Peer Navigators for People with Mental Illness

Training Manual

Preface

People with serious mental illness get sick and die at much higher rates than same-aged peers. This pattern is significantly worse in people of color. In 2012, a coalition of advocates, 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 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 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 PN manual.

Peer navigators (**PNs**) are also known as community health workers (**CHWs**) in other settings. Both kinds of providers travel into the participant'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 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 person's health goals.

Much of this curriculum was adapted from work by others. Specific citations are provided in the manual and workbook where appropriate. Some of the materials and exercises were developed for the Psychiatric Rehabilitation Certification Program (PRCP) for peer counselors developed by Patrick Corrigan, Annette Backs, Stanley McCracken and others while they were at the University of Chicago Center for Psychiatric Rehabilitation (2000). The PRCP was developed through support of the Illinois Department of Mental Health.

This project was only made possible with significant guidance and commitment of many. Karen Batia, Stephanie Luther, and Ed Stellon, HHO senior leadership, had varied roles in setting up the vision as well as pounding out the specifics of the program. Erin Hantke, Valery Shuman, and Chris Robinson gave us hands on assistance to make this a reality. Several from the research team were vital to our progress including Dana Kraus, Raymond Burks, Annie Schmidt, and Jon Larson. Finally, we are extremely grateful for the advice and wisdom of the CBPR team: Sonya Ballentine, Curlee Jenkins, Joyce Johnson, Robert Johnson, Christina Jones, Rodney Lewis, Lee Taylor, and Monica Williams.

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

Patrick Corrigan
Susan Pickett

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Table of Contents

There is a **WORKBOOK** that accompanies this manual.

Introduction

GOALS

This curriculum seeks to provide a fundamental understanding of the kinds of health problems experienced by African Americans, especially those with mental health and/or substance use challenges. More importantly, the curriculum reviews broad strategies which peer navigators (**PN**s) might draw on to help people address these problems. Our goal is to focus on skills and resources.

- SKILLS: the specific actions and behaviors PNs may use to help the person meet his or her health goals; and
- RESOURCES: the existing services exist throughout Chicago that PNs might avail to meet the person's health needs. As such, this manual is meant to be the foundation of an ever-evolving resource book for PNs and African Americans challenged by mental illness and/or substance abuse.

Training is meant to be **brief**. Training starts with the introduction of ideas, skills, and resources in a "classroom" setting. We will provide brief *fact sheets* which PNs might use to answer their own questions about health and healthcare for people with mental illness. We will also provide *in-the-field practice sheets* which PNs can use collaboratively to help people achieve health goals through specific actions.

Training is meant to be **experiential** in the classroom. For this reason, training is guided by *work sheets* and *exercises*. Experiential work will be augmented by role plays informed by the examples from people's lives.

Training is meant to be **hands-on** in the community. Hence, PN trainees will travel into the community to conduct *homework*.

Training is meant to be **short**. Many of the ideas, skills, and resources here make sense only when the PN gets into the community and tries them on. The manual provides information so training can be completed in about 20 hours. PNs need to get to work and into the field quickly. Students start to lose information when spending too much time in class.

Training is **ongoing**; it never ends. Although trainees might complete this 20 hour curriculum, further education and supervision will be necessary once PNs start on-the-job. We hope that PNs embrace a commitment to lifelong learning and an appetite for ongoing learning.

Fact sheets, work sheets, and exercises summarized in this manual are provided in a **WORKBOOK** for trainees

CONTENT

The Table of Contents on Page 5 summarizes the subjects of the PN training program. After a brief review of the problem in Chapter 1, the heart of training and the program can be found in Chapters 2 & 3.

- Chapter 2 reviews basic helping skills. These might be viewed as the complete tools of the trade from which PNs, like any helpers, choose given the need of the participant they are interacting with in the moment. These are meant to be a fluid set of tools; PNs select among them depending on the needs of the moment. Tools are divided into three groups. Items discussed in subsection **(II)**, Working with the Person, refer to set(s) of skills or approaches for optimal interactions with the participant. Items discussed in subsection **(III)**, Responding to their Concerns, refer to set(s) of skills or approaches for the PN to help participants get their needs met. Items discussed in subsection **(IV)**, Managing my Role, refer to set(s) of skills or tools so that the PN can flourish in their role.
- Chapter 3 reviews solutions. These are the daily work activities that define the PN program. These are focused on the practical goals of program participants and their health goals; getting into the community, engaging participants, understanding their goals, linking them with services, while providing support at all points along the way.

Note one recurring theme of the manual. PNs are helpers, just like other mental health providers: nurses, social workers, psychologists and psychiatrists. Hence, they learn many of the same, fundamental set of skills as all providers.

LOGISTICS

Given these goals, we propose the manual be taught to trainees and their supervisor over a protracted period of time.

- Pre-service (prior to PNs first working with program participants: seven 3-hour days with lunch and breaks);
- Transition: start up and windshield tours interspersed with three 3-hour didactic sessions
- Start-up inservice: one afternoon per week for six weeks for three hour didactic
- Inservice: one afternoon per month (every other month) led by PN team member

PN training is to be conducted in addition to pre-service and inservice training required by the parent agency in which the program is embedded.

We reiterate a point made in the preface and highlighted in the header of this manual. **Peer navigators** and **community health workers** do essentially the same tasks. Peer navigator was an especially meaningful idea for our CBPR team.

Chapter 1 Overall Goals and Values of Peer Navigators (PNs)

Lesson Objectives

1. Understand the health problems of African Americans with mental illness.
2. Review basic principles of PNs.
3. Obtain an overview of the PN job and duties.

Introduction

African Americans with mental illness are troubled by significant health problems. In this chapter, we review with trainees what our qualitative research showed about the extent of the problem in the Edgewater-Uptown community. Among the problems here is access to services that meet the person's perceptions of health concerns. Peer navigators -- PNs are African Americans in recovery and now provide in-the-community practical support -- are one way to address this problem. We review our research about community perspectives of peer navigators in this chapter. This includes a review of basic principles for PNs in order to obtain an overview of PN job duties.

1.1 OVERVIEW OF HEALTH PROBLEMS

The place to begin is by understanding the kinds of health problems experience by African Americans with mental health challenges. We got this information by reviewing the research literature from across the United States AND, more importantly, by interviewing people from the neighborhood: African Americans who have experienced significant mental health challenges, and who have suffered physical health problems.

Handout FACT SHEET 1.1, Overview of Health Problems

Let's take a look at Fact Sheet 1.1, which provides an Overview of Health Problems. Rather than focus on diagnoses, we seek to make sense of problems into clusters relevant to PN efforts. Review the four clusters of health needs in the fact sheet. In addition, we sought to identify barriers to addressing these health needs, also summarized in Fact Sheet 1.1. Finally, our survey examined how health care problems are even worse among African Americans with mental illness.

FACT SHEET 1.1, 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 and substance abuse 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

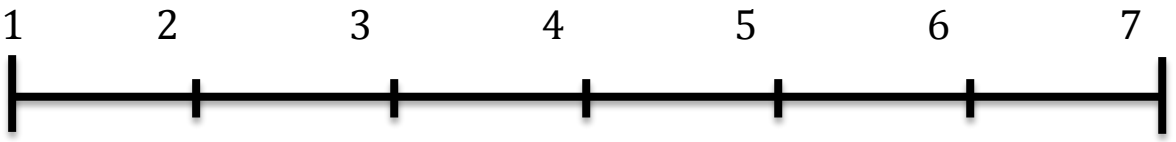
How do these problems seem to you? In Work Sheet 1.1, we repeat the problems and ask you to rate their importance. Should some issues be viewed more importantly than others?

Handout WORK SHEET 1.1, Your Experience with Health Problems

We then ask you to provide an example from your life, or the life of someone you know, for each area.

WORK SHEET 1.1, Your Experience with Health Problems

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



Not at all important — Somewhat important — Very important

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

Now provide an example of one key issue from your life story:

1.2 BASIC PRINCIPLES OF PNs

Based on interviews with African Americans with mental illness, AND with service providers and other professionals in the neighborhood, we generated a list of basic principles meant to guide PNs work. It is summarized in Fact Sheet 1.2.

Handout FACT SHEET 1.2, Basic Principles for Providing PN Services.

While reviewing Fact Sheet 1.2 with trainees, note how they are organized into three sets: Basic Values, Part of the Team, and Fundamental Approach. Ask trainees how each of these might help PNs obtain their health care needs.

Basic Principles of PNs

FACT SHEET 1.2, Basic Principles for Providing PN Services

BASIC VALUES:

Accepting: Peer Navigators (**PN**s) work with people who are different from them. PNs respect these differences and appreciate the participant as he or she is.

Empowering: PNs recognize self-determination. Participants 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: PNs recognize recovery and not mental illness as the expectation, promoting goalachievement and hope.

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

Peer Experienced: PNs are peers! They are African Americans who have lived experience with mental illness and are in recovery.

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

Patient and Consistent: PNs need to provide services regularly and over the long term. Most problems experienced on the street do not change quickly.

In the Community: PNs work in the participant's community and health care system.

PART OF THE TEAM:

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

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

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

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

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

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

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

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

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

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

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

Boundaries: PNs know there are limits to what they can do to help the participant.

Basic Principles of PNs

1.3 WHO ARE PEERS?

Fact Sheet 1.3 reviews the question of who can be a peer navigator. While reviewing with trainees, note the importance of personal experience. Ask trainees to come up with good qualities a PN should have.

Handout FACT SHEET 1.3, Who are Peers?

Who are Peers?

FACT SHEET 1.3, Who are Peers?

Who can be a peer navigator?

