Peer Health Navigators

Supporting People in Mental Health Recovery to Meet their Health and Wellness Goals

Training Workbook – Revised

Preface

People with serious mental illness get sick and die at much higher rates than same-aged peers. In 2012, a coalition of people with lived experience, providers, and researchers from Heartland Health Outreach (HHO), Advocates for Human Potential (AHP), and the Illinois Institute of Technology (IIT) were awarded a grant by the National Institute of Minority Health and Health Disparities (NIMHD) to better understand the problem, craft a program meant to impact these health inequities, and evaluate the program in a rigorous pilot study. We did this in the frame of Community Based Participatory Research (CBPR), partnering with people with lived experience to develop the qualitative research program meant to understand the health disparity problem. We learned from this work that **peer health navigators** might be an effective approach to helping African Americans with mental illness engage in and fully benefit from the primary care health system. The CBPR team used findings from our qualitative research to develop this PHN manual.

Peer health navigators (**PHNs**) travel into the member's community to understand the nature of a person's health needs and then partner with that person as he or she pursues these goals in the health care system. We chose to frame the role here as Peer Health Navigators because:

- PEER is an especially important concept in psychiatric services; namely that individuals with lived experience are *capable* of meaningfully helping others despite their disabilities with an approach based on mutual experience and
- NAVIGATING the system is a practical task essential to the success of a one's health goals.

Since then, Peer Health Navigators (PHNs) have been tested in studies funded by NIMHD and PCORI. In 2021, the IIT team, in partnership with Thresholds, was awarded a grant by the National Institute for Disabilities, Independent Living, and Rehabilitation Research to upscale PHNs for people with serious mental illness. This was a five year, randomized controlled trial with half of Thresholds members receiving PHN to address their health and wellness goals. To do this, we assembled a CBPR team of people with lived experience, providers, and scientist to oversee the project, including the revision of the PHN manual.

This workbook is a companion to the revised PHN manual. Included are all fact sheets, worksheets, and in-the-field practice sheets. Fact sheets are informational: use them when you need to look up a term or need a refresher on something learned in your training. Work sheets are hands-on: use the exercises to practice the skills you learned in your training. In-the-field practice sheets are practical: use them with members as a guide for your work in the field.

Team members include Sonya Ballentine, Pat Corrigan, Carla Elliott, Carla Kundert, Nancy Little, Elliott Morris, Ron Otto, Steve Ruppert, Ashley Scott, Angie Thinnes, and Paul Williams. The CBPR team worked with an additional collection of Thresholds and IIT leaders to move ahead on this project including Mary Blaney-Rychener, Nicole Pashka, Lisa Razzano, Anabel Ruiz, and Lindsay Sheehan. Additional thanks to Beatrice Gaurean and Snigdha Talluri as research assistants on the project.

One final point about language: how do we refer to the person for whom PHN provided services? In this manual, we refer to member which is consistent with the way Thresholds refers to its participants: as members of their service.

More can be learned about this and related projects at www.chicagohealthdisparities.org

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Table of Contents

There is a **MANUAL** that accompanies this workbook.

FACT SHEET 1.1, Who are Peers?

Who can be a peer health navigator?

- A peer health navigator (PHN) is someone whose lived experience and training allows them to help others in similar situations or circumstances.
- A PHN can learn skills and strategies to help others in similar situations.
- PHNs are people with serious mental illness
- PHNs have lived experience with mental illness and are now in recovery.
- Personal experience with physical health challenges is also a strength.

How does personal experience help?

- Personal experience means that people have lived through similar challenges and can help others by providing "tricks of the trade" and sharing strategies to cope.
- Along with personal experience comes tolerance, dedication, passion, and motivation.
- Peers who share the experience can provide support by being empathic.

What do peer health navigators do?

- PHNs help other individuals who are in similar situations.
- PHNs help people with mental illness access healthcare clinics to address their health needs.
- PHNs lead by example and share resources and knowledge.

What are some good qualities a peer health navigator should have?

- _____
- _____
- _____

FACT SHEET 1.2A, Basic Principles for Providing PHN Services

BASIC VALUES:

Accepting: Peer health navigators (**PHN**s) work with people who are different from them. PHNs respect these differences and appreciate the member as he or she is.

Empowering: PHNs recognize self-determination. Members have the ultimate power in defining their health and health goals. They make the final decision in participating in services meant to impact their goals.

Recovery-Focused: PHNs recognize recovery and not mental illness as the expectation, promoting goal achievement and hope.

Goals-Focused: PHNs are goals-focused. While other people may have goals for an individual, the member makes the final decision about the pursuit of health and wellness goals.

Peer Experienced: PHNs are peers! They are people who have lived experience with mental illness and are in recovery.

Available: PHNs need to be flexible and available according to their member's schedule within reason.

Patient and Consistent: PHNs need to provide services regularly and over the long term. Most problems experienced by members do not change quickly.

In the Community: PHNs work in the member's community and health care system.

PART OF THE TEAM:

Networked: PHNs seek to meet the member's needs by linking with all health care providers.

Access: PHNs need access to clinics and information about their members. With permission, this may mean accompanying the member into an exam room or accessing medical records.

Informed and Resourced: PHNs need to have knowledge and resources outside the member's healthcare system, keeping aware of resources related to homelessness.

Supervised: PHNs are supervised and receive regular, supportive feedback about their performance. Supervisors should be active members of the patient's health service team.

Teamwork: PHNs work as part of a team with other PHNs and providers. In this way, PHNs benefit from a range of skills and knowledge, and teams broaden the human resource available.

Diplomatic: To be successful with networking and accessing information, PHNs must be polite and friendly. However, PHNs may sometimes need to be assertive with colleagues.

Credentialed: PHNs need to complete a training program and test, participate in regular reliability checks to maintain their skills, and earn continuing education credits to maintain knowledge of related information.

FUNDAMENTAL APPROACH:

Proactive: PHNs are attentive to places and times where action is needed. Rather than awaiting direction, PHNs may suggest goals and strategies when encouraged to do so.

Broad Focus: PHNs attempt to help members address all health and wellness concerns. This may mean working in related areas such as housing or criminal justice.

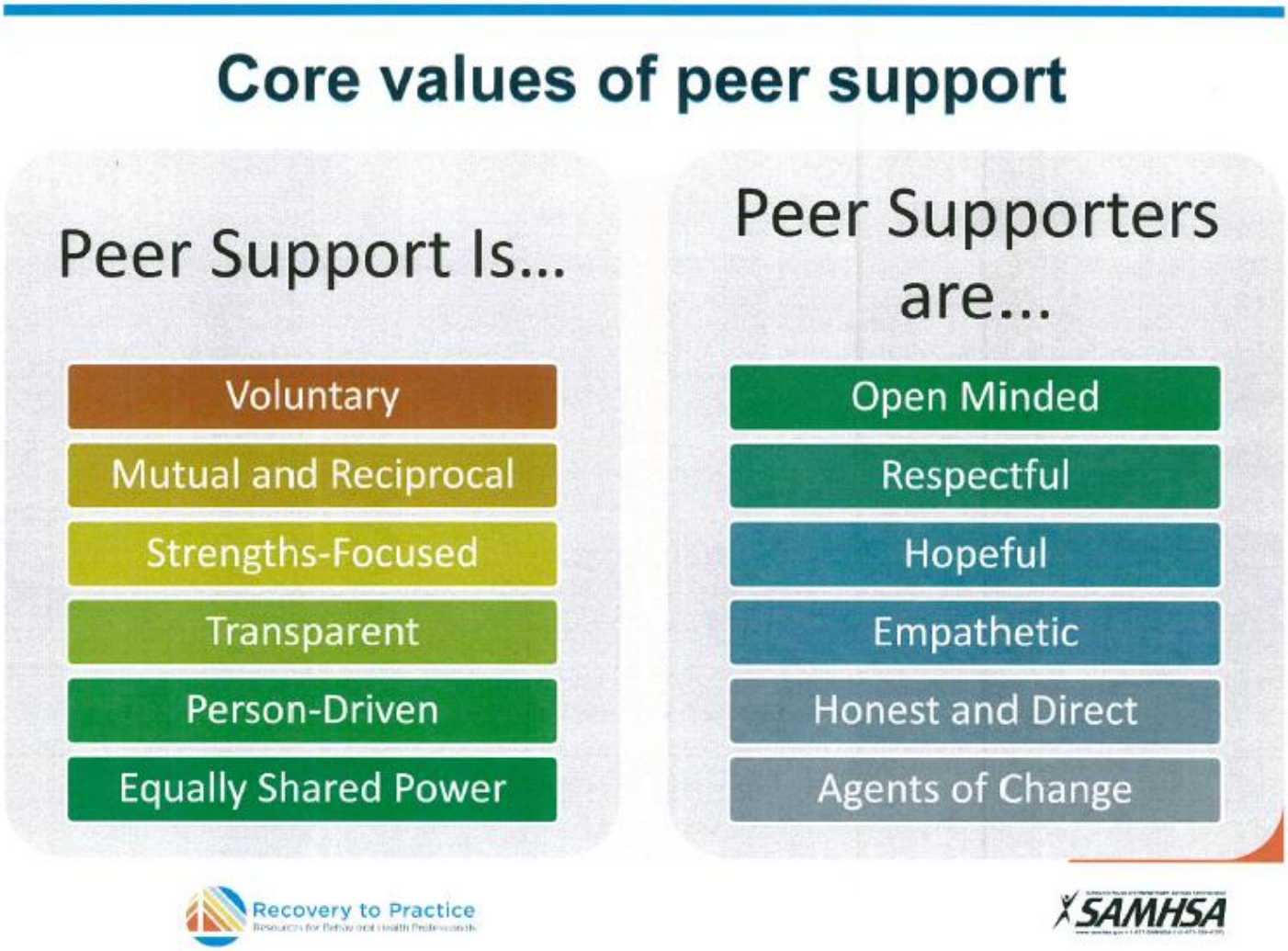
Active Listener: PHNs must be active listeners. This includes careful attention to detail, and a reflection of what the member is communicating, including exploration of the meaning behind what they say.

Shared Decision Making: PHNs help the member identify pros and cons of individual health and wellness decisions. PHNs use active listening to help the member make decisions.

Problem-Solving Focused: PHNs partner with members to define the goal, brainstorm solutions, plan out a specific solution, apply it, and evaluate it to determine its effect.

Boundaries: PHNs know there are limits to what they can do to help the member.

FACT SHEET 1.2B, Core Values of Peer Support



FACT SHEET 1.3A, Overview of PHN Duties

Below is a brief description of what will be covered in this training.

MANAGING MY ROLE: Items discussed in this section refer to set(s) of skills or tools so that the PHN can flourish in their role.

Office Etiquette: A set of guidelines to help PHNs familiarize themselves with an office setting.
Street Smarts: A set of skills designed to help PHNs cope and stay safe while working in a large urban area
Time Management: The act of planning and exercising control over the time spent on specific activities, in order to increase effectiveness and productivity.
Self-Care to Manage Burnout: A way to reduce the stress reaction experienced by PHNs exposed to traumatic experiences and stories of members.
HIPAA: A guide to managing members' private health information.
Team Approach: An overview of the team-based approach for PHNs to use in working with members.

ACTIVE LISTENING SKILLS: Items discussed in this section refer to set(s) of skills or approaches for listening to members actively.

Roadblocks to Good Listening: An outline of potential barriers to listening to member needs and concerns.
Good Listening Skills: A communication strategy that aims to reconstruct what the member is expressing and to relay this understanding back to the member.
Engagement Tips: A list of tips to help with engaging when PHNs and members want to increase engagement.
Elicit, Provide, Elicit: A motivational interviewing technique to share information without lecturing and maintain a two-way conversation while providing information
Seeking Permission to Discuss Thorny Issues: An outline for asking permission to address difficult topics with members.
Dancing with Discord: A set of strategies for dealing with differences of opinion or tension in the working relationship.

WORKING WITH THE PERSON: Items discussed in this section refer to set(s) of skills or approaches for optimal interactions with the member.

Overview of Common Health Problems: Helps confront and resolve problems in a manner that shows respect for and investment in the relationship.
Relationship Boundaries: The limits we set in relationships that allow us to protect ourselves from the emotional needs of others in order to stay healthy.
Checking In & Agenda Setting:
Strengths Model: An approach that identifies the positive resources and abilities that members already have.
Strengths-Based Goal Setting: The process of discussing what a member wants to accomplish and devising a plan to achieve the result they desire.
Stages of Change & Motivational Interviewing: A way to engage members, elicit change talk, and evoke motivation to make positive changes
Harm Reduction: Helping people minimize the negative impacts to self, loved ones, and community when engaging in risky behaviors.
Relapse Management: A set of skills designed to reduce the likelihood that symptoms leading to a relapse will worsen or that a person will return to an unhealthy behavior.
Dealing with Stigma and Shame of Health Conditions:
Smoking Reduction

RESPONDING TO THEIR CONCERNS: Items discussed in this section refer to set(s) of skills or approaches for the PHN to help members get their needs met.

Advocacy: The act or process of supporting a cause or position that is important to your member.

Interpersonal Problem Solving: Helps confront and resolve problems in a manner that shows respect for and investment in the relationship.

Cultural Competence: The ability to interact effectively with people of different cultures and backgrounds.

Self-Disclosure: A process of communication through which one person reveals aspects of himself or herself to another.

Trauma-Informed Care: An approach that realizes the prevalence of trauma, recognizes how trauma affects members, and responds by putting this knowledge into practice to understand current behaviors and to avoid retraumatization.

CRISIS MANAGEMENT: This set of skill will help PHNs prevent and/or respond to crises related to physical or mental health.

Mental Health Crisis Management: A set of skills to assist the person in crisis (related to mental health) until appropriate professional help is received.

Physical Health Crisis Management: A set of skills to assist the person in crisis (related to physical health) until appropriate professional help is received.

Distress Awareness & De-Escalation: A set of skills to help PHNs handle possible aggression to avoid harm to members or others.

FACT SHEET 1.3B, Staff Role in Appointments

Staff presence at medical and psychiatric appointments can often feel awkward. We want to empower members to take ownership over the process, and at the same time, we know that for most members it is very helpful for staff to be involved. This tip sheet will help you know what you are supposed to do and say in an appointment with a member and provider and feel confident about your role.

Background:

People with mental illness have been and are negatively affected by ***social determinants* of health**, such as

- Poverty
- Substandard housing
- Stigma
- Health literacy limitations
- Unemployment
- Lack of support
- Co-occurring disorders (alcohol, drugs, smoking, etc.)

These social determinants have impacted and continue to impact members' health, and their **comfort** with, **willingness**, and **ability** to access healthcare such that their life expectancy is significantly – 25-30 years – lower than the general population. The average life expectancy in the US is about 79 years; many members will die in their 40s and 50s.

To the extent that PHNs can be an active member in members' integrated healthcare we can play an important role in **overcoming the barriers posed by social determinants of health**, and help members develop the skills to be more independent, take charge of their healthcare, and live longer more fulfilled lives.

Here are a few things that we believe can help guide Thresholds staff when thinking about their role in these situations:

- Remember that **the member is in charge**.
- If we use a stage-based approach to being involved in member healthcare, we will be more effective.
  - Let Motivational Interviewing, stages of change and Harm Reduction principles be your guide.
- Seek a positive relationship everywhere (member-provider, provider-staff, member-staff).
- **Some members may not want us there** and we need to work to understand it and respect it. When this occurs it increases the importance of efforts before and after the appointment to help prepare and follow up.
- Most of the time our supportive presence in medical and psychiatric appointments is helpful. Why?
  - To help overcome barriers to accessing the maximum amount of support from the provider.
  - Helps us to follow up on the information/education/referrals given to the member. This can increase the likelihood that they understand and follow through on often confusing health information, prescriptions, and recommendations.
  - Improves engagement with member around recommendations from providers in a stage-based fashion.
  - Increases the likelihood that follow up appointments will occur and be fruitful.
  - Extends member's life expectancy.
- There can be times when it makes sense to not be in the room with the provider (i.e., some physical exams). Be proactive to work with the member and provider to determine when extra privacy is needed.
- The capacity of the Thresholds staff and how we work with members (i.e., harm reduction and stages of change) is not understood by all providers. They are hopeful that we can do more than we can (i.e., get people to take medications, stop smoking, stop using substances, eat more veggies, etc.) When we explain what we can and can't do we should avoid being defensive. Keep in mind that the shared goal is for the member to get their needs met.
- Get releases of information for all doctors and other medical professionals. If the member is seeing one of our partners (Heartland, Howard Brown, Aunt Martha's) a referral is not needed.

- **Be creative.** Find ways to have effective communication between the member and provider. Use your supervisor and team to brainstorm.
- **Be proactive.** Planning and being assertive prior to provider visits can go a long way in avoiding pitfalls.
- **Most of the work begins after the doctor visit ends.** Engage the member on their health and wellness and psychiatric symptoms. These conversations should be ongoing.

Tasks to do PRIOR to an appointment:

- Ensure the member has **signed a release of information** if the provider is not one of your partners. If they are seeing Heartland, Howard Brown, Aunt Martha's releases aren't needed.
- Fill out the first page of the Pre/post medical appointment form or Planning my psychiatrist visit form as a way to **identify goals for the appointment**.
  - Explore the member's expectations for the appointment.
  - Use the discussion when filling this form out to identify areas that might be beneficial to discuss. There are often areas they might not be thinking about that could be beneficial to address.
- Talk through reluctance to tell medical providers **sensitive information** (substance use, consistency of taking medication, sexual side effects of meds, etc.).
- Discuss **anxiety or other mental health symptoms** that might arise during the appointment and identify strategies to manage them.
- Develop a plan to bring a complete list of **all medications** taken to every PCP visit. This could mean 1) bringing the actual meds or 2) bringing the MAR in addition to a list of all non-pill medications taken (injections, creams, inhalers, etc.). This can sometimes feel like a lot of work but it helps to minimize confusion. (This is also needed if it is the first time a member sees other providers. They may not be needed on subsequent non-PCP visits as long as they are kept abreast of what medications are currently prescribed.)
  - If the member is on an **injection** identify the
    - Name of the medication
    - How often it is prescribed (e.g., every two weeks or is it every month?)
    - When the medication was last given
  - Has member gone to the **hospital or ER** and gotten medications from another prescriber since the last appointment? Provide as much info as possible.
- Consider the type of appointment (e.g., gynecological exam) and **which team member** would be best to attend.
- Discuss with the member how it is **normal for people who have complex health problems to have someone accompany them to medical and psychiatric appointments**, due to the volume of complex information. Then confirm with them that this is OK for their upcoming visit.
  - Try and think through how to ask permission in a way that increases the likelihood that they will let you help. What works with one member is different than another member.
- If possible, arrive with member 15 minutes early.
- Consider getting in touch with the provider about issues (e.g., member is very symptomatic) prior to the appointment if this would help them be more effective **and** if they are from a partner organization or there is a signed release of information. Use supervision to determine when this might be needed.

Tasks to do DURING an appointment:

Introduce yourself to the provider and let them know that you are there to support their work together.

⇨ Make sure they have a way to get in touch with your team if necessary.

- Find a balance between being inactive or overly active in the appointment. Your being confident in your role helps the member to be confident as well. Keep in your mind that you are there to support the process.
    - Be aware that some providers will ask YOU all of the questions. **The member is the expert on themselves.** If this happens, work to rebalance the visit to have the provider ask the member the questions.
- Find ways to be supportive of the member and ways to **ensure that information is flowing effectively between the member and the provider**. As anxiety, shame, paranoia, cognitive difficulties, or memory deficits arise, find creative ways to minimize their impact on the member's appointment.
- If the Pre/post medical appointment form or Planning my psychiatrist visit form was used, with member's prior permission, consider giving it to the provider.
- Advocate for the member as needed.
- Prompt the member as needed to **draw out pertinent facts** (e.g., recent symptoms, a recent ER visit, side effects of meds, consistency of taking meds, barriers to following through on recommendations, etc.).
- Prompt member as needed to use **coping strategies** for anxiety or other mental health symptoms that are impacting the visit.
- **Listen.** Then…
    - Find ways to shine light on areas not being addressed but which could impact the likelihood of the provider's recommendations being followed or being effective, for instance behavioral patterns of the member (e.g., substance use, diet), or limitations of the member's situation (lack of supports, insurance issues, etc.).
    - Consider whether or not the member is really understanding what the provider is telling them. Find ways to **increase member understanding**.
        - Ask if the member understands
        - Ask the provider to repeat the information
        - Ask the provider to write it down, or you write it down and confirm you have it correct.
        - Say something like… "let me see if I've got that right. I think you are saying…. …. Is that correct? "
        - Be mindful of the member's literacy level and adapt the information to meet their needs.
    - **Prompt the member to ask any unanswered questions.**
    - **Take notes.**
- As the visit is ending try and find a way to **revisit/summarize the high points** of what happened and what the provider's recommendations are.

Tasks to do AFTER an appointment:

- Consider using the second page of the Pre/Post form to **review** what occurred and what possible follow up is recommended by the provider.
- Explore the **member's perspective** on the visit and how they want to move forward.
- Explore with the member their thoughts on the **provider's recommendations**.
  - Make **plans** around the recommendations based on their level of motivation and stage of change.
  - Identify **supports** for the member following through on recommendations.
  - Address **barriers** to following through on the recommendations.
  - Think Harm Reduction and find areas the member is willing to change even if they don't want to fully follow a recommendation.
  - Set up an expectation to talk through the recommendations again in the future.
- Make plans around referrals or follow up appointments.
- Make arrangements with the member and their pharmacy to ensure any **medication changes** are completed (e.g., new meds in their blister pack and old meds removed from blister pack).
  - Problem solve with the member around barriers to taking the medications as prescribed.
- Review information from the provider. Do **"teach back"** to check to see what the member understands from the interaction and to increase the likelihood that the information will be retained.
  - Teach back as often as needed and as a part of upcoming visits.
- Explore if any issues were not addressed in the appointment, and make a plan to have them addressed.
- Communicate what occurred and the plan going forward in the team meeting.

Member+Staff+PCP+Psychiatrist= Integrated Healthcare

THRESHOLDS
HOME | HEALTH | HOPE

JUNE 2018

What is the role of staff?

