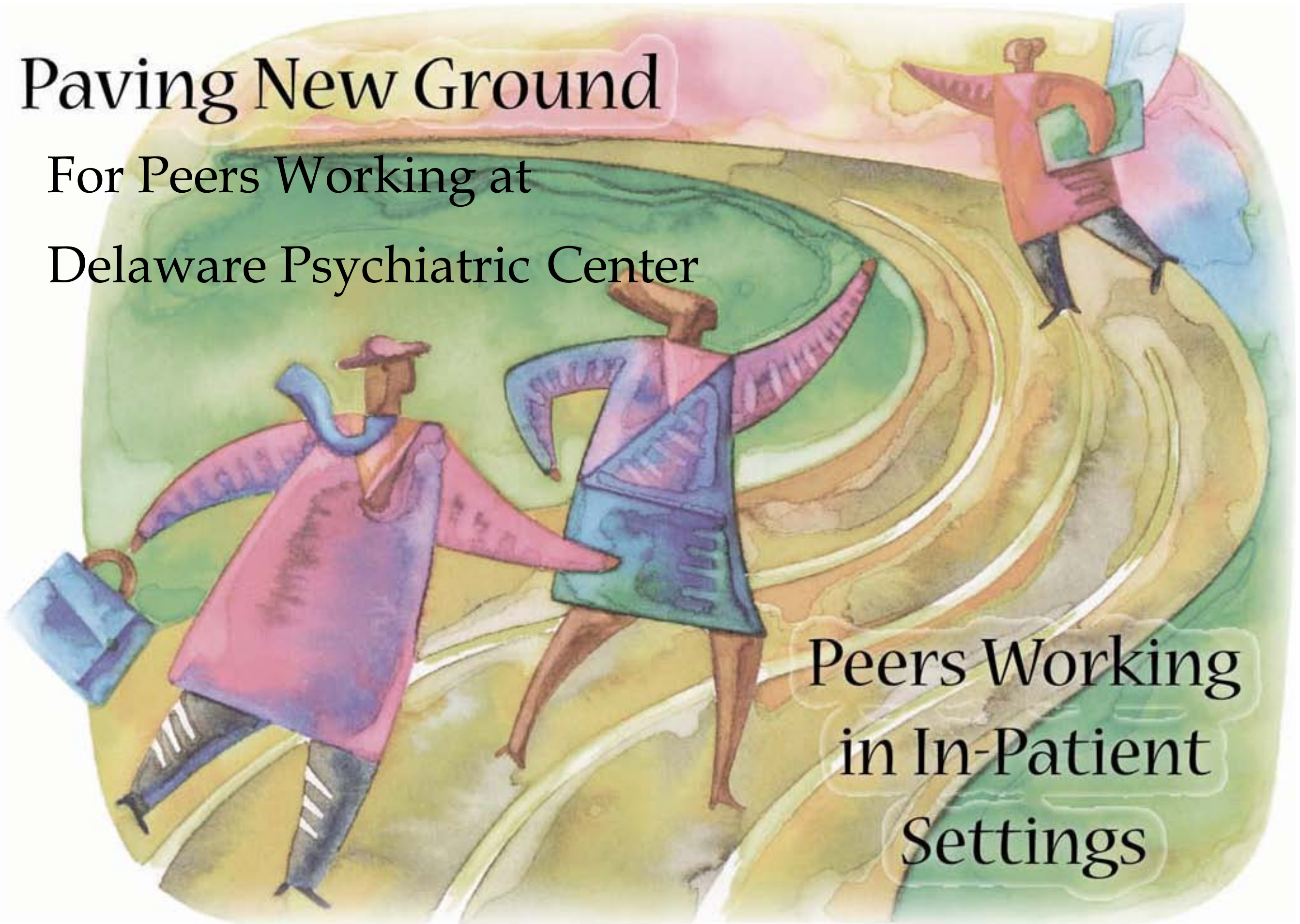
Paving New Ground
For Peers Working at
Delaware Psychiatric Center
Peers Working
in In-Patient
Settings

Paving New Ground II

Purpose of this Guidebook

The purpose of this guidebook is to provide information to peers beginning their work in inpatient settings. You will find information that provides steps and how-to's, lots of experiential anecdotal experiences from other peer specialists and resources for additional information.

Most peers, even those certified as peer specialists do not receive training that prepares them for work in an acute care or inpatient setting. Working with clients who are receiving services in a clinical setting is different than working in a community setting. The needs are more acute, persons have more difficulties, they may have trauma histories that have been ignored and they most likely have not heard of recovery.

In an acute care setting a peer specialist spends a lot of time with people individually in order to get to know them and to learn about their strengths, interests and hobbies. Peers need to understand what factors may have led to them being admitted and what circumstances might cause them to be upset or trigger a crisis. Most importantly peers will want to find ways to help them transition back into the community as quickly as possible.

Working in an inpatient setting is not easy. This is an environment that operates in a way that is not always recovery oriented. Clients often are required to adhere to rigid schedules, rules, and "levels systems" that keep people from gaining independence. Crises often erupt because a person has not received enough support and, in all fairness, staff, simply do not have the time to give them the attention that they need.

The peer role can be significant in many ways. Changing physical environments to become more calming and pleasing to the eye, helping to change policies, working with staff as an equal team member, providing training to staff and clients about recovery and "telling your own recovery story"—both to clients and staff--one of the most powerful tools that you have to teach others that recovery is possible.

Activities are also very different. While you cannot do as many things with clients due to safety regulations, there are so many ways for peers to be creative both in thinking and in action. Adding humor, engaging in creative arts projects, creating opportunities for clients to get more fresh air and exercise, and visiting community programs can all be part of the peer role.

In this guide you will learn about the necessary tools required to do this job: how to read a clinical record, prevent crises, develop good communication skills, take on an advocacy role, provide trauma informed care, and recognize boundary issues, among many others.

The goal for this guide is for you to love your job, to do it with confidence and to provide peer support to others while helping yourself in the process.

More …About this Guidebook:

This guide is a work in progress and is very much in draft form. I think the materials in it will be helpful to you now but know that it may be revised and/or have more materials added later as it goes through stages of development.

The guide is being developed as part of my work at Delaware Psychiatric Center where I am working as a consultant to train peer specialists to work in the state hospital setting. Very recently seven peer specialists have been hired, two who will work in the state hospital and five who will work as "Bridge Peers" (Peer Bridgers) whose work will focus more in the discharge process for clients transitioning into the community.

I would like to acknowledge and thank my close working associates in this project: Penny Chelucci, Office of Consumer Affairs Director for the state of Delaware, Kevin Huckshorn, Delaware Mental Health and Substance Abuse Commissioner, and Pam Freeman, Client Advocate at Delaware Psychiatric Center. All of us work together to structure their supervision and training with Penny as their project supervisor.

Also serving as an advisor to this project, is Holly Dixon, Peer Support Director at Riverview State Hospital in Maine. She has contributed to the materials contained in this guide and has been a valuable resource in many different ways.

Ed Pazicky, Altered States of the Arts Coordinator and Advocate, is formatting and designing the guide. I thank him for always friendship, tolerance of my non-techy abilities, and his steadfastness and helpfulness.

Others have contributed as well and will be acknowledged when the guidebook is finalized.

Please accept my apologies if you find errors. Also, please feel free to contact me with feedback or advice.

Thanks,

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For other immediate resources go to:

www.nasmhpd.org/consumernetworking.cfm Office of Technical Assistance for Peer Networking

www.naops.org the National Organization for Peer Specialists.

Are You Ready?

- ✓ Do you have a job description?
- ✓ Do you know how you will disclose your history of mental illness—to staff, to clients?
- ✓ Are you able to be calm in difficult situations without judging or reacting?
- ✓ Have you met with the leadership of the hospital (e.g. executive director, director of nurses)?
- ✓ Do you know if there are adequate resources for your education and support?
- ✓ Have you had sufficient training on the meaning of Recovery?
- ✓ Do you know how to define "trauma informed care"?
- ✓ Do you know what term you will use for yourself and for people you serve?
- ✓ Do you know the facility's policy on seclusion and restraint?
- ✓ Do you know on which unit of the hospital you will be working?
- ✓ Do you have a designated office space?
- ✓ Do you know the hours that you will be working?

Orientation:

New employee orientation is intended to welcome you to the hospital. During orientation, you will receive information, resources, and supports necessary for an easy and successful tranisiton into your new job.

You will attend orientation with new employees regardless of position or status. These one-week to two-week sessions will provide you with information regarding health and safety, risk management, employee benefits, and health insurance as it applies to full and part time workers.

You may have the need for certain accommodations, but you should first address these with your supervisor rather than with the Human Resources Director. Some of these might include need for flexible work hours, physical accommodations, time off for periods of stress, need for occasional quiet space.

