BEACON HEALTH OPTIONS
SUBSTANCE USE DISORDER
PEER SPECIALIST TRAINING MANUAL

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INTRODUCTION

This manual was created to train Peer Specialists who are or who will be working in treatment programs with clients who are eligible for Colorado Medicaid. Peer-based recovery support services are an important part of the service delivery system under Colorado Medicaid. Beacon Health Options, in partnership with 8 community mental health centers, formed Colorado Health Partnerships (CHP). CHP has a contract with the state of Colorado to manage the behavioral health benefit for forty three (43) of Colorado’s sixty-three (63) counties, so the information in this manual is written to support Peer Specialists working in the Beacon Health Options Provider Network. It has been necessary to tightly condense complicated ideas in this manual, so the writers encourage trainees to further explore the concepts contained in the training.

Special Thanks

Terry Krow, the Substance Use Disorder Coordinator for Beacon Health Options was the primary author of the manual. Peter Broderick, M.D. the Beacon Health Options, Colorado, Vice President of Clinical Operations and Haline Grublak the Beacon Health Options, Colorado, Vice President of Member and Family Affairs deserve special thanks for supporting the work of Peer Specialists. They provided administrative support, technical expertise and time for meetings, consultation and editing from their demanding schedules to insure this project’s success.
CHAPTER 2

Learning Objectives – You will learn the answers to the following questions:

1. What is a Peer Support Specialist?
2. What kinds of work do Peer Support Specialists do?
3. Where are Peer Support Services offered?

UNDERSTANDING THE ROLE OF A PEER RECOVERY SUPPORT SPECIALIST

What is a Peer Support Specialist?

A Peer Support Specialist is a person who has progressed in their own recovery from alcohol or other drug abuse or mental disorder and is willing to self-identify as a peer and work to help others with chemical dependency or a mental disorder. Because of their life experience, such persons have expertise that professional training cannot replicate.

Who Delivers Peer Recovery Support Services?

Services are delivered by people with the lived experience of recovery from addiction to alcohol and other drugs, either as a person in long-term recovery or a family member or significant other. There is a mutuality to peer recovery support, with the person giving and receiving support benefiting from the interaction. (White, 1998.) Whether paid or volunteer, there are various levels of training offered to members/peers who are providing services. Organizations that have an all-volunteer peer base have paid staff whose primary job is to train and supervise volunteer peers. In a growing number of states, certified peer addiction recovery support specialists are employees of the organization and are supervised by other paid staff in the organization.

When are Peer Recovery Support Services offered in the Recovery Process?

Peer services can be helpful at any time in a person’s recovery journey and there are roles for Peer Specialists across the full continuum of recovery, even if a person doesn’t use formal treatment services. They can be offered before an individual enters treatment or when they are waiting for a service opening. They can complement treatment services while a person is in a
program. Peer services can help after a person finishes treatment, helping a person manage their own recovery while living in the community. Peer specialists can connect clients with community resources to support ongoing recovery or give a person the opportunity to further enrich their recovery by volunteering in recovery support settings.

For the millions of Americans who are not receiving clinical treatment, peer services provide an important community network (including or in lieu of mutual aid groups) and infrastructure for recovery initiation.

Peer support programs are an important way for increasing a person’s self-efficacy beliefs and decision making abilities. Evidence shows that seeing persons similar to oneself successfully performing activities can increase a person’s belief in his or her own ability to perform those activities successfully.

**Where are Peer Recovery Support Services Delivered?**

Depending on where a person is in his or her recovery process, they can receive services in a variety of settings. Peer recovery support services are being delivered in urban and rural communities to many different population groups defined by age (adolescents, seniors); race or ethnicity (Native American, Latino, African American); gender and sexual orientation (women’s groups, groups for gay men); and/or co-existing conditions/status (incarceration, homelessness, mental illness or HIV/AIDS).

Many recovery community organizations have established recovery community centers where education, advocacy, and sober social activities as well as a place for mutual-aid meetings are offered in addition to peer recovery support services. These recovery community centers are helping to bridge the gap between treatment and incarceration and long-term recovery. Peer recovery support services are also offered in churches and other faith-based institutions; in recovery homes or sober housing; in jails and prisons; as part of probation and parole programs; in Drug Courts; in health care settings for people with HIV/AIDS and other health care centers; and addiction and mental health service agencies.

In Colorado, SUD services are now a covered benefit for Medicaid members. Most peer services will be delivered through a community mental health center or program that exclusively serves persons with a SUD diagnosis.

**Types of Peer Recovery Support Services**

**Peer/Recovery Coach:** These are individuals who are trained to serve as a personal guide and mentor for people seeking or already in recovery, regardless of pathway to recovery. Some activities of a peer/recovery coach include:

- Providing emotional support
• Helping the client set recovery goals and develop a recovery plan
• Assisting clients in restructuring daily activities and schedules to accommodate recovery
• Supporting clients while they develop new social networks
• Aiding clients in improving life skills and gaining access to services and resources

The peer/recovery coach does not perform mutual aid service work, but can link individuals to mutual aid support. (The role of Peer/Recovery Coach often includes tasks of Peer Resource Coordinator: see below.)

**Peer Resource Coordinator:** Connects individuals (and sometimes families) to resources in the community. These resources support recovery and include programs such as housing, employment, medical and professional services. Peer specialists teach people how to navigate different systems, services, and cultures such as child welfare, criminal justice, mental health, primary health (including HIV), and dental services.

**Support Group Facilitator:** Organizes, convenes, and facilitates general and special topic recovery support groups. Groups are often ongoing, can be gender and culture-specific, and cover issues such as living with HIV and/or Hepatitis C, living without substances and criminal activity, family reunification, and developing new friendships and support circles.

**Workshop Facilitator:** Develops and gives educational workshops that distribute information, develop knowledge, and build skills to support recovery. Workshops can be single or multiple events and cover a range of topics including job-readiness skills, reentry, expunging a criminal record, nutrition, and healthy relationships.

**Coordinate Drug-free Activities:** Provides opportunities for individuals and family members to access social inclusion, association and kinship with community, and leisure and socialization activities in substance-free settings.

**Recovery Community Centers:** Provide a hub for peer recovery support services, other community supports, and public space for individuals and families to convene in an environment that supports and promotes recovery.

**Peer Mentor:** The mentor often meets with the client individually, and works with the client to set goals and identify barriers to reaching those goals. Although these interactions often happen one on one, they are very different than clinical services. The Peer Specialist uses his own experiences as an example or as an analogy to events in the client’s life. This can create a context that is familiar to the client and helps when the client is struggling with their own choices and decisions.
CHAPTER 3

Learning Objectives – You will learn the answers to the following questions:

1. What is a practice standard?
2. How do practice standards for Peer Support Specialists affect their work?
3. What are three things a Peer Support Specialist should not do when working with others?

GUIDING PRINCIPLES FOR PEER SUPPORT

Working Definition and Guiding Principles of Recovery

SAMHSA developed a Working Definition and Guiding Principles of Recovery. These documents were put together after several years of study and talking to hundreds of consumers. In addition to the SAMHSA Working Definition and Guiding Principles of Recovery, the following core values have been endorsed by peer supporters across the country as the core ethical guidelines for peer support practice. These principles are relevant to Peer Specialists in both the mental health and substance use fields:

1. Peer support is voluntary
2. Peer supporters are hopeful
3. Peer supporters are open minded and non-judgmental
4. Peer supporters are empathetic
5. Peer supports are respectful
6. Peer supporters facilitate change
7. Peer supporters are honest and direct
8. Peer support is mutual and reciprocal
9. Peer support is equally shared power
10. Peer support is strengths-focused
11. Peer support is transparent
12. Peer support is person-driven

Practice Standards for Peer Specialists

The peer support workforce is at a critical time in its development. Research reveals that peer support can be valuable to those overcoming mental health and addiction challenges and their
families. (Resnick, 2008) Thousands of peers have been trained and are working in a wide variety of settings, but because this is a relatively new profession, questions about peer roles, duties and philosophies must still be explored.

In an effort to create broader understanding, reduce workplace tensions and frustrations and develop effective peer support roles, a universal set of practice standards is necessary. Such standards will enable peer support workers, non-peer staff, program administrators and developers, systems administrators, funders, researchers and policymakers to better understand peer supporter values, and the appropriate roles and tasks that can and should be carried out by peer support workers in a way that benefits all.

Professional practice standards

Professional practice standards generally have three basic components: 1) practice guidelines, 2) identification and description of core competencies and 3) ethical guidelines or a code of ethics. A project is currently underway to develop a universal set of practice guidelines for Peer Specialists. This project is under the direction of a consortium of stakeholder organizations, led by the International Association of Peer Supporters, and they have developed a draft.

The goals of national practice guidelines include:
- The identification of guidelines for developing appropriate and meaningful job descriptions.
- Providing a foundation upon which peer support core competencies can be identified.
- Creating a basis for peer support ethical guidelines.
- Creating a foundation for a potential national credential.
- Facilitating reciprocity policies (recognized in multiple states).
- Providing information that could be used to examine peer supporter training curricula.

Core Competencies

The state of Colorado has set forth a list of core competencies for Peer Specialists working in Medicaid funded programs. While there is not a state-approved credential for Peer Specialists, all Peer Specialists working for a mental health center or substance abuse program should be proficient in these competencies. The competencies can be found in the appendix.
**Practice guidelines**

With nearly 1,000 peer supporters responding to surveys and participating in focus groups, twelve key values were identified and validated as a basis for peer work. Those values include:

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<thead>
<tr>
<th>ETHICAL GUIDELINES</th>
<th>PRACTICE GUIDELINES</th>
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<tbody>
<tr>
<td><strong>Peer support is voluntary</strong></td>
<td><strong>Practice: Support choice</strong></td>
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<tr>
<td>Recovery is a personal choice.</td>
<td>1) Peer supporters do not force or coerce others to participate in peer support services or any other service.</td>
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<tr>
<td>The most basic value of peer support is that people freely choose to give or receive support.</td>
<td>2) Peer supporters respect the rights of those they support to choose or cease support services or use the peer support services from a different peer supporter.</td>
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<tr>
<td>Being coerced, forced or pressured is against the nature of genuine peer support.</td>
<td>3) Peer supporters also have the right to choose not to work with individuals with a particular background if the peer supporter’s personal issues or lack of expertise could interfere with the ability to provide effective support to these individuals. In these situations, the peer supporter would refer the individuals to other peer supporters or other service providers to provide assistance with the individuals’ interests and desires.</td>
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<td>The voluntary nature of peer support makes it easier to build trust and connections with another.</td>
<td>4) Peer supporters advocate for choice when they observe coercion in any mental health or substance abuse service setting.</td>
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<p>| <strong>Peer supporters are hopeful</strong> | <strong>Practice: Share hope</strong> |
| Belief that recovery is possible brings hope to those feeling hopeless. Hope is the catalyst of recovery for many people. Peer supporters demonstrate that recovery is real—they are the evidence that people can and do overcome the internal and external challenges that confront people with mental health, traumatic or substance use challenges. As role models, most peer supporters make a commitment to continue to grow and thrive as they “walk the walk.” By authentically living recovery, peer supporters inspire real hope that recovery is possible for others. | 1) Peer supporters tell strategic stories of their personal recovery in relation to current struggles faced by those who are being supported. |
|  | 2) Peer supporters model recovery behaviors at work and act as ambassadors of recovery in all aspects of their work. |
|  | 3) Peer supporters help others reframe life challenges as opportunities for personal growth. |</p>
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<tr>
<th><strong>Peer supporters are open minded</strong></th>
<th><strong>Practice: Withhold judgment about others</strong></th>
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| Being judged can be emotionally distressing and harmful. Peer supporters “meet people where they are at” in their recovery experience even when the other person’s beliefs, attitudes or ways of approaching recovery are far different from their own. Being nonjudgmental means holding others in unconditional positive regard, with an open mind, a compassionate heart and full acceptance of each person as a unique individual. | 1) Peer supporters embrace differences of those they support as potential learning opportunities.  
2) Peer supporters respect an individual’s right to choose the pathways to recovery individuals believe will work best for them.  
3) Peer supporters connect with others where and as they are.  
4) Peer supporters do not evaluate or assess others. |

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<tr>
<th><strong>Peer supporters are empathetic</strong></th>
<th><strong>Practice: Listen with emotional sensitivity</strong></th>
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| Empathy is an emotional connection that is created by “putting yourself in the other person’s shoes.” Peer supporters do not assume they know exactly what the other person is feeling even if they have experienced similar challenges.  
They ask thoughtful questions and listen with sensitivity to be able to respond emotionally or spiritually to what the other person is feeling. | 1) Peer supporters practice effective listening skills that are non-judgmental.  
2) Peer supporters understand that even though others may share similar life experiences, the range of responses may vary considerably. |
**Peer supporters are respectful**

Each person is valued and seen as having something important and unique to contribute to the world. Peer supporters treat people with kindness, warmth and dignity. Peer supporters accept and are open to differences, encouraging people to share the gifts and strengths that come from human diversity.

Peer supporters honor and make room for everyone’s ideas and opinions and believe every person is equally capable of contributing to the whole.

**Practice: Be curious and embrace diversity**

1) Peer supporters embrace diversity of culture and thought as a means of personal growth for those they support and themselves.
2) Peer supporters encourage others to explore how differences can contribute to their lives and the lives of others.
3) Peer supporters practice patience, kindness, warmth and dignity with everyone they interact with in their work.
4) Peer supporters treat each person they encounter with dignity and see them as worthy of all basic human rights.
5) Peer supporters embrace the full range of cultural experiences, strengths and approaches to recovery for those they support and themselves.

**Peer supporters facilitate change**

Some of the worst human rights violations are experienced by people with psychiatric, trauma or substance use challenges. They are frequently seen as “objects of treatment” rather than human beings with the same fundamental rights to life, liberty and the pursuit of happiness as everyone else. People may be survivors of violence (including physical, emotional, spiritual and mental abuse or neglect). Those with certain behaviors that make others uncomfortable may find themselves stereotyped, stigmatized and outcast by society. Internalized oppression is common among people who have been rejected by society. Peer supporters treat people as human beings and remain alert to any practice (including the way people treat themselves) that is dehumanizing, demoralizing or degrading and will use their personal story and advocacy to be an agent for positive change.

**Practice: Educate and advocate**

1) Peer supporters recognize and find appropriate ways to call attention to injustices.
2) Peer supporters strive to understand how injustices may affect people.
3) Peer supporters encourage, coach and inspire those they support to challenge and overcome injustices.
4) Peer supporters use language that is supportive, encouraging, inspiring, motivating and respectful.
5) Peer supporters help those they support explore areas in need of change for themselves and others.
6) Peer supporters recognize injustices peers face in all contexts and act as advocates and facilitate change where appropriate.
**Peer supporters are honest and direct**

Clear and thoughtful communication is fundamental to effective peer support. Difficult issues are addressed with those who are directly involved. Privacy and confidentiality build trust.

Honest communication moves beyond the fear of conflict or hurting other people to the ability to respectfully work together to resolve challenging issues with caring and compassion, including issues related to stigma, abuse, oppression, crisis or safety.

**Practice: Address difficult issues with caring and compassion**

1) Peer supporters respect privacy and confidentiality.
2) Peer supporters engage, when desired by those they support, in candid, honest discussions about stigma, abuse, oppression, crisis or safety.
3) Peer supporters exercise compassion and caring in peer support relationships.
4) Peer supporters do not make false promises, misrepresent themselves, others or circumstances.
5) Peer supporters strive to build peer relationships based on integrity, honesty, respect and trust.

**Peer support is mutual and reciprocal**

In a peer support relationship each person gives and receives in a fluid, constantly changing manner. This is very different from what most people experience in treatment programs, where people are seen as needing help and staff is seen as providing that help. In peer support relationships, each person has things to teach and learn. This is true whether you are a paid or volunteer peer supporter.

**Practice: Encourage peers to give and receive**

1) Peer supporters learn from those they support and those supported learn from peer supporters.
2) Peer supporters encourage peers to fulfill a fundamental human need -- to be able to give as well as receive.
3) Peer supporters facilitate respect and honor a relationship with peers that evoke power-sharing and mutuality, wherever possible.
**Peer support is equally shared power**

By definition, peers are equal. Sharing power in a peer support relationship means equal opportunity for each person to express ideas and opinions, offer choices and contribute.

Each person speaks and listens to what is said. Abuse of power is avoided when peer support is a true collaboration.

**Practice: Embody equality**

1) Peer supporters use language that reflects a mutual relationship with those they support.
2) Peer supporters behave in ways that reflect respect and mutuality with those they support.
3) Peer supporters do not express or exercise power over those they support.
4) Peer supporters do not diagnose or offer medical services, but do offer a complementary service.

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**Peer recovery support is strengths-focused**

Each person has skills, gifts and talents they can use to better their own life. Peer support focuses on what's strong, not what's wrong in another’s life. Peer supporters share their own experiences to encourage people to see the positive things they have gained through adversity. Through peer support, people get in touch with their strengths (the things they have going for them). They rediscover childhood dreams and long-lost passions that can be used to fuel recovery.

**Practice: See what’s strong not what’s wrong**

1) Peer supporters encourage others to identify their strengths and use them to improve their lives.
2) Peer supporters focus on the strengths of those they support.
3) Peer supporters use their own experiences to demonstrate the use of one’s strengths, and to encourage and inspire those they support.
4) Peer supporters encourage others to explore dreams and goals meaningful to those they support.
5) Peer supporters operate from a strength-based perspective and acknowledge the strengths, informed choices and decisions of peers as a foundation of recovery.
6) Peer supporters don’t fix or do for others what they can do for themselves.
### Peer support is transparent

Peer support is the process of giving and receiving non-clinical assistance to achieve long-term recovery from severe psychiatric, traumatic or addiction challenges. Peer supporters are experientially credentialed to assist others in this process. Transparency refers to setting expectations with each person about what can and cannot be offered in a peer support relationship, clarifying issues related to privacy and confidentiality. Peer supporters communicate with everyone in plain language so people can understand.

They “put a face on recovery” by sharing personal recovery experiences to inspire hope and the belief that recovery is real.

### Practice: Set clear expectations and use plain language

1) Peer supporters clearly explain what can or cannot be expected of the peer support relationship.
2) Peer supporters use language that is clear, understandable and value and judgment free.
3) Peer supporters use language that is supportive and respectful.
4) Peer supporters provide support in a professional yet humanistic manner.
5) Peer supporter roles are distinct from the roles of other behavioral health service professionals.
6) Peer supporters make only promises they can keep and use accurate statements.
7) Peer supporters do not diagnose nor do they prescribe or recommend medications or monitor their use.

### Peer support is person-driven

All people have a fundamental right to make decisions about things related to their lives. Peer supporters inform people about options, provide information about choices and respect their decisions. Peer supporters encourage people to move beyond their comfort zones, learn from their mistakes and grow from dependence on the system toward their chosen level of freedom and inclusion in the community of their choice.

### Practice: Focus on the person, not the problems

1) Peer supporters encourage those they support to make their own decisions.
2) Peer supporters, when appropriate, offer options to those they serve.
3) Peer supporters encourage those they serve to try new things.
4) Peer supporters help others learn from mistakes.
5) Peer supporters encourage resilience.
6) Peer supporters encourage personal growth in others.
7) Peer supporters encourage and coach those they support to decide what they want in life and how to achieve it without judgment.
CHAPTER 4

Learning Objectives: You will learn answers to the following questions:

1. What is Trauma?
2. What are 2 different types of trauma?
3. What kind of impact can trauma have on a person’s wellbeing?

TRAUMA INFORMED SUPPORT

Psychological trauma

Trauma is often the result of an overwhelming amount of stress that exceeds one's ability to cope or integrate the emotions involved with that experience. A traumatic event involves one experience, or repeating events with the sense of being overwhelmed that can be delayed by weeks, years, or even decades as the person struggles to cope with the immediate circumstances, eventually leading to serious, long-term negative consequences, which can often be overlooked even by mental health professionals.

Trauma can be caused by a wide variety of events, but there are a few common aspects. There is frequently a violation of the person's ideas about the world and of their human rights, putting the person in a state of extreme confusion and insecurity. This is also seen when institutions that are depended upon for survival, violate or betray or disillusion the person in some unforeseen way.

Psychologically traumatic experiences often involve physical trauma that threatens one's survival and sense of security. Typical causes and dangers of psychological trauma include harassment, embarrassment, sexual abuse, employment discrimination, police brutality, bullying, domestic violence, indoctrination, being the victim of an alcoholic parent, the threat of either, or the witnessing of either, particularly in childhood, life-threatening medical conditions, and medication-induced trauma. Catastrophic natural disasters such as earthquakes and volcanic eruptions, war or other mass violence can also cause psychological trauma. Long-term exposure to situations such as extreme poverty or milder forms of abuse, such as verbal abuse, exist independently of physical trauma but still generate psychological trauma.

However, the definition of trauma differs among individuals by their own experiences, not the objective facts. People will react to similar events differently. In other words, not all people who experience a potentially traumatic event will actually become psychologically traumatized. This discrepancy in risk rate can be attributed to protective factors some individuals may have that enable them to cope with trauma. Some examples are mild exposure to stress early in life that
enable the person to develop coping strategies, resilience characteristics, and actively seeking help.

**Childhood trauma**

Some theories suggest childhood trauma can increase one's risk for psychological disorders including PTSD, depression, and substance abuse. Childhood adversity is associated with heightened neuroticism scores during adulthood. Childhood abuse tends to have the most long-term complications out of all forms of trauma because it occurs during the most sensitive and critical stages of psychological development. It could also lead to violent behavior, possibly as extreme as serial murder. For example, Hickey's Trauma-Control Model suggests that "childhood trauma for serial murderers may serve as a triggering mechanism resulting in an individual's inability to cope with the stress of certain events."

**Understand the impact of trauma and responses to trauma**

People who go through these types of extremely traumatic experiences often have certain symptoms and problems afterward. How severe these symptoms are depends on the person, the type of trauma involved, and the emotional support they receive from others. Reactions to and symptoms of trauma can be wide and varied, and differ in severity from person to person. After a traumatic experience, a person may re-experience the trauma mentally and physically, hence avoiding trauma reminders, also called triggers, as this can be uncomfortable and even painful. They may turn to psychoactive substances including alcohol to try to escape the feelings. Re-experiencing symptoms is a sign that the body and mind are actively struggling to cope with the traumatic experience.

**Triggers and cues**

Triggers and cues act as reminders of the trauma, and can cause anxiety and other associated emotions. Often the person can be completely unaware of what these triggers are. In many cases this may lead a person suffering from traumatic disorders to engage in disruptive or self-destructive coping mechanisms, often without being fully aware of the nature or causes of their own actions. Panic attacks are an example of a psychosomatic response to such emotional triggers, which can sometimes lead to severe-case psychosis.