- A peer navigator (PN) is someone whose lived experience and training allows them to help others in similar situations or circumstances.
- A PN can learn skills and strategies to help others in similar situations.
- PNs are African Americans with serious mental illness
- PNs 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 navigators do?

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

What are some good qualities a peer navigator should have?

- _____
- _____
- _____

1.4 OVERVIEW OF PN DUTIES

The remainder of this manual is dedicated to the specific duties PNs must master to help African Americans with mental illness address their health care needs. Duties are divided into three groups: (1) Working with the person: the basic helping skills that help the PN to clearly and fully hear the person's priorities; (2) Responding to their concerns: providing the skills so the person can make sense of and overcome hurdles to their health care; and (3) Managing my role: mastering boundaries and other skills so the PNs relationship with participants is optimal. Fact Sheet 1.4 reviews these.

Handout FACT SHEET 1.4, Overview of PN Duties

Overview of PN Duties

FACT SHEET 1.4, Overview of PN Duties

During the course of this training we will go over the following materials. Below is a brief description of what we will be covering.

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

Reflective Listening: A communication strategy that aims to reconstruct what the participant is expressing and to relay this understanding back to the participant.

Engaging People through Goal Setting: The process of discussing what a participant wants to accomplish and devising a plan to achieve the result they desire.

Motivational Interviewing: A way to engage participants, elicit change talk, and evoke motivation to make positive changes.

Strengths Model: An approach that identifies the positive resources and abilities that participants already have.

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

Time Management: The act of planning and exercising control over the time spent on specific activities, in order to increase effectiveness and productivity.

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

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

Aggression Management: A set of skills to help PNs handle possible aggression to avoid harm to participants or others.

Relapse Prevention: 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.

Harm Reduction: Helping people minimize the negative impacts to self, loved ones, and community when engaging in risky behaviors.

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

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.

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

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

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.

Managing Burnout: A way to reduce the stress reaction experienced by PNs exposed to traumatic experiences and stories of participants.

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

Street Smarts: A set of skills designed to help PNs cope and stay safe while working in a large urban area **Office Etiquette:** A set of guidelines to help PNs familiarize themselves with an office setting.

Overview of PN Duties

Chapter 2 Basic Helping Skills

Lesson Objectives

1. Learn reflective listening skills that promote introductions and engagement. Also learn roadblocks to communication that undermine relationships.
2. Learn ways to help people develop goals for their health. This includes understanding each particular individual's pros and cons to different options.
3. Master approaches to personal and interpersonal problem solving.
4. Learn ways to prevent or diminish the impact of lapses and relapses.
5. Learn ways to handle aggression and crises.
6. Master time management strategies.

CHAPTER 2 SECTION I: Introduction to Basic Helping Skills

Items discussed in this section refer to set(s) of skills or approaches for optimal helping relationships with participants.

Ch. 2 Section I: Introduction to Basic Helping Skills

2.1 BASIC HELPER PRINCIPLES

We begin here with the idea of helper. PNs are helpers just like case workers, psychologists, and medical doctors. There are basic principles that govern all helping relationships. Some of these are reviewed in Fact Sheet 2.1.

Handout FACT SHEET 2.1, Basic Principles in Helping Relationships

The top half of the sheet refers to the three stages of a helping relationship. Review these briefly. The bottom half of the page refers to basic values of a helping relationship. Take a few minutes to help trainees make sense of these ideas.

FACT SHEET 2.1, 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.

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.

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.

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

Work Sheet 2.1 provides an exercise meant to help trainees better understand basic helper principles.

Handout WORK SHEET 2.1, Basic Helper Principles in Your Life

First, have the group review the example of a helper who used basic skills, Mrs. Olivia. Then have trainees provide examples of two people from their life -- real people, not made up -- who used these principles to assist them with a problem.

WORK SHEET 2.1, 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).

CHAPTER 2 SECTION II: Working with the Person

Items discussed in this section refer to set(s) of skills or approaches for optimal interactions with the participant.

Ch. 2 Section II: Working with the Person

2.2 REFLECTIVE LISTENING SKILLS

All helping begins with listening; making sure the PN provides the person space so he or she can come to understand the health problem. Despite good intentions, helpers often undermine conversation with roadblocks to good listening. Some of these roadblocks are summarized in Fact Sheet 2.2A.

Handout FACT SHEET 2.2A, Roadblocks to Good Listening

Review each of the roadblocks. Ask trainees to be mindful of roadblocks that one might actually think are useful for helping conversations. *Wow. I didn't realize giving advice could block good listening. I thought my job was to provide advice to give them direction.* Have trainees write down the roadblocks that were surprising to them.

Note the roadblocks are organized into three groups. Ask trainees to write down roadblocks they have observed in others. *Please be concrete. Who, what, when and where.*

FACT SHEET 2.2A, 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.

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.

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

One way to become aware of roadblocks in your own communication is to be able to listen to them in others. Work Sheet 2.2A is meant to help trainees develop this ear.

Handout WORK SHEET 2.2A, Examples of Roadblocks

In this exercise, the instructor is going to role play with a class volunteer BAD listening skills. Prepare the volunteer by asking him or her to role play concerns about an officemate; e.g., they play their radio loud, talk socially on their cell phone a lot, and are rifling through the volunteer's personal belongings. The instructor begins the conversation by saying…

"Hey _____, what's up?"

Then the instructor is to use different roadblocks in Fact Sheet 2.2A. Continue the role play for about five minutes. When done, ask the rest of the class to identify the roadblocks demonstrated by the instructor. Ask trainees to be specific. *"What exactly did I do to make you think I was diagnosing?"*

Ask the volunteer how he or she experienced the role play. "*What was this conversation like for you? What were its strengths and limitations?"*

If time permits, the instructor should pick another volunteer; in this role play, have the volunteer speak about concerns about her or his health.

WORK SHEET 2.2A, Examples of Roadblocks

Try to identify which type of roadblock is being modeled by the instructor and volunteer:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____ Now that we know what to be careful of, let's begin to get a sense of good listening skills.

Handout FACT SHEET 2.2B, Good Listening Skills

Ask the class to review the three sets of skills. They are divided into three sets: Attending, Following, and Reflecting Skills.

Now the trainer should demonstrate the skills. Ask a PN trainee to engage with the trainer in a discussion about an exciting life experience in the trainee's past 10 years. The discussion should take about 5 to 7 minutes. First, the trainer should set up and demonstrate Attending skills. Then as the conversation progresses, the trainer should add Following and Reflecting Skills. When done, the class should have a discussion on what they observed.

FACT SHEET 2.2B, 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.

Nondistracting 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 closedended question that can be answered with one or two words does not encourage conversation, whereas an openended 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.

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).

The secret to good listening rests with reflecting skills. This requires hearing both the obvious and hidden messages in a conversation. Obvious is what the person said.

"I hope I'm not too late."

The hidden message depends on context and emotion. Consider how the obvious message above changes when the speaker is 20 minutes late for a meeting and says this sarcastically.

Handout WORK SHEET 2.2B, Obvious and Hidden Messages

Work Sheet 2.2B is meant to help trainees develop their ear for hidden messages. Ask trainees to complete the task and then discuss with the class.

WORK SHEET 2.2B, 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 content/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).

Key to reflecting both obvious and hidden messages is developing an ease for identifying feeling words. Consider the PN who is able to reflect an experience such as

"The religious service was sad." into

more feeling words:

"The religious service was depressing, glum, below par, displeasing…." The speaker will feel better heard as a result.

Handout WORK SHEET 2.2C, Feeling Words

The front side of Work Sheet 2.2C lists many emotion words in alphabetic order. The trainee's task is to sort these words into the grid on the back side of the work sheet. Give trainees about 15 minutes to do this and then have the class discuss as a group.

WORK SHEET 2.2C, 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).

Mastering listening skills is so important, three practice exercises are provided.

Handout WORK SHEETS 2.2D, 2.2E, 2.2F, Practice Good Listening – 1, 2, and 3

Ask trainees to partner and do each exercise in turn.

WORK SHEET 2.2D, 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).

WORK SHEET 2.2E, 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 **helper:**

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).

WORK SHEET 2.2F, 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 has lost their job due to their company cutting back on staff. 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).

2.3 ENGAGING PEOPLE THROUGH GOAL SETTING

Most helping behaviors are focused around goals, in the case of PNs, around health goals. The skilled PN helps participants voice their wishes and desires in terms of their physical and mental health. This includes examining barriers to getting good health care.

Handout IN-THE-FIELD PRACTICE SHEET 2.3, Assessing Health Goals

Practice sheet 2.3 is meant for PNs to use in the field to help participants get a sense of their health goals. It starts with two open-ended questions.

- What is good health for you?
- What illnesses are you concerned about?

Then, participants are asked to check specific concerns that are current health goals for them; e.g., eyes, teeth, or smoking. Participants are also asked about concerns with mental health or substance use. The back side of the sheet lists health care needs. The participant is asked to check all that apply. Some goals might not be among the check boxes. Hence, participants are asked to list other possible needs on the bottom lines.

The practice sheet can be completed as an interview with the PN running through the questions. Alternatively, participants might complete the sheet on their own and then have the PN review it with them so priorities can be set. Let's practice doing it as in interview. The trainer should get a trainee to come to the front of the room to assume the role of a program participant. After completing the sheet, the trainer should ask the class for their feedback about the process. Then, trainees should break into pairs and role play the health goals assessment, with one trainee acting as participant, the second as interviewer.

IN-THE-FIELD PRACTICE SHEET 2.3, Assessing Health Goals

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 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)

2.4 MOTIVATIONAL INTERVIEWING

Handout FACT SHEET 2.4, Motivational Interviewing

Fact Sheet 2.4 summarizes motivational interviewing. Review types of behaviors to change and possible pros and cons of a decision to act. Discuss the four principles of motivational interviewing with the class.