Some of the subjects covered in orientation include:

- Mission statement of the hospital
- Policies and procedures
- Emergency procedures
- Code system for emergencies
- Risk management
- Health insurance
- Tour of hospital facilities
- Crisis prevention and intervention

The training on crisis prevention and intervention may be one or two days and always includes hands-on restraint and seclusion training. As this will not be part of your job description, make sure you are not expected to participate unless as an observer.

First Day:

What to Expect:

Find out in advance whether there have been preparations made for your arrival. The best approach may be for you to start working on one unit only and then, after you feel comfortable working on one, branch out to others. Staff members on the unit where you will be working will have information about your role and duties, but may still have some confusion about what you will be doing. Even with the best-laid plans, you may find that not all staff will be prepared for your arrival. Some staff may not be welcoming due to the fear that you will take over or push to have people discharged before staff thinks they are ready. It may take a while to win them over.

Sometimes the hospital will plan a first day celebration or welcoming ceremony for you and other peer specialists. If there is a staff advisory group in place, they may plan a welcoming event as part of their goal to educate staff about your role and to support you in your transition. This will give you a good start as it will be a pleasant experience for everybody and will serve to heighten awareness about your presence and your role in the hospital. They may ask you to speak. If they do, be sure to keep it brief. Introduce yourself, explain where you will be working, say a few words about your background, but do not take this opportunity to "tell your story." There will be other occasions where it will be appropriate for you to share your recovery story in more depth and detail.

Make sure you have designated office space. Find out it you will share space with others and whether it is in is in a quiet area. You should have a computer, office supplies, access to a printer, etc.

To be successful on first days:

- Observe what clients are doing: Are they actively engaged in some type of activity? Is the TV on during daytime hours? Do most clients go to the Recovery Mall activities during regularly scheduled hours?
- Attend a treatment team meeting. Note the number of persons sitting at the table; is anyone there to support the client, such as a family member, friend or advocate? Where is the client sitting? (S/he should be sitting at the head of the table.) Who does most of the talking? Is the client asked to express him/herself? Is the treatment plan updated during the meeting?
- Read facility policies and procedures;
- Meet with the patient advocate: Find out how many complaints are received per month. How many of these are serious? Does the advocate have a working relationship with staff?
- Review patient rights: Rights posters should be visible and at eye level. Are you able to read the information; is it in tiny letters; is it too long? Note where the poster is located; are phone numbers for rights organizations posted at the phones?
- Observe client-staff and staff-client interactions:

- If there is an emergency situation observe how it is handled.
- Attend a Community Meeting (make sure you are introduced).
- Determine whether most of the clients are going to the Recovery Mall.
- Attend different classes at the Recovery Mall.
- Read client records: This is optional as some peer supporters feel they will be influenced negatively if they read a person's history. I recommend reading certain portions of the record, such as the treatment plan, progress notes, whether or not there is a personal safety plan. Note whether the language is personalized or clinicalized; is the person's name used or are they referred to as "patient" in progress notes?

Scenarios for discussion:

You have just started working and you find that most staff welcome you and are warm. They offer to help, answer your questions, and introduce you to other staff. There are two staff members, though, who are distant and at every opportunity give you the looks that indicate their distrust.

How would you handle this situation?

The day you are scheduled to start working, you discover that your supervisor is out due to an emergency. Staff are busy and are confused about what you should be doing. One of the staff says, "Do your best."

What would you do?

While you observe an incident on a unit when a client gets angry and starts throwing things. Two of the staff are attempting to de-escalate the angry client but there are not enough staff nearby to do usher other clients away from the area.

What would you do?

What other situations so you think you might encounter?

Supervision:

Your supervisor is a consumer; however, there are examples of many excellent non-consumer supervisors who are sensitive and supportive of peers and who have received high marks from peers working under them. If there are two or more peers, the supervisor will serve as the team leader. In either case, your supervisor will be your support system at all times. S/he will help orient you to the units, introduce you to the staff and ensure that you receive proper training to do your job.

Job Description:

You should have a job description by the time you are ready to start working. It should be generic for all of the peers working on the team and should contain all required duties as well as optional ones, distributed according to how much time you will be working. Your job description should allow for updates and additions as many peers find their own niches in areas that were not included on the original job description.

The job description should be updated during regularly scheduled meetings between the peer specialist and supervisor. It will be important for the supervisor to know and approve all new or added duties in order to evaluate whether they are enhancing and contributing to the job. For example, one peer specialist began to involve people she worked with in the production of a newsletter. She was able to provide peer support while she did this, which made the experience valuable. She found that doing something practical helped people feel worthwhile, and they enjoyed accomplishing something.

Your supervisor/team leader will make available the resources and materials that relate to the job. S/he will evaluate your performance periodically and assist you in areas where you have difficulty. Your supervisor will also be on the lookout for opportunities for you to network and learn from other peer specialists that are working in other parts of the country.

Consider getting on consumer listservs that provide training webinars and/or information about conferences and other educational opportunities. Lists are often maintained by consumer/survivor technical assistance centers (see resource section). These centers and several national organizations provide webinars for training that is advertised on line and for which you can sign up.

I would also recommend that all peer specialists belong to the National Association of Peer Specialists (NAPS), an organization that provides ongoing support and information to promote this new profession through education and advocacy. An annual conference sponsored by NAPS (now in its fourth year), held in different parts of the country, would be a valuable experience for all new Peer Specialists as well as ones with more experience.

What to Wear:

Wear clothes that are comfortable but do not overdress. Make sure you know the policy of the hospital in which you are working. You want to be casual enough to connect with people with whom you are working, but professional enough to appear acceptable by staff.

Make sure you are not wearing anything provocative. Be “conservative,”avoiding tight tee shirts, revealing blouses, tight jeans, etc. Also, be aware of tattoos or symbols on clothing that may be triggering or offensive to people (i.e. dragons, religious symbols, etc.). Sometimes, however, you may choose to dress in accordance with the group with whom you are working. When working with youth, you might dress more “flamboyantly”, or with lots of bright colors, whereas with elders you will likely wish to dress more

conservatively. If you are of a particular culture, it is perfectly fine to reflect that in your dress. In fact, emphasizing your cultural background will make it easier for people from the same background to feel comfortable with you.

Make a Statement:

Before you outfit yourself, check to see if there is a hospital dress code with any restrictions on what you cannot wear. In general, be colorful, not drab. You can add to “casual dress” by wearing something that calls attention to your unique style or personality-- something that makes a statement. Examples are tee shirts with an inspirational or humorous statement, a unique hat, ring, bracelet or other item of clothes or jewelry. (You can wear earrings but avoid dangly ones as someone could reach out and pull on them.) You will be amazed how this might be the first thing that people notice and remark on—making it easier to start a conversation. You might even have something you carry that makes an unusual statement, a notebook with an unusual design, for example.

Commentary:

I have seen many different types of wearing attire that are unique and different; for example, a staff person sitting behind a desk wearing a tee shirt with a Smiley Face! A peer specialist from Maine, who loved humor, wore funny hats while working in an emergency department. This same peer brought with him, the Joke of the Day from “Comedy Central”, which he found on the internet to share with people with whom he sat in the emergency room. Another peer liked to wear cowboy boots and, sometimes, denim jeans and shirts; her attire stimulated immediate comments and questions. I also saw a Tech wearing a bright orange suit with gold jewelry and other decorations. Seeing him (this was in Texas) was memorable and made me smile. I was sure that he would make many clients feel comfortable. (As an aside, this same hospital was discussing having a standard dress code, which would not have allowed the tech to wear his “orange suit”. I made a recommendation they not change the dress code; and when I last checked, they had decided against it.)

Shoes can be another way to make a statement; there are so many varieties of tennis shoes in different colors or you can wear decorative and colorful shoe- laces or even decorative socks.

My own creative dress style is to wearing crocheted hats and bright colored jumpsuits. I always make sure that everyone knows my name, Bluebird; I let them know this during my opening statement. After hearing the story of how I chose my own name, I have everyone’s attention; everyone is listening, interacting, and eager to participate, even those who started out on the sidelines determined they would never come to the group.

Tour of Facility:

One of the first things you will do on your first day is to take a tour of the facility. You should look at this as not just a tour, but also as an opportunity to observe the physical aspects of the environment and see

what it communicates. It would be helpful if you had a notepad with you to take notes, since part of your job will be to advocate for environmental changes.

Make sure to look at the colors of walls, whether muted, or bright, or are they the old standard “minty greens” or “muted mauves”?   Are there paintings on the walls? Do you think they would have appeal to clients? Find out whether clients help to make decisions about environmental décor.