**Intense feelings**

Consequently, intense feelings of anger may frequently surface, sometimes in inappropriate or unexpected times, as danger may always seem to be present, as much as it is actually present and experienced from past events. Upsetting memories such as images, thoughts, or flashbacks may haunt the person, and nightmares may be frequent. Insomnia may occur as lurking fears and insecurity keep the person vigilant and on the lookout for danger, both day and night. Trauma doesn't only cause changes in one's daily functions but could also lead to changes at the cellular level. These changes can be passed on to the next generations, thus making genetics one of the components of the causes of psychological trauma. However, some people are born or later
develop protective factors such as genetics and gender that help lower their risk of psychological trauma.

The person may not remember what actually happened, while emotions experienced during the trauma may be re-experienced without the person understanding why. This can lead to the traumatic events being constantly experienced as if they were happening in the present, preventing the subject from gaining perspective on the experience. This can produce a pattern of prolonged periods of acute arousal punctuated by periods of physical and mental exhaustion. In time, emotional exhaustion may set in, leading to distraction, and clear thinking may be difficult or impossible. Emotional detachment, as well as dissociation or "numbing out", can occur. Dissociating from the painful emotion includes numbing all emotion, and the person may seem emotionally flat, preoccupied, distant, or cold. The person can become confused in ordinary situations and have memory problems.

**Long term effects**

Some traumatized people may feel permanently damaged when trauma symptoms do not go away and they do not believe their situation will improve. This can lead to feelings of despair, loss of self-esteem, and frequently depression. If important aspects of the person's self and world understanding have been violated, the person may call their own identity into question. Often despite their best efforts, traumatized parents may have difficulty assisting their child with emotion regulation, attribution of meaning, and containment of post-traumatic fear in the wake of the child's traumatization, leading to adverse consequences for the child. In such instances, it is in the interest of the parent and child for the parent to seek professional help as well as to have their child receive appropriate mental health services.

**Situational trauma**

Trauma can be caused by man-made and natural disasters, including war, abuse, violence, earthquakes, motor vehicle accidents (car, train, or plane crashes, etc.) or medical emergencies. Responses to psychological trauma: There are several behavioral responses common towards stressors including the proactive, reactive, and passive responses. Proactive responses include attempts to address and correct a stressor before it has a noticeable effect on lifestyle. Reactive responses occur after the stress and possible trauma has occurred, and are aimed more at correcting or minimizing the damage of a stressful event. A passive response is often characterized by an emotional numbness or ignorance of a stressor.

Those who are able to be proactive can often overcome stressors and are more likely to be able to cope well with unexpected situations. On the other hand, those who are more reactive will often experience more noticeable effects from an unexpected stressor. In the case of those who are passive, victims of a stressful event are more likely to suffer from long-term traumatic effects and often enact no intentional coping actions. These observations may suggest that the level of trauma associated with a victim is related to such independent coping abilities.
There is also a distinction between trauma induced by recent situations and long-term trauma which may have been buried in the unconscious from past situations such as childhood abuse. Trauma is often overcome through healing; in some cases this can be achieved by recreating or revisiting the origin of the trauma under more psychologically safe circumstances, such as with a therapist.
CHAPTER 5

Learning Objectives: You will learn answers to the following questions:

1. What factors contribute to personal resilience?
2. What are at least 6 elements of recovery?
3. What can be done to maintain good health?
4. How can person-centered planning help a person reach their recovery goals?

RESILIENCY, RECOVERY AND WELLNESS

Understanding the Principles and Concepts of Resiliency, Recovery, and a Wellness Oriented Lifestyle

Peer Specialists should make every effort to foster independence in their clients. This occurs in part by helping clients to identify their strengths and helping them to focus and implement ways to develop and maintain healthy lifestyles. Changing from a dysfunctional substance abusing lifestyle to a healthy recovery lifestyle can be stressful for the client. Managing the stress of this transition can improve the client’s self-esteem as well as teaches the client how to tap into their own psychological resilience needed for independent long-term recovery.

Psychological Resilience

Psychological resilience is defined as an individual’s ability to properly adapt to stress and adversity. Stress and adversity can come in the shape of family or relationship problems, health problems, or workplace and financial stressors. Individuals demonstrate resilience when they can face difficult experiences and rise above them with ease. Resilience is not a rare ability; in fact, it is found in the average person and it can be learned and developed by virtually anyone.

Resilience should be thought of as a process, rather than a trait to be had. There is a common misconception that people who are resilient don’t experience negative emotions or thoughts and display optimism in all situations. The reality is that resiliency is demonstrated when a person effectively navigates their way around crises and uses effective coping methods without being overcome by negative feelings. In other words, people who demonstrate resilience are people who can balance negative emotions with positive ones.

There are a number of factors, which together, contribute to a person’s resilience. The primary factor in resilience is having positive relationships inside or outside one’s family. It is the single
most critical means of handling both ordinary and severe levels of stress. These positive relationships are mutual, reciprocal, supportive and caring. Such relationships strengthen a person’s resilience. Studies show that there are several other factors which develop and sustain a person’s resilience.

**Factors promoting resilience**

These factors are not necessarily inherent; they can be developed in any individual and they promote resiliency.

1. The ability to make realistic plans and being capable of taking the steps necessary to follow through with them.
2. A positive self-concept and confidence in one’s strengths and abilities.
3. Communication and problem-solving skills.
4. The ability to manage strong impulses and feelings. There are differences of opinion about the indicators of good psychological and social development when resilience is studied in different cultures or contexts. People who cope well may show "hidden resilience" even though they don’t conform to society’s expectations for how someone is supposed to behave. For example, in some situations, aggression may be required to cope, or emotional withdrawal is protective in abusive situations.

In all these instances, resilience is best understood as a process. It is often mistakenly assumed to be a trait of the individual, an idea more typically referred to as "resiliency." Resilience is how individuals are able to interact with their environments in a way that either promotes well-being or protects them against the influence of risk factors. These processes can be individual coping strategies, or may be helped along by supportive families, schools, communities, and social policies, all of which can protect an individual from external risks. In this sense "resilience" occurs when there are cumulative "protective factors". Protective factors play a more important role as the individual is exposed to more "risk factors". The phrase "risk and resilience" in this area of study is quite common.

**Recovery**

A recovery approach to mental illness or substance abuse emphasizes and supports a person's potential for recovery. In this approach, recovery is generally seen as a personal journey rather than a specific outcome. The “recovery journey” may involve:

- having hope,
- developing a secure sense of self,
- having and maintaining supportive relationships,
- empowerment,
• social inclusion,
• possessing coping skills, and
• having a sense of meaning and purpose in their life.

In medicine and psychiatry, recovery has typically referred to the end of a particular experience or episode of illness. When the term recovery is used to describe a philosophy or a model for services, the meaning is somewhat different. It doesn’t mean a specific point in time where the illness “ends.” It refers to a service delivery process that focuses on developing hope, meaning and other attributes that will result in a person living a satisfying and meaningful life. Recovery can be life-long for some individuals.

Recovery from substance dependence

Particular kinds of recovery models have been adopted in drug rehabilitation services. While interventions in this area have tended to focus on harm reduction, including medication assisted therapy (or alternatively requiring total abstinence), recovery approaches have emphasized the need to simultaneously address the whole person, and to encourage goals and ambitions while promoting access to opportunities. From the perspective of services the work may include:

• helping people to "develop the skills to prevent relapse into further illegal drug use,
• rebuilding broken relationships or forging new ones,
• actively engaging in meaningful activities and
• taking steps to create a home and provide for themselves and their families.”

Milestones could be as simple as gaining weight, re-establishing relationships with friends, or building self-esteem. What is key is that recovery is sustained.

Another key tenet is that each individual's journey to recovery is a deeply personal process, as well as being specific to an individual's community and society. A number of features or signs of recovery have been proposed as core elements.

Elements of recovery

Hope

Finding and nurturing hope has been described as a key to recovery. It includes not just optimism but a sustainable belief in oneself and a willingness to persevere through uncertainty and setbacks. Hope may start at a certain turning point, or emerge gradually as a small and fragile feeling, and may fluctuate with despair. It also involves trust, and risking disappointment, failure and further hurt.
Secure base
Appropriate housing, sufficient income, freedom from violence, and adequate access to healthcare are other elements of recovery. It has been suggested that home is where recovery may begin. Housing services, if required, need to flexibly involve people and build on individuals' personal visions and strengths, instead of "placing" and potentially "re-institutionalizing" people.

Sense of self
Recovering a sense of self (if it had been lost or taken away) is another important element. People have described a process where they learn about themselves, their interests and goals, and form an identity that is unrelated to their mental illness. “I’m Joe, and I’m an artist,” as opposed to “I’m Joe and I’m a schizophrenic.” The process is usually facilitated by experiences of interpersonal acceptance, mutuality, and a sense of social belonging; and is often challenging in the face of the negative messages that come from society and the stigma of mental illness or substance use disorders.

Supportive relationships
A common aspect of recovery is said to be the presence of others who believe in the person's potential to recover, and who stand by them. While mental health professionals can offer a limited kind of relationship that helps to foster hope, a person’s relationships with friends, family and peers are more important in the longer-term. Others who have experienced similar difficulties, who may be on a journey of recovery, can be of particular importance. Those who share the same values and outlooks can serve as role models and mentors in a way that professionals cannot. Reciprocal relationships (with peers) and mutual support networks are valuable to self-esteem and recovery and are more sustainable than the hierarchical relationship between a client and a professional.

Empowerment and Inclusion
Empowerment and self-determination are important to recovery. This means developing the confidence to make decisions and follow through on those decisions. Becoming part of a social network offers support and challenges the stigma and prejudice that many individuals have experienced. Participating in a mutual support group gives a person the opportunity to be the helper instead of the person being helped. Some people have described an experience or feeling of “learned helplessness,” where others make decisions for them and they are protected from failure. Empowerment can mean taking risks that have the potential for failure, but consumers see this as positive and necessary to their growth.

Coping strategies
Developing personal coping strategies (including self-management or self-help) is an important element. This can mean psychotherapy or taking medication. Participation in self-help groups is also valuable because people learn coping strategies from someone who has experience with similar issues or symptoms. For example, a person in a mutual self-help group may be able to learn new ways to deal with distressing voices from others who hear voices. Developing problem
solving skills may require a person to become their own expert, so they can identify triggers and crisis points, and find new ways of responding and coping.

Moving on can mean having to cope with feelings of loss, which may include despair and anger. When an individual is ready, this can mean a process of grieving. It may require accepting past suffering and lost opportunities or lost time.

Structure is very important in any model of recovery. Continuing one's education or getting and keeping work can be very therapeutic and boost self-esteem. Self-development keeps a person focused on doing positive things and on personal growth.

**Meaning**

Developing a sense of meaning and overall purpose is important for sustaining recovery. This may involve recovering or developing a social or work role. It may also involve renewing, finding or developing a guiding philosophy, religion, politics or culture. It may also mean developing a new role in life, where the person is no longer a “mental patient” or “drug addict” but is a student, husband, wife, construction worker, or other description of who they are. Work, going back to school or resuming child rearing can give a person a sense of meaning and purpose, a reason to get up in the morning.

**Wellness**

The World Health Organization describes mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community”.

**Maintaining health**

Achieving and maintaining health is an ongoing process, shaped by both the evolution of health care knowledge and practices as well as personal strategies and organized interventions for staying healthy. An important way to maintain your personal health is to have a healthy diet. A healthy diet includes a variety of plant-based and animal-based foods that provide nutrients to your body. Such nutrients give you energy and keep your body running. Nutrients help build and strengthen bones, muscles, and tendons and also regulate body processes (i.e. blood pressure).

The food guide pyramid is a pyramid-shaped guide of healthy foods divided into sections. Each section shows the recommended intake for each food group (i.e. Protein, Fat, Carbohydrates, and Sugars). Making healthy food choices is important because it can lower your risk of heart disease, developing some types of cancer, and it will contribute to maintaining a healthy weight. Some believe that eating a healthy diet can prevent depression.

**Exercise**

Physical exercise enhances or maintains physical fitness and overall health and wellness. It strengthens muscles and improves the cardiovascular system. It improves sleep, and some studies
show that regular exercise has been shown to decrease symptoms of depression. Even small amounts of exercise, such as short walks, or getting off the couch to do chores, is better than nothing. For persons who have not exercised for a long period of time, small efforts such as parking far away from your building, or taking the stairs, can help. Once you can do these things effortlessly, you can graduate to more intense exercise such as walking around the block, with the ultimate goal being to find an exercise you can do for at least 30 minutes, several times a week.

Prevention or health maintenance
Personal health depends partially on personal actions people take for preventing or minimizing the effects of a disease. They also include personal hygiene practices to prevent infection and illness, such as bathing and washing hands with soap; brushing and flossing teeth; storing, preparing and handling food safely; and many others. You can use the information you gather from paying attention to your daily habits to help you make decisions and take action. For example "I feel tired in the morning so I am going to try sleeping on a different pillow” helps you maintain your wellness. Also, clinical decisions and treatment plans are used to take action. (e.g., a patient who notices his or her shoes are tighter than usual may be retaining fluids, and may require diuretic medication to reduce fluid overload).

Personal health also depends partially on the social structure of a person's life. Maintaining strong social relationships, volunteering (giving back to others), and other social activities have been linked to positive mental health and also increased longevity. One American study among seniors over age 70, found that frequent volunteering was associated with reduced risk of dying compared with older persons who did not volunteer, regardless of physical health status. Another study from Singapore reported that volunteering retirees had significantly better cognitive performance scores, fewer depressive symptoms, and better mental well-being and life satisfaction than non-volunteering retirees.

Negative impacts to personal health
Prolonged psychological stress may negatively impact health, and has been cited as a factor in cognitive impairment with aging, depressive illness, and being vulnerable to disease. Stress management is the application of methods to either reduce stress or increase tolerance to stress. Relaxation techniques are physical methods used to relieve stress. Psychological methods include cognitive therapy, meditation, and positive thinking, which work by reducing response to stress. Improving relevant skills, such as problem solving and time management skills, reduces uncertainty and builds confidence, which also reduces the reaction to stress-causing situations when those skills are applicable.

Helping others with their own resiliency and recovery

Working as a Peer Specialist, you will have the opportunity to share your own recovery successes and recommend strategies that have worked for you. It’s important to mention that
there is no “magic bullet.” What works for you may or may not work for your client. That’s why it’s important not to proselytize or push your way of recovery onto others. It’s also important for you not to discourage programs or strategies you know nothing about, or didn’t work for you. Everyone’s recovery journey is unique, and what works for one person may not work for another. Keep an open mind with programs you know little about (unless you are concerned a specific program will cause harm. If that’s the case, you should talk to your supervisor). As a final note, never make recommendations about medical or clinical interventions. Leave that to the experts. While it may be tempting to discourage a client from taking a specific medication because it didn’t work for you, don’t do it. Those decisions should be made by the client and their doctor.

**Encourage Options and Choices**

People with addictions may have cognitive distortions. One is commonly known as black and white thinking or all-or-nothing thinking, which is the inability to bring together both positive and negative qualities of a person or situation into a cohesive, realistic whole. The individual tends to think in extremes (i.e., an individual's actions and motivations are *all* good or *all* bad with no middle ground.)

**All-or-nothing thinking**

All-or-nothing thinking creates uncertainty in relationships because one person can be viewed as either saintly or evil at different times, depending on whether the person meets your needs or makes you mad. This can lead to chaotic and unstable relationship patterns and mood swings. The relationship with the Peer Specialist can be affected because the Peer Specialist can be seen as all good or all bad.

All-or-nothing thinking contributes to unstable relationships and intense feelings. All-or-nothing thinking is common during adolescence, but is regarded as transient. All-or-nothing thinking has been noted especially with persons diagnosed with borderline personality disorder. Treatment strategies have been developed for individuals and groups based on dialectical behavior therapy. There are also self-help books on related topics such as mindfulness and emotional regulation that have helped individuals who struggle with the consequences of all-or-nothing thinking.

**Impacts of Labels, Stigma, Discrimination, and Bullying**

Labeling theory is the theory of how the self-identity and behavior of individuals may be influenced by the words used to describe or classify them. It is related to the idea of self-fulfilling prophecy and stereotyping. As a Peer Specialist, it is important to use “people first” and respectful language. People first language does not describe a person in terms of their disability or diagnosis but rather describes the person as an individual. For example,” Joe is a schizophrenic” puts the emphasis on Joe’s diagnosis, and dismisses him as a person. “Joe is a person who has schizophrenia,” describes Joe as an individual who has a diagnosis. Respectful
language avoids labeling and stereotyping labels such as “alcoholic,” “mental patient” or “dope fiend.” Instead, it uses respectful terminology, or avoids pointing out a disability unless it is relevant to the discussion. People who are labeled often internalize these roles, so the Peer Specialist should always avoid using negative labels.

Stigma and discrimination are very real experiences for persons with a substance use disorder or mental illness. Our clients have experienced discrimination in overt ways such as being denied housing or jobs, and in subtle ways such as people crossing the street when they are on the sidewalk. Some kinds of discrimination have resulted in bullying, which itself can be traumatic. Since some of these experiences have been traumatic, it’s important for the Peer Specialist to acknowledge the impact these events have had on our client’s lives. In fact, some people have described that the consequences of having a mental illness or substance use disorder (discrimination, bullying, fear and resentment) are just as traumatic as the symptoms of the illness itself.

Other kinds of language or labels can be disempowering. Think of the word “compliance” versus “adherence.” The word compliant means that a person is following another’s instructions or set rules. The word adherence on the other hand, means that a person chooses to follow a rule or a plan. Other words that are often used in treatment can have the same impact. We’ve put together a short list of terms that can be power-robbed and their alternatives.

<table>
<thead>
<tr>
<th>Power-Robbing Language</th>
<th>Empowering Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>You should do…</td>
<td>You may want to think about doing…</td>
</tr>
<tr>
<td>You need…</td>
<td>What choices do you have?</td>
</tr>
<tr>
<td>You can’t….</td>
<td>What can you do to…….?</td>
</tr>
<tr>
<td>Problem</td>
<td>Challenge, situation</td>
</tr>
<tr>
<td>But</td>
<td>And</td>
</tr>
<tr>
<td>It only works when…</td>
<td>What other ways might work for you?</td>
</tr>
<tr>
<td>Your only option is…</td>
<td>Let’s look at some options together</td>
</tr>
<tr>
<td>My advice to you is…</td>
<td>What has worked for you in the past?</td>
</tr>
<tr>
<td>Here, sign your treatment plan.</td>
<td>What problems do you want to work on?</td>
</tr>
</tbody>
</table>

Adapted from peers in the Illinois Collaborative for Recovery and Choice
The Office of National Drug Control Policy recognizes the power of language and drafted a preliminary glossary of suggested language. While the project is not complete, this list shows how changing the language can change the way we view a problem.

<table>
<thead>
<tr>
<th>Instead of:</th>
<th>Try:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addict</td>
<td>Person with a substance use disorder</td>
</tr>
<tr>
<td>Addicted to X</td>
<td>Has a X disorder</td>
</tr>
<tr>
<td>Addiction</td>
<td>Substance use disorder (the term “addiction” can be used when talking about a disease process, name of a program, etc. but should not be used describing people or a person’s disorder)</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>Person with an alcohol disorder</td>
</tr>
<tr>
<td>Clean</td>
<td>Abstinent</td>
</tr>
<tr>
<td>Clean Screen</td>
<td>Substance-free OR Testing negative for substance use</td>
</tr>
<tr>
<td>Dirty</td>
<td>Actively using OR Positive for substance use</td>
</tr>
<tr>
<td>Drug Habit</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td>Drug Abuser</td>
<td>Person with a substance use disorder OR Person who uses drugs (if not qualified as a disorder)</td>
</tr>
<tr>
<td>Former Addict or former alcoholic</td>
<td>Person in Recovery</td>
</tr>
<tr>
<td>Methadone Maintenance</td>
<td>Medication assisted treatment</td>
</tr>
<tr>
<td>Recreational or casual users</td>
<td>People starting to use drugs OR People who are new to drug use</td>
</tr>
</tbody>
</table>

Source: White House Office of National Drug Control Policy

You can probably think of more terms that are power-robbing and empowering language you can put in its place.
Understand person-centered resiliency and recovery planning for all ages and stages

Person Centered Planning (PCP) is a set of approaches designed to assist someone to plan their life and supports. It is used most often as a life planning model to enable individuals with disabilities or otherwise requiring support to increase their personal self-determination and improve their own independence.

PCP is accepted as evidence based practice in many countries throughout the world. It is most often used for life planning for people with learning or developmental disabilities. Recently, however, it has been used as a way to plan support for many other groups who have been disempowered by traditional methods of service delivery. These groups include children, people with physical disabilities, people with mental health issues, veterans and older people.

Person Centered Planning discovers and acts on what is important to a person. It is a process for listening, learning, and focusing on what is important to someone now and in the future, and forming a support plan in alliance with their family and their friends.

Person-centered planning was created in response to some specific problems with the way in which society responds to people with disabilities. It offers an alternative to traditional models, striving to place the individual at the center of decision-making, and treats family members as partners. The process focuses on discovering the person's gifts, skills and capacities, and on listening for what is really important to the person. It is based on the values of rights protection, interdependence, choice and social inclusion, and can enable people to direct their own services and supports, in a personalized way.

Techniques

Person-centered planning utilizes a number of techniques, with the central premise that any methods used must be relevant to the individual and can help them outline their needs, wishes and goals. The process is just as important as the outcomes because the client is included in all aspects of the plan. Beth Mount (Mount & O'Brien, 2005) described four themes in the person centered planning process:

- see people first, rather than diagnostic labels;
- use ordinary language and images, rather than professional jargon
- actively search for a person's gifts and capacities in the context of community life
- strengthen the voice of the person, and those who know the person best in putting together their history; evaluate their present conditions in terms of defining desirable changes in their life

The plan may be in any format that is accessible to the individual, such as a written document, a drawing or an oral plan recorded onto a CD or MP-3 player. Multimedia techniques are becoming more popular for this type of planning because it is relatively inexpensive and
accommodate a client’s reading difficulties or other barriers to understanding a written plan. Another important feature of the plan is that the client is put at the center of the plan, and their ideas are given preference over recommendations made by clinical or social services staff.

Peer Specialists may be involved in treatment planning either directly, or by talking to the client about the treatment plan. If you are not directly involved in the process, you may want to talk to the client about their plan, and help them define goals and objectives that they can take into the treatment planning meeting. If you are part of the team meeting, you can help the client articulate the goals, objectives, hopes, and strengths they’ve already talked to you about in other peer encounters.
Shared decision-making (SDM) (Makoul, 2006) is an approach for clients and staff to communicate using a structured format, or a visual aid to help the client make decisions about treatment. The clients are given information about the potential benefits and consequences of a specific treatment, and have a structured discussion so that the client is able to make a decision about the best action that is in the client’s best interest. Shared decision making respects both the provider’s knowledge and expertise and the patient’s personal preferences, goals and desires.

