partner to help the person sustain their recovery. The recovery coach helps the person access recovery, as well as access systems needed to support recovery.

- A network of peer-run recovery centers in Wisconsin provides 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/peer-services/peer-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-services/peer-run-respites.htm

- Alternative therapies and practices are primarily found outside of the mental health and substance use services system. 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 adjusting 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.

Person-centered and community supports

Person-centered and community supports, sometimes referenced as natural supports, that aid people in their recovery are numerous, diverse, and sometimes specific to different cultures. These supports do not always take the form of people or organizations, but also include activities, animals, and the natural world. A non-comprehensive list of person-centered and community supports is provided here:

- Family (of origin, chosen, and/or ancestral)
- Friendships
- Community groups and social or cultural organizations
- Religious or spiritual supports
- Political or advocacy groups and organizations
- Recreational pursuits
- Artistic expression, including storytelling, writing, visual arts, music, dance, and so on
- Educational or mentoring involvement
- Natural world and animal supports

These 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.

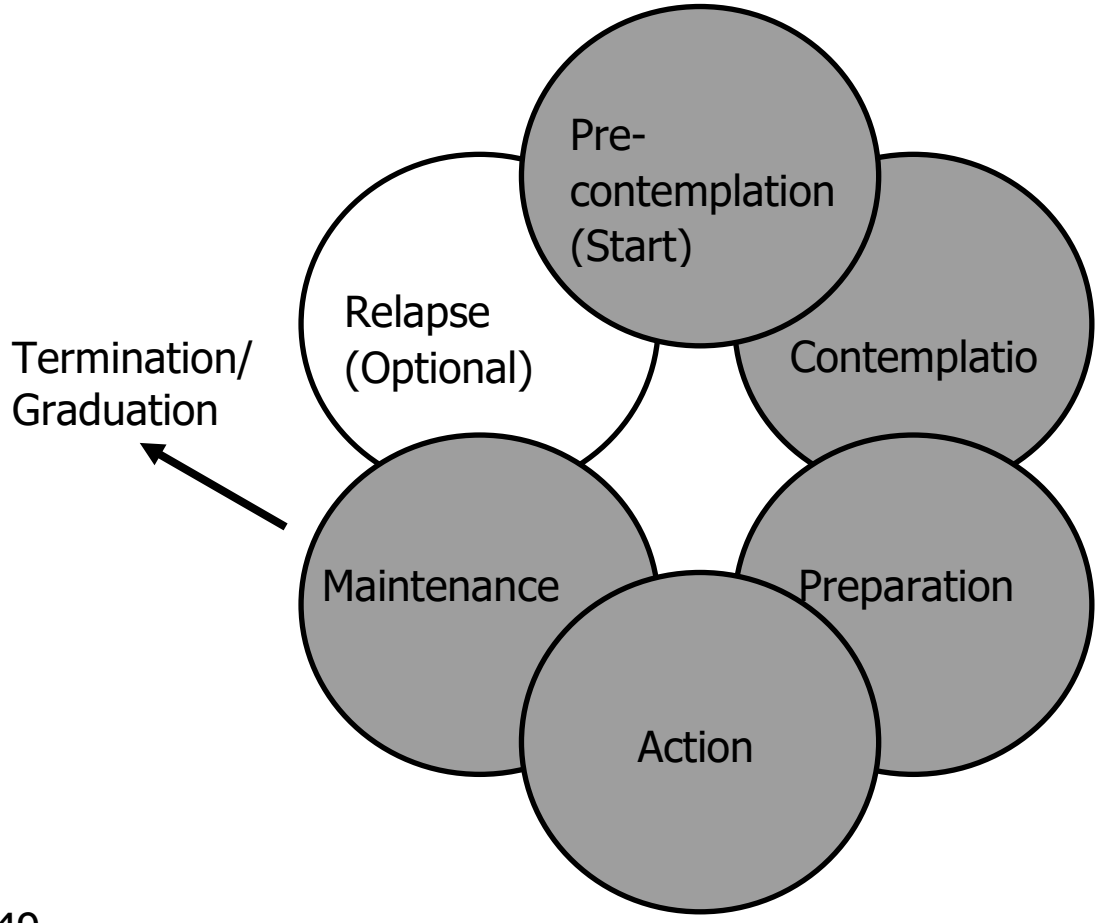
Certified peer specialists provide support to people with diverse experiences and support the meaning people make of their own experiences and struggles. This allows peers to self-determine the most accurate language to describe their experiences, as well as how to navigate them.

Stages of Change

(Core Competencies: 1.1; 1.7; 1.9; 2.2; 2.4; 3.3; 4.4; 4.8; 4.10)

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



Stages of change described

This stage model is not prescriptive, nor should it be used as an assessment. It 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 counterproductive.

Application to peer support

Here are some ways to consider peer support informed by a peer's general stage of change:

Stage of Change	Peer Support
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.

Stage of Change	Peer Support
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 adjusting the recovery plan. • Express optimism for recovery.

Stage of Change	Peer Support
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 adjusting 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

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 two. In each group, decide these roles:

- Peer. You may present a role-play, or a real play based on prior lived experience with ambivalence. Get ready to discuss some benefits of (advantages), as well as the downsides or risks (disadvantages) of your ambivalent experience.
- 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.

Advantages and Disadvantages Worksheet

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

_____

_____

ADVANTAGES – What are the advantages or the positives for making this decision? What else?	**DISADVANTAGES –** What are the disadvantages or the negatives for making this decision? What else?

Summarize, advantages and disadvantages.

Exploration question: So where does this leave you?

Listen carefully and reflect.

Review Questions

1. What are some of the risks of determining someone's stage of change?

2. How do the peer support processes of connecting, exploring, and supporting seem relevant across the Stages of Change?

3. 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?

Section 9

This section begins by navigating crisis in peer support. Next, the content of this section shifts to focus on 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. Meaningful self-care and community care is also revisited in this section.

Course Guide – Section 9
(3 hours 10 minutes)

10 minutes	Homework Review
100 minutes	Navigating Crisis in Peer Support
10 minutes	Practicing Self-Care and Community Care
15 minutes	Break
50 minutes	Difficult Conversations: Self-Harm
5 minutes	Homework Assignment

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.2	Believes in and respects people's rights to make informed decisions about their lives
1.4	Believes in the importance of empathy and listening to others
1.6	Believes in the importance of self-awareness and self-care
1.9	Believes that recovery is a process
2.5	Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.6	Knowledge of trauma and its impact on the recovery process
2.7	Knowledge of person-centered care principles
2.9	Knowledge of the impact of discrimination, marginalization, and oppression
3.3	Knowledge of the scope of practice of a certified peer specialist
3.4	Knowledge of confidentiality standards
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
3.7	Knowledge of cultural competency
4.4	Ability to assist people in exploring life choices, and the outcomes of those choices
4.5	Ability to identify and support a person in crisis and know when to facilitate referrals
4.6	Ability to listen and understand with accuracy the person's perspective and experience
4.7	Effective written and verbal communication skills