Handout WORK SHEET 2.4, Motivational Interviewing

Work Sheet 2.4 is a role play exercise. Trainees are asked to come up with an example of a behavior to change and act out a dialogue. One person is the speaker who is considering a behavioral change, while the other is the listener who uses motivational interviewing to listen and engage the speaker. At the end of the exercise, trainees should give each other feedback. Pairs then switch roles and repeat the exercise.

Handout IN-THE-FIELD PRACTICE SHEET 2.4, Motivational Interviewing

In-the-Field Practice Sheet 2.4 is used by the PN with participants to decide whether to change a behavior. First, they are asked to think of a target behavior they have been thinking about changing. Next, the PN uses motivational interviewing to help the participant list the pros and cons of changing the behavior. The PN reviews the pros and cons with the participant, who then decides whether to change the behavior.

FACT SHEET 2.4, 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 back to work) or negative (abusing drugs).
- 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 back to work might be making more money and meeting more friends. Cons might be adding to daily stress and having to pay for public transportation.
- Something negative like drug abuse has pros; feeling happy when high and being funnier. But they also have cons; getting in trouble with the law or having too many absences at work.
- 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 participant'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 participants and consider the pros and cons of changing the behavior. These are pros and cons the participant 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. Rather, it is informative and by listening and responding with warmth and understanding, you can help reduce the resistance.
- With any change comes concerns about the unfamiliar or unknown. Participants 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 participants by reinforcing positive statements about capabilities and worth.
- The participant always makes the final decisions about change. PNs can make suggestions about possible strategies for change, but participants make the final call.

Arkowitz & Miller (2008).

WORK SHEET 2.4, 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 2.4, 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 these pros and cons, do you want to change the target behavior?

☐ Yes ☐
No

2.5 STRENGTHS MODEL

Fact Sheet 2.5 summarizes a practice used to assist people to recover, reclaim, and transform their lives.

Handout FACT SHEET 2.5, Strengths Model

While reviewing Fact Sheet 2.5 with trainees, note how they are organized into six principles. Remind them that these principles are done WITH participants not to them. Ask trainees how each of these might help in their work with participants.

Working with the Person: Strengths Model

FACT SHEET 2.5, 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 participant. 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 participant. The PN is not *doing* something *to* the participant, but *with* the person.

Principle 1: ***People can recover and transform their lives.*** Your participants have the ability to affect their own recovery. As a PN 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 participant, and instilling hope.

Principle 2: ***Focus on strengths not deficits***. This does not mean that you ignore problems that participants 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 Uptown/Edgewater is no different. As a PN working in this community it is your job to focus on the good things there (free clinics, food pantries, good people) and emphasize the parts that can be sources of wellbeing for the participant.

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

Principle 5: ***The PN/participant 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 participant; going shopping, playing cards, or having coffee.

Rapp & Goscha (2012).

Working with the Person: Strengths Model

2.6 ADVOCACY

PNs are advocates, actively engaging with various health care providers on behalf of and with participants to meet their goals. Fact sheet 2.6 summarizes various roles PNs might assume as advocates.

Handout FACT SHEET 2.6, Advocacy

After reviewing the roles, ask trainees to list examples of real world people who have effectively assumed these roles.

Next is Work Sheet 2.6, meant to be an exercise for trainees to understand each role more effectively.

Handout WORK SHEET 2.6, Strengths and Weaknesses of Different Roles

Helper roles are not "all good," everything we might do with participants has its downside. The purpose of Work Sheet 2.6 is for trainees to actively consider strengths and weaknesses of each role. Ask trainees to complete the worksheet and then pair off with another trainee to discuss their responses.

FACT SHEET 2.6, Advocacy

Peer navigators (PNs) are advocates. An advocate is someone who works in favor of other persons, providing assistance and promoting their interests. There may be times that participants 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 working as **supporter, educator, spokesperson,** and **intermediary.**

Supporter: In this role, PNs provide encouragement and assistance with tasks, seeking to improve clients' 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, PNs help participants understand when they may need to seek services, including which service is needed and where it can be accessed. This may include helping participants recognize and understand their symptoms, medications, and prescriptions.

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

Intermediary: In this role, PNs act as advocates to help resolve problems between participants 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 participants at the individual level means getting the voice of your participant heard by people who need to hear it. Often times, participants are used to hearing the word "NO." Encouraging self-advocacy means helping participants ask questions, stand up for themselves, and understand that there are other answers besides "no."

You can also advocate on your participant's behalf, speaking directly with providers and getting answers to participants' questions. Remind participants--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 participants have the goal of helping others, they sometimes fall short. While your job as a PN is not to fix these problems, you may find yourself in a situation where participants 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 participants face are a result of stigma and laws that do not favor them. As a PN, it is not your job to fix these laws, but to help participants 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).

WORK SHEET 2.6, 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 class what you found.

2.7 TIME MANAGEMENT

PNs will have busy days. They need to use their time wisely and fit many tasks into the day.

Handout FACT SHEET 2.7, Time Management

Fact Sheet 2.7 outlines tips for PNs to effectively manage their time. Review with trainees tips to get organized, avoid procrastination, and limit distractions during the work day.

Handout WORK SHEET 2.7, Time Management

Work Sheet 2.7 contains an exercise for trainees to practice time management by planning out a schedule, including prioritizing certain tasks over others and fitting them into the work day's schedule.

FACT SHEET 2.7, Time Management

As a Peer Navigator, you will need to use your time wisely and fit many tasks into your work day. 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 work day 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 PROCRASTNATION

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 participants, 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 participant so you are not tempted to answer during these times.

Boe (2012).

WORK SHEET 2.7, 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 participants.
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 clients 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	
6:30	
7:00	
7:30	
8:00	

Now, take this same information and enter it in Outlook.

Section III: RESPONDING TO THEIR CONCERNS

Items discussed in this section refer to set(s) of skills or approaches for the PN to help participants get their needs met.

2.8 INTERPERSONAL PROBLEM SOLVING

Fact Sheet 2.8 is meant for PNs to use in resolving interpersonal problems that can occur at work or in the field.

Handout FACT SHEET 2.8, Interpersonal Problem Solving

The emphasis of this section is solution focused. While reviewing with trainees, note there are seven steps to this process. Encourage trainees to come up with real-life examples for each step to gauge their understanding of the material.

Work Sheet 2.8 is a role play exercise.

Handout WORK SHEET 2.8, Interpersonal Problem Solving

In this exercise, trainees are asked to come up with a scenario to act out that problem, with one person being the speaker and the other the listener. At the end of the exercise, trainees should give each other feedback. Pairs should then switch roles and repeat.

In-the-Field Practice Sheet 2.8 is used by the PN with participants in order to strategize solutions to interpersonal problems.

Handout IN-THE-FIELD PRACTICE SHEET 2.8, Interpersonal Problem Solving

First they are asked to define a problem (who is involved, when it occurs, and where it occurs). The second section asks participants to brainstorm possible solutions to the problem and choose one solution. Together the PN and participant will list the pros and cons. The back of the sheet asks them to come up with a plan for implementing the solution. After attempting the solution, it asks the person for feedback on the process.

FACT SHEET 2.8, 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. Participants 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).

WORK SHEET 2.8, 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 PRACTICE SHEET 2.8, 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 pros and cons of implementing it.
What is your solution? _____

PROS **CONS**

Are we going to try it? _____yes _____no (If yes, continue to the back page.)

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?

2.9 AGGRESSION MANAGEMENT

Living on the streets homeless is tough. Sometimes it can make the person aggressive or hurtful. Aggression will undermine PN relationships with participants; PNs, participants, and others can get hurt. Participants can incur harm beyond the actual event as well. They could get arrested. Or they might be barred from services. PNs need to be prepared to derail possible aggression so no one is harmed.

FACT SHEET 2.9, Aggression Management

The top part of Fact Sheet 2.9 describes different types of aggression. Have the class of trainees discuss these.

More important are the causes of and responses to aggression. Let's be clear. There is nothing about mental illness that makes people violent. Participants become angry and hit for the same reasons as everyone else. Seven of these are listed on the bottom of the fact sheet. Review these as well as discuss ways to react to them. Ask trainees to come up with real life examples of the causes.

Responding to their Concerns: Aggression Management

FACT SHEET 2.9, Aggression Management

TYPES OF AGGRESSION

Psychosis related: A person experiencing psychosis can be confused, disorienting experiences such as paranoid delusions or hallucinations are upsetting, and they may become frightened or aggressive.

Non-specific agitation: A person who feels nervous or agitated, even for no identifiable reason, may become aggressive.

Mania: Agitation or nervousness resulting from mania may lead to aggression.

Frustration-related aggression: Frustration can lead to aggression. A person who is frustrated may feel anger, which may lead to aggressive behavior.

Sexual harassment: Making unwanted sexual advances or remarks toward another person. This includes inappropriate touching or intimacy.

CAUSES AND RESPONSES

Decrease frustration: Frustration can lead to aggression. By helping people get their goals met, the PN can decrease the risk for aggression.

Decrease demands: A person may become aggressive when he or she is unable to meet demands. A possible solution is help the person set realistic goals that he or she can meet in a timely way.

Decrease confusion: Confusion about rules or roles may lead to aggression. Be clear about your relationship with the person to avoid confusion.

Decrease stimulation: Be aware of stressors, including other aggressive people that may trigger aggression. Create a non-threatening environment.

Decrease rewards: Do not reward aggression with attention or giving in to what the person wants. Instead, try ignoring the person when he or she is acting aggressively until the behavior decreases.

Promote pro-social behavior: A lack of social support may make a person feel vulnerable and lead him or her to express this through aggressive behavior.

Identify incentives: Try a reward system that reinforces a person for acting in a nonaggressive manner. For example, by giving a person attention when he or she is acting calmly, you promote this nonaggressive behavior. (Catch the person doing something right) Try to identify what a person wants and you can use this as a reward.

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 so that it interferes less.

University of Chicago Center for Psychiatric Rehabilitation (1999).

Responding to their Concerns: Aggression Management

2.10 RELAPSE MANAGEMENT

We have been identifying various problem behaviors that interfere with participants achieving health goals. These behaviors might include alcohol or substance use, criminal activity, unsafe sex, or recurring psychiatric symptoms. Some of the PN skills learned up to now are meant to help program participants manage these problems. In addition, participants might be referred to mental health or substance use treatment providers who can help the person manage these problems. Although program participants might be on the path to controlling these behaviors, slips and relapses occur. For example, despite best intentions, some people who are trying to abstain or moderate their alcohol or drug use may slip and use when faced with a difficult situation or peers who aren't aware or supportive of their goals. Other people trying to break their stealing habit might steal a TV from a store when they feel they have no better options.

Although relapses are not always avoidable, their impact can be diminished. Instead of a slip in sobriety leading to a full blown backslide into drunkenness, participants might learn how to manage this error so they can regain personally meaningful control over their drinking.

Handout Fact Sheet 2.10, Relapse Management

Fact Sheet 2.10 reviews core ingredients of relapse management: signs, triggers, and relapse plan. Take some time to review this with trainees.

FACT SHEET 2.10, 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.

Relapse management is a helper skill that nicely translates to hands on effort with the participant in the community.

Handout IN-THE-FIELD PRACTICE SHEET 2.10, Relapse Management

The Relapse Management In-the-Field Practice Sheet corresponds with the Relapse Management Fact Sheet. It is a step-by-step plan for PNs to help participants develop a relapse plan. First, trainers should review the plan for trainees. Note that relapse plans vary depending on the concern. People who want relapse plans to manage their drug or alcohol use and their mental illness should develop SEPARATE plans for each. Ask the participant to check off the single focus of the specific plan being worked out on this work sheet. Then ask the participant to fully describe the problem: with whom does it occur, when, where, what happens, and what are its effects, both bad ones and good ones. Next, signs and symptoms of relapse are listed. The back side is for developing the specific plan. What can the person do to prevent a relapse? This is frequently accomplished by avoiding triggers or handling signs before they become overwhelming. The bottom half of the relapse plan is to summarize what the participant might do if a relapse occurs. These are frequently coping skills and support systems that can help the person regain control over the problem behavior.

After reviewing the Practice Sheet, trainers should demonstrate the plan with a trainee volunteer. After this, trainee volunteers should break up into pairs to practice the work sheet.

IN-THE-FIELD PRACTICE SHEET 2.10, 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:

2.11 HARM REDUCTION

People living on the streets might choose behaviors that seem harmful to PNs. They might use alcohol or drugs chaotically, participate in unsafe sex, or commit criminal activities. PNs should not direct the participant to just STOP these behaviors. Ultimately, that choice is up to the participant, and there are likely benefits to continuing these behaviors. However, participants might partner with PNs to identify ways to reduce the harm of specific behaviors.

Handout FACT SHEET 2.11, Harm Reduction

Trainers should review with PN trainees the principles of harm reduction summarized on Fact Sheet 2.11. The discussion should also include the grid of examples: behaviors and ways to reduce harm. The table is not meant to be a complete list, only examples of how to proceed.

FACT SHEET 2.11, Harm Reduction

Harm reduction means helping people maximize their health while reducing harm. This involves continuing potentially harmful behaviors while working to minimize the negative impact on participants, their loved ones, and their community.

Principles of harm reduction

- People have the right to treatment and 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.
- 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. Participants have the final say about their behavior. Do not impose your personal values and beliefs.
- **Informative**: Help your participants 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 participants by using good listening skills. Try to understand the costs and benefits of a behavior from their perspective. Remind participants 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).

Harm reduction may seem odd to PNs, challenging their deeply held values and beliefs. It is important to address this issue early and often, in order to ensure greater comfort and continued skill development to implement harm reduction effectively.

Handout Work Sheet 2.11, Harm Reduction

Work Sheet 2.11 is meant to introduce PNs to actual harm reduction strategies in the real world. Have trainees pair up with one acting the role of PN, the other at participant. They should role play the task and complete the sheet. When done, have role payers discuss the experience and then switch roles.

This work sheet is also a useful In-the-Field Practice Sheet. PNs might use the Practice Sheet with participants to help them reduce harm in their personal behaviors.

WORK SHEET 2.11, 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 _____ unsafe sex _____ mental illness

_____ substance use _____ homelessness _____ physical illness

_____ committing crimes _____ spending recklessly _____ 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 aspects 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*

2.12 CULTURAL COMPETENCE

People living on the streets may be culturally different from the peer navigator. The goal is to serve program participants while acknowledging and respecting and embracing differences.

Handout FACT SHEET 2.12, Cultural Competence

Ask trainees to review the key points in Fact Sheet 2.12. Then have them review the cultural competence work sheet to get a better idea of cultural difference and respect. Remind them they do not have to share everything they write in the work sheet.

Handout WORK SHEET 2.12, Cultural Competence Experiences

FACT SHEET 2.12, 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.

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. PNs 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 participant'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.

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. Participants will notice.

***Note:** The Chicago study will have PN's who are African American serving African

Americans with mental illness so cultural competence "issues" may not seem to apply. However, remember that there is much variation within groups as well. Additionally, there are differences between people who are African Americans versus Africans.

Rust et al. (2006)

WORK SHEET 2.12, Cultural Competence Experiences

Pick an ethnic or racial group you know well that is different from you. For example; if you are an African American, choose Caucasians or Latinos, etc. If you are Latino, choose African Americans or Asians, etc. This can be a difficult task so don't feel that you have to share everything you write, but you may find someone else with whom you can get clarity. Please take 15 minutes to complete.

What are some of your **similarities** with people from this group?
What are some of your **differences**?
List one time when you were disrespected by a member of this group because of your culture.
List one time you may have unintentionally disrespected a member of this ethnic or racial group.
What experiences led to mutual respect between you and members of this group?

2.13 MENTAL HEALTH CRISIS MANAGEMENT

Despite best efforts, people living on the street will sometimes experience crises. Fact Sheet 2.13 reviews the different kinds of crises PNs might encounter in program participants. The Fact Sheet includes specific signs as well as practical strategies for talking with the person. Safety is the fundamental goal. The fact sheet also reviews ways to keep the person safe.

Handout FACT SHEET 2.13, Mental Health Crisis Management

FACT SHEET 2.13, Mental Health Crisis Management

Mental Health crises can occur in people in emotional distress. The role of the PN is to assist the person in crisis until appropriate professional help is received. The PN will need to be able to identify **signs, effective communication, and 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.

Ways to keep person safe: A person who is actively suicidal should NEVER be left alone. If you can't stay, arrange for someone else to do so and contact your supervisor. Call 911 if the threat is serious or you do not know what to do next.

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 participant 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.

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 participant 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 help best.

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.

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.

AGGRESSIVE 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.

Ways to keep person safe: If you are frightened, seek outside help immediately. Never put yourself at risk. Call your supervisor or 911.

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

2.14 PHYSICAL HEALTH CRISIS MANAGEMENT

People living on the streets also experience physical health crises. Fact Sheet 2.14 reviews several of these.

Handout Fact Sheet 2.14, Physical Health Crisis Management

Review the fact sheet focusing on signs and what-to-do. Signs are what the participant will exhibit that makes the PN question whether the person is in crisis. What-to-do provides brief direction on how to respond.

FACT SHEET 2.14, Physical Health Crisis Management

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

HEART ATTACK

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 participant 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 or 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. 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).

2.15 TRAUMA-INFORMED CARE

People living on the streets are often traumatized by being victimized by crime or through other frightening experiences. By trauma, we mean "a distressing or disturbing event, leading to fear, helplessness, or lack of control." Peer navigators need skills to help the person manage trauma on the streets. This is called **trauma-informed care**.

Handout FACT SHEET 2.15, Trauma-Informed Care

The goal here is NOT to help the person overcome his or her trauma. This typically requires an especially skilled therapist. Instead, the goal is for PNs to help the person cope with the trauma "on the streets" so he or she can also attend to the other demands of everyday life, especially health.

Fact Sheet 2.15 includes more complete definitions of trauma and trauma-informed care. It then includes do's and don'ts which PNs might consider in helping the person manage his or her trauma. The fact sheet includes ways to: recognize signs of trauma, normalize the experience, establish safety, collaborate with the person, and promote empowerment. Work Sheet 2.15 on the following page helps trainees to think about the ides in the fact sheet in a real world example.

Handout WORK SHEET 2.15, Trauma-Informed Care Experiences

Note the warning: let trainees know they SHOULD NOT discuss a trauma that is still very frightening or unsettling to them. Have trainees complete the work sheet. Instead of pairing up and discussing, ask trainees to review in a class discussion with the trainer moderating the discussion.

FACT SHEET 2.15, 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 participants, 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.

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 participant's distress. Don't neglect the trauma or act as if the symptoms are unimportant, wishing the participant would just get over it.

NORMALIZE THE TRAUMA

Do: Help participants 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: Re-direct the participant by changing the subject to avoid the topic. Don't undermine their story or make them feel ashamed of their trauma. Don't make participants feel guilty or alone in their experience.

ESTABLISH SAFETY

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

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.

COLLABORATE

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

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

PROMOTE EMPOWERMENT

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

Don't: Make the participant feel ashamed of their story. Don't blame participants or make them feel their trauma is unimportant. Don't provide thoughtless responses. Don't fake interest in their experience.

Shuman (2012).

WORK SHEET 2.15, 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:

_____
_____
_
_____
_
_____
_
_____
_

Note: Be aware that any trauma experiences—yours or other people's—can still be frightening or troubling to you and/or your participants. 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?

Chapter 2 Section IV: MANAGING MY ROLE

Items discussed in this section refer to set(s) of skills or tools so that the PN can flourish in their role.

Ch. 2 Section IV: Managing My Role

2.16 RELATIONSHIP BOUNDARIES

Peer navigators will need to build close working relationships with participants to be able to help them with their health problems. The question:

"How close is too close?"

Helpers frequently call this an issue of boundaries. What boundaries are crossed so the PN can help the participant and what boundaries should not be crossed? One place to begin this discussion is to consider the different kinds of relationships PNs and participants might have.

Handout FACT SHEET 2.16A, Types of Relationships

The first five types of relationships are mostly troublesome, approaches peer navigators do not want to take. Each one is defined in terms of assumptions, how to spot them, and problems. Trainees might believe labeling some of these relationships as troublesome seems odd. After all, "aren't we trying to rescue them from the streets where they are victimized?" Ask trainees to identify relationships they were surprised to find in the troublesome list.

The last relationship type – team member/team member – is considered the ideal, the standard which PNs should strive for with participants. Review how to spot this kind of relationship, its key elements, and examples. Also review questions that guide this approach.

Handout FACT SHEET 2.16B, Relationship Boundaries

Fact Sheet 2.16B reviews one more type of relationship – friend/friend. Review with trainees how to stay within boundaries in their relationships with participants.

FACT SHEET 2.16A, Types of Relationships

PARENT/CHILD

Assumption: Assumes that clients cannot function as responsible adults, and make poor choices due to lack of knowledge and skills. PN should do everything because he/she knows best.

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

Problems: Peer Navigators (PN's) underestimate client's ability to problem solve and take initiative for their own lives. This will most likely lead to resistance.

TEACHER/STUDENT

Assumption: Clients make poor choices due to lack of knowledge. PNs have all the knowledge.

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

Problems: PN overlooks knowledge of the client and misses out on opportunities to learn. PNs may force their own beliefs onto clients without hearing client'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 clients follow "our" way rather than supporting them on their own goals.

EMPLOYER/EMPLOYEE

Assumption: Clients are seen as working under PN's and staff. The PN is the boss of the client.

How to spot: Discriminating against 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: PN's know what is best for you; clients should not demonstrate independence or confidence. Clients do not have their own resources. PN's are saints and clients are "damaged."

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

Problem: The PN expects a client to be grateful, which can lead to self-doubt and lack of confidence among clients.

WHAT WE WANT TO STRIVE FOR:

TEAM MEMBER /TEAM MEMBER

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

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

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

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

Dobbins (2012).

FACT SHEET 2.16B, Relationship Boundaries

Before we begin: Please review Types of Relationships factsheet

One last Relationship Type is:

FRIEND/FRIEND:

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

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

Problem: Being friends with a client interferes with being able to provide good services. It can also undermine your relationships with your other clients, as they may not trust you to provide services equally to all clients.

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 clients on limits: Telling a client 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 client on limits.

DO:

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

DON'T:

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

- Use offensive language around your client
- Share alcohol or other substances

2.17 MANAGING BURNOUT

People living on the streets experience lots of trauma; they are frequent victims and witnesses to horrible crimes. Hearing people's stories of trauma can be *traumatizing* to the peer navigator: Fact Sheet 2.17 calls that Trauma-Through-Others which can lead to burnout. Burnout is the sense of emotional exhaustion that interferes with the PN provision of good services. Burnout also takes the joy out of a job. PNs will not want to continue working when feeling burned out.

Handout FACT SHEET 2.17, Managing Burnout

The good news is that PNs can do things to prevent burnout. The front side of Fact Sheet 2.17 lists several signs of burnout. Review these with PNs encouraging them to be vigilant as they start their new work. The back side of Fact Sheet 2.17 lists practical ways to deal with burnout. Have trainees review these.

FACT SHEET 2.17, Managing Burnout

Trauma-through-others is a stress reaction experienced by PNs exposed to traumatic experiences and images of clients. The PN may experience burnout in their 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:** A lot of peer navigators may also have experienced trauma. Sometimes, hearing participant stories can lead to flashbacks of PNs 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 PNs to have a plan in place to keep themselves 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 Boundaries between Client and Peer Navigator Factsheet.**
- **Get Professional Help:** Do not be reluctant to get assistance from a professional when burnout becomes overwhelming, especially when the PN is reliving their own experience with trauma.

Dobbins (2012).

Handout WORK SHEET 2.17, Managing Burnout

This work sheet is meant for trainees to get a better sense of burnout and trauma-through-others. Ask trainees to complete each of the text boxes. Then, pair off with another trainee to review responses.

WORK SHEET 2.17, Managing Burnout

From what you have learned in your life, what might burn you out being a Peer 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.

2.18 SELF-DISCLOSURE

PNs in this project have their own stories of recovery which can be compelling and helpful to the client.

Handout FACT SHEET 2.18, Self-Disclosure

The factsheet gives some guidelines PNs should follow when discussing their history with participants. The trainer should review each section with trainees. Then, break into pairs and have trainees practice telling their story.

Handout WORK SHEET 2.18, Self -Disclosure

FACT SHEET 2.18, Self-Disclosure

As a PN 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 participant. Your relationship with them has to be established. While your work is about participants, hearing how you have overcome struggles can be useful. 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.

Don't: Share experiences that you are currently struggling with or are uncomfortable sharing. Don't ask participants 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 at hospital, I was scared" vs. "I was hospitalized once, too"). Share strategies that worked for you and how you found out about them.

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 unreal expectations.

Do: Be honest about your past struggles and successes. Tell participants 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 participant.

EMPOWER YOURSELF; EMPOWER OTHERS Telling your story helps participants 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 participant feel badly.

Corrigan & Lundin (2012).

WORK SHEET 2.18, 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).

2.19 STREET SMARTS

Many of the people PNs serve may live in areas that present risks of being victimized by crime. One of the best ways to avoid being a victim is to be smart about what you say and do on the streets.

Handout FACT SHEET 2.19, Street Smarts

Like other fact sheets, this one is divided into several do's and don'ts. First, ask trainees to review the do's and don'ts that might help PNs avoid crime. Are there any others the PN might add?

Unfortunately, the person might experience crime during the course of their work. The bottom half of the fact sheet are suggestions should PNs find themselves in crime situations. Again, these are divided into do's and don'ts.

Handout WORK SHEET 2.19, Street Smart Experiences

Next have the person complete the Street Smarts Experience Work Sheet.

FACT SHEET 2.19, 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 PN. 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).

WORK SHEET 2.19, Street Smarts Experiences

What should you do to stay safe?

- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____

2.20 OFFICE ETIQUETTE

PNs in this project are people in recovery. Some of you may have been out of the work environment for a while. Hence, a brief review of some work strategies is provided.

Handout FACT SHEET 2.20, Office Etiquette

Ask the class to consider items listed in the fact sheet. Were any surprises to them?

Managing My Role: Office Etiquette

FACT SHEET 2.20, 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 participant, 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 participants 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 client 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.

Managing My Role: Office Etiquette

CHAPTER 2 SECTION V: The Big Picture

Items discussed in this section summarize the basic helping skills discussed in chapter 2.

Ch. 2 Section V: The Big Picture

2.21 THE BIG PICTURE: SUMMARY

Many ***basic helping skills*** are reviewed in this manual. They will be mastered with practice and experience. We wanted to end Chapter 2 by summarizing the BIG PICTURE. What exactly might the PN be doing with participants each day? These are summarized in the next fact sheet.

Handout FACT SHEET 2.21, The Big Picture

The Big Picture: Summary

FACT SHEET 2.21, The Big Picture

- **GETTING CONNECTED:** How to engage and work effectively with your participants. How to start off on the "right foot" so that your work together can last the duration of the relationship.
    - Introductions ○ Being available ○ Where participants are at
    - Over the long haul

- **UNDERSTANDING THEIR GOALS:** The skills and information you will need to understand what is important to your participant and how best to help them. ○ What do participants want? There are MANY goals, not just one. ○ What are the barriers to achieving these goals?
    - What resources and strengths might participants count on?

- **MAKING A PLAN**: Learning to identify and access the people, places, and things that you will need to best help your participants. ○ What, when, and who?
    - What resources are available

- **LINKING TO AND ACCESSING RESOURCES:** Learning how to best navigate the various resources within the community. How to use the tablet to access that information and give to your participants.
    - Find the resource ○ Get participants there
    - Support participants in using the service

- **STAYING CONNECTED:** How to sustain the relationship you have both worked on forming and continuing the growth that has started with your participants. ○ Being available
    - Where participants are at (emotional/physical health) ○ Over the long haul

The Big Picture: Summary

Chapter 3 Resources

Lesson Objectives

1. Learn how to find up-to-date health care and support services for participants.
2. Learn how to make appointments for participants. This includes scheduling appointments for participants, and helping participants schedule their own appointments.
3. Learn ways to follow up with participants and professionals to make sure participants get connected to services and get what they need.
4. Understand privacy and confidentiality regulations, including HIPAA.
5. Master strategies for interacting with professionals.