A core principle for shared decision-making, states “that at least two participants, the clinician and patient be involved; that both parties share information; that both parties take steps to build a consensus about the preferred treatment; and that they reach an agreement about the treatment to implement”. The goal of SDM is to arrive on an agreement but this final principle is not fully accepted by some providers in healthcare. The notion that it is acceptable to agree to disagree is also an acceptable outcome of shared decision-making.

It was first developed for use with patients who were facing potentially life changing treatments such as surgery or chemotherapy. There are many situations where shared decision making could be beneficial for clients in treatment for substance abuse and the Peer Specialist can have an important role in helping the client reach these decisions.
CHAPTER 6

Learning Objectives: You will learn answers to the following questions:

1. What are the 10 classes of drugs that the DSM recognizes as being drugs of abuse?
2. List 4 behaviors or actions that would result in a person getting a diagnosis of substance use disorder?
3. What are at least 2 kinds of treatments that are provided to persons getting services for a substance use disorder?

SUBSTANCE USE DISORDER CONDITIONS AND TREATMENTS

Recognizing signs of a substance use disorder

Peer Specialists are not expected to diagnose substance use disorders; in fact Peer Specialist are encouraged to avoid labeling because it can cause problems in the peer to peer relationship. However, Peer Specialists need to be able to recognize signs of relapse so they can help clients who are at risk of lapsing or relapsing and to educate clients to understand the difference between risk and impairment. The criteria used to identify substance abuse diagnoses are based on cravings, functional impairment, tolerance, and withdrawal from the substance.

Understanding these concepts will give the Peer Specialist the ability to help clients navigate the service delivery system and to recognize warning signs for the client and the treatment team.

DSM-5 - diagnostic and statistical manual of mental disorders, fifth edition

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, commonly referred to as the DSM-5, is the latest version of the American Psychiatric Association’s gold standard text on the names, symptoms, and diagnostic features of every recognized mental illness, including addictions. The DSM-5 is the guide that is used to diagnose clients in medical and clinical programs. Therefore, our description of substance use disorders is based on the DSM-5.
The DSM-5 recognizes substance related disorders resulting from the use of ten separate classes of drugs:

1. Alcohol,
2. Caffeine,
3. Cannabis,
4. Hallucinogens (phencyclidine or similarly acting arylcyclohexylamines), other hallucinogens such as LSD,
5. Inhalants,
6. Opioids,
7. Sedatives, hypnotics, anxiolytics,
8. Stimulants (including amphetamine-type substances, cocaine, and other stimulants),
9. Tobacco, and
10. Other or unknown substances

DSM 5 and a substance use disorder diagnosis

The DSM 5 criteria for Substance Use Disorders span a wide variety of problems arising from substance use. To meet diagnostic criteria for a Substance Use Disorder, an individual must experience significant impairment due to a minimum of 2 of the following problems resulting from their substance use during a 12 month period:

1. Taking the substance in larger amounts or for longer than they meant to
2. Wanting to cut down or stop using the substance, but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what they should at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts the them in danger
9. Continuing to use, even when they know they have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect they want (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

This list of problems is not complete and certainly individuals can encounter many other problems related to their substance use. It is important to remember that these problems may not always be present, but may come and go with ongoing substance use. The Peer Specialist needs to be aware that if these problems reoccur in someone working on their recovery, it may indicate the person is at risk of relapse into substance use.
Treating substance use disorders

Treatment of substance use disorders can come in many forms and include a variety of services and treatments. Treatment options include:

- Individual and group counseling
- Inpatient and residential treatment
- Intensive outpatient treatment
- Partial hospital programs
- Case or care management
- Medication
- Recovery support services
- 12-Step fellowship
- Peer supports
- Detox – social or medical

Successful treatment of a substance use disorder needs to be tailored to each individual based on their history and preferences. Often an individual will need to combine several of these treatment options to support their recovery efforts and achieve the best outcome.

Individual and Group Counseling

Counseling for the treatment of substance use disorders can be provided on an individual basis or in a group setting. Counselors may use a variety of therapy techniques to help an individual obtain recovery. Some commonly used techniques and programs include:

- **Individual therapy or Psychotherapy** is treatment by a qualified therapist that uses talking as opposed to medication to alleviate symptoms of mental or emotional distress or to bring about changes in behavior, relationships or life situations. Discussing and resolving trauma is often a component of psychotherapy.
- **Cognitive-Behavioral Therapy (CBT)** teaches individuals in treatment to recognize and stop maladaptive behaviors and thinking patterns associated with substance abuse. CBT therapists help patients identify and correct these behaviors by applying a range of different skills.
- **Motivational Enhancement Therapy** helps individuals with substance use disorders identify and build internal motivation to make changes in their life. This type of treatment is frequently used early in treatment to engage the individual in the recovery process.
- **Alcoholics Anonymous or Narcotics Anonymous** are well established 12-step programs typically provided in a group setting with heavy peer involvement.
Inpatient and residential settings

Substance Use Disorder treatment may need to occur in an inpatient or residential treatment setting where an individual stays full time and receives 24-hour supervision and intensive treatment. Such treatment settings are often indicated when an individual has significant mental health or medical issues that accompany their substance use disorder or their recovery environment is so poor that the likelihood of successful treatment would be doubtful outside of a structured setting. Inpatient treatment generally is of short duration, while residential treatment may last weeks to months.

Partial hospitalization or intensive outpatient treatment are options that offer treatment sessions multiple times a week and can be alternatives to residential treatment. These programs offer similar services and treatments to those of a residential program, but have the advantage of treating the patient in their actual recovery environment.

Medication

Medications are increasingly being used to treat substance use disorders. Medication is typically used in combination with other treatments such as individual or group counseling as part of a comprehensive treatment plan. Medications work in treating substance use disorders by various methods including reducing cravings for drugs, preventing symptoms of drug withdrawal, blocking the rewarding effects of substances or causing a negative reaction when a substance is taken. Medication assisted therapy is primarily used for the treatment of opioid use disorder, but is also used for alcohol use disorder and the treatment of some other substance use disorders.

Recovery support services

Recovery support services are non-clinical services that are used with treatment to support individuals in their recovery goals. These services are often provided by peers, or others who are already in recovery. Recovery support can include:

- Transportation to and from treatment and recovery-oriented activities
- Employment or educational supports
- Specialized living situations
- Peer-to-peer services, mentoring, coaching
- Spiritual and faith-based support
- Parenting education
- Self-help and support groups
- Outreach and engagement
- Education about strategies to promote wellness and recovery
CHAPTER 7

Learning Objectives: You will learn answers to the following questions:

1. What are the five stages of grief as defined by Elisabeth Kübler-Ross?
2. How does this theory apply to persons who are becoming clean and sober?
3. Where does grief counseling fit into the Peer Specialist’s work?

GRIEVING AND SUBSTANCE USE DISORDERS

For some, grief and loss play an important role in recovery from substance use disorders. This section is about the grief process experienced by clients who are in the process of changing and giving up their relationships with substances and the substance using lifestyle. It will help Peer Specialists when a client is experiencing some feelings of loss related to giving up their old friends and lifestyle. This is not about grief counseling. Grief counseling is complex with risks of re-traumatizing clients and should only be done by trained counselors.

The Kübler-Ross model, commonly known as the five stages of grief, is a theory first introduced by Elisabeth Kübler-Ross in her 1969 book, On Death and Dying. The popular theory describes five distinct stages people move through when dealing with grief and tragedy. This kind of tragic event might include being diagnosed with a terminal illness or losing a close family member.

The Five Stages:

1. Denial
2. Anger
3. Bargaining
4. Depression
5. Acceptance

The theory explains that the stages occur as people learn to live without what they lost. Lay people and practitioners recognize the stages as tools to help them understand what a person who’s suffered a loss may be feeling. The stages are not points on a linear time line of grief. The theory also states that not everyone goes through all of the stages, nor in any specific order.

Denial

People feel that they do not have a problem with alcohol or drugs. Even if they do feel like they might have a small problem, they believe that they have complete control over the situation and
can stop drinking or doing drugs whenever they want. Example: “I don’t have to drink all of the time. I can stop whenever I want.”

**Anger**
The anger stage relates to how they get upset because they have an addiction or are angry that they can no longer use drugs like the rest of their friends. Examples include “I don’t want to have this addiction anymore.” “This isn’t fair. My friends drink and don’t have problems. Why is this happening to me?!!”

**Bargaining**
This is the stage that drug and alcohol abusers go through when they are trying to convince themselves or someone else that they are going to stop abusing in order to get something out of it or get themselves out of trouble. Example: “God, I promise I’ll never use again if you just get me out of trouble.” “I promise I’ll stop drinking if you take me back and don’t divorce me.” “I’ll never use again if I get custody of my kids.”

**Depression**
Sadness and hopelessness are important parts of the depression stage when dealing with a drug abuser. Most abusers experience this when they are going through the withdrawal stage quitting their addiction. It is important to let the client know that these feelings are a normal part of the process of healing.

**Acceptance**
With substance users, admitting the existence of a problem is different from accepting the problem. When a substance user admits that he/she has a problem, this is more likely to occur in the bargaining stage. Accepting that he/she has a problem is when you realize that you have a problem, acknowledge your responsibility for the problems it’s caused and begin the process of recovery.

According to her hypothesis, Kübler-Ross claimed the stages do not necessarily come in order, nor are all stages experienced by all clients. She stated, however, that a person always experiences at least two of the stages. Often, people experience several stages in a "roller coaster" effect—switching between two or more stages, returning to one or more several times before working through it. Women are more likely than men to experience all five stages.

It is not the role of Peer Specialists to facilitate change while clients are in the grieving process, but Peer Specialists can be better support when they recognize the grieving process and understand that the most important element in the grief process is to maintain stability over time.
CHAPTER 8

Learning Objectives: You will learn answers to the following questions:

1. What are co-occurring disorders?
2. What kinds of treatment work for co-occurring disorders?
3. What are three effects of substance abuse on a person’s physical health?

MENTAL HEALTH, MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Peer Specialists work with clients who have physical and mental health problems in addition to abuse or dependence on substances. Understanding the interaction between physical health, mental health and substance use disorders is important. Peer Specialists need to understand the interventions used by medical professionals when treating substance abuse and mental health disorders.

Historically, there has been a belief that people in recovery should maintain total abstinence, even from prescribed medications. This belief was well intended, but it caused disagreement with others who were treating clients with more complex needs or with co-occurring conditions. It’s also important to recognize that the abstinence philosophy was promoted long before we had the array of medications and well researched interventions we have today. The substance abuse treatment field has learned that an integrated approach is more effective in developing and managing recovery.

Peer Specialists who work with clients who have co-occurring disorders need to seek more intensive supervision and need close working relationships with the clinical team to best support clients with these clinical and medical needs.

Dual Diagnosis

Dual diagnosis (also called co-occurring disorders, COD or co-morbid disorders) is the condition where a person has both a mental illness and a co-occurring substance abuse problem. The term also refers to persons who have a mental illness and a developmental disability, but for our purposes, the term only refers to persons with mental illness and SUD. There continues to be debate around whether or not using a single category for a very diverse group of individuals with
a wide range of problems is appropriate. The concept can be used broadly, for example, depression and alcoholism, or it can be used to specify severe mental illness such as schizophrenia and cannabis abuse, or a person who has a milder mental illness and a drug dependency, such as panic disorder and dependence on tranquilizers. Diagnosing a primary psychiatric illness in substance abusers is challenging, because substance use itself often causes psychiatric symptoms. For example, a person withdrawing from methamphetamines may become severely depressed, or a person taking club drugs has hallucinations and delusions. This is why it is so important to distinguish between substance induced and pre-existing mental illness when treatment first begins.

Those with co-occurring disorders face complex challenges. They have higher rates of relapse, hospitalization, homelessness, HIV and Hepatitis C infection compared to those with either mental illness or substance use disorders alone. What causes co-occurring disorders is unknown, although there are several theories.

**Distinguishing between pre-existing and substance induced mental illness**

Drug abuse, including alcohol and prescription drugs, can cause symptoms which resemble mental illness. This can make it difficult to determine whether person’s symptoms are because of a pre-existing mental health problem or caused by drugs or alcohol. Often, psychiatric symptoms in drug or alcohol abusers disappear with prolonged abstinence. Substance induced psychiatric symptoms can occur both when someone is high and when they are withdrawing. In some cases these substance-induced psychiatric disorders can last long after a person has detoxed.

An example of this is the prolonged psychosis or depression a person experiences after detoxing from amphetamine or cocaine abuse. Abuse of hallucinogens can trigger delusional and other psychotic symptoms long after a person stops using these drugs. People who used LSD at one time describe having “flash-backs” long (sometimes years) after they stopped using LSD. Some people who use cannabis have panic attacks while they are using it or when they stop using it. Severe anxiety and depression can be induced by long-term alcohol abuse, but these symptoms decrease over time if the person remains abstinent. In most cases these drug induced psychiatric disorders fade away with prolonged abstinence. Benzodiazepines (tranquilizers such as Valium or Xanax) are the most notable drugs for inducing prolonged withdrawal effects. Some people experience symptoms for years after they stop using the drug.

**Prevalence**

The 2011 USA National Survey on Drug Use and Health found that 17.5% of adults with a mental illness had a co-occurring substance use disorder. (SAHMSA, 2011) This works out to 7.98 million people in the US. Estimates of co-occurring disorders in Canada are even higher.
Studies on co-occurring disorders among Canadians estimate that 40-60% of adults with a severe and persistent mental illness experience a substance use disorder sometime during their life.

Another study (Kessler, 2005) found that 47% of American clients with schizophrenia had a substance use disorder at some time in their life, and the chances of developing a substance use disorder was much higher among clients who also had a psychotic illness than those without a psychotic illness.

**Theories of Dual Diagnosis**

While we don’t know exactly why mental health and substance use disorders occur so frequently together, there are a number of theories that explain the relationship between mental illness and substance abuse.

*Causality*

The causality theory suggests that certain drugs may actually lead to mental illness. There is strong evidence that marijuana can produce temporary and mild psychotic experiences. Science has not been able to prove that marijuana causes psychosis. Although there has been a dramatic increase in the use of marijuana over the last 40 years, the rate of schizophrenia (and psychosis in general) has remained relatively stable. That is, the number of people being diagnosed with schizophrenia has not increased in proportion to the increased number of people who have used marijuana.

*Self-medication theory*

The self-medication theory suggests that people with mental illnesses use drugs or alcohol to relieve distressing symptoms of a mental illness. Some scientists believe that a person does not choose a drug, but rather, chooses specific effects of a drug. For example, a person who is depressed and fatigued uses stimulants such as cocaine or amphetamines to combat fatigue. People who are anxious and stressed may choose drugs with sedating effects such as benzodiazepines (tranquilizers such as Xanax or valium) or even alcohol, to combat their anxiety.

*Treatment*

Previous models of care would treat each problem separately. In the past, clients with co-occurring disorders were excluded from mental health services if they admitted to be actively using substances, and vice versa. If a person’s symptoms of a mental illness such as schizophrenia were not being controlled by medication, they were denied entry into an addictions program. Mental health wanted the person clean and sober before they would prescribe medications and treat the mental illness. Substance use disorder providers wanted the person’s mental health symptoms under control before they attempted treatment.
Partial treatment involves treating only the disorder that is considered primary. Sequential treatment involves treating the primary disorder first, and then treating the secondary disorder after the primary disorder has been stabilized. Parallel or integrated treatment involves the client receiving mental health services from one provider, and addictions services from another over the same time period.

This segregated model of treatment put the client in a bind. We now know that integrated models are much more effective, and the best programs treat mental illness and substance use disorders at the same time and in the same facility.

Integrated care is a way of delivering services where various providers come together to provide services in a collaborative and team oriented way. With this approach, both mental illness and substance use are considered primary. Integrated care improves access, engagement in treatment, adherence to treatment, mental health symptoms, and overall outcomes. The Substance Abuse and Mental Health Services Administration (SAMHSA), a government agency you’ll read more about later, describes integrated care as being in the best interests of clients, programs, funders, and systems. The Medicaid system in Colorado is moving toward an integrated care model but there is still a lot of work to be done. State contracts for both behavioral health and physical health services have financial incentives for programs that operate in an integrated manner. The private sector is catching up.

**Medication**

Many clients may choose not to take medications because they believe recovery can only occur when a person is totally abstinent. As a Peer Specialist, your role is not to advise or convince a client about a treatment philosophy, but rather to educate clients so that they can make informed decisions. For example, there is new scientific evidence around recovery and how medications can help people in their recovery. Prescribed medications can help manage symptoms such as paranoia, hallucinations, anxiety, and depression. Some medications can help reduce cravings. Medications that have proven effective include opioid replacement therapies, such as long-term maintenance on methadone or buprenorphine. These medications can reduce the risk of relapse, legal problems and even death from overdose in opiate addicts. Other medications have shown to be helpful with reducing cravings for alcohol, cocaine and amphetamines. Taken under the care of a doctor, these medications can free a client from cravings in the early stages of recovery, allowing the client to focus on other problems such as trauma.

In summary, not all people who have a substance use disorder are alike. The severity of their drinking or using, other health habits and genetics all play a role in whether, and to what degree, they will develop medical problems related to their substance use. Nonetheless, it is important that the Peer Specialist be aware that drug and alcohol use can cause significant medical
problems for their clients and that these problems can present both as barriers and motivation for recovery. The following section talks about this in more detail.

**The impact substance use disorders can have on physical health**

Similar to mental health disorders, the relationship between physical health problems and substance use disorders can be complex. The effects of alcohol and other drugs on the body can cause both short and long term problems. Likewise, the presence of long term medical problems, especially those that cause chronic pain, can increase an individual’s risk of developing a substance use disorder.

**One Example – Alcohol**

Studying the physical effects of every drug is beyond the scope of this training, so we will take a close look at some of the physical effects of alcohol. We chose alcohol as the example because most Americans know something about alcohol, alcoholism and the health risks of drinking too much. Other drugs used in excess also cause harm to a person’s health, and we suggest that the reader does research on their own to learn more about the effects of other substances.

**Alcohol’s effects on the brain**

Alcohol impairs a person’s ability to think and remember after only a few drinks. As the amount of alcohol increases, so does the degree of impairment. Large quantities of alcohol, especially when consumed quickly and on an empty stomach, can produce a blackout - an interval of time during which the person can’t remember key details of events, or even entire events. Blackouts are much more common among social drinkers than we once thought, and should be viewed as a potential consequence of acute intoxication regardless of age or whether the drinker is clinically dependent on alcohol.

Long term use of alcohol can cause permanent impairment in memory, physical coordination and an individual’s ability to think clearly. In some severe cases, alcohol can even lead to the onset of hallucinations. Chronic alcohol use is well known to negatively affect mood and is a frequent cause of depression. Not all of these effects are totally reversible even when the person stops drinking and remains abstinent.

**Alcohol’s effects on the Heart**

Excessive drinking over a long period or even too much on a single occasion can cause damage to the heart including cardiomyopathy (damage to the heart muscle), irregular heartbeats, high blood pressure and even strokes.
Alcohol and liver disease
Most people know that heavy, long-term drinking can damage the liver, the organ responsible for breaking down alcohol into harmless byproducts and clearing it from the body. But people may not be aware that prolonged liver dysfunction, such as liver cirrhosis resulting from excessive alcohol consumption, can harm the brain, leading to a serious and potentially fatal brain disorder known as hepatic encephalopathy.

Alcohol’s effects on the pancreas
Chronic alcohol use causes the pancreas to produce toxins that can lead to pancreatitis, a dangerous inflammation of the pancreas that prevents proper digestion, causes severe pain, often results in diabetes and can be fatal.

Alcohol and Cancer
Drinking too much for too long can increase the risk of several cancers including cancers of the mouth, esophagus, liver, throat and breast.

Withdrawal from Alcohol
Alcohol withdrawal syndrome is a set of symptoms that can occur when an individual reduces or stops alcoholic consumption after long periods of use. The withdrawal syndrome is a response of the central nervous system due to lack of alcohol. The severity of withdrawal can vary from mild symptoms such as sleep disturbances, agitation and anxiety to severe and life-threatening symptoms such as delirium, seizures and hallucinations.

Withdrawal usually begins 6 to 24 hours after the last drink. It can last for up to one week. To be classified as alcohol withdrawal syndrome, patients must exhibit at least two of the following symptoms: increased hand tremor, insomnia, nausea or vomiting, transient hallucinations (auditory, visual or tactile), psychomotor agitation, anxiety, seizures, or autonomic instability.

In summary, not all alcoholics are alike. The severity of their drinking, other health habits and genetics all play a role in whether, and to what degree, they will develop alcohol related medical problems. Nonetheless, it is important that the Peer Specialist is aware that drug and alcohol use can cause significant medical problems for their clients and that these problems can present both as barriers and motivation for recovery.
CHAPTER 9

Learning Objectives: You will learn answers to the following questions:

1. What is a SMART goal?
2. What are the 3 components of the Therapeutic Relationship?
3. What is the Working Alliance?

GOAL-SETTING, PROBLEM-SOLVING, AND BUILDING RELATIONSHIPS

People who are active in SUD lifestyles often use drugs or alcohol to cope. As a result, they do not develop adult skills such as problem solving, goal setting, conflict resolution, relationship development, the ability to work in a team. These skills may seem elementary to Peer Specialists who have been in recovery for some time, but it’s good to remember that people who are in the early stages of recovery need to learn, or re-learn some of these basic adult skills.

Goal setting

Peer Specialists can support recovering people and reduce relapse by helping clients develop short and long-term goals. Goal setting involves establishing specific, measurable, achievable, realistic and time-targeted goals. On a personal level, setting goals helps people work towards their own objectives. Goal setting (Locke, 1990) is as a major component of personal development literature. Studies have shown that specific and ambitious goals lead to a higher level of performance than easy or general goals. As long as a person accepts the goal, has the ability to attain it, and does not have conflicting goals, there is a positive linear relationship between goal difficulty and task performance. Achieving personal goals is a measure of success.

SMART Goals

We’ve included a brief description of SMART goals. We like the concept of SMART goals because it helps you define, in specifics, the goals you want to reach, how to reach those goals, and criteria for realistic goals. While this is commonly used in the business arena, we believe it has a place in the self-development arena, especially how it relates to the recovery process. SMART is a mnemonic acronym that sets criteria for setting goals, for example in project
management, or personal development. The letters S and M usually mean **specific** and **measurable**. The other letters have meant different things to different authors, as described below. SMART criteria are commonly attributed to Peter Drucker's *management by objectives* concept. Each letter in SMART refers to a different criterion for judging objectives. The most common criteria are listed in the second column, but people have assigned different terminology to the other letters to make the criteria more personal.

