S U A P

SUBSTANCE USE AND ADDICTION SUPPORT PROGRAM

PEER WORK ESSENTIALS TRAINING

MANUAL

FACILITATOR'S EDITION

The Elizabeth Fry Society of Peterborough

A Different Approach

SUAP Peer Support Program

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the Elizabeth Fry Society of Peterborough

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Introduction to this Manual

How this Training is Developed/Developing - a New Approach

This manual was built by interacting with, and listening to, the training participants over years and years with each iteration reflecting on what worked, what did not and why. It is an ongoing, organic process.

We work within the philosophy that to truly help someone, one had to genuinely '*be*' with them at the most human level, hear them and their struggles with mutual understanding, and to respond in creative and flexible ways that are tailored to them, their experiences, and their strengths. To build a manual that delivers essential skills in a way that upholds raw wisdom and genuine expression, active Peer Support Workers have contributed valuable insights on practical and effective skills based on their own career in Peer Work as well as their lived experiences.

As this document focuses on the use of practical skills and knowledge, there is no set training schedule. A free-form approach based on meeting bench-marks of knowledge to measure progression allows for fuller comprehension and skill mastery over breadth of knowledge. This ensures that Peer Workers of all skills and abilities can engage in supporting their Peers with confidence, effectiveness, and peace of mind.

Why Peer Work '*Essentials*'

This training manual and subsequent training regiments focuses on establishing and building key knowledge and skills that are essential to safe and successful Peer Work. The point of an 'Essentials' manual is to set a standard for care while allowing Peer Workers the freedom and flexibility of creating their own approach and fine-tuning their own skills based on the reach of their lived knowledge and experience.

The '*Come Along Side*' method of training.

As every Peer is complex and unique, so it the Peer Worker training. Trainers will guide and model Workers using the 'Come along side' method to assess their own recovery, development, and needs. Together Workers and trainers will work on goals and educational next steps; simulating the therapeutic relationship in a real-time learning environment. As such, it is a living document acting as a framework for new Workers to guide their own education. With this method of approach, Peer Workers can experience the therapeutic relationship from both perspectives, offering feedback and criticism while observing the trainer model therapeutic response, critical thinking, and cooperative skills.

Who is this manual for?

This manual is intended for use as a guide for the training facilitator, including suggested approaches, exercises, and materials. Ultimately this will pair with concurrent trainee materials and guides for new Peer Support Workers joining the program, making the training regiment more collaborative and synergetic

Introduction to Peer Work

Elizabeth Fry's Mission

The Elizabeth Fry Society of Peterborough provides gender-responsive community supports for people who have been, or are at risk of being, criminalized, while advocating for broader systems change to prevent or provide alternatives to incarceration.

Welcome to Peer Support

Welcome to the PeerWork Essentials manual, created by the Elizabeth Fry Society of Peterborough for the Substance Use and Addiction Support Program (SUAP). A PeerWorker has a uniquely challenging role to play in the community as they strive to use their own lived experience in substance use and recovery to guide their Peers through the healing process.

This manual teaches the basics of PeerWork: What is a PeerWorker? What does a PeerWorker do? Who is a Peer? Fundamental skills from setting boundaries to responding to crisis, this manual can be used as a guide for skill-building and quick-referencing.

What is Peer Support

Peer Support Work is a product of grassroots activism and community development initiatives looking to humanize the experience of substance use, mental illness, homelessness, abuse, and poverty while providing a more supportive and connected avenue for recovery.

A Peer Support Worker uses their own lived experiences to give voice to their Peers' struggles and needs. They understand that sometimes the healthcare system only sees the medical issue of substance use, and so are better able to see the social, psychological, cultural, and economical hardships that doctors often cannot. Together a Peer Support Worker and their Peer create a therapeutic relationship based on mutual understanding, solidarity, and empathy.

What is *not* Peer Support

IPeer Support is not therapy. A Peer Worker's role is to provide support and understanding drawing from their own experiences, to provide tools to cope with substance use and recovery, and to give hope. The best for the Peer is to always connect them with the most qualified professional and support them in committing to recovering.

A Peer's commitment to recovery includes becoming independent, self-sufficient, and competent in their own lives. So while help is welcome, a Peer Support Worker is not meant to be doing all the work for their Peer. Creating appointments, seeking treatment, filling paperwork, etc., are meant for the Peer to do while assisted by their Worker so that they are successful in their goals.

Core Values of Peer Support

As Peer Support is still new there is no set rulebook on what it means to support someone, much less how. Each Worker and their experiences are as unique as their Peers; to ensure that the relationship between them is one of ***dignity, fairness, and respect,*** a set of core values are meant to guide a Peer Worker's approach to supporting people.

Harm Reduction

Generally, 'harm reduction' includes any action taken to lowers the risk or extent of injury or damage. Examples are using with friends, having clean needles, wearing condoms, etc., 'Abstinence', meaning totally stopping drinking, using or engaging in risky activity, is not always possible but reducing harms is very achievable. As the person becomes more self aware and stronger other things can be tried.

Hope and Recovery

No matter how difficult it is or how slowly progress is made, everyone can achieve recovery. In times of doubt or relapse it is important that a Worker remains hopeful and focused on recovery so that they can stay motivated in times when their Peer may feel hopeless.

Partnership

While a Worker has experience, training, and connections in the community to help make progress, Peers have insight in to how they feel, their strengths, fears, hopes, and dreams. In the therapeutic relationship goals and decisions are together allowing the person to choose what their next steps are.

Mutual Trust

The ability to share openly and honestly without fear of judgement, and know that a Worker is always looking out in a Peer's best interest is key to cooperation and the therapeutic relationship.

Honesty and Integrity

Both worker and Peer are responsible for the role that they play in the relationship and recovery; a Peer's role is to be upfront and honest, and the Worker's role is to maintain ethical integrity while working with a vulnerable Peer.

Lifelong Learning

Personal and professional growth is important for a Worker to stay healthy, to think critically, and to be informed about a Peer's recovery as well as their own. Just because they are helping a Peer doesn't mean that they themselves must put their own journey and recovery on hold.

Social Inclusion

The opposite of addiction is connection. As part of recovery a Peer should be reintegrated into the community and rediscover their sense of connection and belonging with those around them.

Health and Wellbeing

The wellbeing of a Peer should never come at the cost of a Worker's health or recovery. Knowing and respecting limitations and maintaining personal safety is as much a Worker's duty to themselves as it is a duty to their Peer.

Peer Work Core Competencies:

Interpersonal Relations

Interacts in a manner that honours the dignity of others and strives to build positive, respectful relationships. Strives to make others feel comfortable and conveys genuine interest in their peer. Even in a difficult or tense situation strives to maintain a level of respect and consideration for the other.

Demeanour

Is sensitive to what others might be feeling, demonstrates a capacity for nonjudgmental empathy, and responds from an equal, genuine, and sharing point of view. Selectively self-discloses own experience in a manner that ensures the relationship remains peer focused.

Hope

Operates from a sense of hope expressing confidence that others will be successful in their own personal journeys of recovery. Strives to model realistic optimism and a belief that even in difficult situations positive choices can be made.

Flexibility & Adaptability

Is open to new ideas, deals comfortably with ambiguity, and adjusts plans or behaviours to better suit a given situation. Is willing to be open-minded and compromises when needed.

Initiative & Commitment

Is dependable and carries tasks through to completion. Demonstrates good judgement knowing when insight or assistance should be requested from another and are trustworthy when working independently.

Continuous Learning & Development

Strives to approach life and work in a curious manner, identifies areas where personal growth may be helpful, and takes advantage of opportunities to learn and develop. Recognizes the value of on-going personal growth and skill development and maintains a connection with a peer support community as a resource to stay ‘grounded’ in the work of authentic peer support.

Communication

Listens with empathy and without judgement, holding their peers in unconditional positive regard. Uses communication styles and skills to improve understanding and adapts the style and tone of communication to suit the listener and the situation. Communicates using recovery language and emphasizes the strengths of their peers.

Critical Thinking

Engages in active listening skills to better understand a situation and recognizes that there is more than one way to look at an issue. Considers the possible implications or outcomes of their actions and, when asked, will help peers to explore the outcome or possible consequences of various options. Demonstrates good judgement in respecting the limits and boundaries of their role.

Self-Management & Resiliency

Understands the importance of self-care and stress management and models the practices that work best for them to remain healthy while supporting others. Strives to maintain calm and diffuse stressful or challenging situations.

Self-Awareness & Confidence

Interacts in a manner that demonstrates a balance of self-confidence with openness to the thoughts and opinions of others. Self-reflects and understands that personal thoughts and attitudes can influence their behaviour and actions.

Teamwork

Shares knowledge, ideas and resources with team members in a cooperative and collaborative manner. Strives to fulfill their role and responsibility within the team while respecting the roles and responsibilities of the other team members.

With thanks, from Peer Support Canada

Who is a Peer Worker?

A Peer Support Worker is a mental health professional who has specialized knowledge and insight through personal lived experience. A Worker must have experience with substance use and recovery specifically, but their experiences in homelessness, mental illness, abuse, poverty, and marginalization can specialize them to working with certain clients or Peers. With their Peer, they will help to create a foundation for recovery and reintegration based on understanding, empathy, and respect. They teach their Peers essential life skills and strategies to help cope with the early stages of recovery, as well as aid and guide Peers towards resources to build stability and safety.

Who is a Peer?

A 'Peer', within the language of Elizabeth Fry and this program, is someone receiving support. They are someone struggling with any of a variety of concerns such as addiction, homelessness, mental health issues and most often a combination of these issues. . They may still be engaged with substances and are looking to recover, or they are in the early stages of recovery and need help to stay committed. Often a Peer will be paired with a Worker based on their current needs (e.g housing stability, mental illness, etc.) so that they can achieve stability and safety quickly and with greater collaboration.

The Value of Experience

The value of lived experience is in how it creates understanding and offers an avenue for more honest communication. Similar experiences encourage meaningful connection and fluid insight into the often turbulent world of a substance user. Like this a Peer can feel hear, understood, validated, and unashamed as they share deep struggles while asking for help. The unique strength of a Peer Worker comes in their relatability and proximity to the position of their Peers, and they give hope through their own successes and triumphs.

" Dear New Peer Worker" From a co-worker

"Before actually being in the mental health/addictions field, self-care looked very different to me. When I pictured self care, I pictured face masks, getting my nails done, bath tubs with too many bubbles, maybe lighting a candle. Now that I am a peer worker, self-care looks nothing like that. When I think of self-care, I think about how I am at work and my ability to not take work home with me. (Which is hard when you work from home 3/5 days of the week.

The first thing I think of when I think of self-care now is boundaries. Without boundaries, I would be taking my work home with me everyday. My work and personal life would be intertwined, and not in a healthy way. There are people who accept and even welcome that intertwining, but in order to care for myself, I need to keep my work life and my personal life separate. This has been easy in the past, but it is so much more difficult to accomplish now. As a peer worker, I see myself in each one of my peers. No matter their gender, race, sexuality, religion... there is a piece of myself in them, and a piece of them in me. We're bonded by experience. We're bonded by trauma. We're bonded by our lowest points in life. My first peer that I ever worked with immediately tested my boundaries without meaning to. Her main issue was not being able to sleep at night due to feeling unsafe. That feeling of being unsafe stemmed from trauma. Right away I related to that trauma, that fear, that feeling of being unsafe. At that time, feeling unsafe at night was the only thing this peer wanted support with. I told her that if she ever feels unsafe at night, to text me and I will reassure her. I immediately regretted that. Not because it turned into a problem, she actually never utilized it. I regretted it because in that moment, I recognized that my own personal nights will now be intertwined with hers. I told her that if she ever feels unsafe at night, to text me and I will reassure her. I immediately regretted that. Not because it turned into a problem, she actually never utilized it. I regretted it because in that moment, I recognized that my own personal nights will now be intertwined with hers. Her bad nights could have triggered bad nights for me.

Setting boundaries gives me the space I need to be with myself. How can I check in with myself when I am experiencing emotions that are someone else's? How can I be okay while I client isn't okay? By setting boundaries."