Introduction

An important part of a PN's job is to connect participants to health care and other support services. Finding the right services for participants is the first step. The second is actually connecting participants to services. This involves making appointments. These steps are outlined in Fact Sheet 3.1. PNs' also need to accompany participants on appointments, including knowing how and when to speak up and advocate for someone, and when to help that person advocate for him/herself. Ways to follow up with participants and providers to make sure that participants got the services they asked for and/or need are outlined in Fact Sheet 3.2. As explained in Fact Sheet 3.3, it's important that PNs understand laws and regulations that protect people's privacy and confidentiality, such as HIPAA (Health Insurance Portability and Accountability Act) rules. Finally, strategies for interacting with professionals throughout the resource connection process are reviewed in Fact Sheet 3.4.

3.1 FINDING SERVICES

One of the biggest challenges PNs will encounter is finding the right services for participants. By "right services", we mean services that help participants achieve these goals. PNs will need to know where those services are physically located, whether participants are eligible to receive services, and how to access those services. HHO has resource sheets that are regularly updated and easily accessible to the Peer Navigator. The Resource sheets are updated by a case manager on a regular basis. Staff notify the case manager of changes to existing resources and alert him of new ones. Once those are verified, the list is revised. Resource sheets are divided into 5 categories: Housing Programs (Appendix A), Food Pantries
(Appendix B), Substance Abuse (Appendix C), Employment Services (Appendix D), Mental Health (Appendix E), and Optical Services (Appendix F). The Peer Navigator should keep copies of these resource sheets readily available to hand out to participants, when needed.

Ch. 3 Resources: Finding Services

3.2 Making Appointments

Handout FACT SHEET 3.2, How to Make Appointments

Peer Navigators will need to help participants make appointments. Factsheet 3.2 discusses making sure participants are prepared and have what they need for appointments, how to schedule appointments, have their benefits and insurance in place, navigate waiting lists, and how to ask questions.

Handout In-the-field Practice Sheet 3.2, How to Make Appointments

In the field practice sheet 3.2 is used by the PN to help keep track of upcoming participant appointments, as well as helping them problem-solve what they need in terms of insurance or benefits.

FACT SHEET 3.2, How to Make Appointments

As a Peer Navigator, your job is to make appointments smooth and worry-free for participants.

PREPARATION

Do:

- Talk to your participants before making or going to appointment. Ask if they would like you to accompany them. Review medical history, as participant may have paperwork to fill out.
- Make sure participant is eligible to receive services at the particular office or clinic. That means calling ahead and talking with intake or appointment coordinator. Find out documentation participant needs for appointment (e.g. insurance or Medicaid card).
- Contact the HHO Benefit/Entitlement Specialist [Sheena Ward] and your supervisor for resources.

Don't: Wait until the last minute to check what is needed. Don't assume participants have the necessary documentation. The more you can do upfront to prepare, the better.

ACCESSIBILITY

Do: Make sure office or clinic location is handicap accessible. Review directions to travel to office or clinic. Offer to help participant get to appointment.

Don't: Assume that participants know where clinic or doctor's office is located, or how to get there. Don't schedule an appointment without ensuring participant can access transportation to the location.

SCHEDULING APPOINTMENTS

Do: Make the appointment with participant. Write down date and time on a piece of paper and give it to participant. Provide reminder calls the day before the appointment.

Don't: Make an appointment for participants without first discussing it with them. Don't assume that they will remember their appointments—give a reminder call.

INSURANCE/BENEFITS

Do:

- Confirm whether participant is currently insured by or eligible for Medicaid. PNs should be aware of current Medicaid and other insurance eligibility requirements. The best way to start is by asking participants whether they currently receive healthcare benefits. If not, connect them with HHO Benefit/Entitlement Specialist.
- If participant wants a HHO clinic appointment, connect them to the HHO Benefits and Entitlements Team by filling out a referral form. These team members are at the clinic every day to help participants navigate Medicaid and other health insurance plans.

Don't: Assume participants have insurance or qualify for Medicaid or other insurance benefits. Don't make appointments that will not be covered by the participant's insurance. Remember: not all providers take Medicaid or the same types of insurance.

WAIT LISTS

Do: Help participants get on wait lists for services and be aware of the process. Continue seeking other options for service if participant is on a wait list. Ask supervisor if you are unsure of anything.

Don't: Let participants get discouraged by long waiting lists. Don't overlook service options because of long wait lists and check list regularly.

MAKING REFERRALS

Do: Help participants with referrals and know what documentation and paperwork is needed. For referrals within HHO introduce participants to HHO provider. Let participant know you are still available if he/she needs help connecting with that provider.

Don't: Make a referral without knowing what documentation is required. Don't abandon your participant once you have connected them with a provider.

ASK QUESTIONS

Do: Empower your participants to ask questions. Encourage participants to write down questions before appointments. Help participants prepare questions using role play.

Don't: Let participants leave an appointment without answers. Don't let them be afraid to disagree with the doctor.

For all information on insurance and entitlements, contact the HHO Benefit/Entitlement Specialist. Consult your HHO directory for his/her contact information.

IN-THE-FIELD PRACTICE SHEET 3.2, How to Make Appointments

Review the **How to Make Appointments Fact Sheet.**

Name: _____ **Date: _____**

Reason for appointment:

_____Check-up **_____Dentist** **_____Eye Care**

_____Blood draw **_____Mental Health** **_____Emergency**

_____Podiatrist **_____Gynecology** **_____Family planning**

_____Other (please explain): _____

Name of healthcare provider: _____

Where: _____ **When: _____** **Follow-up Number: _____**

Do you have insurance?

☐ **Yes**

☐ **No**

If no, can I help you get insurance?

☐ **Yes**

☐ **No**

***If yes, the PN should fill out referral for participant to meet with HHO Benefit/Entitlement Specialist.**

List items that I (PN) can do to help you make appointment, at the appointment, and at follow-up.

1.
2.
3.

For all information on insurance and entitlements, contact the HHO Benefit/Entitlement Specialist. Consult your HHO directory for his/her contact information.

3.3 Follow-up Appointments

Handout FACT SHEET 3.3, Follow-up Appointments

Fact Sheet 3.3 outlines some do's and don'ts to help PNs have success is assisting participants to followup appointments. Discuss the items outlined on the factsheet with trainees.

Handout In-the-field Practice Sheet 3.3A, Contact information log

In-the-field practice sheet 3.3A is used to obtain contact info for finding participants for follow-up appointments. Have the trainees practice on each other.

Handout IN-THE-FIELD PRACTICE SHEET 3.3B, Follow-Up Appointments

In-the-field-practice sheet 3.3B is used by PNs to obtain information for follow-up appointments, as well as help participants remember what they should bring with them. Have trainees practice filling them out, with one person acting as a PN and the other as a participant.

FACT SHEET 3.3, Follow-Up Appointments

Following up with participants to determine whether they made and kept appointments.

CONTACT INFORMATION

Do: Be thorough when asking participants the best way to reach them. Ask for participant's phone number(s), including numbers of other people who know how to contact the participant, and email address. Find out where participants hang out during the day and where they sleep at night. Ask them if they ever use other names. Give participants your contact information as well.

Don't: Assume one phone number is enough. Don't leave participants without having multiple means of contacting them. Don't give your personal contact information (i.e., home address) to participants.

PLANNING AHEAD

Do: Be specific. Make a plan while you are with the participant for your next meeting. Give him/her specific date, time, and place to meet. Do the same for appointment reminders. Ask participants to call you when they leave appointments. Make it clear that if you don't hear from them, you will call them to find out what's happened and make sure that they are ok. Ask them if they have transportation to and from the appointment location. Make sure they are not overscheduled.

Don't: Be vague. Don't make tentative plans. Don't let participants wonder when they will hear from you. Don't make a plan and then fail to follow through with it.

FOLLOWING UP WITH PROVIDERS

Do: Follow up with HHO providers to confirm that participant made it to the appointment. If your participant sees a provider outside of HHO, you may not be able to contact the provider. If unsure, ask your supervisor.

Don't: Share any information about a participant without his/her permission. It is against HIPAA to share protected health information with a provider without a participant's signed permission. Don't let the conversation with providers become anything less than professional (e.g., don't gossip about participants).

MISSED APPOINTMENTS

Do: If participant misses an appointment, determine why and address those reasons. Use motivational interviewing.

Don't: Blame the participant for missing the appointment. Don't get mad or make the participant feel guilty. Don't reschedule the appointment without first understanding why the participant missed appointment.

WRAPPING UP

Do: Make sure that participant has all the information needed from the doctor. If the doctor wrote a prescription for medication, make sure participants understand directions. Determine need for follow-up appointment. If labs are ordered, find out when and where tests are to be done. Determine if there are special instructions. Front desk staff at labs can be helpful with making appointments and other follow-up care questions. Make sure to thank them on the way out.

Don't: Leave an appointment without making a follow-up plan. Don't let questions go unanswered about medications, lab tests, or next appointment time.

IN-THE-FIELD-PRACTICE-SHEET 3.3A, Contact Information Log

Use the space below to obtain contact information from participants. Explain that this information will not be shared with anyone. It will be used to find them for follow-up appointments.

Name: _____

Other names/nicknames used (if, applicable): _____

Where do you currently live: _____

Phone number: _____

Alternative number: _____

Friend or family member's number: _____

Employer's number: _____

Shelter number: _____

Best time to call: _____

Email: _____

Address: _____

Case Manager's name: _____

Case Manager's contact info: _____

Additional info (to help me find you): _____

_____

_____

_____

_____

IN-THE-FIELD PRACTICE SHEET 3.3B, Follow-Up Appointments

Please refer to the Fact Sheet on **Follow-up Appointments.** Use the space below to obtain information from participants. Refer to **Contact information Log** for other information you may need to find participant.

Name: _____

Date of next appointment: _____

Time of Appointment:_____

Type of appointment: _____

Place of Appointment: _____

Do you want me to come with you?