<table>
<thead>
<tr>
<th>Letter</th>
<th>Common</th>
<th>Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Specific</td>
<td>Significant, stretching, simple, sustainable</td>
</tr>
<tr>
<td>M</td>
<td>Measurable</td>
<td>Motivational, manageable, meaningful</td>
</tr>
<tr>
<td>A</td>
<td>Achievable</td>
<td>Appropriate, agreed, assignable, attainable, actionable, adjustable, ambitious, aligned with corporate goals, aspirational, acceptable,</td>
</tr>
<tr>
<td>R</td>
<td>Relevant</td>
<td>Result-based, results-oriented, resourced, resonant, realistic, reasonable</td>
</tr>
<tr>
<td>T</td>
<td>Time-bound</td>
<td>Time-oriented, time-framed, timed, time-based, time-specific, time limited, time/cost limited, trackable, tangible, timely, time-sensitive</td>
</tr>
</tbody>
</table>

**Problem solving**

The term *problem-solving* is used in many disciplines, sometimes with different perspectives, and often with different terminologies. For instance, it is a mental process in psychology and a computerized process in computer science. Problems can also be classified into two different types (ill-defined and well-defined) from which appropriate solutions are to be made. Ill-defined problems are those that do not have clear goals, solution paths, or expected solutions. Well-defined problems have specific goals, clearly defined solution paths, and clear expected solutions. These problems also allow for more initial planning than ill-defined problems. The ability to understand what the goal of the problem is and what rules could be applied represent the key to solving the problem. Sometimes the problem requires some abstract thinking and coming up with a creative solution.

When someone has been using substances as a way to cope with adult life, they don’t experience life’s challenges in a way that allows them to develop problem solving skills. One area where Peer Specialists help clients is to work with the client to develop problem solving skills. They can help the client to identify the problem, identify conditions that contribute to the problem and take steps to resolve the problem.
**Relationship development**

Developing and maintaining the therapeutic or helper relationship is central to the work that Peer Specialists do. Developing these relationships is as much an art as it is a science. This is where the Peer Specialists’ authority through their recovery experience is exercised. The therapeutic relationship is the means by which a Peer Specialists and a client engage with each other, and influence positive change in the client.

**Components of the therapeutic relationship**

The therapeutic relationship has been theorized to consist of three parts: the working alliance, transference/countertransference, and the real relationship. Research has been done on each component's contribution to client outcomes, as well as the interaction between components.

While most of the research has focused on the relationship between a therapist and client, many of the concepts apply to the relationship between a Peer Specialist and a client, such as the “working alliance.” The working alliance can be defined as the joining of a client's reasonable side with a Peer Specialist's working side and can be thought of as consisting of three parts: Goals, Tasks and Bond.

<table>
<thead>
<tr>
<th><strong>Goals</strong></th>
<th>what the client hopes to gain from peer services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tasks</strong></td>
<td>what the Peer Specialist and client agree to do to reach the client's goals</td>
</tr>
<tr>
<td><strong>Bond</strong></td>
<td>forms from trust and confidence that the tasks will bring the client closer to his or her goals.</td>
</tr>
</tbody>
</table>

Research on the working alliance suggests that it is a strong predictor of client outcomes. Also, the way in which the working alliance unfolds has been found to be related to client outcomes. Generally, an alliance that experiences a split that is repaired has better outcomes than an alliance with no splits, or an alliance with a split that is not repaired. These interactions teach the client skills that can be used in their day to day life.

These concepts will be explored in more depth in the face to face trainings.
Learning Objectives: You will learn answers to the following questions:

1. What are 3 reasons why a Peer Specialist would refer their client to a clinician?
2. What are 2 reasons why a Peer Specialist would make a report to their supervisor?
3. How does a Peer Specialist know the process for reporting a Duty to Warn situation?

Know When to Refer

Know when to refer to a clinician

Peer Specialists should know the agency policies and procedures and roles of other staff members so that they can quickly make a referral or respond to an emergency. A referral to a clinician should be made when a client is at risk of relapse, needs to see a clinician between scheduled appointments or in an emergency when a client reports thoughts of self-harm, thoughts of harming others or is becoming so disabled that it will affect their ability to take care of themselves. It’s usually best to talk to your client before making a referral to a clinician, but you shouldn’t wait to inform your client in an emergency situation, or if waiting could cause harm to the client or escalate the client’s symptoms. Peer Specialists should document the concerns in the client record and be prepared to report their observations about clients’ suicidal/homicidal thoughts, inability to function and/or substance use and potential for relapse. Peer Specialists work as members of a team and should never make decisions that impact clients without input from other members of the clinical team.

Know when to report to a supervisor

Peers should learn the chain of command in their agency. In many agencies there are administrative and clinical chains of command so Peers will use different chains of command depending upon the type of issue. There might be a supervisor for administrative issues and a different supervisor for clinical issues or your supervisor could have both these roles.
Some common situations that require seeking supervision

Disagreements with other Peer Specialists or program staff
Conflicts with other program staff, including other Peer Specialists, can and do arise during the day to day activities of staff. When these conflicts become problematic or threaten to interfere with a Peer’s ability to do their work, they should be discussed with a supervisor. The Peer should work with the supervisor and other involved parties to resolve the issue, always maintaining professional communication and relationships with other peers and staff.

Violating Confidentiality
The Peer Specialist is required to maintain the confidentiality of their clients and also report any violation of confidentiality by other staff members that they observe or have knowledge of. Violations of confidentiality should be reported to your supervisor or compliance officer. If your violation was honest human error, there will be consequences, but they are generally related to education about privacy policies. However, if the violation is malicious or repeated, the staff member can be referred to the administrative supervisor for disciplinary action, up to and including termination. Also be aware, if the violation is related to a client who has a diagnosis of substance use, or their participation in a substance use treatment program, the staff member might have financial penalties if they breach confidentiality. Please refer to the section on Client Rights in this manual for further details regarding client confidentiality. When you become employed, all agencies have policies and processes for reporting breaches of confidentiality. This will probably be a significant part of your on the job training.

Duty to Warn
The Duty to Warn is a concept that is important in behavioral health care. It means that a staff member can be held liable for injuries caused to another person, by a client, when the staff member knew about a threat, had the opportunity to warn the other of the danger, but failed to do so. Duty to warn is one of the few exceptions to a client’s right to confidentiality and a clinician’s ethical obligation to maintain confidential information obtained in the context of the therapeutic relationship. In situations where there is a serious concern about a client harming someone, the clinician must breach confidentiality to warn the potential victim about the danger.

Although laws vary in different states, in general, the danger must be imminent and the breach of confidentiality should be made to someone who has the authority to reduce the risk of danger. People who should be informed about the risk include the intended victim and local law enforcement. These laws apply to anyone in a clinical relationship with a client, including Peer Specialists. The Colorado Statute is CSR 19-3-304. Most organizations have policies that guide the way duty to warn information is handled within the organization. For example, some organizations only allow licensed clinicians or a clinical supervisor to do the actual reporting, so all other staff would report a potentially violent client to their supervisor or to an assigned clinician. In any case, become familiar with your organization’s policy, and when in doubt, talk
to your supervisor. **C.R.S. 13-21-117** describes civil liability of mental health providers acting in their capacity of duty to warn, **C.R.S. 12-43-218**, discusses the disclosure of confidential communications and numerous other references throughout title 25. To read more, you can find the Colorado Revised Statutes at [http://www.lexisnexis.com/hottopics/colorado/](http://www.lexisnexis.com/hottopics/colorado/). Always defer to your supervisor in these instances.

**Questions regarding scope of the peer role, ethics or professional boundaries**

Discussion regarding a Peer Specialist’s professional boundaries, relationships and conduct will be covered in length later in this manual. These are complicated areas and any questions or concerns about appropriate, ethical behavior should be discussed with the Peer Specialist’s supervisor.
Privacy and confidentiality are very important concepts in mental health and substance use services. Clients share very private and intimate aspects of their lives with their therapist or Peer Specialist, so maintaining the client’s confidentiality is critical. There are ethical and legal guidelines that protect the information shared in therapy. There are also state and federal regulations that protect a client’s right to privacy and confidentiality. This section will provide a general overview of the confidentiality regulations that Peer Specialists will have to follow. Any questions about confidentiality should always be discussed with the supervisor.

**HIPAA and Confidentiality**

HIPAA is a federal law that protects people in two ways. One, it protects persons who have a long term health condition when they leave a job by ensuring they won’t be denied health insurance because they have a “pre-existing condition.” The other part of HIPAA protects a client’s right to privacy and confidentiality of their health care records. It sets standards for how client’s health information is managed and guarantees clients certain rights in obtaining their own health information. It also sets guidelines for how confidential information in an electronic format should be handled. In this manual, we will only be talking about the privacy portion of HIPAA laws.

**HIPAA in the workplace**

Patients are able to control how their health care information is used according to the HIPAA Privacy Rule. In most cases, patients must sign a release of information form giving the provider permission to share their health care information. There are certain situations where the provider can disclose a patient’s health information without a signed release, but wrongful disclosure of patient medical information is prohibited by law, and providers who violate the law are subject to fines and or imprisonment.
Below is a summary of the HIPAA law:

- Healthcare providers and insurance companies have to explain how they'll use and disclose a client’s health information.
- Clients can ask for copies of their information, and ask that changes be made to it. Clients can also ask for a history of any unusual disclosures.
- If someone who is authorized to see a client’s health information wants to share a client’s health information with a third party, they have to get formal consent from the client.
- Health information is to be used only for healthcare or business related purposes such as paying claims, coordinating care or healthcare audits. Unless the client gives consent, it cannot be used to help banks decide whether to give a loan, or by potential employers to decide whether to hire a person or by law enforcement (except under very specific conditions).
- When a client’s health information gets shared, only the minimum necessary amount of information should be disclosed.
- Clients have the right to complain to the federal Department of Health and Human Services (HHS) about HIPAA rules violations.

In general, providers, including Peer Specialists, should not share any information about a client with anyone other than the treatment team, unless there is a signed release of information from the client. It is okay to share information with your supervisor, or other staff at your agency who are involved in treating the client.

There are monetary penalties for the organization if a client’s health information is released without the client’s consent. Healthcare organizations, including SUD programs, take HIPAA very seriously, so you will probably hear much more about HIPAA in your employment.

You will have other kinds of trainings on the job about HIPAA. When in doubt as to whether you need a release of information, ask your supervisor.

**Confidentiality for clients in SUD treatment**

The confidentiality rules for clients in drug or alcohol programs, or who have a diagnosis of a substance use disorder are even stricter. In addition to more protections for the client, the penalty for violations are higher too. The regulations that cover confidentiality of health information for clients in SUD (substance use disorder) programs are covered by federal regulations 42CFR part 2. The privacy regulations are often referred to as “part 2” regulations.

In general, any disclosure about a client in a SUD program always requires a signed consent by the client. Under HIPAA, health information can be shared with others involved in business activities such as paying claims without a signed release. Under Part 2, the client must sign a release of information for any disclosure.
Under HIPAA, the client’s release of information is good for 1 year, and if the client wants to revoke the release, the client must sign a form saying so. Under Part 2, the release of information is good for 1 year, the client can revoke a release of information at any time, and does not need to do it in writing. They can revoke the release verbally, simply by calling the organization or their therapist.

Under HIPAA, if a client’s privacy rights are violated, the organization may get fined. Under Part 2, if a client’s privacy rights are violated, both the organization and the staff member who released the information can get fined. Also, there may be criminal penalties imposed, such as a jail sentence when information about a SUD client is released.

The strict regulations were put into place to protect individuals who desire treatment for their substance abuse problem, but are worried about the consequences if someone, such as an employer finds out. The strict regulations were enacted so people seeking treatment for a substance use disorder didn’t have to worry about their privacy being violated. These Part 2 rules were signed into law long before the HIPAA laws were enacted. The government is currently looking at ways to revise the regulations.

**Resources**

For details on HIPAA and how it may apply to you, go to [http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html).
Many of the clients you will be serving will be Medicaid eligible. Members who are Medicaid eligible are protected by rights that are listed below. It is important to understand these rights and ensure that the member’s rights are protected while they are in treatment. We won’t go into a lengthy description of what these rights mean. Most are self-explanatory, and if there is something you don’t understand, we suggest you speak with your supervisor. While the list below is specific to Medicaid clients, most agencies have adopted a set of member rights that protect all clients in the same way.

**Member Rights and Responsibilities**

**Members have the right to:**
- Be treated with respect, dignity and regard for their privacy.
- Be free from discrimination on the basis of race, religion, gender, age, disability, health status, or sexual orientation.
- Choose someone to represent their best interests if they need help.
- Share their opinion about their SUD services with others and. Sharing their opinion will not affect their ability to receive services or the quality of their services.
- Make a complaint about any part of their services
- Ask for a state fair hearing if a service is denied or reduced.
- Not be secluded or restrained as a punishment or to make things easier for their provider.
- Be free from sexual closeness in any relationship with their providers.
- Get information about their behavioral health benefits and how to access them.
- Participate in decisions about their health care. This includes the right to refuse treatment unless it is required by law.
- Review or get a copy of their medical records; ask that they be changed or corrected.
• Have their record and the information they give in therapy kept private. Know that federal and state laws permit their information to be shared if:
  o They are a danger to themselves or others.
  o They are gravely disabled (unable to care for themselves).
  o In cases of child abuse or suspected child abuse.
• Get medically necessary behavioral health care services according to federal law.
• Get services that are suitable to their culture.
• Have an interpreter if they have problems communicating or do not speak English.
• Get information about their treatment choices in a way that they can understand.
• Have a service plan that they help write and get a copy of their plan.
• Be told quickly if their services have ended. Be told when there are changes to their services or providers.
• Get help understanding their rights and making a complaint or an appeal.
• Be free to use all of their rights without it affecting how they are treated.

**Member Responsibilities:**

**Members have the responsibility to:**

• Learn about their mental health benefits and how to use them;
• Be a partner in their care. This means:
  o Following the plan they and their care coordinator have agreed on;
  o Participating in their treatment and working toward the goals in their service plan;
  o Taking medications as agreed upon between them and their prescriber.
  o Tell their therapist or doctor if they do not understand their service plan. They should tell him or her if they do not agree with their service plan, or want to change it.
  o Give their therapist or doctor the information he or she needs to give them good care. This includes signing releases of information so that their providers can coordinate their care.
• Come to their appointments on time. They should call the office if they will be late, or if they can’t keep their appointment.
• Cooperate with their BHO when they choose a provider or are seen by their provider.
• Let their BHO know when they change their address or phone number.
• Treat others with the same courtesy and respect that they expect to be treated.

**Recognize Potential Risks**

Peer Specialist must be continuously mindful to maintain client confidentiality, both at work and during time off work. Federal confidentiality laws allow information to be shared on a need to know basis with proper authorities when clients are in imminent danger to themselves or others,
or when a child has been abused and the abuse has not been reported to authorities. Otherwise, sharing client information is strictly regulated under state and federal law.

_Criminal Penalties for HIPPA violations_

A Peer Specialist, who "knowingly" obtain or disclose individually identifiable health information may face a fine of up to $50,000, as well as imprisonment up to one year. Offenses committed under false pretenses allow penalties to be increased to a $100,000 fine, with up to five years in prison. Finally, offenses committed with the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain or malicious harm permit fines of $250,000, and imprisonment for up to ten years.

These fines and penalties typically won’t apply in day to day operations. These situations apply to malicious releases of information, such as sharing medical records with a tabloid in the case of a celebrity, or selling PHI for criminal purposes, such as to an identity theft ring. Careless releases of information, though, can be nearly as damaging. There are instances where an agency was fined tens of thousands of dollars because a staff member had a laptop stolen from their car and the laptop contained member records that weren’t encrypted.

The decision about when to share confidential information should be made with caution and we recommend Peer Specialists restrict sharing information. A release of information form signed and dated and renewed within the past 12 months is necessary. A written release of information is required to release information about substance abuse treatment. When unsure, the Peer Specialist should consult with their supervisor or co-workers. When in doubt, do not share the information.
ADVOCATING FOR CLIENTS, ETHICS AND PROFESSIONAL BOUNDARIES

At times, Peer Specialists may find themselves in a position to advocate for clients whose rights or confidentiality has been violated. Peer Specialists should refer to the member rights and laws discussed in Chapter 10 and 11. The Peer Specialist should also encourage other team members to become familiar with member rights and advocate for clients when their rights have been violated. Whether the violation is by a Peer Specialist, or by another member of the team, the Peer Specialist should encourage the staff person to report the violation to the supervisor. The Peer Specialist should follow up with the supervisor to make sure the violation was reported. If the staff did not self-report, then the Peer Specialist should report the violation. This strategy gives the other staff the opportunity to self-report, which is always looked on more favorably than if another staff reports the violation. It’s never appropriate to keep the violation a secret. It is a violation of ethical conduct. Also, if the violation is discovered at a later time, both the staff who violated the policy and anyone else who knew about the violation will be subject to discipline.

In extreme cases or repeated violations, the Peer Specialist may need to escalate the advocacy efforts by informing higher level administration in their chain of command. If these efforts do not elevate the issue, it may be necessary to make a report to the Colorado Department of Regulatory Agencies (DORA). Our first responsibility is to our clients.

Ethics and code of conduct for peer specialists

Psychiatrists, psychologists, counselors, social workers and nurses all have a code of conduct. So do realtors, architects, attorneys, teachers and people in the military. Codes of conduct don’t
describe hard and fast rules. Instead, they provide general guidelines for individuals working in a certain profession to behave and work in an ethical manner.

There is no specific code of conduct for Peer Specialists nation-wide. The National Organization for Peer Specialists (NAPS) has developed a code of conduct that many state-wide organizations have adopted. In 2010, a local group of Peer Specialists put together a code of conduct that many peers in Colorado have adopted. This Code of Conduct is listed in the Appendix.

**Professional Boundaries**

There are numerous boundaries that Peer Specialists will face when working with their clients. These include physical, psychological, emotional, and social boundaries. Some of these boundary lines may be kind of blurry. The boundary lines are much more specific for clinicians, but even then, some of the boundaries are not clear.

**Traditional Counselor Boundaries**

For example, there are differing opinions on whether touch is ever appropriate between a counselor and their client. Is it okay to hug your client or touch their hand when they are crying and in distress? Sexual touching, of course, is never allowed and everyone agrees with this. Dual relationships, where a counselor holds two or more different roles within a client’s life at the same time, are also avoided, as well as accepting gifts of significant monetary value. Talking to clients about your own experiences or problems is typically forbidden.

**Peer Specialist Boundaries**

For Peer Specialists, it becomes more complicated. Peer Specialists are expected to tell their own stories to inspire hope in their clients. They may hug a client after a support group. And what is the Peer Specialist supposed to do when the client spent time making a small gift in a craft class and wants the Peer Specialist to have it as a token of their appreciation? In the following pages, we are first going to cover the hard and fast professional boundaries. There are very clear rules for these situations. Then, we will discuss some situations that are in the gray areas, where there aren’t hard and fast rules. We’ll present some situations that you’ll have to think about, and think about how you would handle it in a real-life situation.

We are going to use the most recent version of the American Counseling Association Code of Ethics (ACA) for reference and guide for our discussion. The cited numbers refer to the actual section of the code. For a full copy of the 2014 ACA Code of Ethics, see the link Code of Ethics at: [2014 ACA Code of Ethics](#)
**Sexual misconduct in employee-client relationships**

Engaging in sexual or romantic employee-client interactions or relationships with current clients, their romantic partners, or family members is strictly forbidden. This applies to counselors, Peer Specialists and other employees of the agency.

**Examples of Sexual Misconduct:**

- Any type of erotic contact (touching body parts, directly or through clothes)
- Sexual conversations
- Expressing sexual fantasies
- Nonverbal sexual innuendo
- Provocative clothing
- Seductive behavior

The counselor (Peer Specialist) is the one in power. It is his or her duty to set appropriate professional boundaries and then follow through on enforcing them.

**Warning Signs:**

These behaviors indicate that the counselor or Peer Specialist may be getting close to violating this professional boundary. If you see these behaviors in your relationship, step back, and talk about it in supervision.

- Inappropriate sexual jokes or references made by the Peer Specialist.
- Client expressing concern that a treatment relationship is moving from a professional to an inappropriately personal relationship.
- The Peer Specialist tells his or her intimate personal problems to the client.
- The Peer Specialist asks the client to go outside the bounds of a professional relationship (e.g. – going on a dinner date).
- The Peer Specialist tells the client that having a sexual relationship is good treatment/the only way you can get well.
- The Peer Specialist offers recreational drugs or alcohol to the client.
- The Peer Specialist asks the client to keep their relationship a secret.
- The Peer Specialist suggests to the client that intimate forms of touching have been proven to be therapeutic.

**Harm to Clients:**

Any of the behaviors listed above can cause serious harm to clients, and can cause harm to the Peer Specialist as well. Some examples of how sexual relationships can cause harm are:

- Fear, isolation and distrust, often leading to depression, feeling out of control, or even suicide
- Temporary inability to make decisions, to work at a job, or to tend to personal needs
• Guilt, shame, and feelings of responsibility
• Recurrent nightmares, fears or images of intrusion/flashbacks about the experience, and difficulty concentrating in other areas of life
• Identity/boundary/role confusion
• Recurrence of symptoms that had been under control, or inability to manage symptoms in clients who had been managing their symptoms well

Sexual and/or romantic Peer Specialist–client interactions or relationships with current clients, their romantic partners, or their family members are prohibited. This prohibition applies to both in person and electronic interactions or relationships.

Peer Specialists are prohibited from engaging in counseling relationships with persons with whom they have had a previous sexual and/or romantic relationship. If a Peer Specialist is assigned to a person with whom they have had an intimate relationship, they should tell their supervisor immediately so they can be re-assigned.

Sexual and/or romantic Peer Specialist-client interactions or relationships with former clients, their romantic partners, or their family members are typically prohibited for a period of 5 years following the last professional contact. This prohibition applies to both in-person and electronic interactions or relationships. Before engaging in such relationships, it must be demonstrated with forethought and documentation whether it can be viewed as exploitive in any way and/or whether there is still potential to harm the former client; in cases of potential exploitation and/or harm, the Peer Specialist avoids entering into such an interaction or relationship.

With Peer Specialists, this 5 year restriction should be discussed with the supervisor, especially if a Peer Specialist is working at an agency where he or she once received services before becoming employed. The supervisor may decide to assign the client to another Peer Specialist, or may employ some other strategy that is in keeping with the agency’s policies. The important thing is to talk to your supervisor about these kinds of issues before your supervisor learns about your relationship from someone else.

A peer based model of ethical decision making

A model of ethical decision-making is simply a guide to sort through a complex situation and an aid to determine the best course of action that one could take in that situation. One way is to ask questions to guide your decision-making. When confronting a situation with possible ethical consequences, ask yourself these questions:

1. Who has the potential of being harmed in this situation and how great is the risk for harm? This question is answered by assessing the vulnerability of the parties and determining the potential and severity of injury to each. Where multiple parties are at risk
of moderate or significant harm, it is best to consult with others, especially your supervisor. Don’t try to make this decision on your own.