In some hospitals, you will find displays of patient artwork on walls, hallways, and in the lobbies. Very talented artists have often done the artwork, but rarely will you find their names attached to their work. Hospitals often make the mistake of not asking people if they want their names disclosed, thinking they are following HIPPA laws. Most often, people would like their artistic talents to be recognized, but someone needs to ask them first and not make prior assumptions either way. You should be familiar with the HIPPA laws specifying that before disclosing someone’s name, you must get their signed permission with a signed consent form. If a person has a guardian the guardian must give consent for any use of a person’s name, but in addition, you should ask the client as well.

Check bulletin boards for the type of information displayed; is there a schedule of events that is in large enough print to read? Are there announcements that would be of interest to the clients on the unit? Are the posters out of date and looking as though they had never been changed? I have seen examples of bulletin boards meant only for staff. On one geriatric unit, an entire bulletin board was devoted to clinical information about drugs and their side effects. Needless to say, the information was not meant for geriatric patients.

As you move through the units look at signs. Are the messages positive and hopeful? On the other hand, do you find a lot of signs with, “Don’t”, “Beware”, or too much use of the word “No?” In one hospital, a sign in the immediate admitting area said “Danger: Beware of Mold” (the only sign on the wall directly next to the admitting official). This was certainly not a very positive greeting! Another example in an admitting area in a different hospital, a sign said, “Officers, remove your guns.” When it was pointed out, in neither situation had anyone ever thought about what these messages conveyed to clients when they first entered the admitting area.

Treatment Mall (Recovery Mall):

Does your facility have a recovery mall or academy? Most facilities do, but there are still some that do not. The ones that do have a treatment mall have often changed the name to Recovery Mall or Academy Mall— more positive and hopeful titles. We will assume that you are looking at a Recovery Mall (or similar title).

The Recovery Mall should be a happy vibrant place with lots of groups gathering and activities occurring. It should be available to all clients unless they are under special supervision or unwilling to go, which in

some facilities, rarely happens, as clients know they are expected to go.

Check to see what types of groups and activities are available. Do they interest you? Look at the vocabulary used; are the group titles written in clinical terminology or do they use appropriate recovery language?

It will be part of your job to spend time at the Recovery Mall; you may even do special interest groups, such as WRAP, or other recovery-oriented groups there. Be careful, however, that the Recovery Mall is not your primary location or that your duties do not include escorting clients to the Mall, as this would defeat the purpose of your job as a Peer Specialist.

Be sure to visit all of the units including forensic, geriatric, and other specialty units. Look at the day rooms and see what reading material is available, whether there are games, interesting magazines, whether or not the furnishings look comfortable.

Are there comfort rooms on the units? Make sure you look at these rooms to see whether *you* think they are comfortable. Sit in the chair; get a feeling for whether you think people would actually like these rooms. What types of materials are available for use in the room? Later, you can have a direct impact on promoting the use of this room, adding to the décor and asking often or doing surveys to find out whether the people who use the rooms are satisfied with them. As you will have limited time, you may want to come back to the comfort rooms later, as well as other areas you want to see in more detail. (More on comfort rooms later)

Other observations:

The Seclusion Room: (Usually a barren room with a bed or mattress only; someday we will eliminate this room altogether or we will re-design it as a room for sanctuary and protection.)

Outdoor space: Do people go outside on a regular basis? Are the outdoor surroundings pleasant? Do many people have grounds' privileges? Do all clients get fresh air and what is the appearance of the area they are confined to outdoors? Be sure to look at the garden developed for the hospital units.

Exercise Equipment: Is there a room with exercise equipment and how often do people use it?

Computer availability: Do clients have access to computers? Find out under what circumstances they can use them, whether or not they can access the internet.

Library: Do not forget to visit the libraries. In Delaware, there is a library on the recovery academy, K1, and one in the Springer building professional library. All of them are available to clients but you may want to find out more about their availability. Libraries are among my favorite places. I always look to see if there are autobiographies and memoirs written by consumers. Promoting consumer- written books can be a valuable task for you as a peer specialist. (See list of appropriate consumer-written books in Resource Section.)

Client Rooms: Look at clients' personal rooms. How many people sleep in one room? Is there space for their belongings? Do they have personal items on display on top of their dressers? Are there attractive bedspreads on the beds? Note whether the beds have restraint devices attached and if so, how often they are used. (Note: This is common practice for some hospitals, though the length of time for their use is short.)

On one occasion, however, I saw personal rooms in a Texas facility that had overhead TVs in each room and comfortable furnishings. I learned from one of the nurses, that clients could watch TV as late as they wished, and that they did in fact, have fewer problems with people being able to sleep.

Make Suggestions:

While on tour, you can make comments and suggestions, particularly if someone asks, but you would be well- advised during the first look, to take notes only. Begin to think about what changes you would make if you could. Later, as you feel more adjusted, you may want to serve on a committee where they decide on environmental changes. Sometimes you can take matters in your own hands and re-design a bulletin board together with clients who will help you with posters and other decorations.

Does the hospital have suggestion boxes on the units? Some hospitals have them but they are seldom used and if there are suggestions in the box, there is no one to take them seriously. In a hospital in Maine, one of the peer specialists' duties is to maintain the suggestion boxes and respond to all suggestions. This seems to be a good system, as clients like knowing that peer specialists will take them seriously.

Group Training Exercise:

Have a group discussion with your supervisor, comparing notes written by each Peer Specialist. Using a flip chart, write all of the observations down. Note how different areas were more important to some than other areas. If some areas were troubling, discuss why. Did anything trigger anyone or bring back memories or flashbacks? What were the most positive things noted?

While you may not want to be making any suggestions as you are just starting to work, it would be helpful to prioritize which areas people think are the most important to change. You can follow-up with a strategy session at a later time to determine how to go about recommending certain changes and then tracking them.

Meeting Staff on the Unit:

Hopefully, you will have met the immediate staff with whom you will be working prior to your start day, and ideally, a staff advisory group is already in existence. This group will provide you with ongoing support and play a role in educating staff regarding your role and activities. They will be able to answer questions that many staff members ask or help to clear confusion about the peer specialist role.

Use Person First Language:

People with psychiatric labels are too often defined or referred to by their illness. How often have you heard, “That person is a schizophrenic?” In a hospital setting, you may hear things, like; “Johnny is a “Borderline, “or “Suzy is a ‘Cutter,’” or “Rodney has been here for years and is chronic.” Person-first language means that you always preface any descriptor of an illness or disorder with the term “person”. First person language describes the person holistically, since the illness is only part of who a person is.Peer

Here are some acceptable examples:

- Person with a history of trauma
- Person with a bi-polar disorder
- Person diagnosed with a mental illness
- Person with a serious mental illness

Peer specialists should model person- first language at all times. It is also important that peer specialists describe situations and behavior in observable terms and use everyday language. Using clinical language all the time becomes cold or triggering to clients. Avoid using terms such as "High (or Low) Functioning." It is always better to speak of a person as being “not as far along”, “further along in their recovery process“, or as “person with a cognitive disorder.”

Crazy Makers: Stigmatizing Words:

We all know the phrase, “Sticks and stones may break my bones but words will never hurt me.” Some people may agree with this statement and it works for them, but for people labeled with a mental illness stereotypical, words are not only offensive and insensitive, they can be permanently damaging.

Some words poke fun and in some cases words ridicule us. Consider these terms:

- Crazy
- Nuts
- Buffoon
- Stupid
- And others?

Some words describe us as violent, perpetuated constantly by media portrayals:

- Psycho

- Insane
- Violent
- Dangerous

Other words are prejudicial focused on a person's size, religion, gender, sexuality, color, etc. Typically persons who are:

- Gay
- Of Moslem faith
- African American
- Older people
- Transsexual
- And others…

Exercises:

- Have you experienced prejudice in your own life? As you feel comfortable, talk about so of these experiences with your peers in training so that you can better understand you and so that you can be sensitive to the people you will serve.
- Make a list and discuss stereotypical terms that have been used to describe persons wit mental illnesses. Be aware though, that some terms have become colloquial in society are not always meant harmfully or prejudicially. It is quite common to hear the word, "crazy" used in many different contexts. My grandchildren often say, "Grandma, you'r crazy," but it is said with affection and is not intended to mean that I have a mental illn More often, it is because I wear mis-matched socks, or because of the hats that I wear.
- Talk about ways that you can lighten up and help others to lighten up. Think about othe terms that are used with different meanings, such as the word, "mad." Many consumer/survivors have turned this word around, to honor themselves and to reclaim word that had been used against them. They believe that this is a source of empowerm

New Admissions:

Peer Support should be available to help new admissions adjust to the hospital setting whenever possible. The ideal is to have peers assigned to each unit but this is not always possible as usually the hiring starts with one or two peer specialists. As this is probably the most anxious time for anyone admitted, a peer can provide comfort and reassurance, escort them to the unit where they will be

assigned, and orient them to their surroundings.