Before Appointment:	During Appointment:	After Appointment:
Help member prepare, understand where they're at leading up to the appointment	*Advocate! Keep the member at the center of the appointment*	*Follow up on medication changes and recommendations*
If provider is not a Thresholds partner, get a release	Ask if it's ok to bring up relevant concerns if member forgets	Get a copy of any documents for the team and the member *(On J Drive if HBH or HHC)*
Bring medication list	Help clarify communication between provider and member	Engage member in discussion of their health and wellness
Use open-ended questions and reflective listening	Find ways to increase member understanding	Discuss recommendations and follow up
Seek permission to attend appointment and clarify how to address sensitive topics	Help clarify what you can and can't do with the provider	Report updates during next team meeting
Clarify your role and how you can be helpful; coordinate transportation	Set the follow up visit if possible	Put next appointment in team calendar *(Emailed biweekly if HBH or HHC)*
Use worksheets like: *Tips for using your voice, Pre/Post Appointment form*	*Review Pre Appointment form during the appointment*	*Complete Post form*

Integrated Healthcare involves staff as:

- Advocate
- Historian
- Communicator
- Follow Upper with member
- Follow Upper with medical staff
- Follow Upper with team

The aim is to ensure maximum benefits for the member from services

Thresholds Integrated Healthcare Partners:

Heartland Health Centers (HHC)

Howard Brown Health (HBH)

Aunt Martha's

Consider: *Social determinants of health*

Social determinants have negatively impacted the health of persons with serious mental illness as historically healthcare was limited or denied to them. This contributes to the life expectancy of members being 25-30 years lower than the general population. The average life expectancy in the USA is about 79 years; unfortunately this means many members are likely to die in their 40s and 50s.

Seek positive relationships with PCP, psychiatrist, member and Thresholds.

Members may *be* anxious and distrustful from a history of lack of engagement and/or mistreatment in the healthcare system.

Helping members overcome social determinants leads to:

- Increased independence
- Member's being in charge of their own healthcare and increased ability to focus on their mental health recovery
- Live longer, more fulfilling lives

Social Determinants
Poverty
Substandard housing
Limited access to Healthcare
Unemployment
Lack of support
Co-occurring disorders

Details of Staff's role

Before Appointment:	During Appointment:	After Appointment:
Help member prepare, understand where they're at leading up to the appointment	*Advocate! Keep the member at the center of the appointment*	*Follow up on medication changes and recommendations*
If provider is not a Thresholds partner, get a release • Do you have recent hospital discharge information? • Do you need a release to get any other medical information?	Ask if it's ok to bring up relevant concerns if member forgets • Prompt the member first to ask questions	Get a copy of documents for the team and the member • If provider is HHC or HBH, you can access documents on the J Drive
Bring medication list • Bring actual medications or MAR printout from pharmacy • For Injections, how often is it given? When was the last one given? • Are any meds prescribed from a different doctor?	Help clarify communication between provider and member • Make sure that the provider is not only talking to you • Redirect focus to the member	Engage member in discussion of their health and wellness • Were their questions answered? • How effective was the visit? • What do they think about the recommendations?
Use open ended questions and reflective language • *"I understand you 'don't want everyone in your business.. What if I join for part of the time, so that I can help set up the next appointment?"* • *"You said you want to 'feel better', what does this mean to you?"* • *"What are you hoping to get out of this appointment?"* • Complete Pre/Post appointment form	Find ways to increase member understanding • Check to make sure the member understands the information • Ask for repetition • Have the provider write things down or you can write things down • Summarize next steps • Use Teach Back method • Be proactive in addressing health literacy issues	Discuss recommendations and follow up • Identify how they want to move forward with recommendations • Address potential barriers to follow through (stage based interventions) • Determine what support they may need to follow through • Follow up with pharmacy if there were medication changes; review medication changes with member
Seek permission to attend appointment and clarify how to address sensitive topics • Recent hospitalization? • Substance use? • Hasn't been taking medications?	Help clarify what you can and can't do to the provider • Be clear if a member is going to have difficulty with follow through such as taking pills daily or caring for a wound	Communicate with team • What occurred and the plan for what's next with team; communicate any medication changes
Clarify your role and how you can be helpful • How should you be introduced? • Can you ask or answer questions? • Assist member with getting to and from the appointment	Schedule the follow up visit if possible • Specialty referrals from HHC and HBH can be printed from Centricity • Ask member if they have a preference for specialty provider • Assist in setting appointments for specialty referrals	Put next appointment in team calendar • If the provider is HBH or HHC, you will receive appointment reports twice weekly via email

FACT SHEET 1.4A, Basic Principles in Helping Relationships

The goal of a helping relationship is to help another person learn skills to resolve his or her problems. In other words, it is to help others help themselves. Helping relationships may move through these stages regularly as helpers (PHNs) must meet members where they are.

STAGES OF A HELPING RELATIONSHIP

Stage 1: The Current State of Affairs

Goal: Help a person identify and make sense of problem situations in his or her life Skills: Active listening skills

Stage 2: The Preferred Scenario

Goal: Help a person decide what they need and want by weighing the pros and cons of certain decisions

Skills: Decision making skills

Stage 3: Strategies for Action

Goal: Help a person figure out how to get what he or she needs and wants Skills: Problem solving skills

BASIC VALUES OF A HELPING RELATIONSHIP

Empathy: This is a feeling that you can share another person's emotions and experiences and be able to reflect this back to the person. *feeling with rather than feeling for (i.e. sympathy)*

Genuineness: This is an openness and honesty in your reactions to another person. You must be aware of your own reactions to others in order to honestly respond to another person. This may include some self-disclosure, but be mindful of what you disclose. Chapter 5 explores self-disclosure in greater detail to help you incorporate appropriate self-disclosure into the helping relationship.

Unconditional Positive Regard: Even if you do not agree with a person's behaviors, try to separate the person from his or her actions. Warmth and acceptance of the person are important pieces of a good, helping relationship. Unconditional positive regard sounds wonderfully supportive, but it may not always be easy. Challenges to unconditional positive regard that PHNs may experience include members avoiding meetings, becoming confrontational, experiencing challenges with hygiene or incontinence, or not being open about what's going on.

Strengths-Based Approach: An approach that identifies and builds upon the positive resources and abilities that members already have.

Egan (1998), as cited in University of Chicago Center for Psychiatric Rehabilitation (1999).

WORKSHEET 1.4B, Basic Helper Principles in Your Life

Review the Basic Principles in Helping Relationships sheet, considering the values of **empathy**, **genuineness**, and **unconditional positive regard**. Try to think of two times in your life when you needed help. Think of a positive experience, or a time when you benefitted from another person who embodied these values. Then think of a negative experience, or a time when you did not get the help you needed. Here is an example of a positive experience:

Time in your life: *In elementary school*

Helper's name: *Mrs. Olivia, my teacher*

What did he or she help you with? *I was having trouble paying attention in school. I didn't want to be different or bring attention to myself, so I didn't tell anyone. My teacher noticed that I was having trouble and sat me down to talk about it. She didn't ask too many questions and just listened to what I had to say, without interrupting me.*

How did you feel at the time? *I got to say what I was frustrated about without feeling like she was judging me. I really felt like she cared what I had to say and wanted to find a way to help.*

Now let's try examples from your life.

Time in your life:

Helper's name:

What did he or she help you with?

How did you feel at the time?

Time in your life:

Helper's name:

What did he or she help you with?

How did you feel at the time?

University of Chicago Center for Psychiatric Rehabilitation (1999).

FACT SHEET 1.4C, Using Worksheets with Members

1) Keep in mind what you are trying to do. (It could be more than one thing.) Set your intention and plan out what you can do to be effective.

What is your Intent?	What can you do to be effective?
Educate	Tailor information to the member
Understand their experience	Use of reflections often. This helps you communicate you are listening and ensures you are understanding them correctly
Problem solve	Think Harm Reduction and step by step incremental change
Draw out member's strengths	Be ready to probe and ask questions to elicit member's wisdom and experiences
Other	???

2) Make plans ahead of time to get the member a copy of the worksheet.
3) Seek permission to use the form and to explain what it is about and how it can help the member.
   a) Make sure you **sell it**. If you believe it is a good tool it will probably be a good tool. If you don't it won't.
   b) Be clear about what you want them to be involved in when completing it/ going over it and voice your belief that this would be in their best interest. Try to get their buy in to the process.
   c) Are there any hopes for how the worksheet will be used going forward? If they know you will want to revisit the form in the future (next visit?) this helps the discussion to be more realistic. This is particularly important if the intent behind the worksheet is to problem solve or make plans.
      i) When explaining a form include an explanation of why revisiting the worksheet will help them.
   d) Consider if it makes sense to seek permission to bring the worksheet on the next visit.
4) Make the form interesting and relevant so the member will stay engaged in the process.
   a) How does the member learn best? How can you adapt the worksheet to them?
      i) How easy or hard is reading for the member? Would they be willing to read it out loud?
      ii) Are there any distractions that could get in the way (ie. TV on in the background?)
   b) It is best if you both have a completed copy of the worksheet when you finish. This often takes some planning to accomplish.
   c) Use Reflections and Summaries often to keep the focus on the member's perspective and to check to see if you are both understanding it in the same way.
5) When you are done using the worksheet how do you want to finish? What was your intent? How can you draw attention to what will be useful going forward?
   a) Ask the member for a summary or ask an open-ended question to learn what they got out of it. Depending on your intent you will probably have a different question.

What was your Intent?	What is the best way to finish up?	Example
Educate	Use "teach back" to check on understanding	Can you teach this back to me to make sure I explained it to you correctly?
Understand their experience	Invite member to identify what was most important for them	What stands out the most from this? What is was the most important thing we discussed?
Problem solve	Make plans to check back on how things went on future visits	Is it OK if we check back in on this next visit? Any other ideas on what you think might help this go well?
Draw out member's strengths	Reflect on strengths and pivot to steps to take next?	Wow, you've got a lot you are doing right! It makes me wonder if what your plans are moving forward.
Other	???	?

b) Provide your own summary (better to get the member's summary before giving your own). Tailor your summary based on your intent for the worksheet.
c) Develop a plan for moving forward with a specific timeline (homework for you or member?).
   i) Can rewards or cues be set up to prompt the behavior?
      - i.e., Alarm on the phone, plan to practice it after morning coffee..

6) Thank them for doing the worksheet with you.

<u>General Tips</u>

a. Keep in mind that the worksheet is a tool for conversation and not the goal in itself.
b. The member is an expert in themselves. Be curious about their experiences/ beliefs.
c. Think Harm Reduction and Change Talk. The change process is often slow.
d. If you are meeting over the phone you can still use worksheets but you may need to coordinate getting them a hard copy. (This can help with billing)
e. There is value to writing things down. Even if reading doesn't come easy for a member consider drawing pictures.
f. If going over the worksheet brings up more questions it is Ok for you to not know all the answers. For medical issues consider referring them to their doctor.
g. Pacing matters – Don't go too fast or slow. And is the correct pace to seek permission to bring the worksheet on the next visit.
h. Be ready to negotiate with the member to make it go well and to maintain their motivation to go over it. Consider looking at the worksheet over a couple of visits.
i. If on a team, can the worksheet help make information sharing or planning easier?

FACT SHEET 2.1, Office Etiquette

Office etiquette is the manner you should conduct yourself in the workplace. Working in an office may be new to you. While each office has a unique "vibe" to it, the following are some general guidelines to help familiarize yourself to the office setting.

DRESS/HYGEINE

Do: Shower before work and use deodorant. Wear clothes that fit you and that are appropriate for work in the field. Wear shoes that you can walk in.
Don't: Wear revealing clothing or shirts with inappropriate slogans (alcohol or drug related, religiously themed)

CALLING IN SICK/TIME OFF

Do: Let your supervisor know BEFORE your shift starts that you will be out sick. Keep the supervisor posted if illness lasts longer than one day. Ask your supervisor if it is okay before scheduling a vacation. Keep track of sick/vacation days on your own.
Don't: Tell your supervisor you are taking a vacation; ASK. Don't have your supervisor wonder if you are coming in to the office for your shift. Don't schedule personal appointments during work hours, unless it cannot be helped. Don't come to work if you are too sick.

CELL PHONE USE

Do: Keep your personal phone on vibrate while in the office; turn it off when you are in a meeting. Limit personal calls and texting to lunch or break times if possible. Step outside to take personal calls.
Don't: Take calls when you are in a meeting or training or talk loudly about non-work related business during work time. Don't set your ringtone to loud or text friends often during work. Don't use your work phone for personal calls.

SCHEDULE

Do: Know your schedule for the week ahead of time. Let your supervisor know if you are out in the field, at the clinic, or in the office on a given day. Notify your supervisor ahead of time of changes. You are still on duty when you are with a member, even if your usual quitting time has passed.
Don't: Assume that your supervisor knows where you are. Don't run personal errands on work time if you are out in the field.

EMAILING/COMPUTER USAGE

Do: Be formal in your communication; think of emails as you would a formal letter. Be aware that organizations may have access to your email and browser history. Check your email 2-3 times daily.
Don't: Use slang or unknown abbreviations in your correspondence. Don't download personal items onto your work computer or view objectionable websites while at work.

CONFLICTS WITH CO-WORKERS

Do: Try and resolve conflicts before they get out of control. Talk to the person who you are in conflict with before going to supervisor to see if situation can be resolved. If it cannot, then talk to your supervisor about possible solutions. Treat others with respect.
Don't: Talk about co-workers behind their back. Don't call people names, insult them, or curse at co-workers.

WORKSPACE

Do: Keep personal info on members in a safe place. Keep your space neat and tidy. Throw away garbage each night before leaving workspace.
Don't: Take home files that contain confidential information. Don't leave valuable personal items on your desk unattended. Don't leave a mess for others to clean up. Don't listen to loud music at your desk. Don't wear lots of perfume.

FACT SHEET 2.2A, Street Smarts

STAYING AWAY FROM DANGEROUS PLACES

Do: Get acquainted with the area and the people that live there. Walk during daytime hours; avoid walking in alleys. Keep your eyes and ears open. Leave if you feel any danger. If something or someone makes you nervous, cross to the other side of the street or take a different route.

Don't: Walk alone at night. Don't wear headphones that impair your ability to hear what is going on around you. Don't question people's activities or start a fight. If you see something that needs to be reported, call 911.

KEEPING VALUABLES SAFE

It is important to keep your personal items (phone, wallet) in a place that is not easy for burglars or pickpockets to access. Using your work laptop in a safe manner (not on a street corner or out in open).

Do: Keep your personal items in a place that it is difficult to access (zipped pocket of a backpack, front pants pocket). Use your laptop indoors when providing services if possible. If not, don't use in a crowded area where many people can see you. Purse and bag straps should go over your shoulder.

Don't: Flaunt or brag about the valuables you have on you. Don't take your wallet out, unless absolutely necessary. Don't leave valuables unattended for any length of time.

RIDING PUBLIC TRANSPORTATION

You may have to take the train or city bus during your work as a PHN. While public transportation is mostly safe, crime does occur.

Do: Know where you are going and the route you plan on taking before you get on the bus or train. Wait in well-lit areas so you are visible. Sit in the front of the train (near the conductor or bus driver) if you are at all nervous or it is late at night. Know where the emergency communication button is located.

Don't: Take out a map on the train; it shows that you may be lost and can make you look vulnerable. Don't fall asleep, leave valuables unattended, or take them out of your purse or bag. Don't tell strangers where you are going or give out personal information to fellow riders.

TALKING TO STRANGERS

Do: Be polite and say hello if approached. Smile and nod if a stranger keeps on trying to talk to you. Know you are not obligated to keep a conversation going if you are nervous. Call the police if the person does not leave you alone or you feel threatened.

Don't: Give out any personal information to someone you do not know (phone number, address or neighborhood you live in, or where you work). Don't yell at someone if they are bothering you; this could escalate the situation.

WHAT TO DO IF YOU ARE A VICTIM OF A CRIME

Avoid being a hero: Do not chase someone who has stolen from you. Give up your property in a theft and move away peacefully. Do not get involved in trying to rescue someone else from being a victim. When needed, don't yell "help." Yell "fire!" Always call the police if you have been the victim or witnessed a crime.

Make police report: Always report any crime, no matter how small, to the authorities. Provide as much detail as you can. If the police are not nearby, go to the nearest police station or call 911.

Talk to your supervisor: Let your supervisor know what happened immediately. Talk openly about the incident if you are able and tell the supervisor if you feel traumatized.

Corrigan (1998).

WORKSHEET 2.2B, Street Smarts Experiences

What should you do to stay safe?

- _____

  _____

- _____

  _____

- _____

  _____

- _____

  _____

- _____

  _____

- _____

  _____

- _____

  _____

FACT SHEET 2.3A, Time Management

As a PHN, you will need to use your time wisely and fit many tasks into your workday. Below are some tips for **managing your time**.

GET ORGANIZED

Do:

- Check your email first thing in the morning to see if any last-minute items need attention.
- Spend the first 5 to 10 minutes of your workday making a to-do list.
- Enter your schedule for the day into your Outlook calendar.
- Go over your written to-do list and identify which items are of highest importance and start your day on those.
- Before making or returning a call, write down the things you need to accomplish, so you don't forget something.
- Stick to your schedule as much as possible, but be willing to re-arrange items as needed.
- If you begin to feel overwhelmed by too many tasks, talk to your supervisor BEFORE you fall behind.
- Take lots of notes throughout the day.

AVOID PROCRASTINATION

Do:

- Be realistic about the time it will take you to complete tasks and make sure to schedule ample time to complete them.
- When traveling to appointments with members, overestimate travel times, in case of traffic or public transportation issues.
- Don't push tasks off for later that can easily be done now. You may forget to do them.
- If you need to reschedule an appointment, do so as far in advance as possible.

LIMIT DISTRACTIONS

Do:

- Limit time spent on computer for personal use, especially websites like Facebook, YouTube, and personal email.
- Make personal phone calls during your break or lunch hour.
- Run personal errands before or after work hours.
- Turn your phone to vibrate when you are in meetings or with a member so you are not tempted to answer during these times.

Boe (2012).

WORKSHEET 2.3B, Time Management

Instructions: Sort these tasks into your daily schedule.

1. Fred has a 9:00 am appointment with the podiatrist at UIC medical center.
2. Recruit new members.
3. Attend staff meeting at 3:00 pm
4. Morris has a 12 noon chest x-ray at John Stroger Hospital
5. Take a break
6. Meet with program supervisor
7. Have lunch
8. John has a 1:00 pm dental appointment
9. Fred and Mary do not like each other
10. Check email
11. Help a coworker with problem(s)
12. Do paperwork, fill out time log
13. Tell supervisor about weekly in-the-field schedule
14. Return phone calls
15. Mary has a 9:00 am appointment at John Stroger hospital to have her blood drawn
16. Call members about appointment

Date _____

Appointments

AM 6:00	
6:30	
7:00	
7:30	
8:00	
8:30	
9:00	
9:30	
10:00	
10:30	
11:00	
11:30	
PM 12:00	
12:30	
1:00	
1:30	
2:00	
2:30	
3:00	
3:30	
4:00	
4:30	
5:00	
5:30	
6:00	

Now, take this same information and enter it in your electronic calendar (e.g., Outlook, Google Calendar).

FACT SHEET 2.4A, Managing Burnout

Trauma-through-others is a stress reaction experienced by PHNs being exposed to traumatic experiences of your members. As a result, you may experience burnout in your interactions with others and the world.

SIGNS OF TRAUMA-THROUGH-OTHERS

- **Feeling of hopelessness and helplessness:** Thinking you are not able to do anything for yourself or others, or you can never do enough.
- **Hypervigilance:** Being constantly on guard or tense.
- **Diminished Enjoyment:** Not being able to or not feeling like doing things you used to enjoy.
- **Chronic Exhaustion:** Feelings of extreme fatigue despite getting enough rest.
- **Inability to listen:** Having trouble paying attention to others or focusing on others.
- **Sense of paranoia:** Feeling like others are "out to get you."
- **Guilt:** Feeling badly because you think that you have done something wrong.
- **Fear:** Being scared of things you used to not be scared of.
- **Anger:** Having feelings of rage at times when it is not appropriate to the situation.
- **Inability to Empathize:** Not being able to feel appropriately for someone else's pain or suffering.
- **Addictions:** Use of alcohol and other substances in ways that are harmful to you and have been problematic in the past.
- **Grandiosity:** Over exaggeration of feelings; seeming to be impressive but not really practical.
- **Reliving One's Own Trauma:** You may also have experienced trauma. Sometimes, hearing member stories can lead to flashbacks of one's own traumatizing memories.

WAYS TO DEAL WITH BURNOUT

- **Reframing your approach:** Changing the way you look at and approach a situation. Instead of worrying you may not be able to help, try thinking about how you are going to help.
- **Things to remember:** There is only one of you and you are important to the work you do.
- **Supervision:** Talk to your supervisor about obstacles/issues that come up in your work on a regular basis (think of a release valve letting off steam so it doesn't blow up).
- **From other team members:** Bounce ideas and problems that arise off your team members in order to work through an issue and come up with a solution.
- **Relapse plan:** It is vital for you to have a plan in place to keep yourself healthy. **See Relapse Prevention factsheet.**
- **Positive time:** Take time for yourself during the workday to have a cup of coffee or lunch with a team member.
- **Positive Self-statements:** Tell yourself things like, "I can do this" or "I am good at this."
- **Boundaries:** Maintaining clear guidelines, rules or limits for yourself as to what are reasonable, safe and permissible ways for other people to behave around you. **See Relationship Boundaries Factsheet.**
- **Get Professional Help:** Do not be reluctant to get assistance from a professional when burnout becomes overwhelming, especially when you are reliving your own experience with trauma.

Dobbins (2012).

WORKSHEET 2.4B, Managing Burnout

Based on what you've learned from your life experiences, what might burn you out being a Peer Health Navigator?

1.

2.

3.

4.

What are some signs you may be burned out?

1.

2.

3.

4.

Let's come up with a plan to handle burnout. What might you do if you notice that you are starting to feel burnt out?

1.

2.

3.

4.

FACT SHEET 2.5, HIPAA

HIPAA, (Health Insurance Portability and Accountability Act), of 1996, is a federal law that gives people rights over their health information, and sets rules and limits on who can look at and receive their health information. As a PHN, it's important that you understand basic HIPAA rules.

Members have the right to:

- Get a copy of their health records.
- Have corrections made to their health information.
- Receive notice that explains how their health information may be used and shared.
- Decide if they want to give their permission before their health information can be used or shared.
- Receive a report on when and why their health information was shared.

Who must follow this law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, **peer health navigators**, and all other healthcare providers; including clerical and administrative staff.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What information is protected?

- Information that healthcare providers put in members' medical records.
- Conversations doctors have with their patients.
- Information about member's health insurance.
- Billing information.
- Other health information, held by those who must follow this law.
- Other examples of protected health information (PHI) include:
    - Names
    - Birthdates
    - Social Security numbers
    - Addresses, telephone numbers, and email addresses
    - Medical record numbers.

What does HIPAA mean for Peer Health Navigators?