2. What laws, organizational policies or ethical standards apply to this situation and what actions would they suggest or dictate? Don’t violate any guidelines that are also against the law. This is a sure way to get fired. In other situations where there is no clear rule, consult with your supervisor.

In the next section, we will explore a wide variety of ethical dilemmas that can come up in the context of delivering peer services and illustrate ways that these two questions can be used to help your decision-making.

**Ethical arenas**

Ethical issues can crop up in many areas in the day to day work of Peer Specialists. In this section, we will present and discuss case vignettes to highlight issues in five arenas:

1. Service context
2. Personal conduct of the Peer Specialist
3. Conduct in service relationships
4. Conduct in relationships with other service providers
5. Conduct in relationships with local peer organizations and recovery communities.

The vignettes and discussion were developed in consultation with the *PRO-ACT Ethics Workgroup* and other organizations delivering Peer Specialist and recovery support services. The responses to the vignettes are not intended to generate rules for behavior; they are intended to present food for thought and open a discussion about key ethical issues in programs that use peer services.

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<thead>
<tr>
<th>Agency XYZ visibly promotes itself as providing peer-based recovery support services, but their reputation is being hurt by key practice decisions.</th>
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<tr>
<td><strong>XYZ hires Peer Specialists who have minimal sobriety time.</strong></td>
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<td><strong>XYZ does little to orient, train, or supervise</strong></td>
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<td>Supervise their Peer Specialists.</td>
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<td><strong>XYZ pays Peer Specialists a meager wage and asks them to work long hours that interfere with their own recovery activities.</strong></td>
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<td><strong>XYZ assigns volunteer Peer Specialists to perform counselor functions and then bills for these services.</strong></td>
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<td><strong>XYZ assigns Peer Specialists to work in isolation delivering home-based services in drug and crime ridden neighborhoods.</strong></td>
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<td><strong>XYZ uses Peer Specialists almost exclusively to recruit clients into treatment.</strong></td>
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<td>XYZ uses Peer Specialists to perform duties other than support clients in their recovery.</td>
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<td>Using Peer Specialists to do office work, transport clients or other tasks is a waste of resources. It deprives clients of the Peer Specialist’s special training and experience in recovery, while at the same time, devalues the importance of the Peer Specialist’s role within the agency. In smaller agencies such as in rural areas, all employees share the work load. But if the practice is to always assign the Peer Specialists to these tasks, it takes away from the value that peer services offer to clients.</td>
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**SCREENING PRACTICES:**

*DEF is a grassroots recovery advocacy organization that provides Peer Specialist services through a team of volunteers from the recovery community. Today, a man notorious for his predatory targeting of young women entering NA arrives at DEF announcing that he would like to volunteer as a Peer Specialist. How should DEF respond to this request?*

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<tr>
<th>Principles of Fairness; Appropriate credentials; Protecting stakeholders</th>
<th>Screening of volunteers and staff for recovery support roles protects the hiring agency, its staff and its clients. This protection function must be assured at the same time the agency practices standards of fairness in their selection procedures, e.g., not excluding someone based only on second-hand gossip. Selecting individuals for Peer Specialist roles is unique in that a past addiction-related felony conviction (followed by a long and stable recovery career) might be viewed as more of a credential than grounds for disqualification. On the other hand, a history of and reputation for exploitive behavior within the recovery community could be grounds for disqualification. The reason for disqualification would be to protect clients and protect the reputation of the organization, e.g., assuring that people will feel safe and comfortable seeking services at the organization.</th>
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<tr>
<td>The Peer Specialist’s credibility comes from character, relationships and performance in the community</td>
<td>Experiential expertise is granted through the community “grapevine” (community story-telling) and gives a person credibility that no university can grant. It is given to those who have sustained living proof of their recovery. Such persons may be professionally trained, but their authority comes not from their education but from their character, relationships and performance within the community.</td>
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<tr>
<td>Determine the level of supervision and or independence the Peer Specialist needs to do their job</td>
<td>The community “grapevine” can withhold as well as give the credential of experiential expertise, and it can grant such expertise with conditions, e.g., using the person in the above example as a closely supervised Peer Specialist, but only with men and not risking female clients with this Peer Specialist.</td>
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PERSONAL/SERVICE CONDUCT OF THE PEER SPECIALIST

These examples show Peer Specialists who run into situations that have possible ethical implications; most of these situations are not covered or guided by a specific policy, but fall into that grey area where good decision-making, consultation and supervision are necessary to reaching the best decision.

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<th><strong>Self-Care:</strong> Jerome brings great passion to his role as a Peer Specialist, but does not take good care of himself. He is overweight, smokes excessively, and has chronic health conditions that he does not manage well. To what extent are these ethical issues related to his performance as a Peer Specialist? What is the link between private behavior and Jerome’s performance as a Peer Specialist?</th>
<th>Private behavior of the Peer Specialist is just that—private, UNTIL there is a link between private behavior and one’s performance as a Peer Specialist. In this case, Jerome’s poor self-care can impact his effectiveness as a Peer Specialist. The expectation here is not one of perfection, but one of reasonable match between one’s values and the life one is living. In this case, Jerome is modeling potentially lethal behaviors that clients might adopt in their own lifestyles, e.g., “It is okay for me to smoke because Jerome smokes.” Part of the job of the Peer Specialist is to make recovery attractive. To become a Peer Specialist requires being not only a face and voice of recovery but also a person whose character and lifestyle others want to emulate. Our ability to achieve that is enhanced by self-care training that is built into the overall Peer Specialist orientation and training program.</th>
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<td><strong>Personal Impairment:</strong> Mary has functioned as an exceptional Peer Specialist for the past two years, but is currently going through a very difficult divorce. The strain of the divorce has resulted in sleep difficulties, significant weight loss, and concern expressed by Mary about the stability of her sobriety and sanity. When do such events in our personal lives become professional practice issues? What should Mary and her supervisor do in response to these circumstances?</td>
<td>Events in our personal lives are of concern when they ripple into how we perform in the service arena. All of us experience life events that require focused self-care and temporarily diminish our ability to serve others. Mary and her supervisor need to consider what would be best for her, for those she coaches, and for the agency. One option is for Mary to decrease her hours or number of people served and to get increased supervisory or peer support (e.g., team coaching) for a period of time. Another option would be for Mary to take time off to focus on improving her own</td>
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**Lapse:** Ricardo has worked as a Peer Specialist for more than a year and experienced a short lapse while attending an out-of-town wedding. Because the lapse was of such short duration, Ricardo plans not to disclose the relapse to the organization where he works. What ethical issues are raised by this situation? What should Ricardo do? How should Ricardo’s supervisor respond if this situation is brought to their attention? What organizational policies need to be established to address the issue of lapse/relapse?

There are several core values that apply to this situation. They are honesty, credibility, primacy of recovery. All of these values suggest a course of action that would begin with Ricardo’s disclosure of the lapse to his supervisor and focusing on re-establishing the stability and quality of his personal recovery program. The organization should follow the guidelines it has established to respond to such an event. Some programs might view this event as a non-issue because no harm or damage resulted from the lapse. Other programs, where abstinence is a core value, might see this as a serious breach of the employment contract. The organization should offer options, depending on their policies and philosophy. Options might include Ricardo taking a break from his Peer Specialist responsibilities, performing activities that do not involve peer support to clients, and later phasing back into Peer Specialist responsibilities via co-coaching and more intensive supervision.

**Personal Bias:** Zia has many assets that would qualify her as an excellent Peer Specialist, but in her interview for a Peer Specialist position, you are concerned about one potential problem. Zia passionately believes that AA’s Twelve Step program is the ONLY viable framework for long-term addiction recovery. She expresses disdain for alternatives to AA. What ethical issues could arise if Zia brought her biases about AA into her work as a Peer Specialist?

The core value of tolerance recognizes and respects different routes to long-term recovery. Bill Wilson (1944) was one of the first advocates of such diversity. If Zia cannot develop such tolerance, she may be better suited to the role of sponsor in a Twelve Step program rather than the role of Peer Specialist that works with multiple recovery programs. The same principle would apply to someone who uses recovery programs that are not based on the Twelve Steps. What we know from research on recovery is that ALL recovery programs have optimal responders,
### Pre-existing Relationships:

Barry’s supervisor has assigned Barry to visit a new client in his Peer Specialist role. Barry recognizes the name as a person to whom Barry once sold drugs in his earlier addicted life. Who could be harmed in this situation? What should Barry do? Does Barry have a responsibility to report this pre-existing relationship to the supervisor?

Multiple parties are potentially at risk here: Barry, his client, the client’s family, and Barry’s agency. Barry should disclose the relationship and request another assignment. If the alternative is Barry or no service (e.g., a situation where Barry might be the only Peer Specialist in a community), Barry and his supervisor should explore additional options or explore how these Peer Specialist services could be provided while minimizing harm to all parties. The most critical factor here is ensuring the comfort and safety of the individual/family receiving services. A best-practice policy would be for Peer Specialists to immediately declare the existence of any pre-existing relationship with those to whom they have been assigned.

### Use of Information across Roles:

Rebecca is a natural listener. Everyone talks to her—in her Peer Specialist role and outside her Peer Specialist role. Rebecca is also very active in the local Twelve Step community. Today, a person Rebecca is coaching mentions she has a new boyfriend. Rebecca recognizes this boyfriend as a man with whom one of her sponsees is involved. The relationship between the sponsee and this man has been a major source of sabotage to the sponsee’s recovery, and the sponsee also contracted an STD from this man. Can Rebecca use information gained from roles in her personal life in her role as a Peer Specialist? How should she handle this situation?

This vignette generated considerable disagreement among the recovery support agency representatives who reviewed it. Opinions split into two camps. The first group suggested that Rebecca could, and had a duty to, disclose this information as long as it was judged to be reliable and as long as no anonymity was violated related to the disclosure. The other camp took the position that disclosing this information would violate AA etiquette (“What’s said here, stays here”), that it was not Rebecca’s role to disclose this information, and that Rebecca needed to stay supportive through whatever unfolded within this relationship. A good general guideline is: moving information from one role into another role (e.g., using information gained at a Twelve Step meeting into one’s Peer Specialist activities) is very risky and could result in harm to several parties. It should be...
brought to supervision before any information is disclosed to anyone.

| Advocacy: Many Peer Specialists are also involved in advocacy activities in their local communities. Are there any situations that could arise out of one’s advocacy role that could conflict with one’s role as a Peer Specialist? Could any of these situations involve potential harm to others? | This depends on the nature of the recovery advocacy activities. There are many Peer Specialists who are also very involved in the recovery advocacy movement who experience minimal conflict in these roles. Conflicts could arise if the Peer Specialist/advocate:  
• Used the respect and loyalty many people feel about their Peer Specialist to zealously recruit clients into advocacy activities,  
• Used the Peer Specialist role to push particular ideological propositions, or  
• Took such extreme, controversial positions that clients were not comfortable having the individual serve as their Peer Specialist.  
These potential conflicts are best processed with one’s supervisor. |
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<td>Conflict of Interests: Jeremy works as a Peer Specialist and also owns a recovery home. In his Peer Specialist role, Jeremy frequently encounters people who need sober housing. What ethical issues could arise from Jeremy referring people to the recovery home that he owns? How could Jeremy best handle any real or perceived conflicts of interest? What organizational policies address the issue of conflicts of interest?</td>
<td>Referring clients to his own recovery home raises potential conflicts between the client’s best interests and Jeremy’s financial interests. Even the perception of a conflict of interest could injure Jeremy’s reputation as a Peer Specialist and the reputation of the organization where Jeremy works. It would be better for Jeremy to refer his clients to other recovery homes or to offer a list of all available resources and let clients make their own decision. In addition, Jeremy may want to assign a “manager” to do all screening for potential residents to his home, so he not only doesn’t refer his own clients, but also doesn’t make decisions related to their entrance. At a minimum, Jeremy will want to make sure that those he serves always have a choice of options and that he does nothing to steer people toward programs in which he has a financial interest.</td>
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**Role Integrity:** Marcella is in long-term recovery and works as a volunteer Peer Specialist and also works full time as a certified addictions counselor. What problems could be posed by Marcella bringing the clinical orientation from her counselor role into her volunteer role as a Peer Specialist? How can the organization/supervisor help “counselors as peers” relinquish their clinical orientation?

The potential problems in this situation are numerous. First, if Marcella drifted into her counseling role as a volunteer, she would be providing counseling without the client protections and supports built into traditional treatment agencies, e.g., informed consent, legal confidentiality, clinical documentation, clinical supervision, and agency liability insurance. Assuming Marcella’s client is still in treatment, the therapy Marcella provides may be counterproductive to the therapy the client is already receiving. And perhaps most importantly: during the time Marcella is doing counseling, the client is not receiving needed recovery support services.

**Compassion Fatigue:** Elizabeth has worked as a Peer Specialist for the past 2 ½ years, supporting the recovery processes of individuals with very severe, complex, and long-term substance use disorders. In recent months, she has noticed that she is bringing less energy and enthusiasm to her work and dreads seeing those clients with the greatest needs. How should Elizabeth respond to this diminished motivation for her work as a Peer Specialist?

The danger here is a process of emotional and physical disengagement that could do a great disservice to those in need of recovery support services. Elizabeth is exhibiting signs of burnout, which need to be acknowledged and addressed in supervision. Elizabeth may need a break in her coaching activities, might consider reducing hours or being assigned clients with a different level of problem severity. It might also be a good time for Elizabeth to refresh her stress management skills via training or her own personal coaching. Peer Specialists have a responsibility to recognize this need early enough to plan an orderly transition or termination process for their clients.
## CONDUCT IN SERVICE RELATIONSHIPS

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<th><strong>Choice/Autonomy</strong></th>
<th><strong>Ethical Issue</strong></th>
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<td>Cherise works as a Peer Specialist in a women’s program that is known for its assertive, some would say aggressive, style of outreach to women referred from the child welfare system. The women Cherise attempts to engage in treatment are ambivalent in the early stages of engagement—not wanting to see her one day, thrilled to see her the next. The question is: “When does ‘NO’ really mean ‘No’?” What is the line between assertive outreach and stalking? How do we reconcile a person’s right to choose with the knowledge that volitional will is compromised if not destroyed through the process of addiction?</td>
<td>The ethical issue here is between the values of autonomy and choice versus paternalism and outright domination. What complicates this situation is working with people who by definition (addiction) have compromised capacities for free choice, leaving the Peer Specialist questioning whose free choice they should listen to. In short, what do we do with someone who one moment wants recovery and the next minute wants to get high?</td>
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### Discussion/ Suggested Responses

The answer is that we recognize that addiction is a disease of the will and that recovery involves a “rehabilitation of the will.” The Peer Specialist’s job—particularly in early outreach activities—is to jumpstart motivation for recovery where little exists and to guide the person through the early stages of recovery until they can make choices that support their own best interests. At a practical level, that means that “no” (“I don’t want you to contact me anymore”) has to be said several times to different people on different days before we give up on someone for the time being. If after a reasonable period of time, the answer is still “no”, then we disengage with the assurance that we will be available in the future if the person should CHOOSE to call us. The notion that recovery is voluntary means not only freedom to choose different pathways of recovery but also the freedom to choose not to recover.
<table>
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<tr>
<th><strong>Choice/Autonomy</strong></th>
<th><strong>Ethical Issue</strong></th>
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<tr>
<td>Roberto has been assigned as a Peer Specialist for Oscar, but four weeks into this process, Oscar requests a change in Peer Specialists on the grounds that he is having difficulty relating to Roberto. Do those receiving Peer Specialist services have the right to select their own Peer Specialist?</td>
<td>The ethical issue here is whether or not Oscar has the right to select a different coach, or is this related to a long-time issue in Oscar’s life where Oscar always cuts relationships before they become too intimate. The client’s rights have to be balanced with the agency’s responsibility to provide services addressing Oscar’s recovery needs.</td>
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**Discussion/ Suggested Responses**

Mismatches in the assignment of Peer Specialists are inevitable, just as mismatches occur in the assignment of counselors. A match between a Peer Specialist and a client may be even more important because of the length of time spent together. Occasional mismatches are best acknowledged early and either resolved by changing the coaching style or assigning the counselor to a new Peer Specialist. The impact of peer services results from personal relationships, not from any power or authority ascribed to the role. An essential principle of peer-based recovery support services is that those receiving services ultimately get to define who qualifies as a “peer.” Evaluating and resolving potential mismatches is an integral part of good supervision. It is also very important that Peer Specialists are supported in these situations.

Notes

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<th>Friendship</th>
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Raymond volunteers as a Peer Specialist for a recovery community organization. This is a freestanding organization that is not affiliated with any treatment program that provides recovery support services. Raymond shares a lot in common with Barry, a person who has been assigned to Raymond. Over a period of two or three months, Raymond and Barry have developed quite a friendship and now share some social activities such as fishing and going to the movies. These activities are after the hours when Raymond serves as Barry’s Peer Specialist. What, if any, are the ethical issues raised by this friendship?

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<tr>
<th>Ethical Issue</th>
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Friendships may develop within the context of peer services, but there is one thing that distinguishes the Peer Specialist relationship from other social relationships, and that is the service dimension of that relationship. This means that Peer Specialist relationships are not fully reciprocal, whereas friendships are. There is a power difference in this relationship as well.

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<tr>
<th>Discussion/ Suggested Responses</th>
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The Peer Specialist has pledged that the focus of the Peer Specialist relationship is on the needs of the person being coached. In that light, ethical problems could arise: 1) if the friendship was initiated by Raymond to meet Raymond’s needs, not Barry’s needs, 2) if problems in the friendship interfered with Raymond’s ability to provide effective coaching services, or 3) if the friendship with Raymond prevents Barry from developing other sobriety-supportive relationships within the recovery community and the larger community. Peer Specialist relationships will, by definition, be less hierarchical and more reciprocal than relationships between a counselor and his or her client. It’s not that one boundary limit is correct and the other is wrong; it’s that boundaries are maintained that are role-appropriate. In other arenas of peer-based services, their effectiveness has been attributed in great part to the lack of professional detachment and distance that is inherent in professional services. When a developing friendship is getting in the way of providing effective peer support, it is the Peer Specialist’s responsibility to raise this concern with their supervisor. One potential option is to assign and transition the client to another Peer Specialist to avoid potential problems with a dual relationship.
**Sexual Exploitation**

You supervise Peer Specialists for a local recovery support organization. It comes to your attention that Joshua, one of your Peer Specialists, is sexually involved with a person to whom he is delivering recovery support services. What are the ethical issues involved in this situation?

**Ethical Issue**

How would these issues differ depending on:
1) Age or degree of impairment of the person receiving services? 2) Whether this was a person currently in services or a person who had previously received recovery support services? 3) The amount of time that had passed since the service relationship was terminated? Would you view this situation differently if the relationship was not with the primary “client” but with a family member or friend who was involved in the service process? Could the Peer Specialist or the agency face any regulatory or legal liabilities related to this relationship?

**Discussion/ Suggested Responses**

The Peer Specialist service relationship is not a relationship of equal power. The vulnerability of those seeking Peer Specialist services and the power of the Peer Specialist role create an environment where a Peer Specialist could exploit service relationships for his or her personal, emotional, sexual, or financial gain. It is that power difference that makes an intimate relationship between a Peer Specialist and those they work with ethically inappropriate. The harm that can come from such relationships extends to the person and family being served (emotional trauma, severance of services, resistance to seeking future services), injury to the reputation of the Peer Specialist and damage to the reputation and financial solvency of the service organization (law suits against the organization for improper hiring, training, supervision, etc.). The prohibition against intimate relationships between a Peer Specialist and client extends to the client’s family and close personal friends. As for relationships with persons who previously received peer services, agencies are defining a period of time (mostly in the two year range) in which such relationships would still be improper. The key here is to prevent situations that might arise because of exploitive intent. In these situations, even the perception of exploitative intent can be damaging. For example, a Peer Specialist could be involved with person he met in the recovery community. They later discovered that the other person once received services from the Peer Specialist’s organization. The Peer Specialist did not work at the organization at the time, never served as the person’s Peer Specialist, had no knowledge of the person’s status as a service recipient, and did not use the influence of their Peer Specialist role and organizational affiliation to initiate the intimate relationship. In short, there was no exploitive intent.
### Financial Exploitation

Alisha is providing Peer Specialist services to a very socially prominent and wealthy individual and his family. She has repeatedly turned down the family’s offers of money for her services and told the family that her services are provided through a federal grant and are available to all local citizens without charge. It has casually come up in conversations that Alisha is saving money to begin taking courses at the local community college. When Alisha arrives for her visit today, the family announces that they have discussed it among themselves and that they want to pay Alisha’s tuition to return to college. What should Alisha consider in her response to this offer?

### Ethical Issue

Money changes relationships. Accepting this gracious offer would threaten the integrity of the relationship.

### Discussion/ Suggested Responses

Alisha should express her appreciation for the family’s offer, but explain that she must decline because accepting this gift while the person is receiving peer services could affect that relationship. The family’s feelings can be further protected if Alisha tells them that there is an agency policy that forbids any staff member from accepting any gifts of substantial value. The situation might be viewed differently if some time after the service relationship was ended, this same family wanted to donate money to Alisha’s education or to the service organization. The key here is that the vulnerability or gratitude of the family is not used in an exploitive manner. All offers of gifts to an individual during or following a service relationship should be discussed with the supervisor.

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<tr>
<th><strong>Gifts</strong></th>
<th><strong>Ethical Issue</strong></th>
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<tr>
<td>Marie works as a Peer Specialist in an addiction treatment unit within a local community hospital. Her job is to provide recovery support services to patients discharged from treatment. She serves a predominately Native American population and conducts most of her work via home visits on two reservations. When she arrives for one of her visits today, the family she is visiting presents her with an elaborate, culturally appropriate gift as a token of their appreciation for her support. The problem is that Marie works in a hospital whose personnel code prohibits any staff member from accepting a personal gift. Marie is concerned about the consequences of accepting the gift, but is also concerned that refusing the gift could harm her relationship with the family and the tribe. What are the ethical issues here? What should Marie do?</td>
<td>Ethical decision-making must be culturally grounded. What this means is that the pros and cons of any action must be evaluated in the cultural context in which it occurs. What might be unethical in one cultural context (e.g., accepting a gift) might be not only ethical but essential in maintaining the service relationship in another.</td>
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<th><strong>Discussion/ Suggested Responses</strong></th>
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<tr>
<td>In this case, Mary could accept the gift in the name of the hospital, protecting herself from the hospital policy, and leaving the Peer Specialist relationship intact. Mary could report the gift to her supervisor and display the gift in a common area of the hospital for all to enjoy. What would be equally appropriate would be for Mary to raise the broader issue of the need for more flexible interpretations of this particular policy when working in this tribal context. Ironically, a policy designed to protect patients could actually result in injury to patients, severance of the service relationship, and damage to the reputation of the service institution. Peer Specialists working across cultural contexts need policy flexibility and good supervision to protect the service relationship.</td>
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**Boundaries of Competence**

During a visit today with Camilla, a person you are coaching, asks you what you think about the effects of anti-depressant medications on recovery from alcoholism. She is clearly ambivalent about the medication she is being prescribed, and your first inclination is to tell her to forget the medication and get to more meetings. What are the ethical issues in this situation? How would you respond?