Developing Welcome Kits for new admissions:

A very helpful task for peer specialists is creating Welcome Kits for persons at time of admission. When the kits are filled with simple items they are cost effective and can go far to reassure someone who is frightened and anxious soon after arriving. Each item has to be checked for safety before selecting them, including the packaging for the items. You might choose a manila envelope that has WELCOME written on the front in magic markers with a pretty seal of sticky design.

Some items to consider:

- inspirations,
- simple affirmations with instructions on how to use,
- tissues,
- appropriate pencil (some agencies purchase bendable pens that are non-injurious)
- writing paper or postcards,
- a band aid, (very helpful for persons with self-injurious behaviors),
- a daily schedule,
- a lollipop,
- something soft,
- Client Handbook/resource information
- Peer Support brochure of access information

Meetings and Greetings:

Meeting a client for the first time may seem simple; surely, we all know how to meet and greet someone. Nevertheless, meeting persons in an inpatient environment can sometimes be more difficult. Not everyone wants to talk to you; some people are angry, some people are withdrawn or frightened, and do not want to talk to *anyone*.

You can start with the standard, "Hi, my name is…" "What's yours?" (You might want to add that you are a peer specialist in your greeting.)

Extend your hand for a handshake. There are too few opportunities for people in institutions to receive touching, but a handshake is acceptable. Make sure you shake their hand firmly; a weak handshake will not do! Make sure you are smiling when you shake someone's hand; this will convey that you sincerely want to speak to him or her. However, if someone does not want to shake your hand, then do not press them, but know that you probably made an impression with the gesture.

Non- Verbal Speaks Volumes:

What you say with your body will say more than words. It is a fact that at least 75 per cent of

communication is non-verbal.

1. Respect each other's space: are you too close? Try to be at the same level with the person to whom you are speaking, though this is not always possible.

2. Facial expression: Is your face saying what you are saying? Use appropriate gestures.

3. Eye Contact: Look at the person—not at the ground. Avoid a fixed stare. Use a comfortable gaze.

4. Volume: Do not speak too loud or too soft. Check your speed.

Other variations:

- Does the person have a nickname? Use it and remember it!
- Say something light
- If the person does not want to talk do not rush away; pause for a moment
- Find something in common e.g. baseball or other interest
- Always let someone know you will be back

Training Exercises:

1. First, try to remember when you received a friendly handshake from someone that was memorable. Have a group discussion. Each person talks about an experience s/he can remember when someone introduced them self with a handshake or was especially friendly in some way. Talk about the specifics. How did it make you feel? Many consumer/survivors talk about someone who said something that started them on their recovery journey in a hospital setting; often it was a person working in housekeeping or other menial job.

2. Pair off in twos. Start with the standard introduction and a handshake, following all of the guidelines for eye contact, smile, etc. Follow that by saying, "You look fabulous today." Then something specific, "I like the way you have your hair today," Conversation can follow regarding personal hobbies, interests, etc. Switch partners.

3. I have done this exercise many times, often between clients and staff to create understanding and to indicate how similar they all are, whether client or staff. Always, participants start giggling when told they look fabulous. It opens up conversation, and usually people are still talking past the time limit given them.

How to answer client who asks, "What is a peer specialist?"

Following are some possible answers:

- We (peer specialists) have similar backgrounds as you
- We have suffered hardships and challenges but have overcome them
- We have been diagnosed with a mental illness
- We have been hired to provide support and understanding
- We will teach you about Recovery and how it is possible for you to recover
- We will sit in on your treatment team meetings (if you would like us to)
- We will work with you on being discharged and to return to the community
- We are interested in finding out what you like to do and help you do those activities

Exercise:

Pair off again and introduce yourself, this time with the purpose of explaining what you do, what a peer specialist does. One of you is the peer specialist, the other the client. The person playing the patient will ask a lot of questions. The person playing the peer specialist will answer each question and tell them about their role.

It is important to avoid talking too much about your personal life. Telling someone that you are married or single may be appropriate but not where you live, your phone number or other personal information that would encourage them to visit you after they are discharged.

After exchanging for approximately three minutes each, stop to give each other feedback. Was the information shared enough or too much? Was the person giving the answers reassuring?

Boundary Issues:

(Explain difference between boundaries and ethics)

It is important to note that there are boundaries and ethics rules that apply to all staff, including peer specialists. Peer Specialists may need some flexibility for certain situations to be evaluated on case-by-case basis.

Some typical boundary issues:

- Dual roles: Friendships between consumers and peer-providers that existed prior to the peer being hired
- Pre-existing relationships between peers that are hired in the same workplace
- Peer providers accepting gifts with value from clients
- Lending money to clients when asked
- Breaching confidentiality in outside settings
- Visiting patients in the hospital when they were admitted for medical reasons
- Giving out home phone numbers
- Peer providers sharing too much of their own stories (to be discussed In more detail later)
- Peer providers developing friendships with persons they are serving
- Non-consumer staff reading peer-providers' records in situations where they were previous patients
- Breaches of intimacy, sexual or otherwise
- Touching that is inappropriate
- Cultural discrimination or biases
- Questions about what to document, and what not to document
- Role confusion: Peers representing agency vs. representing the peers they are serving
- Peers being viewed as clients by colleagues, and not as equals

Role Play Scenarios

1. A client approaches you stating that he is very angry and is having trouble calming down. You know that one of his coping strategies is to get a soda and take a walk. He does not have any money, staff will not allow him to leave the unit, and no one will go get the soda for him. You have a dollar and access to the vending machines. What do you do?

2. Three staff are sitting behind the nurses' station on the unit discussing client information while 1-2 clients are standing at the nurse's station waiting for assistance. The staff does not acknowledge that anyone is there. Clients have complained about staff discussing confidential information in an open area many times before. What do you do?

3. Your best friend has been admitted to the hospital. She comes in crying and upset. You usually help with the admission process, helping someone to feel comfortable, giving them an admission kit and accompanying them to their unit. You want to go over and talk to her but you don't know what to say or whether you should say anything. What would you do?

4. A client is upset and yelling on the unit. A staff person approaches them, gets very close to the person, demanding that the person quiet down, and go to their room. Peer support sees this interaction is making things worse and the client is getting more upset. The client has a relationship with you and you are available. How do you respond?

5. You have worked for many years as a traditional provider of mental health services. You have now started working as a Peer Specialist at another organization where a former client receives services. When the client finds out you work there, they request you to be their peer support person. What do you do?
6. A client is in their treatment team meeting and discharge is being discussed. The client has been clear that he/she wants to live in their own apartment with some in-home supports a couple times per week. The social worker is only discussing group home placement and applying for those. History has shown that the client does not do well living on their own. What do you do?

Hawaii Peer Code of Ethics

The primary responsibility of Certified Peer Specialists is to help individuals achieve their own needs, wants, and goals. Certified Peer Specialists will be guided by the principle of self-determination for all.

1. Certified Peer Specialists will maintain high standards of personal conduct. Certified Peer Specialists will also conduct themselves in a manner that fosters their own recovery.
2. Certified Peer Specialists will openly share with consumers and colleagues their recovery stories from mental illness and will likewise be able to identify and describe the supports that promote their recovery.
3. Certified Peer Specialists will, at all times, respect the rights and dignity of those they serve.
4. Certified Peer Specialists will never intimidate, threaten, harass, use undue influence, physical force or verbal abuse, or make unwarranted promises of benefits to the individuals they serve.
5. Certified Peer Specialists will not practice, condone, facilitate or collaborate in any form of discrimination based on ethnicity, race, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other preference or personal characteristic, condition or state.
6. Certified Peer Specialists will respect the privacy and confidentiality of those they serve.
7. Certified Peer Specialists will not enter into dual relationships or commitments that conflict with the interests of those they serve.
8. Certified Peer Specialists will never engage in sexual/intimate activities with the consumers they serve.
9. Certified Peer Specialists will not abuse substances under any circumstance.
10. Certified Peers Specialists will keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their colleagues.
11. Certified Peer Specialists will not accept gifts of significant value from those they serve.
12. The following principles will guide Certified Peer Specialists in their various roles, relationships and levels of responsibility in which they function professionally.

Communication:

***Notice how you listen Honor what people have to say*.**

- Listen intently
- Remain curious and ask questions
- Use “I” statements instead of “you” statements
- Avoid labeling and jargon
- If someone says something about you, try to hear them without becoming defensive and take time to reflect before responding.

Active or Reflective Listening:

Repeating parts of what a person said is a great technique to use in any conversation. This is a standard communication technique that is valuable to learn for many situations. It involves “repeating back” portions of what the other person said. It both validates the other person and helps to ensure that you understand what they said.

“I think I hear you say……”

“You’re saying that someone on staff was rude to you?”

“If I heard you correctly, you said…….”