Domain	Item Description
4.10	Ability to foster engagement in recovery
4.11	Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.12	Ability to facilitate and support a person as they find and utilize resources
4.14	Ability to know when to ask for assistance and/or seek supervision
4.15	Ability to set, communicate, and respect personal boundaries of self and others
4.16	Ability to utilize own recovery experience and skillfully share to benefit others
4.17	Ability to balance own recovery while supporting someone else's
4.18	Ability to foster the person's self-advocacy and provide advocacy when requested by the person
4.19	Ability to advocate for self in the role of a certified peer specialist

Exploring and Navigating Emotional Crisis

(Core Competencies: 1.2; 1.4; 1.6; 2.9; 3.3; 3.4; 3.7; 4.5; 4.6; 4.7; 4.15; 4.16; 4.17)

Before exploring the topic of crisis and how certified peer specialists can best contribute to crisis supports, it is important to review some of what is considered best practice from the Substance Abuse and Mental Health Services Administration's crisis training and guidance:

> "Too often, public systems respond as if a mental health crisis and danger to self or others were one and the same. In fact, danger to self or others derives from common legal language defining when involuntary psychiatric hospitalization may occur—at best, this is a blunt measure of an extreme emergency. A narrow focus on dangerousness is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether an individual is dangerous or immediate psychiatric hospitalization is indicated… Because only a portion of real-life crises may result in serious harm to self or others, a response that is activated only when physical safety becomes an issue is often too little, too late or no help at all in addressing the root of the crisis. And a response that does not meaningfully address the actual issues underlying a crisis may do more harm than good."

The above best practice guidance outlines that understanding crisis only as "danger to self or others" is not just limiting but harmful in practice. What then constitutes a crisis in a more holistic lens?

Conversations Around Suicide

(Core Competencies: 1.2; 1.4; 1.6; 2.5; 2.6; 2.7; 3.3; 3.5; 3.7; 4.4; 4.5; 4.6; 4.11; 4.12; 4.14)

Suicide is a difficult and emotional topic. Most people 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 critical 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

Many trainings that prepare people to offer support to those considering suicide offer lists of suicide warnings signs. Three facts should be considered in the context of these types of warning sign lists: most people at some point in their life have shown a warning sign because these signs are highly prevalent in the population; the presence of warning signs does not necessarily imply a person is at-risk for suicide; and 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 a crisis, specifically if it does entail intended serious harm to self or others or abuse from caregivers, the certified peer specialist should remind the peer of the protocols set forth by their agency. This should not be the first time this information has been shared with the peer. It is important for the certified peer specialist to seek supervision in reporting to the appropriate staff member when there is an exception to confidentiality. The certified peer specialist could invite the peer to meet with the appropriate staff member.

Supporting a Peer Considering Suicide

(Core Competencies: 1.2; 1.4; 1.6; 2.6; 2.7; 3.3; 3.5; 3.7; 4.4; 4.5; 4.6; 4.14)

It is critical that certified peer specialists approach conversations about suicide with curiosity, empathy, and compassion. 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.

Discussing Suicide for Peer Support

(Core Competencies: 1.2; 1.4; 1.6; 2.6; 2.7; 3.3; 3.5; 3.7; 4.4; 4.5; 4.6; 4.14; 4.18; 4.19)

Connecting

- Avoid listening roadblocks such as sympathy, giving advice, offering reassurance, warning, persuading, or asking closed-ended, fact gathering, and assessment-oriented questions.
- The goal is to 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.
- Acknowledge internally where your own emotions are in the conversation, especially fear, as well as the risk and vulnerability shown by the peer discussing suicide.

Exploring

- Ask open questions to explore the person's experience:
  - When you say you are feeling suicidal, what emotions are most present for 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?
- Explore the possibilities of alternatives to suicide.

Supporting

- Identify your role; remind the peer that the peer relationship is important to you and that you are there to support them in their path forward.
- Ask open questions: How can I best support you right now? What does your support system look like? What would you want a support system to look like?
- Support the person in leading the conversation, do not pursue a personal agenda or assess for safety.

Planning

- Remind the peer that you are there to move alongside them at the pace and rhythm that makes sense for them. No decisions need to be rushed.
- Explore together the advantages and disadvantages of potential support options or pathways forward.
- Practice informed consent by researching together the possible impacts of involving others in the conversation. Possibilities include but are not limited to:
    - Identifying if there is a Crisis Intervention Team available in your area
    - Writing together a list of approaches that would feel more trauma-informed for the peer when involving others
    - Exploring and naming the resources and community-specific supports that might influence a more positive outcome

Advocating

- Identify your role as someone there to advocate alongside the peer that their wishes and perspectives are honored and centered in supports, including crisis responses
- Advocate for change in your workplace and in systems so that policies and procedures support your role as a certified peer specialist and trauma-informed approaches
- Advocating in your workplace and in service systems that people considering suicide or experiencing crisis still possess valuable insight and self-awareness

Consider the following

- If the person is in a 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 to pursue emergency services intervention.

Self-Harm

(Core Competencies: 1.2; 1.4; 1.6; 1.9; 2.6; 2.7; 3.3; 3.5; 4.4; 4.6; 4.10; 4.19)

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.

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 stopping the behavior, but that is not true. Shifting the focus from stopping 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 complete abstinence from a behavior.

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. This 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 abstinence unless that is their stated goal.

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, abstinence, 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 as 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 used for many years. As the support for multiple pathways to recovery is a core tenet of being a certified peer specialist, it is critical 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.

VIDEO: "What is Harm Reduction?"
– National Institute on Drug Abuse
https://www.youtube.com/watch?v=ikmKxgCTXFA

VIDEO: "Harm Reduction 101"
– HRAC Denver
https://www.youtube.com/watch?v=W7epsLmN604

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 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 been done or said to be supportive? Consider OARS communication skills and provide specific examples of application.

- What should not be done or said? What listening roadblocks (see handout from earlier session) should we be sure to avoid?

Review Questions

1. What are the two or three most important takeaways from this section?

2. What is one thing I did during this section to take care of myself?

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 we discussed in Section 2, 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 to 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?

ADVANTAGES of anger	DISADVANTAGES of anger

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 you discuss these topics. The section then covers anger and how to prepare and respond to anger within a peer support relationship. Activities and examples are given to solidify understanding.

Course Guide – Section 10 (3 hours 40 minutes)

5 minutes	Homework Review
65 minutes	Read Discussing Spirituality and Religion
30 minutes	Discussing Spiritual and Religion Practice Activity
15 minutes	Break
100 minutes	Anger: Preparing and Responding in Peer Support
5 minutes	Homework Assignment

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.4	Believes in the importance of empathy and listening to others
1.5	Believes in and respects all forms of diversity
1.6	Believes in the importance of self-awareness and self-care
1.7	Believes in lifelong learning and personal development
1.9	Believes that recovery is a process
1.11	Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery
2.2	Knowledge of mental health and substance use disorders and their impact on recovery
2.5	Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.7	Knowledge of person-centered care principles
2.8	Knowledge of strengths-based planning for recovery
2.9	Knowledge of the impact of discrimination, marginalization, and oppression
2.10	Knowledge of the impact of internalized stigma and shame
3.2	Knowledge of ethics and boundaries
3.3	Knowledge of the scope of practice of a certified peer specialist
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interaction
3.7	Knowledge of cultural competency