- PHNs are required to follow HIPAA and keep all member information private and secure.
- PHNs cannot use or share members' PHI without members' signed permission.
- Even if you have a members' signed permission to share PHI, agencies still have rules about keeping their members' PHI secure. For example, some agencies never allow staff to email certain PHI, such as member's full name and Social Security number—to anyone. Be sure to discuss your agency's PHI security rules with your supervisor.

2.6 TEAM APPROACH

PHNs, like other providers in community mental health, should consider taking a team-based approach to working with members. A team approach means that PHNs share caseloads, so all members are served by all PHNs. Members will likely have a "primary" PHN to serve as the primary point of contact with the clinical team and for documentation purposes. This team approach can help alleviate the stress of a singular caseload and allow for maximum coverage and flexibility.

The team PHNs can serve a limited number of clinical treatment teams at a time for maximum collaboration. PHNs should aim to attend clinical treatment team meetings regularly and communicate member needs, upcoming appointments, progress, and barriers to engagement. Discuss with trainees what this might look like in practice, possible advantages, and talk through any anticipated challenges.

2.7 DOCUMENTING SERVICES

Documentation (sometimes referred to as notes) is what providers call records that are used to describe mental health services that people receive. Typically, each service provided (e.g., a meeting with a member in the community, going into a medical appointment with a member, consulting with a member and their mental health provider) should be recorded in a note. Where these notes are recorded—in an electronic health record system (EHR), in paper charts, or another system—and who has access to them will differ based on the organization you work with. Refer to your organization's documentation system and requirements for specific information—this section will cover effective documentation of peer services more generally.

First, we will have a brief discussion about the use of notes and their purpose. Let's work through work sheet 2.7.

Handout WORK SHEET 2.7, Why Document Services?

Take a few moments and write down some responses to the first question about the overall purpose of documentation, then we will discuss. (Some responses might include payment from insurance, tracking progress toward goals and recovery, continuity of care, credentialing bodies like CARF that ensure the quality of services being provided.)

Now let's look at the second question about the different audiences who may read their notes (e.g., the member themselves, an insurance provider, another service provider) and why. After each one listed, identify WHY your documentation/notes might be important to them. What problems may arise if your notes are inadequate or incomplete? What might be important for them to see written in your notes? Afterwards, we will discuss anything that seems particularly important or anything that stands out.

On pages, 47 through 51, we'll read aloud the information on common components of a note and ways to incorporate recovery-promoting language. Then, to yourself, read the example of an effective note. Mark where you see the different components mentioned above (e.g., Problem/Need, Intervention, Response, Progress/Plan). Underline where you see recovery-promoting language used. Circle any jargon or abbreviations that could be spelled out and look up their meanings if you're unfamiliar.

Finally, I will describe a meeting that you as a PHN might expect to have with a member. Under "Practice Writing a Note," encourage the PHN(s) to write up a note, either all together as a group, by dividing the note with each PHN writing a section or two (e.g., problem, intervention, response, progress, plan), or individually. Then discuss each component and how you could incorporate as much recovery-promoting language as possible.

Facilitator note: When describing the meeting, be sure to include a bit of background about the member, such as diagnosis, their challenges and goals, their behavior during the meeting, and response as well as what the PHN did and how the member reacted.

WORK SHEET 2.7, Why Document Services?

What are some of the reasons we should document services accurately and thoroughly?

1. _____
2. _____
3. _____
4. _____

Below are some groups/individuals who may be interested in reading your notes about the peer navigation services you provide. After each one, identify WHY your documentation/notes might be important to them. What problems may arise if your notes are inadequate or incomplete? What might be important for them to see written in your notes?

- The member/service recipient: _____

  _____

- Payers (e.g., insurance companies, managed care organizations): _____

  _____

- Other providers (e.g., the member's mental health provider): _____

  _____

- Credentialing organizations (CARF – Commission on Accreditation of Rehabilitation Facilities):

  _____

  _____

- Judges/lawyers in court proceedings: _____

  _____

How does your organization require you to document services (e.g., in an electronic health record, written notes in a physical chart, etc.)? How soon after completing a service should you have your note completed according to your organization (e.g. within 48 hours, 2 business days, 1 week)? Is there a format that they prefer notes to be written in (e.g., SOAP, PIRP, BIRP)? Consult with leaders, supervisors, and staff in other departments if needed to find out more about what your organization will ask of you.

_____

_____

_____

_____

Common Components of a Note

Different organizations and payers will require different things to be described in a note. Refer to your organizations' training for the style of notes they prefer. Below we list some common components in documentation that may be helpful to consider:

Problem/need: Your notes may be used to determine whether the service was medically necessary. Usually, this is framed as a challenge or deficit experienced by the member in some area of functioning (e.g., social/interpersonal interactions, managing finances, remembering appointments) due to symptoms of their mental illness.

> Example: "Due to excessive anxiety and persistent worry, staff supports Arielle in maintaining healthcare appointments."

Intervention: These usually describe the actions you as the peer health navigator took to help address the problem or need. These will use action verbs like "coached," "taught," or "reviewed."

> Example: "PHN coached Arielle through making calls to providers using role play and reviewed coping strategies the member has learned in therapy to reduce anxiety."

Response: How did the member respond to your intervention? You'll want to use observations or quotes rather than opinion here.

> Example: "Arielle stated, 'I feel a bit more confident now!' as she smiled, stopped wringing her hands, and relaxed her shoulders."

Progress & Plan: Describe what progress toward their goals the member made during the session—this may tie back toward goals and objectives in their treatment plan. Again, use observation statements rather than your own impressions. Then discuss what you and the member plan to do next.

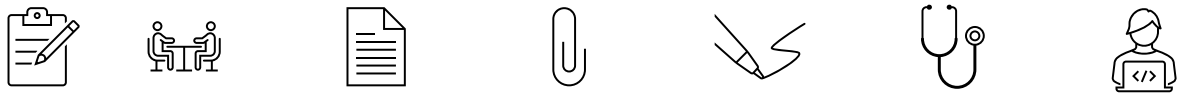
> Example: "Arielle made progress as evidenced by completing role play of a scheduling phone call with minimal distress. Staff and member will next develop a script for her to use during scheduling calls to further address feelings of anxiety on the phone."

Recovery-Promoting Language

As you may have noticed, the deficit-focused language used in documentation does not always align with the hopeful, strength-based approach you take as a peer health navigator. However, there are ways to make your notes more recovery-oriented and less stigmatizing. We have included some below—what other ways can you think of?

- **Write as if the member will read it.** It is, after all, their right to access their health records, so they very well may! Your word choice may shift naturally when thinking this way.

- **Emphasize autonomy over compliance.** Rather than using words like refused, resisted, noncompliant, try using words like "declined," "said no," or "disagreed."
- **Write about symptoms they experience rather using labels.** A member may be experiencing delusional or paranoid thoughts, but you should not describe them as being "delusional" or "paranoid." Labels such as this can make their experiences and challenges seem permanent and unchanging; use language that allows for change and progress.
- **Focus on what is working rather than simply naming deficits being addressed.** Be specific about what actions are contributing to progress. For example, "Rich stated that writing down upcoming appointments in the planner the PHN helped him get has helped him remember and attend all health appointments this month," is specific and strengths-focused, rather than "Rich is treatment compliant and has no missed appointments this month."
- **Include client perspective and narratives.** This includes things they share about their services, treatment decisions, accurate accounts of their challenges, and things they identify as helpful to their recovery.
- **Avoid jargon when possible.** Abbreviating words and phrases are often used as a sort of shorthand (e.g., "ETOH" instead of alcohol, "tx" instead of treatment, "AEB" instead of as evidenced by). Reducing jargon will make the document more accessible to future providers and peers to help continuity of care. This will also make it easier for the member to read and understand if they access them.
- **Briefer is usually better.** While there are quite a few components that may be important to include in your notes, try not to write with *too much* detail. Keep in mind the key information that will be crucial for someone to see and stick with facts about the member and the appointment. This balance will become easier with practice.



An Example

Review the following example of an effective note. Mark where you see the different components mentioned above (e.g., Problem/Need, Intervention, Response, Progress/Plan). Underline where you see recovery-promoting language used. Circle any jargon or abbreviations that could be spelled out, and look up their meanings if you're unfamiliar.

Due to sx of schizoaffective d/o including disorganized thought patterns, experiences of paranoia, and AVH, Jamie experiences difficulty remembering healthcare appointments and following up on treatment of their diabetes, so staff supports them in attending appointments. PHN met with Jamie to review the pre-appointment checklist and coached them to write down important questions to ask their doctor. PHN then supported Jamie in taking public transportation to their appointment by listing out the directions, showing them how to use their bus pass, and modeling safe travel behaviors. PHN also helped Jamie identify and implement coping skills to deal with feelings of paranoia such as grounding techniques and reality testing while riding the bus. Jamie was on time for the visit and was prepared to discuss the upcoming healthcare appointment with staff. Jamie presented with a neutral mood and flat affect at the

start of the visit. Jamie identified several questions they wanted to ask the doctor but reported they did not want to write them down because of privacy concerns related to PA. While traveling to the appointment, Jamie appeared stressed, AEB frequent fidgeting and looking over their shoulder in response to AVH. After the appointment on the way home, Jamie appeared more relaxed and stated, "Riding the bus alone is a little scary, I don't always remember where I'm supposed to go, and I feel like people are looking at me. Practicing with you makes it a little easier." Jamie continues to make progress toward their goal of attending healthcare appointments and following doctor's recommendations independently as evidenced by their preparedness for the meeting with PHN and willingness to ride the bus with support. Next week, PHN will accompany Jamie to the local farmer's market to help them identify diabetes-friendly foods recommended by the doctor and manage mental health symptoms when shopping with crowds.

Practice Writing a Note

Write a note for the service described by the training facilitator. Collaborate as a team to complete the different components and edit as necessary to use more recovery-oriented, strengths-based language.

Mental Health America Allegheny County, (2012). "A Guide to the Use of Recovery-Oriented Language in Service Planning, Documentation, and Correspondence." Created by Jamie Harris & Kristyn Felman. https://assets.website-files.com/5a13853ae83c4100019201c8/5fd91448e81d685e8729a58a_Recovery-Oriented%20Language.pdf

FACT SHEET 3.1A, Roadblocks to Good Listening

Good listening results in the listener being able to help the speaker recognize and identify problem situations and help to find potential solutions. The listener can help the speaker by employing good listening skills, but certain roadblocks exist that will keep speakers from telling their story. Categories of roadblocks include: **judging**, **problem solving,** and **avoiding**.

JUDGING

Criticizing: Negatively evaluating the person, his or her actions, and attitudes.
Name-calling: Labeling the person with negative names or terms, putting the person down disrespectfully.
Diagnosing: Minimizing the complexity of the person's thoughts and behaviors, perhaps attributing them to nonsense due to his or her mental illness.
Praising Evaluatively: Broad praise can lead the listener to depend on this praise and can limit the openness of the conversation.

PROBLEM SOLVING

Ordering: Demanding the person to do something in order to solve a problem.
Threatening: Warning the person that his or her behavior will unavoidably result in harm.
Moralizing: Informing the person that his or her behavior is sinful or indecent.
Excessive Questions: Controlling the conversation by asking too many questions. This may help the listener control the situation but it does not help speakers tell their story.
Advising: Similar to asking too many questions, advising prematurely does not allow for the person's story to be heard or for their existing strengths and ideas to be honored and brought to bear on the situation. Advice can be distracting.
Directing: Telling the person what to do to solve a problem instead of presenting choices and options.

AVOIDING

Diverting: Changing the topic from the speaker's concerns to another topic, either in a way to move the attention back toward the listener or to avoid feeling uncomfortable about the topic being discussed.
Logical argument: Ignoring the emotional parts of the person's message while focusing on the logical facts of what the speaker is saying.
Reassuring: Soothing or consoling the person in a way that it is perceived as diminishing the person's story or the message they are trying to express.
Pre-Contemplation: Sometimes it is easy to avoid discussing a topic that the person is in pre-contemplation around for fear that it is too sensitive. And while we don't want to make the person feel judged, we also don't want to ignore the issue either. Striking a balance between ignoring the problem and making them feel judged is what we are aiming for.
Drawing attention to self: Focusing too much on one's own self, actions, and story.

Bolton (1979), as cited in University of Chicago Center for Psychiatric Rehabilitation (1999).

WORKSHEET 3.1B, Examples of Roadblocks

Try to identify which type of roadblock is being modeled in the role play:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

FACT SHEET 3.2A, Good Listening Skills

Good listening skills help the listener understand both the obvious and hidden messages behind what the speaker is saying. These skills help the speaker feel confident that his or her story is being heard. Categories of good listening skills include: **attending**, **following**, and **reflecting** skills.

ATTENDING SKILLS

A posture of involvement: The listener's posture can let the speaker know that his or her message is being heard.

Appropriate body motion: A listener who is too still may appear distant to the speaker. Simple motions of nodding or leaning forward can let the listener know you are paying attention.

Eye contact: The listener should continue to make eye contact with the speaker while he or she talks, unless the eye contact is making the speaker uncomfortable.

Non-distracting environment: A noisy or distracting environment can create a barrier between speaker and listener. The listener should try to limit the interruptions and talk in a space where the speaker can talk freely.

FOLLOWING SKILLS

Door openers: Make sure not to start the conversation with a roadblock. Good door openers provide an invitation to talk followed by silence, giving the person a chance to talk.

Minimal encouragers: Simple statements, such as "right" or "go on" or a nod of the head can let the speaker know you are listening.

Infrequent questions: Questions can help direct the speaker, but not all questions are helpful. Asking a closed-ended question that can be answered with one or two words does not encourage conversation, whereas an open-ended question does. This type of question begins with a word like what, why, or how, encouraging the speaker to continue.

Attentive silence: Being quiet, while showing the speaker you are listening, is one of the best ways to help. Eye contact and minimal encouragers can let the speaker know you are listening, while letting the speaker do most of the talking.

REFLECTING SKILLS

This type of listening skill involves reflecting, or returning, the speaker's message, including both the obvious and potentially hidden message. The obvious message is the exact meaning of what the person says, while the hidden message takes into account the mood and emotions of the speaker.

Paraphrasing: Restating the core of the speaker's message in the listener's words. It is concise, focusing on the content of what was said, balancing the speaker and listener's speaking styles. This focuses on the obvious message.

Reflecting feelings: This focuses on the hidden message of what the speaker is saying. By listening for feeling words and observing body language, the listener can hear the speaker's feelings and echo them back to the speaker. This often works well when the feeling to reflect is hesitancy. It can be good to acknowledge when things can feel stuck.

Reflecting meanings: This involves tying the obvious and hidden messages together. By tying the speaker's feelings to the content of his or her message, speaker and listener can think about the overall meaning of what the speaker is saying.

Summary reflections: By summarizing the flow of the conversation, the listener can reflect themes or common statements the speaker is repeating.

Bolton (1979), as cited in University of Chicago Center for Psychiatric Rehabilitation (1999)

WORKSHEET 3.2B, Obvious and Hidden Messages

PART 1

Write down the possible hidden messages for each of these examples. Remember, the hidden message is defined by the context of the situation and the speaker's mood.

Context/Mood: *The speaker is a sore loser and just lost to the listener.*
Obvious Message: *Nice game.*
Hidden Message:

Context/Mood: *The speaker is a frustrated teacher.*
Obvious Message: *I can see you're really paying attention.*
Hidden Message:

Context/Mood: *The listener wants to learn something from the speaker.*
Obvious Message: *What were you thinking?*
Hidden Message:

Context/Mood: *The speaker is with a friend who just ran a marathon.*
Obvious Message: *I can't believe you did that.*
Hidden Message:

Context/Mood: *The speaker is standing with his arms crossed and frowning.*
Obvious Message: *I'm fine.*
Hidden Message:

PART 2

Write down the hidden message and context/mood for two example situations and see if your fellow trainees can guess the hidden message.

Context/Mood:
Obvious Message:
Hidden Message:

Context/Mood:
Obvious Message:
Hidden Message:

University of Chicago Center for Psychiatric Rehabilitation (1999).

WORKSHEET 3.2C, Feeling Words

Here is a list of words describing emotions. Looking at the chart on the next page, try to identify the best place for each of these words.

affectionate	empathetic	intimidated	sad
angry	energetic	isolated	satisfied
annoyed	enervated	jealous	scared
betrayed	exasperated	jumpy	shocked
blissful	fearful	kind	spiteful
blue	flustered	left out	stunned
burdened	foolish	loving	stupid
charmed	frantic	melancholy	sympathetic
cheated	guilty	miserable	tense
cheerful	grief-stricken	nervous	terrible
condemned	happy	OK	thwarted
contented	helpful	outraged	tired
crushed	high	peaceful	trapped
defeated	horrible	persecuted	troubled
despairing	hurt	pressured	vulnerable
distraught	hysterical	put upon	wonderful
disturbed	ignored	rejected	worried
dominated	imposed upon	relaxed	weepy
eager	infuriated	relieved	

Try to find the best place for the words on the previous page and write them in this chart:

Levels of intensity	LOVE	JOY	STRENGTH	SADNESS	ANGER	FEAR	CONFUSION	WEAKNESS
Strong	Adore Love Cherish Devoted _____ _____ _____ _____	Ecstatic Elated Overjoyed Jubilant _____ _____ _____ _____	Dynamic Forceful Powerful Mighty _____ _____ _____ _____	Desolate Anguished Despondent Depressed _____ _____ _____ _____	Violent Enraged Furious Angry Seething _____ _____ _____	Terrified Horrified Panicky Desperate _____ _____ _____ _____	Bewildered Disjointed Confused Muddled _____ _____ _____ _____	Crushed Helpless Done for Washed up _____ _____ _____ _____
Mild	Affection Desirable Friend Like _____ _____ _____ _____	Turned on Happy Cheerful Up _____ _____ _____ _____	Effective Strong Confident Able _____ _____ _____ _____	Glum Blue Sad Out of sorts _____ _____ _____ _____	Mad Frustrated Aggravated _____ _____ _____ _____	Frightened Scared Apprehensive Alarmed _____ _____ _____ _____	Mixed-up Foggy Baffled Lost _____ _____ _____ _____	Powerless Vulnerable Inept Unqualified _____ _____ _____ _____
Weak	Trusted Accepted Cared for O.K. _____ _____ _____ _____	Glad Good Satisfied Contented _____ _____ _____ _____	Capable Competent Adequate _____ _____ _____ _____	Below par Displeased Dissatisfied Low _____ _____ _____ _____	Irritated Annoyed Put out Perturbed _____ _____ _____ _____	Worried On edge Nervous Timid _____ _____ _____ _____	Undecided Unsure Vague Unclear _____ _____ _____ _____	Weak Ineffective Feeble _____ _____ _____ _____

Bolton (1979), as cited in University of Chicago Center for Psychiatric Rehabilitation (1999).

WORKSHEETS 3.2D, Practice Good Listening 1

An Anxious Time

Before you begin, review the **Good Listening Skills** Fact Sheet. Pair up with a partner and choose one of you to be the speaker and one to be the listener. Speakers should talk about a time they have experienced worry in the past six months, and listeners should use attending, following, and reflecting skills to demonstrate and practice their listening skills. For example, the speaker can pretend to be a person with heart problems who is worried about having a heart attack.

Switch roles after 10 minutes.

After you are finished, take a minute to think about the following:

As the **listener:**

What did I do that felt/seemed helpful?

- _____
- _____
- _____
- _____

What would I do differently next time?

- _____
- _____
- _____
- _____

As the **speaker:**

What did the listener do well?

- _____
- _____
- _____
- _____

What are my suggestions for the listener to do differently next time?

- _____
- _____
- _____
- _____

University of Chicago Center for Psychiatric Rehabilitation (1999).

WORKSHEETS 3.2E, Practice Good Listening 2

Pending Decisions

Choose a new partner. One person, the speaker, should talk about a pending decision. For example, the speaker can pretend to be a person trying to quit smoking or deciding whether or not to sign a new lease for an apartment. The other person, the listener, should use **Good Listening Skills** to help the speaker with the decision.

Switch roles after 10 minutes.

After you are finished, take a minute to think about the following:

As the **listener:**

What did you do that felt/seemed helpful?

- _____
- _____
- _____
- _____

What would I do differently next time?

- _____
- _____
- _____
- _____

As the **speaker:**

What did the listener do well?

- _____
- _____
- _____
- _____

What are my suggestions for the listener to do differently next time?

- _____
- _____
- _____
- _____

University of Chicago Center for Psychiatric Rehabilitation (1999).

WORKSHEETS 3.2F, Practice Good Listening 3

Uncertain Times

Choose a new partner. One person, the speaker, should talk about an uncertain time in their life. The speaker can pretend to be a person who recently separated from their partner. The second person should listen to the speaker using attending, following, and reflecting skills. You can review these skills on the **Good Listening Skills** Fact Sheet.

Switch roles after 10 minutes.

After you are finished, take a minute to think about the following:

As the **listener:**

What did I do that felt/seemed helpful?

- _____
- _____
- _____
- _____

What would I do differently next time?

- _____
- _____
- _____
- _____

As the **speaker:**

What did the listener do well?

- _____
- _____
- _____
- _____

What are my suggestions for the listener to do differently next time?

- _____
- _____
- _____
- _____

University of Chicago Center for Psychiatric Rehabilitation (1999)

FACT SHEET 3.3, Engagement Tips

Things to do on a <u>first</u> PHN visit:

- Ask/seek permission to ask about their health.
- Be curious about how they are feeling and their perception of their health.
    - Try and use more reflections than questions (e.g., "You have a busy schedule and it's hard to find time for these additional meetings. Am I understanding you correctly?")
    - Try to use more open-ended questions than closed ended questions
- Explore what help the member might want from their PHN around their health, and project hope.
- Describe the services you can provide.
    - Is your team set up to have you come consistently? Weekly or every other week?
    - Can you go with them to medical appointments?
    - Do tasks with them? (e.g., shopping, walking, or bringing information)
- Does the member have other questions?
- Try and develop commitment to health and wellness.
- Develop a plan of when you will see them again and what will be worked on.
    - Consider asking if you should bring any information about a health issue that they are concerned about.

Things to think about on <u>early</u> visits:

- Ask/seek permission, then bring information the member is interested in.
- Explore what is going on with their health currently. Connected to medical providers? How is that going?
- Explore their history around their health. For example, what went well, what was hard and how this might be relevant now.
- Consider using "Strengths-Based Goal Setting" in Chapter 4 to identify what they are already doing around health and wellness.
    - Use this form as a jumping off point for developing a SMART goal. For example: "That is great that you are already doing some walking to the store and that you notice it helps with your weight. Do you ever think about increasing your walking a little bit by taking a slightly longer route to the store?"
- Try to make space for both the usual things that are dealt with on visits and also health and wellness issues.
  At the beginning of the visit consider asking permission to split visits into these sections or develop an agenda.
- Try and have the member develop SMART goals by asking something like…"So we've been talking a lot about what healthy diets look like. Is there anything you might want to do differently this week?"