De-escalation: Basic Principles

- Be firm but kind
- Set limits
- Assess yourself on your ability to be calm
- Stay calm and do not yell or argue back
- Do not threaten
- Do not laugh at the person
- Do not challenge the person
- Do apologize if you did or said something that may have inadvertently upset them
- Take to a safe place—perhaps a comfort room or quiet space
- Call nurse or therapist

Watch for Possible Warning Signs

- Restlessness
- Agitation
- Pacing
- Breathing heavy
- Clenching fists
- Rocking
- Swearing

You might ask, are these always warning signs? I caution you to think of these as warning signs as sometimes these behaviors might be ones a person uses to calm themselves from something that triggered them or to reduce stress. You will begin to know the difference as you get to know the client.

Because you are forming relationships, you will be able to determine the differences between normal variations in behavior and those that might lead to an escalation. You will feel comfortable approaching someone to find out why, and, if, they are they are upset about something, what might have caused them to be upset and to look for helpful solutions.

Examples; (Role Plays)

De-escalation Techniques: Simple responses

Simple listening: Sometimes people only want to vent their anger and all you need to do is listen. In fact, rarely do the experts state that one of your most powerful responses is not to say anything. This does not mean ignoring; you should be listening attentively. You can nod or acknowledge, occasionally, with one-words ("Yes, Uh huh") affirming that you are hearing them, while not necessarily agreeing with the content of what they are saying. Often they will wear themselves out. You might say, "Is there something I can do to help?"

Acknowledgement: If you agree with what the person is angry about, be sure to acknowledge and agree with their right to be angry. You might say, "Gee, I understand what made you angry. I would be angry too, if someone had done that to me." Use a calm voice. Be sure you are being honest. Your acknowledgement will open up the possibility for more expression and communication. You might also apologize for what happened to them, "I am sorry for what happened." "I am sorry you are having such a rough time."

Finding the small Element of Truth: Even if you do not agree that a person's anger is justified it is helpful to find the small bit of truth that you agree with. Just acknowledging that element may help to diffuse their anger. "Jane might have had a tone of voice that may have led you to think she was angry with you." (You may not agree that she should not have turned off the TV when the time limit was over)

Inviting Criticism: Ask the person to share any anger they might have with you or the situation. Invite them to talk more about their anger in detail. Expect the person to become calmer as they can see the reality of the situation. Determine whether there are some action steps to put into place. "If you don't agree that the TV should be turned off at ten, let's make a suggestion at the next community meeting for there to be occasions when the rule does not apply, for example when a ballgame is on TV."

Remain Calm: It is most important that you remain calm during this conversation. If at any time, you think that their person is losing control you will need to take steps to seek assistance. There should be staff nearby that you can call to the situation. At all times you should not be in isolation or stuck away from others' view. Most often, if you can remain calm during someone's outburst of anger the situation will not escalate further. Maintaining your own sense of calm and security helps the other person to regain their own sense of dignity and ability to regain calm.

Treatment Team Meetings:

Treatment team meetings bring together staff who are directly involved with one individual client, to discuss the concerns, goals, and treatment options regarding that person. These meetings used to involve only the professionally licensed staff such as the physician, nurse, and social worker. Now, these meetings may include the client, the peer specialist(invited by the client), mental health counselor, and other staff such as recreation therapists and dieticians and advocates. Each of these individuals has a role to play and a job to fulfill. Ultimately, their efforts will help the client fulfill their personal treatment goals with their team members and to build a solid foundation to make personal recovery efforts while hospitalized and after intensive hospitalization.

Staff roles in treatment team meetings include and are not limited to include:

- Physician: help the client find the best medical treatment by recommending options including prescription medications, referrals to specialists to diagnose medical conditions influencing their mental health, intensive approaches such electro-convulsion, and by overseeing that the individual's intensive hospitalization is as short as possible for the client's safety and wellbeing.

- Nurse: help identify goals, help the client self-educate about medications, understand their medical conditions and how they affect their mental health, help prepare an individual for intensive treatments such as electro-convulsive sessions, oversee and dispense prescribed medications, consider preventive health concerns, monitor the use of "as needed" medications.

- Social Worker: focus on discharge needs to make a smooth transition after leaving the hospital. They might listen for any gaps in housing, transportation, access to medications, and supportive therapy available after discharge.

- Dietician: helps fulfill the medical orders concerning nutrition and help educate the client about nutrition. Several factors make the nutritional component very important in the foundation for

successful recovery. These include the interactions of medications with certain foods; the incidence of health problems that can arise such as metabolic syndrome that affects persons treated with some medications; the incidence of obesity among persons with mental illness due to a variety of reasons, all of which make persons with mental illnesses higher risk for a shortened lifespan.

- Recreation Therapist: helps with options for recreational tools an individual can use in their self-management of recovery while hospitalized as well as after discharge. Their input and observations about a client's interactions with others and ability to overcome frustration and manage stress are valuable for recovery.

As a Peer Specialist, you are there at the request of the client to help the client fulfill their goals for the meeting. Whenever possible, it will be helpful for you to schedule a meeting immediately before the treatment team meeting in order to help the person decide what they want to say. This is often critical, since the role of the peer specialist does not include talking for others, but helping clients to speak for themselves.

When you have had a peer-to-peer support relationship, your role is to find out what *kind* of support the client needs during a treatment team meeting. Are they having trouble defining what they want to say or to request at the meeting? Are they afraid of speaking in front of a group? Help the client decide what will be possible. Have them write a list of what they want to say. In some of these sessions, I have actually rehearsed with some clients how to present themselves, which has turned out to be successful.

Often someone's major goal is to ask the question, "when will I be discharged?" Sometimes this becomes the entire thrust of the meeting, often because this is the traditional way in which this treatment team practices. In some situations the meetings are quick, the discussion centers on whether or not the client is following the "plan" or "orders" e. g. taking their meds, etc. which results in a lot of important information being overlooked. For example, when are they most productive and in what activity. When a meeting focuses only on discharge, you will note that the meeting is hurried and lacking in substance. You, as a peer specialist can always introduce information on behalf of the client. The more preparation time spent with the client, the better.

There might be times when you are asked by other members of the treatment team to attend the meeting but the client is not invited at times like this, it would be helpful to spend some time with the person and find out if they know what to expect in the meeting and how your presence could be helpful to them. Sometimes it may mean that you are just now introducing yourself to them for the first time because of the timing of the meeting in relation to the person's admission to the hospital.

Additional suggestions to enhance your role at a treatment team meeting:

- What observations did you make during a treatment team meeting? Make notes after the meeting for later discussion with your supervisor.
- Did people seem to have “assigned seats”? Who was sitting at the head of the table? This should be where the client sits.
- Are you sitting next to the client to support them?
- How do members of the treatment team refer to the client? By name, or in third person, as though they were not present. This often happens when the client is less communicative.
- Is the treatment plan current and updated with relevant information? Is the treatment plan coordinated with the personal safety plan, information from one plan transferred to the other, when pertinent?
- Does the team encourage the client throughout the meeting and at end of the meeting?

Variations for discussion:

A client refuses to attend their treatment team meeting. Though the peer specialist has encouraged him/her to attend, they continue to refuse. What would you do? (Taking into consideration a person's rights)

A client is a forensic client with little hope for discharge in the near future, as she/he has already been in the hospital for 10 years. How can the peer specialist be encouraging and in what ways can their treatment plan be useful as part of their ultimate goal for what things offer them hope and how could you help to advocate for them during a treatment team meeting.

A client disagrees with suggestions made Cheney. The individual does not want to go to a particular group and absolutely refuses. What can the peer specialist due to be helpful?

At one treatment meeting someone his own restriction and has no hope for getting off. You notes that some of their issues are based in religious practices which result in a person not bathing, refusing to go to the recovery mall, and wanting to pray at certain times of the day. How would you help this client?

Training on this subject can be ongoing. Ongoing meetings with the supervisor can focus on current situations that are difficult.

Community Meetings

Community meetings are a tradition that is part of most inpatient settings. You are probably familiar with these meetings if your history includes hospitalization. Most often in the past, someone called out, “Community Meetings” in the same “loud” way they called people to line up for medications. A rushed through meeting included time for reviewing the day’s agenda, asking if anyone had concerns or complaints. Attendance was optional and for those who did attend, often boring. Delaware Psychiatric Center, along with other hospitals finds that these meetings are a valuable way to bring staff and clients together to foster collaboration and promote joint planning. You may find that these typically 30-minute meetings have become a time for lots of different agenda items. For example, I recently attended a meeting led by

someone who spoke Spanish and those in attendance got a very short lesson in speaking and singing a song in Spanish. I noted that almost everyone participated and were laughing as they were singing.