Domain	Item Description
4.2	Ability to be self-aware and embrace and support own recovery
4.4	Ability to assist people in exploring life choices, and the outcomes of those choices
4.6	Ability to listen and understand with accuracy the person's perspective and experience
4.7	Effective written and verbal communication skills
4.8	Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.9	Ability to recognize and affirm a person's strengths
4.10	Ability to foster engagement in recovery
4.11	Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.12	Ability to facilitate and support a person to find and utilize resources
4.15	Ability to set, communicate, and respect personal boundaries of self and others
4.16	Ability to utilize own recovery experience and skillfully share to benefit others
4.17	Ability to balance own recovery while supporting someone else's
4.18	Ability to foster the person's self-advocacy and provide advocacy when requested by the person

Discussing Spirituality and Religion

(Core Competencies: 1.4; 1.5; 1.7; 1.11; 2.5; 2.7; 2.8; 2.9; 3.2; 3.5; 3.7; 4.4; 4.6; 4.8; 4.11; 4.16; 4.18)

The topic of spirituality and religion is important for a certified peer specialist to consider because of the positive and negative impacts spiritually and religion can have on a peer's life. Additionally, spiritually and religion can influence a person's recovery journey. First, 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.

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 several 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, a professor at The George Washington University.

> "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. Individuals express their spirituality in many ways. Spirituality 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 because 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.

Assumption of Christian faith tradition

A 2014 Pew Research Center 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 most 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.

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

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.

Spiritual experiences through a non-pathologizing and 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 validate how people make meaning of their religious or spiritual experiences alongside their broader lived experience. Likewise, a certified peer specialist is not in a position 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, especially if the person does not view them that way.

It is important to reflect on how our biases may impact our perception of people's experiences as a symptom versus an intense spiritual experience. Other examples of intense spiritual experiences that could be easily misunderstood in the context of mental health or substance use services system include, but are not limited to, speaking tongues, shamanistic cultural experiences, spiritual visions or messages, and cultural ceremonies to name a few.

Among many Indigenous cultures, mental health and substance use are not defined as diseases, diagnoses, or moral maladies, nor are they viewed as physical or character flaws. Instead, they are seen as symptoms of imbalance in the individual’s relationship with the world. For indigenous communities, healing is often intuitive; it is interconnected with others and comes from within, from ancestry, from stories, and from the environment.

FURTHER READING:

- Multicultural Competence, Intense Spiritual Experiences, and Mental Health: A Self-help, Peer Support and Service Provide Technical Assistance Tool https://www.yumpu.com/en/document/read/30746226/multicultural-competence-intense-spiritual-experience-star-center
- CRAZYWISE: A Traditional Approach to Mental Illness, Phil Borgese, TEDxSanJuanIsland https://youtu.be/9_KSYu1Tqx8
- Judaism Madness and Spirit, Caroline Mazel-Carlton, Madness Radio https://www.madnessradio.net/judaism-madness-and-spirit-caroline-mazel-carlton-madness-radio/
- Widening the Circle, Indigenous Education Conference https://www.wideningthecircleconference.com/?fbclid=IwAR2-MAh1nH_8Du8yHt74GSBiiUZRB7vtk17-_51uk0HKJKz2jCOk1m4CWCE
- White Bison https://whitebison.org/

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 create 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 the peer role and who will start in the certified peer specialist role.

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.

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.

What is Anger?

(Core Competencies: 1.4; 1.6; 1.9; 2.2; 2.5; 2.6; 2.7; 2.8; 2.10; 3.2; 3.3; 3.5; 3.7; 4.2; 4.4; 4.6; 4.7; 4.8; 4.10; 4.12; 4.15; 4.17)

Anger is a complex, normal human experience involving 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.

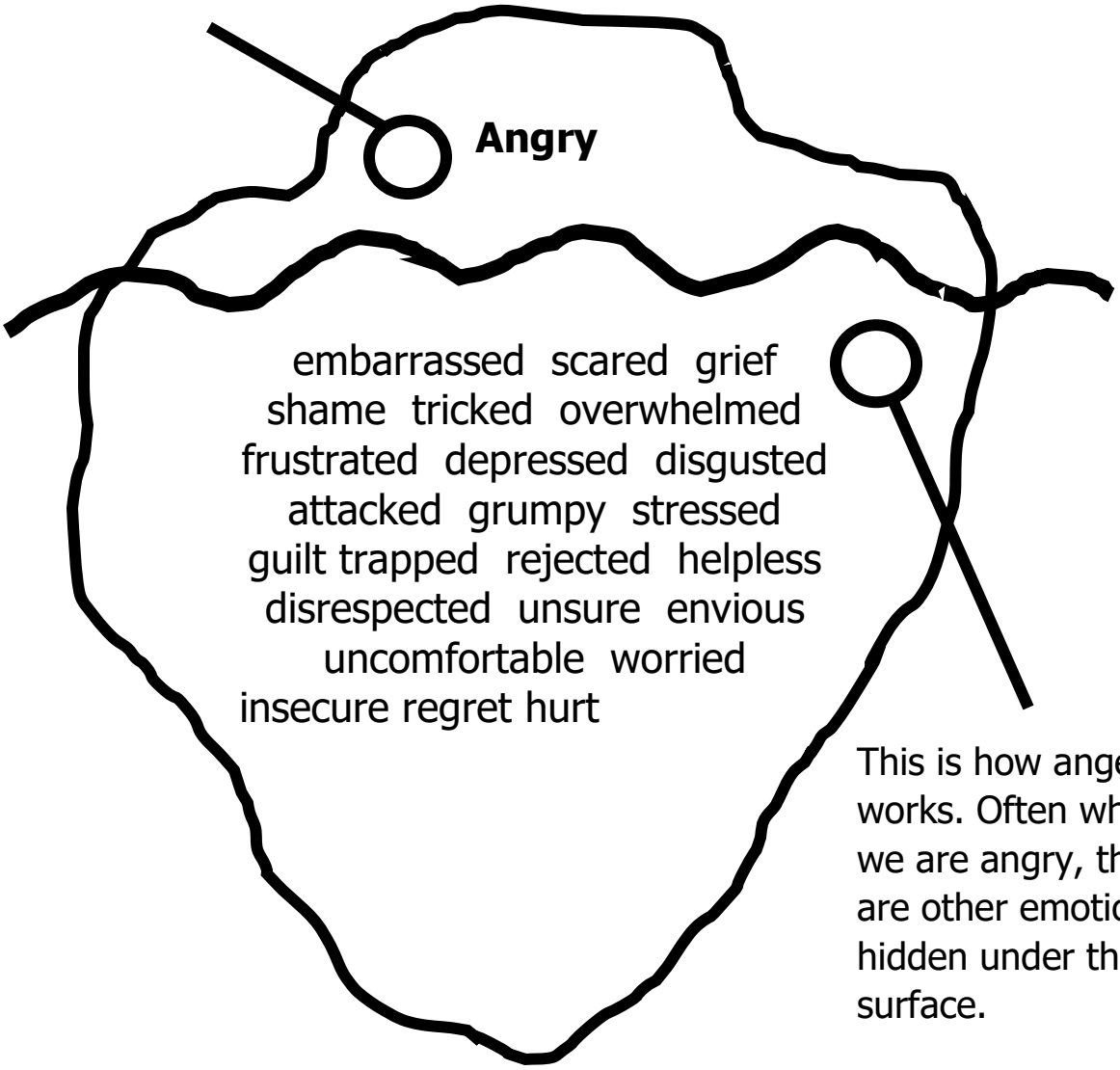
How do these understandings of anger fit with your understanding? What would you add?