Caica Gomez

Elizabeth Fry Peer Worker

Notes to the Facilitator

Approach

Given the history and demographic of incoming Peer Workers, it is very important to create a mutually respective learning environment wherein all participants can engage in the 'Come Along Side' learning method. Facilitators should focus on modelling the following skills:

- Listening and Reflecting
- Mutual respect and Cooperation
- Implementing and committing to Goals, Roles, and Boundaries
- Exploring all points of view and flexible solutions
- Avoiding field-related or academic jargon

Facilitator TIP:
Identify strengths the participants have that can be drawn on. Knowledge on chronic illness, trauma, brain injury, etc., can facilitate learning through anecdotes.

Managing First Session

- Creating a 'Safe and Brave' Space: set expectation for language, swearing, and maintaining respect.
- Getting to know participants, and mapping hard triggers to avoid.
- How to bring up conflict, and how to deal with it in the space.
- Anger & frustration are likely; what that means, and how to express it appropriately.

Exercise

Create boundaries and expectations for the training sessions by establishing participants' interests, expectations, and needs for the training regiment. Discuss the topics and identify points of focus in the training framework. Have these written down and visible during all following sessions.

Managing Following Sessions

- Starting on time every session with materials fully prepared
- Review notes from last session and follow up on key concepts and questions
- Keep conversation on topic
- Use Goals, Roles, and Boundaries (Page ___) every session
  - Goals: Set break time, end time, and knowledge goals for the session
  - Roles: Make aware of expectations for participation, session activities, and homework
  - Boundaries: Reiterate boundaries agreed-on in first session, make sure they are visible.
- Check in with time markers for breaks and ending time (i.e. "We have X minutes left until break...")

'Positive and Brave' Space

While Peer Support Workers are mental health professionals, and should be integrating into a professional environment and adopting appropriate etiquette, the need to be politically correct cannot interrupt learning or communication. Many topics related to substance use and addiction are crude, and a lot of the language is specific and informative if not appropriate for a conventional office space. It is up to the Worker, then, to be able to talk about these issues/topics/ideas in a way that is respectful for the sake of maintaining dignity for the Peers, and out of consideration for their fellow Workers and supporting staff.

Setting you up for success

The Peer Worker's Environment

It is rare to find a Peer Worker at a desk. More often they will be out in the community with their Peers. So the environment that a Worker finds themselves in can be unpredictable and at times unsafe. It is not uncommon to be come in contact with alcohol, drugs, paraphernalia, unsafe living conditions (including street life and shelters), weapons, and even dangerous people. To be a Peer Worker often means reentering the life of a substance user and reliving their own experience again with the intention to lead a Peer out. It takes strength and the ability to be self aware and grounded, to deal with the things you are exposed to. This environment is not for the faint of heart, or for those who are struggling in their own recovery.

This Work Will Change You

Opportunities

- Bringing a deeper level of connection and belonging to people in need.
- Using experience and living knowledge to help Peers advocate for themselves.
- Help open communication between Peers and other mental health/health professionals.
- Reduce stigma around substance use and users.
- Increase presence and importance of recovering users in professional roles.

Challenges

- The Peer Worker is frequently exposed to potential triggers, possibly putting their own recovery at risk.
- The role of Peer Worker comes with its own stigma-- or may not be recognized by other professionals.
- Relationships with those in the community, professionals, support and services programs will be impacted.
- Maintaining a healthy work-life balance can be difficult

Effects

- Repeated exposure to suffering, loss, abuse, and injustice can affect a Worker's mental health, self-esteem, and worldview. This is known as **Vicarious Trauma**.
- The community views Peer Workers differently than Peers.
- Exposure to peers' experiences changes personal relationships.
- The successful Peer Worker can detach themselves from the community once they take on the role.

Triggers

Due to the nature of Peer Support, Workers *will* be exposed to triggers and past traumas. From drug use to loss to abuse, it is critical that a Peer Worker recognize and understand their limitations and honestly consider whether they can safely navigate their own trauma without risking their own recovery. Workers must always be checking-in when faced with significant stress or distress whether they can safely proceed; it is out of dignity and respect for both them and their Peer that Workers stay safe, take care of their health, and maintain recovery.

"A Peer Worker's environment is often the one they've just escaped from."

Not only old traumas and triggers, but being exposed to new instances of acute and significant suffering can create new trauma as substance use and addiction can be extremely stressful for both the user and those around them. It can be especially troubling for Workers who are seeing the process they themselves have gone through but from an outside perspective.

Duty to Report

A Legal Obligation

As a community service working with vulnerable people, The Elizabeth Fry Society of Peterborough has a legal obligation to report instances of abuse, neglect, and imminent threats of harm against recognized populations. This obligation extends to all workers that engage in client support services or client case work including employees, Peer Support staff, students, and volunteers. Duty to report applies to the following:

- Children in need of protection from abuse or neglect
- Long-term care residents in need of protection from abuse or neglect
- Retirement Residents or Senior citizens in need of protection from abuse or neglect
- If a vulnerable person is in need of protection from abuse or neglect
- If someone poses a real and immediate threat to themselves (i.e. Threat of suicide)
- If someone poses a real threat to others

Vulnerable Persons

A vulnerable person is someone who falls under one or more of the following categories:

- Minors (Children under 18)
- Elders (Adults over 65)
- Low Income workers
- Newcomers/Immigrants
- People with physical and mental disability who require assistance to meet basic needs, manage finances or property, or to make informed legal decisions

Numbers to Remember

Children's Aid Society:

Police non-Emergency:

Retirement Homes
Regulatory Authority:

When it's time to report

Once a vulnerable person has been recognized as needing protection, the client/Peer should be made aware of the Peer Support Worker's duty to report and made aware that the authorities will be involved (E.g. Police, Ambulance, CAS, etc.) so that they can be prepared.

Before reaching out to authorities, it is encouraged that the Peer Worker try to involve the Peer in as much of the process of placing a report as possible. Creating a cooperative partnership can help to build trust, lower distress, and provide the Peer with a chance to emotionally ready themselves and ask questions.

Reassure the Peer that this is a legal obligation and that it is out of concern and respect for them and the victim. Keep communication open and honest during the process to ensure continuous and consistent support; it will also reassure them that they are still part of a team and that they are not being punished but receiving help.

If for some reason a Peer Worker is unwilling or unable to provide support (especially in the case of personal safety, trauma, or personal values) a supervisor should be contacted for support and next steps.

Reporting

Knowing what information to gather and who to call can make sure that the proper authorities are being contacted and that they are able to respond based on need. Useful information to gather include:

- Is there a clear risk to an identifiable person (the Peer, first responders, or victims)
- Is there a clear risk of serious harm or death
- Have authorities been involved before
- Details about the abuse/neglect
- Addresses and contact information
- Is the danger imminent

'Childhood trauma isn't something you just get over as you grow up."

ACES - Adverse Childhood Experiences

Adverse Childhood Experiences (ACES) are events before the age of 18 that cause significant distress. While these experiences are common, some events result in long-lasting and debilitating trauma that can contribute to the mental illness and substance use Peers bring with them into the SUAP program. Below is a list of 10 categories of ACEs:

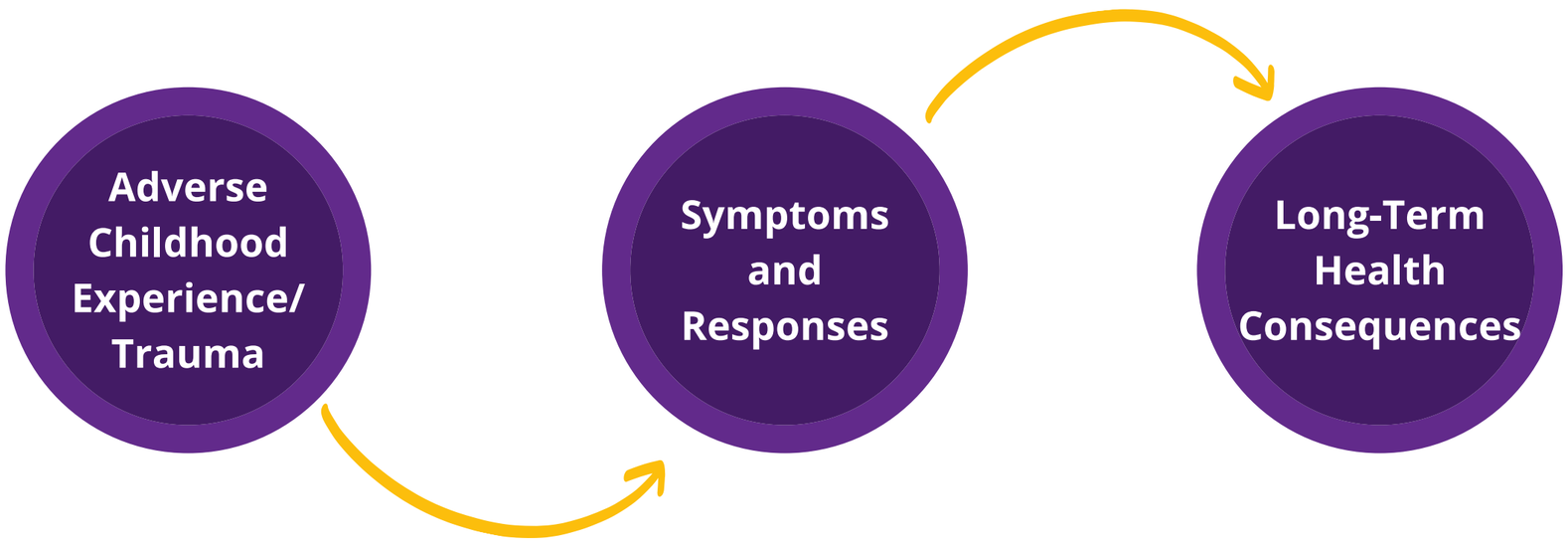
- [ ] Not having enough to eat, wearing dirty clothes, feeling like no one was there to protect/take care of them.
- [ ] Lived with someone who was depressed, mentally ill, or had attempted suicide
- [ ] Having witnessed parents/adults hit, punch, beat, or threaten eachother
- [ ] Was sworn at, insulted, or put-down by a parent/adult in the home
- [ ] Feeling no one in the family loved or thought kindly of them
- [ ] Losing a parent through divorce, abandonment, death, or other
- [ ] Lived with someone who struggled with using drugs (legal or illegal) and/or alcohol
- [ ] Lived with someone who went to jail or prison
- [ ] Was hit, beaten, kicked, or physically harmed by a parent/adult in the home
- [ ] Experienced unwanted sexual contact

[How Childhood Trauma Affects Health Across a Lifetime](#)

- Nadine Burke Harris

Discussion

- What struck you about the video?
- How might this support Peers?
- Can people heal? How long would they need?
- Does this affect your idea of what 'recovery' means?



Facilitator:
Watch for reactions for 'aha' moments. People might see things in themselves that are significant

Impact of Trauma

Physical

- Disrupted brain development
- Difficulty controlling emotions
- Multiple physical issues
- Depression/Anxiety
- Panic reactions
- Hallucinations
- Sleep problems
- Impaired memory
- Flashbacks
- Dissociation

Health risk/behaviours

- Suicidality
- Smoking
- Physical inactivity
- Eating disorders
- Substance (mis)use
- Multiple sexual partners
- "Chaotic" relationships
- Self-harm
- Violence

Long Term Consequences

If the ACE and its resulting trauma/symptoms are not therapeutically addressed , short-term health risks and coping mechanisms can develop into long-term, debilitating, and sometimes irreversible issues:

Disease and Disability

- Heart disease
- Cancer
- Lung diseases
- Asthma
- Liver disease
- Bone fractures
- Poor self-rated health
- STDs/STIs
- HIV/AIDS

Social Issues

- Homelessness
- Involvement in the juvenile justice system
- Poor educational outcomes
- Poverty and unemployment
- Vulnerability to being re-victimized
- Impacted ability to parent
- Intergenerational transmission of trauma and abuse
- Prostitution
- Long-term dependency on social service programs
- Removal of children to care

Facilitator:
This discussion is important and can lay out ideas for all future work. Give it space, make good notes

Trauma incudes the bad things that happened as well as the good things that didn't happen.

Discussion

What are some good things could be traumatic not to have experienced?