☐ **Yes**

☐ **No**

If YES:

Documentation to bring: _____

_____

_____

Additional info: _____

_____

_____

_____

_____

_____

3.4 HIPAA

Handout FACT SHEET 3.4, HIPAA

Fact Sheet 3.4 summarizes HIPAA, the federal law that outlines patients' rights over their health information. Review the information in the fact sheet with the class and address any questions they may have.

Resources: HIPAA

FACT SHEET 3.4, HIPAA

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

Participants have the right to:

- Get 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 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 participants' medical records.
- Conversations doctors have with their patients.
- Information about participant's health insurance.
- Billing information.
- Other health information about you, held by those who must follow the 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 Navigators?

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

Resources: HIPAA

3.5 Strategies for Interacting with Professionals in a Medical Setting

Handout FACT SHEET 3.5, Strategies for Interacting with Professionals in a Medical Setting

Fact Sheet 3.5 discusses tips for PNs for their interactions with medical professionals. Review the fact sheet and answer any questions they may have.

Handout WORK SHEET 3.5, Strategies for Interacting with Professionals in a Medical Setting

Work Sheet 3.5 is a role pay exercise. Trainees are asked to choose one of the scenarios and act out the problem. One person should pretend to be a patient, and the other should pretend to be a health care professional. At the end of the exercise, trainees should give each other feedback. Pairs should then switch roles and repeat.

FACT SHEET 3.5, Strategies for Interacting with Professionals in a Medical Setting

As a PN your main role is connecting participants to health services. It is important for you to know how to appropriately **interact with professionals in the medical setting,** in order to benefit your participants.

INTRODUCE YOURSELF

If the participant—and clinic—allow you to be in the room during the appointment, be sure to introduce yourself to staff and explain your relationship to the participant. Do not speak for the participant.

BE PREPARED

Help participants go to their appointments prepared. Make sure they bring their insurance cards and ID with them. They should always bring a personal ID, too. Go over their medical history with them, as they will likely have paperwork to fill out. Even if you are not accompanying them to an appointment, go over these items with them.

UNDERSTAND PRIVACY

Understand HIPAA rules about what questions you can and cannot ask professionals, as well as what information you can and cannot share. Please refer to the **HIPAA factsheet** in the Resource section of this manual.

BE COURTEOUS

Be friendly to medical office staff. Be patient if they are helping someone else. If this is an office you visit often, learn the names of front desk staff and nurses. Never get angry with front desk staff, nurses or doctors. Kindness and respect go a long way.

DEALING WITH PROBLEMS

Even if you and your participants are polite, prepared, and ask questions, you may not get the "service" you want. If providers and front desk staff don't act professional or don't treat you with respect, don't get angry. Keep your cool and ask if there is someone else you can speak with. If that is not a possibility, remove yourself from the situation. Do not put your conflict above the health needs of the participant and talk to your supervisor.

WORK SHEET 3.5, Strategies for Interacting with Professionals in a Medical Setting

Before you begin, review the **Strategies for Interacting with Professionals in a Medical Setting** factsheet. Pair up with a partner, and choose one of you to be the speaker and one to be the listener. The speaker should pretend to be the PN accompanying a participant to an appointment, while the listener

should pretend to be someone working in a medical office (e.g., front desk staff, nurse, or doctor). Here are some ideas for topics to role play:

- Participant appointment time was 12noon. At 12:30 you are still waiting to be seen by doctor.
- Participant did not receive lab results from last visit.
- Nurse that took vitals was very rude.
- Participant forgot when his/her next appointment was. You both show up on the wrong day.

Switch roles after 10 minutes.

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

As the **speaker:**

What did I do well?

- _____
- _____
- _____
- _____

What would I say or 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?

- _____
- _____
- _____
- _____

Chapter 4 Research Study Logistics

Lesson Objectives

1. Understand the basic outline of the research project being completed as part of this PN program.

2. Understand the PN's role in the research project.

Introduction

The project in which PNs are working is part of a larger research study supported by the National Institute of Minority Health and Health Disparities. The project is being conducted by researchers from the Illinois Institute of Technology and Advocates for Human Potential. In this Chapter, we briefly review what is entailed for participants to belong to the study. We also review the role of PNs in the study.

Review the specifics of the study. Instruct PNs to contact project director Dana Kraus (312 567-3051; dkraus@iit.edu) with any questions or concerns.

FACT SHEET 4.1, Research Study Logistics

Comparison study

- Treatment as usual (Integrated care) Or
- Treatment as usual PLUS peer navigator

Random Assignment: (By flip of a coin)

- People will have equal chance of getting assigned to treatment as usual or treatment as usual, plus PN.
- Research participants will be African Americans with mental illness and receiving services from Heartland Health Outreach. Sixty adults will be recruited for the study; thirty assigned to treatment as usual or treatment as usual plus PN.

Length of time

 Research participant in the treatment as usual plus peer navigator group will receive services from 8 to 10 months. They may decide to stop participating in services at any time during the year and in no way jeopardize receiving other services from Heartland Health Outreach.

Assessment

- All research participants will be assessed about every four months during the course of the study to determine impact of peer navigators on their health and quality of life. All research participants will be fully informed about the study and asked to sign a form that says that they consent to participate. Research participants will be paid about $20.00 per hour for every hour they complete questionnaires for the study.
- All research data will be gathered by research assistants from IIT. Peer navigators will have no role in collecting data.

Research Study Logistics

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References

APPENDIX A

Assistance Finding Housing

P.A.T.H. – Team- Case Managers: James/ Susie

Here in **Clinic** – 2nd Fl.
Every Wednesday 10am to 12pm
773.751.4133 or 773.751.4171

Inspiration Corporation

4554 N Broadway, Suite 207
773.878.0981
Walk-ins Thurs 9-12; call for appt

Lift

4554 N Broadway, Suite 329
773.303.0700
9am-3pm

Ezra

909 W. Wilson
773.275.0866
Requirements: proof of income, ID
Screening: Mon 1:30-3:30; Tues 9:30-11:30

HOW (Housing Opportunities for Women)

1607 W. Howard, 2nd Floor
773.465.5770
Need a referral

Northside Housing Day Support Center

4750 N Sheridan 2nd Floor
773.271.8330
M-F 9-5

Resources: Housing Programs

Chicago House

773.248.5200

-Scattered Site Housing

HIV – positive individuals; rent-subsidy

-Hospital to Housing (HHP)

Homeless individuals with chronic illness; intensive case management; increasing life and tenancy skills to ensure housing stability

Ext. 347

-Samaritan Housing Program

Disabled and homeless individuals; need referral from hospital, housing program, or street outreach; intensive case management; harm reduction model Ext. 385

Shelters

Name	Address	Phone	Eligibility, etc.
Cornerstone Community Outreach (Uptown)	4628 N. Clifton	773.506.6396 x22	
Lincoln Park Community Shelter	600 W. Fullerton	773.549.6111	Call Mon 9am to schedule intake
Franciscan House of Mary and Joseph	2715 W. Harrison	773.265.6683	
Franciscan Annex (Walls Memorial)	200 S. Sacramento	773.533.4535	Call after 5pm
Pacific Garden Mission	1458 S. Canal St.	312.492.9410	

Sarah's Circle	4750 N. Sheridan	773.751.7475	Call	
Northside Shelter-Uptown	941 W. Lawrence	773.564.9093	Men	
Interfaith House	3456 W. Franklin		773.533.6013 referral	Specific eligibility;
Green House Shelter (CAWC)	Admin: 1116 N. Kedzie, 5th floor	Hotline: 773.278.4566	Domestic violence shelter	
Inner Voice	2425 W. Jackson	312.455.9767	Vet House; homeless verification, ID, SS card	
Inner Voice	4458 W. Jackson	773.921.5290	homeless verification, ID, SS card	
	Inner Voice: Intake at 1700 W. 18th St, 9am-3pm M-F			
Connections for the Homeless-Evanston (Hilda's Place)	1458 Chicago Ave, Evanston	847.475.7070 or 847.424.0945	Call for intake	
Department of Human Service (DHS)	Hotline	1800.654.8595		

Resources: Housing Programs

APPENDIX B **Food Pantries**

Hours	Name	Address	Phone
Wed 1-3	Faith Tabernacle	Broadway and Grace (by IHOP)	773.978.6000
Wed 9:30-11:30am	Cornerstone Outreach	4628 N. Clifton	773.271.8163
Tue 5:30-7:70	All Saints	4550 N. Hermitage and Wilson	771.561.0111
Mon/Wed 7:3010:15am	Uptown Ministries	4720 N. Sheridan	773.271.3760
Wed/Fri 9:00am11:30pm	St. Mary of the Lake	4220 N. Sheridan	773.525.8610
Thurs 9:30-12, 1-2:30	American Indian Center	1630 W. Wilson	773.275.5871

Tue 9:30am-12:00pm (some Fridays)	St. Thomas of Canterbury	4827 N. Kenmore	773.878.5507
3rd Mon of the month 10-12pm,1-3pm (Bring picture ID)	St. Augustine Center	4512 North Sheridan Road	773.784.1050
3rd Wed of the month 8am-2pm	Uptown Baptist Church	1011 W. Wilson	773-784-2922
Sun 9-11am	SDA Food Pantry	2120 W. Sunnyside Ave.	773.481.1894
Mon, Wed, Fri 9am12pm; Sat 9am-1pm (bring ID, proof of residency, low income)	Care for Real	5341 N. Sheridan Rd.	773.769.6182
Tues 5:30-7:30pm	Ravenswood Comm. Services	4550 N. Hermitage	773.769.0282
Tues 10:30-1pm	Saint Vincent's Mother Seton	1010 W. Webster	773.325.8610
Wed 2:30-4	EZRA	909 W. Wilson	773.275.0866
1st Thurs, 3-5pm	*Care for Real*** ***Pet Food***	5341 N. Sheridan	773.769.6182