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.

ANGER ICEBERG

Icebergs are large pieces of ice found floating in the open ocean. What you can see from the surface can be misleading. Most of the iceberg is hidden below the water.



This is how anger works. Often when we are angry, there are other emotions hidden under the surface.

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, 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, community 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, 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.

Feeling inventory (from Center for Nonviolent Communication)

AFRAID	**EMBARRASSED**	**FATIGUED**	**SAD**
apprehensive	ashamed	beat	depressed
dread	chagrined	burnt out	dejected
foreboding	flustered	depleted	despair
frightened	guilty	exhausted	despondent
mistrustful	mortified	lethargic	disappointed
panicked	self-conscious	listless	discouraged
petrified		sleepy	disheartened
scared		tired	forlorn
suspicious	**DISCONNECTED**	weary	gloomy
terrified	alienated	worn out	heavy hearted
wary	aloof		hopeless
worried	apathetic		melancholy
	bored	**PAIN**	unhappy
	cold	agony	wretched
ANNOYED	detached	anguished	
aggravated	distant	bereaved	
dismayed	distracted	devastated	**CONFUSED**
disgruntled	indifferent	grief	ambivalent
displeased	numb	heartbroken	baffled
exasperated	removed	hurt	bewildered
frustrated	uninterested	lonely	dazed
impatient	withdrawn	miserable	hesitant
irritated		regretful	lost
irked		remorseful	mystified
	DISQUIET		perplexed
	agitated		puzzled
ANGRY	alarmed	**TENSE**	torn
enraged	discombobulated	anxious	
furious	disconcerted	cranky	
incensed	disturbed	distressed	**VULNERABLE**
indignant	perturbed	distraught	fragile

irate livid outraged resentful **AVERSION** animosity appalled contempt disgusted dislike hate horrified hostile repulsed	rattled restless shocked startled surprised troubled turbulent turmoil uncomfortable uneasy unnerved unsettled upset	edgy fidgety frazzled irritable jittery nervous overwhelmed restless stressed out	guarded helpless insecure leery reserved sensitive shaky **YEARNING** envious jealous longing nostalgic pining wistful

Needs inventory (from Center for Nonviolent Communication)

CONNECTION acceptance affection appreciation belonging cooperation communication closeness community companionship compassion consideration consistency empathy inclusion intimacy love mutuality nurturing respect/self-respect safety security stability support to know and be known to see and be seen to understand and be	**PHYSICAL WELL-BEING** air food movement/exercise rest/sleep sexual expression safety shelter touch water **HONESTY** authenticity integrity presence **PLAY** joy humor **PEACE** beauty communion ease equality harmony	**MEANING** awareness celebration of life challenge clarity competence consciousness contribution creativity discovery efficacy effectiveness growth hope learning mourning participation purpose self-expression stimulation to matter understanding **AUTONOMY** choice freedom independence space spontaneity

understood trust warmth	inspiration order	

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

(Core Competencies: 1.4; 1.6; 1.9; 2.2; 2.5; 2.7; 2.8; 3.2; 3.3; 3.5; 3.7; 4.2; 4.4; 4.6; 4.7; 4.8; 4.9; 4.15; 4.17)

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 nonverbals.
    - 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.
    - Explore how the peer’s values may be informing a response of anger, as well as potential value clashes that are taking place.
- Model a holistic understanding of boundaries while meeting people where they are at.
    - Be aware of personal space and boundaries.
    - Recognize when a boundary is crossed, as well as, when it may be a time to connect deeper.
    - Explore how any biases, whether conscious or not, may be impacting your response to anger as well as your understanding of boundaries.
    - Acknowledge your internal emotional response and, if necessary, name what is needed to sustain connection in the peer relationship.

Communication Styles

	PASSIVE	AGGRESSIVE	PASSIVE-AGGRESSIVE	ASSERTIVE
BEHAVIOR	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.	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.	Failure to meet the expectations of others through "deniable" means; forgetting being delayed, and so on. Deny personal responsibility for your actions.	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.

NONVERBAL	Make yourself small. Look down, hunch your shoulders, and avoid eye contact. Speak softly.	Make yourself large and threatening. Eye contact is fixed, and penetrating voice is loud, perhaps shouting.	Usually mimics the passive style.	Body is relaxed, movements are casual. Eye contact is frequent, but not glaring.
BELIEFS	Others' needs are more important than yours. They have rights; you do not. Their contributions are valuable. Yours are worthless.	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.	You are entitled to get your own way, even after making commitments to others. You are not responsible for your actions.	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.

EMOTIONS	Fear of rejection. Helplessness, frustration, and anger. Resentment toward others who "use" you. Reduced self-respect.	Angry or powerful at the time, and victorious when you "win." Afterward: remorse, guilt, or self-hatred for hurting others.	Fear that you would be rejected if you were more assertive. Resentment at the demands of others. Fear of being confronted.	You feel positive about yourself and the way you treat others. Self-esteem rises.
GOALS	Avoid conflict. Please others at any expense to yourself. Give others control over you	Win at any expense to others. Gain control over them.	Get your own way without having to take responsibility.	Both you and others keep your self-respect. Express yourself without having to win all the time. No one controls anyone else.

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 these communication styles). How does your communication style impact others?

3. Self-care, community care, and setting boundaries have been themes during this course. Which communication style best reflects your **current** practice of self-care? For community care? For setting boundaries?

4. Are you happy with your current results of self-care, community 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. This section 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.

Course Guide – Section 11
(3 hours 40 minutes)

10 minutes	Homework Review
130 minutes	The Planning Process
15 minutes	Break
60 minutes	Planning Possibilities
5 minutes	Homework Assignment