Beyond ACES

Note that the list of ACES is not exhaustive and that some pf these experiences may not fit into any mentioned criteria. Trauma can be caused by any event that causes significant distress-- especially fear and sadness. It is more important for Workers to recognize the symptoms and consequences of ACES and how it can impact the work that they do with their Peer, rather than focus on the nature and meaning of the event itself.

Discussion

Are there any ACES that are surprising? What other events/experiences could be added to the list?

Facilitator:
Explore contributions of complex trauma with the group, noting all suggestions and fine-tuning language to draw similarities with the current list of ACES.

Knowledge Essentials

What do we need to know?

Facts about mental health, addiction, trauma, brain injury, etc

In working with marginalized folks we do not focus solely on a mental health or addiction diagnosis or any particular issue. We do not need to analyze the folks or explore birth order, early childhood neglect etc. But since these issues are major factors in all of the support work. a basic understanding helps you work with folks, have reasonable expectations, be more able to help, and to interact with the qualified professionals engaged in the persons' life. Because they are so common we will works towards some common knowledge of the issues with a focus on trauma, addiction, 'mental health' as well as other considerations.

Discussion:

Look at various words for 'mental health'. Coolect slang and other words and phrases see how many you can get. Reflcect on how they fel, what they mean and 'poilitical correct!

Facilitatgor Tip

This is a good opportunity to discuss and land some ideas about the importance of language

Knowledge Essentials

Homelessness and Street Life

Being 'homeless' has many forms. One can be sleeping in stairwells or camping etc. or have a place indoors where they are allowed to sleep but is not a 'home', not safe,nurturing or dependably available.

Cumulative and Exacerbating Effects of Street Life

Being homeless is not just about not having a 'home' or a place to sleep. It is much more.

- Lack of knowing where one will sleep tomorrow night and forever
- Will I ever be accepted and loved again?
- Have you ever not eaten for 2-3 days? Dehyrdation alone can cause disorientation and lack of focus.
- Lack of sleep can make one tires and over time can trigger (or cause?) psychosis. (ref https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6048360/)
- Chronic pain
- Living in hypervigilance for a long time, hard to come out.
    - going through adolescence in hypervigilance can change how your body, brain and mind are and store and react to stress and threat.
    - being in hypervigilance for years as an adult can change your body in ways that tale years to adjust\
    - often need to learn all new coping, thinking and being skills.
- Contributing factors such as brain injury, lexdysia,
- Possibly high, severe craving or acute withdrawal

Cognitive Impairments Related to Street Life

Here are some factors that effect ones ability to think.

- Lack of food. Have you ever not eaten for 2-3 days? Weeks? Months?
- Dehydration alone can cause disorientation and lack of focus.
- Lack of sleep can make one tires and over time can trigger (or cause?) psychosis. (ref 2)
- Possibly high, severe craving or acute withdrawal
- Infections can cause disorientation and brain fog

Permanent Consequences

- FASD
- Acute anxiety
- Depression
- Brain injury
- Lexdysia,
- Possibly high, severe craving or acute withdrawal
- learning/cognitive disabilities

Discussion

- Thoughts, ideas, reflections?
- What else might impair thinking, decision making?

"Street Shock"

The cumulative effects of all of the above combined with extremely high anxiety take one to a place similar to shock where memories don't form, are distorted and other shock symptoms

Homework

The cumulative effects of all of the above combined with extremely high anxiety take one to a place similar to shock where memories don't form, are distorted and other shock symptoms

Reflection

When you add up all of the above and other factors what can you expect from the folks in terms of awareness? Memory? Thinking skills? What else?

Addiction - 'Substance use' etc

A note about Language: Sometimes people, particularly social work and health professionals, call addiction 'substance abuse' or even 'substance use'. This is to avoid apparent stigma about the idea of addiction and being an addict. In any case, addiction is a known thing that can be hard to describe.

EXERCISE: Part 1:

In groups of 2 to 3 people list three things that are true or very common about addiction.

EXERCISE: Part 2:

In your groups work on the list and separate out ,

A - The effects of addiction

B - What addiction *actually is*

C - Causes and contributing factors

D - Myths and misconceptions

Facilitator: *This is an opportunity to learn a lot about the participants, help them feel heard, etc. Look for language, term or ideas that can be carried on through the training.*

Addiction is using a substance or doing something (like gambling ...) compulsively and ongoing even with negative consequences. Your body can become chemically dependent and your mind, heart and soul can as well

Chaos & Urgency

Have you ever met someone who seems to be in crisis all the time? And sometimes the thing they are focused on does not need to be a crisis, in fact, for others the issue may be quite small?

'All addiction is about soothing or distracting from pain, usually childhood pain"

Dr. Gabor Mate

Chaos and Urgency
are as addictive
as any substance.
And serve much the same functions .

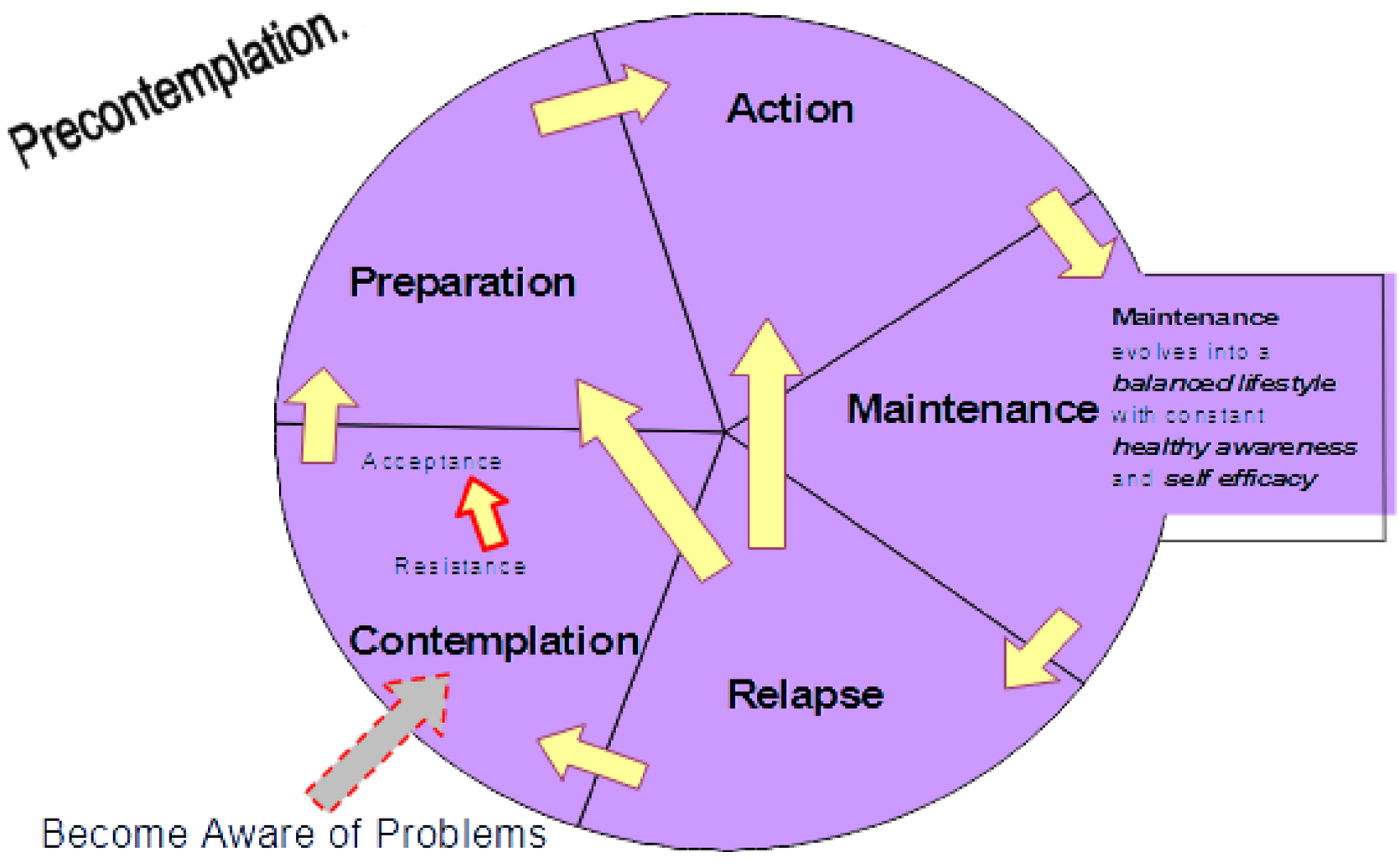
Discussion Points

Does the concept of Chaos and Urgency functioning as an addiction resonate?
Can you relate personally?

Background Essentials

Stages Of Change

This model is a handy framework to know about. It allows some good overview level thinking about where people are. Are they ready to change? Do they see it as possible. Do they even need it? Or are they farther along and stuck in one area of life?



Discussion

Explore this model, comments, thoughts? How is it helpful?
D we remember being where Snoopy is?

Facilitator Tip

Have some open discussion before showing the 2nd model

Background Essentials

Caution

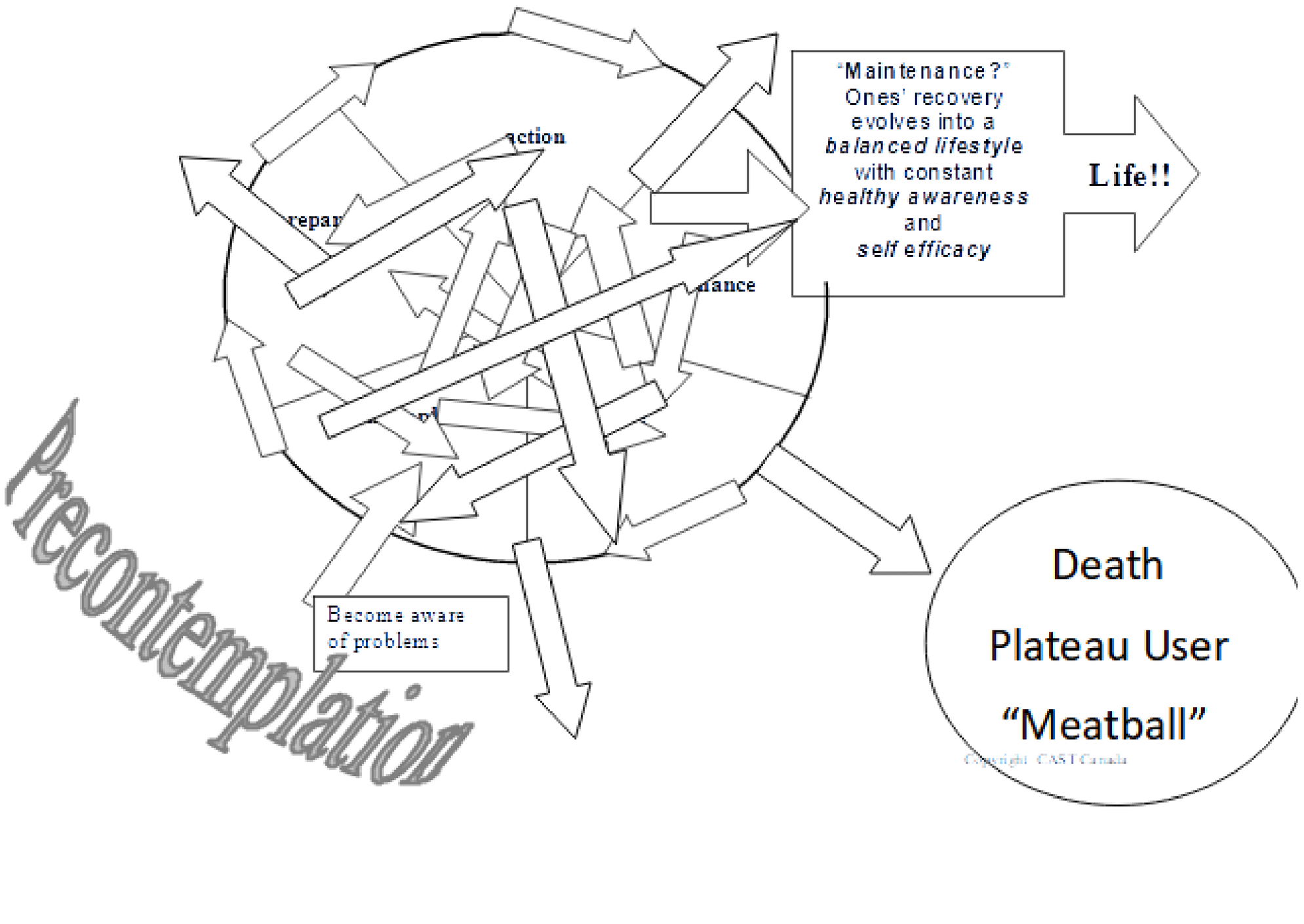
As good as this model is as a framework, we know that people are not this simple. There are always more things going on than apparent. So use the Stages of Change as a way to look at things from a distance note the model below that reflect input from people in early efforts of change with addiction.