Building relationship with members (ongoing):

- Be curious about the member. What are they interested in? Where do they feel things are going well and where do they feel stuck? Use OARS to engage in active listening.
- Try to meet people where they are, both in how they think and also their location.
- Try to find things to work on with the member that they are interested in working on and not just topics you, the team or their doctor are motivated for. Developing an agenda with the member can help.
- Try to work around any barriers that arise to the relationship going smoothly. It is not your job to "fix" the problems that a member has but it is your responsibility to find ways to stay engaged in a helping relationship.
- As barriers to engagement arise seek support from your team and supervisors and consider using a strengths-based meeting to come up with new ideas around engagement.
- Setting and following up on SMART goals is hard. Don't get discouraged if things are rocky but also don't lose motivation to seek them. When it is rocky, consider a smaller goal based on something they are already doing.
- At the end of visit ask, "What was useful from what we talked about today?" Then use this to seek SMART goal.

FACT SHEET 3.4, Elicit, Provide, Elicit

Elicit – Provide – Elicit *(EPE) is a motivational interviewing technique that helps us determine what a member may already know about a topic, allowing the staff to avoid the perception of 'lecturing' and maintaining a two-way conversation while providing information. It can also be used as a guide of how to go over a handout. The hope is that EPE generates a conversation about the change process and any ambivalence. In this conversation we can focus on increasing understanding and evoking change talk while making sure we don't get too far ahead of the person. If all goes well we should be seeking to develop a SMART goal with the member (see Chapter 4).*

Outline of Elicit – Provide - Elicit

ELICIT	Staff asks the member what they know about a topic. *Member responds.* Staff listens and affirms insight the member has.
PROVIDE	Staff provides clear information/feedback that builds on what the member says
ELICIT	Staff asks member for their reaction to the information or feedback provided. This question makes it feel less like a lecture and can be used to draw out change talk. Consider what the best question is.

EXAMPLE:

Seek Permission – Seek permission to talk about the subject – "Hey, I was wondering can we talk a bit about your high blood pressure?" - Member says *"yes"*

Elicit – "What do you know about managing high blood pressure?"

Listen as the member responds – "Well, I know the white pill I take twice a day is for that"

Provide – "Yeah, you are right that medications can help. Here is a bit more information your doctor provided on how to address cardiovascular issues without using meds. This first part is an overview and then there is also this more specific information… And do I remember right that you are already working on this part? Maybe let's look at that together.." *(Then you go over the handout)*

Elicit – "So which part of this was important for you?"

Possible Questions for the second "elicit" after going over some of the information:

- What do you think about _____?
- Of the information we just looked at what is the most important part for you?

- Which of the "tips" in this handout seem like the hardest to work on? Which seem like the easiest?
- Is there a part of this you are already working on or have worked on in the past? Tell me about that…
- What would it look like if you worked on _____ just a little bit? And what would it look like if you worked on it a lot?
- How would it affect you if you worked on _____ just a little bit? And what if you worked on it really hard?
- Who do you know that was successful when working on _____? What was difficult for them? And what worked?
- Who do you know who would support you in working toward _____?

What are some other "elicit" questions you can think of?

- _____
- _____
- _____

WORKSHEET 3.5, Seeking Permission

Consider using parts of the script below as a way to seek permission. It can help to plan out what to say.

Combine a few of sections 3-6 into a single statement. Then ask permission to talk about the subject (Step 7).

	Example #1: Increasing exercise to reduce pain	**Example #2: Drinking soda when diabetic**
1. <u>Ask how the member is doing</u> around an issue related to the thorny issue.	"How is it going with your pain?"	"Hey, how's it been going with your diabetes lately?"
2. <u>Listen</u> to the member's response. And keep an ear out for change and sustain talk. You can use this later in the conversation.		
3. <u>Validate</u> the difficulty of the situation for the member.	"I'm sorry the pain in your back has been so bad lately."	"Sounds like you really hate giving yourself those insulin shots."
4. Look for ways to **<u>acknowledge possible reasons to change</u>**, maybe feedback from medical professionals.	"And If I remember right the last time we saw your Doc they thought that increasing your activity level might help with the pain."	"And If I'm remembering right your doctor thought you might not need those shots if you reduced your soda."
5. <u>Express empathy</u> that change is hard.	"But I also know it is hard to do those back exercises."	"But I also know that you really look forward to your 2 liter of soda and you aren't sure about changing it."
6. <u>Assert hope</u> that things can get better.	"And yet I also don't want to see your pain continue like this."	"And yet I also know that you have had times when your diabetes has been better."
7. <u>Ask permission</u> to discuss the subject and affirm the orientation of the conversation will be what they want to do.	"So I wonder if we can just take a minute or two to go over how things are going with your pain and what you think are ways to manage it or reduce it."	"So I wonder if we could talk a little about your diabetes, those shots and soda and what you want to do."

Choose one of the following examples and practice the steps outlined above:

- Improving sleep hygiene
- Reducing caffeine intake to manage kidney health
- Cutting down on smoking
- Setting medication reminders

Follow the steps to seek permission:

1. Ask: _____

   _____

2. Listen: _____

   _____

3. Validate: _____

   _____

4. Acknowledge: _____

   _____

5. Express empathy: _____

   _____

6. Assert hope: _____

   _____

7. Ask permission: _____

   _____

FACT SHEET 3.6, Dancing with Discord

IMPORTANT THINGS TO CONSIDER WHEN DANCING WITH DISCORD:

- If discord or sustain talk occurs, ***avoid the natural impulse*** to rebut or debate it.
- How *we* respond to discord or sustain talk can alter the behavior and change the dynamic.
- Sometimes the goal is simply reducing discord.
- Implicit in the MI approach is that persistent member discord/resistance is not a member's problem but a skill or delivery issue on the part of staff.
- Try to avoid excessively affirming or negative responses as this often leads to discord. "Wow, I'm so happy to hear this. Let's get started right away!!!" or "Oh no!! That's awful!" The key is to discern the member's subjective experience by asking an open ended question or offering a neutral reflection and then responding in a manner congruent with member affect. "How are you feeling about that?" "Sounds like you're not quite sure"
- We can ***change our style*** in ways that will decrease discord and make collaboration and agreement more likely.- See below for strategies

STRATEGIES TO DANCE WITH THE DISCORD:

Shifting focus
Attempts to get around a contentious or defensive issue by ***side-stepping*** it. Staff validates the member's experience and asks for clarification instead.

Example:
- *Member*: "I know I made a mistake, but the hoops they are making me jump through are getting ridiculous."
- *Staff:* "You're upset by all of these hoops. What mistake are you talking about?"

Coming alongside
Allows the helper to align/join with the member. It demonstrates empathy and support and invites the member to modify the original statement or agree with it.

Example:
- *Member:* "I know I made a mistake, but the hoops they are making me jump through are getting ridiculous."
- *Staff*: "You may be at your limit and might not be able to keep up with all this."

Emphasizing personal choice and control
Members ultimately have the choice to take action or not. Acknowledging this may help the member recognize that they have the right to make a choice.

Example:

- *Member:* "I know I made a mistake, but the hoops that they are making me jump through are getting ridiculous."
- *Staff:* "You have tried even though you haven't liked what they are asking you to do. Sounds like you are reconsidering whether you can or want to continue . . ."

Reframing

This technique takes a member communication and gives it a twist. It may be useful in providing a positive spin to a seemingly negative assertion.

Example:

- *Member:* "I know that I made a mistake, but the hoops they are making me jump through are getting ridiculous."
- *Staff:* "You are not happy about others having so much control, but so far you've been able to keep up with all the expectations and have been quite successful!"

Agreement with a twist

This is a technique that combines a reflection with a reframe. It gives confirmation of being "heard" and then offers another perspective.

Example:

- Member: "I know that I made a mistake, but the hoops that they are making me jump through are getting ridiculous."
- Staff: "You're feeling frustrated with all these expectations. It's clear, though, you are also committed to moving forward and being successful."

Ask an open-ended question

Instead of a statement, a question can be used to seek a better understanding of the members' perspective.

Example:

- Member: "I know that I made a mistake, but the hoops that they are making me jump through are getting ridiculous."
- Staff: "Sounds like you're pretty frustrated. What do you think is the best way forward?"

Dancing with Discord is a way of reframing "rolling with resistance." In Motivational Interviewing (see Chapter 4) there has been an appreciation that members often will not be ready to change and this can manifest itself in sustain talk or behaviors that make it clear that they are not at a point to consider change. Viewing this dynamic as discord indicates a misalignment between the clinician and member and signals the staff to change their approach with a member without judgment that the member is 'resisting' efforts to help.

FACT SHEET 4.1A, Overview of Health Problems

What are specific health care needs?

Illnesses:

- *Acute:* comes on suddenly; may get over with straightforward treatment; may lead to chronic condition if untreated.
- *Chronic:* forms over a longer period of time. Common illnesses include diabetes, high cholesterol, asthma, heart problems, arthritis, hypertension.

Other health concerns:

- Eye care
- Dental care
- Foot care
- Women's health
- HIV/AIDS services
- Mental health & substance use services
- Preventive care

Other relevant health issues:

- Nutrition
- Housing
- Hygiene

Personal decisions about health:

Personal decisions may differ from provider recommendations.

What are some barriers to using services?

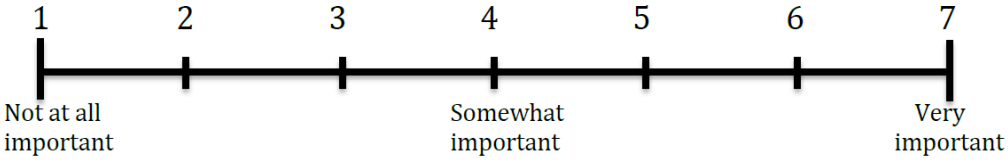
- Not enough services
- Long waits
- Lack of coordinated care
- Insurance/money
- Crisis oriented services
- Overuse of emergency rooms

How are problems worsened because of homelessness, mental illness, or ethnic disparity?

- Lack of transportation to services
- Insensitivity of staff
- Stigma
- Lack of identification
- Unaware or unconcerned with health needs
- Other more pressing needs
- Procrastination
- Confusion about treatment decisions

WORKSHEET 4.1B, Your Experience with Health Problems

Now rate how important each of these issues is on this seven-point scale:



Health issues and services

_____ Eye care
_____ Dental care
_____ Foot care
_____ Women's health
_____ HIV/AIDS services
_____ Mental health and substance abuse
_____ Nutrition
_____ Housing
_____ Hygiene
_____ Personal decisions about health

Barriers to services

_____ Not enough services
_____ Long waits
_____ Lack of coordinated care
_____ Insurance/money
_____ Crisis oriented services
_____ Overuse of ER services

Problems worsened due to

_____ Lack of transportation
_____ Insensitivity of staff
_____ Stigma
_____ Lack of identification
_____ Unaware or unconcerned with health needs
_____ Procrastination
_____ Confusion about treatment decisions

<u>Now provide an example of one key issue from your life story:</u>

FACT SHEET 4.1C, Common Health Conditions Cheat Sheet

Blood Pressure

The top number (systolic blood pressure) is a measure of the pressure in your blood vessels when your heart beats. The bottom number (diastolic blood pressure) is a measure of the pressure in your blood vessels when your heart rests between beats.[1,2]

BLOOD PRESSURE REFERENCE RANGES	
Low ("hypotension")	Systolic: 90 or less
	Diastolic: 60 or less
Normal	Systolic: 90 – 120
	Diastolic: 60 – 80
At risk ("pre-hypertension")	Systolic: 120 – 139
	Diastolic: 80 – 89
High ("hypertension")	Systolic: 140 or higher
	Diastolic: 90 or higher

Cholesterol

Cholesterol is a "waxy, fat-like substance."[2] The body needs some cholesterol, but it can build up and lead to heart disease and stroke if there's too much in your blood.[3] There are 2 types of cholesterol: LDL ("bad" cholesterol) and HDL ("good" cholesterol).

CHOLESTEROL REFERENCE RANGES	
Total cholesterol	Desired range is less than 200
LDL cholesterol ("bad" cholesterol)	Desired range is less than 100
HDL cholesterol ("good" cholesterol)	Desired range is 60 or higher
Triglycerides	Desired range is less than 150

Blood Sugar and Diabetes

The amount of sugar in your blood (also known as "blood glucose") changes throughout the day based on what you eat. When you go to the doctor to have your blood sugar tested, they will usually measure your blood sugar after a period of not eating for at least 8 hours before the test.[4] The doctor can also test the average of your blood sugar over the past 2-3 months using a test called A1C.[3]

BLOOD SUGAR REFERENCE RANGES (FASTING TEST)	
Normal	Less than 100
Pre-diabetes	100 to 125
Diabetes	126 or higher

1C REFERENCE RANGES	
Normal	Less than 5.7%

[1] Centers for Disease Control. "High Blood Pressure Fact Sheet." (2014). Available at: http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_bloodpressure.htm
[2] Mayo Clinic. "Low blood pressure (hypotension)." (2014). Available at: http://www.mayoclinic.org/diseases-conditions/low-blood-pressure/basics/definition/con-20032298
[3] Centers for Disease Control. "Cholesterol Fact Sheet." (2014). Available at: http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_cholesterol.htm
[4] American Diabetes Association. "Diagnosing Diabetes and Learning About Prediabetes." (2014). Available at: http://www.diabetes.org/diabetes-basics/diagnosis/?loc=db-slabnav

Diagnosed as having pre-diabetes	5.7% to 6.4%
Diagnosed as having diabetes	6.5% or higher. ***Most people with diabetes aim to keep their A1C levels around 7%, but this can vary from patient to patient. Consult with the doctor to determine what is best for you.

Symptoms of LOW blood sugar include[5]: Hunger, feeling shaky/weak/clammy, blurred vision or glassy eyes, feeling dizzy or having a headache, feeling sweaty, hot, or flushed, feeling tired or drowsy, mood or behavior changes, feeling inattentive or spacey, or slurred or garbled speech

Symptoms of HIGH blood sugar include[4]: Frequent urination, extreme thirst or dry mouth, sweet, fruity breath, tiredness or fatigue, increased hunger, blurred vision, nausea or vomiting, stomach pain or cramps, or unusual weight loss

[5] Wisconsin Diabetes Mellitus Essential Care Guidelines. (2012). Pages 48-49.

FACT SHEET 4.1D, Common Symptoms Requiring 911

Common Symptoms of a Heart Attack needing a 911 call (adapted from CDC website)

Pain, discomfort, pressure, squeezing, fullness in the chest
Feeling weak, light-headed, or faint
Shortness of breath
Pain or discomfort in the jaw, neck, or back
Pain or discomfort in arms or shoulder
Pain or discomfort in stomach with nausea

Common Signs of Stroke needing a 911 call (adapted from CDC website)

- Sudden numbness or weakness in the face, arm, or leg, especially on one side of the body.
- Sudden **confusion**, trouble speaking, or difficulty understanding speech.
- Sudden **trouble seeing** in one or both eyes.
- Sudden **trouble walking**, dizziness, loss of balance, or lack of coordination.
- Sudden **severe headache** with no known cause.

Acting F.A.S.T. Is Key for Stroke (adapted from CDC website)

Acting F.A.S.T. can help stroke patients get the treatments they desperately need. The most effective stroke treatments are only available if the stroke is recognized and diagnosed within 3 hours of the first symptoms. If you think someone may be having a stroke, act F.A.S.T. and do the following simple test:

F—Face Drooping: Ask the person to smile. Does one side of the face droop?
A—Arm Weakness: Ask the person to raise both arms. Does one arm drift downward?
S—Speech Difficulty: Ask the person to repeat a simple phrase. Is their speech slurred or strange?
T—Time to call 911: If you observe any of these signs, call 9-1-1 immediately

Common Warning Signs of Asthma Emergency needing a 911 call (adapted from Web MD)

- Symptoms that keep getting worse, even with treatment
- Difficulty catching your breath or talking
- Flaring your nostrils as you breathe
- Sucking in your chest or stomach with each breath
- Difficulty walking
- A bluish or grayish tinge to your lips or fingernail

Common Warning signs of a COPD exacerbation: <u>use your best judgment, but if the member is showing distress call 9-1-1.</u> (adapted from WebMD)

1. **Shortness of breath**. A sense of not getting enough air when at rest or with little physical activity.
2. **Noisy breathing.** Wheezing, whistling, gurgling, or rattling sounds.
3. **Increased anxiety.** If you feel like you're not getting adequate oxygen and feel anxious and panicked.
4. **Chest breathing.** Breathing from the chest instead of your abdomen. Breathing may become more irregular.
5. **Cough.** Coughing that's more frequent or severe than usual could indicate a COPD exacerbation.
6. **Changes in skin or nail color.** Bluish tint around the lips, purple nails, or the skin having a sallow/gray tone.
7. **Difficulty sleeping and no interest in eating.**
8. **Lack of speech.** Using hand gestures may be the only way to tell a family member that something is wrong.
9. **Morning headaches.** If morning headaches are a new symptom, it could be a sign of a COPD exacerbation.
10. **Ankle/leg swelling or abdominal pain**. If new, or increase suddenly, it could be a sign of exacerbation.
11. **Unresponsive to meds.** If prescribed medications are not controlling the breathing problems -get help ASAP.

*** When in doubt, be cautious and call 9-1-1 ***

IN-THE-FIELD PRACTICE SHEET 4.1E, Pre-Appointment Planning Sheet

Appointment Information:	Provider Information:
Date:	Provider Name:
Time:	Psych/Medical (circle one)

How am I feeling today?

What am I doing to keep myself physically/mentally well?

What physical/mental health issues have I been working on? What is the hardest issue for me to manage?

Questions I have for my provider (e.g., how can I improve my physical mental health? Are there lifestyle changes that can help me to improve my health?):

1.
2.
3.
4.

How are my medications working for me? Have I had any side effects? Have there been any medication changes since my last visit? Do I have question about my medications?

Since my last appointment I feel: WORSE SAME BETTER

Appointment Checklist:	Blood Sugar Levels (for members w/diabetes):
□ ID □ Medical Card □ Medication List	How often do I check my blood sugar? This morning my blood sugar was:

IN-THE-FIELD PRACTICE SHEET 4.1F, Post-Appointment Planning Sheet

Next Appointment Information:	**Provider Information:**
Date:	Provider Name:
Time:	Psych/Medical (circle one)

What was covered in this appointment?

What recommendations or referrals did I receive to improve my physical/mental health?

1.
2.
3.

What is my plan for these recommendations/referrals?

1.
2.
3.

Do I have any questions that were left unanswered?

1.
2.
3.

Medications Added:	**Medication Discontinued:**
Name: Dosage: Was the script sent to pharmacy Y/N (circle one) What is my plan to pick it up?	Name: Dosage: Was the discontinuation sent to pharmacy? Y/N What is my plan to remove it from my blister or to dispose?

Important Vitals:

Weight: _____ Blood Pressure: _____ AIC: _____ Other: _____

WORKSHEET 4.1G, Hospitalization Admission Checklist

Member Name:

Date:

Hospital:

The following should be provided to hospital staff upon admission *(with member permission)*.

Member signed ROI so Thresholds staff can communicate with hospital staff	□
List of member's current medications provided to hospital (copy of MAR from pharmacy if available) □ Allergies included in list? □ If member is on long-acting psychotropic injection, inform staff of date of last injection as well as done □ Provide list of any medications not included on MAR (i.e., PRN meds, injectables, inhalers, eye drops, patches)	□ □ □ □
List of member's psychiatric and physical health diagnoses provided to hospital ▪ Pertinent member history that may help hospital staff establish a therapeutic relationship and/or effective treatment plan	□ □
Names and contact info provided for the following as necessary for follow-up: ▪ Member's psychiatrist ▪ Member's PCP ▪ Team contact info (i.e., Team Leader or person assisting with admission)	□ □ □
Request team be informed of discharge plans and inform hospital staff of request	□
Advocate as necessary to ensure appropriate discharge planning begins as soon as possible for member's safe return to the community	□
Open life event in EHR to document the hospitalization	□

WORKSHEET 4.1H, Hospitalization Discharge Checklist

Member Name: Date:

Hospital:

List of current medications	□
Prescriptions for medications started in hospital to be continued at home ▪ Establish plan fill prescriptions and/or return blister packs to be repackaged with new medications	□ □
Discharge paperwork regarding what was done during hospitalization: ▪ Any pertinent lab results, procedures/tests/imaging ▪ **Date(s) of LAI administered in hospital: _____**	□ □
Have member sign ROI and fax to medical records department to request anything that unit is unable to provide	□
Provide documentation to PCP/psych providers	□
Any specialist referrals/scheduled follow-up appointments ▪ Ensure that follow-up scheduled with PCP and/or psychiatrist in timely manner *(within 5-7 for IHC)*	□
Wound care instructions *and* dressing materials ▪ Member should be aware of how to care for any wounds, when showering can resume, etc. ▪ **Member should have orders for home services if unable to complete necessary tasks independently**	□
Diet or activity restrictions:	□
Necessary assistive devices (e.g., walker, oxygen, CPAP) **& post-care instructions supplied**	□
Member trained in self-administration of injectable medication (i.e., insulin) **prior to discharge, if started on any**	□
Member able to verbalize understanding of all discharge instructions given	□
Member able to demonstrate any necessary skills	□
Document the discharge in EHR life event	□

FACT SHEET 4.2A, Types of Relationships

TROUBLESOME APPROACHES

PARENT/CHILD

Assumption: Assumes that members cannot function as responsible adults and make poor choices due to lack of knowledge and skills. PHN should do everything because they know best.

How to spot: Phrases like "If the rules are not followed, there are consequences"

Problems: Peer health navigators (PHN's) underestimate member's ability to problem solve and take initiative for their own lives. This will most likely lead to resistance.

TEACHER/STUDENT

Assumption: Members make poor choices due to lack of knowledge. PHNs have all the knowledge.

How to spot: PHN tells the members how they should feel and act and what services they should use.

Problems: PHN overlooks knowledge of the member and misses out on opportunities to learn. PHNs may force their own beliefs onto members without hearing member's experience. It is disempowering.

DRILL SERGEANT/RECRUIT

Assumption: Our way is the best!

How to spot: Rigid rules; lack of flexibility.

Problems: Efforts are focused on having members follow "our" way rather than supporting them on their own goals.

EMPLOYER/EMPLOYEE

Assumption: Members are seen as working under PHN's and staff. The PHN is the boss of the member.

How to spot: Discriminating against people with physical or mental disabilities or playing an "investigator" role when determining who comes on your caseload. (i.e., "I don't want to work with him.")

Problems: It creates a dynamic where accountability is not mutual. Opportunities for advocacy and support are lost.

RESCUER/VICTIM

Assumption: PHN's know what is best for you; members should not demonstrate independence or confidence. Members do not have their own resources. PHN's are saints and members are "damaged."

How to spot: "It is my fault if a member makes choices I do not agree with" This can lead to over-involvement (i.e., not letting a member do things for themselves) and burnout.

Problem: The PHN expects a member to be grateful, which can lead to self-doubt and lack of confidence among members.

WHAT WE WANT TO STRIVE FOR:

TEAM MEMBER /TEAM MEMBER

How to spot it: Shared learning, mutual respect, no power imbalance.

Key elements: PHN's see themselves as learners. The focus is on learning from the situation rather than controlling it. It is an environment where people can admit mistakes without shame.

Examples: Members are involved in their own healthcare goals and have the ability to voice their opinions.

Questions to guide this type of relationship: "Is this member centered?" "What can I learn in this moment?"

Dobbins (2012).

FACT SHEET 4.2B, Relationship Boundaries

Before we begin: Please review Types of Relationships factsheet

One last Relationship Type is:

FRIEND/FRIEND:

Assumption: My member does not have a lot of friends and could probably use one.

How to spot it: PHN asks member to go for a cup of coffee or hang out after work hours.

Problem: Being friends with a member interferes with being able to provide good services. It can also undermine one's relationships with other members, as they may not trust the PHN to provide services equally to all members.

STAYING WITHIN BOUNDARIES

Ignore overtures: Not giving attention to statements like "I'd love to take you to see a movie after our meeting."

Educate members on limits: Telling a member that it is against company policy for you to lend him or her money.

Make assertive comments: "Please don't ask me for my private number again." This type of communication is advised after you attempted to educate a member on limits.

DO:

- Share your story with members to the extent you are comfortable
- Express appropriate concern for your member
- Talk to your supervisor if you are unsure how to respond to a member request
- Know when to walk away

DON'T:

- Share information about yourself that is problematic or unresolved
- Socialize with members after work hours
- Engage in an intimate relationship with your member
- Offer your member a place to stay
- Promise to keep a secret for your member or ask your member to keep secrets for you
- Provide financial loans to members
- Give out private information to your member (home phone number, address, etc.)
- Use offensive language around your member
- Share alcohol or other substances

WORKSHEET 4.3, Checking In and Agenda Setting

Beginning interactions with a few "check-in" questions can be helpful for both the PHN and the member. Potential benefits of checking in include:

- Building rapport and showing care for the member
- Monitoring for changes or patterns in physical or mental health
- Increasing bodily and emotional awareness
- Identifying urgent needs or significant distress early on

Can you think of other potential benefits of regular check-ins?

_____

Please keep in mind that PHN agendas are meant to mostly focus on the person's health and wellness goals.

Check-in questions may be quite simple and straightforward but will ideally open the floor for meaningful conversations. You can use the same question every week if you're interested in how a member is doing in a specific area, or you can change it up to learn something new each meeting. Below are some examples, feel free to add your own!

- "How are you feeling today?"
- "What is something that has brought you joy today?"
- "How does your body feel today?"
- "What's your personal weather status today (e.g., mostly cloudy, foggy, sunshine and clear skies)?"
- "What have been your highs and lows this week?"
- "On a scale of 1 to 5, how do you feel coming into this meeting?"

<u>Agenda-Setting</u>

Setting an agenda can serve as an additional way for you as the PHN to get more information about the members' needs while also encouraging self-determination and empowerment. These don't need to be formal agendas. They may simply help guide your meetings with members and set the stage for goal setting. It can also help keep you from being "surprised" with important news or updates from a member at the end of a meeting.

Examples of ways to set the agenda:

- What are some things you want to discuss today?
- Do you have anything you want to prepare for or follow up on (e.g., doctor's appointment, fasting for bloodwork, a big dental procedure coming up)?
- Where would you like to start today?
- What would you like to have accomplished by the end of today's meeting?

How might you ask about or keep track of "agenda items" with members?

_____

_____

FACT SHEET 4.4, Strengths Model Fact Sheet: Overview of study

The **Strengths Model** is a type of practice used to assist people to recover, reclaim, and transform their lives. Practice is individually tailored to the unique needs of the individual. The strengths model helps people achieve goals they set for themselves. There are several principles that make up this model of practice.

PURPOSE: To assist another human being, not treat a patient. The work done and decisions made are done in partnership with the member. The PHN is not *doing* something *to* the member, but *with* the person.

Principle 1: ***People can recover and transform their lives.*** Your members have the ability to affect their own recovery. As a PHN you do not have the ability to make someone recover but can create the conditions where growth can occur. This can be done by: helping identify good things (friendships, skills, talents) that the person has present in their life, establishing a trusting connection with the member, and instilling hope.

Principle 2: ***Focus on strengths not deficits***. This does not mean that you ignore problems that members may face. However, focusing on what they already do well and the opportunities they already have will promote growth within that person, and that is good. This focus should also enhance their motivation to make needed change.

Principle 3: ***The community is viewed as a resource.*** Every community has its problems, and the South Side is no different. As a PHN working in this community it is your job to focus on the good things there (free clinics, food pantries, park districts, good people) and emphasize the parts that can be sources of wellbeing for the member.

Principle 4: ***The member is the director of the helping process.*** While you may think you know what members should do in a situation, they are the experts on and architects of their lives.
Members with mental illness have the right and the capabilities to make decisions about the help they receive. It is not your job to tell members how they should solve an issue they are facing. You should never do anything without the permission of your member.

Principle 5: ***The PHN/member relationship is primary and essential.*** It takes a strong and trusting relationship to discover a detailed view of someone's life and create an environment where a person is willing to share what is important to them. This type of relationship can withstand challenging times and can support and encourage confidence. Start out by doing things with the member; going shopping, playing cards, or having coffee.

Rapp & Goscha (2012).

IN-THE-FIELD PRACTICE SHEET 4.5A, Assessing Health Goals

DATE: _____

What is good health for you?

What illnesses are you concerned about?

Do you have any concerns about your:

_____eyes _____teeth _____smoking _____nutrition

_____exercise _____housing _____safety

Do you have concerns about your mental health? _____yes _____no

Do you have concerns about alcohol or other drug use? _____yes _____no

Peer Health Navigators are here to help you get all your health needs met. Please let us know how we might help you: (check ALL that apply)

- ☐ Find a doctor
- ☐ Find a better doctor. Why? Please explain:

  _____

  _____

  _____

  __
- ☐ Find a clinic
- ☐ Find a better clinic. Why? Please explain:

_____

_____

_____

- ☐ Help me get my medication
- ☐ Help me remember my appointments
- ☐ Help me get to my appointments
- ☐ Help me remember my prescription
- ☐ Help me pay for treatment
- ☐ Help me better understand my health concerns
- ☐ Help me with diet, exercise, and smoking
- ☐ Other:

_____

_____

What strengths do you have in addressing health needs?

What resources do you have? (For example; money, friends, Medicaid)

IN-THE-FIELD PRACTICE SHEET 4.5B, Developing SMART Goals

Sometimes goals we create, particularly in health and wellness, focus on outcomes. While it can be helpful to identify areas for improvement, goals that identify clear action steps to *achieve* the desired outcome can be even more helpful. SMART is an acronym for goal writing to help you remember useful guidelines for goal-writing:

Specific

Rather than choosing a general outcome you hope to achieve (e.g., lower cholesterol) think about how specifically you will get there (e.g., eat more vegetables).

Measurable

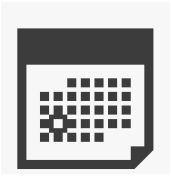
Choosing a goal with a number (e.g., 3 servings/day) will help you visualize how to get there—and recognize when you've achieved your goal!

Attainable

Think of something that you'll have to put in effort to achieve (more than you're already doing) but is do-able for you and where you are now, the goal sweet-spot.

Realistic

Some things are just physically not realistic or healthy—like losing 12 pounds in three days or running a marathon without training at all. Keep in mind the strengths and boundaries of <u>your</u> body.



Trackable

Having goals you can track on a calendar that is time-bound will provide natural times to check in with your progress and re-assess your goals.

The goal of having lower cholesterol can be re-written using the SMART outline:
"I will eat at least three servings of vegetables on Monday, Wednesday, and Friday next week."

<u>Now you try:</u>
Specific behavior goal you hope to implement: _____

How you'll measure it: _____

Is it attainable for you right now?
_____

Is it realistic? _____

What is your time frame? How will you track it? _____

FACT SHEET 4.5C, Tips for Using SMART Goals

Below are some traps or challenges in SMART goal writing, explanations as to why they are not as effective, and potential suggestions for improving the goal or moving forward.

The weight loss trap: "I want to lose five pounds in the next two weeks."

- **Why it's less effective:** Weight isn't always a good metric of improved health. As well, this is harder to envision, implement, and check in on.
- **What to try instead:** Identify instead the change in diet or physical activity they are willing to try. This is something the member can directly control, track, and notice changes from, making it more rewarding, too!
    - *"I will buy some frozen peas to eat at dinner twice next week. I've always liked peas!"*

PHN setting the goal for the member: "What if you try eating peas twice this week?"

- **Why it's less effective:** It's not the member's goal! The hope is for members to be empowered to identify and work toward their own self-directed goals.
- **What to try instead:** Reflect on the motivation for the behavior change, then work with them to identify what specifically they hope to change and how.
    - *"We've been talking about your desire to eat healthier now to lower your cholesterol. Is there anything you had in mind to move you in that direction in the next week?"*

Using the term "SMART goal": "Why don't you set a SMART goal on your diet?"

- **Why it's less effective:** This can be confusing and draw focus from the purpose of goal setting. It may also become too directive (e.g., telling a member what to do instead of following their lead).
- **What to try instead:** Summarize the conversation to check you're on the same page, then ask about what they might do in the next week (time-bound and trackable) to move that direction.
    - *"Let me see if I've got this right. You've been hoping to eat healthier to lower your cholesterol. Does that sound about right? Is there anything you might want to do in the next week to move in that direction?"*

Creating goals that are too ambitious/not realistic: "I want to stop eating ALL unhealthy foods."

- **Why it's less effective:** Sometimes members will say what they think staff want to hear and no realistic plans follow.
- **What to try instead:** Praise the motivation rather than the plan; normalize how hard that change might be; and identify what parts of the goal might be easier/harder. From there, try to identify a goal that might be more attainable (even if it is framed as a "plan B", to set them up for success).
    - *"I think it's terrific that you want to eat healthier and have an idea of what that might look like! It would be awesome if you could do that, but I know that would be hard for most people to make that much change all at once. Is there any part of not eating unhealthy foods that you think would be hardest? What about the easiest? What if we pick one of the easier ones for this week, and go from there?"*

Getting frustrated when a member does not do a previously developed SMART goal: "So you didn't end up eating peas last week at all?"

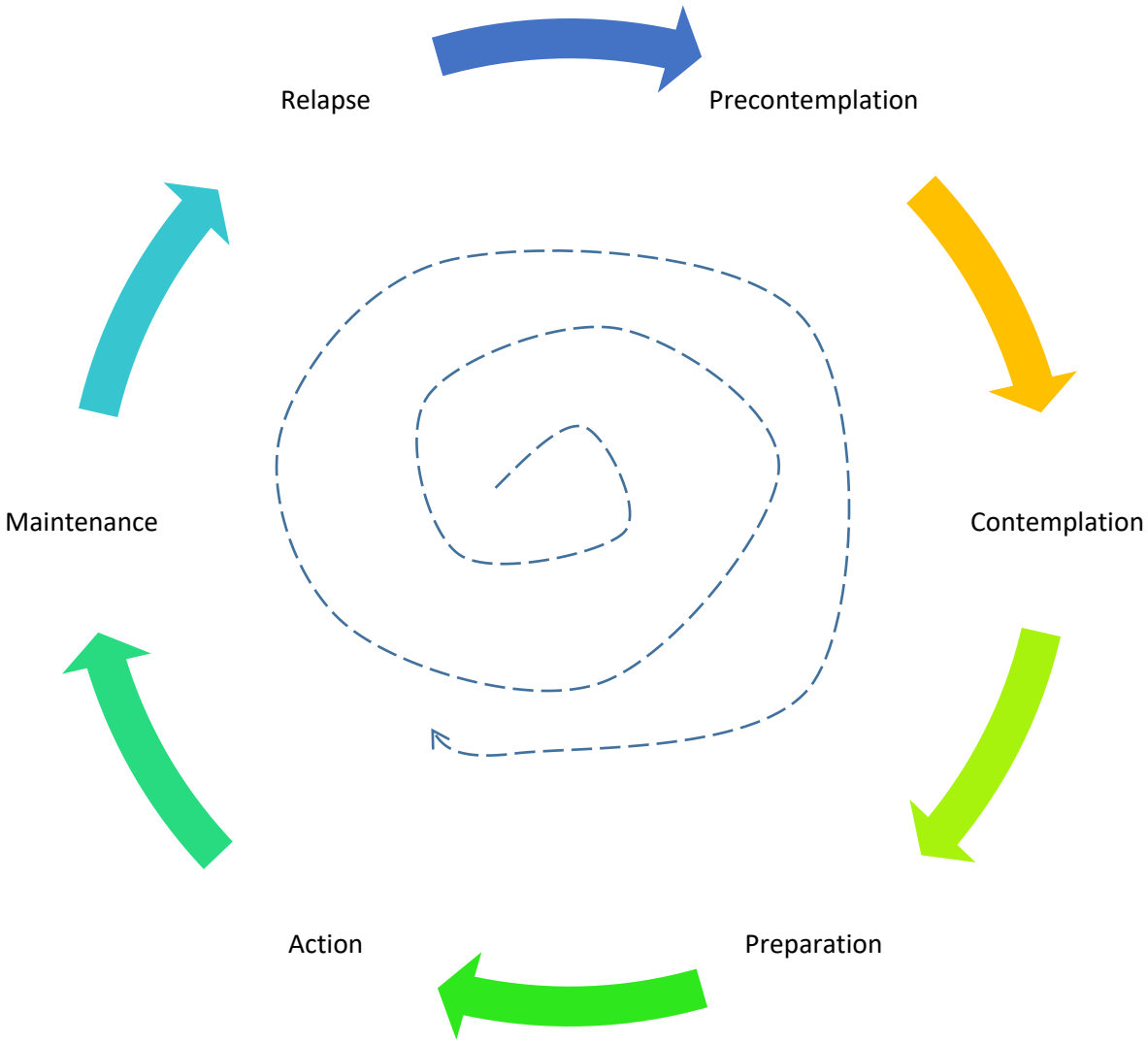
- **Why it's less effective:** Responding with frustration can make the member feel judged, which can be really damaging to the supportive peer relationship.
- **What to try instead:** Assess the motivation for goal attainment by asking them to tell you how it went, highlighting why they wanted to make the change to start, normalize how hard change can be, and ask where they are now with their motivation to make a change.
    - **If member has low motivation:** Normalize the challenge and give permission to move on from this goal for the time being.
    - **If member has made positive steps but hasn't met the goal:** In discussing how it went, normalize how hard it can be but focus on the positive progress first. Then help them identify barriers and subsequent coping strategies. Redevelop SMART goal if they want.
    - **If there is a pattern of not working on SMART goals:** Ask permission to discuss, then note that it seems that you might be stuck on this particular plan. Give permission to move on from this goal and move back to goal setting if they wish.

Claiming a member isn't motivated if they avoid setting a SMART goal: "It seems like you aren't motivated to work on this. You never want to do anything about it when we talk."

- **Why it's less effective:** Again, responding this way can cause the member to feel judged.
- **What to try instead:** Consider that they are not yet ready to make the change. Utilize strategies of motivational interviewing (covered in the next section) to help sit with members in their ambivalence while finding ways to tip the scales toward action.
    - *"So I know we've been talking about you eating healthier, but I wanted to check in with you again about whether this is important for you right now. How would eating more veggies affect you?" Then utilize open-ended questions, reflections, summaries, the readiness ruler, etc. to draw out "change talk."*

Handout FACT SHEET 4.6A, Stages of Change: How to Respond

Fact Sheet 4.6A covers the stages of change and how the PHN might respond and work with the member toward health and wellness goals at each step. Share the following visual with trainees before reviewing the stages, noting that people can enter and exit at any point.



FACT SHEET 4.6A, Stages of Change: How to Respond

Pre-contemplation (does not think there is a problem that needs to be changed)

- Explore / Identify strengths – What is being done already around health and wellness
- Explore the effects of member's routines on health and wellness and on larger life goals
- Seek / Ask permission from the member then provide education around the issue
- Explore pros and cons to behavior
- Do a motivational interview
- Explore health risks of not making a change
- Explore how health and wellness and mental illness symptoms affect each other
- Explore a non-health and wellness goal in a full way and then work backward to see how a health and wellness issue might be a barrier to achieving it
- Explore harm reduction strategies and identify a smaller goal where they might be in preparation or action even if they are still in pre-contemplation or contemplation around the larger issue

Contemplation (Acknowledges concerns and is considering the possibility of change but is ambivalent and uncertain)

- Same as pre-contemplative (Except don't use pros and cons)
- Explore barriers to making a change.
- Group to learn about issue
- Seek/ask permission from the member then offer a suggestion to try a small change and then ask them what they did and didn't like about it
- Develop motivation to change
    - Importance/ Confidence/ Readiness Ruler
    - Seek change talk from member using motivational interviewing techniques (ie. OARS)
    - Explore times when they might have made the change earlier in their life and seek change talk
    - Explore how personal values might affect ambivalence to change
    - Explore what the member might already know about the issue using "Elicit – Provide – Elicit"

Preparation (Committed to and planning to make a change in the near future but is still considering what to do)

- Develop and support reasons to stay motivated
- Address/plan for barriers to making a change- consider role playing how to respond to possible barriers
- Have they made the change before? What can be learned about what worked or didn't work?
- Connect large goal to the small incremental goals needed to move toward the larger goal.
- Develop or identify supports for the change (role play asking for the support, group?)
- Try out the change for a short time (behavioral experiment)
- Develop a SMART Goal. (Specific, Measurable, Attainable, Realistic and Timely)
- Identify start date for the change.

Action (Actively taking steps to change but has not yet reached stable state)

- Continue to develop the plan for change (Align it with SMART goal concepts?) And role play how this might look
- Celebrate successes
- Identify/support member's reasons for wanting the change as a way to keep motivation level high
- Identify supports for the change and include them in planning (family, PCP, group…)
- Identify who to talk to when motivation drops
- Problem solve around barriers that arise or are foreseeable to arise in the future.
- Normalize the difficulty and messiness of making changes

Maintenance (Achieved initial goals and is now working to maintain gains)

- Review positive effects due to the change (celebrate successes)
- Affirm member's efforts to make the change
- Explore barriers to the change continuing and consider role playing or problem-solving strategies
- Ask the member how you can help them if they return to the old behavior
- Assess and adjust the plan to change as needed
- Help member consider if they want to change something else now that they have done so well with this change
- Group to receive ongoing support

Relapse/ Lapse/ Slip/ Reoccurrence of old behavior (Often a normal part of the change process)

- Normalize relapses and be sensitive to the member's language in identifying it
- Support the capacity the member showed to make a change as they have done it before
- Explore the triggers that contributed to the relapse and develop plans to address them
- Assess to see what stage of change the member is in now and adjust your approach accordingly
- Consider relapse prevention

FACT SHEET 4.6B, Motivational Interviewing

Review **Roadblocks to Good Listening Skills** and **Good Listening Skills** Fact Sheets. The goal of Motivational Interviewing is to strengthen an individual's motivation for change. Use good listening skills and the principles outlined below to conduct motivational interviews.

- Behaviors can be positive (going to see a doctor) or negative (eating fatty foods).
- Motivation is partly a comparison of the pros and cons of a target behavior. Both positive and negative behaviors have pros and cons.
- Pros to going to see a doctor might be checking up on my health goals with a doctor and finding early interventions when needed. Cons might be adding to daily stress and having to pay for public transportation.
- Something negative like eating fatty foods has pros; liking the tastes because it is comfort food. But they also have cons; weight gain and worse heart health.
- Short term pros and cons are more powerful in the moment.
- Long term pros and cons have a bigger influence over your life.
- Pros and cons of a target behavior differ by the person with that behavior.
- The purpose of motivational interviewing is to help people fully appreciate the range of pros and cons for themselves.

There are four principles for motivational interviewing.

Principle 1: Express Empathy

- Take on member's perspective. Put yourself in their shoes and think about their statements and behavior in terms of where they are coming from. Ask yourself, what would I be doing in their situation?
- Adopt a nonjudgmental attitude. This does not mean condoning their behavior, but try to understand their motivation without being disapproving or critical of their choices.

Principle 2: Develop Discrepancy

- Discrepancies are differences between one's values and behavior. If an individual's behavior varies from his or her values, increasing awareness of these differences may increase motivation to change the behavior.
- Reflect these differences back to your members and consider the pros and cons of changing the behavior. These are pros and cons the member comes up with, not your own suggestions. Note every argument for change and compare to arguments against change.

Principle 3: Roll with Resistance

- Resistance is normal and expected. It should not be ignored nor disparaged. Rather, it is informative; listening and responding with warmth and understanding can help reduce the resistance.
- With any change comes concerns about the unfamiliar or unknown. Members may experience fear of failure or uncertainty about what the change will bring. Rather than dismissing any resistance, listen with empathy and understanding.

Principle 4: Support Self-Efficacy

- Self-efficacy is the belief that one has the capacity to change a behavior. Encourage members by reinforcing positive statements about capabilities and worth.
- The member always makes the final decisions about change. PHNs can make suggestions about possible strategies for change, but members make the final call.

Arkowitz & Miller (2008).

WORKSHEET 4.6C, Motivational Interviewing

Choose a partner. One of you is the speaker and one is the listener. As the speaker, think of something about yourself that you want to change, need to change, or should change. This can be something you have been thinking about but have not changed yet, such as drinking two bottles of wine every night. As the listener, listen carefully in order to understand the speaker's problem. Use **Motivational Interviewing** Fact Sheet to guide you through the process of motivational interviewing.

Switch roles after 10 minutes.
After you are finished, take a minute to think about the following:

As the **speaker:**
What did I do that I liked?

- _____
- _____
- _____
- _____

What would I do differently next time?

- _____
- _____
- _____
- _____

As the **listener:**
What did the speaker do well?

- _____
- _____
- _____
- _____

What are my suggestions for the speaker to do differently next time?

- _____
- _____
- _____
- _____

Shuman & Tolliver (2013).
University of Chicago Center for Psychiatric Rehabilitation (1999).

IN-THE-FIELD PRACTICE SHEET 4.6D, Motivational Interviewing

List a target behavior you have been thinking about changing.

Target Behavior: _____

Now consider the pros and cons, both short term and long term, of changing the behavior.

PROS:	CONS:

Given the pros and cons, do you want to change the target behavior?

___ Yes

___ No

FACT SHEET 4.6E, Readiness Ruler

How important would you say it is to make this change?

Not at all important				Somewhat important					Extremely important
1	2	3	4	5	6	7	8	9	10

Why did you choose a _____ and not a lower number?
What would it take for you to be at a higher number?
What concerns do you have about changing your behavior?

If you were to decide right now to make a change in your behavior, how confident are you that you could succeed?

Not at all confident				Unsure					Extremely confident
1	2	3	4	5	6	7	8	9	10

Why did you choose a ____ and not a lower number?
What would help you to have a higher number?

How ready are you right now to make a change in your behavior?

Not at all ready			Unsure		Ready				Trying to change
1	2	3	4	5	6	7	8	9	10

What changes are you interested in making?
Please list your goal for making a change.
Is there a first step you can take now to make the change you identified? If so, what is it and when could you do it?

FACT SHEET 4.7A, Harm Reduction

Harm reduction helps people maximize their health by reducing the risk of harm. Harm reduction means that the person continues the potentially harmful behaviors (e.g., drinking alcohol) but makes **some** behavior changes (e.g., limit drinks on weekdays) to minimize the negative impact on themselves, their loved ones, and their community.

Principles of harm reduction

- People have the right to treatment and should not be denied or expelled for behavior that brings them to treatment; a relapse should not be reason to be expelled.
- People currently participating in a potentially harmful behavior can participate in treatment.
- Success is related to self-efficacy. Small successes in reducing harm help people become more confident about making changes in the future.
- People will reduce harm where *they* see harm, not where others see harm.
- Recovery is a process, so any reduction in harm is a step in the right direction.

Harm reduction is…

- **Nonjudgmental**: Be accepting of people on their own terms. Members have the final say about their behavior. Do not impose your personal values and beliefs.
- **Informative**: Help your members make well-informed decisions. It is important to list all options for reducing harm, not simply the option you would take for yourself.
- **Understanding**: Listen to your members by using good listening skills. Try to understand the costs and benefits of a behavior from their perspective. Remind members that they have the final say and ask what they think would be helpful. Avoid pushing them to somewhere they may be unwilling to go.

Here are some **examples** of potentially harmful behaviors and ways to reduce harm:

BEHAVIOR	WAYS TO REDUCE HARM
Dangerous driving	Follow speed limits Wear seat belt Use a designated driver
Drug use	Reduce frequency of use of drug Reduce quantity of drug used Use clean needles/don't share Use with someone you trust
Sexual practices	Use condoms Avoid risky sexual practices Know your partner

Shuman & Jones (2014).

WORKSHEET 4.7B, Harm Reduction

Harm reduction means helping people minimize the negative impact of a behavior that they aren't ready or willing to stop. Here are some examples of these behaviors. Check which behaviors you or someone you know has been involved in.

Check all that apply:

- □ Alcohol use
- □ Substance use
- □ Illegal activity
- □ Unsafe sex
- □ Living on the street
- □ Reckless spending
- □ Not taking prescribed mental health medications
- □ Eating unhealthy foods
- □ Other: _____

Pick an example of a potentially harmful behavior of yours. No judgments about you and this behavior will be made.

Behavior _____

Now list the potentially harmful parts of that behavior and try to come up with ways to address each one. Follow the **examples** listed.

Negative	Ways to address them
EXAMPLES	*EXAMPLES*
I got so drunk that I lost my ID	*I will keep my ID in a safe place and always keep it there*
I woke up with someone I did not know	*I will make sure to carry condoms with me*
I woke up with a terrible headache	*I will stick with one type of drink next time*

FACT SHEET 4.8A, Relapse Management

Relapse Management is a set of skills designed to reduce the likelihood that symptoms leading to a relapse will worsen or that a person will return to an unhealthy behavior, such as chaotic substance use. Skills include: identifying **signs** that symptoms may be worsening, recognizing **triggers** (high risk situations for relapse) and understanding how everyday decisions may put you on the road to relapse (**relapse prevention plan**).

SIGNS:

It is important to recognize the signs that can lead to a relapse. This can be a change in mood, experiencing a life changing event, or even boredom. Recognizing these can help you stay on course in your recovery.

TRIGGERS:

Sometimes there are people, places, and situations that are difficult for people in recovery to navigate and can make it difficult to maintain sobriety. Look out for:

Who: People who you used to use with or who do not support you in your recovery goals. Limiting time with them or avoiding them until you feel stronger may be necessary.

When: Times of the day, month, or year when you may feel more like using. Having supports in place for these moments are key to maintaining your goals.

Where: Environments that are dangerous to you maintaining your goals. These can include specific places, (bars and friends' houses) neighborhoods, or cities where you used to engage in the behaviors you are trying to change.

What: There can be other associations (the smell of alcohol or tobacco) for people that increase their desire to use.

RELAPSE PREVENTION PLAN

This is a specific list of steps to help plan for future relapse. Here are some examples of what that might look like.

Alcohol: Staying away or limiting your interactions with people that drink. This could mean you stop by your family's house early on Christmas Eve before people start drinking.

Substance Use: Avoiding areas where you used to buy drugs or not hanging out with others while they are using. This can mean altering your way home from work and having regular visits with friends who are pursuing similar goals or supportive of your efforts.

Homelessness: Keeping on top of budgeting for rent, following the rules of your lease and housing program (if applicable), meeting with caseworkers regularly, and alerting your support system early if you think your housing is in jeopardy are keys to keeping yourself housed.

Unsafe Sex: Making sure that you have the tools you need to practice safer sex (condoms, birth control, etc.) and know where to go if you need further assistance.

Mental Illness: Talking to a close friend or family member about ways they may help if they notice some warning signs that you are becoming unwell (e.g., isolating self, report hearing voices, etc.) and who to call when that happens.

Physical illness: Keeping regular appointments with your doctor and having someone come with you to provide support and advocacy. Prioritizing medications in your budget if you are able, and making sure you are getting enough rest.

IN-THE-FIELD PRACTICE SHEET 4.8B, Relapse Management

Initials: _____ Date: _____

Concern you want to focus on: (please check one)

_____Alcohol _____Other drugs _____Committing Crime

_____Homelessness _____Spending recklessly _____Unsafe Sex

_____Victim _____Mental Illness _____Physical Illness

Briefly describe what a relapse would look like for you:

List SIGNS that might lead you to relapse:

I know I'm going to _____ again, when

_____

_____

_____

_____

_____

_____

_____

List TRIGGERS that might lead you to relapse:

WHO:

WHEN:

WHERE:

WHAT:

What might I do to prevent a relapse at the time of signs and triggers?

BEFORE RELAPSE

WHO:

WHEN:

WHERE:

WHAT:

What might I do if I relapse?

RELAPSE PLAN

WHO:

WHEN:

WHERE:

WHAT:

FACT SHEET 4.9, Stigma of Obesity

Negative Social Consequences of Being Obese

https://www.psychologytoday.com/us/blog/food-junkie/201306/the-obesity-stigma
Posted June 12, 2013

Most of us are well aware of the negative health consequences that result from obesity and yet many people remain *unaware* of the negative *social* consequences that also result from obesity.

A couple of years ago, the Children's Healthcare of Atlanta began a controversial campaign depicting overweight children in an emotionally harmful way. Outrage ensued because of how the children in the ads are being portrayed in society: In short, the campaign is labeling them as people that no kid should want to be. See http://theweek.com/article/index/222972/georgias-grim-anti-obesity-ads

Perhaps this campaign may have taken their message a bit too far, but we need to realize that we ourselves perpetuate this same message to society every day, just in a much more covert way.

Obesity is stigmatized as a condition that is changeable and controllable. In essence, obesity is subconsciously construed as a person's choice. While factors other than controllable eating habits are at play in the obesity crisis, many people still perpetuate the erroneous assumption that overweight people are impulsive, lazy, and less likeable overall.

For example, a study that measured the attitudes of 400 medical professionals towards obese individuals, found that physicians associated obesity with other conditions associated with poor hygiene, hostility, and dishonesty. Other studies found that many physicians relate obesity to a lack of love or attention, lack of willpower, and large amounts of overindulgence.

Unfortunately, an obese individual must face these stigmas in situations outside of the doctor's office as well. When applying for a job, obese individuals are less likely to be hired, are more likely to be perceived incompetent, and are also more likely to leave negative impressions on their future employers. Attitudes of employers towards obesity were found to be similar to the physicians' attitudes mentioned earlier.

Even as children, we still fall prey to this negative way of thinking. In one study, children that are shown drawings of other kids with different "handicaps", are reported to like the drawings of obese children a lot less than drawings of children with facial disfigurements, children in wheelchairs, or children with other types of handicaps.

Again, much of this goes back to the idea of the "controllability" factor behind obesity. In a similar study, high school girls had to decide how likeable they found photos of other girls. The photos of obese girls were, once again, ranked last on their scale of likeability. However, when subjects were told that the overweight girls suffered from weight issues because of a thyroid problem, the photos of overweight girls were liked just as much as the photos of normal-weight girls. In the first condition, the overweight girls were their own perpetuators of their obesity and in the second condition, the overweight girls were the victims of their condition.

When joining the fight against obesity, it is important to remember that many of the assumptions that we make toward obese children and adults are not true. There are many aspects of obesity that are controllable through diet and exercise, but we must also not forget that obesity also has genetic and

medical causes that are uncontrollable. Furthermore, marketing, hyperpalatable ingredients (e.g. large amounts of sugars or HFCS and fats) may keep many of us "hooked" and always wanting more of these foods. regardless of whether we actually feel hungry.

DeJong (1980); Puhl & Brownell (2001); Richardson et al., (1961)

WORKSHEET 4.10, Smoking Conversation Guide

This guide sheet is intended to help clinicians have conversations about smoking and nicotine dependence with people who are ambivalent about quitting or reducing smoking.

ASK all people who smoke or use tobacco if you can have a conversation about their current tobacco use. If they say yes, use the prompts below to help guide the conversation. If they say no, ask if you can bring it up again in the future.

- How is it going with your smoking?
- What do you like about it?
- When did you first start?
  - Do you recall how old you were?
  - How has your smoking changed over time?
- When are the times you tend to smoke more?
- When are the times you smoke less?
- Have you ever cut down or quit smoking?
  - How did you do it?
  - Did you use a quit smoking medication? Yes / No
    - ____ Nicotine Replacement Therapy (NRT) (circle: Patch, Lozenge, Gum, Inhaler, Nasal Spray)
    - ____ Chantix
    - ____ Bupropion
    - For how long? _____
    - Did it help? _____ Why did you stop taking it? _____
- What do you think will happen if you continue smoking the way you do?
- Is there anything that makes you think that your smoking is a problem for you?
- If you were to quit smoking, what do you think it would be like when you don't smoke anymore?
- If you wanted to quit or reduce smoking, what do you think would help you be successful?

ADVISE all tobacco users to quit. If they are not ready to quit now, advise them to to consider reducing use.

Examples:

- *"Reducing or ideally quitting smoking is a really important thing you can do to improve your health (and protect those around you), and we can help."*
- *"Smoking is very addictive for most people and quitting 'cold turkey' generally isn't effective. The majority of smokers need help quitting. Can I share some information about what helps people quit or cut back?"*
- *"I hear you that making changes to your smoking would be hard and that is why it is recommended to take a medication that can make you feel more comfortable during this process. And it usually helps to talk to your doctor about which medication is best for you."*

Ask, is quitting or cutting down (Circle the one they want) on smoking something you want to do?

- ☐ Now
- ☐ Soon (in the next month)
- ☐ Someday (not right now but thinking about it)
- ☐ Not thinking about it

If the member answered "Now" or "Soon" ask….

- Are you currently on any medications or would you like to be on any medications to help you?
- **REFER them to the person on their clinical team who has been trained to help members quit (if their team has one) or the Illinois Tobacco Quitline or their doctor.**

If the member is not thinking about quitting or cutting down within the next month we should ask permission to talk about it again in the future. We could say something like…

"I hear you that you aren't thinking about quitting or cutting down at this point, and I respect that. I'd also like to ask about possibly bringing this up again in the future so I can better understand the role smoking plays in your life (or to better understand how important it is to you). If you don't want to talk about it then, I'll respect that. What I'm asking for is permission to bring it up again. Would that be okay with you?"

4.11 GETTING AND USING FEEDBACK FROM MEMBERS

Why Do We Need to Ask for Feedback?

Getting feedback from members is essential for engaging members in services and improving the quality of services. If you regularly ask for feedback, this communicates to members that you are committed to meeting their needs and genuinely care about helping them. Some members will easily give direct feedback, while others will be more hesitant. Many times, if a member is dissatisfied with services, they will start to withdraw or disengage, rather than communicate what is wrong. They are not sure whether you can handle the feedback. This is why it is important to ask for feedback often and become skilled in how to accept feedback.

Handout FACT SHEET 4.11A, Getting and Using Feedback from Members

Fact Sheet 4.11A contains information on how to obtain and use feedback from the members you serve. Review this, then practice asking the questions on In-The-Field Practice Sheet 4.11B.

Handout IN-THE-FIELD PRACTICE SHEET 4.11B, Asking for Feedback

WORKSHEET 4.11A, Getting and Using Feedback from Members

Types of Feedback

Formal Feedback

Formal feedback happens at regular time periods and is usually in written form. For example, a satisfaction survey, program evaluation, or fidelity assessment are types of written feedback that your supervisor or agency might collect every year. Some members might feel more comfortable giving feedback in this way, since they can remain anonymous. However, it is important that you get regular, informal feedback on your own work with a client as we discuss below.

Informal Feedback

Informal feedback happens in your day-to-day interactions, is often unplanned, and is usually done verbally. For example, at the end of a meeting, you might ask "How do you think our visit went today?" The way you ask for feedback can make a big difference. You want to ask questions in a neutral way, which makes the member feel more open to giving challenging feedback. See the table below for examples of neutral versus leading questions.

Neutral Questions	**Leading Questions—AVOID THESE**
What can I do to better help you with your goals?	Is there anything I can do better? You are satisfied with my services, right?
From your perspective, how have things been going in our work together?	I think our work together has been going really well. How about you?
What did you think about our session today?	Today went pretty well didn't it?
What are your thoughts on the program so far?	Do you like the program so far?
What suggestions do you have for improving the program?	Is there anything wrong with the program?
Are there any concerns we have not addressed yet or anything we should spend more time on?	We have addressed all your concerns, right?
Hey, I wanted to ask you a question—is that OK? Of what we did today, I'm wondering what is the most helpful?	

Accepting Feedback

The way you react to positive and negative feedback will set the tone for future interactions.

- If a member gives you negative feedback, respond something like this:
  - "Thank you for sharing that—I know it can be hard to tell me. Please know that I am taking your feedback seriously and really want to do my best to help you."
- If a member gives you only positive feedback or no feedback at all, you may want to probe a little bit more or open the conversation for future feedback.
  - "There's nothing you think I might do differently?"
  - "Well, if you think of anything in the future, please know that I'm open to hearing it."
- If you are not sure how to respond, or disagree with the feedback:
  - Thank the person for providing the feedback, and consult with your supervisor.

Using Feedback for Quality Improvement

When you get feedback from a member, either about your work, your colleague, or the program itself, make a note and bring this up during your supervision session or team meeting. With your supervisor, decide if there is a way to take action on the feedback. If there is not a way to take action on the feedback/ request then you and your supervisor should figure out a way to communicate this to the member. Here are some actions you might take in response to feedback:

- Attend training on specific areas of personal development
- Practice/role play skills during supervision sessions
- Make notes/reminders about actions you will take
- Make the issue a standing agenda item in your supervision meeting

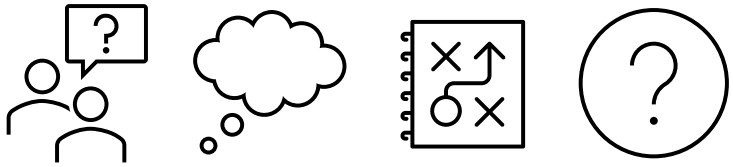
How Often Should I Ask for Feedback?

At a minimum, you should informally ask for feedback once a month from your members. If the member is just entering the program, you should ask at the end of each session for the first several sessions.

Practice sheet 4.11B is meant for help PHNs ask for feedback. The practice sheet includes questions that you might ask members at the end of a session to get feedback and also reminds you to reflect on your response to feedback.

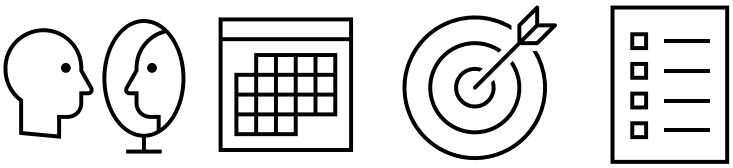
- Role-play asking each of the questions in practice sheet 4.11B with your fellow PHNs.
- Select a few feedback questions that feel most comfortable for you or create your own feedback question.
- Post sheet 4.11B somewhere you will see it often as a reminder to ask for feedback.
- Make sure to take action on feedback that you get.

WORKSHEET 4.11B, Asking for Feedback



Ask Members:

- What did you think about our session today?
- Of what we did today (last week/last month), what has been the most helpful?
- We all have health challenges, but, for you, which are the ones that are most important? And how do you think things are going with our efforts to work on them?
- What can I do to better help you next time?
- What would you like to talk about that we haven't discussed yet?
- How do you think the program is going so far?
- What feedback do you have for me?
- Others? _____



Reflect:

- Am I asking for feedback often enough?
- How am I reacting to feedback?
- What actions am I taking to respond to feedback?
- What support do I need?

4.12 TRANSITIONS AND CONTINUATION OF CARE

Sometimes, members will decide to leave the PHN program or will need to transition to a new PHN staff. Preparing in advance (when possible) can ensure that the member stays engaged and gets the best services possible.

Handout FACT SHEET 4.12, Transitions and Continuation of Care

Read each situation below and how to respond.

FACT SHEET 4.12, Transitions and Continuation of Care

Member says that they no longer want PHN services

A: PHN seeks to understand what the problems are and if they can be resolved

- Normalize that sometimes working with the PHN can be hard and ask if it would be OK to talk more about it.
- Speak with members to better understand their reasons for wanting to end services.
- Explore how the PHN has helped or not helped and see if things can be adjusted to better meet their needs.

B: If the member continues to not want to work with the PHN – seek to connect them to other services or providers

- Determine if there are unmet needs that could be filled within the existing organization.
- Consult with your supervisor and other clinical staff to determine if referral to other services or organizations are needed.
- Communicate with member about any referrals.
- If you are not able to speak directly with the member, send a letter outlining referrals and guidelines for how they could rejoin the program if they wish to in the future.

Member is moving to new geographic area or will begin getting services from another organization

- Start planning at least one month beforehand, if possible.
- Assist the member and their clinical team in determining how their physical health needs will be met in the new location/organization and if they may need referrals to additional services.
- Work with the member's clinical staff to ensure that medical records and other information is transferred with member consent.

The PHN is leaving the organization, transitioning into a new position, or is out of the office on an extended leave.

- Explain the upcoming change to members at least two weeks in advance.
- Ask them to talk about any feelings or concerns they have about the PHN staff's departure.
- Clearly communicate with the member who they should contact in the PHN's absence.
- Existing PHN staff or PNH supervisor should hold transition meeting with each member when new PHN staff begin.

4.13 Annual Preventive Medicine Appointments

Many illnesses can be prevented, managed, or improved by regular checkups with one's primary care provider. An annual review of prevention strategies can help. These are divided into a (1) Prevention Checklist, (2) Next Steps, and (3) After the Appointment activities. These are reviewed in Fact Sheet 4.13A and In-The-Field Practice Sheet 4.13B. Also, please review the summary of PHN tasks before, during, and after medical appointments beginning on page 21.

Handout FACT SHEET 4.13A, Annual Prevention Assessment

Read through the three steps listed on Fact Sheet 4.13A before reviewing the Prevention Assessment for Annual Checkups (In-the-Field Practice Sheet 4.13B).

Handout IN-THE-FIELD PRACTICE SHEET 4.13B, Prevention and Annual Checkups

FACT SHEET 4.13A, Annual Prevention Assessment

Annual check-ups and preventive care can significantly reduce harmful effects of illness. Preventive care includes structured clinic visits with one's primary care provider where the provider reviews patient concerns, symptoms, and tests that might suggest possible or worsening illness. These visits might also include review of vaccines and therapies that will stop illnesses in their tracks. PHNs should review guidelines outlining their before, during, and after medical appointments on page 21. Prevention Assessment for Annual Checkups is summarized in Worksheet x.x and includes three steps.

1. Prevention Checklist

When should the prevention checklist be completed? Members and PHNs should discuss whether an annual physical was completed in the past year. If so, then complete Worksheet X.X about six weeks before the next expected appointment. Primary health clinics are often very busy so several weeks may be needed prior to the appointment for the annual check-up. PHNs should check with service recipient whether the PHN might make the appointment.

If the person has not had an annual physical in the past year, PHNs may want to discuss benefits of these checkups. Motivational interviewing discussed on page X can be useful. PHNs may also help members find the preferred primary care clinic near the recipient.

Members should be encouraged to complete the Prevention Checklist in Worksheet. PHNs should ask the member if they can help in going over the checklist and completing it with them. The checklist summarizes common questions which a primary care provider and patient might discuss during the appointment. This checklist is for adults only and is organized by age. The first set of questions is for people between 18 and 39 years old. The second set -- 40 to 64 – includes all the questions for the 18 to 39 group PLUS several extra. The final set -- 65 and older -- includes one last set of items.

2. Next Steps

Members should then review the checklist and decide how to proceed. Many people may prefer to make the appointment themselves, and then go on their own. Most benefit from the PHN supporting them to schedule and accompanying them. PHNs can increase the likelihood that members will see the benefits of their presence if the PHN uses motivational interviewing strategies to discuss how the PHN can be useful. Members should check the items that best reflect their preferences. This may include PHNs helping to find a primary care clinic and set up the appointment. Members may also wish to list particular concerns to discuss during the appointment. Please review PHN tasks before, during, and after medical appointment on page 21.