**Ethical Issue**

It is quite appropriate for the Peer Specialist to listen to Camilla’s concerns about her medication, encourage her to talk to her physician about these concerns, and link her to resources to get additional information about recovery and anti-depressant medications. It is not appropriate for the Peer Specialist to offer their opinion or advice about any prescribed medication. To do so would be to move beyond the boundaries of the Peer Specialist’s education, training, and experience. Even if the Peer Specialist was a physician volunteer, their responsibility in the Peer Specialist role would be to link Camilla to medical resources she could consult about this question rather than to provide that information directly.

**Discussion/ Suggested Responses**

Under no circumstance should a Peer Specialist ever advise anyone to stop taking a prescribed medication. If the Peer Specialist has concerns about the effects of particular medications on Camilla’s recovery (e.g., prescribed sedatives or narcotic analgesics), the Peer Specialist’s role is to link Camilla to someone with expertise to discuss these issues, e.g. a physician trained in addiction medicine.

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### When to Refer

Martha has tried to engage Rita in recovery services for the past five weeks, but the chemistry between the two of them seems to have gone from bad to worse. All efforts to work through these difficulties in supervision have not improved the situation. At what point should Martha acknowledge this situation to her supervisor and Rita and seek to get another Peer Specialist assigned to Rita?

### Ethical Issue

The value of honesty dictates that Martha acknowledge to Rita and to Martha’s supervisor her concerns about the relationship difficulties, and raise the question of whether Rita would be better served with a new Peer Specialist.

#### Discussion/ Suggested Responses

This question should first be raised with the supervisor, and if efforts to improve the relationship fail, then a meeting between Martha, Rita, and the supervisor may be in order. The agenda is to avoid harm to Rita from a relationship mismatch, to establish an effective coaching relationship, but to also avoid any feelings of abandonment Rita might experience by the suggestion of a new Peer Specialist.

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### Discretion

Maria serves as a Peer Specialist for women and their families who are participating in a local women’s treatment program. Maria frequently hears from those she coaches, “I want to tell you something, but you can’t tell my family” or “I want to tell you something important about Jennifer, but I don’t want you to tell her I told you.” What ethical issues are raised by the Peer Specialist being in the middle of such communications? How should Maria handle such requests?

### Ethical Issue

Communication ground rules need to be established at the beginning of the Peer Specialist relationship. The values of discretion, respect, and fidelity demand that the Peer Specialist not disclose information beyond those established ground rules. Those ground rules include review of circumstances in which disclosures will be made, e.g., supervision, medical emergencies, imminent threat of harm to self or others.

#### Discussion/ Suggested Responses

Before agreeing to the requested promises above, Maria should again review those communication ground rules and the disclosure exceptions.
### Discretion versus Duty to Report

A person you are serving as Peer Specialist tells you he has been using the past week with another person who lives with him in a local recovery home. The disclosure makes it clear that the other person provides the drugs and may be dealing in the home and in the larger community. Further complicating the situation is the fact that the owner of the recovery home is a member of your board of directors.

### Ethical Issue

Do you have an ethical responsibility to protect this disclosure or to report the content of the disclosure to the house manager or owner of the recovery home? Would a Peer Specialist have a similar obligation to report the presence of a “script doctor” who was pumping massive quantities of prescription opiates into the community—when the source of that information was from those he or she was coaching?

### Discussion/ Suggested Responses

This information could not be ethically reported without permission for such disclosure. In both cases, the Peer Specialist could discuss with the client who disclosed whether they thought that information should be reported to responsible authorities, if the client was comfortable making such a report, or if the client would want you to make such a report without disclosing his or her identity as the source. Using this process would address the threat to the recovery home environment or the community without violating the promise of confidentiality.

### Threat to Community

When you arrive for a home visit with Joe Martin, a person you are coaching, you find him intoxicated. Joe says he can’t talk to you right now because he has to return to the bar he just left to pay off a debt. Joe has his car keys in his hand. What do you do?

### Ethical Issue

Allowing Joe to get into his car and drive to the bar could put other members of the community at risk. If someone did get hurt in an accident caused by Joe Martin, and people knew that the Peer Specialist had an opportunity to stop Joe from driving, you could be sued, or in a worst case scenario, be criminally liable.

### Discussion/ Suggested Responses

Use all of your persuasion skills to keep Joe out of the car. Ask Joe to forfeit the car keys, and let him know that if he gets in the car, you will have no recourse but to call the police. If he gets in his car and drives away, call the police informing them that you observed an intoxicated man by the name of Joe Martin get in a car and provide the vehicle description and location. Do not identify yourself in your service role and do not identify Joe as a service recipient of the organization. The challenge here is to address the threat to public safety without disclosing Joe’s status as a service recipient.
**Personal Bias**

Fred has worked hard to educate himself about medication-assisted recovery since he was first hired as a Peer Specialist, but he still has very negative feelings about methadone in spite of the research literature he has read about it. It’s not a head thing; it’s a gut thing. Marcy, another Peer Specialist, has similarly negative feelings about explicitly religious pathways of recovery because of the number of people she has known in AA for whom religion alone did not work as a framework for recovery. Describe how the personal biases of the Peer Specialist could result in harm or injury to multiple parties. How could Fred separate what he knows about methadone (the facts) from his feelings (opinions) about methadone?

**Ethical Issue**

As individuals, we may have all manner of biases about different addiction treatments, but in the Peer Specialist role, we have a responsibility to outline the choices available to those we serve as objectively as possible and support each person’s choice of the option that seems best for them at this moment. Discouragement of a particular method of treatment could prevent a client from getting the “one” treatment method that might be most successful.

**Discussion/ Suggested Responses**

Fred and Mary should continue to acknowledge and discuss their biases with their supervisor. Fred and Mary may not need more information and training on alternative treatments and pathways to recovery as much as they need direct contact with people who have successfully used these methods to achieve long-term recovery. As experiential learners, many Peer Specialists won’t credit the research findings until they experience this evidence face-to-face.

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# CONDUCT IN RELATIONSHIPS WITH OTHER SERVICE PROVIDERS

## Responding to Unethical Conduct

Susan, a client you have been serving for the past month, tells you today that she is in a sexual relationship with the counselor she is seeing at a local addiction treatment agency. The counselor is a very prominent person in the local recovery community and is very active in the state addiction counseling association. What are the ethical issues presented by this situation? How would you respond?

### Ethical Issue

There are several needs raised in this situation. The first is to acknowledge to Susan that such a relationship is a breach of professional ethics, and ask if she wants a referral to a different treatment agency, and whether she wants to file a formal complaint with the state certification board or seek other legal redress.

### Discussion/ Suggested Responses

Linking Susan to these resources would be a natural Peer Specialist function, as would supporting Susan through this process. Depending on the policies of your agency, you may also let Susan know that you will need to report this disclosure to your supervisor who may in turn, report this to the Peer Specialist’s supervisor. You may also be required to report it to the state certification board either with Susan’s name or without it.

## Representation of Credentials

Samuel works as a Peer Specialist doing post-treatment telephone monitoring. Samuel has represented himself working as a “counselor.” in his interactions with the larger community. He also makes periodic mention of his plans to “get back” to graduate school, but Samuel has only completed two years of college and has not been in school for more than ten years. What ethical issues are raised by this situation?

### Ethical Issue

The values of honesty and credibility require the Peer Specialist to accurately represent their education, training, and experience.

### Discussion/ Suggested Responses

The supervisor should acknowledge that he or she has heard the above reports and emphasize why it is important that, if true, these communications stop and be replaced with an accurate description of Samuel’s role and educational credentials. This might well be accompanied with a broader discussion of how Peer Specialists establish credibility and legitimacy within the larger service community.
<table>
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<tr>
<th>Role Clarity/Integrity</th>
<th>Ethical Issue</th>
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<tr>
<td>George has worked as Larry’s Peer Specialist for the past two months. Today, Larry asks George if George would be his NA sponsor. George has a long history in NA and a long history of sponsorship activities, but agreeing to this arrangement would mean that he would be both Larry’s Peer Specialist and sponsor. What harm and injury (if any) and to whom could result from such a dual relationship?</td>
<td>Failure to maintain boundary separation between the roles of Peer Specialist and sponsor could harm Larry, George, others receiving Peer Specialist services, the relationship between George’s organization and the local recovery community, and the larger community. The effect of dual relationships is often to “water down” both relationships.</td>
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<tr>
<th>Discussion/ Suggested Responses</th>
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<tr>
<td>The following are some suggestions to help George make the best ethical decision:</td>
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<tr>
<td>1. Performing sponsorship functions (e.g., making a Twelve Step call as an AA member, meeting with sponsees) during the time one is working as a Peer Specialist is a violation of Twelve Step Traditions and professionally inappropriate (beyond the scope of most agencies’ Peer Specialist job descriptions and explicitly prohibited in many).</td>
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<tr>
<td>2. Performing sponsorship functions through the Peer Specialist role could weaken local sponsorship practices and diminish community recovery support resources by replacing such natural support with the formal support of local treatment agencies.</td>
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<tr>
<td>3. Seeking reimbursement for sponsorship functions performed by a Peer Specialist is, at best, a poor stewardship of community resources and, at worst, fraud.</td>
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<tr>
<td>4. Role ambiguity and conflict resulting from a mixing of sponsorship and Peer Specialist functions could cause harm to clients/families, service workers, service agencies, and the community.</td>
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<tr>
<td>5. The Peer Specialist role represents a form of connective tissue between professional systems of care and indigenous communities of recovery and between professional helpers and sponsors; when those filling this role abandon this middle ground and move too far one direction or the other, that connecting function is lost.</td>
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## Role Clarity/Integrity

George, who is a salaried Peer Specialist, has a practice of linking those he coaches to recovery communities by taking them to and participating with them in recovery support meetings. A complaint has come to the agency about George “getting paid” for the time he is in meetings and that this constitutes accepting money for Twelve Step work. What are the ethical issues here? How could George more clearly delineate his paid activity from his NA service work?

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<th>Ethical Issue</th>
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<tr>
<td>The values of stewardship requires that the Peer Specialist carefully allocate their time.</td>
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### Discussion/ Suggested Responses –

George should be careful to separate Peer Specialist hours from hours spent in recovery support meetings so as not to receive payment for meeting time. The Peer Specialist function stops at the doorway of recovery support meetings: George should introduce his client to other recovery support group members and “hand him off” for 12 stepping.

## Discretion:

You are working as a Peer Specialist attached to a treatment agency. You take an assigned client, Troy, to a local recovery support meeting and also stay for the meeting. At the meeting, Troy discloses information that he has not told his counselor at the treatment program. Is this information you have heard confidential or do you have an obligation to report it to the counselor?

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<th>Ethical Issue</th>
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<tr>
<td>The information disclosed at the meeting may not be revealed outside the meeting. To do so would violate recovery mutual aid values and place the Peer Specialist in the role of “undercover agent” at such meetings.</td>
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### Discussion/ Suggested Responses –

You could encourage Troy to take the information to his counselor. This is another example of the strong need for ongoing supervision and support to help the Peer Specialist deal with complex issues regarding his or her role.
**Discretion:**

Claude has been in and out of treatment and NA multiple times and has an off and on again relationship with you as a Peer Specialist. Today, you run into Rudy, one of Claude’s former NA sponsors with whom you collaborated. Rudy’s first comment to you is, “How’s our boy doing?” How do you respond? Would this be an appropriate disclosure or simply gossip? Do the confidentiality guidelines that cover treatment relationships (and which would prohibit any disclosure to Rudy’s question) extend to the Peer Specialist relationship?

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<th>Ethical Issue</th>
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<tr>
<td>There is both an ethical and a legal dilemma here. Not only are you required to maintain confidentiality because of your professional guidelines, there are federal and state laws and regulations around disclosing treatment information without a consent signed by the client.</td>
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</table>

**Discussion/ Suggested Responses**

If you work in a treatment agency covered by federal confidentiality regulations, you cannot answer Rudy’s question or even acknowledge that Claude is a client at your organization unless you had a signed release to talk to Rudy about Claude. If you work in an organization not covered by federal confidentiality regulations (e.g. a freestanding recovery support organization, a recovery ministry within a church, etc.), your response should be guided by your policies on confidentiality and the agreement about permitted disclosures negotiated with Claude at the beginning of the Peer Specialist relationship. The key thing here is the value of fidelity: to keep our promises.

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<th><strong>Anonymity</strong></th>
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<tr>
<td>Ernest is a long-time AA member, recovery advocate, and recently hired Peer Specialist. In his earlier recovery advocacy work, Ernest has always been very careful in identifying himself publicly as a “person in long-term recovery” without noting his AA affiliation. Today, Ernest is on a panel at a social service conference to talk about the pilot Peer Specialist project where he works. The conference is being covered by local media who ask to interview Ernest after the panel. One of the reporters follows up Ernest’s report of his recovery status and its duration with the question, “Are you a member of AA?” What are the ethical issues involved in this situation? How should Ernest respond? How would this be different if Ernest was in an alternative recovery support group that did not have a tradition of anonymity?</td>
<td>There is both an ethical and a legal dilemma here. Not only are you required to maintain confidentiality because of your professional guidelines, there are federal and state laws and regulations around disclosing treatment information without a consent signed by the client.</td>
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**Discussion/ Suggested Responses**

Ernest should NOT disclose his membership in AA. This would violate AA’s anonymity tradition as well as be potentially viewed as a personal endorsement of a particular mutual aid group. Such a disclosure and the potential controversy spawned by it could interfere with Ernest’s service relationships, isolate Ernest from the local AA community, and harm the relationship between Ernest’s organization and the local AA community. If Ernest was not in AA or another Twelve Step program, there would be no explicit anonymity guideline, but Ernest would still need to be cautious in any disclosures to the press.

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### Predatory Behavior

Felicia works as a Peer Specialist for women who are just entering intensive outpatient treatment and who are living in a women’s recovery home. One of Felicia’s responsibilities includes linking these women to local recovery mutual aid meetings. Many of the women Felicia works with have histories of sexual victimization as well as long histories of violent intimate relationships. Felicia is aware that predatory behavior (“Thirteenth Stepping”) is common in some local recovery meetings. To what extent is Felicia responsible for preparing the women she refers for such behavior or protecting them linking them only to meetings where this behavior has not been reported?

### Ethical Issue

Peer Specialists may have intimate knowledge about their client’s vulnerabilities. Her clients have the right to make their own choices about which meetings they attend. Felicia should explain the risks of some of these meetings. This does not take away the decision-making power of the client, she is only offering additional information allowing her clients to make an informed choice.

### Discussion/ Suggested Responses

Felicia needs to honor the potential of her clients to be harmed in groups with little “group conscience.” She should help her client find meetings with a “climate” that is safe and supportive.

### Potential Iatrogenic Effects of Peer Services

Ellen, a highly respected elder in the local AA community, is expressing criticism of peer services and the broader recovery support services offered by a local recovery advocacy agency. It is Ellen’s position that such roles and services will undermine the importance of sponsorship and weaken the service ethic within the local recovery community. How do you respond?

### Ethical Issue

There is no single program and intervention that works for everyone. When clients return to the community, they will be working to find their own supports for recovery. AA should be an alternative should a client so choose.

### Discussion/ Suggested Responses

Ellen should be invited to discuss her views on peer services and shown the statistics and local experience related to the role of peer services in successful long-term recovery. Ideas should also be solicited from Ellen about how the Peer Specialist role could be designed and supervised to assure that it enhances rather than undermines the service ethic within the local AA community.
**Role Integrity**

Mel is an elder statesman in AA who offers to volunteer as a Peer Specialist. Mel’s orientation to coaching is to do what he does as a sponsor: help people work the steps and develop a life of sobriety and serenity. What harm, if any, could come from this merger of the sponsor and Peer Specialist roles?

**Ethical Issue**

The main driver for any decision is how will this benefit my client in the long run?

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**Discussion/ Suggested Responses**

The primary harm in this merger of Peer Specialist and sponsor roles would come from the broader recovery support needs (e.g., sober housing, medical needs, transportation, day care, etc.) that would be addressed in the fully developed Peer Specialist role but not addressed in the Peer Specialist as sponsor role. Harm to the client could also result from the role confusion between the Peer Specialist and sponsor roles.

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This grid was modified from an essay written by William L. White. The original essay described a model of ethical decision-making for Peer Specialists and their supervisors and identified some of the emerging ethical issues in the delivery of peer-based recovery support services. Ethical sensitivities and approaches to ethical decision-making will continue to evolve as recovery support services become more formalized and the collective experience of Peer Specialists and their sponsoring organizations grows. This growing foundation of experience will spawn formal ethical guidelines for Peer Specialists and more formal approaches to ethical decision-making.
CHAPTER 13

**Learning Objectives:** You will learn answers to the following questions:

1. What percentage does non-verbal communication play in our day to day communications?
2. Name 2 barriers to active listening?
3. What are 3 elements of reflective listening?

**INTERPERSONAL AND COMMUNICATION SKILLS**

The most important skills that a Peer Specialist must learn are interpersonal and communication skills. These skills are used in almost all work activities. This section provides information about relating and communicating with others verbally, nonverbally and in writing.

**Interpersonal Skills**

Interpersonal skills are sometimes also referred to as people skills or communication skills. Interpersonal skills are the skills a person uses to communicate and interact with others. They include negotiation, persuasion, active listening, delegation, and leadership. The term "interpersonal skills" is used often in business contexts to refer to the degree of a person's ability to operate within business organizations through social communication and interactions. Interpersonal skills are how people relate to one another.

"Social skills” can be measured by how you treat other people and how you react to them. It's a matter of dealing with the people around you. Different tests can tell what kind of personality you have towards others. If you are concerned about your abilities, then this kind of test may give you good information. This would help you change behaviors and could serve as a guide to your communication qualities. Often, employers offer these kinds of tests for their employees. These tests aren’t always available, but you can learn more about your skills in this area in supervision.

**Verbal Communication**

Effective verbal or spoken communication depends on a number of things and cannot be fully isolated from other important qualities such as non-verbal communication, listening skills and clarification. Human spoken and pictorial languages can be described as a system of symbols and the grammars (rules) by which the symbols are manipulated. The word "language" also refers to
common properties of languages. Language learning normally occurs most intensively during human childhood. Most of the thousands of human languages use patterns of sound or gesture for symbols which enable communication with others around them.

Communication is the flow or exchange of information from one person to another or a group of people. In modern business, people are said to have good verbal skills if they are able to use language to accurately convey ideas and feelings using words and gestures. Good grammar is also important.

Nonverbal Communication

Nonverbal communication describes the process of conveying meaning in the form of non-word messages. Some forms of nonverbal communication include gesture, body language or posture, facial expression and eye contact, object communication such as clothing, hairstyles, symbols such as tattoos and piercings, and tone of voice, as well as through a combination of the above.

Speech also contains nonverbal elements known as paralanguage. These include voice quality, emotion and speaking style as well as rhythmic features such as rhythm, intonation and stress. Research has shown that up to 55% of human communication may occur through nonverbal facial expressions, and a further 38% through paralanguage. Likewise, written texts include nonverbal elements such as handwriting style, spatial arrangement of words and the use of emoticons to convey emotional expressions in pictorial form.

Oral Communication

Oral communication, while primarily referring to spoken verbal communication, can also employ visual aids and non-verbal elements to support the conveyance of meaning. Oral communication includes speeches, presentations, discussions, and aspects of interpersonal communication. As a type of face-to-face communication, body language and tone of speech play a significant role, and may have a greater impact on the listener than the information conveyed by the speaker. Picture someone crying while describing a fun experience. What kind of message will the listeners interpret? Will they listen to the words that describe something fun and happy or will they pay attention to the speaker’s tears and crying?

Active Listening

Active listening is a communication technique used in counselling, training and conflict resolution. It requires the listener to “feedback” or repeat what they hear to the speaker. They re-state or paraphrase what they have heard in their own words, to confirm what they have heard is accurate and to confirm the understanding of both parties.

Comprehension

Comprehension is "shared meaning between parties in a communication transaction". This is the first step in the listening process.
Retaining
This is the second step in the listening process. Memory is essential to the listening process because the information we retain when involved in the listening process is how we create meaning from words. We depend on our memory to fill in the blanks when we're listening. Because everyone has different memories, the speaker and the listener may attach different meanings to the same statement. However, our memories are fallible and we can't remember everything that we've ever listened to. Using information immediately after receiving it enhances information retention and lessens the tendency to forget. When we engage in mindless listening, where little effort is made to listen to a speaker's message, we are much less likely to retain what we've heard. Mindful listening is active listening.

Tactic
Active listening requires that the listener observes the speaker's behavior and body language. Having the ability to interpret a person's body language lets the listener develop a more accurate understanding of the speaker's message. After observation, the listener can paraphrase the speaker's words. It is important to note that the listener doesn’t necessarily agree with the speaker—they simply restate what was said.

Persons in conflict often contradict each other. Ambushing occurs when one listens to someone else's argument for its weaknesses and ignore its strengths. This may distort the speaker’s argument to gain advantage in the conversation. On the other hand, if one person finds that the other person understands, they create an atmosphere of cooperation.

Use
Active listening is used in a wide variety of situations, including public interest advocacy, community organizing, tutoring, medical workers talking to clients, counseling, management, and journalistic settings. In groups it may aid in reaching consensus. It may also be used in casual conversation or small talk to build understanding, though this can sometimes be interpreted as condescending.

A listener can use several degrees of active listening, each resulting in a different quality of communication. The proper use of active listening results in getting people to open up, avoid misunderstandings, resolve conflicts, and build trust. In a medical context, benefits may include increased client satisfaction, improved cross-cultural communication, improved outcomes, or decreased litigation.
**Barriers to active listening**

Barriers to active listening are those things which interfere with effective communication between the speaker and listener. Some of the barriers may be physical, such as the listener being tired or hungry, or a listener gets irritated and doesn't want to listen to the speaker. Sometimes it is due to the language which the speaker uses (high sounding and pretentious words) which can affect the active listening. Other barriers include distractions (noise, smell, and activity), trigger words, vocabulary, and limited attention span. In short, listening barriers may be psychological (e.g. emotions) or physical (e.g. noise and visual distraction).