THE STAGES OF CHANGE

After Review with some CAST Canada Consumers

CAST Canada - Stages of Change

Cribbed from Prochasaka and DiClemente et al , modified by CAST Canada



Discussion

Explore the two models, remembering that the changes came from people working on an addiction, Look at the added arrows, the one that shoots off with no place there. Look at the language for exits of the cycle. How does the idea of 'plateau user' sit?

Note:

The folks in the group that added these changes use the word meatball for somone who has brain damage and are not fully functioning.

Brain Injury

Signs and Symptoms of Brain Injury

Many of the Peers who come into the SUAP program will have some history of brain injury. For a Peer Worker this is vital information to know as early as possible to avoid critical mistakes that could do much more harm than good. While it is not necessary to have an official diagnosis or even a proper history, understanding how a brain injury can impact a Peer's ability to navigate recovery, learn new skills, and communicate with their Worker can save everyone from unnecessary frustration.

Physical

- Trouble walking, balancing, or with coordination
- Changes in sensation (oversensitivity or numbness)
- Sensitivity to light and sound
- Changes in appetite or issues swallowing
- Chronic pain (including headaches)
- New or worsening seizures

Communication

- Trouble speaking or understanding words
- Low reading comprehension
- Difficulty expressing ideas or finding right words
- Unable to write
- Unable to stay on topic

Mental

- Poor concentration and memory issues
- Slowed thinking and responses
- Trouble reasoning, problem solving, and making decisions
- Trouble with multitasking or remembering order of tasks
- Needs more direction and structure to complete tasks
- Impulsive and unable to gain insight into their own problems
- Rigid thinking and struggles with accepting change

Emotional

- Easily frustrated or irritated
- Increased vulnerability to stress
- Emotional outbursts
- Inappropriate emotions (i.e. crying for no reason)
- Withdrawing from friends/family
- Feelings of grief, loss, or depression

Behavioural

- Struggle to 'keep up' in social situations
- Childish or inappropriate behaviour
- Personality changes and difficulty with relationships

Functional

- Impaired self-care and coping skills
- Lowered work performance/unable to return to work
- lowered ability to complete household tasks
- Inability to engage in previous hobbies.

obia.ca/resources/brain-injury-information

Types of Brain Injury

Acquired Brain Injury (ABI): Damage caused to the brain after birth that is not related to an underlying disorder or disease. These can be due to either Traumatic or non-traumatic injuries.

Traumatic Brain Injury (TBI): Damage caused by a physical blow to the head. Falling, sport-related concussions, accidents, fights, etc., are examples of traumatic injuries.

Non-Traumatic Brain Injury: Damage caused by illness or disease that is not present at birth or inherited. Illness like meningitis, a stroke, or even oxygen deprivation are considered not to be traumatic as they are not caused by impact or force.

HELPS: Traumatic Brain Injury Screening Tool

		Yes	No
H —	Have you ever Hit your Head or been Hit on the Head?	☐	☐
E —	Were you ever seen in the Emergency room, hospital, or by a doctor because of an injury to your head? *Note:* Even those who thought about seeing a doctor or went to the hospital and left before being seen	☐	☐
L —	Did you ever Lose consciousness or experience a period of being dazed and confused due to a head injury?	☐	☐
P —	Do you experience any of these Problems in your daily life since you hit your head?	☐	☐

- ☐ Headaches
- ☐ Dizziness
- ☐ Anxiety/Depression
- ☐ Poor Judgment
- ☐ Difficulty Concentrating
- ☐ Difficulty Remembering
- ☐ Poor Problem Solving
- ☐ Difficulty Reading, Writing, Calculating
- ☐ Difficulty Performing your Work/Job
- ☐ Change in Relationships with Others
- ☐ ***Other Chronic issues***

S —	Any significant Sickness? E.g: Brain tumour, meningitis, West Nile virus, stroke, seizures. *Note:* Events that can cause oxygen deprivation (heart attack, CO2 poisoning, drowning, suffocating) can also cause brain injury.	☐	☐

This screening tool is not meant to diagnose an ABI, but is meant to help inventory and contextualize cognitive and physical symptoms. To confirm the presence of an ABI consult a medical professional.

Supporting a Peer

Connecting with a Peer

Space and Time

Many workers are eager to get start with their Peer: identifying struggles, brainstorming goals, mapping next steps. etc. Many Peers coming into the program are eager to get started too, but it is just as important to set an easy and sustainable pace. Building trust is slow, making changes take time, and rushing to get started and make progress can be overwhelming and frightening. True progress with a Peer requires genuine understanding and respect for their situation, abilities, and experiences. Spend time with a Peer to simply listen to their concerns, goals, hopes, and expectations without trying to push for movement. It is easier to begin slow and create a solid foundation based on mutual understanding and consideration than it is to stop progression and correct goals and expectations later on.

Sharing the Moment

In times of distress the natural inclination is to move on, change subjects and refocus. A Worker's greatest skill and asset to staying connected with their Peer is to be able to withstand the urgency to escape moments of discomfort. Peers have been abandoned in these moments of weakness and vulnerability, a Worker's strength is in recognizing those moments and choosing to be the person to stay with them.

Staying in these moments can be difficult even for the most resilient Worker. Here are some tips to staying grounded and showing acceptance in these moments of vulnerability:

- Using very shallow small talk (i.e. weather) to try and stimulate the Peer back into a two-way conversation. To allow them to settle back into a shared space. This will reorient the Peer back to the Worker and help gauge how ready they are for a conversation or interaction.
- Getting more information on what is it exactly they are experiencing, thinking, and feeling, or trying to better understand what they are trying to say. Reflect back on what was said in moments of crisis or high emotion to better understand the source of crisis.
- Staying in silence is a very powerful tool. Peers can use the space to organize their thoughts, to speak more, or to help calm themselves with the support of a Worker's presence and patience. Speaking too much or too soon can interrupt coping, exploration, and introspection.
- Reacting genuinely and appropriately to what a Peer is saying. Sighing, nodding, exclaiming (e.g. "Huh" "Really?"), a comforting touch if a Peer welcomes it, all are examples of ways to lean into the narrative with support and signals solidarity.

What to Avoid When Staying in the Moment

- Using "I know what you mean" types of affirmations. Even if it's genuine, it can come off as insincere.
- Avoid repetition.
- Avoid asking questions that are unrelated to the current crisis or conversation.
- Avoid triggering subjects or questions unless a Peer brings them up first. If a Peer is emotionally elevated, respond to resistance by backing off-- don't push.

Breathing

Breathing is an easy way to regulate, moderate, and communicate nonverbally with a Peer. Here are ways that breathing can be used to help build rapport and influence emotional reactivity.

- A Worker can use breathing to calm themselves, sooth emotional reactivity, and increase focus and executive thought.
    - Slow breathing can communicate comfort, respect, attentiveness, and safety
        - Breathing slowly-- especially while talking-- can pace the conversation by slowing down speech and decreasing urgency.
            - A Peer may reflexively mirror a Worker's breathing, even if they aren't actively trying to engage in breathing exercises.

Presence

This refers to a Worker's mood, attitude, stance, speech pattern, and worldview. Generally a worker can choose on a spectrum whether they want to have a more intense and stimulating presence or let the Peer take the lead and take on a more passive, quiet, and subtle one. This can be more helpful for some Peers who are more responsive to actions than words. Ways that Workers can change and make use of their presence include:

- **Eye Contact:** Attention can be redirected. When speaking, eye contact can communicate interest, thought, and comfort.
- **Attention:** Increasing attention can energize, motivate, or direct focus. Reducing attention can minimize, discourage, or redirect.
- **Rate of Speech:** Slower speech encourages critical and creative thought. Faster speech raises stress for quick thinking, reactivity, and urgency
- **Energy:** Holding tension in the body or voice (positive or negative) can indicate stress or reactivity. Lack of tension and reactivity can indicate feelings of comfort, safety, close attention, and patience.
- **Affect:** Facial expressions. Flat or muted expressions can look bored, hostile, or disinterested. Muting expression in times of significant disclosure can signal normalcy or lack of surprise, disgust, anger, disapproval, or shock in what a Peer is saying.

Crisis Intervention

During times of intense emotions, intolerable stress, and desperation, Peers can find themselves in crisis and call their Worker for support and reassurance. A worker's first and most important task is to assess the risk the Peer poses to themselves or others, and create a plan of approach to help de-escalate and safety plan.

1 Start the Conversation

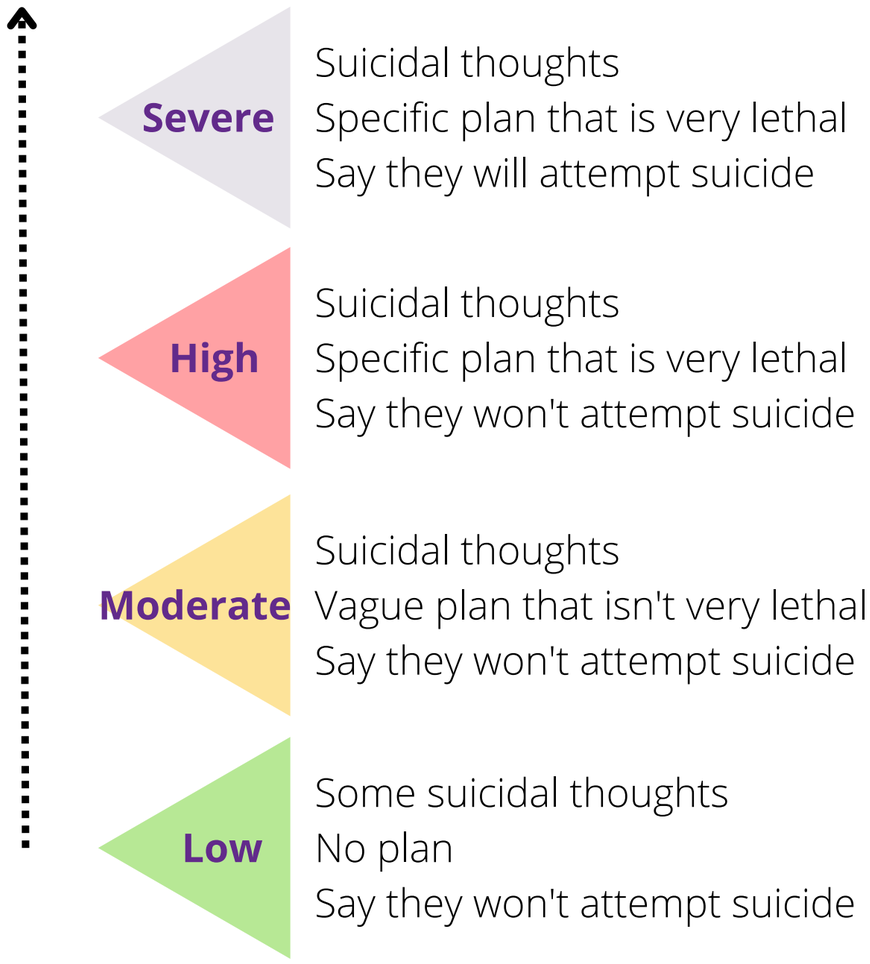
If a Worker is concerned about a Peer's immediate safety, it might be up to them to voice their concerns. Whether it's relapse, self-harm, or suicidal ideation, it is crucial going forward that any immediate dangers are identified. The most effective approach is ask specific and plain questions. Examples include:

2 Assess the Risk

When deciding how to approach a Peer in crisis-- including calling 911 or creating a safety plan-- the level of risk needs to be assessed to determine the most appropriate course of action. A vital part of assessing level of risk includes determining if a Peer already has an idea or a plan for dealing with their crisis. Questions to ask include:

- What are you going to do after this call?
- Are you worried about your sobriety/safety?
- Do you have a plan? Can you tell me about it?