Resources: Food Pantries

Soup Kitchens

Hours	Name	Address	Phone
Daily 8-9am, 12-1pm, 4:30-5:30pm	Cornerstone Outreach	4626 N. Clifton Ave.	773.271.8163
Tue, Fri 5:30pm-7pm	St. Thomas of Canterbury	4827 N. Kenmore Ave.	773.878.5507
Wed 5:30-6:30pm	Our Lady of Lourdes	4641 N. Ashland Ave.	773.561.2141

Every day except Wed; @ 12	Preston Bradley Center (People's Church)	941 W. Lawrence Ave. 2nd Floor	773.784.6633
Tues, open @ 5:30, dinner @ 6:30	Ravenswood Community Services	4550 N. Hermitage	773.769.0282
Sat, 11:30-12:20	Pilgrim Lutheran Church	4300 N. Winchester	773.477.4824
Mon-Sat, 8:30-10	Saint Vincent's Mother Seton	1010 W. Webster	773.325.8610
Mon 5-6	Uptown Baptist Church	1011 W. Wilson	773.784.2922
Mon, Tues, Thurs 5:307:30; Sun 10:30am12:30pm	JUF Uptown Café (@EZRA)	909 W. Wilson	773.275.0866
Mon-Fri 10:3011:30am	Sarah's Circle **Women Only**	4838 N. Sheridan	

Resources: Food Pantries

APPENDIX C Substance Abuse Resources

Lutheran Social Services of Illinois (LSSI)

Main Address: 5517 N. Kenmore Phone: 773.275.7962

ADD Detox, Non-Medical; call for availability; *Must have MEDICAID
*Inpatient, Outpatient, and Residential treatment available

Recovery Point

Address: 4007 N. Broadway Phone: 773.305.1101

Intake-Assessment & Referral

Salvation Army

Address: 1515 W. Monroe Phone: 312.421.5753

Salvation Army Work Therapy Program

Adult Rehabilitation Center Phone: 773.477.1771
2258 N. Clybourn Ave

* NOT a detox program
* Faith-based
* must be eligible for SNAP

Haymarket Center

Main Site: 932 W. Washington, Chicago, IL 60607 Phone: 312.226.7984

Uptown Site: 4753 N. Broadway, Suite 612, Chicago, IL 60640 Phone: 773.506.2839

West Site: 1990 Algonquin, Suite 211, Schaumburg, IL 60173 Phone: 847.397.5340

*Multiple Women's and Men's Programs available
*Residential and Outpatient treatment available

Alcoholics Anonymous

Address: 200 N. Michigan Ave Phone: 312.346.1475 Toll-free: 800.371.1475

Narcotics Anonymous

Address: 212 S. Marion Phone: 708.848.4884

CTCC – II

Address: 4453 N. Broadway Phone: 773.506.2900

Community Counseling Centers of Chicago (C4)

Address: 4753 N. Broadway Phone: 773.878.9999

Men's Residence/North (CDPH Program)

Address: 1640 W. Morse Ave Phone: 773.338.5105

Victor Neumann Association

Address: 5547 N. Ravenswood Phone: 773.769.4313

New Vision – Jackson Park Hospital & Medical Center

Address: 7507 Stony Island Ave Phone: 773.947.7347 or 800.939.2273

*for those in need of medical stabilization
*accepts Medicaid

Cathedral Shelter of Chicago – Cressey House & Higgins House

Address: 1668 W. Ogden Ave Phone: 312.997.2222

*Permanent Supportive Housing with addiction treatment services
*Outpatient services

RESIDENTIAL:

Treatment Center	Address	Phone Number
Women's Treatment Center -medically supervised detox *transitional living also available	140 N. Ashland	312.226.0050
Healthcare Alternative Systems (Hispanic Men Only; Spanish-Speaking)	1949 Humboldt	773.252.2666
Passages	5517 N. Kenmore	773.275.7962
Harbor Light	1515 W. Monroe	312.421.5753
Gateway West	3828 W. Taylor	773.826.1916 x 2813
Gateway Aurora	400 Mercy Lane	630.966.7400
Interventions	5701 S. Wood	773.737.4600
LSSI Elgin	675 Varsity Lane	847.741.2600
South Shore (Medicare only)	8012 S. Crandon	773.356.5302
Chicago Lakeshore Hospital (SpanishSpeaking)	4840 N. Marine	773.878.9700
Harriet Tubman (women only)	11352 S. State	773.785.4955
Loretto Hospital	645 S. Central	773.854.5445
New Life Center (women only)	1666 N. California	773.384.2200
Share Program	1776 Moon Lake	847.882.4181

OUTPATIENT:

Gateway (Spanish-speaking)	4301 W. Grand	773.862.2279
.H.A.S. (Hispanic Men Only)	2755 W. Armitage	773.252.3100
Bobby Wright	9 S. Kedzie	773.722.7900
St. Mary Hospital	1127 N. Oakley	312.770.2317
Association House (Spanish-speaking)	1116 N. Kedzie	773.772.8009
Interventions	5517 N. Wood	773.737.4600
Loretto Hospital (Spanish-Speaking)	645 S. Central	773.854.5608
LSSI	5825 W. Belmont	773.637.1144
LSSI	1758 W. Devon	773.764.4350
SEADAC	8640 S. South Chicago	773.731.9100
Women's Treatment Center -medication assisted opioid treatment Available -Project Futures if referred by DCFS	140 N. Ashland	312.850.0050
Polish American Association	3934 N. Cicero	773.282.8206

SUBOXONE TREATMENT:

Access Clinic	5835 W. North Ave	773.745.1200
Access Clinic	3202 W. North Ave	773.489.6333

Access Clinic	4401 W. Division	773.252.3122
Access Clinic	3752 W. 16th St	773.762.2435
Access Clinic	3435 W. Van Buren	773.265.0300
Dr. Lubben/JPH	7531 S. Stoney Island	773.947.7765
Dr. Dixie	3525 S. Michigan	312.945.4010

APPENDIX D Employment Services

Inspiration Corporation

Address: 4554 N Broadway, Suite 207

Phone: 773.878.0981

Walk-ins Thurs 9-12, call for appt

Goldie's Place – Employment Assistance Program

Address: 5705 N. Lincoln Ave

Phone: 773.271.1212

Need a referral

Services include:

Gateway Track: help with resumes, online job searches/applications

Bridge Track: intensive employment case management

Workforce Development Training

Job Readiness Training Workshops

Clothes Closet Program: work-appropriate clothing available

EZRA

Address: 909 W. Wilson

Phone: 773.275.0866; call to find out re: next training

LIFT

Address: 4554 N. Broadway Suite 329

Phone: 773.303.0700

Hours: 9am-3pm

Resources: Employment Services

Connections

Address: 1458 Chicago Ave

Phone: 847.424.0945; call for intake

Resources: Employment Services APPENDIX E

Counseling Referrals

Howard Brown Health Center
404025 N. Sheridan Road
Chicago, IL 60613
(773) 388-1600
Offers: Therapy/counseling; must be Comfortable with LGBTQ population

Chicago Women's Health Center
3435 N. Sheffield Ave #206A
(773) 935-6126
individual/group- not specific for SA

Community Counseling Centers of Chicago (C4)
4740 N. Clark Street
(773) 769-0205
Offers: Case management; some therapy
Eligibility: Homeless, MI,
CM services with them

Metropolitan Family Services
3249 North Central Avenue
Chicago, Illinois 60634
(773) 371-3700
Offers: Counseling: children 6-17 years old & DV
Eligibility: DV, Children, Medicaid or Countycare

NAMI-national info help line
(312) 563-0445
Offers: Referral resources

Thresholds
(773) 572-5400

Mental Health Association of Greater Chicago
(312) 781-7780
Offers: referrals (recommendations) on website

North River MHC
5801 North Pulaski Road
(312) 744-1906
Offers: Therapy/Counseling/Psychiatry
Eligibility: Takes all, Medicaid, CountyCare, sliding scale

Trilogy
1400 N. Greenleaf
(773) 508-6100

Erie Family Health Center
(312) 666-3494
Offers: Therapy/counseling and groups
Eligibility: Getting medical services at their program

(Continued on back)

Resources: Mental Health Resources

Alcohol and Drug……1-800-622-2255 Child Abuse……1-800-252-2873 Chicago
Rape Crisis Hotline……1-888-293-2080
Domestic Violence……1-800-799-7233
Drug Abuse……1-800-444-9999
Hunger……1-800-359-2163
Mental Health Crisis Intervention……1-800-248-7475
Suicide Prevention/Crisis Intervention……1-800-248-7475
County Care Behavioral Health*……1-800-753-5456
*Have ID # ready

Resources: Mental Health Resources

APPENDIX F

Optical Services

	Name	Address	Phone
North Side	Wilson Optical	1056 W. Wilson (Wilson&Broadway)	(773)271-5774
	Vision 20/20 Family Eyecare	4863A N Broadway (Broadway&Ainslie)	(773)506-7887
Downtown	Lakeside Eye Clinic	180 N. Michigan Ave. 19th Floor (Michigan&Lake)	(312)553-1818
	Doctors for Visual Freedom	875 N. Michigan Ave. Suite 1550 (Michigan&Delaware)	(312)291-9680
South/West Side	Illinois Eye Institute	3241 S. Michigan Ave. (33rd&Indiana)	(312)949-7250
	Buena Vista Optical	6455 S. Kedzie Ave. (65th&Kedzie)	(773)863-9234
	Midwest Eye Clinic	6254 S. Pulaski (63rd&Pulaski)	(773)581-1515

May need a referral. There may be a $3-$4 copay. (Must have Medicaid).

Resources: Optical Services