**Shift response**

Another barrier is the “shift response” which is the tendency in a conversation to affix the attention to you. This is a type of conversational narcissism; the tendency of listeners to turn the topic of conversations to themselves without showing sustained interest in listening to others. A support response is the opposite of a shift response; it is a cooperative effort to focus the conversational attention on the other person. Instead of being me-oriented like shift response, it is we-oriented. It is the response most likely to be used by a competent communicator or Peer Specialist.

**Understanding Non-verbal cues**

Ineffective listeners are unaware of non-verbal cues, although non-verbal cues dramatically affect how people listen. To a certain extent, it is also a perceptual barrier. As much as 93 percent of people’s attitudes are formed by non-verbal cues. In most of the cases, the listener does not understand the non-verbal cues, which the speaker is using. A person shakes their fist to emphasize a point, but the listener comprehends that the speaker is shaking his hand because it fell asleep. Overuse of non-verbal cues also create distortion and the listeners may be confused about whether or not they understood the correct meaning.

**Overcoming listening barriers**

To use active listening techniques to improve interpersonal communication, a Peer Specialist has to put their personal emotions aside during the conversation, asks questions and paraphrases back to the speaker to clarify understanding. The Peer Specialist may also have to ignore all types of environment distractions. Judging or arguing prematurely is a result of holding onto a strict personal opinion. This hinders the ability to be able to listen closely to what is being said. Eye contact and appropriate body languages are seen as important components to active listening.

**Open questions, Reflections and Summaries (ORS)**

A closed-ended question is a question format that limits the answers respondents can give to a question. Respondents are given a list of answer choices to answer the question and must choose one selection. Commonly these type of questions are in the form of yes/no or multiple choice.
They also can be in scale format, where respondent rates a situation along the scale continuum. An example of this is “never, sometimes, and always.”

A closed-ended question contrasts with an open-ended question, because it cannot be answered with a simple "yes" or "no", or with a specific piece of information. A closed-ended question gives the person answering the question enough freedom to give the information that seems to them to be appropriate. Open-ended questions are sometimes phrased as a statement which requires a response.

Examples of open-ended questions:
- Tell me about your relationship with your supervisor.
- How do you see your future?
- Tell me about the children in this photograph.
- What is the purpose of government?
- Why did you choose that answer?

At the same time, there are close-ended questions which are sometimes impossible to answer correctly with a yes or no without confusion, for example: "Have you stopped taking heroin?" (If you never took it).

**Reflective Listening**

Reflective Listening is the most advanced form of active listening. Its basic premise is that the speaker knows best what his/her experience is, and the role of the listener is to reflect the experience back to the speaker, to mirror it.

How do you reflect? You tune in to people’s words, nonverbal messages, and mood. You listen in a nonjudgmental way and then mirror what the speaker is saying and feeling using your own words. The reflection of words and emotions makes the person feel understood and gives them space to get to the bottom of their feelings and their experience.

**Actively engaging**

**Actively engaging** in the conversation calls for reducing or eliminating distractions of any kind to allow for paying full attention to the conversation at hand.

**Genuinely empathizing**

**Genuinely empathizing** with the speaker’s point of view doesn’t mean agreeing with the speaker, just viewing things from his/her perspective. The listener encourages the person to speak freely, by being nonjudgmental and empathetic.
**Mirroring Mood**

**Mirroring Mood** of the speaker, reflecting the emotional state with words and nonverbal communication. This calls for the listener to quiet his mind and fully focus on the mood of the speaker. The mood will be apparent not just in the words used but in the tone of voice, in the posture and other nonverbal cues given by the speaker. The listener will look for congruence between words and mood.

**Summarizing**

**Summarizing** what the speaker said, using the listener’s own words. This is different than paraphrasing, where words and phrases are moved around and replaced to mirror what the speaker said. The reflective listener recaps the message in his own words.

**An example**

Tom: “I wonder why Laura got a bigger raise than me. She's been with the company a lot less time than me, and she hasn't done anything significant to merit a raise.”

Listener: “You think Laura should have gotten a smaller raise.”

Notice how the person listening did not question the validity of Tom's feelings, the listener just reflected in his own words what he heard.

Tom's possible reactions are: (a) He feels understood and free to explore the subject more in depth or (b) He feels discovered and may try to deny to the listener and to himself his feelings of jealousy.

Whatever reaction Tom has, the listener continues mirroring what he hears, helping the speaker sort out his own experience. If the person speaking gets defensive, the listener remains non-judgmental, hoping to open up the space for true communication.

When a person listens without passing judgment, it frees up others to be authentic, to express themselves and to accept who they truly are.

The premise of Reflective Listening is that the speaker knows best what he/she is experiencing, the listener helps the speaker see it by reflecting it back as a mirror would. This listening creates a space for the deepest and most effective communication between two people to take place.
CHAPTER 14

Learning Objectives: You will learn answers to the following questions:

1. What are 3 components of the recovery-focused helping relationship in Peer Services?
2. When should mutual support be used in Peer Services?
3. How does self-disclosure offer hope in Peer Services?

USING YOUR PERSONAL STORY TO HELP OTHERS

The ability to tell a recovery story with its struggles, success, lapses and relapse is the most powerful tool that Peer Specialists possess. Peer Specialists must be selective in what they choose to disclose to clients, just like other professionals. Peer Specialists make careful decisions about which personal information to share based upon the needs of clients. Information provided by Peer Specialists should be restricted to information that will help clients to gain skills, insight or understanding into problems or goals being addressed by the client or group or to provide hope. Peer Specialists should avoid putting clients in the position of being a counselor when it’s not going to be helpful to the client. Peer Specialists should continue to be open to feedback about information provided to clients from other trained Peer Specialists or Clinical Supervisors.

Exposure to the personal stories and lives of people in recovery can serve as a catalyst of change for people with SUD as shown in these statements about peer support dating back to 1841.

“They [reformed men] understand the whole nature of intemperance in all its different phases; they are acquainted with the monster in every shape which he assumes; they know the avenues to the drunkard’s heart; they can sympathize with him; they can reason with him; they can convince him that it is not too late to reform..”. (From the Mercantile Journal, May 27, 1841)

Self-Disclosure

The emphasis on reciprocal self-disclosure and mutual identification in peer support services is in contrast to the notion of self-disclosure in psychotherapy and addiction counseling, where self-disclosure by the counselor is discouraged, except under strict clinical guidelines. In contrast, persons who received peer services view self-disclosure as an offering of hope to those in recovery, and an instrument of public education that dispels social stigma and widens the
doorways of entry into recovery for others. An important role for Peer Specialists is to use your story to help others. Persons who are not willing to share their story should find another way to help people.

The self-disclosure debate reflects a broader difference in the degree of personal involvement in the helping relationship by the Peer Specialist. Peer support providers must always evaluate how much to invest emotionally and how much to refrain from investing. They must decide how much they want to be distanced from the recipient versus how much they want to be emotionally invested through empathy, compassion, and caring. This means that support providers must work at finding a balance that guides them in their decision about how much of their personal story they will share.

**Mutual Identification**

The peer’s degree of personal involvement is both a strength and a vulnerability of peer support specialists. The distancing guidelines of treatment professionals are intended to ensure objectivity in assessment and counseling, reduce the risk of exploitation in the helping relationship, and minimize the effects of vicarious traumatization — also known as secondary traumatic stress. Vicarious traumatization occurs when helpers lack the defenses necessary to protect themselves against the emotional impact of clients’ stories of victimization, degradation, and/or perpetration.

In the world of peer support, the helper has greater levels of emotional exposure. For the peer specialist, protection comes from a larger recovery community. In other words, the emotional intensity of reciprocal self-disclosure and the intimacy produced by such disclosure are diffused within a larger community of mutual support. When peer helpers work in isolation from this support, they may injure themselves through the helping process. Some stories are so traumatic that they have a serious emotional impact for the peer helper. This is why, in recovery communities, members are expected to tell “in a general way what we used to be like, what happened, and what we are like now” and leave the disclosure of the more intimate details in their life stories to fifth steps, religious confession, or psychotherapy.

**Story Telling**

The use of self-disclosure, mutual identification, and respect are important components of the recovery-focused helping relationship. Peer Specialists will develop their own personal guidelines for telling their stories as they work in the field. In the face to face training, peers will be able to practice their own story telling. In the meantime, Peer Specialists should keep their story telling to the following limits:
Hopeful
Make sure there is a “moral of the story” that focuses on hope. An important part of the Peers’ work is to engender hope. So the personal story you choose should highlight how you worked, your struggles and triumphs that led to your recovery today.

Relevant
In order for a story to inspire hope, it should be relevant to your client. Try to identify elements in your story that you think your client can relate to. For example, if your client is a combat veteran, your personal story of becoming a single mother isn’t going to be relevant. But there are elements of the story that your client can relate to, such as the loneliness or feeling of worthlessness you have both experienced.

The Peer Specialist encounter is not a time for mutual help

Another benefit of peer services is that the Peer Specialist is on a similar level as the client. Similar, but not the same. This means that the Peer Specialist’s primary role is to serve the client, and in that sense, you and the client are not equal. If you find yourself telling your story in a way to meet your own needs, you should stop and ask for supervision. If you need guidance with a problem, talk to another Peer Specialist or bring it up in a mutual support group. The focus of the Peer Specialist encounter should be on helping the client.
CULTURAL COMPETENCY

Tolerance, respect for diversity, and learning ways to communicate with people from different cultures is critical in today’s world, especially healthcare. Not only are we, as a country, becoming more diverse, we are also aware that we have to expand our knowledge so we can communicate better with people from other cultures. Finally, we are recognizing how important culture is to an individual’s identity.

America was once referred to as a “melting pot,” implying that all Americans, including immigrants, came together to form one culture. While this is somewhat true, Americans also hold on to elements of their ethnic, religious, or regional cultures. This would make America more of a “salad,” in that we are all unique, but come together to create a rich, colorful and flavorful American culture by bringing the unique features of our own cultures. The phrase "cultural diversity" is sometimes used to mean the variety of human societies or cultures in a specific region, or in the world as a whole. We don’t expect that people give up their native cultures in order to become American. Our cultural histories are part of our identity.

Cultural competency is the term used to describe the process of using cultural knowledge to improve our ability to relate to various people with different backgrounds and worldviews. It is a process, not an event. In that respect, it is much like recovery. A person doesn’t become culturally competent at a point in time after completing a required set of steps. People build their cultural knowledge throughout their lives. That knowledge transforms into practice, which tells us we need more knowledge and the process repeats itself. It’s a lifelong process, much like recovery. Therefore, we are only going to touch on the topic of cultural competence in this training and we hope that it inspires you to learn more.

Importance of Becoming Culturally Competent

There are many reasons to become culturally competent. For example:
• Minorities in America have lower access to good health care. This lack of access has a negative impact on the individual, the community and the country as a whole.
• Professionals who are culturally competent are more successful in doing outreach and getting clients to engage in treatment.
• Providers and staff who are knowledgeable about a person’s cultural attributes will be much more successful in treating their clients.
• American demographics are changing. According to the US census, by the year 2060,

<table>
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<th>2060 population (in millions)</th>
<th>Percentage change</th>
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<td>17</td>
<td>38</td>
<td>128%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>55</td>
<td>119</td>
<td>115%</td>
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<td>3</td>
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</tr>
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<td>42</td>
<td>60</td>
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</tr>
<tr>
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<td>5.6</td>
<td>41%</td>
</tr>
<tr>
<td>White</td>
<td>246</td>
<td>285</td>
<td>15%</td>
</tr>
</tbody>
</table>


**Definition of Culture**

So, what is culture? There are many definitions of culture. This is a good one –

A shared set of learned attitudes, values, goals and practices that characterize a group, and are passed from generation to generation.

This means that culture is not just about race or ethnicity. A Culture can be any group a person belongs to that shares common values, ideas, practices and attitudes. In addition to race and ethnicity, other cultures include military, religion, ability/disability, education, occupation, socio-economic status, sexual orientation, and regional (region of the US where a person lives or was raised). So, when it comes to culture, people are multi-dimensional. Most of us belong to several different cultures, each of which influence our attitudes, values, beliefs and behaviors in some way.

As mentioned earlier, becoming culturally competent means that individuals go through different stages. There are several academic models that describe this process, but most of them all describe similar steps.
1. **Awareness and acceptance of differences** – first, the person becomes aware that people are different. They begin to accept the fact that people are different and recognize that many things they don’t understand may be attributed to these differences. (Some models of cultural competency describe a stage that comes before this, where a person is prejudice, and dislikes differences).

2. **Awareness of own cultural values** – the second stage is where the person becomes aware of their own cultural values and recognizes how they affect their own behavior and attitudes about others.

3. **Recognizing that differences impact relationships** – this stage is where the person starts to understand how some of his or her negative impressions result from misunderstanding or a lack of knowledge. This leads to the next stage.

4. **Development of cultural knowledge** – the person is interested in learning about different cultures so that he or she can communicate and relate better. He or she is also learning about his/her own culture and is willing to teach this to people from other cultures.

5. **Ability to adapt activities to fit into different cultural contexts** – this stage is where the knowledge learned in stage 4 translates into changes in communications styles and the ability to modify behavior and language to communicate effectively with people from various cultures. Stages 4 and 5 are repeated as the person meets new people from new cultures.

**Our Worldview**

We each have a personal lens that was shaped by our parents, our family, our teachers, our role models and our experiences. They helped shape who we are today. Our perceptions about the world are not carved in stone, but rather molded in clay. As we learn more about ourselves, our worldview changes as well. And vice versa. This section is intended to inspire you to start thinking about your personal biases and how they impact your interactions with others, especially clients/patients.

Our culture(s) affect many aspects of our personalities and behaviors that we are not even aware of. For example, a person’s culture affects:

- How people see time
- How people develop trust
- How people make decisions
- How people take risks
- How people communicate (verbally & non-verbally)
- How people seek help
- How people work to achieve goals

We don’t have the resources to describe all of the cultural features that influence a relationship, but it’s important for the Peer Specialist to understand certain things that can create problems in
a relationship with persons from different cultures. If you are working with a person from a different culture, it is important to have some basic understanding of the rules and acceptable behaviors in a relationship. This is just a very basic list. There may be other rules you need to be aware of that aren’t on this list.

- **Gender roles** – some cultures have very specific roles for men and women. For example, in some cultures, it is inappropriate for a male provider to treat a female patient. Learn whether or not there are any guidelines related to gender roles.

- **Age or authority** – again, some cultures have very specific roles based on a person’s age, or perceived authority. Will they only listen to an MD or a male when discussing a treatment plan? Are there rules for how you address persons of a certain age?

- **Individualism vs. integrity of the tribe or group** – Americans place a high value on individualism and independence. Other cultures place a priority on what the individual contributes to the group or family and the impact of their behavior on the group. You may ask a female client to make a decision about her future. She is reluctant to do so, not because she lacks confidence in herself but because, in her culture, it is inappropriate to make a decision without first discussing it with the family.

- **Facial expressions** – in some cultures, it is considered rude or aggressive to look people in the eye. In America, people are thought to be dishonest if they don’t look someone in the eye when speaking. This is considered rude in other cultures. Do facial expressions match their emotions? For example, in some parts of China, people laugh when they are very sad. Even if an immigrant appears to be fully acculturated, they may still possess these subtle cultural communications.

- **Touching / personal space** – In American cultures, particularly with people who work in behavioral health, touching is acceptable, even expected. Hugging someone after an emotional group therapy is appreciated. A brief touch on the hand or shoulder conveys compassion. Other cultures, on the other hand, may see uninvited touching as a serious violation. An individual’s personal space is another important element of the relationship. Some cultures tolerate close personal contact. Other cultures respect an individual’s personal space and won’t get closer than 3 or 4 feet. American’s personal space is moderate compared to other cultures.

- **Relationship with Time** – Time and respect of time is a driving force in American life. “Time or money” is a common American phrase when referencing important resources. Other cultures have a much more casual relationship with time. They may consistently be late or early for appointments, or may not understand the concept of scheduling a procedure 6 months in the future.

If you work with clients who come from other cultures, learn about the behavior guidelines, the rules of etiquette and anything else that will help you communicate. If you have questions, ask the client. Don’t make assumptions.
Prejudice, Discrimination, Racism and other “isms”

Most people who work in our line of business would never admit to being prejudice or racist or discriminating against others from different cultures (by the way, most people in our line of work would never admit to being prejudice because tolerance and acceptance is one of the values in our occupational culture). But all of us have some subtle beliefs that were passed down to us from our parents, teachers or ministers. Some of these beliefs may be discriminating against a group of people. These negative attitudes might be about people from a different race, those who have a different sexual orientation, uneducated people, people from another part of the United States, or a variety of other human characteristics.

These attitudes that have been passed down may be overtly racist, or a very subtle dislike of a quality possessed by certain people. One Peer Specialist had a negative attitude about people who were overweight because his mother told him fat people were lazy. It is important for you to be aware of these attitudes so that they don’t affect your relationship with the clients you serve. If one of your prejudices is so strong that you think it might affect your work with your client, tell your supervisor immediately. Perhaps the client can be reassigned. If the feelings are so strong that you can’t overcome them with education or logic, you may want to think about getting therapy to help you work out these feelings. The final word is not to let your personal biases affect your work as a Peer Specialist.

Conversely, becoming culturally competent will not only make you a better Peer Specialist, it will open up a whole new world of experiences and relationships.
CHAPTER 16

Learning Objectives: You will learn answers to the following questions:

1. What are 4 social determinants of health that if resolved, improve a person’s chances of recovery?
2. Where can a Peer Specialist find information about local resources?

RESOURCES

Community Resources

This training isn’t going to go into the specifics about all of the resources that are available in the community, because that is something that each peer will have to learn and develop locally. You’ll have to become familiar with the resource directories for your community. These may include online directories, a 211 system or paper directories found at the library. You will have to learn about resources in your day to day work.

It’s important to briefly talk about why having this information is so important in Peer Specialist work. Most people with a substance use disorder, mental illness or chronic health condition need other services to reach their recovery goals. The following list represents some of the barriers to recovery. They are also known as the “social determinants of health,” meaning that if these situations in a person’s life are resolved, their overall health will improve.

1. **Safe, affordable housing** – some of our clients are homeless, live with friends or have a living situation that is not healthy or desirable.

2. **Employment** – some of our clients are unemployed, or under employed. Their drug use or mental illness prevented them from finishing school and finding a career. This results in chronic poverty and unemployment.

3. **Nutrition** – Homelessness, poverty, and the drug life style prevent people from eating well. Unhealthy eating can lead to a variety of long term health consequences including obesity, heart disease, diabetes, dental caries (rotting teeth) and a host of other problems which contribute to drug and alcohol abuse.
4. **Finances** – clients who are homeless, who are actively using drugs or who have an unmanaged mental illness have unstable incomes. This prevents them from renting an apartment, eating well, or managing their medical problems. They don’t have transportation, so they can’t get to their job on a regular basis. Some clients may be eligible for benefits such as SSI, veteran’s assistance or food stamps, but haven’t ever finished all of the paperwork. If they are unemployed and don’t get benefits, any income they get is the result of “hustling” or street crime, which makes them vulnerable to a whole list of legal problems.

5. **Medical problems** - clients who are homeless, who are actively using drugs or who have an unmanaged mental illness are likely to have medical problems that are not being treated. Diabetes, heart disease and hepatitis C are common diseases in our clients.

We can go on and on, but this gives you an example of the kinds of problems our clients face. It’s not enough to get a client detoxed and abstinent if they have no home, no income and their diabetes is out of control. The Peer Specialist can have an important role in helping the clients connect with services that will benefit their recovery. That’s why it is a very important part of the Peer Specialist’s job to understand where to go to connect clients with the services they need.

**Where to find resource information**

Most of the time, there isn’t a nice, organized resource list that exists on line. You’ll have to collect contacts from various places. Spend time researching the internet, talking to other staff about programs serving our clients. One Peer Specialist in a rural town went through the yellow pages to find resources for his client. Another Peer Specialist did “cold-calling” to agencies to find emergency food for a client and her family. The point here is that you have to know where to find information. And don’t forget churches and synagogues. Many have charitable programs that aren’t advertised.
CHAPTER 17

**Learning Objectives:** You will learn answers to the following questions:

1. **What is the difference between a natural support system and clinical support?**
2. **What are 2 benefits Peer Specialists gain from their role?**
3. **What kinds of life skills can the Peer Specialist teach their clients?**

**NAVIGATING THE BENEFITS SYSTEM**

A very specific and important resource for our clients is benefits acquisition. If a person isn’t receiving benefits, and you believe they are eligible, find the person in your community who is an expert. You may have a benefits specialist in your SUD program. If not, check with the community mental health centers. Most of our Colorado mental health centers employ a benefits specialist or a person who is knowledgeable, and has inside information about how to get benefits for clients. If you don’t understand the process, leave it to the experts, because it can be a daunting and frustrating experience if you don’t know who to talk to.

Getting a client connected with benefits can have a major positive impact on their lives. Having a regular income, such as SSI or SSDI will provide the funds to rent an apartment, buy groceries and pay utilities. If a person is eligible for one of these programs, they will probably be eligible for other programs such as food stamps, utilities assistance and Medicaid. They may also connect your client with employment programs, childcare, training to get a GED and even pay for college tuition or technical school.

**Help Individuals and Families Recognize Their Natural Supports**

In addition to community agencies and benefits, family members, friends and past mentors can support your client in their recovery. Many clients are estranged from their families because of past bad behavior when they were drinking or using. Some families may be willing to give their loved one another chance since he is now in treatment and is sober. If your client is getting care in the community where he grew up, he may have supporters such as employers, teachers or ministers. The important thing to remember here is that the client is the one who makes the decision to reach out to family or old friends.
An important task for persons in recovery is identifying the people and systems that will support them. Your role as a Peer Specialist is to help the client identify those support systems. You should also talk about the consequences of connecting with friends who are still in the lifestyle or will put the client at risk. While you will talk to your client about the advantages and disadvantages of a particular strategy, the final decision is theirs.

Encourage the Development of Natural Supports

A natural support is something that exists in the client’s community and is something the client would like use for support. For example, a natural support may be the client’s faith community, or support he gets from the pastor, rabbi, and members of the parish or temple. Family and extended family may be a natural support if the client isn’t estranged from family. Relationships formed at work or school can also be supportive. 12-step groups are natural supports for some clients.

On the other hand, formal clinical or medical services are not considered a natural support. They only exist in a person’s life for a short period of time and once the person is discharged or completes the service, the agency is no longer a support system.

Social support is the belief and the reality that one is cared for, can get help from other people, and that one is part of a supportive social network. These supportive resources can be emotional (e.g., nurturance), tangible (e.g., financial assistance), informational (e.g., advice), companionship (e.g., sense of belonging) and intangible (e.g. love, caring, respect). Support can come from many sources, such as family, friends, pets, neighbors, coworkers, organizations, etc.