In the case that a Worker feels a Peer may have suicidal ideations, the following tool can be used to assess whether a safety plan should be put in place or to call 911:



3 Offer a Listening Ear

Research

- When did you begin feeling like this?
- Did something happen around the time you started feeling this way?
- How can I best support you right now?
- Have you reached out for help in the past? If so, where or to whom?

Reasons

Listen for possible reasons or triggers for the crisis, and validate them while underscoring that, while extremely distressing, they are survivable and that the Peer is strong enough to cope through this. It doesn't mean agreeing with them, but focusing on acknowledging the pain they're enduring as real and serious.

Reassure

Reassure them that the urgency and intensity of being in crisis will fade over time-- likely within an hour. Guide them through familiar coping strategies or teach them a new one that can be done together to help draw their attention away from the moment. It may help some Peers to be reassured that they've endured worse and that these feelings never last. Staying with them until the moment has passed and they've calmed down enough to hold a conversation

AGES

Another useful approach for de-escalating crisis situations. This tool is particularly efficient with Peers whom Workers have rapport with and who are at lower risk (Low-High). A Worker might consider adopting this as a first-line approach with a Peer who is often overwhelmed or who enters crisis frequently to establish routine and model problem-solving and coping behaviours.

A — Affirm difficult feelings and, if applicable, intense or distressing situations. Acknowledge feelings that are 'normal' or expected.

G — use Grounding techniques to lower emotional reactivity by lowering breathing and heart rate, relaxing muscles, and drawing attention away from immediate triggers.

E — Establish the facts of the situation. Speak plainly and matter-of-factly about events, feelings, and consequences to keep reactivity low and increase self-awareness and encourage deliberate thought.

S — plan out next Steps, keeping details and goals Small and Simple to help reestablish control and direct attention and energy towards achieving a goal. Keep momentum moving forward and away from the crisis moment.

Self Disclosure

Lived experiences are invaluable to the Peer Support Worker; knowing exactly what their Peers are thinking, feeling, and struggling with is what separates Peer Workers from other mental health professionals. Shared experiences are a great way of connecting with a Peer who's struggling and helps model coping behaviours, offers hope of progression, and reinforces the Worker as an ally and an equal in the therapeutic relationship. Some Workers, however, are uncomfortable sharing experiences they feel are embarrassing, painful, or even traumatic.

Facilitator:
Remember to model self disclosure, drawing Workers' attention to the level of detail and content

For Workers who are still struggling with processing their experiences or feel uncomfortable sharing intimate details, it can be helpful to remember that the central focus is on the Peer and what they are currently going through in the moment. Details of past experiences aren't necessary, but what information could be used to help the Peer move forward in the present moment. A Peer doesn't need to know how a Worker felt in a critical moment of suffering, or the thoughts they struggled with when facing a similar setback, but that they too struggled and how they were able to survive and recover.

If a Worker chooses to disclose, they should make sure the disclosure is:

- **Specific**: Making sure to stay close to the point to avoid confusion
- **Short**: Brief enough to establish a connection and relevant experience, but not long enough to distract Peers from the problem at hand
- **Simple**: The more context and detail a disclosure has, the less relatable it will be. Keeping it simple can let Peers decide for themselves if they can relate or not.
- **Successful**: Disclose about issues that have been resolved. Even if the initial approach or the story is about a past failure, the Worker should already feel secure and concluded with what they are disclosing.
- **Sparse**: Don't introduce disclosures too early or too often.

Peer Work vs. Therapy

Therapy involves exploring and processing deep feelings, worldviews, and triggers that stem from past trauma. A therapist will explore the core anxiety, fear, and pain and help process these in real time to help reduce distress and address resulting problematic behaviours. Often they work as an external regulator and modifier to help model positive coping and restructure thoughts as they are actively processed. Therapy leans *into* the pain and trauma, making clients address and face these experiences head-on to resolve recurring problems.

Peer Work relies entirely on the present and provides real-time problem solving and behaviour modification to reach goals and improve wellbeing. Peers may bring up past trauma, but the focus of the Peer Worker is how this affects present behaviour and what specifically about that trauma is hindering progress and how can it be addressed in the moment. When Peer Workers engage take on the role of a therapist, they risk overhwhelming themselves and their Peer with extreme feelings as they expose deep suffering and pain. Ultimately this can damage the Worker-Peer relationship and could potentially set back the Peer as suffering is increased long-term.

When Peers bring up past trauma, a Worker can provide a quiet ear, comfort, and compassion. Their pain can be validated and the Worker can share in the moment with them, using pacing skills to come alongside and let the Peer either process their pain in their own time or intervene to help avoid crisis.

"I FOUND I WAS TELLING PEOPLE THINGS BECAUSE I WANTED THEM TO THINK I WAS COOL, THAT I 'GOT IT". IT WAS HARD TO STOP!"

Facilitator:
Refer to Helping Model and 'What is not Peer Work'

Roles, Goals, and Boundaries

A successful therapeutic relationship between a person and their Worker requires trust, honesty, respect, and cooperation. Due to the professional and therapeutic nature of the relationship, it is critical that the Worker establish and maintain clear and firm boundaries, that they create distinct roles, and ensure that the working relationship is always progressing towards a goal.

Roles

What tasks will the Worker complete to help the person choose and achieve their goals? What tasks will the personagree to take on, to be responsible for.

Goals

Define what the person looks to accomplish in their time with the worker or with a task or activity. We ask "What are we trying to achive here? "

Boundaries

Boundaries are the things we don't do, on both sides. The sides of the container

Again, It is important that roles, goals and boundaries be made clear right away, be firm, and visited regularly. If the lines of the relationship are not clear, then the person may feel insecure, lose trust, feel hurt, and their success may suffer. Goals, Roles, and Boundaries can also be used in conversation to help remind Peers and set their expectations:

A Container, a safe place to heal

"Roles, goals and boundaries are crucial, they are the container in which the person heals and grows. They have lost so much, they need one thing to count on, one place to feel safe. "

Sarah Werth, Peer Worker

"Sure, I can talk about apartment hunting and filing applications (**GOAL**) . Email me the links to the forms and I can print them (**ROLE**). I have an hour so I can drop them off today and help fill them out tomorrow (**BOUNDARY**)."

Roles, Goals, and Boundaries Worksheet

A worker receives a call on the peer phone during their shift. The person on the phone says that they are in the hospital and that they needs emotional support and help talking to the doctors. The worker has time to assist before their meeting and immediately drives to the hospital to meet the peer.

They find the peer in the ER and sit next to them, listening and validating their frustration and listening to the peer express how overwhelmed they feel. At one point the peer mentions that they hadn't eaten since the night before so the worker offers to get a sandwich from Tim Hortons; the peer seems relieved and agrees to have lunch. They eat together while they wait and spend some more time talking and keeping busy.

Eventually the worker notices that the person hasn't been called back yet but they have a meeting soon. They tell the peer that they have to leave but wrote down a list of things to remember to tell the doctor when they see them. Shocked, the person says "What do you mean you're leaving? I can't do this alone. Why are you even here?!"

The worker explained that they had a meeting and had to leave, but the peer became upset and began to panic. Ultimately they decide to leave the hospital before seeing a doctor.

Take some time to reflect on this story. Identify below the ways the worker could have established and maintained appropriate roles, goals and boundaries.

Roles _____

_____

_____

Goals _____

_____

_____

Boundaries _____

_____

_____

Do you think the outcome could have been different if the worker took the time to establish roles, goals and boundaries? If yes, how so?

_____

_____

_____

_____

Dysregulation & Pacing

Dysregulation refers to an emotional response that is stronger or more exaggerated than what we may normally expect. These responses are so overwhelming that someone might struggle to ‘get it together’, and it can impact their day-to-day functioning. This can be seen in self-harming behaviours, suicidal thoughts, substance use, or angry outbursts and tantrums.

Peers may come into the SUAP program after weeks or even months of crisis; a Peer Support Worker may be the first person to take the time to really listen, and often they're speaking so quickly they may not make sense, jump from topic to topic, or stop to make sure their Worker even understands.

Workers may be overwhelmed by this explosive energy, and might be tempted to interrupt or slow them down. A Peer in this state is not ready to be 'helped' and is likely struggling to process what it is they are saying; they may repeat or fixate on specific details. Interrupting to try and calm or orient them may be extremely frustrating or at times unhelpful as they try to give voice to their pent-up emotions.

A Worker's intrusion may not always be welcome and may come off as dismissive or argumentative. Pacing techniques can help a Worker stay in the conversation with their Peer while giving space to work through their agitation until the emotions settle and they're ready to move on

Pacing is a way of matching someone's energy so that they are engaged in a conversation where they are able to vent pent-up emotion and feel heard. This is a subtle skill that soothes potential feelings of guilt, shame, hesitation, and discomfort when an excitable Peer finally calms. Pacing techniques include:

DO Match the speed of the conversation

DO Affirm that it makes sense for them to be upset

DO Offer sympathy and empathize with their struggles

DO Model calm

DO Use short, simple sentences

DO NOT humour 'what ifs' or worst-case scenarios.

DO NOT Agree to what is not true or impossible

DO NOT Support extreme or degrading opinions of others

Once the conversation slows and the energy has calmed, the Peer is ready to move on Using Egan's Helping Model, focus on creating simple next steps. Start with **Direct Immediate Awareness**: take inventory of how the Peer feels and get their insight into root problems, goals moving forward, and maybe their hopes for the future.

Note: People who struggle with substance use, severe or persistent mental illness, street life, or disability may struggle with some aspects of therapeutic interventions (like those in the Helping Model) short-term. Progress may be slower and need more Worker intervention to learn new skills.

Pacing Exercise

During drop-in hours the doorbell rings; it's a peer, and the worker recognizes immediately that they're in crisis. The worker tries to deescalate but the peer is too scattered and jumping from one thought to the next between bouts of crying and cursing.

Below are some of the thoughts and feelings that the worker was able to understand. How could the worker use Pacing skills to help support the peer through their crisis?

I just walked over an hour to get here. It's freezing, my hands and feet hurt so bad!

My phone died so I had no one to call-- now I have no way to tell my mom I can't meet her to get my forms!

I have no food; I haven’t eaten in 2 days!

I was supposed to pick up my prescription last week but I have no money.

My roommate gets pissed when I play music, but nothing else makes me feel better! I hate it there.

Someone stole my headphones! I can’t go on without them-- I need my music!

I am so lonely, I don’t know what to do.

Scenarios like these are common in Peer Support Work; often Peers will get overwhelmed and get 'stuck' in these intense feelings. Think back to when you were last in crisis: What were your needs in the moment? How were you feeling? Would it have been helpful for someone to have 'paced' with you?

The Helping Model
+*PLUS*

Created by Gerard Egan, this model was created to better fit the emotional needs of those being helped, and guide those helping through practical steps to finding a solution. This is crucial in a Peer Worker's toolkit as they'll face a lot of sudden, unique, and complex problems that require quick thinking and maybe a little creativity.

1 Exploring the Present

- Look at, identify, and clarify the problem
- Focus on the main concern and talk about them using *real* feelings, experiences, and behaviours
- Help create a new perspective on the problem that uses facts and obervations rather than feelings and opinions.

+

The process of acceptance is where Peer Workers should spend the most time and energy with their Peer. Here Peers will learn to process intense and often distressing emotions head-on with guidance from their Worker; often recurring overwhelming emotions are tied directly to past trauma, and being able to process them as they arise can help Peers learn how to address and tolerate distress. Over time the emotional burden stemming from past trauma can be alleviated and the intensity of emotions weakened.

1a Accepting the Situation

- Summarize the situation plainly with fact-statements, including how the Peer has reacted to them and what they're thinking/feeling
- Assert that this situation has happened and that nothing will change or 'fix' it.
- Have the Peer acknowledge their role in the situation verbally.

2 Developing Preferred Scenarios

- Help develop a vision of a better future
- Begin planning actual changes that need to be made to make that vision possible
- Start with small steps that are easy to achieve at first to build momentum and confidence

3 Creating Strategies and Plans

- Brainstorm ways to approach meeting goals (actions to take, resources to use, etc.)
- Find approaches that have worked before and see if they can be applied to new goals
- Pick the ideas that are most appealing and are most realistic and reasonable, keeping in mind available resources
- Ensure that the goal and approach is within the Peer's abilities, then create a plan with

Nurturing Independence

If we want to actually *help a person ...*

It is great to feel liked and wantd. It feels good to help people, see them suffer less. As we said earlier it is important to involve the person in the exploring, thinking, decisions and actions. But to truly help you will be helping the people to not need you anymore. We want to work ourselves out of a job!

Stasis and Dependence

Every single interaction with a person either moves them towards or away from independence.

Reflection

You can be just 2 of these things. Which two matter most?

Liked - Trusted - Respected

Promoting Independence

Your work is always focused on helping people to become more connected to themselves, to feel worthy, and to be able to do things for themselves. If you do things for them they may become dependent on you. Not good! Opposite of good! In every interaction work towards the people doing things for themselves. You are supporting will learn to help themselves and your help will not be needed anymore.

"There Is No Stasis"

"Stasis' is a state where something does not move or change, it stays the same.

Discussion

What are some scenarios where you can imagine folks would become dependent.

People are not going to be independent right away. How do we proceed? We strive for "**Appropriate Effort -- Appropriate Progress**

IF THEY ARE NOT BECOMING INDEPENDENT

THEY ARE BECOMING DEPENDENT.

"There Is No Stasis"

Exercise:

Choose one scenario and outline how to use RGB and promote independence

Speaking of *Roles, Goals and Boundaries.*

We know that things happen such as program funding gets cut, people get sick, change jobs. You will not be around forever. When is the best time to prepare someone for when the helping relation ends? Hmmm?

Taking Care of You …

This work can be deeply rewarding. And it can also be tiring and .on different levels. Stress can where you down.

Stress is caused by the tension from being pulled in two different directions, sometimes to the point they snap!

There are many effects of stress, we are going to explore these (slides)

- Career Fatigue
- Burnout
- Moral Distress/Conflict
- Compassion Fatigue
- Trauma
- Vicarious – 'Secondary' Trauma

Facilitator:
Introduce the Complex Emotional Burdens slides

STRATEGY: **Transition times.**

It is important to allow for time to breath, relax, de-stress, get grounded after any type of activity

- After a days work is most common

also,

- Between meeting folks
- After phone calls
- weekend, holiday starts and end

It is also a good idea to transition *into* work. Arrive a bit early.

"Sometimes after work I go to the park, and just sit in my car and look at the trees until my chest relaxes."

Facilitator Tip
End sessions with "So, what does the rest of you day look like? "

Exercise:

Ask the participants to pay attention to their day, to stress and using transition times until next session.

H.A.L.T.S. is for everyone.

Are you:

Hungry
Angry
Lonely
Tired
Stressed, scared

Working with Professionals in the community . . .

'Professional' Just what is that, and why does it matter?

You are now a professional. You get a fixed pay, represent a larger organization and have responsibilities as such. An essential part of supporting people is the ability to advocate for them. And to do that you need to work successfully with other professionals in the community. Those professionals need to respect you to engage fully, to respond and, in many cases, bend the rules or take the extra step. Like all professional **you need to earn that respect.** It is not a given. There are some simple and common ways to do this, mostly around communications. To most successfully work with other professionals

- Learn about the person. What is their role? What are they able to do? What are their hours? Keep this in mind. It also allows you to know who to ask for things, and to not waste their time and yours.
- RESPECT- See this section in your general orientation.
- Keep your word. Make commitments carefully but <u>always</u> keep them. When changes happens, let the person know. Always.
- Always return or acknowledge emails or calls. 24 hours is a good limit. Even if is just 'Got it! Thanks!' Thi is in your orientation but deserves extra attention.

MYTH: Tattoos, piercings or funky hair etc. are seen as unprofessional and unacceptable.
FACT: So wrong, don't worry!
TRY THIS: Appearance is a personal thing. Be yourself, be comfortable. Remember that your role is connecting to others. Be unique or not, but think about the effect. Are you drawing attention away from where it belongs? Balance is key.

MYTH: Big words impress folks.
FACT: Wrong. In fact, in some ways the opposite is true. If you use common, easy to understand language everything improves. The goal is to communicate accurately, to effect change *with your ideas,* not the delivery of the ideas.
TRY THIS: Sincerity, accuracy, authentic and moving things ahead in appropriate ways.

Exercise:

Think about someone you have never heard of showing in an email asking you to do something that may be part of your job, but not fully within your duties. They just want you to do something for one of their clients and expect you to do it, by the way, the person is suffering and you need to hurry. List the feelings and ideas that come to your mind and heart.

Homework Project:

Think about someone you are supporting who would benefit from the services of an agency where you do not have a cinact. What are the steps to find that person and make contact.
For next week bring a sample email or points to consider in a phone call. Leave the completed work in our shared folder.

HINT

To earn respect, the one thing to do along with good communication is to **understand the persons roles, goals *and frustrations.***

Facilitator:

You may choose to point out the way you show respect to the participants as a way to help them feel it.

Working in the community . .

Given their knowledge of the 'system'-- the network of services a particular community has in place-- and how to access these services, a Peer Worker often plays the role pf "System Navigator". Often it's the Worker who plans and coordinates the services they and their Peer use, and figures out next steps in ensure continuous care.

Homework Project:

As a group, create a spreadsheet listing Peterborough's social services. Organize the list by name, type, size, and contact. Include a link to each organization's website. As a group, choose an online platform and then collaborate remotely.

Facilitator:
Give the participants as much freedom as possible for the first week; let them come up against barriers and questions. Guide them through the decision making process to fine tune the database by identifying needs & functions.

Homework Project:

- Search for Peer Support Worker programs around the world
- Choose 3 that you find interesting, ideally with differing approaches
- Note some similarities and differences among them
- Compare these approaches and be prepared to discuss them

"As We Learn & Grow" Living Glossary

These terms are collected and listed during our discussions.

When new terms come up, add them here

Glossary	Terms, Definitions & Acronyms
ABI - "Acquired Brain Injury"	An Acquired Brain Injury (ABI) is damage to the brain that occurs after birth from a traumatic or non-traumatic event. ABI is not related to a congenital disorder or degenerative disease, such as Alzheimer's Disease, Multiple Sclerosis or Parkinson's Disease. obia.ca
Advocate / Advocacy	Generally used to mean to try to bring something about in a public way, we mean to try to bring things about for a person. "My worker called the landlord to advocate for me, to help me get the apartment."Self advocacy is when a person works to bring something about for themselves.
Agency	1 - An organiztion, usually such as an addiction agency. 2- The capacity to make change
Cognitive	To do with thinking. Same root word as recognize and others
Disenfranchised	Strictly it means 'not connected to'. In this sector it often means not connected to people, society, services etc.
Diversion	To ove away from' often used in the justice system, where courts have 'sentence diversion' where the person is moved away from getting a sentence in to a program. And possible 'charge diversion, with the same outcome.
Entropy VS Atrophy	Entropy is a tendency towards randomeness,. Atrophy means to slowly degrade like muscles that do not get used.
Funder	A body that funds,m or pays for a program or item. The federal governeent in Ottawa poayd for the SUAP program. The local United Way funds some training for outreach. Local donors fund the drop-in supplies.
Vigilance	Alert watchfulness. The state or character of being vigilant; watchfulness in discovering or guarding against danger, or in providing for safety; circumspection; caution.
Hypervigilance:	In trauma we talk about hypervigilance to mean a very high awarness ovrer and aboive waht is needed in the moment.
Marginalized	Kept to the margins, often of folks who can;t access services or opportunites
Non-profit', Charity	A type of organization, that unlike companies like stores and businesses that make money, and are 'for profit', non-proiftss strive to do good for others as oppsed to make money. Some non-profits can take donations and give tax recipts, these are charities.
Oppression	Generally oppression means to put down and hold doiwn. And further, to restrain from growth. When stigmatized populations or marginalized groups are held down or oushed down etc, it is referred to as 'oppression'
Resources	1 - pamphlets, posters and information to put in a rack and hand out - 2 - Money, an agency will talk about not haveing the resources to run a program. 3 -Internal resources. I to mean persoinal strength, as is 'She did not have the resources to get to her appointment, she was too bagged."

Glossary	Terms, Definitions & Acronyms
Sector	General a sector is a part of a square, or part of an area. In social services a sector is an are of responsibility or action such as the hospoital sector or the justice sectot ... need another example
Self Efficacy	Doing this for one self and/or the belief that one can do for oneself.
Squat	A place where somone one puts a tent or stashes belongings to sleep while homeless. Squats are generally not legal.
Substance use/abuse etc	Addiction made paltable for politically correct folks. Innaccurate and unhelpful at communication but needed to get by with othe profrssionals due to pressure to be nice and conform.
Syndrome	That bar where you go to wath roller blading themed sins, doing too.
Trauma	Any event or series of events that overcome your ability to cope.
Vicarious Trauma	Real trauma that one experiences from hearing about anothers traumas.
Complex Trauma	The cumulative effect os childhood deprivations, lack of personal skills, multiple traumas and acute losses . As complex as life itself. Our area of work.
Vulnerable	Cambridge Dictionary: able to be easily physically or mentally hurt, influenced, or attacked. Tourists are more vulnerable to attack, because they do not know which areas of the city to avoid

References

2 Severe Sleep Deprivation Causes Hallucinations and a Gradual Progression Toward Psychosis With Increasing Time Awake. Flavie Waters, Vivian Chiu, Amanda Atkinson and Jan Dirk Blom.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6048360/

BOOK - Judith Herman - Trauma & Recovery

BOOK - Babette Rothschild, The Body Remembers

BOOK - Dr. Gabot Mate, In The Realm of Hungry Ghosts

BOOK - Norman Doidge - The Brain that Changes Itself

BOOK - Lisa Najavitz - Seeking Safety

WEBSITE - Excellent general Resource can be searched.
https://**trauma**researchfoundation.org/

WEBSITE - The TEND Academy - Francoise Mathieu. Excellent resource for **compassion fatigue, stress etc**. Based in Kingston ON.
https://www.tendacademy.ca/

WEBSITE - https://www.cast-canada.ca/. Tom Regehr

WEBSITE - General Resource can be searched. **Trauma, addiction, mental health** https://www.samhsa.gov/

KEY

Trauma – Blue wave at Top
ABI – Caramel back ground
TDNE – Grey background
Tools – white

Quote by Pearlman

Working with survivors of trauma teaches us not only about the devastation of cruelty and neglect, but also about the resilience of the human spirit and resourcefulness of the human mind.

Laurie Anne Pearlman,1995

1

Discussion Points:
"Trauma"

- Acute
- Relational
- Cycles of Abandonment
- Severe Ongoing Neglect/Environment
- Long term impacts
- 'Process Trauma'
- Definition from survivors

2

Acute

An acute trauma is a single, isolated event of short duration. It is one that is often 'resolved.'
Identifier – threat is ended.
Chance to heal for 2-3 years.

3

4

Relational

Ie. Bullying, domestic violence, sexual assault by an individual with an established relationship

Attachment

A factor in healthy growth and development – necessary for trust and self esteem and security

Cycles of Abandonment

Dr. Gabor Maté.
Constant factor among panel members.
Breeds distrust and insecurity.

7

Neglect is sometimes considered less severe than other forms of maltreatment. However, a study comparing developmental repercussions for four types of child maltreatment--neglect, physical abuse, sexual abuse, and psychologically unavailable parents- concluded that ***neglected children suffer the worst consequences***
(Gaudin, 1993).

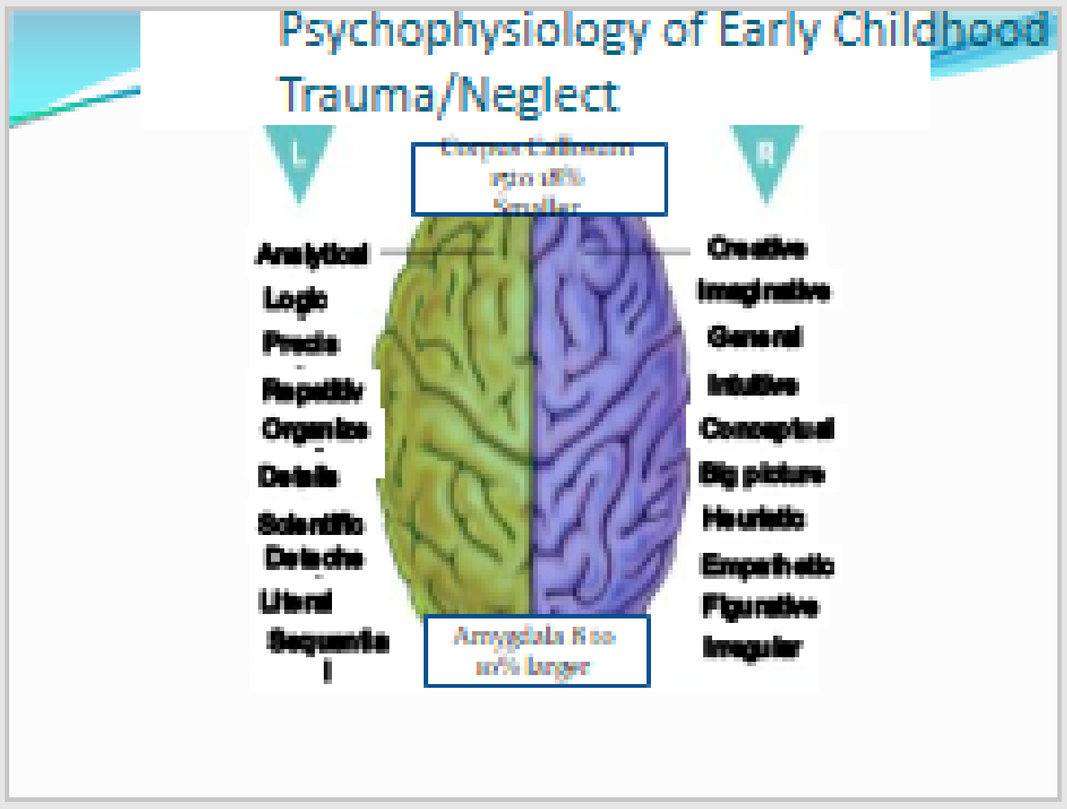
8

The ongoing nature of **chronic neglect** significantly impacts the brain in infancy and early childhood. According to Perry (2002), neglect at this phase impedes formation of neurological pathways essential to communication in the brain.

9

In particular, neglect has been shown to harm the frontal cortex, the area of the brain responsible for planning, decision making, and memory (Perry, 2002; DeBellis, 2005).
Extreme neglect can actually make children's brains smaller.

10



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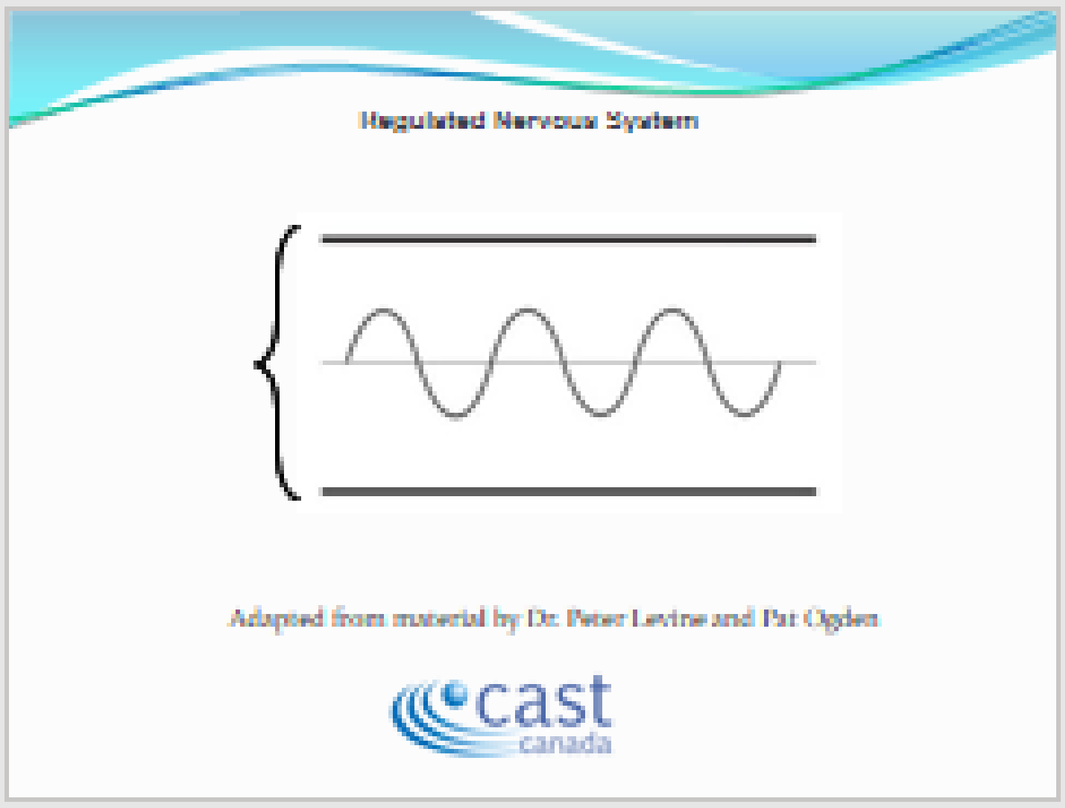

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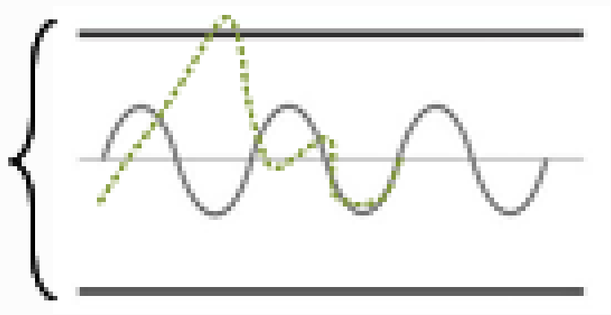
A crisis for a healthy person



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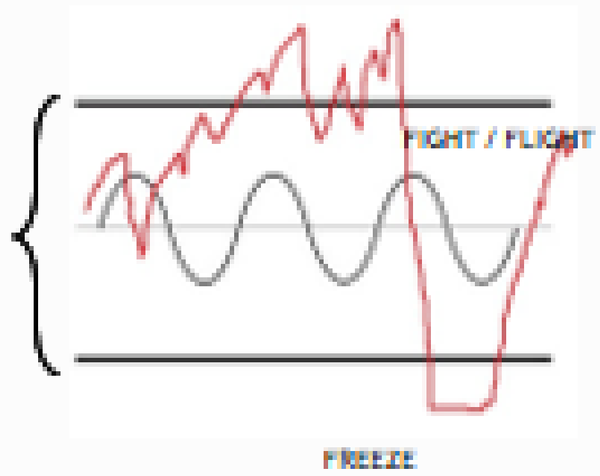
Dysregulated Nervous System
Living in a state of TDNE



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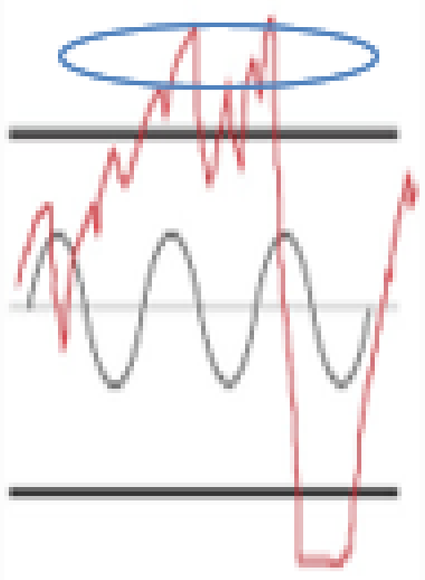
People often get stuck in the higher ranges

Some Consequences
- Limited insight
- Inability to calm/regulate self
- Escalation of circumstances

Sample of Physical effects
- diet
- ulcers
- lack of sleep
- Higher risk of Cancer,
- Heart or Stroke problems
- Type 2 Diabetes
- Chronic pain



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'Process Trauma'

The disruption and compromise of internal processes in growth, development and decision making

16

A definition of trauma from a group of unfacilitated survivors ...

17

ANYTHING that knocks you off your pins, keeps you from seeing clearly and making healthy choices.

18

A visit with addiction ...

Bio/psycho/soc/spiritual ...

It is never about the substance or behaviour...

"It is impossible to understand addiction without asking what relief the addict finds, or hopes to find, in the drug or the addictive behaviour."

-Gabor Maté

19

Dr. Gabor Maté video

20

About "Addiction"

All addictive behaviour is about soothing, or distracting, from past pain.

Discussion

21

A Review of Some Complexities ...

- Trauma
- Mental Health
- Addictive Behaviours
- Developmental Disorders
- Acquired Brain Injury
- Homelessness
- Justice

22

Brain Injury

Connecting dots, bridging gaps...

Acquired Brain Injury :

(ABI) is damage to the brain that occurs after birth and is not related to a congenital or degenerative disorder

(Ontario Brain Injury Association)

Why is ABI relevant to you?

- Brain injuries are the leading cause of death and disability for Canadians under the age of 35; with the highest rate of injury occurring between 15-24 age range
- Over 800 Ontarians die annually as a result
- Over 12,000 people in Ontario sustain an ABI annually
- Males are more likely than females to incur a TBI

× Brain Injury Association of Peterborough Region

25

ABI

Statistics also show that the need to support those living with severe, ongoing and persistent mental health is great, the same with people living with addictions, HIV/AIDS, judicial concerns, at risk youth etc. This is also true for those living with the effects of ABI.

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Symptoms of Mild/Moderate ABI: Cognitive, Physical, Behavioural

- Headache	- Lack of insight/awareness
- Anxiety	- Sensitivity to light or sound
- Fatigue	- Disturbed sleep
- Irritability	- Personality change
- Memory problems	- Mood swings
- Nausea	- Reduced concentration
- Depression	- Reduced attention span
- Balance problems	- Impulsivity / dis-inhibition
- Disorganized thought	- Impaired problem solving
- Reduced anger control	- Inappropriate social behaviour

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Brain Injury Survivors, coupled with other factors are often labeled as:

+The Complex Client

+'Difficult to engage'

+Non –compliant

Brain injury is often unrecognized by our system of care, they fall through gaps, remain homeless, misunderstood, misdiagnosed

× Ottawa Inner City Health

28

Homelessness/Brain Injury

× Study by Dr Stephen Hwang et al, St Michael's Hospital, Toronto ON - 53% of homeless people in this Toronto study have a history of brain injury

× Of the 53% of the Homeless population who have a history of brain injury, 70% sustained a brain injury prior to becoming homeless

× Stephen W. Hwang MD MPH

Justice/Brain Injury Incarcerated Populations

× 43% of people in our Ontario prison systems have been identified with a history of brain injury

× Of those, 62 per cent were men, while 37 per cent were women. More than half of the affected women experienced traumatic brain injury before or during the year leading up to their first criminal offence.

× Toronto Rehabilitation Institute

Mental Health/Brain Injury - Australia:

As a brain injury is a risk factor for developing a mental illness, or one may have preceded the brain injury – one report indicates 42% of people have a dual diagnosis

Hibbard, MR, Uysal S, et al (1998). Axis1 Psychopathology in Individuals with Traumatic Brain Injury

31

Substance Use/Brain Injury

- 1/3 of ABI survivors have a history of substance abuse prior to their injury
- 1/3 of incidents that cause brain injury are drug or alcohol related
- 20% of survivors who do not have a history of substance abuse problems become vulnerable to an abuse problem

Ontario Brain Injury Association

32

Better outcomes for all

Collaborative service provision would/could help with:

- Appropriate housing
- Appropriate screening
- Case management approaches
- More equipped crisis teams
- Reducing suffering/Improving quality of life

33

Remember ...

Every brain injury (like trauma) is unique...

Every recovery (like trauma) is unique

34

I suspect brain injury

What do I do?

H.E.L.P.S. tool
(go to handout)
Screening tool for awareness

What do I do?

Adopt a trauma informed/aware lens

Choice
Voice
Control

Resources:

Ontario Brain Injury Association

Ottawa Inner City Health

Brain Injury Association of Peterborough Region

Dr Stephen W Hwang: The effect of traumatic brain injury on the health of homeless people

Synapse.org

Hamilton Health Sciences

Toronto Rehabilitation Institute

37

Visiting …

Obsessing	Catastrophizing
Lack of hope	Lack of self worth
Suicidal thoughts	No affect
Short Attention span	Lack of follow-through

Over developed defense mechanisms

Over developed denial mechanisms

Anger – sudden or irrational

Black and white thinking

38

Origin of the name 'HeartSet'

We were talking with a woman who had just done this exercise. It was suggested that it changes one's *mind*set. She said,

"No, it is my heart that has been shifted."

39

The Heartset Narrative …
(video)

40

Loss of Control of Loss

For people who have suffered so much loss they feel they cannot retain or regain good things, they reach a point where they have a

'loss of control of loss' i.e.,

they feel that they cannot control the loss of existing positives in their life. They then choose to push away existing good things so as to not have them to lose -- they choose to not have good things, to not have hope – they enter a state where

The Nature of the Individual for whom Tomorrow Does Not Exist…

How do you identify this person?
Hints: Extremes in any behaviour, mannerisms, appearance; incongruence in body language and dialogue
Indicators:
The Hulk: Nice but anger surfaces when any positive futures are suggested
The Invisible Person - utterly compliant, no follow through.

43

In thinking about your clients, do a ny of these resonate with you?

Obsessing
Catastrophizing
Lack of hope
Lack of self worth
Suicidal thoughts
No affect
Short Attention span
Lack of follow-through
Black and white thinking
Over developed defense mechanisms
Over developed denial mechanisms
Anger – sudden or irrational

44

"Don't ever take a fence down un til
you know why it was put up."

-Robert Frost

45

How do you identify the size of their 'today'?

'Today'

How to stretch their 'today'?

46

Exploring Curiosity – Judson Brewer

- Curious not critical
- Self awareness & exploration
- Investment without urgent change

Exploring Curiosity

Wisdom in the dust ….

90% of what we do here is paying attention to, and fully exploring where we are, understanding it, accepting it …

Exploring Curiosity – some examples

- Cravings
- Anxiety, anger
- Sample behaviours … resistance or obsession
- Depression … as awareness of progress

49

Approach to …

A.G.E.S.

- **A**ffirm Angst – 'It makes sense…'
- **G**rounding – 'Let's take a breath… '
- **E**stablish facts – 'Ok, so…'
- **S**mall, Solid, Simple steps – Just what is next and real

50

Example – Client Interaction - Approach

- Pacing. Watch when to stay with the pace, when to change (see main body)
- Stay in the now as much as possible, avoid scenarios of a future not in sight.
- Use short, simple sentences.
- Model calm
- Make concrete, repeat, as needed ask them to say in their words …

1

WELCOME

Complex Emotional Burdens & Trauma

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2

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet"

Rachel Naomi Remen,
Kitchen Table Wisdom, 1996

3

On a scale of 1 -5
1 being 'not much' - 5 being 'very much

Slide 1

1. I am aware of the role of trauma and it's impact on my clients
2. I am aware of the impact of stress and emotional/traumatic overwhelm on myself
3. I have a deliberate self – care plan
4. I am comfortable/confident engaging in challenging communication with my team/management
5. I feel skilled in conversations that are charged with conflict

4

So, did they tell you?

When you received training for your job, was self care or compassion fatigue part of the training?

Discussion Points (ppt off)

5

Effects of Stress

Reduced Quality of Care for Clients
Turnover
Cycle downward – leads to other
Personal *and* Professional

All Relationships suffer

6

Physical Symptoms		
Exhaustion	Sleep loss of and excessive	Digestion
Headaches	Insomnia	Impaired Immune System
Body ache	Appetite loss or gain	Cortisol

7

Behavioural Symptoms

Increased use of alcohol/drugs	Problems in personal Relationships	Impaired ability to make decisions
Withdrawn	Moody	Regression
Irritable	Hypervigilance	Nightmares
Impatience	Accident Proneness	Losing things
Self harm behaviour	Absenteeism	Anger
Avoidance of clients	Forgetfulness	

8

Psychological Symptoms

- Distancing
- Negative self Image
- Depression
- Reduced ability to feel sympathy/empathy
- Cynicism
- Resentment (of people wanting something from you)
- Dread of working with certain clients
- Feeling professional helplessness
- Depersonalization
- Disruption of your world view

9

Psychological Symptoms (cont'd)

Slide 1

- Problems with Intimacy
- Intrusive imagery
- Heightened anxiety or irrational fears
- Hypersensitivity to emotionally charged stimuli
- Insensitivity to emotional material
- Increased sense of personal vulnerability
- Loss of hope
- Difficulty separating personal and professional lives

10

Unique Stresses

- Career Fatigue
- Burnout
- Moral Distress/Conflict
- Compassion Fatigue
- Trauma
- Vicarious - 'Secondary'

11

2 physical

2 psychological

2 Behavioural

2 de-escalation strategies/actions

2 things that fuel you , that fill your soul

12

Career Fatigue

"I am simply tired and bored of this work.
I need a change"

Only affects work.

13

Burn Out

Physical or emotional exhaustion

Caused by prolonged stress and frustration

Can occur with ANY occupation

Conditions: Environment & atmosphere

Does not change view of outside world – just the workplace

14

Moral Distress/Conflict

" … happens when there are inconsistencies between a (helpers) beliefs and and his/her actions in practice."

Effects … work … personal?

Thoughts?

15

Compassion Fatigue

Slide 1

16

Compassion Fatigue

A Deep Erosion of our compassion, of our ability to tolerate strong emotions/difficult stories in others (F. Mathieu, 2012)

Exists throughout our personal *and* professional lives

17

Compassion Fatigue

Affects professional and personal Life.

Continually evolving

Looks different for everyone

Subject to interpretation

18

Who Gets Compassion Fatigue?

- Affects the most caring
- The more traumatic the work=the higher incidence
- Social support system
- Helpers own trauma history
- Training
- Supportive work environment

(F. Mathieu, 2012)

9

"Must Be Nice"

- Have you ever heard yourself saying (in response to someone else's good news)
  "Must be nice"?
- This is a good indicator for ourselves, it begs the question of ourselves, "what is going on with me for me to feel/respond in such a way"
- Guilt/Anger/Jealousy
  Empathy vs. Sympathy

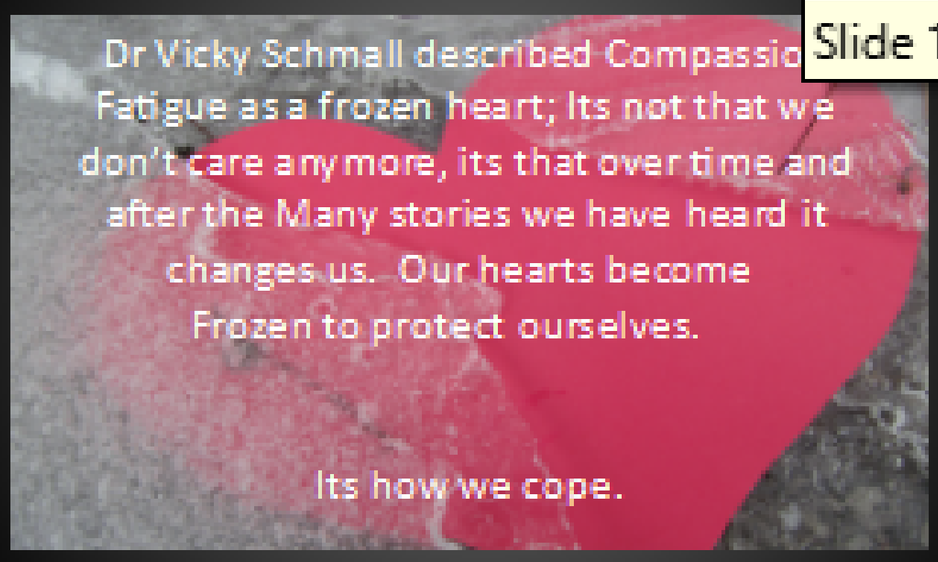
(F. Mathieu, 2012)

20

VIDEO

21

Frozen Heart



Slide arranged by Christie Lee, Peterborough

22

Vicarious – 'Secondary' Trauma

Trauma of being exposed to other suffering

…

It is not any less real or impactful

*

23

Vicarious Trauma

- Repeated exposure to difficult stories changes our view of the world
- Outcome of the work we do
- Effects are cumulative and build upon memories obtained through listening
- Permanent, (not daily) subtle or marked change in outlook
- Life-changing effect on individuals, relationships, connections to family, friends and community
- Occupational hazard

24

Vicarious Trauma

"The Effects of Vicarious Trauma extend to all realms of Workers 'lives and are cumulative, unavoidable and applicable to everyone uniquely. Experiences such as a change in beliefs and Values and the way that one looks at the world, intrusive imagery and physical effects are normal consequences of the work"

(Guidebook on Vicarious Trauma, 2001)

25

"(our goal) … is not a state of rest.
It's a dynamic, ever changing balancing act that occurs on several continuums: financial, business, relationships, kids, spirituality, you name it. With so many elements to juggle you

need to look at each one separately and evaluate its importance to you."

Patrick Fanning

www.cast-canada.ca

26

Communication for Trauma Exposed Workplaces

27

Slide 1

In Any communication

Is this my job?

Who to CC?

What is the intent, what are you trying to achieve

What is the action you hope for.

28

How will you know it is achieved

The more time you spend on this the better the outcome. The communication will be easier to deliver and more likely to be successful

What Ise do they need to know? What will help them along the way.

Close communication with

closing issue

next steps

"Happy to help/So-nSo woul be happy to help

(as needed) Thank You

29

t h a n k y o u

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Directing Movement

For clients who are in the **pre-contemplative or contemplative stage of change** – the focus is often more on how clients talk to themselves about change.

Motivational Interviewing is a specific type of interviewing/counselling which focuses on addressing how a client speaks with you (and themselves) about the behavior they are considering or being asked to change.

Evoking 'Change Talk'

- 'Change Talk' is a dialogue that takes place in order to **prompt change** rather than reinforce the benefits of the avoiding change.
  - **Collaborative**, not confrontational
  - Involves closer examination of **'hot spots' for ambivalence**.
  - Try to **increase awareness** of how uncomfortable this ambivalence is
  - Divided into '**preparatory**' and '**mobilizing**' change talk.

Types of 'Preparatory Change Talk'('DARN')

DESIRE – statements about a wish to change
- I would like to, I wish, etc.

ABILITY – statements about what one is willing or able to do
- I think I could..., Right now I can.....

REASONS – statements about why change is desirable
- I know I should change because..., I know if I changed it would,....

NEED – statements about feeling obligated to change
- I should/need to _____ because

None of the 'DARN's – alone or combined, indicate that change will happen...they are only factors which might motivate one towards action

Types of 'Mobilizing Change Talk'('CAT')

COMMITMENT – statements about what one is committed to doing in order to promote change
- I will..., I am going to.. (high level commitment)

ACTIVATION – statements that indicate that one is going to take action, but are not a high level commitment to do so
- I'm willing to, I'm ready to, I'm prepared to....

'Sustain Talk'

- Sustain talk refers to **any statements which are against change/for staying the same**
- Sustain talk **can also be classified using DARN-CAT**
  - ie: desire to keep drinking, reasons to keep drinking

Types of 'Mobilizing Change Talk'('CAT')

TAKING STEPS – statements which suggest that the person has already taken a step/action towards a change goal

ie: I bought a gym membership, I started going to AA etc.

All of the CATS suggest some actual movement towards the resolution of ambivalence in favour of change

'Sustain Talk' vs. 'Change Talk'

- A person who mostly engaged in sustain talk, or in relatively equal amounts of sustain talk and change talk is not likely to change their behaviour
- Thus, it is important to **listen for change talk and highlight it** + ask questions which **evoke change talk**
- **Balance of change talk vs. sustain talk should shift during session and over time**

"ROCK AND ROLL !!!