At some meetings, people were asked to rate how they felt that day on a one-to ten scale. I noted that most people rated themselves high and wondered if they knew how to make an evaluation. Another part of the meeting asked people what they planned to do during the day; an exercise I thought much more positive. As a peer specialist, you will be expected to attend these meetings as part of your job description. You have an opportunity to make these meetings more interesting and meaningful. It is also an opportunity to work cooperatively with staff to improve these meetings and create agendas that change daily or weekly. Here are some ways that you might be asked to participate:

- Encourage reluctant participants to attend and agree to sit with them
- Help to create an opening that makes people have a sense of belonging to the group; read an inspirational short story or vignette, for example.
- Help and encourage clients to make comments, suggestions and report complaints that regard the environment on the unit.
- Add to the agenda items; report on activities that relate to recovery; you might suggest speakers for future meetings, special events, what is happening with the newsletter and would anyone in the group like to submit a poem, etc.
- Help to ensure that birthdays and other special events are celebrated. Ask if anyone would like to help bake a cake (If that is a possibility).
- Make sure there is time for you to introduce yourself, to talk about what peer specialists do and provide information about how they can contact you.
- Make suggestions to staff on how to improve community meetings or to add to the agenda
- End each group by asking if a person in the group would like to sing a song, read a poem, share a joke, etc. (This could be staff or clients.)
- Offer to lead a group yourself as well as look for leadership within the group who might help lead a group.

Advocacy Role versus Peer Support Role:

Roles are delineated for peer specialists and peer advocates though there may be some overlap. Persons in the advocacy role generally work with the legal services department of the hospital; or they work for an outside agency such as the Protection and Advocacy Agency (Disability Rights Organization). The Peer

Advocate role is focused on ensuring that a person's rights are protected, taking and following up on grievances and complaints and administering satisfaction surveys, among other duties.

Peer Specialists do serve as advocates but their role is limited to helping an individual advocate for themselves, rather than advocating for them directly. The peer specialist's role includes informing people of their rights, listening to their complaints and helping them find ways to resolve them before it gets to a higher level. At Riverview State Hospital in Maine, peer specialists are responsible for maintaining suggestion boxes. Instead of suggestions or complaints going through staff or executive administration, peer specialists sort them out, review them and handle them according to whether they are actual suggestions or complaints. Naturally, all are tracked and followed up on, with some requiring higher intervention by staff, administration, or advocacy staff. According to Holly Dixon, Peer Services Director, the number of grievances reduced greatly after peers began to work with people at the lower levels of advocacy.

Pointers regarding Advocacy by Peer Specialists:

- Spend time with clients listening to them talk about their issues. They may not always say directly what they want to say; you may have to listen closely for clues.
- Help them find solutions before having to go to a formal advocate or attorney. Work closely with advocacy staff as these are usually allies, some may be persons with psychiatric histories.
- Help clients write grievances even if you feel the exercise unnecessary. It is important for them to feel validated.
- Pay careful attention to forms used for grievances; are they person friendly, clear, and easy to use.
- Be creative in seeking solutions. Sometimes there are simple answers to people's problems that can result in lessening the possibility of a crisis developing.

Scenarios:

Abby liked to read a more advanced technical book but was not able to access the book from the inpatient library. With help from the peer specialist, the central library was used to access the books she desired.

Joe did not like eating with a group in the main dining area and stated that he would prefer eating on the patio near the cafeteria. With some discussion, the group decided that it would be acceptable for people to take their meals to the patio to eat thereby avoiding discomfort experienced by some.

Clients in one hospital complained that they did not want to get up to eat breakfast on Sunday morning. Dietary staff complained that they made breakfasts that no one ate. The solution was to make breakfast bags that clients could pick up at their leisure allowing them to sleep later on Sundays.

(Check with staff before using this form. It may duplicate something they already do.)

Date: ______________________

Name: ____________________________ **Facility:** _____________________

Personal Safety Plan

(For Advance Crisis Planning to be used in Inpatient Facilities Only)

This form will allow you to suggest calming strategies IN ADVANCE of a crisis. It will allow you to list things that are helpful when you are under stress or are upset. It will also allow you to identify things that make you angry. Staff and individuals receiving services can enter into a "*partnership of safety*" using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions.

1. Calming Strategies:

It is helpful for us to be aware of things that help you feel better when you're having a hard time. Please indicate (5) activities that have worked for you, or that you believe would be the most helpful. If there are other things that work well for you that we didn't list, please add them in the box marked "Other". We may not be able to offer all of these alternatives, but we would like to work together with you to determine how we can best help you while you're here.

❑ Listen to music	❑ Exercise
❑ Reading a book	❑ Pacing in the halls
❑ Wrapping in a blanket	❑ Having a hug with my consent
❑ Writing in a journal	❑ Drinking a beverage
❑ Watching TV	❑ Dark room (dimmed lights)
❑ Talking to staff	❑ Medication
❑ Talking with peers on the unit	❑ Reading the Bible or other religious/spiritual readings
❑ Calling a friend or family member	❑ Writing a letter
❑ Voluntary time in the quiet room/comfort room	❑ Hugging a stuffed animal
❑ Taking a shower	❑ Doing artwork (painting, drawing)
❑ Going for a walk with staff	❑ Other? (Please list below) ________________________ ________________________

2. **What are some of the things that make you angry, very upset or cause you to go into crisis? What are your "triggers"?**

❑ Being touched	❑ Called names or made fun of
❑ Security in uniform	❑ Being forced to do something
❑ Yelling	❑ Physical force
❑ Loud Noise	❑ Being isolated
❑ Contact with person who is upsetting	❑ Some else lying about my behavior
❑ Being restrained	❑ Being threatened

1. **Preferences regarding gender and others:**

Do you have any preferences or concerns regarding who serves you when you are upset or angry?

Women staff____ Men staff______ No preference_________ Language________ Race_________
Culture _______Of a particular religion_________

2. **Signals of Distress:**

Please describe your warning signals, for example, what you know about yourself, and what other people may notice when you begin to lose control. Check those things that most describe you when you're getting upset. This information will be helpful so that together we can create new ways of coping with anger and stress:

❑ Sweating	❑ Clenching teeth
❑ Crying	❑ Not taking care of self
❑ Breathing hard	❑ Running
❑ Yelling	❑ Clenching fists
❑ Hurting others:	❑ Swearing
❑ Injuring self: (Please be specific)	❑ Not eating
❑ Pacing	❑ Being Rude
❑ Throwing objects	❑ Other? (Please list below) ______________________ ______________________

3. **Seclusion and Restraint:**

This facility is trying to eliminate the use of seclusion and restraints, therefore, it would be helpful to know if you have ever been placed in a seclusion room or been restrained. This information will be used only for collecting data and for training purposes, not to predict any future behaviors.
Have you ever been placed in a seclusion room? Yes ____ No ____
Have you ever been restrained? Yes ____ No ____

4. In Extreme Emergencies:

In **extreme** emergencies seclusion and restraint may be used as a last resort. Is there anything you find helpful in emergency situations that could prevent them from being used?

Alternative physical spaces such as:

Comfort Room _____ Quiet Room_____ Other such as exercise _____

Medication by mouth________Emergency injection________

Other:____

5. Medical Conditions:

Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc., that we should be aware of when caring for you during an emergency situation?

____

____

6. Physical Contact Preferences:

We would like to know about your preferences regarding physical contact. For example, you may not like to be touched at all or you may find it helpful to have a hug or be touched *appropriately* when you are upset.

Do you find it helpful to be hugged or touched appropriately when you are upset? Yes____ No____

Comments:

____

____

____

7. Helpful Medications:

We may be required to give you medications if other measures do not help you to calm down. In this case, what medications have been especially helpful to you? Please describe:

____

____

8. Not Helpful Medications:

Are there any medications that are not helpful? What and why?

____

____

9. Room Checks:

Room checks are done at night to make sure you are okay. In order to make room checks as non-intrusive as possible is there anything that would make room checks more comfortable for you?

____

____

10. **Trauma History:** Do you have any issues regarding abuse such as sexual or physical abuse that you would like to talk about with staff, or with counselor?

Yes_____ No____

Would you like more information on these issues in classes or support groups? Yes_____ No_____

13. Anything Else?

Is there anything else that would make your stay easier and more comfortable? For example, do you have any special issues like cultural, diet, sexual preference, appearance, etc. that you think could contribute to misunderstandings or cause problems for you? Please describe:

____

____

____

The Personal Safety Form Information should be presented to the treatment team and incorporated into the treatment plan for this individual. Each individual shall receive a copy. This form has been adapted from an original form created by the Massachusetts Department of Mental Health and is currently being used in the State of Florida as a recommended form under the Baker Act.

Guidelines for Personal Safety Plan

1. The Personal Safety Form should be completed within 24-72 hours of admission**.**

2. It is preferable that this form **not** be included in the initial admission packet because people who are newly admitted are required to sign multiple legal forms, which can be overwhelming. It is often a time when an individual is anxious and not able to focus on questions related to personal safety preferences.

3. Careful consideration should be given as to who will administer the form. Ideally, it should be a nurse or other clinical staff person who will have frequent contact with the individual. A Peer Advocate employed by the hospital would also be ideal because peers are often less threatening. The information gathered is presented as helpful information that will be included in the individual's treatment plan.