Peer support is distinct from other forms of social support in that the source of support is a peer, a person who has similar experiences as the recipient of the support; their relationship is one of equality. A peer is in a position to offer support by virtue of relevant experience: he or she has "been there, done that" and can relate to others who are now in a similar situation. Trained peer support workers such as Peer Specialists, receive special training and if they are certified, are required to further their education and knowledge, just like clinical staff.

Colorado does not have a Peer Specialist credential yet. The credential is still in the planning stages. Also, this training was structured to cover all of the required subjects so that peers taking this training will have completed some of the training requirements for certification.

Also, a Peer Specialist may be in a better position to give recommendations about support networks. They know about the culture, both positive and negative aspects, and can make realistic referrals based on this knowledge. The list below explains some of the reasons why peer support can aid persons in their recovery. It also describes some of the benefits Peer Specialists gain from their role.
- **Positive psychosocial interactions with others** - Social support is the existence of positive psychosocial interactions with others with whom there is mutual trust and concern. Positive relationships contribute to positive adjustment and buffer against stressors and adversities by offering (a) emotional support (esteem, attachment, and reassurance), (b) instrumental support (material goods and services), (c) companionship and (d) information support (advice, guidance, and feedback).

- **Experiential knowledge** - Experiential knowledge is specialized information and perspectives that people obtain from living through a particular experience such as substance abuse, a physical disability, mental illness, or a traumatic event such as combat, domestic violence or a violent crime. Experiential knowledge, when shared, contributes to solving problems and improving quality of life.

- **Credibility and role modeling for others** - Social learning theory suggests that peers, because they have undergone and survived relevant experiences, are more credible role models for others. Interactions with peers who are successfully coping with their experiences or illness are more likely to inspire positive behavior change.

- **Principles of self-help** - The helper-therapy principle proposes that there are four significant benefits to those who provide peer support: (a) increased sense of interpersonal competence as a result of helping another person; (b) development of a sense of equality in giving and taking between himself or herself and others; (c) gaining new personally-relevant knowledge while helping; and (d) receiving social approval from the person they help, and others.

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**Life skills**

For addicts, maintaining their addiction can dominate their lives. Overcoming an addiction requires a lifestyle change, and life skills lessons are often necessary to make this change possible. By helping former addicts learn basic life skills you can help them handle freedom and make the transition less painful. Below are some suggestions for the basic skills adults need to function in today’s world. As the Peer Specialist, you will be helping them lean these skills.

**Help the individual secure housing.**

Getting a place to live is the first step towards independent living. Help him peruse the housing ads and select a place that fits both his needs and his budget. This step can be scary for the recovering addict.

**Goal Setting**

Work with the recovering addict to set goals. Help the person prioritize by helping him set goals. Recovering addicts face many steps ahead to get their lives headed in a positive direction. Help create a list of all of plans and rank them in order of importance.
Prioritize activities
Create a schedule to help the person properly manage his or her time. Use a dry erase or poster board to create a daily schedule, which helps create stability. This also helps recovering addicts use their time effectively and productively.

Regular and healthy eating
Regularly share meals with the person you are working with. If the recovering addict is not an adept cook, some general lessons would be helpful. Direct them to simple cooking lessons and recipes on the internet. Sharing meals helps recovering addicts with feelings of isolation that often accompany the transition to a sober life.

Financial planning
Assist the recovering addict in setting up and maintaining a bank account and budget. When the individual has saved some money, take a trip to the bank to set up the account. Demonstrate how to keep a hand-written or computerized budget to ensure that money is well spent and financial obligations are met. Teach them how to prioritize bills so that the necessities such as rent and utilities are paid first.

Computer skills
Teach the individual computer skills or help him enroll in a computer skills course. Today, most occupations require at least some computer and keyboard skills. Helping recovering addicts develop these technology skills means they are preparing for their futures. Check out local libraries or community colleges for free or inexpensive computer courses.

Create a Resume
Take steps toward building a resume. A well-written resume is often needed to get any job interviews and helps candidates land a position. Most Microsoft programs have resume templates. Work with the individual to build a resume and polish it prior to submitting it to potential employers.

Transportation
The person you’re working with may not have her own transportation. If not, teach her how to read a bus schedule and use the bus.
CHAPTER 18

Learning Objectives: You will learn answers to the following questions:

1. What are 2 strategies for accepting difficult feedback?
2. How can workplace conflict affect clients?
3. What are 2 strategies for handling conflict with co-workers?

BASIC WORK COMPETENCIES

Getting a new job is an exciting and anxiety-producing experience. Will I do a good job? Do I have what it takes to do my job? Will people like me? Will I like my boss? For Peer Specialists, it can be doubly challenging because they may have been out of the workforce for a long time. Or they may have had problems with authority in the past.

Everyone who works or volunteers has a boss, someone they have to answer to, an authority figure. If you’ve had problems working with authority figures in the past, now is the time to get over it and learn how to work with authority. Most employers won’t put up with employees who challenge or ignore authority. Employees are expected to know and respect the chain of command. At the same time, there will be situations where you and your boss don’t see eye to eye. There are appropriate and respectful ways for handling these interactions. We’ve tried to pull together some tips on handling difficult situations at work. Not every situation is covered, but we wrote about the common situations.

Accepting Feedback

Everyone has heard it at some point or another—the dreaded "See me after this meeting/class/practice. I'd like to have a word with you...” But this comment should not conjure up feelings of horror and anxiety. Following these tips, will help you build your ability to accept constructive feedback.

Realize that the person in authority was in your position once.

All bosses were kids, underlings and gofers at one time, and all of them have been talked to by someone they saw as a superior or authority figure. They too have suffered the awkward conversation, and they know how it feels when talking to an authority. Many bosses will go easy
on you because of this. Remember, they want to either ask you a simple question or give you some helpful advice.

Obviously, some authority figures are just plain bad bosses. They might use scare tactics as a means of seeking to control others. The operative word here is "seeking"; they can only control you or frighten you if you let them. There is no need to be rude or abrasive when replying to your boss, but you can still maintain your dignity and self-respect. Remain calm and assertive in the face of people who try to scare you. If this is the case in your workplace, you may want to evaluate whether or not this is the best place for you to work.

*Put a hold on defensiveness.*

It can be easy to get defensive and to try to pass the blame or reject responsibility. Yet, defensiveness takes a lot of energy and can block you from hearing the real message. It can also make you seem guilty, even where you aren't. And ultimately, being defensive is like being defiant, which gets you nowhere. Be open to what is being said; you'll learn more and you'll realize that taking it personally is pointless. Instead, take it as constructive advice or a timely warning that is worth heeding. Stay calm and focus on doing better next time.

*Answer questions at appropriate times.*

Don't interrupt the other person with your answer before they've finished asking the question. If you do so, you will seem either suspicious or rudely overconfident about yourself. If they ask you a question that asks for information, like "Why did you take over the meeting from Shane when we didn't plan for that?", then look down a little for a moment, then answer politely and succinctly. Most people look down when they're thinking and this buys you time. If they ask you a question that requires you to look into past memories, look up for a moment and answer. This is where most of us look when remembering something.

Make sure you don't answer rhetorical questions (often posed by those in positions of power, for effect or as a way to think through their own thoughts), and yet be sure that you answer real questions. For instance, if your supervisor asks something like "What were you thinking", don't answer. Simply look at them for a moment, showing in your expression that you know you did something wrong or lapsed in judgment.

If they ask you a question like "What do you think you did wrong?", then do answer. All they want to know is that you realize what you did and understand the consequences. If your supervisor is harsh asking these questions, you may not want to answer, out of fear or anxiety. Make sure you catch yourself, and answer the questions.

*Control your nervousness*

For some people, being in the presence of a person in authority is nerve wracking. Whether it's previous bad experiences with people in authority, or just the idea of being in the presence of a person who can have control over you, managing your nervousness is very important. Try to
focus on breathing deeply, drawing slow and gentle breaths direct from your diaphragm. This will calm your nerves and give you time to focus. Take everything slowly, even if the authority figure appears to want immediate responses.

**Trust in the guidance capacity of the authority figure.**

If you're in a situation where the supervisor is pointing out your behavior or attitude, use this as a learning opportunity. Most people in authority are in a position to see the big picture and they are trying, in their own way, to guide you and to keep you from repeating mistakes. The supervisor is qualified to impart wisdom or expertise, so trust that responsibility as a source of guidance or even as warnings that can help improve your future approaches or thinking. Ultimately, this person is on your side and they care enough to give you honest feedback.

**Focus on the positive.**

Accept that your boss has a point to make that is in your best interest. Rather than trying to make excuses, focus on what you can do to improve the situation from this point on. This will show your boss that you're stepping up to their challenge or accepting their points and that you're finding solutions.

For example: Betty's boss complained that Betty has a bad habit of taking control of meetings that have nothing to do with her. This results in confused clients and angry coworkers. Betty acknowledges her enthusiasm and says that she will continue to remain enthusiastic but in future she will channel it all into the projects belonging to her. She'll contribute to meetings led by other coworkers if invited or if she has asked them if it's okay to add her piece. Her boss is reassured and Betty discovers that focusing more on her own work is more rewarding than trying to meddle in everyone else's.

**Navigating complex work environments**

In the modern world, there are many reasons for workplace conflict scenarios. In today's world, conflicts in the workplace are complex. We no longer work in a black and white world where the extremes are obvious for everyone to see. There are a lot of gray areas in every conflict and management may have a hard time seeing who is right and who is wrong.

Having a conflict in your workplace takes a toll on productivity, hampers performance and creates a very uneasy atmosphere for everyone. People who are in conflict contradict each other, are uncooperative and try to cramp each other's styles. They don't work on mutual grounds and they don't want to see the larger picture. Bickering can also bring on huge problems for a place of work.
Workplace conflict can affect clients

For the Peer Specialist, it’s important to be aware of how seriously workplace conflict can affect clients. Even if staff tries to hide the conflict from clients, the tension is felt even if no one says anything negative. The atmosphere may no longer feel safe to clients. It can also spill over in the form of staff performance such as poor customer service (front desk staff is rude to clients), forgetfulness (staff forgets to make an appointment with a client’s vocational rehab counselor), absenteeism (clients appointments are changed or delayed because people call off) and mistakes (the nurse signed off on the wrong medication). Clients know the agency is under stress.

If you are a part of the conflict, put an end to it immediately. You can’t control others, but you can control your own interactions and your own responses. If you are not directly involved in the conflict, show leadership by NOT participating in gossip, reminding staff about how the conflict is affecting clients, and being vocal about the problem in staff meetings.

Occasionally, a conflict will be so serious that it creates a toxic environment for your recovery. You will have to think carefully about whether or not you can weather the storm, or if you need to find another job. If you leave the organization under these circumstances, it won’t be a failure on your part.

Conflict Resolution

Conflict resolution is defined as the methods and processes involved in facilitating the peaceful ending of conflict. Often, members who are committed to the group try to resolve group conflicts by actively communicating information about their disagreements to the rest of the group (e.g., intentions; reasons for holding certain beliefs), and by engaging in collective negotiation. Cognitive resolution is the way persons in dispute understand and view the conflict, according to their beliefs, perspectives, understandings, attitudes. Emotional resolution is in the way persons in dispute feel about a conflict, the emotional energy. Behavioral resolution is how one thinks the disputants act, their behavior. There is a wide range of methods and processes for addressing conflict. They include negotiation, mediation, diplomacy, and creative peace-building.

The term conflict resolution may also be used interchangeably with dispute resolution. When personal conflict leads to frustration and loss of efficiency, counseling may prove to be a helpful solution. Although few organizations can afford the luxury of having professional counselors on the staff, many managers may be able to perform this function. Nondirective counseling, or "listening with understanding", is little more than being a good listener—something every manager should be.
Sometimes the simple process of being able to vent one's feelings—that is, to express them to a concerned and understanding listener, is enough to relieve frustration and make it possible for the frustrated individual to move to a problem-solving frame of mind. The nondirective approach is one effective way for managers to deal with frustrated subordinates and coworkers.

**Conflict Resolution Skills**

The ability to deal with people is even more important today with the pressures of our fast-paced environment. Being able to handle conflict in a productive way is frequently mentioned as one of the most challenging skills for people. Conflict resolution is defined as the methods and processes involved in facilitating the peaceful ending of conflict and retribution. Asking yourself questions about the conflict prior to trying to solve it can help better define problem and lead to a positive outcome.

Ask yourself: “Exactly how do I perceive my role in relation to others involved in this situation?

- Take responsibility for clarifying your role with others involved.
- Be prepared to change your perception of your role.
- Show your willingness to be flexible in achieving your organization’s goals.
- Stay positive. View any role change in terms of the opportunities it presents.

Ask yourself: “How much control do I have over this conflict?”

- Identify the root cause of the problem and analyze the improvement opportunity.
- Talk first to the owner of the process.
- Describe the current problem and get agreement.
- Suggest a workable solution and action plan.
- Follow-through on the plan and give recognition to the owner of the process.

Ask yourself: “How much do my personal biases and prejudices affect this relationship?”

- Write down three behaviors that you could change in order to reduce the conflict in this situation. Commit to following through on these changes for at least three months.
- Ask the other person involved how you could defuse the existing conflict. Encourage honest feedback.
- Put yourself in their position. How do you think they view your commitment to reducing conflict in your relationship? Why?
- Make a list of 5 strengths that you see in the other person. Then list five ways that improving this relationship would benefit you.

Ask yourself, “Am I clear on the direction or vision?”
• Clarify the disagreement so it can be easily described in neutral, non-emotional words; then take action.
• Ask permission to address the disagreement with the other person in a friendly, non-confrontational way and gain agreement.
• Use “I” and “we” messages rather than “you” messages.
• If there is a difference in values, always go with the higher value.
• Make authentic commitments.
Conflict Resolution Plan

Sometimes it can be helpful to put your thoughts and plans in writing when resolving a conflict. This will help clarify the nature and details of the conflict and spell out a plan for its resolution. This template can help you create your own action plan:

1. Specific Conflict:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

2. People Involved:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

3. Plan of Action:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

4. Results Expected:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

5. Accountability Partner:
   __________________________________________________________
   __________________________________________________________
**Benefits of Teamwork**

Teamwork is work done by several individuals with each doing a part but all individuals giving up personal status to reach a common goal.

**Problems solving:** A single brain can’t bounce different ideas off of each itself. Each team member has a responsibility to contribute equally and offer their unique perspective on a problem to arrive at the best possible solution. Teamwork can lead to better decisions, products, or services. The quality of teamwork may be measured by analyzing the following six components of collaboration among team members: communication, coordination, balance of member contributions, mutual support, effort, and cohesion. In one study, teamwork quality as measured in this manner correlated with team performance in the areas of effectiveness (i.e., producing high quality work) and efficiency (i.e., meeting schedules and budgets).

**Healthy competition:** A healthy competition in groups can be used to motivate individuals and help the team excel.

**Developing relationships:** A team that continues to work together will eventually develop an increased level of bonding. This can help people avoid unnecessary conflicts since they have become well acquainted with each other through team work. Team members’ ratings of their satisfaction with a team is correlated with the level of teamwork processes present.

**Everyone has unique qualities:** Every team member can offer their unique knowledge and ability to help improve other team members. Through teamwork the sharing of these qualities will allow team members to be more productive in the future.
Self-care is anything you do to keep yourself healthy and which is under your control, deliberate and self-initiated. Self-care is a fundamental pillar of health and an essential component of a long range recovery plan. Working as a Peer Specialist requires that you take care of yourself and your health, both mental and physical. Peer Specialists offer hope to clients, and you want to present the best version of yourself to those you work with. You can’t do that unless you are in good health.

Taking care of your physical and mental health is also important because Peer Specialists serve as role models for their clients. If they see their Peer Specialist smoking, consistently eating fast food, and being sedentary most of the time, the client might say, “I don’t want to quit smoking. Joe still smokes and he is sober, working and doing well. I don’t see why I have to stop.”

Just like working on your recovery, getting healthy doesn’t just happen; you have to invest a little bit of work and a lot of self-discipline each day to keep yourself healthy.

Sleep
Sleep is a fundamental human need. Self-care includes getting enough sleep. If you have problems sleeping, these are some ideas to improve the quality of your sleep:

- Allow enough time for sleep. Most people need 7 to 9 hours of sleep each day.
- Avoid heavy meals and alcohol before bedtime; reduce your intake of caffeine and other stimulants several hours before bedtime.
- Arrange your sleep environment so it is very dark, comfortable, quiet, and cool to facilitate falling asleep quickly and staying asleep.
- Avoid TV beds and other media-furniture.
Exercise for twenty to thirty minutes, at least 3 times a week, but don’t exercise immediately before bedtime.

Some medications cause drowsiness, so you may be sleepy during the day and unable to sleep at night. If so, talk to your doctor to find out if there is a different medication or if you can take it at a different time during the day.

If you still have problems sleeping, talk to your PCP. You might have a sleep disorder that can be treated by your PCP. Even if you don’t have a disorder, your PCP might help you identify problems with your habits or your environment that are contributing to your sleep problems.

Exercise
This training isn’t going to go into a long description of exercising. We just want to remind you that it is important to exercise at least 3-4 times a week. You can find an exercise routine that works with your life-style. You can join a gym or a group exercise program. If you prefer to exercise alone, there are hundreds of apps and programs to help you get fit. Find one that works and stick with it. You’ll be encouraging your clients to exercise.

Mental Health
Maintaining good mental health is critical to your recovery. If you have stress, anxiety, depression or other issues that affect your functioning, find help. You may be able to get support in your recovery group. If not, you may want to reach out to the mental health community. If you have feelings of depression that don’t go away, talk to your PCP or a mental health professional. Depression is very treatable with therapy and or medications. There are various support groups in the community that support people dealing with all kinds of issues unrelated to drugs or alcohol. You can find support groups for anxiety, divorce, child rearing, bereavement and many other issues commonly faced by adults in the community.

Chronic illnesses
If you have a chronic health condition such as diabetes, high blood pressure, asthma or others, get an appointment with your PCP to make sure you are on track to managing your illness. If your doctor prescribes medication for your condition, take it as prescribed.

Time Management
Most of us feel like we have too much to do and not enough time to do it all. Learning how to prioritize a schedule for optimal time management can help you gain control of your life. You’ll be able to focus on what's important and get it done. Lists are an important first step in prioritizing and time management. Whatever kind of schedule you make, it must allow time for family. When you ignore family, everyone's unhappy. Don't forget yourself. What's an important personal goal you want to accomplish this week? What activity gives you pleasure? Include that activity in your schedule. Don’t forget to make time to exercise and eat well.
Simple time-management strategy

1. Write down all of the tasks you must accomplish in a day or in a week. Once you’ve done that, you will prioritize tasks in order of importance.
2. Give each activity that is important and urgent an A.
3. Assign a B to important tasks that aren't urgent.
4. Finally, place a C by anything you would like to do but doesn't carry any urgency or importance.
5. Choose tasks that can be removed from your list or that you can delegate to someone else. Then do it.

Recognize When Your Health May Compromise the Ability to Work

We’ve all been there … we start getting headaches; we begin feeling blah or worry constantly; we argue with family and co-workers. These are all reactions to stress. A stressor is anything, positive or negative, that urges or pushes you to make an adjustment, to make a change from what you are currently doing. “Distress” is the result of too many stressors OR too few stress management skills.

This section is going to talk about what to do if your stress becomes distress. There may come a time when you feel like you aren’t going to be able to help people because of things going on in your personal life. You may start feeling the urge to drink or use again. The feelings may be so intense that you wonder about your own sobriety.

At times like these, it is important to have a recovery plan. When you get to this point, it’s critical to focus on your own wellness. As a Peer Specialist, it is important to have a good relationship with your supervisor, so that if you get to this point, you can talk to them and develop a plan to regain your stability. It might mean taking time off, increasing your medication (if you take meds), attending more meetings or doing something else that keeps you well. You have a responsibility to your employer, your clients and yourself to keep yourself well. If you are not doing well, it’s your responsibility to intervene and do the things that will get you well and back on the right path.

Crisis Plans

Many Peer Specialists put together a crisis plan. A crisis plan describes:

1. Things to do to stay well
2. Triggers, or things to avoid in order to stay well
3. Behaviors or symptoms that occur when stress is becoming overwhelming.
   a. Things to do when you are at that point
4. Things that indicate a crisis or breakdown is imminent.
   a. Actions to take to prevent the breakdown.
As part of your recovery planning, you should have something that resembles the list above. We aren’t able to predict the future stressors in our lives. Even if we have a firm hold on our recovery, we still need to make plans “for a rainy day.” For Peer Specialists, this means that you have a plan that contains specific actions you will take to get back to your healthy self. You also have to share the relevant parts of this plan with your employer, so together, you can make preparations to take care of your work responsibilities in case you have to take time off.

**Setting Boundaries between Work and Personal Life**

*Leaving Work at Work*
Many Peer Specialists are so eager to help others into recovery, that they are willing to spend all of their time and resources doing so. They give their clients their personal cell phone number and allow clients to call them after work hours. They go out of their way to help clients meet their needs, such as giving them rides to their medical appointments, or letting them use their tools to work on their car.

While initially, these activities will be much appreciated by your clients, they can ultimately lead to more serious problems. For example, constantly dealing with clients’ problems even during your days off will lead to burnout. Burnout can lead to feelings of resentment, disliking your job, and even jeopardize your own recovery. You need to have the ability and permission to separate your private life from your work life. If you’d rather be at work than at home, maybe it is time for you to develop your private life.

Taking that extra step for clients can also make you vulnerable to boundary violations. For example, what would you do if your tools were “stolen?” What if the client needs a tool you don’t have? Will the client expect you to give him rides whenever he needs them? It can be very risky to put yourself in these situations and can put you in a position where you might even lose your credibility or your job.

Many Peer Specialists are committed in ways that other staff are not. You have the gift of recovery to share with your clients. But it’s important to have a clear distinction between your work life and your personal life. To be a great Peer Specialist, you want to protect yourself from burnout and boundary violations so you can continue with your great work.

**Set limits with your clients.**
If you do give a client your cell phone number, give specific times when they can call you, and if they call outside those times, don’t take the call. If you want to loan a client tools, or give them a ride when other transportation isn’t available, talk it over with your supervisor first. If she agrees, you will again want to set clear limits on when your property is to be returned, where it can be used, and when it starts to become a boundary violation.
Anytime you have questions about the boundaries between your work and your private life, seek advice and guidance from your supervisors and other peers.
CHAPTER 20

SUMMARY

This training only gives the basic foundation for the work Peer Specialists will be doing in the field. There is much more to learn. As you begin work, you will learn more and will learn more about things you need to learn more about. We encourage you to continue your study, and take every opportunity possible to attend trainings, webinars and workshops. The internet can be an important resource for you, as well as books, journal articles and talking to senior Peer Specialists and clinicians. We have provided some additional reading in the bibliography. Peer Specialist work is important in the health care world and we are glad we have played a part in preparing you for your Peer Specialist journey.