3. After the Appointment

Often the primary care provider will prescribe tests, medicines, and/or therapies as next steps after the appointment. Members should check items they wish specific help on after the appointment.

IN-THE-FIELD PRACTICE SHEET 4.13B, Prevention and Annual Checkups

Name: _____ Date: _____

Peer Health Navigator: _____

Check each issue you think important to talk with your primary care provider about at your annual checkup.

1. Prevention Checklist

18 to 39 years old

___weight and height
___blood pressure
___cholesterol check (every 5 years)
___skin check (suspicious lesions or moles)
___tuberculosis testing
___diabetes screening (and foot care)
___chronic pain (e.g., dental, joint/arthritis)
___immunizations and vaccines (e.g., tetanus, flu and COVID and other pandemic vaccines)
___sexually transmitted disease (STD: depending on lifestyle or personal request)
___contraceptive methods counseling (including for protections from STDs)
___healthy eating counseling
___physical activity counseling
___interpersonal and domestic violence counseling
___tobacco use
___alcohol use
___other drug use
___depression screening

Extra screenings

___cervical cancer screening (pap smear every 3 years)
___HPV vaccine (if not received earlier)
___breast exam (self-exam monthly, by primary care provider annually)
___testicular exam

40 to 64 years old (in addition to 18-39 year old concerns):

___shingles vaccine
___flu shot
___colorectal screening and maybe colonoscopy
___osteoporosis screening (bone density)
___lung cancer screening
___noticeable chest pain

Extra screenings

___mammogram
___pelvic exam
___prostate exam

65 years and older (in addition to 18-64 year old concerns):
___pneumonia vaccine
___high dose flu vaccine
___accidental fall prevention screening

2. Next Steps

Some people choose to go to their doctor's appointments by themselves but many find it helpful to have someone with them since there can be so much to remember. If you wish, please ask your peer health navigator (PHN) when they can accompany you to appointments. If there is ever a time during the appointment when you wish to talk to your doctor privately, your PHN will step out.

___I want assistance in setting up an annual checkup. I have a primary care provider.
___I want assistance in setting up an annual checkup. I do not have a primary care provider
___I do not want assistance in setting up an annual checkup.

Particular concerns I wish to talk with my primary care provider about:

- _____
- _____
- _____
- _____
- _____

3. After the Appointment

Often the primary care provider will prescribe medications, tests, or other therapies after the appointment. Check off all those you want help on.

___Review doctor's recommendations including therapies and lifestyle changes (e.g., nutrition, physical activity, smoking cessation, etc.)
___Call the doctor for interpretation of labs and tests obtained after the appointment.
___Travel to the pharmacy to pick up prescriptions.
___Make appointments and travel for prescribed therapies such as physical, or occupational therapies or minor surgical procedures.
___Discuss what I want to do about the recommendations given. What do I feel ready to do, and what am I not ready for right now? Develop a plan for what I am ready to do.

Adapted from Thresholds Health Toolkits (NIDILRR 90DPHF0001, Lisa Razzano, PI); Preventive Care for Women (BlueCross BlueShield of Minnesota) Complete Guide to Annual Health Screening by Age (Columbia Doctors Nurses Practitioner Group [Primary Care]); and the United States Preventive Services Taskforce.

FACT SHEET 5.1A, Advocacy

Peer health navigators (PHNs) are advocates. An advocate is someone who works in favor of other persons, providing assistance and promoting their interests. There may be times that members ask for something that seems impossible. Your job is not to make the impossible happen, but to show them what is possible and help them attain it.

ROLES OF ADVOCACY

An advocate takes on different roles, including **supporter, educator, spokesperson,** and **intermediary.**

Supporter: In this role, PHNs provide encouragement and assistance with tasks, seeking to improve members' overall ability to engage in the health care system. This may include using good listening skills, providing assistance with making appointments, and accessing transportation.

Educator: As an educator, PHNs help members understand when they may need to seek services, including which service is needed and where it can be accessed. This may include helping members recognize and understand their symptoms, medications, and prescriptions.

Spokesperson: The role of a spokesperson involves sharing important information with providers on behalf of the member. In order to be able to "speak" for a member, PHNs must have a thorough and accurate understanding of the member's situation, including skills, abilities, and limitations.

Intermediary: In this role, PHNs act as advocates to help resolve problems between members and their health care system. The role of intermediary involves collecting information from the system, including policies, procedures, administrative structure, system rules, eligibility requirements, and names of key people to connect with.

LEVELS OF ADVOCACY

An advocate can act on the **individual, agency,** and **community** level.

Individual: Advocating for members at the individual level means getting the voice of your member heard by people who need to hear it. Often times, members are used to hearing the word "NO." Encouraging self-advocacy means helping members ask questions, stand up for themselves, and understand that there are other answers besides "no."

You can also advocate on your member's behalf, speaking directly with providers and getting answers to members' questions. Remind members--and remember this for yourself--never use anger when making a request, but be firm and polite with professionals.

Agency: While most agencies that serve the members have the goal of helping others, they sometimes fall short. While your job as a PHN is not to fix these problems, you may find yourself in a situation where members ask for help. This may mean putting them in touch with someone at the agency or helping them find services at another agency.

Community: Many of the barriers that members face are a result of stigma and laws that do not favor them. As a PHN, it is not your job to fix these laws, but to help members voice concerns about community issues by encouraging them to join community action groups, neighborhood associations, and advocacy groups that are working to change these stigmatizing attitudes.

Dobbins (2012).

WORKSHEET 5.1B, Strengths and Weaknesses of Different Roles

Each of the advocacy roles have strengths and weaknesses. Write down strengths and weaknesses of each.

SUPPORTER	
Strengths:	Weaknesses:
EDUCATOR	
Strengths:	Weaknesses:
SPOKESPERSON	
Strengths:	Weaknesses:
INTERMEDIARY	
Strengths:	Weaknesses:

Now review with the group what you found.

FACT SHEET 5.2A, Interpersonal Problem Solving

Problems are blocked goals. These goals may be blocked by the situation as well as by other people. In an interpersonal problem, both people need to be actively involved in the problem-solving process.

There are **seven** steps in problem solving:

1. Adopt a positive problem-solving attitude. Persons involved in problem solving need to acknowledge possible solutions to the problem exist (HOPE).

2. Define the problem in terms of how it blocks goals. Who is involved? What is the problem? When are goals blocked? Where does it occur? If two people are frustrating each other, both persons must agree to work together to define the problem from all perspectives.

3. Brainstorm solutions to the problem. Members should be encouraged NOT to edit solutions at this stage. All possible solutions are encouraged no matter how silly they seem.

4. Select one solution and consider its costs and benefits. These should be listed by all persons involved. Decide whether you want to implement it. If not, select another solution and consider its pros and cons.

5. Plan out solution's implementation. Be specific in your plan. Who will do what, when and where to achieve the goal? Are there several small goals (baby steps) needed to accomplish the larger goal?

6. After planning the solution, set a time for its implementation and try it out.

7. Evaluate the solution's success. Everyone involved should decide whether the problem has been resolved. If the solution was unsuccessful, decide as a group to amend/refine the solution or pick another and try again.

University of Chicago Center for Psychiatric Rehabilitation (1999).

WORKSHEET 5.2B, Interpersonal Problem Solving

Interpersonal Problems

Get into pairs. As a group, come up with a problem two people may have. For example, two people who are living together may argue about how often to take out the trash. Group members should role play this problem, and using the **Interpersonal Problem Solving In-the-Field Practice Sheet**, use problem solving skills to help the other two resolve their problem.
After you have finished, take a minute to think about the following:

As the **listener:**
What did I do well?

- _____
- _____
- _____

What would I do differently next time?

- _____
- _____
- _____

As a **speaker:**
What did the listener do well?

- _____
- _____
- _____

What should the listener do differently next time?

- _____
- _____
- _____

Also, what was difficult about the process?

University of Chicago Center for Psychiatric Rehabilitation (1999).

IN-THE-FIELD SHEET 5.2C, Interpersonal Problem Solving

Do I have hope and belief in the possibility of a solution? _____ yes _____ no

Who is involved? What is the problem? When are goals blocked? Where does this occur?

WHO:

WHAT:

WHEN:

WHERE:

Is the other person involved in problem solving? _____ YES _____ NO

Brainstorm Solutions (anything goes!)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Pick ONE solution and come up with the pros and cons of implementing it.

Solution: _____

PROS	**CONS**

Are you going to implement it? _____ YES _____ NO (If yes, continue to the back side of this sheet.)

Plan: Who will do it? What will people do? When will it occur? Where will it occur?
WHO:

WHAT:

WHEN:

WHERE:

How long will we try it? _____ When will we meet to reevaluate? _____

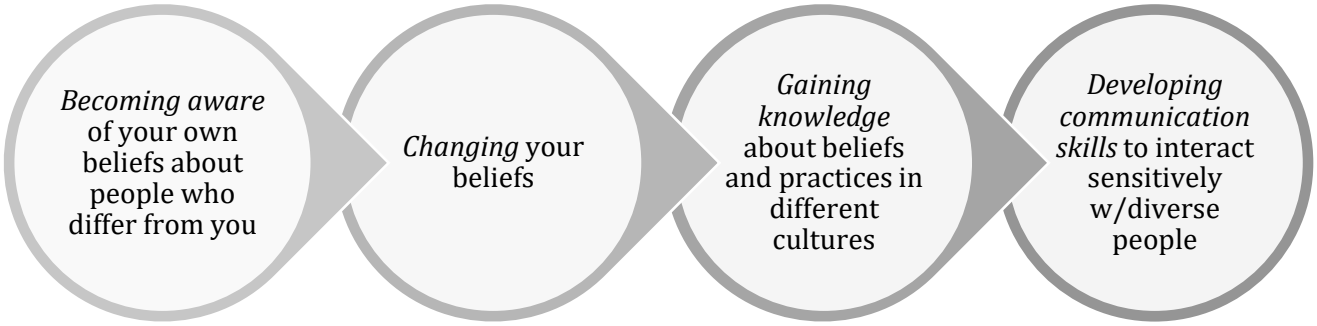
How did it go?

How did you change the plan?

New plan?

FACT SHEET 5.3A, Cultural Competence

Cultural competence is the ability to interact effectively with people of different cultures, races, and ethnicities. The traditional definition of race and ethnicity is related to sociological factors. Race refers to a person's physical appearance, such as skin color or eye color. Ethnicity, on the other hand, relates to cultural factors such as nationality, culture, ancestry, language and beliefs. The four aspects of cultural competency are described below.



SELF-AWARENESS: Being aware of your own cultural norms, values, and "hot button" issues that might lead to misjudging or miscommunicating with others. For example, your faith may be a very important part of your life, but not for others.

RESPECT FOR DIFFERENCE: Respect does not mean merely tolerating different cultures. Respect also means encouraging expression of one's culture and being curious to learn more about others' culture.

AFFIRMATION: Sometimes other cultural values challenge our own comfort zone. PHNs must recognize each individual as the expert on his or her own experience, and be ready to listen and affirm that experience. Avoid controversial conversations.

DON'T ASSUME: If you are unsure of a member's cultural background, socio-economic status, or language (and it is important for you to know), ask them. This is a good way to start: "Tell me about where you come from." Or, "What is your primary language?" Also, don't assume all people from a specific ethnic group act the same way or believe the same things, and don't assume that because you share common aspects of your identity with another person that they also share your perspective.

LANGUAGE: Just because people may not understand the words you are speaking does not mean they will not be able to "read" your body language. It is important that you do not make faces, mutter things under your breath, or speak disrespectfully. Members will notice.

PRIVILEGE: This term refers to a position of power and entitlement based on societal norms. Most often, it is referred to in the context of White privilege, where people who are White or White-passing are presumed to have a "superior" status.

CULTURAL HUMILITY: Cultural humility is a way of approaching relationships that have power and privilege imbalances. Its key components are openness, self-awareness, remaining "egoless," and self-reflecting and self-critiquing after interactions with diverse people.

Rust et al. (2006); National Association of Peer Supporters (2020); Foronda et al., (2016); SAMHSA (2014)

FACT SHEET 5.3B, Social Identity Wheel

FACT SHEET 5.3C, Racism & White Privilege

Considering how pervasive racism is within society, it is likely to impact you, the members you serve, your helping relationship, and/or their experience in the health care system in some capacity. Concepts of racism and privilege may not be unfamiliar to you, but this fact sheet will explore racism and White privilege in the context of your work as a PHN.

Racism may be enacted in big and small ways: from microaggressions to overt discrimination, bigotry, and violence. Racism in any form has no place within the peer relationship, as it is built on respect, empathy, and open-mindedness. To create an environment of mutual respect and diminish the impact of racism, it is important that PHNs:

1. Become aware of and acknowledge their own racial biases—these are often learned all through our lives and need to be acknowledged so they can be changed.
2. Avoid lumping people's behavior into their racial group—behaviors are individual, not racial. Attributing behavior to race is often the root of most negative stereotypes.
3. People categorized into one race are often very diverse! For example, while people from South and Central America are classified as Latinx, there is tremendous diversity in language, tradition, norms, indigenous heritage, government systems, etc. between *and* within subgroups. If you want to learn more about a person, ask with respectful curiosity (e.g., "Would you mind telling me more about _____?") rather than making assumptions.
4. Avoid using race as a noun to describe a group of people (e.g., "Whites" or "Hispanics"). Race is part of someone's identity, sometimes a large part, but it is reductive to frame people <u>only</u> by their race.
5. If you think you've said something hurtful or racist, address it, apologize and acknowledge the harm you may have caused, and remain open to criticism, then take note and learn from it so you don't do it again.
6. Do not imitate accents, appearances, or cultural practices, even if you think it is a "joke" or a way to communicate appreciation. If you appreciate something about a person or their culture, tell them directly.

<u>What is a microaggression?</u>

These are verbal or behavioral slights that put down another person based on race or other social identity. These may be well-intentioned and are not always noticed by the perpetrator but still can cause great harm. Examples of microaggressions and the message implied or perceived by these types of comments or actions are included below.

MICROAGGRESSION	IMPLIED MESSAGE
"Your English is so good!"	*You do not "look" like you're from here or like English is your first language.*
"What is your <u>real</u> name?"	*Based on the way you look, you must be from somewhere else.*
Locking car doors/clutching bag/crossing the street	*People who look like you are dangerous/criminals, and I don't feel safe around you.*

"I don't see color."	*Your experiences of race/racism/distinct culture are not important to me.*
"You are a credit to your race."	*I don't think most people who look like you are as intelligent as you are.*

Because of racism, people of color (POC) are likely to experience health and healthcare disparities, leading to increased rates of chronic illness, shorter life expectancies, and worsened quality of life. Health inequities can be directly caused by racist biases of providers. For example,

- A 2016 study of White medical students found that 73% endorsed at least one false belief about biological racial differences (e.g., higher pain tolerance, stronger immune systems).
- POC receive less thorough emergency care than White people.
- Medical providers over- and under-diagnose mental health and substance use disorders based on race (e.g., Black men are 4x more likely to be diagnosed with schizophrenia than White counterparts).

Structural or systemic racism—policies, institutions, laws, and social norms that disadvantage and harm POC—also contributes to healthcare inequities. For example, zip codes where the majority of residents are Black are 67% more likely to have a shortage of primary care doctors. Black and Latinx people are significantly less likely to have health insurance than White people. Geographic access to health providers, affordable and nutritious food, and safe space for exercise is limited in more racially segregated areas, contributing to worse health outcomes.

White privilege is a term used to describe "an invisible package of unearned assets" afforded to White people because of racism. White privilege can impact the way one is able to navigate the healthcare system, have providers with similar experiences, or be believed by providers. PHNs should be aware of how their experiences will differ from members because of White privilege or lack thereof.

PHNs should understand the impact of racism on the health and wellness of members they serve. Namely, the long history of racism within healthcare has contributed to justified hesitancy in engaging with providers. PHNs should be aware of and validate members' hesitancy. Efforts to address these concerns should not be coercive or convincing; PHNs can use tools from motivational interviewing and incorporate reliable information to build trust. Other strategies PHNs might employ to support members in dealing with racism in healthcare include:

- Look for providers or clinics that have training and experience serving marginalized people.
- Utilize medical translators with members who are non-native English speakers to ensure information is being shared and understood fully.
- Ask what is important to the member in trusting a healthcare provider (e.g., racial/ethnic match, experience working with people with SMI, inclusive language use).
- Talk about their interest in using self-advocacy skills when facing prejudice from providers (e.g., asking providers to document when they refuse to provide a test or treatment, requesting more collaborative treatment planning, requesting another provider, etc.).

FACT SHEET 5.3D, Affirming Gender Identity & Sexual Orientation

Your relationship with members should be inclusive, supportive, and affirming of all aspects of their identity including their gender identity and sexual orientation. Sometimes, these topics may be relevant in receiving quality healthcare, especially in finding providers that will meet their needs. Sometimes, it will not come up at all. **However, creating an inclusive and affirming space for members will allow them to share with you what is important and relevant for them**. This sheet defines important concepts in gender identity and sexual orientation, when these concepts may be important in healthcare, and how to establish inclusive language and practices with members.

IMPORTANT TERMINOLOGY REGARDING GENDER, SEX, AND SEXUAL ORIENTATION

Sex: A term used to refer to the biological categorization of people into categories such as male, female, and intersex based on things like hormones, genetics, and physical characteristics.

Gender: Traits, characteristics, and stereotypes that society attributes to masculinity or femininity (e.g., pink is for girls and blue is for boys, women are more emotional than men, etc.)

Gender identity: How a person internally identifies their gender (e.g., man, woman, non-binary, trans). This may or may not correspond with one's biological sex assigned at birth and can change over time.
Gender expression: How someone outwardly portrays their gender through things like clothing, hair, mannerisms, etc. Again, this may or may not correspond with sex or gender identity, and all gender expressions are valid.
Gender binary: The false idea that only two genders exist: man and woman
Gender nonconforming: Characterization outside the gender binary (only male or female), which may include people who identify as gender fluid, gender-queer, gender neutral, or androgynous.
Transgender: Used to describe someone whose gender identity/expression is different from their sex assigned at birth or is different from societal expectations and may involve a transition (e.g., changing one's gender expression to better match how they feel).

***Note**: Transgender people do not necessarily identify as gay, even though they are part of the LGBTQ+ community. They should be accepted with their gender expression regardless.*

Cis-gender: Someone whose gender identity and expression (how they feel/what they wear) matches their biological sex

Sexual orientation: How someone classifies their emotional, romantic, and sexual attraction to others. This is the "LGB" in LGBTQ+. Some examples are defined below:

Bisexual: people who experience attraction to people of both sexes
Pansexual: people who experience attraction to people regardless of sex/gender identity
Heterosexual: people who experience attraction to people of the opposite sex
Homosexual/gay/lesbian: people who experience attraction to people of the same sex

Note that these terms are adjectives or descriptive words, not nouns. Using only someone's sexual orientation or gender identity to describe them is reductive and can contribute to stereotypes.

Pronouns: how someone should be referred to in conversation (e.g., she/her, he/him, they/their)

CREATING AN AFFIRMING WORKING RELATIONSHIP

Unfortunately, much of society's norms and practices favor people who are cisgender and experience opposite-sex attraction, called cis- and hetero-normativity. This includes applications asking about gender with M/F as the only options, the use of gendered pronouns (he/his and she/her), labeled bathrooms, and assumption of heterosexual relationships (e.g., "Do you have a partner?" instead of "Do you have a girlfriend?"). Worse yet is the prejudice, discrimination, and violence experienced by people who identify outside the gender binary or do not identify as heterosexual. To ensure that *all* members know that they are safe and welcome working with you, consider the following guidelines for inclusivity:

✓ DO's:	✘ DON'Ts:
• **Ask about pronouns** and offer yours when meeting (e.g., "Hi, Walt! I'm Jesse, my pronouns are she/her. What are yours?") • **Use the correct pronouns once you've learned them**. Sometimes silently practicing to yourself a few times when you meet someone can help you remember. (e.g., "Sam's pronouns are they/their. They like going to the movies. They have great style and love shopping at thrift stores. Their favorite color is teal."). • If you use the wrong pronouns, **correct yourself quickly and immediately**. (e.g., "Sorry, Sam! I know your pronouns are they/their and I said it wrong just now. I'll get it right next time, I apologize.") • **Consider the privilege you may have** given your gender identity/sexual orientation and know that not everyone will have that. • **Use "gender affirming"** rather than "reassignment" or "replacement" when talking about healthcare for people who are transitioning.	• **Assume**. Don't assume pronouns, romantic partners, desire for medical transition (e.g., hormones, surgery), what bathroom someone uses, etc. • **Use or ask about their "dead name"** (assigned or legal name) if someone uses a new or different name. Use the name they introduce themselves with (or even ask when meeting them "What do you want me to call you?") when talking to/about them. • Use words like "it," "she-him," "tr*nny," or "h*rmaphrodite." These are **outdated and derogatory terms** meant to objectify and belittle people who exist outside the gender binary. • Frame gender and sexual orientation as a **choice or deviation from normal**. When people express their gender and sexual orientation openly, they are not preferences or attempts at "reassignment" but external affirmations of their true identity.

GENDER AND SEXUAL ORIENTATION IN HEALTHCARE:

Not only is affirming gender identity and sexual orientation crucial to respectful peer relationships, it can also be important in members' healthcare. People from the LGBTQ+ community may face discrimination from providers that prevents access to care. Insurance providers have historically denied gender affirming treatments and procedures for trans people. As a PHN, you may consider talking with members about finding welcoming and safe providers, gender affirming treatment, and accessing appropriate mental health support.

FACT SHEET 5.4A, Self-Disclosure

As a PHN and a person with lived experience, you have your own story that may be helpful for others to hear. It is important to note that telling your story does not usually occur early in your relationship with your member. Your relationship with them has to be established. While your work is about members, hearing how you have overcome struggles can be useful in the right moments. How you tell your story is important.

MAKE IT PERSONAL: Telling your story to another person can feel risky and uncomfortable if you have not done so before.

Do: Make sure the story you tell is your own and that you are comfortable sharing these details with another person. Be natural and emphasize the trials you have overcome. Use "I" statements (e.g., "I experienced stigma when talking to my family about my new diagnosis…".

Don't: Share experiences that you are currently struggling with or are uncomfortable sharing. Don't ask members for advice or guidance; remember this work is about them.

USE CONCRETE EXPERIENCES: Generalizations can be difficult for others to relate to, so use real-life examples when telling your story.

Do: Provide examples of your experiences (e.g., "When I was hospitalized for a suicide attempt, I was scared" vs. "I was hospitalized once, too"). Share strategies that worked for you and how you learned about them, though be mindful not to disclose anyone else's identity or private information when telling of these strategies (e.g., avoid saying something like, "My friend, Bob Smith, who I was in therapy groups with, told me about this resource.")