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

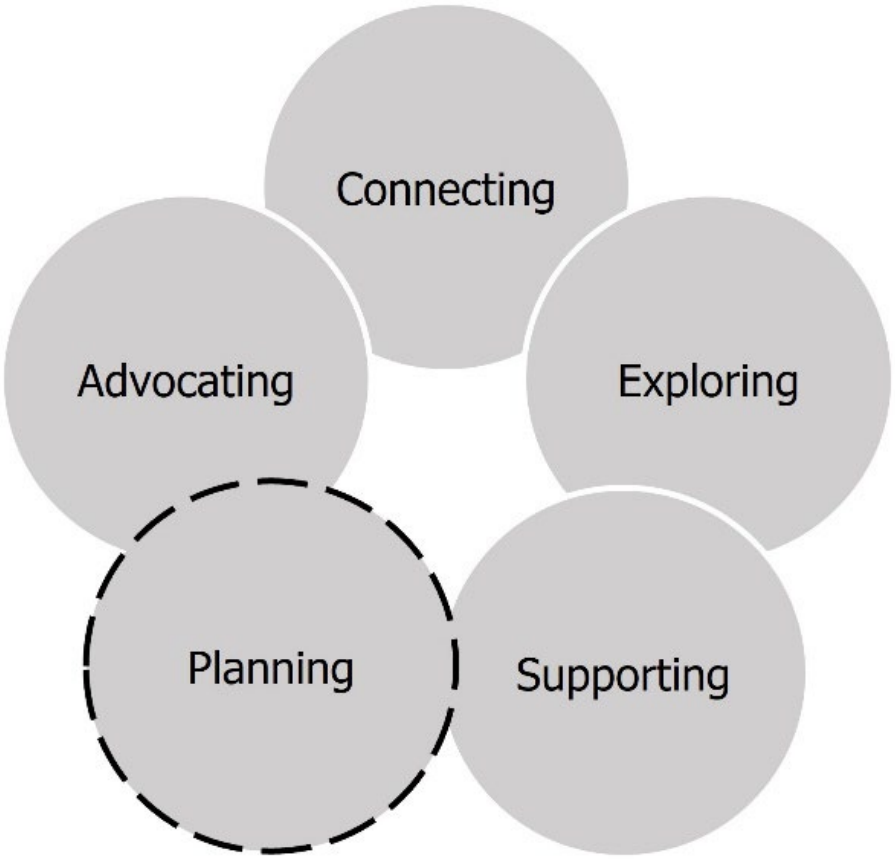
Domain	Item Description
1.2	Believes in and respects people's rights to make informed decisions about their lives
1.3	Believes that personal growth and change are possible
1.4	Believes in the importance of empathy and listening to others
1.5	Believes in and respects all forms of diversity
1.7	Believes in lifelong learning and personal development
1.9	Believes that recovery is a process
1.11	Believes and understands there are a range of views regarding mental health and substance use disorder and their treatment, services, supports, and recovery
2.1	Knowledge of 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"
2.2	Knowledge of mental health and substance use disorders and their impact on recovery
2.4	Knowledge of stages of change and recovery
2.5	Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.7	Knowledge of person-centered care principles
2.8	Knowledge of strengths-based planning for recovery
2.9	Knowledge of the impact of discrimination, marginalization, and oppression
2.10	Knowledge of the impact of internalized stigma and shame

Domain	Item Description
3.3	Knowledge of the scope of practice of a certified peer specialist
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
3.7	Knowledge of cultural competency
4.3	Ability to problem-solve
4.4	Ability to assist people in exploring life choices, and the outcomes of those choices
4.6	Ability to listen and understand with accuracy the person's perspective and experience
4.7	Effective written and verbal communication skills
4.8	Ability to draw out a person's perspective, experiences, goals, dreams, and challenges
4.9	Ability to recognize and affirm a person's strengths
4.11	Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.12	Ability to facilitate and support a person to find and utilize resources
4.13	Ability to work collaboratively and participate on a team
4.18	Ability to foster the person's self-advocacy and provide advocacy when requested by the person

The Planning Process

(Core Competencies: 1.2; 1.7; 1.9; 1.11; 2.1; 2.2; 2.5; 2.7; 2.8; 3.3; 3.7; 4.3; 4.4; 4.7; 4.8; 4.9; 4.12)

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.

Pitfalls	Possibilities
Getting ahead of the peer's readiness and jumping to a solution, plan, or action step before the peer is ready.	It is okay to stay in the exploration process indefinitely as a source of useful support. Contemplation is a valid stage of change.
Staying in exploration when the peer is ready to plan.	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.
Judging a peer's goal to be unrealistic or certain to fail.	Conveying acceptance and honoring of a peer's self-determination to set their own course is a powerful form of peer support.
Being personally or professionally invested in a particular plan outcome and viewing the outcome as a reflection of one's peer support competency.	Being able to let go of a peer's outcome is to set a heathy 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 and community care.

Pitfalls	Possibilities
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.	Person-centered planning requires exploration of many options with careful listening to understand the peer's desires, goals, and needs.
Seeing a plan as a formal, written document that must be revisited.	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.
Viewing planning as a technical problem-solving activity to search for and find solutions and resources.	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.

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
  https://www.store.samhsa.gov/product/Creating-a-Healthier-Life-/SMA16-4958

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 **reflective 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

(Core Competencies: 1.3; 1.4; 1.7; 2.7; 2.8; 3.3; 3.5; 4.4; 4.7; 4.8; 4.11; 4.13; 4.18)

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 the 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 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

(Core Competencies: 1.4; 1.5; 1.11; 2.5; 2.7; 2.9; 2.10; 3.3; 3.5; 3.7; 4.6; 4.7)

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. This is due to the medical model approach being centered on what is wrong with a person. The language that is used in service settings, linked to people in documentation or medical records can either support a person's well-being and care or perpetuate stigma and marginalization.

One of the efforts people have been engaged in to transform the way services are provided is advocating for strengths-based approaches. This has often been seen as best achieved using person-first language. Person-first language is language that is centered around personhood and people having experiences or diagnoses rather than being defined by those experiences or diagnoses. There is ongoing debate and discussion on the value of person-first language. Many people with lived experience find meaning in language and terms that could sometimes be perceived as deficit-based by others. It is important that certified peer specialists honor the terms and language that their peers find meaningful or as an element of their healing.

Positionality matters when it comes to language. This means that one's position or lived experience matters the most when it

comes to the value of labels and language. The term addict may be seen as deficit-based language by some who prefer a person-first alternative, "person with substance use challenges." Whereas, to some others with lived experience of addiction, meaning and value, including a sense of strength, may be found in identifying as an addict in a community of fellow addicts. Whether labeled deficit-based language, identity-first language, strengths-based language, or person-first language, certified peer specialists should center the person they are supporting and their wishes around the language that is most meaningful and least harmful to them. As always, avoiding assumptions and listening roadblocks, while remaining curious and asking open, exploring questions will aid any certified peer specialist in using language that promotes healing and a sense of understanding.

The following tables show what has been understood as deficit-based language terms as well as strengths-based or person-first language terms within the mental health and substance use services system when describing people, behavior, and services.

Describing a person

Deficit-based language	Strengths-based language
Schizophrenic, borderline, bipolar, hoarder	Person diagnosed with… Person who experiences the following… Person in recovery from… Person living with…
Addict (when used by people without lived experience), 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

Deficit-based language	Strengths-based language
Good/bad, right/wrong	Different, diverse, unique
Suffering from	Person is experiencing, living with, working to recover from
Acting out, "having behaviors"	Person is experiencing strong emotions Person is upset/angry/overwhelmed
Attention-seeking	Looking for support, looking for connection Having a hard time

Deficit-based language	Strengths-based language
Criminal, delinquent, dangerous	Specify unsafe behavior Person who has experienced incarceration
Denial, unable to accept illness, lack of insight	Person disagrees with diagnosis Person sees themselves in a strengths-based way
Manipulative	Resourceful; trying to get help; able to take control in a situation to get needs met; boundaries are unclear; trust in relationship has not been established; learned to navigate the world differently
Oppositional, resistant, non-compliant, unmotivated	Constraints of the system don't meet the individual's needs; preferred options are not available; services and supports are not a fit
Danger to others, danger to self, general danger	People should not be reduced to acronyms; describe behaviors that are threatening
Entitled	Person is aware of their rights, empowered, self-advocate
Puts self and/or recovery at risk	Person is trying new things that may have risks, exploring recovery pathways
Weakness, deficits	Barriers, needs, opportunity to develop skills

Describing service activity

Deficit-based language	Strengths-based language
Baseline	Self-determined quality of life
Clinical decompensation, relapse, failure	Challenges, potential setback
Discharged to aftercare, maintaining	Person is connected to social, or community supports Person is following up with recovery-oriented supports
Clinical stability, abstinence	Promoting and sustaining recovery, building resilience, using harm reduction approach
Non-compliant with medications, treatment resistant	Person prefers other strategies and pathways Person is making their own decisions Person's concerns are not being acknowledged by the treatment team
Enable, learned dependency	Providing support in a person-centered manner, opportunity to clarify boundaries
Front-line staff, "in the trenches"	Avoid using war metaphors Use job title

Self-reflection activity instructions: Review the tables on the previous pages and respond to the following.