4. To provide effective provide information, persons administering the form should be knowledgeable about how this material pertains to treatment. It would be helpful for them to learn and know about efforts being made at the facility to reduce seclusion and restraint and how this information will be used as part of that initiative. Facilitators should be able to answer questions or provide clarification. For example, it is important that information about touching at the facility be presented as promoting appropriate, *rather than inappropriate*, touching.

5. When individuals are not communicative enough to answer the questions, they may be provided an opportunity to answer the questions at another time, if they so desire.

6. Individuals must always be given the option to decline answering *any* or *all* questions.

7. The form, when completed, should be placed in the client's record. Information gathered should be used on the person's treatment plan and or kept as ready-reference material at the desk in the nurses' station for easy access in potential emergency situations.

8. Individuals should be told how the form is to be used. They shall be given a copy of the form to keep.

9. It may be helpful for the facility to collect data on answers to some of these questions to identify patterns and trends that are important to individuals receiving services that can be used to determine how to improve treatment and programming.

Key Components of a Personal Safety Plan: Questions to Ask

What do you want to share about your history that can help the staff keep you safe (examples: losing control, self-injury, history of others hurting you, feeling unsafe)?

Triggers: What kinds of things upset you (e.g. yelling on the unit, codes, slamming doors, being ignored) so that you may need to self-soothe or get help from staff to avoid a crisis?

Distress Cues: What are some of the signs/cues/actions that you exhibit when you are feeling worse (examples: pacing, crying, talking under my breath, yelling, face gets flushed, swearing) that you want the staff to be aware of?

What are some things that make you feel worse when you are already upset (examples: being touched, being sent to your bedroom, excluded from activities, being approached when others are around, being offered medication)?

Nurturing Interventions

a. Ask the person to list the self-soothing practices and techniques they have used in the past. This is a time to recognize strengths; ask how they have managed difficult situations in the past successfully. You may also provide a list of some new things that are available in the hospital like a comfort room or comfort kit, a weighted blanket, or relaxation tapes.

b. Ask - What are some things staff can do that will help you calm down? (Examples: encourage you to use your plan and remind you of soothing tools, allowing you to use comfort room or comfort box in your own room, individual time with staff, getting you some soothing lotion or a cold face cloth, giving you time outside, holding your hand, using a calm low voice affirming you are safe, spending time with the peer specialist)

Success Stories Shared WRAP:

Gay Dowling, NC

- Reformatting Wellness Recovery Action Plan (WRAP Classes in the Treatment Mall

Peer specialists began providing WRAP classes three weeks out of every month in the PM Treatment Mall. But it did not seem like enough time and that there needed to be more variety in the way it was presented. We now format our clashes with the first 45 minutes being a traditional WRAP-IN-Action where we spend time processing what we did the first half hour through the activities like art, games, field trips to the hospital library and hospital history Museum, etc. we have gotten ideas from a number of sources including Gail Bluebird's Creativity Cookbook.

- Allowing nursing students to attend and participate in the WRAP classes

a nursing professor from East Carolina University had asked us if her nursing students could periodically observe our clashes. With the permission of the group, they began coming in and observing. Eventually we ask them to join in and participate. We have received feedback from the

nursing professor at the students really enjoy the class. It is an opportunity for them to learn a little about Peer Specialists and recovery while students.

Creating Safe Spaces

Comfort Rooms

Comfort Rooms were developed At South Florida State Hospital in the early 90s as a means of using old seclusion rooms developed to be a prevention tool to avoid the use of seclusion and restraint. Comfort rooms are distinguished from “time out” rooms or “quiet rooms” as they are strictly voluntary and used by people who want to use them for sanctuary, to get away, have quiet space and to reduce stress. It is a place where people can experience their feelings within acceptable boundaries, and where persons can participate in a variety of activities of their own choice.

The concept of comfort rooms differs from sensory rooms though there are many similarities. Sensory rooms require professional oversight with use of specially designed materials developed to enhance sensory integration. Comfort rooms, on the other hand, are developed as self-help projects. They are most successful when the participants who use the rooms help to design them and to develop policies for their use. They also make choices regarding what types of activities they wish to engage in; most often, this will be listening to music, reading, doing artwork, crossword puzzles, and a myriad of other possibilities according to individual and group requests.

Conducting Satisfaction Focus Groups

Doing a focus group with consumers in an inpatient setting sometimes requires you to be innovative in your approach.

First, bringing people together can be a challenge. It is a good idea to have a flyer posted on the unit with a nice pictorial (of either yourself or a colorful symbol) to announce the focus group, time and purpose. It would also be helpful that staff announce the event to people in the morning community meeting.

Make sure you have a time for the focus group to begin and end, always no more than an hour. People should be told in advance that they do not have to participate, though often I have found that if staff support it and give it a level of importance there will be a good response. (This can be tricky; if people are told they do not attend, they may decide not to.) Make sure the group does not interfere with their cigarette or break time.

It will be helpful for participants to know that you are a peer specialist leading the group with others who may include peer or non-peer advocates. They should be told the purpose of the group and that their comments and suggestions are important, often resulting in positive policy or program changes. Be sure to

tell them in several different ways that they can make a difference by attending. For example, "This is a chance for your voice to be heard."

The amount or preparation may make a difference in the level and quality of participation. Put some energy into this area.

Make sure you have a co-facilitator. Usually the preference would be the resident advocate, but occasionally one of the supportive staff is happy to help facilitate. I would suggest not doing these groups alone as there a variety of scenarios that could occur, including someone getting agitated in the group (only happened to me once). More importantly, you want to make sure you receive the information correctly. Ask your co-facilitator to take notes. In fact, if there is a flip chart that you can have made available, you or your designee can place the information on the flip chart so that everyone can see the information and verify its correctness.

Occasionally, staff will insist on being present. I usually play this by ear. Sometimes I may suggest that they stay outside of the room or make occasional checks to make sure everyone is ok. They may also have guidelines that include checking on everyone every 15 minutes or half hour. There are times that more than one staff may sit in the group, but this is not ideal.

When starting the group it is important to get people's attention. Tell the group the purpose of the group as part of the introduction. However, in order to warm up the group, tell them something about yourself, including sharing part of your "consumer" experience, and about ways in which you are involved in local and national changes. Ask people whether they know the term consumer, and their preference of what they would like to be called. Explain to them that you will be using their first names to address them, not their last, and that, though terms are sometimes used to differentiate them from staff or others, that you prefer calling them individuals or persons. Give them just a few sentences of our consumer/survivor history and the fact that we have heroes; for example, for example, Mary Ellen Copeland, the founder of WRAP.

Other icebreakers can be used: What is your favorite food, hobby, where you would most like to go on a vacation, etc.

If you do introductions allow only for first names as too much time will be taken to do full names. You have to be extremely cautious because most people want to talk a lot. Sometimes it is best to avoid introductions, altogether, particularly, if it is large group, if it took a long time to get the group together and time has already been lost. Another option may be to go around the circle and introduce yourself individually while you shake their hands. Everyone likes individual attention and to be recognized.

Three basic questions are good ones to get information:

1. What do you feel good about with your care and treatment?
2. What do you feel negative about or you think are problems?
3. What are their suggestions for change?

I have done many satisfaction focus groups and gotten lots of information with just those three questions. Alternatively, you may want to use them in conjunction with others that I list below.

It is important to establish guidelines for the group:

1. Courtesy required.
2. Keep comments short.
3. Comments to be general, not specifically targeted at any staff person.
4. Purpose of group is not to set up discussion on any particular topic, though issues that many people agree on are considered consensus issues.
5. Explain how report of the focus group will be handled.
6. People's comments will not have names attached.

In addition to the open-ended questions here are some specific ones:

1. How much input do you have on your treatment plan?
2. Do you attend your treatment team meetings?
3. Do you feel you are given enough choices in your treatment plan?
4. What was your admission like? Did you get explanations of what would happen?
5. Did you fill out a personal safety plan? What was that process like?
6. Do you feel safe in this environment?
7. What is your favorite group?
8. Are most treatment groups interesting?
9. If you could add a group, what would it be?
10. Do you receive enough information re medications you take?
11. Do you receive rights training?
12. Do you have any opportunities for employment while in the hospital?
13. Do you know about WRAP?
14. Are you involved in your discharge planning?
15. What is the best thing about your hospitalization?
16. What is the worst?
17. Do you have a past history of trauma? Was this recorded or included in your treatment plan?
18. Is there a peer specialist on staff and are they available to you?
19. Do you have access to the resident advocate?

Specific Questions related to Seclusion and Restraint:

1. Have you ever been secluded or restrained?
2. Do you think it could have been prevented?
3. Did you attend a de-briefing?
4. How would you change the environment so that S/R would not occur?
5. What has lead to conflict on your unit?
6. Has anyone recently been secluded or restrained?