Don't: Use vague language or stories that are not yours (e.g., "My friend had something similar happen"). Don't jump around from experience to experience; it can be confusing for others to follow.

BE TRUTHFUL; DON'T EXAGGERATE Embellishing your story in any way is not encouraged. It puts the person listening to your story in a position of living up to unrealistic expectations.

Do: Be honest about your past struggles and successes. Tell members what worked for you.

Don't: Lie about things that happened to you or choices you made. Don't talk about things that did not work for you, as they may work for the member.

EMPOWER YOURSELF; EMPOWER OTHERS Telling your story helps members recognize that you are no longer a passive responder to your illness, nor to a society that looks down on people like you.

Do: Be confident when you are telling your story. Show pride in yourself and your experiences and emphasize how recovery is the norm, not the exception.

Don't: Share experiences that are too personal or you are uncomfortable sharing. Don't talk about how easy it was for you to recover, as that can make the member feel badly.

Consider the acronym "WAIST" when deciding about self-disclosure:
Why Am I Sharing This?

Corrigan & Lundin (2012).

WORKSHEET 5.4B, Disclosure of Information

Before you begin, review the **Self-Disclosure** Fact Sheet. Pair up with a partner and choose one of you to be the speaker and one to be the listener. Share your story of recovery with them.

Switch roles after 10 minutes.
After you are finished, take a minute to think about the following:

As the **speaker:**
What did I do that I liked?

- _____
- _____
- _____
- _____

What would I do differently next time?

- _____
- _____
- _____
- _____

As the **listener:**
What did the speaker do well?

- _____
- _____
- _____
- _____

What are my suggestions for the speaker to do differently next time?

- _____
- _____
- _____
- _____

University of Chicago Center for Psychiatric Rehabilitation (1999)

FACT SHEET 5.5A, Trauma-Informed Care

- **Trauma** is a distressing or disturbing event, leading to fear, helplessness, or lack of control. An example is being the victim of a violent assault. Trauma can result from a one-time occurrence or prolonged traumatic events, such as abuse or neglect.
- **Trauma-informed care** is an approach that realizes the prevalence of trauma, recognizes how trauma affects members, and responds by putting this knowledge into practice. Additionally, being trauma informed means that we work to ensure that our settings, policies, and procedures are not retraumatizing for people.

Sometimes you won't know exactly what to say when someone shares their experiences with trauma, but the suggestions below can help you listen, acknowledge their experience, and support them.

RECOGNIZE SIGNS:

Do: Recognize signs of trauma, such as re-experiencing the trauma (nightmares, bad memories), avoiding people or places that are reminders of the event, loss of interest in activities, or distress when reminded of the event. Recognize that trauma impacts each person differently.

Don't: Ignore signs or minimize member's distress. Don't neglect the trauma or act as if the symptoms are unimportant, wishing the member would just get over it.

NORMALIZE THE TRAUMA

Do: Help members tell their story if they want to. Explain why you are asking about their trauma, and be sensitive to their experience while curious and respectful of their desire to talk about it.

Don't: Redirect the member by changing the subject to avoid it. Don't undermine their story or make them feel ashamed of their trauma. Don't make members feel guilty or alone in their experience.

ESTABLISH SAFETY

Do: Make the member feel safe, building trust with the member. Provide a safe setting to talk and promote a sense of safety through your communication and interactions with members.

Don't: Don't question their story. Don't drive the person outside of their comfort zone by making them talk if they are uncomfortable. Don't break promises or give reasons to be mistrusted. Keep facial expressions and body language open & friendly.

COLLABORATE

Do: Create a partnership between you and your members. Your relationship should be collaborative, sharing the power in decision making. Ask the member what they have found helpful in the past. Connect the member to services in the community.

Don't: Don't let the members feel alone or unsupported. Don't allow the members to feel that their voices aren't heard or they are not a part of the decision-making process.

PROMOTE EMPOWERMENT

Do: Recognize members' strengths, emphasizing their resiliency needed to survive the trauma.

Don't: Make the member feel ashamed of their story. Don't blame members or make them feel their trauma is unimportant. Don't provide thoughtless responses. Don't fake interest in their experience. Remember that body language speaks volumes.

Shuman (2012).

WORKSHEET 5.5B, Trauma-Informed Care Experiences

Share an experience of trauma that you are aware of. This can be your own experience or something experienced by someone else (if using someone else's experiences as an example, be sure not to disclose their identity):

_____
_____
_____
_____

Note: Be aware that any trauma experiences—yours or other people's—can still be frightening or troubling to you and/or your members. Don't feel like you have to share something that is still traumatizing.

What were the signs of trauma?
How was safety established?
How did collaboration help?

5.6 LOW-COST HEALTH RESOURCES

One of the most challenging barriers to gaining access to healthcare is cost. As a PHN, finding affordable healthcare options for members will often open possibilities to increase your members' quality of life and overall health.

Handout FACT SHEET 5.6A, Low-Cost Health Resources

Ask trainees to review the resources and information listed in the fact sheet, then move to Worksheet 5.6B to answer questions about the needs your members may have.

Handout WORKSHEET 5.6B, Identification of Resources

Answer these questions either alone or as a group of PHNs. Any that you are unsure of the answer to, highlight and revisit later on.

Handout FACT SHEET 5.6C, Prescription Discount Cards

FACT SHEET 5.6A, Low-Cost Health Resources

Knowing where to look for affordable healthcare options may be one of the most significant challenges you will face. One of the best resources to explore your city's, county's, and/or state's health department for low-cost healthcare and treatment options. Typically, these healthcare facilities provide free, low-cost, or sliding scale services. In some instances, members will need to prove their income by bringing with them their Medicaid card or showing pay stubs, or tax returns to their first appointment. PHNs should work to help members secure Medicaid if they do not have and/or are unable to afford private insurance. If the local health department does not offer services, they may provide you with referrals to other healthcare providers.

In addition to health departments, it may be wise to consider other healthcare options such as local community organizations and social services agencies. Building a list of go-to references should start with a search from within your organization. Find out if there are healthcare services that your members are typically referred to by others on your team. You may also want to contact partner agencies and ask about the contacts to whom they refer their own members.

Another great resource to utilize in finding inexpensive healthcare services is through the use of online resources. One such resource, The Hub, allows PHNs to input a zip code to find a variety of healthcare, social services, and financial assistance options for members. The Hub's web address is https://healthconnectionhub.org/.

If you or your organization are just beginning to provide services to members and have little experience in healthcare, another good option would be to contact a local affiliate of a national organization. Non-profits such as The Salvation Army, United Way, and Catholic Charities all should have local offices in or near your city. As they often provide direct services, they should be able to connect you with low-cost healthcare options.

To help you better find and identify your needs and opportunities for low-cost health services, the worksheet on the next page may prove invaluable.

WORKSHEET 5.6B, Identification of Resources

What kind of healthcare cost concerns are most common among the members you serve?

_____

_____

Does your organization already have an agreement or memorandum of understanding with any low-cost healthcare providers?

_____

_____

Are there any established low-cost healthcare providers already working in your city or county?

_____

_____

Are there any free local databases you can use to help build a list of affordable healthcare options for your members to use? One such example is the above provided www.healthconnectionhub.org.

_____

_____

How far are your members able and willing to travel to access more affordable care?

_____

_____

FACT SHEET 5.6C, Prescription Discount Cards

Many pharmacies offer their own unique prescription drug savings cards. With an inexpensive annual or monthly fee, the cards can save hundreds of dollars off the retail price of various prescriptions.

Walgreens offers an annual discount card for $20 for individuals and $35 for families. Through using the card, members may gain access to prescriptions that are usually outside of their budget at a flat rate fee in 30-day, 60-day, and 90-day increments. Many common medications for chronic illnesses such as high blood pressure, high cholesterol, and mental health issues are offered at a substantial discount.

GoodRx is another prescription discount option for those seeking expanded pharmacy options. Members can select pharmacies based on their location or prescription price offerings. GoodRx offers some discounts free of charge, whereas others require a gold-level membership. The free version of GoodRx may not include discounted savings on some medications. Your members can sign up for free or opt-in for a 30-day free trial if interested. After the free trial, gold-level monthly benefits cost $5.99 for an individual and $9.99 a month for a family. Anything in the standard formulary can be purchased on these cards. GoodRx is complimentary to Medicaid and Medicare and can provide members with an additional avenue for savings. Additional charges may apply for home delivery of prescriptions depending upon the pharmacy.

Web Addresses for Prescription Cards:

- Walgreens Savings Club - https://www.walgreens.com/psc/prescription-savings-club
- GoodRx - https://www.goodrx.com/

FACT SHEET 6.1, Mental Health Crisis Management

Mental Health crises can occur when people are in emotional distress. The role of the PHN is to assist the person in crisis until appropriate professional help is received. The PHN will need to be able to identify **signs, utilize effective communication, and practice ways to keep a person safe.**

SUICIDAL THOUGHTS AND BEHAVIORS

Signs: Threatening to hurt or kill self, seeking access to ways to harm self, talking about death, acting recklessly, and feeling trapped.

Effective communication strategies: Tell the person you care and want to help. Express empathy and clearly state that thoughts of suicide are often associated with a *treatable* mental disorder (instilling hope). Directly ask the person if he or she is thinking about killing themselves. It is OK to ask direct questions—this will not cause someone to become suicidal or exacerbate existing thoughts of suicide.

Ways to keep person safe: Work with a person to increase safety. If a person is acutely suicidal, always call your supervisor. If your supervisor isn't available, call THEIR supervisor. If the threat they pose is imminent, then call 911. A person who is actively suicidal should NEVER be left alone and needs help. Work with the person, your supervisor, and other clinical staff (if possible) to ensure safety. Other problems in the person's life can be addressed after safety is ensured.

NON-SUICIDAL SELF-INJURY

Signs: Cutting, pinching, or scratching of the skin enough to cause bleeding or a mark that remains.

Effective communication strategies: If you suspect a member is deliberately self-injuring, discuss it calmly. Do not ignore it.

Ways to keep person safe: If you have interrupted someone in the act of deliberate self-injury, intervene in a non-judgmental way. Remain calm and avoid shock or anger; express your concern. Ask if medical attention is needed. Refer to the appropriate professional. The only way to determine if an injury is non-suicidal is to ask directly.

ACUTE PSYCHOSIS

Signs: A person experiencing psychosis may have trouble distinguishing what is real and what is not, such as hearing things or not speaking clearly. He or she may exhibit disruptive or disturbing behavior. Sometimes this is dangerous for the person, and sometimes it is not.

Effective communication strategies: Stay calm. Communicate in a clear, concise manner, using short simple sentences and speak quietly in a non-threatening voice. Comply with requests unless they are unsafe or unreasonable (i.e., it is okay to go for a walk around the block; it is not okay to take a bus to New York with them).

Ways to keep person safe: You may not be able to de-escalate the situation, so be prepared to call for help. Call a crisis staff to come help and explain to your member when they arrive that they are there to help.

TRAUMATIC EVENTS

Signs: A traumatic event is any incident experienced by the person that is perceived to be overwhelming and frightening. A person may exhibit crying, yelling or outbursts, shaking or withdrawn behavior, and irritability.

Effective communication strategies: When talking to someone who has experienced a traumatic event, be genuinely caring. Ask the person how you might best help them.

Ways to keep person safe: If you are on the scene of the traumatic event, call 911 and wait for professional help. It is important not to force a person to talk. After the event, encourage the person to talk about it if he or she is ready and share resources with them for professional help. It can also be helpful to ask the person how they help themselves feel better.

PANIC ATTACKS

Symptoms of a panic attack can resemble a heart attack. It is not possible to know for sure unless you know the person. If there is any doubt call 911.

Signs: Chest palpations or rapid heart rate, feelings of unreality or being detached from oneself, trembling and shaking, shortness of breath or choking sensations.

Effective communication strategies: Reassure the person that he or she is experiencing a panic attack. Remain calm. Speak clearly and use short sentences. Ask directly what might help.

Ways to keep person safe: Model normal breathing rate (breathe together). If the panic attack does not pass quickly, refer to a professional.

ALCOHOL OR DRUG OVERDOSE

Signs: Significantly impaired thinking and behavior, aggression, cursing, and even passing out.

Effective communication strategies: Talk in respectful manner using simple, clear language. Do not make fun of, laugh at, or provoke the person.

Ways to keep person safe: Do not leave the person alone. Keep the person away from dangerous objects; do not let him or her drive. If the person is unconscious, place him or her in the recovery position (laying down on him or her side with airway open) and call 911.

INTERPERSONALLY CONCERNING BEHAVIOR

Signs: Argumentative, hostile, threatening or yelling, trying to hit, punch, throw objects, and kick or bite.

Effective communication strategies: Do not argue or threaten the person or restrict his or her movement. Speak slowly and in a calm manner. Consider taking a break from the conversation to allow the person to calm down. Use supervision to process these experiences and how to problem solve how to handle similar situations that occur in the future.

Ways to keep person safe: If you are frightened, seek outside help immediately. Never put yourself at risk. Consider if you also need to call 911. Always call your supervisor. If the aggressive behavior is verbal or emotional but is not abusive, use the effective communication strategies above. If you are frightened, seek outside help immediately.

See 6.3 – Distress Awareness and De-Escalation to recognize and respond to early signs of a heightened emotional state to prevent crises.

Mental Health Association of Maryland, Missouri Department of Mental Health, and National Council for Behavioral Health (2013).

FACT SHEET 6.2, Physical Health Crisis Management

Physical health crises are medical issues you may encounter while with members. The role of the PHN is to assist the person in crisis until appropriate professional help is received. The PHN will need to be able to identify **signs** and **what to do** until help arrives**.**

HEART ATTACK

Symptoms of a panic attack can resemble a heart attack. It is not possible to know for sure unless you know the person. If there is any doubt call 911.

Signs: Chest discomfort, pain in upper body and arms, unexplained shortness of breath, cold sweats, nausea or vomiting. Chest pain is the most common symptom in both men and women, but women may also experience extreme fatigue as well as back pain.
What to do: Call 911. Do not wait more than five minutes to make the call. Have the person sit down, loosen any tight clothing, and encourage them to keep calm. If the person becomes unconscious, perform CPR until help arrives.

SEIZURES

Signs: Temporary confusion, staring off into space, uncontrollable jerking movements of the arms and legs, and loss of consciousness or awareness.
What to do: Ease the person to the floor. Roll the person onto their side so they do not choke if they vomit. Make sure the person is breathing, and check that nothing is blocking their airway. Put something soft (like a towel or shirt) under their head to prevent injury. Check for medical bracelet. Call 911 if the seizure lasts more 90 seconds.

STROKE

Signs: Sudden numbness, weakness, or paralysis of face, limbs, or one side of the body; confusion or trouble speaking or understanding others; blurry vision or sudden trouble with mobility or loss of balance; sudden headache accompanied with a throbbing sensation.
What to do: Call 911. Remain calm and provide reassurance. Get the person to a sitting position. If the person loses consciousness, help them to the floor and make sure their airway is open. Keep any paralyzed limbs warm and do not give the person any food or water.

COUGHING OR VOMITING BLOOD

A variety of lung conditions can cause a person to cough up or vomit blood.

Signs: Bright red blood, brown-tinged sputum, or frothy pink mucus.
What to do: Encourage the person to make an appointment with a doctor immediately or go to the ER. If an excessive amount of blood is present or condition is persistent, call 911.

FROSTBITE

Frostbite is the freezing of a specific body part, such as fingers, toes, the nose or earlobes.

Signs: Numbness in the affected area; skin that appears waxy, is cold to the touch, or is discolored (flushed, white or gray, yellow or blue).

What to do: Move the person to a warm place; do not rub affected area. Soak the affected area in warm water until it is red and feels warm. Loosely bandage the area with a sterile dressing. Do not allow the area to refreeze, and seek medical care as soon as possible.

HEAT STROKE

Signs: Hot, red skin which may be dry or moist; changes in consciousness; vomiting; and high body temperature.

What to do: Call 911. Move the person to a cooler place. Remove or loosen tight clothing and apply cool, wet clothes or towels to the skin. Fan the person. If the person is conscious, give small amounts of cool water to drink. Make sure the person drinks slowly.

BROKEN BONES AND SEVERE SPRAINS

Signs: Significant deformity in affected area, including bruising and swelling; inability to use the affected part normally; bone fragments sticking out of a wound; the injured area is cold and numb. A good way to tell if an area is not normal is to compare it with an un-injured part of body.

What to do: Keep the injured part from moving. If the affected area is in the back or neck, call 911 for ambulance transport. Seek medical attention immediately for all other parts of the body.

SEVERE CUTS

Signs: Caused by sharp-edged objects, such as knives, scissors, or broken glass. Cuts usually bleed freely; deep cuts can bleed severely. A cut may not be painful if nerves are injured.

What to do: Control bleeding by placing a clean covering over the wound and applying pressure; elevate the injured area. Apply a bandage snugly over the dressing. If the bleeding cannot be controlled, put pressure on the nearby artery (pressure point) and seek medical attention. Wash your hands immediately after providing care.

ASTHMA ATTACK

Signs: Coughing, wheezing, or shortness of breath; difficulty walking or an inability to talk; tightness in the chest and sweating; lips or fingernails turning blue.

What to do: Stay calm and be reassuring. Make sure the person is sitting upright. Ask the person if they have an inhaler. If they do, get it and encourage its use. If they don't, and symptoms continue, seek medical help or call 911.

OVERDOSES

Signs: Drug overdose symptoms may include: agitation, convulsions, delusions, difficulty breathing, drowsiness, nausea and vomiting. The person may also have tremors, extreme sweating, and unconsciousness, and may exhibit violent or unorthodox (i.e., taking off clothing) behavior.

What to do: Ask the person what they took (type of substance, amount, and when). Check the person's airway, breathing, and pulse. If the person is unconscious but breathing, carefully place in the recovery position (laying down on him or her side with airway open). If conscious, loosen the clothing, keep the person warm, and provide reassurance. Try to keep person calm. Try to prevent the person from taking more drugs. Call 911. **FAINTING**

Signs: The person is dizzy or falls to the ground suddenly; not due to an injury.

What to do: Make the person safe; lay the person flat on their back, elevate their legs, and loosen tight clothing (like a necktie). Try to revive the person; tap briskly or yell. Once the person wakes, give them some fruit juice. If the person doesn't respond, call 911 immediately.

American Red Cross (2014).

FACT SHEET 6.3, Distress Awareness & De-Escalation

What is DISTRESS?

Distress can be defined as a temporary state of suffering, danger, need, or great physical or mental strain. People experience distress for various reasons and may express it quite differently as well. Review the table below, and add other possible causes and examples of distress that you think of.

POSSIBLE CAUSES OF DISTRESS	EXAMPLES
Frustration	• Dissatisfaction with one's life circumstances, services, or relationships with others • Experiencing discrimination • Feeling lonely
Triggering or upsetting event (usually evokes a traumatic memory)	• A trauma anniversary • A stimulus (e.g., sound, smell, sight) that triggers a traumatic memory
External stress or pressure	• Pressure from family members, school, or work • Financial strain • Major life changes like moving or divorce
Anxiety or nervousness	• An upcoming dental appointment or court date
Symptoms of mental or physical health conditions	• Delusions or hallucinations that are upsetting • Brain injury, seizures, or dementia • Intoxication

HOW DO PEOPLE EXPRESS DISTRESS?

Sometimes it will be very obvious to you that a member is feeling distressed. They may flat-out tell you with words or may communicate it with tone or body language. Other times, members will become more withdrawn.

Below are some ways you might know that someone is feeling distressed. Can you think of others?

- **Verbally expressing frustration:** using more swear words than usual, talking faster or louder than usual, interrupting others, criticizing others or self
- **Body language:** grimacing, crying, crossed arms, sighing repeatedly, shaking, balled fists, flailing arms, closing eyes
- **Actions:** repetitive motions like pacing, banging their fist on the table or snapping a rubber band on their wrist, encroaching on personal space
- **Withdrawing:** not responding how they normally would, having low energy, refusing to answer calls or meet, ending meetings early
- **Physical manifestations:** aches and pains including stomachaches and headaches, lethargy, eating or sleeping more or less than usual, increased substance use

Think to yourself of a time you or someone you know experienced distress. If there were people around at that time, what were things that they did or said that you found helpful? What about things they did or said that were unhelpful?

RESPONDING TO SIGNS OF DISTRESS:

When you notice signs of distress when working with a member, it's important to be mindful of how your words, body language, and actions can help support them or potentially worsen their distress.

Remain open and relaxed: Keep arms uncrossed, palms out, and your body angled toward the person while remaining at least arm's length away (i.e., not closed off but not directly confronting the person, leaving room to breathe). Keep movements slow and calm so as not to create additional stress or anxiety.

Maintain a respectful tone: By communicating calmly and respectfully, you set the groundwork for effective communication without triggering further distress. Avoid a condescending or patronizing tone to convey mutual respect.

Be respectfully curious: If you feel a member may be in distress and you're not sure why, consider posing a question but don't interrogate. Allow members the space to experience negative emotions while offering your support.

Decrease frustration: By helping members get their goals met, PHNs can help decrease frustration—even if these goals are not the original cause of the distress.

Decrease demands: A member may become distressed when he or she is unable to meet external demands (e.g., making an appointment on time, calling a provider without support, sticking to a meal plan). A possible solution is help the person set realistic goals that he or she can meet in a timely way.

Decrease confusion: Confusion about boundaries, expectations, or roles may lead to distress. Be clear about your relationship with the person to avoid confusion.

Decrease stimulation: Be aware of stressors, including other people that may trigger distress. Create a quiet, non-threatening environment when possible.

Identify incentives: Consider how you may encourage or reward adaptive coping skills rather than maladaptive responses to distress (e.g., providing verbal encouragement when the member takes a walk instead of engaging in an argument with a neighbor). This can reinforce positive coping skills that will help them avoid negative consequences of distress.

Promote pro-social behavior: A lack of social support can make a person feel vulnerable and worsen distress. Encourage them to engage with supports to promote more adaptive distress tolerance.

Manage substance use: If the person's behavior is impacted by substance use, give them some time to sober up. Provide a safe place to sober up. Have conversations about planning substance use frequency and amounts around responsibilities, like medical appointments or grocery shopping, so that it interferes less.

Set limits without antagonizing: If a member expresses distress by making verbal or physical advances, set clear boundaries (e.g., "I see that you're very frustrated, and I want to work this out, but we're going have to reschedule our meeting if you continue calling me names.") without becoming argumentative.

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