- 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?

- What is an example of language that you would like to **reflect** more on or feel ambivalence around?

- What is an example of language that you find invalidating or contradicts your lived experience or sense of community?

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. During small group debrief, certified peer specialist role should start by stating what they liked and what they could have done a differently.
- Observer: Observe the certified peer specialist and share one or two supportive observations using the Ask-Share-Ask procedure.

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. An activity is provided to encourage the exploration of this topic. Working collaboratively on integrated teams is covered with an overview of mental health and substance use diagnoses. The section then transitions to reviewing state and federal regulations that include information on government assistance programs, client rights, the American with Disabilities Act, and involuntary commitment.

Course Guide – Section 12
(2 hours 35 minutes)

10 minutes	Homework Review
90 minutes	Advocacy in the Certified Peer Specialist Role
15 minutes	Break
20 minutes	Working Collaboratively on Integrated Teams
20 minutes	Federal and State Regulations
5 minutes	Homework Assignment

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.6	Believes in the importance of self-awareness and self-care
1.9	Believes that recovery is a process
1.11	Believes and understands there are a range of views regarding mental health and substance use disorders and their treatment, services, supports, and recovery
2.2	Knowledge of mental health and substance use disorders and their impact on recovery
2.5	Knowledge that recovery and wellness involves the integration of the whole person including spirituality; physical, vocational, and emotional health; sexuality; gender identity; and community
2.6	Knowledge of trauma and its impact on the recovery process
2.7	Knowledge of person-centered care principles
2.9	Knowledge of the impact of discrimination, marginalization, and oppression
2.10	Knowledge of the impact of internalized stigma and shame
3.1	Knowledge of the rights of peers seeking support, such as state and federal law regarding client rights, civil rights, and the Americans with Disabilities Act (ADA)
3.2	Knowledge of ethics and boundaries
3.3	Knowledge of the scope of practice of a certified peer specialist
3.4	Knowledge of confidentiality standards
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
3.7	Knowledge of cultural competency

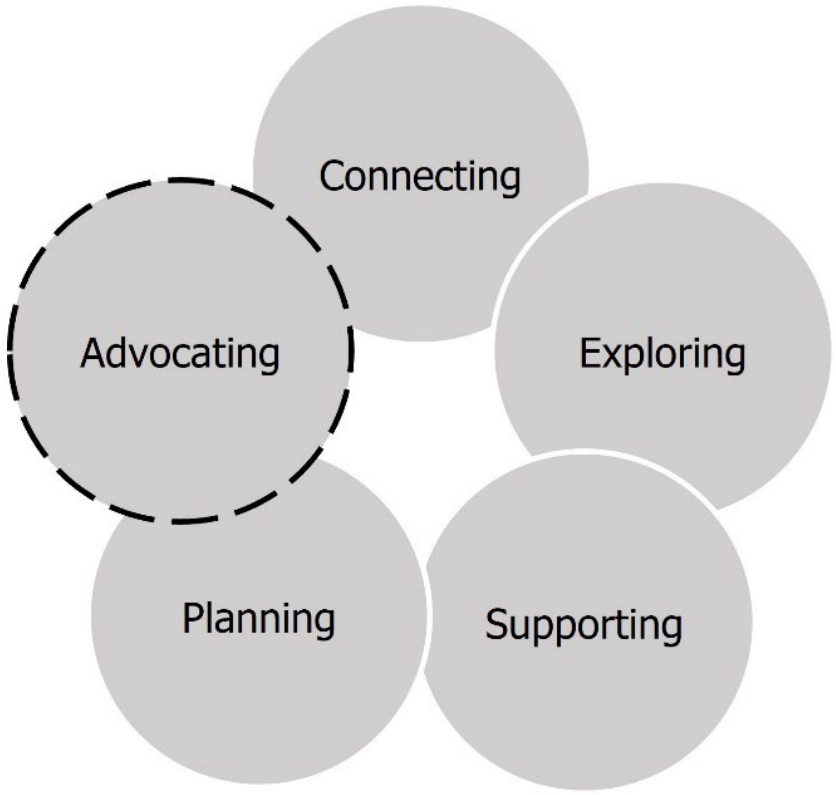
Domain	Item Description
4.3	Ability to problem-solve
4.4	Ability to assist people in exploring life choices, and the outcomes of those choices
4.7	Effective written and verbal communication skills
4.11	Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.13	Ability to work collaboratively and participate on a team
4.18	Ability to foster the person's self-advocacy and provide advocacy when requested by the person
4.19	Ability to advocate for self in the role of a certified peer specialist

The Advocating Process

(Core Competencies: 1.6; 1.9; 2.2; 2.7; 2.9; 2.10; 3.3; 3.7; 4.3; 4.4; 4.18; 4.19)

Connecting, exploring, supporting, planning, and advocating are fundamental processes of certified peer specialist practice. The purpose of advocating is to bring about change at the team, agency, community, and systemic levels.

There are several important areas of advocacy that certified peer specialists advance: co-advocating with a peer, advocating for professional needs in the workplace, advocating for clear understanding and support of 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 and community care is essential.



Areas for Advocacy

(Core Competencies: 1.6; 1.9; 1.11; 2.2; 2.5; 2.6; 2.7; 2.9; 2.10; 3.1; 3.3; 3.4; 3.5; 3.7; 4.3; 4.4; 4.7; 4.11; 4.18; 4.19)

There are several important areas for advocacy that certified peer specialists advance: co-advocating with a peer, advocating for professional needs in the workplace, advocating for clear understanding and support of 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 process of advocating with or alongside a peer is consistent with certified peer specialist practice centered on the peer's self-determination. Examples of advocating with a peer include:

- Exploring their options and rights without advising them in any 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 them in speaking to their needs and concerns at team meetings or in other settings, including going with them if asked.
- Accompanying them 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 opinion, taking the lead, solving problems, making decisions, or second-guessing a peer's decision.

Advocating for professional needs

Lived experience of mental health or substance use challenges can sometimes mean that a peer's opinions and ideas are not taken seriously. This is why advocacy is required. Similar dynamics will be replicated for certified peer specialists as professionals within their employing agencies. 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 diversity, equity, accessibility, and inclusion.
- Establishing boundaries around one's personal recovery. The employer's role is not to oversee its employees' recovery.
- Requesting reasonable accommodations as guaranteed by the Americans with Disabilities Act.

Advocating for the certified peer specialist role

The Wisconsin Certified Peer Specialist Scope of Practice identifies the many roles for certified peer specialists, with which an employing agency's leadership or supervisor may be unfamiliar. Advocacy and education are 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—best practice shows that certified peer specialists are best supervised by experienced certified peer specialists
- Transparent conversations about workload that honors the importance of each peer relationship as well as the well-being of certified peer specialists

- Clear and accurate job descriptions that align with the role and day-to-day work expectations
- Understanding that certified peer specialists are trained to provide professional services of offering peer support.
- Understanding that certified peer specialists are not mandated reporters by virtue of completing this course
- Recognizing that the certified peer specialist role is to be resource rich and to explore options in a collaborative way with peers

Advocating for systems change

Certified peer specialists practice within the broader mental health and substance use services system. 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. Change can be slow and incremental in organizations. It could be considered an ethical obligation of a 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, valuing, and supporting multiple pathways to recovery, including harm reduction and access to supports inside and outside of evidence-based practice services.
- Implementing trauma-informed practices based on an ongoing quality improvement process.

- Expecting that organizations will recognize the harm that can be perpetuated through dictating which language or terms are to be used to describe lived experience in service settings or documentation.
- Providing person-centered and self-directed services that recognize each person as the expert on their own lives and recovery, as well as members of wider communities.
- Adopting informed consent practices in multiple ways throughout the agency that truly support peoples' self-determination and reduce systemic harm.
- Organizing movements, coalitions, or teams against the harm of force, coercion, and restrictive measures anywhere they take place.
- Advocating for services and supports that meet people where they are at and honors that struggle is part of healing, and that recovery is a non-linear process.
- Moving toward viewing crisis as an opportunity for growth and connection.
- Supporting organizational diversity, equity, accessibility, and inclusion initiatives.

Activity: Exploring Advocacy

As a certified peer specialist, there will be many times you are called on to step into an advocacy role. The previously covered four areas of advocacy are often interconnected. In Section 6, the topic of moral injury was introduced. Moral injury can occur when asked to betray or ignore a peer specialist's core values, ethics, or principles.

Below are some examples of situations that could lead to moral injury in peer support:

- 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 police involvement and the peer is not a danger to themselves or others.
- A certified peer specialist works in a program that does not meet the linguistic, cultural, or accessibility needs of peers, leaving peers with varying linguistic, cultural, or accessibility needs to go without peer support or other resources.
- A certified peer specialist who is expected to participate in developing a treatment plan for their peer when the peer is 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.

- A certified peer specialist is asked to share an organizational job posting with their circles when that certified peer specialist has been harmed and felt undervalued within the organization.

Without engaging in the advocacy process, moral injury for the certified peer specialist and harm to peers they support can occur. Situations such as those outlined above can be addressed through changes as a result of advocating. When advocating, it is worthwhile to reflect on both what values or ethical principles guide you in your role and what you have already learned about boundaries. Remember:

- **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. 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.

Break out into pairs for an advocacy planning conversation using one of the above situations that could cause moral injury. You may also use examples from your own life.

Discuss with one another to identify if the advocacy area is one happening alongside a peer, within an organization, or in the

context of larger systems. Once that is identified, use the following exploring and planning questions to plan advocacy:

- Who are the people or decision-makers involved? What roles or relative positions of power are held?
- What perspectives, values, or needs may be showing up for the people involved? How do they align or conflict?
- What resources or supports are available to assist in advocacy efforts?
- What is the clear objective to aim for, and what are the impacts (positive or negative) for achieving that?

Certified Peer Specialists on Integrated Teams

(Core Competencies: 1.11; 2.5; 2.9; 3.1; 3.2; 3.3; 4.13; 4.19)

Working collaboratively on teams is a core competency for Wisconsin certified peer specialists. The skills and experience that comes with the processes of connecting, exploring, supporting, planning, as well as advocating uniquely position certified peer specialists as collaborative professional partners across disciplines.

Many certified peer specialists will find themselves working alongside those in other roles in the mental health and substance use services system, including but not limited to case managers, therapists, doctors, mental health technicians, nurses, and more.

Each of these professional roles comes with a unique set of ethical considerations as well as skills, training, and experience.

Where do certified peer specialists work?

- Advocacy organizations
- Community mental health and substance use programs
    - Community Support Programs
    - Crisis services
    - Comprehensive Community Services
    - Community Recovery Services
    - ED2Recovery
    - Substance use residential programs

- County jails
- Hospitals
- Independent living centers
- LLCs founded by certified peer specialist entrepreneurs
- 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 DHS and the Wisconsin Department of Justice
- Tribal youth and social service programs
- Even in peer-run settings, certified peer specialists may find themselves partnering with or engaging with those in other roles in human services or the mental health and substance use service system.

Funding for peer support services

Funding for certified peer specialist services comes from a variety of sources. Wisconsin Medicaid provides reimbursement for services delivered by certified peer specialists within the service

arrays of community psychosocial rehabilitation services and substance use treatment services. Other funding sources include Wisconsin's 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 and state tax revenue. Federal grants to tribal nations, county, and municipal governments may provide funding for services.

Other funding sources may include fee-for-service peer support programs where certified peer specialists offer specific supports, such as those connected to vocational peer support or peer support offered through Independent Living Centers. Additionally, private or community donations may be a source of funding for peer support services. Lastly, there are emerging examples of certified peer specialists employed by for-profit businesses so that employees may have access to peer support through their employer.

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 and complete continuing education. The supervision must be coordinated within the context of service plans. In addition, these mental health and substance use programs will be certified. This means supervision requirements that must be followed. Certified peer specialists, who receive supervision from a mental health professional in Medicaid reimbursable programs, can and do also receive supervision from an experienced certified peer specialist in a form of dual supervision.

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.

An ideal situation would be for the supervision to have 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 supporting peers. Certified peer specialists and employers should be aware if the program or agency's funding sources have supervision requirements.

Documentation

Documentation of peer support services provided is required for certified mental health and/or substance use programs (examples of certified programs include but are not limited to 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, documentation generally 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 said in confidence and the person requested that it not be included in their case notes. When this occurs, it is essential that certified peer specialists document in such a way that honors the privacy and wishes of their peer. 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. 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. At times, this may be against 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 offered by the employer may be available.

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

Mental Health and Substance Use Diagnoses

(Core Competencies: 1.11; 2.2; 2.5; 3.7)

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 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 course. This information is included primarily to support a basic understanding of how diagnoses are structured.

Within the substance use and mental health service system, there is sometimes a misunderstanding that certified peer specialists can only offer peer support to people with relatively mild or moderate challenges. This is a myth that withholds potentially valuable peer support opportunities from them.

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) (examples: 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 overeating 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 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:
  - A need for markedly increased amounts of the stimulant to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of the stimulant.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for the stimulant.
  - 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 opioids, use opioids, or recover from their 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:
  - A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
  - A markedly diminished effect with continued use of the same amount of an opioid.
- Withdrawal, as manifested by either of the following:
  - The characteristic opioid withdrawal syndrome.
  - Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms

Some questions to consider after reviewing these diagnoses:

- 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?
- 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 empower self-determination?
- How can we as certified peer specialists foster connection with a peer who finds value or helpfulness in diagnosis language?
- In what ways do you think certified peer specialists can offer support to discovering strengths and making meaning of one's experiences?
- What were some of the questions that came up for you while reviewing these descriptions?

Social Security, Supplemental Security Income, Social Security Disability Insurance, Medicare, and Medicaid

(Core Competencies: 3.1; 3.2; 3.3; 4.11)

Certified peer specialists may work with people who 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.

HIPAA

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** 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 is this information 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.

FURTHER READING: U.S. Department of Health and Human Services - Your Rights Under HIPAA
https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

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 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 like 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 several significant changes to the definition of disability. The changes in the definition of disability in the ADAAA apply to all titles of the ADA.

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 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, 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.

FURTHER READING: 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 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 their consent.
- Have privacy in toileting and bathing. *
- Have a reasonable amount of secure storage space for their 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 their care.
- Refuse electroconvulsive therapy.
- Refuse drastic treatment measures.
- File complaints about violations of their 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. This position decides whether the study will receive final approval from the 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.

FURTHER READING: Wisconsin Department of Health Services – Client Rights Office
https://www.dhs.wisconsin.gov/clientrights/index.htm

Involuntary Commitment

There are three Wisconsin laws that govern the detainment 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 laws and processes involved in involuntary commitment.

The first phase of an involuntary commitment is a detainment. This is when an individual, who has been diagnosed with a 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 are 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 a 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:
    - Dismissal.
    - A determination whether a protective placement is a better option.

- A commitment order to the care and custody of the appropriate county department for six months, with potential renewals.
- An individual with alcoholism is committed to county for 90 days.

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.

FURTHER READING: Wisconsin State Law Library – Mental Health
https://wilawlibrary.gov/topics/medlaw/mentalhealth.php

Review Questions

1. Why do you think advocating is considered a distinct process that is included alongside connecting, exploring, supporting, and planning?

2. What is the importance of having a certified peer specialist on an integrated team?

3. What role does understanding federal and state regulations play as certified peer specialist? How does this relate to advocacy?

Section 13

This section is the last section of this course. Discussions center on concluding the peer relationship. Participants need to complete a course evaluation. You will receive a certificate of completion.

Course Guide – Section 13
(3 hours 40 minutes)

10 minutes	Homework Review
15 minutes	Course Evaluation
90 minutes	Concluding the Peer Relationship
15 minutes	Break
60 minutes	Recap, Review, and Reflection
30 minutes	Wrap Up and Celebrate Success

CERTIFIED PEER SPECIALIST CORE COMPETENCIES COVERED

Domain	Item Description
1.1	Believes that recovery is an individual journey with many paths and is possible for all
1.4	Believes in the importance of empathy and listening to others
1.5	Believes in and respects all forms of diversity
1.6	Believes in the importance of self-awareness and self-care
1.7	Believes in lifelong learning and personal development
1.9	Believes that recovery is a process
1.10	Believes in the healing power of healthy relationships
2.6	Knowledge of trauma and its impact on the recovery process
2.7	Knowledge of person-centered care principles
2.8	Knowledge of strengths-based planning for recovery
3.2	Knowledge of ethics and boundaries
3.3	Knowledge of the scope of practice of a certified peer specialist
3.5	Knowledge of ways to encourage safe, trauma-sensitive environments, relationships, and interactions
4.1	Ability to bring an outlook on peer support that inspires hope and recovery
4.2	Ability to be self-aware and embrace and support own recovery
4.4	Ability to assist people in exploring life choices, and the outcomes of those choices
4.7	Effective written and verbal communication skills

Domain	Item Description
4.11	Ability to locate appropriate recovery resources, including basic needs, medical, mental health and substance use disorder care; supports, including social support and mutual aid groups; and to facilitate referrals
4.12	Ability to facilitate and support a person to find and utilize resources
4.17	Ability to balance own recovery while supporting someone else's
4.18	Ability to foster the person's self-advocacy and provide advocacy when requested by the person
4.19	Ability to advocate for self in the role of a certified peer specialist

The Choice is Yours…

Peer Support Not Trauma-Informed	Trauma-Informed Peer Support
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.

Peer Support Not Trauma-Informed	**Trauma-Informed Peer Support**
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.

Concluding the Peer Relationship

(Core Competencies: 1.1; 1.7; 1.10; 2.7; 2.8; 3.2; 3.3; 3.5; 4.1; 4.4; 4.7; 4.12)

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 person may be served for few months in a crisis stabilization program or around one week at a peer-run respite. It is important that a certified peer specialist clearly communicate guidelines about the 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.

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, as well as excitement, hopefulness, and joyfulness. It is important to be self-aware of your 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 community care by turning to your supports. It is important to be fully present and emotionally available to the peer during the conclusion of peer support services.
- 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 in various ways, such as grief and loss, abandonment, uncertainty, and anger or a sense of satisfaction, gratitude, and excitement for next steps.

Best Practices for Concluding the Peer Relationship

(Core Competencies: 1.1; 1.4; 1.6; 1.7; 1.10; 2.7; 2.8; 3.2; 3.3; 3.5; 4.1; 4.2; 4.7)

- **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 shutdown during the final meeting. Others may not even show up. The certified peer specialist's understanding that there are various ways on how people navigate goodbyes will allow them to 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.

Next Steps

(Core Competencies: 3.3; 4.11; 4.19)

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 your training peers in preparation for the state-approved certified peer specialist exam.
- Use virtual 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/
- Review the "Wisconsin Certified Peer Specialist Emerging Best Practice Guide." https://www.wicps.org/resource_cat/certified-peer-specialist/?post_types=resource
- Participate in the certified peer specialist communities of practice.
- When you find a job as a certified peer specialist, encourage your employer to request 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

(Core Competencies: 1.5; 1.9; 2.6; 2.7; 3.3; 3.5; 3.7; 4.1; 4.17; 4.18; 4.19)

This course has described the certified peer specialist practice in terms of the fundamental processes, key concepts, tools, and resources that inform practice.

Fundamental Process	Description	Key Concepts	Tools and Resources
Connecting	Connecting is task number one in every meeting. Establish the peer relationship. Maintain a good working relationship.	• Self-awareness • Benefits of the peer Relationship • Strengths-based recovery principles • Trauma-informed care • Confidentiality	• Practicing self-care and community 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 challenges and mental health • Resilience and protective factors • Ambivalence • Multiple pathways to recovery	• OARS skills • Exploring open questions • Look for strengths and affirm • *Advantages and Disadvantages Worksheet* • Exploring values • Listening, revisited

Fundamental Process	Description	Key Concepts	Tools and Resources
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 (examples: 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

Fundamental Process	Description	Key Concepts	Tools and Resources
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
Advocating	Advocating is done with peers for change in workplace and change in service systems. Advocacy honors the value of certified peer specialists, the wishes of peers, and centers the supports needed for harm reduction.	• Advocate with peer • Advocate for professional needs in workplace • Advocate for certified peer specialist role and supports • Advocate for systemic change • Advocate for intentionality in integrating diversity, equity, and inclusion in all spaces	• OARS skills • Connect with resources and others with shared values • Applying understandings of culture, power, and privilege • Exploring values • Brainstorming • Collaboration and fostering connections through organizing advocacy efforts

Wrap Up and Celebrate Success

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 and professionally)?

- What might be one or two next steps on the path to becoming a certified peer specialist?