Summary:

Naturally, you will not ask all of the questions above. You may ask some of these questions individually with people in conversations, or you may ask questions that you think can be answered by this group. You may want to add some questions of your own.

Stories:

- *We had a young woman who was desperately trying to find a door out of the hospital. Staff kept approaching her, trying to get her back on to the ward, which was only making her feel more panic. Darlene approached her and was able to get her calmed and return to the ward. When Darlene described her own hospitalization, the patient made eye contact for the first time, then turned to the social worked and stated, "Did you hear that". Darlene was able to convince her to take her meds and cooperate with the treatment team.*

- *Ashley has been working with a young woman who is going through a messy, stressful divorce and who self-injures to relieve stress. She and Ashley were able to talk about complicated relationships and the woman was able to start processing moving on after the divorce.*

- *Pam talks about a male who spoke rapidly and mostly incoherently. Pam would listen for phrases of coherence and engage him on those topics, which slowed down his thoughts and got him more engaged.*

- *Sarah was talking with the adolescence about hitting walls with their fists. She asked if they would use a punching bag and they said that they would. She took the idea to the treatment team and they agreed. The bags are on order.*

- *Upon returning home from a severe depression, my peer and I found her house to be quite disorganized. Since many people who have depression experience exhaustion and fatigue, I noticed the bedroom was a very discouraging reminder of her struggles. We visited her home before release, and made a list. I found some nice sheets and a blanket. When we visited her house in preparation for returning home, I told her I would clean the bedroom. I made the bedroom look somewhat different, and opened the curtains, and windows, and we cleaned and organized. The house smelled better, and looked more welcoming. It made a big difference! We posted emergency phone numbers near each phone, and got some bags ready for donating to charity. Clutter is stressful, and we enjoyed helping each other reduce this stress and create a happier, safer place for her to return.*

- *Every time a person leaves the hospital, I am really happy. One peer was interviewing for an Oxford House. I waited in the car while he interviewed for the room. I waited and waited... about an hour later he returned and said, "You gotta come in and explain recovery - they want to know about the WRAP plans." Whoa! I was surprised to find that there was a group of men who were so eager for this information. I explained and told them how they could get more information. I know that recovery is a new concept for many, and I feel that it offers hope for so many. My experience tells you to be ready to explain and offer hope anywhere, and at any time for any group or person... I believe that this experience offered great hope to this group of guys. The peer got the room, and the guys invited me over anytime I was in the area and wanted a cup of coffee and some company!*

- *Wayne reported that more staff are recognizing self-injury as a sign of distress and not of attention seeking. A giant leap for humankind!*

*C.W. Kansas a consumer in Kansas said: "When you have PTSD (Post Traumatic Stress Disorder, ed.) the worst thing for a person is to be restrained. Sometimes you re-live the past trauma that may have happened years ago. Sometimes that causes aggression towards others that you think are trying to harm you. The last time I was hospitalized at OSH I had an incident that required physical restraint. I became aggressive and combative with staff. A very nice young man (named E***) sat by my side for the first hour. He was very calming, gave me water, and took a cool rag to my face. After an hour, I had calmed down to the point I should have been released. E****'s shift ended and he left me. He was replaced by another staff member who completely ignored me. I screamed as I began to have extreme pain in my arms from the restraints. I was offered no water, no calming voice. I felt so alone and in so much pain. I believe that when restraint is deemed necessary, one to one contact must be in place and a calming and supportive voice should be at the person's side... and restraints should be discontinued as soon as possible."*

Protocol for Personal Soothing (Safety) Plan

Special lists can also be designed for individuals with cognitive impairments, who cannot read, or prefer to use pictures. They can create a picture list that they can post in their room. When it is posted then it is easy for a staff to redirect them to go look at their list of calming tools.

1. First meeting: Met with young man, who had cognitive impairments, after he had a restraint episode. He shared with me what was bothering him and what upset him. I invited him to work with me on developing his own "wellness book" of things that would help him calm down. We looked at pictures I had already compiled and identified other things he would like in his book. (recovery principles, ownership, choice)

2. I created pictures specifically for him that I didn't have, (2 x3 inches) and I had them laminated. Punched a hole, and tied with a string (less than 12 inches). You also have to make sure laminated cards are flexible (not like a credit card). Any items you give to a patient in forensics have to be considered in terms of our contraband policy. I also did a flyer that has his pictures with words that he could post in his room for visibility for staff and a copy for the treatment team (see attachment).

3. Second Meeting: Brought him his book, flyer, and I encouraged him to show it to staff and explain it to them. He was very eager to do this. We went around to the technicians on the unit and he showed it to them. We posted his flyer in his room.

4. After getting his permission to give a copy to his treatment team, I took it to morning meeting and shared what we had accomplished.

Success:

He did not have any further restraint. He moved to the unit where my office was located. He liked to visit me in my office. I had several opportunities to redirect him to his book in moments when he was upset. One day he came in when I was returning from off the unit. I was in a hurried state and could not find a document I was looking for. I was a little agitated. I will never forget him sitting there with the stuffed lion he loved to cuddle with in my office and saying, "maybe you should take some deep breaths and try to relax.".

> Pet Therapy—Staff indicated that you had had pets at the hospital or active pet therapy programs in the past. This was a lively discussion at the comfort room presentation as all attendees seemed to think reviving this program was a good idea.

Suggested Resources:

Acquire Mary Ellen Copeland videos (WRAP) and other recovery videos and books and house them in the library; use them actively in treatment—there is a huge variety of these available at our consumer TA centers (see listings in resources

Books List for Inpatient Settings

The following books are recommended for persons being served in psychiatric settings,--in state hospitals and private facilities. These books are written by authors who have had similar mental health expereiences to those in inpatient settings; authors whose lives went from no hope to a future filled with possibility. The books selected are easy to read, engaging and contain a message that is inspiring.

Arnold, W. *Frances Farmer: Shadowland*.New York: Berkley Book. 1978

Bahati, W: *You Don't Know Crazy*, (a memoir) JLW World Press, New York, NY. 2008 Go to: www.you-dont-know-crazy.com for information on how to order

Balter M, Katz R: Nobody's Child. Reading, Mass, Addison-Wesley, 1991

Beers C: A Mind That Found Itself (1908). Garden City, NY, Doubleday, Doran, 1945

Clay, S. Schell,B., Corrigan.P, Ralph,R., *On Our Own Together: Peer Programs for People with Mental Illness.* Nashville, TN: Vanderbilt Press. 2005

Corrigan,P., and Lundin, R. *Fear is no longer my reality: How I overcame panic and social anxiety disorder and you can too.* New York: McGraw-Hill. 2004

Duke P, with Turan K: *call Me Anna: the autobiography of Patty Duke*. New York, Bantam Books. 1987

Duke P, with Hochman G: *A Brilliant Madness: Living With Manic-Depressive Illness*. New York, Bantam, 1992

Dukakis K, with Srovell J: *Now You Know.* New York, Simon & Schuster, 1990

Hartman, B.: Hammerhead 84: A Memoir of PersistenceKiskayuna, New York; 2005

Jamison, K.R. , *An unquiet mind: A memoir of mods and madness*. New York: Knopf. 1997

Lenz, Two., *Walking Through the Walls*. Selfpublished available at www.twolenz.com

Plath S: The Bell Jar (1963). New York, Bantam Books, 1971

Saks E.R.: *The Center Will Not Hold: My Journey Through Madness*, New York, NY, Hyperion, 2007

Schaefer, E., *Writing through the Darkness: easing your depression with paper and pen*, Ten Speed Press, Berkeley, California. 2008

Schreber DP: Memoirs of My Nervous Illness (1903). Edited by Macalpine I, Hunter RR. London, William Dawson, 1955

Schiller,L.. *The Quiet Room. New York, NY:*Warner Books. 1996

Simon, L.: *Detour: My Bipolar Road Trip in 4-D.* New York, NY, Washington Square Press. 2002

Steele,K., and Berman,C. *The day the voices stopped: A memoir of madness and hope*. New York: Basic Books

Styron,W. *Darkness visible: A memoir of madness*. New York: Random House. 1990

Susko MA (ed): Cry of the Invisible: Writings From the Homeless and Survivors of Psychiatric Hospitals. Baltimore, Conservatory Press, 1991

Vincent, N., *Voluntary Madness*. New York, NY: Penguin Books. 2008

Yates, L: (1996) *Beyond,* Vernon, Texas. Bum Productions, $25.00, To order write to llyates1@comcast.net

VOCAL, *Firewalkers: madness, beauty & mystery*, Charlottesville, VA, 2009 (www.thefirebook.org)

West, C*: Human Hand Wordworks*; self-published, Call Corrina West: 816-392-6074 to order this wonderful poetry book

Other well- known books: