Becoming a Peer Mentor: Participant Training Guide

Index – *Becoming a Peer Mentor*: Participant Training Guide

Peer Support Toolkit for People living with HIV and/or Hepatitis C

Toolkit Purpose and Objectives: This toolkit provides practical guidance and tools to assist community-based organizations or groups to deliver social and emotional peer support services to people living with HIV and/or Hep C. It includes four parts.

1. Getting started: a guide to develop and deliver peer support services.
2. Training peer mentors: facilitation guide.
3. Becoming a peer mentor: participant training guide.
4. Peer mentor policy and procedure handbook.

Target Population: This toolkit is intended to support the development or enhancement of social and emotional peer support services for people living with HIV and/or Hepatitis C (Hep C) in the Interior Health Region of BC. The Interior Region includes East Kootenay, Kootenay Boundary, Okanagan and Thompson Cariboo Shuswap.

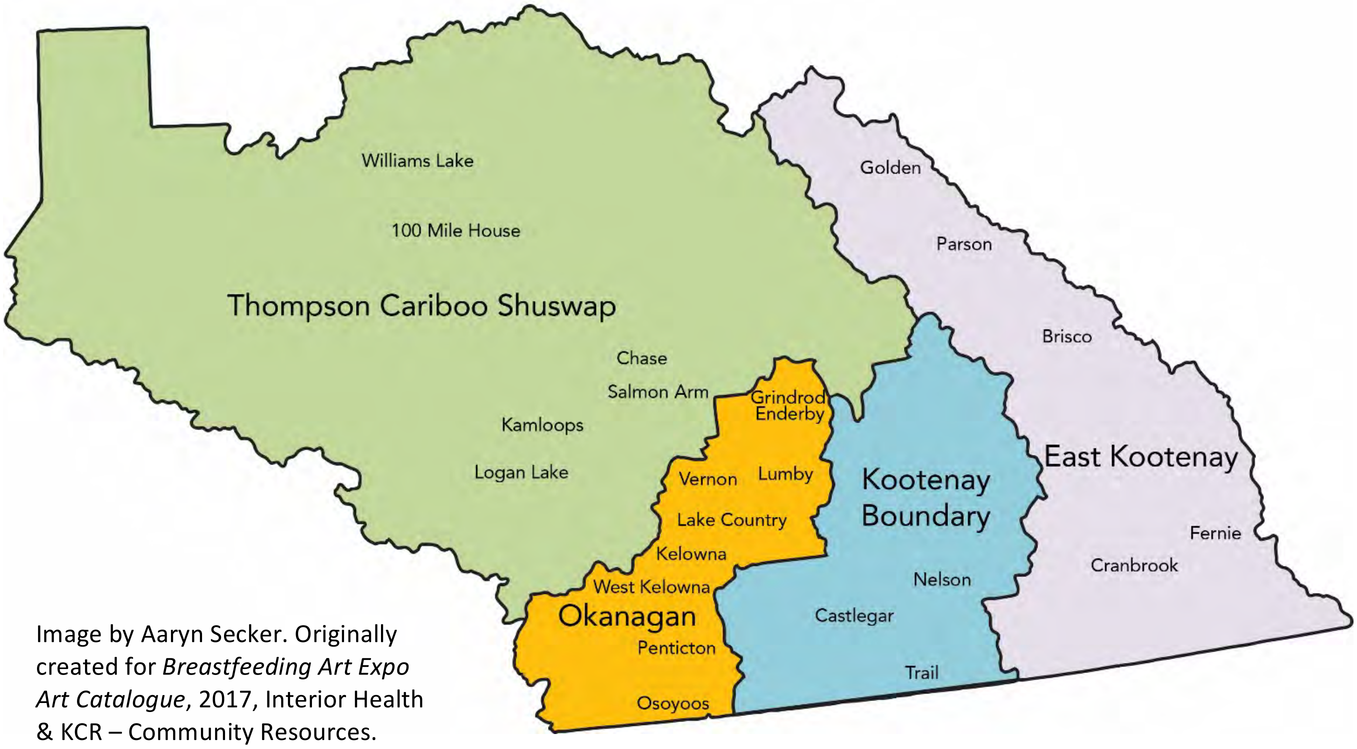

Image by Aaryn Secker. Originally created for *Breastfeeding Art Expo Art Catalogue*, 2017, Interior Health & KCR – Community Resources.

How the Toolkit Was Developed: CMHA Kelowna engaged two advisory groups (content experts and context experts) to provide guidance and expertise to the development of the toolkit. CMHA Kelowna reviewed peer support materials from a wide variety of sources and identified key guiding documents. The advisory groups met a combined total of nine times over the course of six months shaping the content and layout of the toolkit to ensure it is relevant to people living with HIV and/or Hep C in the interior region of British Columbia.

Acknowledgements:

a. Advisory Groups: One advisory group involved the participation of 8 individuals with lived experience of HIV and/or Hepatitis C and one health outreach nurse, most of whom are members of the Peer Advisory Committee for STOP HIV.

The other advisory group involved the participation of 16 individuals from the following 10 organizations:

    i. ANKORS: AIDS Network Kootneys Outreach and Support Society.
    ii. ASK Wellness: AIDS Society of Kamloops & Merritt Branch.
    iii. Canadian Mental Health Association Kelowna & District Branch.
    iv. Interior Health Authority, HIV and Health Outreach Program, Population Health.
    v. Living Positive Resource Centre Kelowna.
    vi. North Okanagan Youth & Family Services Society.
    vii. Pacific Hepatitis C Network.
    viii. Penticton & District Community Resource Society.
    ix. Positive Living BC.
    x. REL8 Okanagan.

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d. Formatting: Aaryn Secker and the Canadian Mental Health Association Kelowna & District Branch

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Editable Templates: Form and certificate templates in editable word documents are available by request. Please email Ihhealthoutreach@interiorhealth.ca at the Interior Health Authority, HIV and Health Outreach Program, Population Health.

Editable Handbook: Part 4, the peer mentor policy and procedure handbook is available by request as an editable word document. Please email Ihhealthoutreach@interiorhealth.ca at the Interior Health Authority, HIV and Health Outreach Program, Population Health.

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The complete toolkit can be found at www.interiorhealth.ca/PeerToolkit.

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Module 1: Welcome to Peer Mentor Training

What to Expect

Module 1 introduces the Peer Mentor training program and aims to create a safe environment for learning, sharing and getting to know one another.

Concepts Covered

- Land acknowledgement.
- Housekeeping details.
- Preferred pronouns.
- Introductions.
- Creating a safer space agreement.
- Journaling and keeping track of the process.
- Course outline review.
- Pre-training evaluation.

Preferred Pronouns[1]

Why discuss preferred pronouns? A goal of this training and the Peer Mentor role is to create the safest space possible for everyone, which includes referring to individuals respectfully. Having an understanding of different pronouns will benefit future peer mentor work by avoiding misidentifying individuals and challenging our assumptions about gender.

1	2	3	4	5
(f)ae	(f)aer	(f)aer	(f)aers	(f)aerself
e/ey	em	eir	eirs	eirself
he	him	his	his	himself
per	per	pers	pers	perself
she	her	her	hers	herself
they	them	their	theirs	themself
ve	ver	vis	vis	verself
xe	xem	xyr	xyrs	xemself
ze/zie	hir	hir	hirs	hirself

Journaling and Keeping Track of the Process

Purpose: A crucial piece of being a peer mentor is our ability to self-reflect on our own actions, reactions and experiences. Journaling is a tool for personal and professional development and a way to help process the learning and experiences taking place during training. This can also be a good tool to continue with after training and to share with a future peer.

Suggested Writing Prompts:

- What is interesting to me about this training?
- What goals do I have for my day, week or month?
- What are my goals for my role in peer support?
- What am I doing here and how do I feel about it?
- Who or what inspires me?
- How have my communicative skills changed since I started this training?

Pre/Post-Training Evaluation[2]

Scale: 1=Strongly Disagree 2= Disagree 3= Neutral 4= Agree 5= Strongly Agree

Name__________________________________ **Date**___________________________

Before Training					Self-assessment of Knowledge and Skills	After Training				
1	2	3	4	5	I understand the wellness model of health and wellbeing	1	2	3	4	5
1	2	3	4	5	I understand key concepts of making personal choices	1	2	3	4	5
1	2	3	4	5	I understand the basic principles of trauma informed care	1	2	3	4	5
1	2	3	4	5	I understand the values and principles of practice to promote an authentic peer support relationship	1	2	3	4	5
1	2	3	4	5	I understand the code of conduct and its importance in peer support	1	2	3	4	5
1	2	3	4	5	I am familiar with the historical context of peer support	1	2	3	4	5
1	2	3	4	5	I understand the effects of stigma and ways to reduce the impact	1	2	3	4	5
1	2	3	4	5	I understand the factors that influence good health and wellbeing	1	2	3	4	5
1	2	3	4	5	I am familiar with the range of settings that peer support is offered	1	2	3	4	5
1	2	3	4	5	I understand skills of being an effective and empathic communicator	1	2	3	4	5
1	2	3	4	5	I understand how to build supportive, wellness focused peer support relationship	1	2	3	4	5
1	2	3	4	5	I understand the process/continuum of wellness and change	1	2	3	4	5
1	2	3	4	5	I understand personal and role specific limits and boundaries and how to negotiate and communicate them	1	2	3	4	5
1	2	3	4	5	I am aware of crisis situations that peers may encounter and strategies for supporting peers in crisis	1	2	3	4	5
1	2	3	4	5	I am familiar with the elements and importance of a self-care plan	1	2	3	4	5
1	2	3	4	5	I understand how to support peers to identify their needs, choices and supports	1	2	3	4	5

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Module 2: Understanding Peer Support

What to Expect

Module 2 will be mostly discussion based and will provide an overview of concepts related to the foundation of peer support and how to apply these concepts to the peer mentor role.

Concepts Covered

- History of peer support.
- Peer support in different settings.
- Core values and principles of practice.
- Code of conduct.
- Person centered approach to health and wellbeing.
- Social determinates of health.

The History of Peer Support

Defining Peer Support

Peer support is the practical, social, and emotional support between people in a community of common interest. Peer support is unique, offering the kind of support and practical help that one can only get from others who share similar experiences. There is no “one-size fits all” approach to peer support around the world, but can be done one-to-one or in groups, in person, by telephone or online. [3,4]

Historical Context of Peer Support

“The philosophy of peer support and its values of hope, self-determination and wellbeing were part of a response to the historic prevalence of social injustice and stigma. Understanding the historical context can help to explain challenging issues, such as why some may be reluctant to disclose their illness and/or seek treatment or support.” [5]

A Brief History of Peer Support

The history of what is now referred to as peer support had its beginnings centuries ago, spanning communities across the globe, in a wide array of settings, shaped by the diverse cultures and people it benefits. The roots of peer support in mental health care dates back to the 18th century in Paris when recovered patients were hired to help ensure hospital staff were treating patients with respect and compassion.[6] Support groups surfaced within the Early German Homosexual Rights Movement [ca. 1894–1933]. In Berlin in the late 1800’s, a campaign for social recognition of gay, bisexual and transgender men and women, and against their legal persecution led to LGTBQ support groups and an awareness of sexual self-ownership. Research has long since shown that small LGTBQ support groups have been the driving force behind Germany's first LGBTQ social justice movement.

In North America in the 1960’s, around the same time as the civil rights movement, gay rights, the women’s movement and the Native American movements, a new wave of peer support that valued self-determination emerged as a reaction to oppression and inhumane treatment.[6] Former mental health service users were empowered to help each other and advocate for themselves. From these roots, peer support quickly found new applications in areas such as: diabetes, mental health, heart disease, cancer, asthma, HIV/AIDS, Hep C, substance abuse, and maternal and child health including: breastfeeding, nutrition, and post-partum depression.[7] Contemporary peer support as it is practiced in the mental health field, further evolved in the 1990’s and has been growing steadily since.[6]

History of Peer Work at the Positive Living Society of British Columbia

Positive Living Society of British Columbia (PLBC) has a long history of providing peer-focused information to people newly diagnosed with HIV. They have been educating their membership and communities since 1986 about HIV/AIDS and the key role that peers play in HIV/AIDS care, treatment and support. For example, PLBC developed the first HIV information brochures for people living with HIV, by people living with HIV, in British Columbia. They have also developed and carried out a number of peer-led workshops and one-on-one education programs for people living with HIV.[8]

Why Peer Support Works

Peer support is grounded in the belief that hope and support is the starting place to enhance wellbeing. Although everyone's journey is unique, peer mentors can inspire hope, promote a sense of inclusion and belonging and demonstrate the possibility of wellbeing while relating to the challenges and stigma attached to their diagnosis. [5]

Peer Support in Different Settings

The various types of peer support fall along a spectrum ranging from informal support to formal peer support within a structured organizational setting. Informal peer support occurs when acquaintances notice the similarity of their lived experience and listen to and support each other. Peer support within a structured clinical setting can involve programs where peer support workers offer the opportunity for a supportive, empowering relationship. The values, principles of practice and skills of peer support workers apply to all types of peer support and all types of organizations that offer it.[5]

Spectrum of Types of Peer Support

INFORMAL PEER SUPPORT
Naturally occurring, voluntary, reciprocal relationship(s) with peers one-to-one or possibly in a community

CLUBHOUSE/WALK IN CENTRE
Mainly psychosocial and social recreational focus with peer support naturally occurring among participants

SELF-HELP, MUTUAL PEER SUPPORT
Consumer operated/run organizations/activities/programs, voluntary, naturally occurring, reciprocal relationships with peers in community settings e.g., housing, social/recreational, arts/culture, traditional/spiritual healing, recovery education/work, anti-discrimination education/work, human rights/disability rights education work

FORMALIZED/INTENTIONAL PEER SUPPORT
Consumer run peer support services within community settings (either group or one-to-one) focusing on issues such as education, employment, MH systems navigation, systemic/individual advocacy, housing, food security, internet, transportation, recovery education, anti-discrimination work, etc.

WORKPLACE PEER SUPPORT
Workplace-based programs where employees with lived experience are selected and prepared to provide peer support to other employees within their workplace

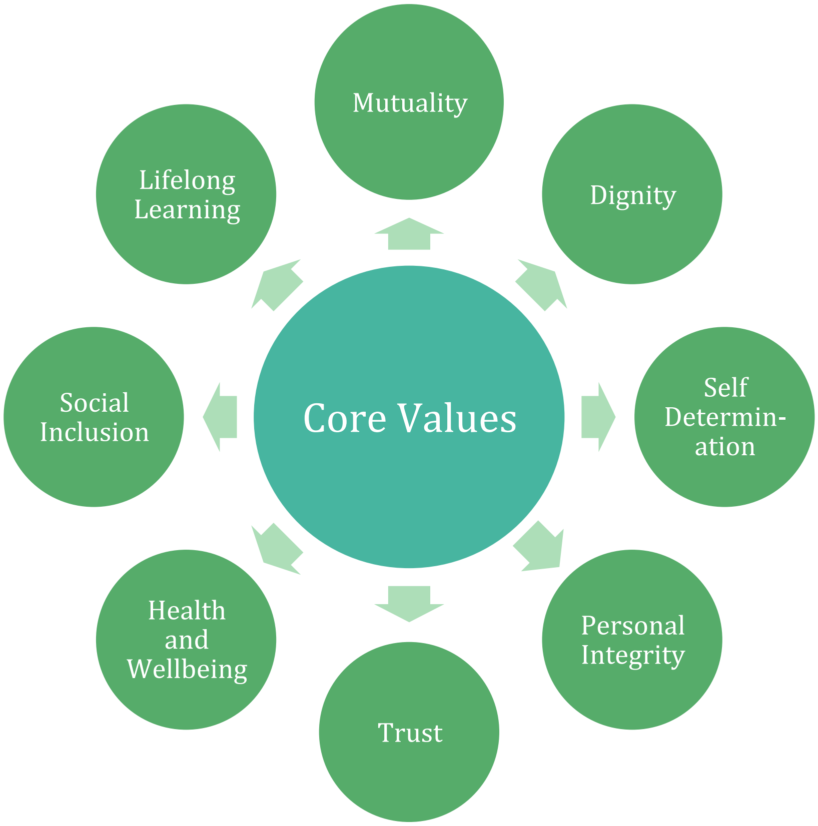
COMMUNITY CLINICAL SETTING PEER SUPPORT
Peer support workers are selected to provide support to patients/clients that utilize clinical services, e.g., Outpatient, A.C.T teams, Case Management, Counselling

CLINICAL/CONVENTIONAL MH SYSTEM-BASED PEER SUPPORT
Clinical setting, inpatient/outpatient, institutional peer support, multidisciplinary groups, recovery centres, or Rehabilitation Centres Crisis response, Crisis Management, Emergency Rooms, Acute Wards

These guidelines are focused on this segment that provides a more formal and intentional style of peer support

Figure from *Guidelines for the Practice and Training of Peer Support*[5].

Core Values[9]



Mutuality	**Dignity**	**Self Determination**	**Personal Integrity**
We value the empathy that comes from shared experience.	We honour and respect the intrinsic worth of all individuals.	We honour an individual's autonomy and inherent right to make their own choices as they determine their path to wellbeing.	We value interpersonal relationships that honour authenticity, trust, respect and ethical behavior that uphold our Code of Conduct.
Trust	**Health and Wellbeing**	**Social Inclusion**	**Lifelong Learning**
We are honest, reliable and accountable for our actions.	We value health, wellbeing and the power of hope for others and ourselves.	We respect diversity and value social justice.	We value personal growth through professional and personal development.

Principles of Practice[9]

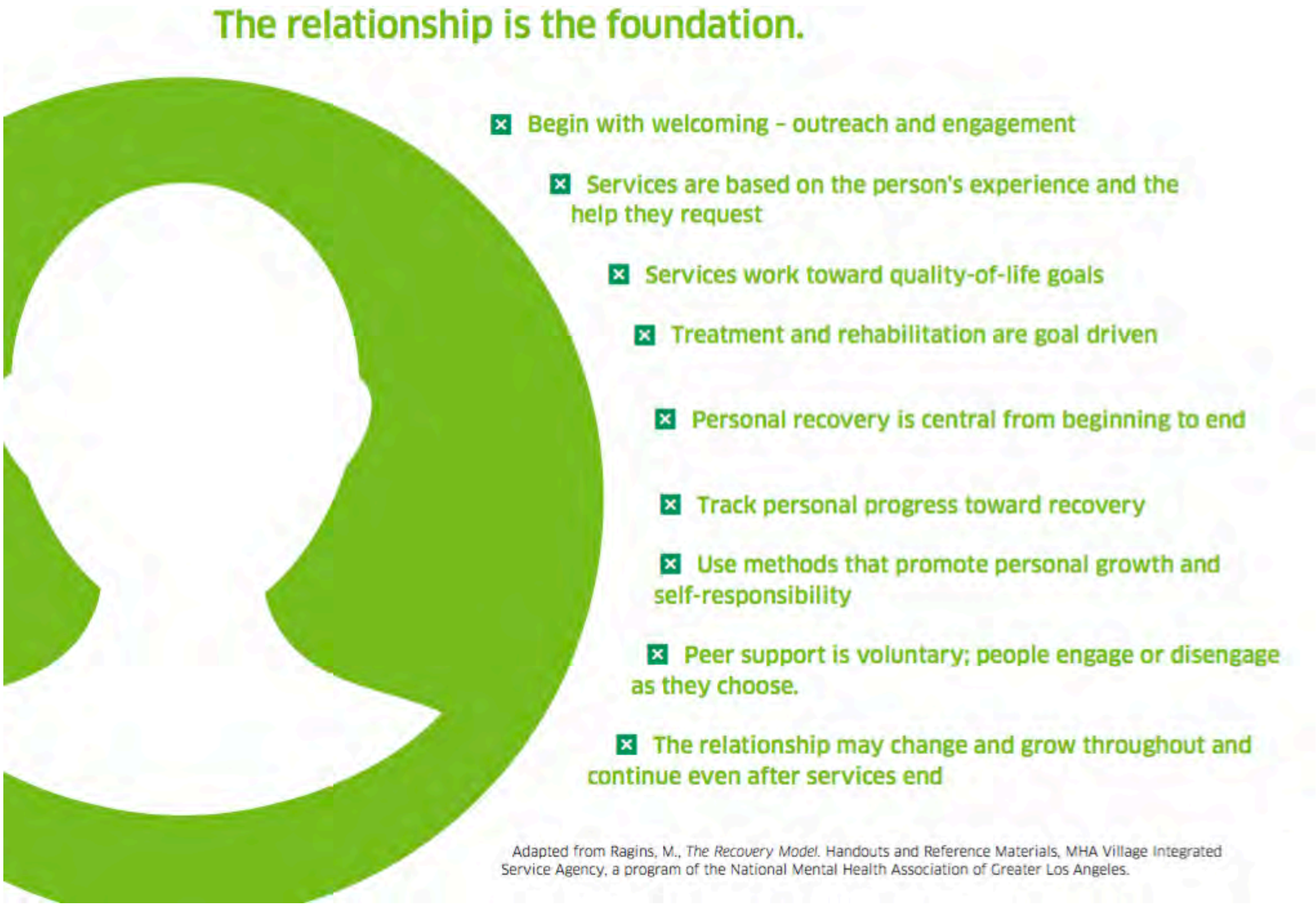
- Recognize the importance of an individual approach to wellbeing.
- Honour and respect where each individual is in their own unique journey of wellness, recognizing that the focus is on the process and not just the end result.
- Facilitate the self-determination and empowerment of peers to take an active role in their health and wellbeing.
- Recognize that the goals, values, and beliefs of their peers may not be the same as their own.
- Are collaborative in building equal, open and trusting relationships with peers.
- Share their lived experience in a manner that demonstrates compassionate understanding and inspires hope for wellness.
- Ensure that the knowledge gained from personal experience is used in a manner that contributes to the wellbeing of the peer and that the relationship is always peer-focused.
- Maintain mutually agreed upon limits and boundaries in the peer support relationship.
- Respect external limits and boundaries within the context of their role as a peer mentor.
- Practice self-care, monitor their own wellbeing and are aware of their own needs, as well as promote self-care for their peers.
- Play an active role in connecting peers to other resources and are open to seeking help when needed.
- Are collaborative with community partners, service providers and other stakeholders.
- Aspire to be current within their field of practice by remaining up-to-date regarding available resources, especially those that are locally available and by engaging in continuous learning.
- Conduct oneself in an ethical manner upholding the core values and principles of practice.

Code of Conduct[9]

- I will act ethically, according to the values and principles of peer support.
- I will treat all people with respect and dignity.
- I will respect human diversity and will foster non-discriminatory activities.
- I will honour the rights, beliefs and personal values of individuals.
- I will behave with honesty and integrity in providing support to peers.
- I will respect the privacy of individuals and maintain confidentiality within the limitations of program policies and the law e.g. potential harm to self or others.
- I will not knowingly expose a peer to harm.
- I will not take advantage of the peer relationship for personal benefit, material or financial gain.
- I will respect the boundaries of peer support work and will not engage in romantic or sexual relationships with the peers that I support.
- I will not provide peer support in a manner that negatively affects the public's confidence in peer support.

Person-Centered Approach to Health and Wellbeing

> “The philosophy of peer support is that each individual has within themselves the knowledge of what is best for them and a strong desire to find a path towards improved health. The peer mentor supports that person as they search for that inner knowledge and re-ignite that hopeful desire. Peer support is based on relationships in which each person is considered equal within the relationship and self-determination is highly respected. Peer support is focused on health and wellness rather than on illness and disability.” [5]



The relationship is the foundation.

- ☒ Begin with welcoming – outreach and engagement
- ☒ Services are based on the person's experience and the help they request
- ☒ Services work toward quality-of-life goals
- ☒ Treatment and rehabilitation are goal driven
- ☒ Personal recovery is central from beginning to end
- ☒ Track personal progress toward recovery
- ☒ Use methods that promote personal growth and self-responsibility
- ☒ Peer support is voluntary; people engage or disengage as they choose.
- ☒ The relationship may change and grow throughout and continue even after services end

Adapted from Ragins, M., *The Recovery Model*. Handouts and Reference Materials, MHA Village Integrated Service Agency, a program of the National Mental Health Association of Greater Los Angeles.

Figure from *Guidelines for the Practice and Training of Peer Support*[5].

A person-centered approach allows the peer to identify what they need for their health and wellbeing rather than being directed by a professional or the peer mentor. As peer mentors, we recognize that what is important to one person for their health and wellbeing may feel unnecessary, or even undesirable, to another. We also allow space for perceptions and desires to change over time, as the individual’s needs change.

3

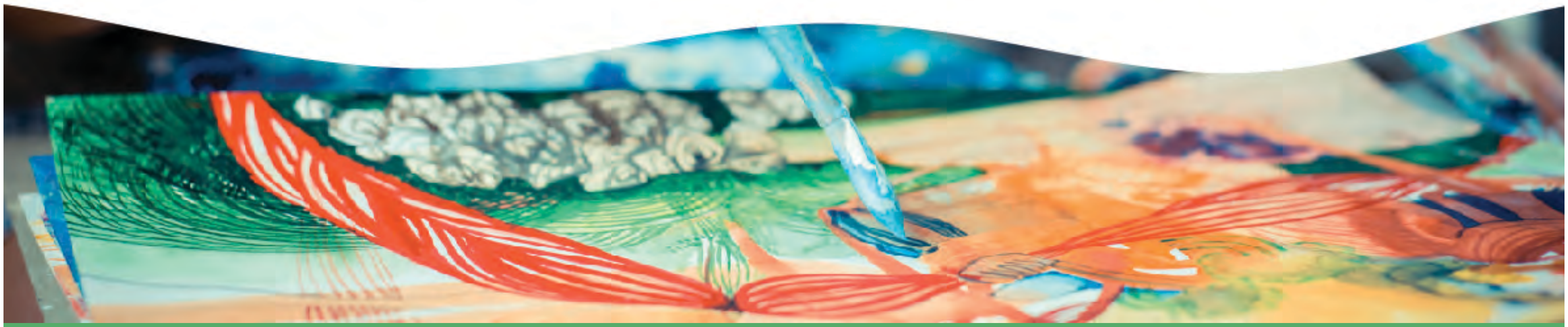
Module 3: Basics of Peer Mentoring

What to Expect

Module 3 will review the basics for peer mentoring including confidentiality and self-care and will be an opportunity for participants to learn more about themselves, their personal views and how perceptions and values can impact us in our role as a mentor.

Concepts Covered

- Key concepts.
- Helpful responses questionnaire.
- Perceptions.
- Personal values.
- Confidentiality.
- Duty to report.
- Why peer support?
- Self-care.



Key Concepts for Health and Wellbeing[10]

Hope	Having a vision that includes hopes and dreams and working towards a place of wellbeing and go on to meet those goals and live a fulfilled life.
Personal Responsibility	Making the personal decision to take action and do what needs to be done to keep ourselves well. This can be done with others when help is requested.
Education	Taking responsibility to learn about our health, wellness, symptoms and treatment in order to make effective decisions about all aspects of our life.
Self-Advocacy	Effectively reaching out to others so that you can get what it is that you need, want and deserve to support your health and wellbeing.
Support	Receiving support from friends, family and health care professionals, as well as giving support to others can help enhance quality of life.

The Helpful Responses Questionnaire[11]

1. Your new peer has been feeling extremely isolated and has finally contacted you. You have been connecting well and she's been responsive to your care and concern and wants to hang out more. You feel like you need to set boundaries so that the relationship remains as a peer mentor and not as a friend.

Your response:

2. Your peer discloses that they are struggling with the shame and stigma surrounding their (HIV/Hep C) diagnosis. They state feeling helpless and just wanting to give up on life completely

Your response:

3. Your peer tells you, “I'm having a problem that's tearing me apart. I don't know how to tell my family that I am (HIV/Hep C) positive, I have been able to tell my best friend, and after the initial shock, they were able to accept me. I don't think it will be like that with my family, especially my parents - they are pretty 'old school'. I fear that they will judge me and maybe reject me. What should I do?”

Your response:

4. A newly diagnosed peer tells you that she's in an abusive relationship. She's concerned that if she discloses to her partner she could be at risk for more violence, and yet if she doesn't disclose and continues having unprotected sex while on medication she could be charged with sexual assault, even if she does not infect her partner.

Your response:

Why Peer Support?

Benefits to the peer:	Benefits to the mentor:

Self-Care[12]

What is Self-Care?

Self-care is finding ways to help enhance health and wellbeing and manage stress in our personal lives as well as in the role of a peer mentor. This can be accomplished by learning to identify activities and practices that support health and wellbeing as part of day-to-day life.

Self-Care is Unique

There is no “one-size-fits-all” self-care plan; by practicing a person-centered approach to wellness it is up to the individual creating the plan to choose what is best for them. Although the details of a self-care plan are unique to each individual there is often a common theme of making changes/goals in all aspects of wellness, including physical, psychological, social, spiritual and environmental needs.

Burnout and Compassion Fatigue

Compassion Fatigue:

- Often referred to as "the cost of caring".
- Secondary or vicarious traumatization.
- Symptoms may include:
    - hyperarousal (poor sleep, irritability),
    - avoidance ("not wanting to go there"),
    - re-experiencing (intrusive thoughts/dreams when triggered).

Burnout:

- Emotional exhaustion.
- Reduced personal accomplishment and commitment to the role.
- Depersonalization:
    - a negative attitude towards peers/role;
    - personal detachment;
    - loss of ideals.

How Can We Mitigate Burnout?

- Mindfulness Meditation.
- Reflective Writing.
- Adequate supervision and mentoring.
- Sustainable workload.
- Promotion of choice and control.
- Appropriate recognition and reward.
- Supportive work community.

Wellness Inventory[13]

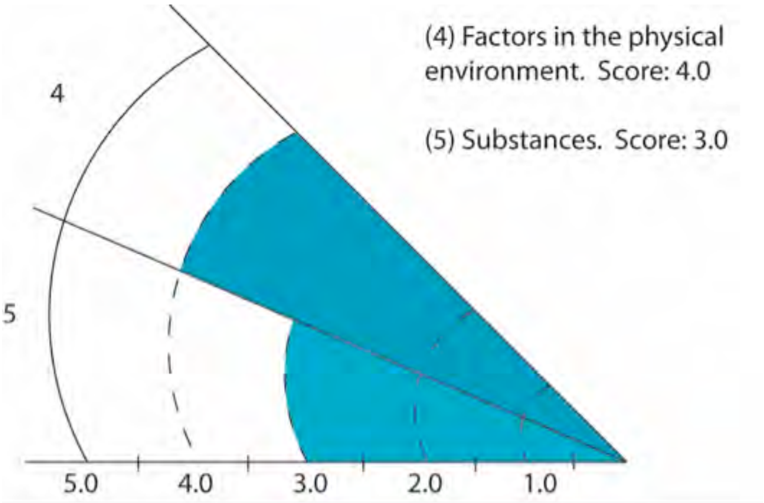
Instructions:

1. Rate your agreement with the following statements throughout the next several tables by putting a check in one of the columns from 0-5.
2. Add up your total points in each table (i.e. if you scored a "5" beside one of the statements, that would be 5 points toward your total in that table).
3. Then, calculate your average in each table by taking that total number of points and dividing it by the number of statements in the table.
4. Each "slice" of the Wellness Wheel corresponds to one of the tables you completed. Using your average points in each table, colour in the Wellness Wheel.

Example of Completed Table[13]:

5	4	3	2	1	0	Sample Statements (Physical Activity)
x						**When participating in physical activities, I include stretching and flexibility exercises.**
	x					**I run at least one mile three times a week (or equivalent aerobic exercise).**
	x					**I am aware of the calories expended in my activities.**
				x		**I walk, run, or ride my bicycle instead of drive/ride in a vehicle whenever feasible.**
		x				**I maintain a healthy weight.**
5	8	3	0	1	0	**Total Points=17**

Example of Colouring in a Slice of the Wellness Wheel[13]:



How to Determine Your Rating[13]**:**

5 – Yes, always (95% or more of the time)
4 – Very often, usually (approximately 75% (3/4) of the time)
3 – Often (approximately 50% (1/2) of the time)
2 – Sometimes, maybe (approximately 25% (1/4) of the time)
1 – Almost never, rarely (less than 10% of the time)
0 – No, never

Physical Wellness (4 tables)[13]

5	4	3	2	1	0	Section Physical 1.1: Activity
						1. I engage in strength-building exercises/activities at least two times per week.
						2. I engage in moderate to vigorous movement activities for at least 60 minutes per day.
						3. I keep track of my fitness/exercise (e.g., in a journal, notebook, using technology) and I share my fitness achievements with my family and friends.
						4. I stretch for several minutes each day to keep my body flexible.
						5. I use active transportation (e.g., walk, run, skateboard, ride bicycle) whenever possible.
						6. I am aware of the calories expended in my movement activities.
						7. I participate in movement activities that provide relief from stress.
						8. I maintain realistic and healthy personal fitness expectations.
						9. I have energy at the end of the day.
						10. I have developed appropriate complex skills (e.g., passing to avoid a defender, hitting a ball) to participate confidently in a variety of movement activities.
						11. I look for opportunities to enhance my physical fitness in my daily routines (e.g., take the stairs, walk to friend's house).
						Total points =
						Average points (total points /11) =

5	4	3	2	1	0	**Section: Physical 1.2: Healthy Eating**
						1. I eat at least five servings of fruits and vegetables each day.
						2. I make a conscious effort to choose/make foods, when possible, that are low in sugar, sodium, and saturated fat.
						3. I drink fewer than two soft drinks (including diet drinks, energy drinks) per week.
						4. I eat at restaurants no more than once per week.
						5. I intentionally include foods high in fiber in my diet on a daily basis (e.g., whole grain breads and cereals, beans).
						6. I drink enough water (i.e., six-eight glasses per day) to keep my urine light yellow.
						7. I read the nutrition labels when selecting and purchasing food and beverages.
						8. I avoid "fad" dieting but rather make healthy lifestyle changes that can be maintained.
						9. I avoid caffeine.
						10. I am mindful about consuming alcohol.
						Total points =
						Average points (total points /10) =

5	4	3	2	1	0	**Section: Physical 1.3: Self-Care**
						1. I have routine yearly health checkups rather than only seeking medical attention when I have concerns/symptoms.
						2. I complete regular/monthly personal breast/testicular exams.
						3. I complete a regular skin check for signs of skin cancer.
						4. I take vitamins on a regular basis.
						5. I brush my teeth after meals and floss once/day.
						6. I take care of personal injuries
						7. I get at least seven hours of uninterrupted sleep/night.
						8. I regularly wash my hands (e.g., after using bathroom, before eating)
						9. I always check with my medical practitioner before taking supplements.
						Total points =
						Average points (total points /9) =

5	4	3	2	1	0	**Section: Physical 1.4: Safety**
						1. I wear a seat belt while riding in and driving any motorized vehicle.
						2. I use sunscreen or take other precautions to prevent overexposure to the sun.
						3. I advocate that nonsmokers should not have to breathe tobacco smoke in public places.
						4. I always wear a helmet when I ride a motorcycle, bicycle, skate board, all-terrain vehicle, etc.
						5. I avoid extremely noisy areas or wear protective ear covers.
						6. I identify and attend to safety and risk factors involved in movement activities.
						7. Injury prevention is a focus in all that I do.
						8. I never drive while under the influence of substances (or ride with someone under the influence).
						9. I do not use tobacco products and avoid second-hand smoke.
						10. I use prescription drugs only as intended.
						11. I know where to seek help if I feel unsafe and/or if I am injured.
						12. I practice safe sex.
						13. I am aware of risks within my environment and make adjustments to my lifestyle accordingly.
						Total points =
						Average points (total points /13) =

Social Dimension of Wellness (2 tables) [13]

5	4	3	2	1	0	**Section: Social 1.1: Intrapersonal Relationships**
						1. I try to live in a way that causes as little personal damage and suffering as possible.
						2. I value spending time alone, not “plugged in” to the outside world.
						3. I regularly reflect on who I am and what I value.
						4. My wellness is a priority to me and I schedule my days accordingly.
						5. I am aware of my strengths and weaknesses as they relate to personal well-being.
						6. My self-talk has a positive influence on my personal well-being.
						Total points =
						Average points (total points /6) =

5	4	3	2	1	0	**Section: Social 1.2: Interpersonal Relationships**
						1. I try to live in a way that causes as little damage and suffering as possible to others.
						2. I am able to communicate with and get along with a wide variety of people.
						3. I have at least one person in whom I can confide.
						4. I am involved in social activities at school and/or in my community.
						5. I get along well with the members of my family.
						6. I feel safe being sexually intimate with my partner(s).
						7. I feel safe disclosing my HIV/Hep C status to friends and family.
						8. When I make mistakes, I apologize (if appropriate) and do not try to cover them up.
						9. I am able to listen to people without interrupting them or finishing their sentences for them.
						10. I am accepting of others who have differing sexual orientations, abilities, and religious beliefs (not meaning I have to agree with their beliefs).
						11. I feel like I belong at school.
						12. I assertively address conflict with others in “face to face” conversations (i.e., do not avoid it or use social network).
						13. I seek and accept constructive criticism.
						Total points =
						Average points (total points /13) =

Psychological Dimension of Wellness (3 tables) [13]

5	4	3	2	1	0	Section: Psychological 1.1: Mental
						1. I develop and assess personal goals on an ongoing basis.
						2. I achieve goals I set for myself.
						3. I am looking forward to the future as an opportunity for further personal growth.
						4. I enjoy expressing myself through art, dance, music, drama, movement, etc., and make time to do so.
						5. I schedule enough time to accomplish what I need to do.
						6. I avoid putting off important tasks (i.e., procrastination).
						7. I have at least one activity (e.g., hobby, sport) that I regularly do/enjoy.
						8. I often reflect on my attitudes and biases towards mental health and mental illness.
						9. I promote a realistic and positive understanding of mental illness.
						10. I have the self-awareness to know when to seek help for personal mental health challenges.
						11. I know how to keep myself mentally healthy.
						12. I practice mental fitness (e.g., place things in perspective, use stress management techniques).
						Total points =
						Average points (total points /12) =

5	**4**	**3**	**2**	**1**	**0**	**Section: Psychological 1.2: Emotional**
						1. I am able to develop and maintain close relationships.
						2. I feel positive about my life and myself.
						3. I avoid blaming others for my failures or problems.
						4. I easily fall asleep and stay asleep at night.
						5. I try to associate with people who have a positive attitude.
						6. I avoid people who are “down” all the time and bring down those around them.
						7. I express my feelings or anger in ways that are not harmful to self and/or others.
						8. I include relaxation as part of my daily routine.
						9. When I make mistakes, I take responsibility and I try to learn from them.
						10. I avoid giving mixed signals.
						11. I know who and what pushes my buttons.
						12. I can accurately identify and appropriately respond to the emotions of others.
						Total points =
						Average points (total points /12) =

5	**4**	**3**	**2**	**1**	**0**	**Section: Psychological 1.3: Intellectual**
						1. I keep abreast of current affairs – locally, nationally, and internationally.
						2. I am interested in learning new things and in deepening my learning of what I know.
						3. I am happy with the amount and the variety that I read.
						4. When seeking medical care, I plan ahead regarding how to describe my problem and what questions I should ask.
						5. I am able to see more than one side of an issue.
						6. I learn from my mistakes and plan to act different the next time.
						7. I consider various alternatives before making decisions.
						8. I am interested in continuing to learn beyond grade 12.
						9. I look for ways to use my creativity.
						10. I know the “way” I learn best and advocate to learn this way when necessary.
						Total points =
						Average points (total points /10) =

Spiritual Dimension of Wellness (2 tables)[13]

5	4	3	2	1	0	Section Spiritual 1.1: Sense of Identity
						1. I am committed to following what I believe.
						2. I take time alone to think about what's important in life - who I am, what I value, etc.
						3. I turn inward for a sense of strength in difficult situations.
						4. I am mainly guided by my "inner self" rather than the expectations of others.
						5. I treat all things with respect.
						6. I value my uniqueness (e.g., abilities, heritage, experiences)
						Total points =
						Average points (total points /6) =

5	4	3	2	1	0	Section Spiritual 1.2: Sense of Meaning and Purpose
						1. I try to relate to myself, to my community, and to my planet in a non-harming way.
						2. I spend a portion of every day praying, meditating, smudging, etc.
						3. I take time alone to think about what's important in life - where I fit in and where I'm going, etc.
						4. I take time to enjoy nature and I feel connected to the earth.
						5. I am mainly guided by my "inner self" rather than the expectations of others.
						6. I believe that there is a bigger "purpose" in life.
						7. I understand that true happiness is about more that accumulating wealth or "stuff".
						8. I reach out to comfort or help others.
						9. I volunteer my time at least once per week.
						Total points =
						Average points (total points /9) =

Environmental Dimension of Wellness (2 tables) [13]

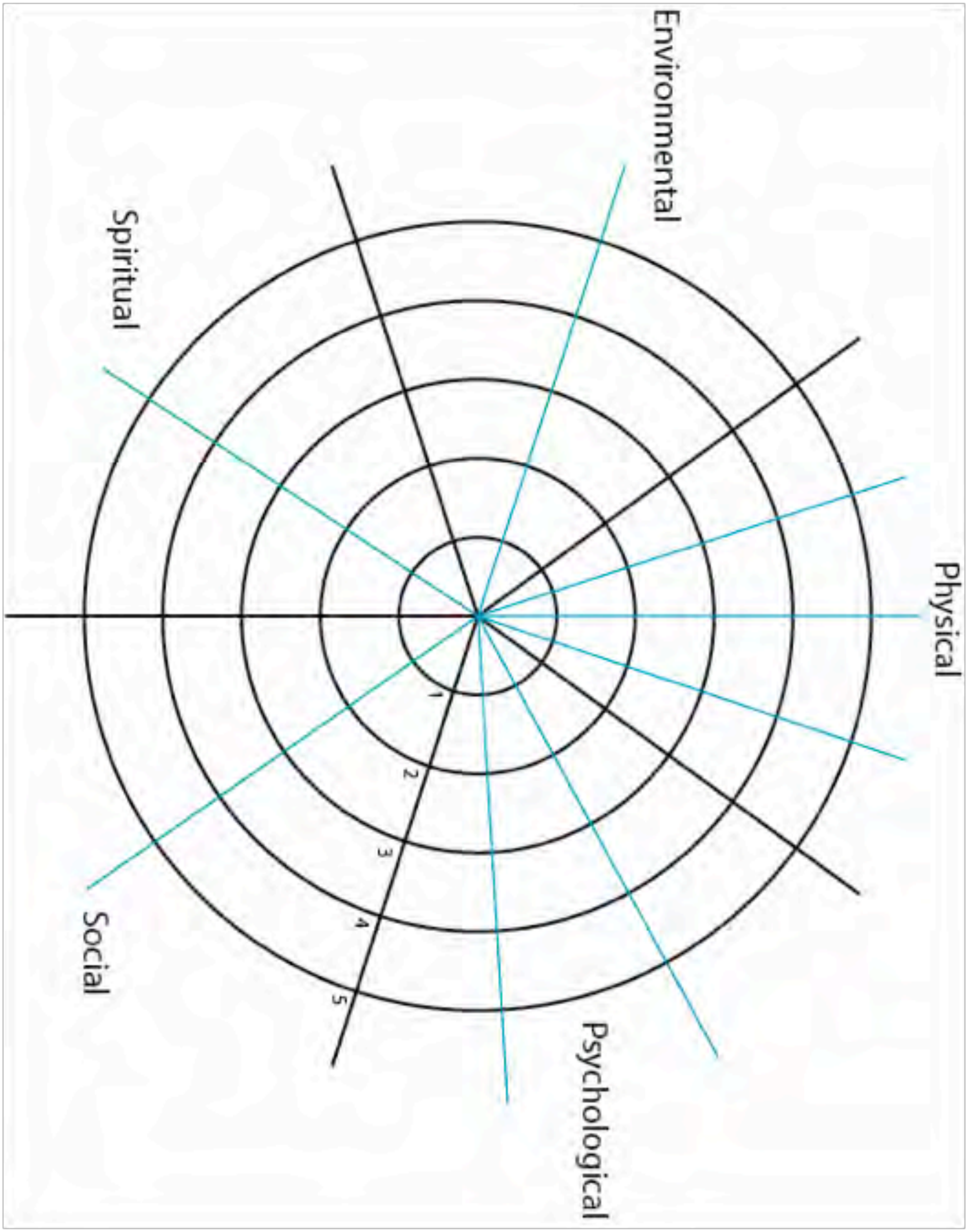
5	4	3	2	1	0	Section Environmental 1.1: Environmental Footprint
						1. I try to live in a way that causes as little damage and suffering as possible to my environment.
						2. I use active transportation (e.g., ride a bicycle, walk) to conserve fuel energy and to lessen the pollution in the atmosphere.
						3. I do not litter.
						4. I advise others on the importance of maintaining a healthy environment.
						5. I try to conserve energy by turning off lights and electrical appliances when they are not being used.
						6. I look for recycled materials when purchasing products.
						7. I try to not leave the tap running too long when I brush my teeth, shave, or bathe.
						8. I network with people/organizations who advocate for the environment (e.g., social media, online publications).
						9. I support efforts in my community to reduce environmental pollution.
						10. I know where my food comes from and its journey from “seed to plate”.
						11. My decisions are informed by the impact of consumerism on the environment.
						12. I use reusable shopping bags.
						Total points =
						Average points (total points /12) =

5	4	3	2	1	0	Section Environmental 1.2: Social Justice
						1. I support local businesses and their products.
						2. I recognize that certain groups of people have privileges (e.g., white, male, educated, Christian, socio-economics, abilities, appearances, culture).
						3. I advocate for equal opportunity (e.g., access to healthy foods, clean water, housing, physical activity).
						4. I feel empowered to contribute to the greater good of my community.
						5. I recognize, name, and challenge instances of inequality, bias, and intolerance.
						6. I resist negative media portrayals and other imposed images.
						Total points =
						Average points (total points /6) =

Totals:

Physical Dimension	Avg. Score	Psychological Dimension	Avg. Score
1.1 Physical Activity	_____	1.1 Mental	_____
1.2 Healthy Eating	_____	1.2 Emotional	_____
1.3 Physical Self-Care	_____	1.3 Intellectual	_____
1.4 Safety	_____		
Social Dimension	**Avg. Score**	**Spiritual Dimension**	**Avg. Score**
1.1 Intrapersonal Relationships	_____	1.1 Sense of Identity	_____
1.2 Interpersonal Relationships	_____	1.2 Sense of Meaning and Purpose	_____
Environmental Dimension	**Avg. Score**		
1.1 Environmental Footprint	_____		
1.2 Social Justice	_____		

Wellness Wheel[13]:



4

Module 4: Communication Skills

What to Expect

Module 4 will review various qualities of an effective communicator and identify communication enhancers and roadblocks in a peer mentor relationship.

Concepts Covered

- Nonverbal communication.
- Empathy.
- Cultural iceberg.
- Communication blocks and enhancers.
- Experience cube.

Non-Verbal Communication[14]

S – STANCE

O – OPEN POSTURE

L – LEAN TOWARD

E – EYE CONTACT

R – RELAXED POSITION

S – Stance – Face the person you are talking with. Physical distance between you and your peer is important as well. In North American culture, 1 to 1.5 meters distance is usually appropriate. Some people will want more or less distance between you and them.

O – Open posture – Saying through your posture that you are willing to be involved and accessible. Crossed arms and legs can be seen as defensiveness or withdrawal.

L – Lean forward – As understanding increases, people tend to draw closer together physically, leaning toward the other person.

E – Eye contact – Demonstrates a sign of involvement and can directly influence trust. Maintaining a comfortable amount of eye contact signals that you are engaged in the conversation and allows you to develop a sense of the person's emotional state.

R – Relaxed position – Avoid fidgeting as it could make it seem that you are preoccupied, in a rush nervous or uncomfortable with the discussion. If you are relaxed you are able and willing to listen. If a person feels that you are judgmental or overwhelmed, they may stop the conversation or change to
a subject they feel you would be more comfortable with.

Active Listening[11]

What is active listening?

There are both verbal and nonverbal approaches to active listening. Active listening means mindfully paying attention to what another person is saying to help enhance understanding and connection. Often we are surrounded by internal and external distractions that can impact how well we are listening.

Obstacles to active listening:

- Cultural, familial and personal biases.
- Becoming distracted with our own thoughts.
- Interrupting unnecessarily.
- Labeling.
- Becoming too emotionally involved.
- Misunderstanding nonverbal/verbal communication.

Skills for being an active listener:

Pay attention:

- Look at the person you are speaking with.
- Avoid distractions.
- Notice the speaker’s body language.
- Avoid being pre-occupied by your own thoughts or by preparing for a response.
- Avoid unnecessary interrupting.

Silence:

- Hold space for the speaker.
- Avoid jumping in with a response too soon.
- Allow time for emotion.
- Give head nods and slight verbal cues that show you are listening.
- It’s okay to not have an answer.

Ask Questions:

- Ask open ended questions that don’t require a “yes” or “no” answer.
- Encourage the speaker to expand on their experience.
- Ask fact finding questions (who, what, when, where, how).
- Consider the intention of your questions: are they about compassion or curiosity?

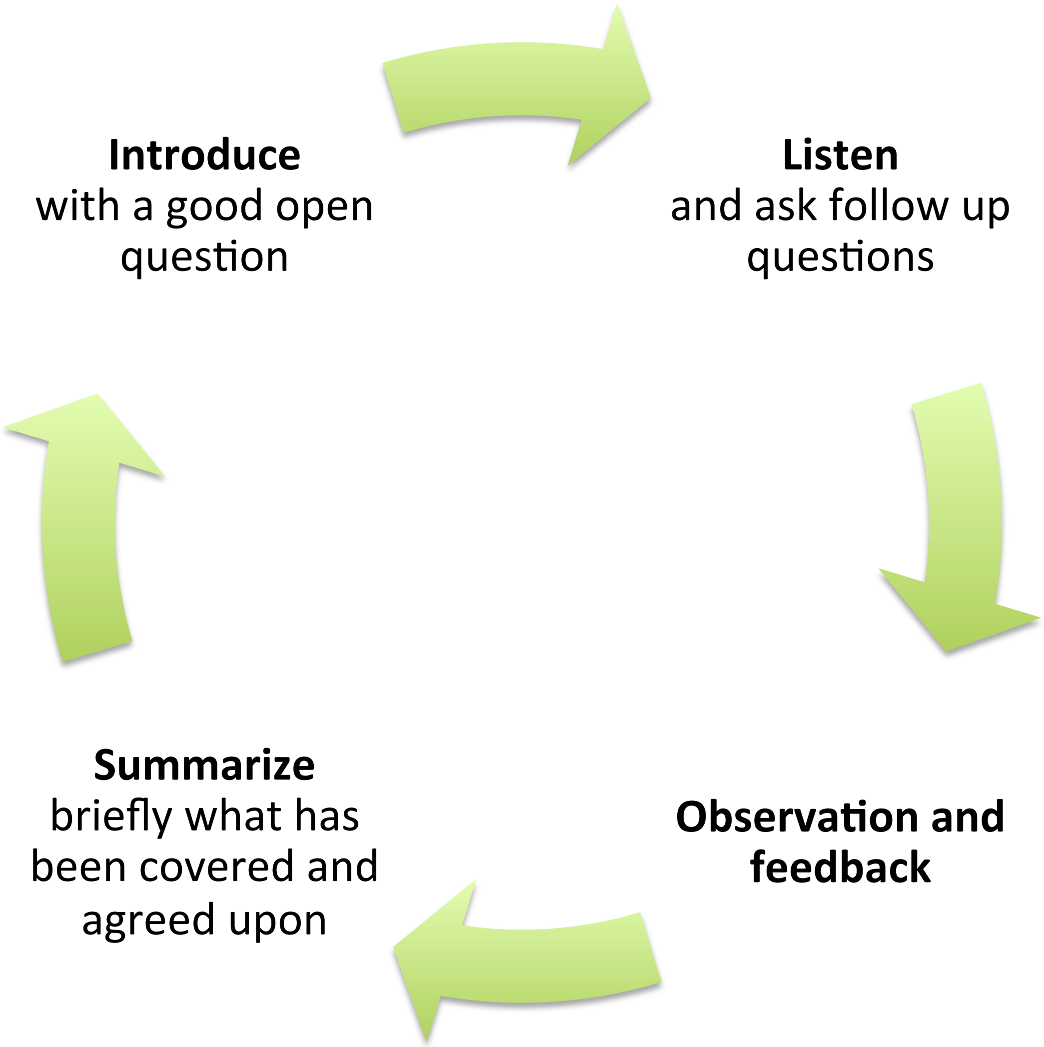
Paraphrasing:

- Give a response that reflects back to the speaker what they saying.
- Give the same meaning in your own words.
- Be brief, clear and concise and capture the key message(s).
- Word the response as a question to help clarify your understanding.
- “Sounds like you are…is that right?”
- “Let me see if I have this right…is that what you are saying?”
- “So I hear you say _______ is that correct?”

Summarizing:

- Reviewing the key points covered in a visit or several visits helps limit the peer from repeating themselves and reflects understanding.
- Helps to focus the peer and peer mentor on main issues.
- Moving forward in goal setting.

Having a Mentoring Conversation[15]



Introduce
with a good open
question

Listen
and ask follow up
questions

Observation and feedback

Summarize
briefly what has
been covered and
agreed upon

If the peer wanders off topic, you can bring the discussion back on track by acknowledging the point, while saying something like, “let’s come back to that when we talk about [related topic] later.”

Cultural Iceberg [16]

Directions: For each feature of culture, think of one example common to people in Canada or in the country where you were born. Use another sheet of paper if you need more space to write.

1. Style of dress

____

2. Ways of greeting people

____

3. Beliefs about hospitality

____

4. Importance of time

____

5. Paintings

____

6. Values

____

7. Literature

____

8. Beliefs about raising children

____

9. Attitudes about personal space/privacy

____

10. Beliefs about the responsibilities of children/teens

____

11. Gestures to show you understand what you've heard

____

12. Holiday customs

____

13. Music

____

14. Dancing

____

15. Celebrations

____

16. Concept of fairness

____

17. Nature of friendship

____

18. Ideas about clothing

____

19. Foods

____

20. Greetings

____

21. Facial expressions and hand gestures

____

22. Concept of self

____

23. Work ethic

____

24. Religious/spiritual beliefs

____

25. Religious/spiritual rituals

____

26. Concept of beauty

____

27. Rules of polite behaviours

____

28. Attitude toward age

____

29. The role of family

____

30. General worldview

____

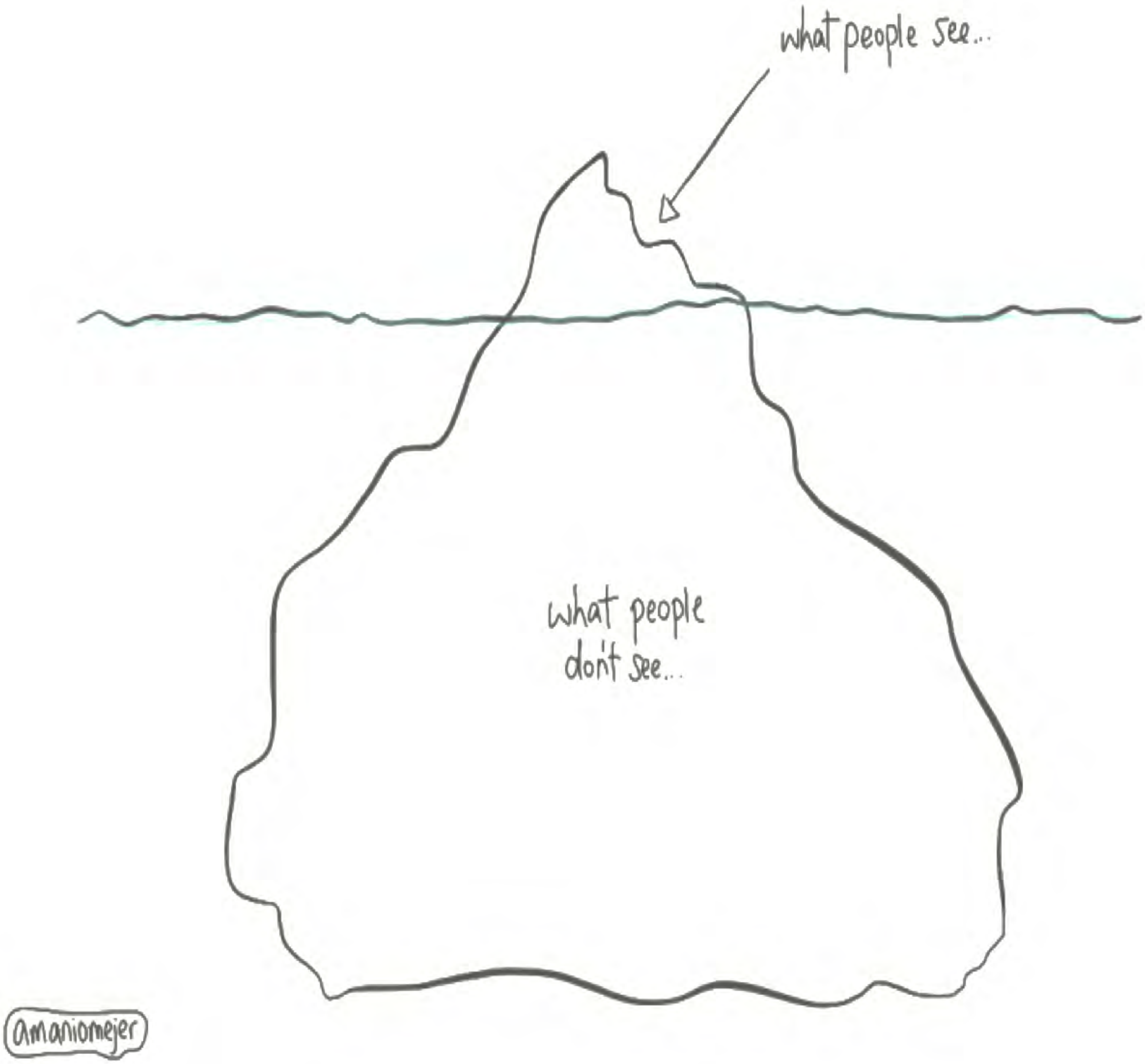


Image source: https://themighty.com/2017/02/emotion-loneliness-of-being-sick/

Experience Cube Activity[17]

Feeling Words:

Happy	Safe	Scared	Helpless	Vengeful
Good natured	Secure	Anxious	Vulnerable	Provoked
Jubilant	Warm	Afraid	Disappointed	Useless
Joyful	Trusting	Fearful	Ashamed	Pessimistic
Glad	Trusted	Nervous	Repugnant	Dull
Festive	Inviting	Harassed	Indignant	Careless
Cheerful	Desired	Insecure	Lousy	Apathetic
Elated	Satisfied	Unsure	Unhappy	Disjointed
Loved	Receptive	Worried	Confused	Rejected
Brotherly	Free	Cowardly	Disoriented	Menaced
Playful	Certain	Desperate	Disillusion	Agonized
Aroused	Self-assured	Suspicious	Stupefied	Disrespected
Esteemed	Inspired	Doubtful	Stunned	Shy
Confident	Encouraged	Victimized	Perplex	Torn
Provocative	Enthralled	Cheated	Doubtful	Conflicted
Comforted	Manic	Terrified	Worthless	Ambivalent
Strong	Energetic	Alienated	Energetic	Bold
Optimistic	Healthy	Offended	Amazed	Flattered
Frisky	Inquisitive	Hurt	Stressed	Lonely
Animated	Curious	Rejected	Humbled	Resentful
Glorious	Dependable	Disorganized	Angry	Touched
Energized	Mellow	Tired	Trapped	Respected
Vigorous	Relaxed	Forgetful	Annoyed	Tearful
Engrossed	Affectionate	Wary	Outraged	Irritated
Fluid	Sympathetic	Sad	Explosive	Numb

Coaching Questions:

1. What do you want?
2. What are you afraid of?
3. What is this costing you?
4. What are you attached to?
5. What is the dream?
6. What is beyond this problem?
7. What is ahead?
8. What are you building toward?
9. What has to happen for you to feel successful?
10. What are your healthy sources of energy?
11. What's stopping you?
12. What would you change?
13. What's in your way?
14. What would make the biggest difference?
15. What do you like to do?
16. What do you hope to accomplish by having that conversation?
17. What do you hope to accomplish by doing that?
18. What's the first step?
19. What's important about that?
20. What would it take for you to treat yourself like your best friend?
21. What benefit/payoff is there in the present situation?
22. What's the ideal outcome?
23. What would it look like?
24. What are you going to do?
25. What's working for you?
26. What would you do differently?
27. What decisions would you make from a position of strength?
28. What other choices do you have?
29. What if there were no limits?
30. What haven't I asked that I should ask?
31. What are you willing to give up?
32. What do you have invested in continuing to do it this way?
33. What are the consequences?
34. What is the value received?
35. What is motivating you?
36. What might you have done differently?
37. What do you suggest?
38. What is underneath that?
39. What is this person contributing to your quality of life?
40. What are you denying yourself?
41. What do you need to put in place to accomplish this?

5

Module 5: Goal Setting and Relationship Building

What to Expect

Module 5 identifies the framework of building a healthy relationship and setting goals with a peer. The participants will learn ways to begin, maintain and end the helping relationship.

Concepts Covered

- Stages of the helping relationship.
- Building a relationship with peers.
- Giving information.
- Goal setting.
- Egan’s helping model.

Stages of the Helping Relationship

Beginning the helping relationship:

- Review your role and what to expect from the relationship.
- Discuss confidentiality.
- Create a welcoming and safe environment.
- Treat each peer and relationship as unique.
- Suspend judgement.
- Ask, listen and learn about the needs of the peer and what they want to achieve from the helping relationship.

Maintaining the helping relationship:

- Help the peer to understand and manage their concerns through discussion and support.
- Help the peer to develop goals and set action plans.
- Check on progress of goals throughout visits.
- Provide ongoing emotional support and encouragement.
- Give information and resources to help guide when requested.
- Empower the peer to ask for what they need.
- Show continued acceptance.
- Encourage the 5 key concepts: hope, personal responsibility, self-advocacy, education and support.
- Demonstrate empathy.
- Let the peer know when visits are coming close to the end so they are prepared.

Ending the helping relationship:

- Can be ended through mutual agreement, one person’s choice or through a natural end.
- Keep in mind that the end of the relationship can be felt as a significant loss for both the peer and mentor.
- Discuss other community resources, networks and supports that could be utilized.
- Review successes from the relationship and how they can maintain their success/well-being.
- If their goal is not completed, brainstorm ways they can continue working on it.
- If it comes up, discuss if a friendship will continue once the helping relationship is complete (depends on agency policy).
- Avoid discussing new concerns in the last few sessions as there is not enough time to see them through and can leave the peer vulnerable.

Giving Information

Why we give information:
Lack of information can keep peers from looking at problems objectively and seeing all the options available to them. A peer mentor should strive to be familiar with the various resources in the community and make that information available when appropriate. It's important that the peer requests the information or agrees to hear your suggestion before information is given.

Although information does not solve the problem, it can give new perspectives on handling these problems. Information sharing includes giving information as well as correcting misinformation, in some cases, the information can prove to be quite confirming and supportive. [18]

When giving information, Egan[18] suggests the following pointers:

- Do not overwhelm the peer with information.
- Make sure that the information you provide is true, clear and relevant to the peer's situation.
- Don't let the peer go away with a misunderstanding of the information.
- Be supportive.
- Be sure not to confuse information giving with advice giving.
- Show respect and keep the peer's values in mind.

SMART Goals[19]

How to use SMART Goal Setting:

S

- **SPECIFIC**
- Answer the 5 W's**:** **What** do I want to accomplish? **Why** is this goal important? **Who** is involved? **Where** is it located? **Which** resources or limits are involved?

M

- **MEASURABLE**
- Can you track the process and measure the outcome?
- How much? How many? How will I know when it is accomplished?

A

- **ACHIEVABLE**
- Your goal should be attainable, it can stretch your abilities but important that it remain possible
- How can I accomplish this goal? How realistic is the goal based on constraints?

R

- **RELEVANT**
- Your goal matters to you
- Does this seem worthwhile? Is this the right time? Does this match other efforts/needs? Am I the right person to reach this goal? Is it applicable to my life right now?

T

- **TIME BOUND**
- Setting target dates for the goal
- What can I do six months from now? What can I do six weeks from now? What can I do today?

Different meanings to the acronym:

- **S**pecific (simple, sensible, significant).
- **M**easurable (meaningful, motivating).
- **A**chievable (agreed, attainable).
- **R**elevant (reasonable, realistic and resourced, results-based).
- **T**ime bound (time-based, time limited, time/cost limited, timely, time-sensitive).

Egan’s Helping Model[15]

Stage 1 (present)
What's going on?

- helping peers tell their stories
- helping peers break through their blind spots
- helping peers choose the right issues or opportunities to work on

Stage 2 (preferred)
What do I need or want instead of what I have?

- helping peers use their imaginations to spell out possibilites
- helping peers choose realistic and challenging goals
- helping peers find incentives that will help them commit to their agenda

Stage 3 (action)
How do I get what I need or want?

- helping peers see the different ways they can achieve their goals
- helping peers choose best-fit strategies
- helping peers craft an action plan

6

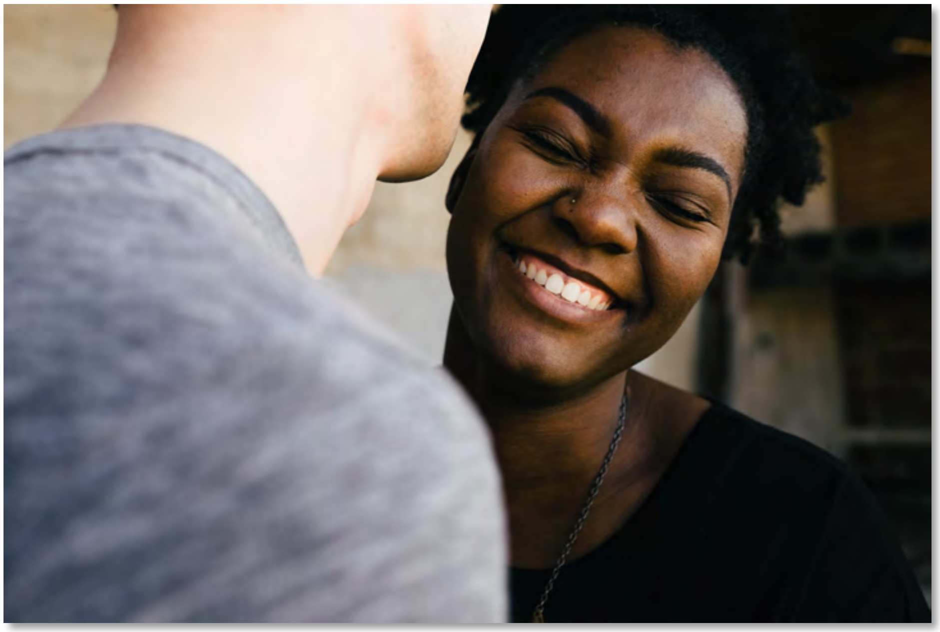
Module 6: Introduction to Boundaries

What to Expect

Module 6 discusses the importance of setting clear boundaries as it will help inform the work done as a peer mentor, keep the mentors engaged, reduce burnout, anxiety and frustration for the mentors.

Concepts Covered

- Introduction to boundaries.
- Personal boundaries.
- Factors that influence boundaries.
- Setting limits.
- “I” statements.
- Self-disclosure.



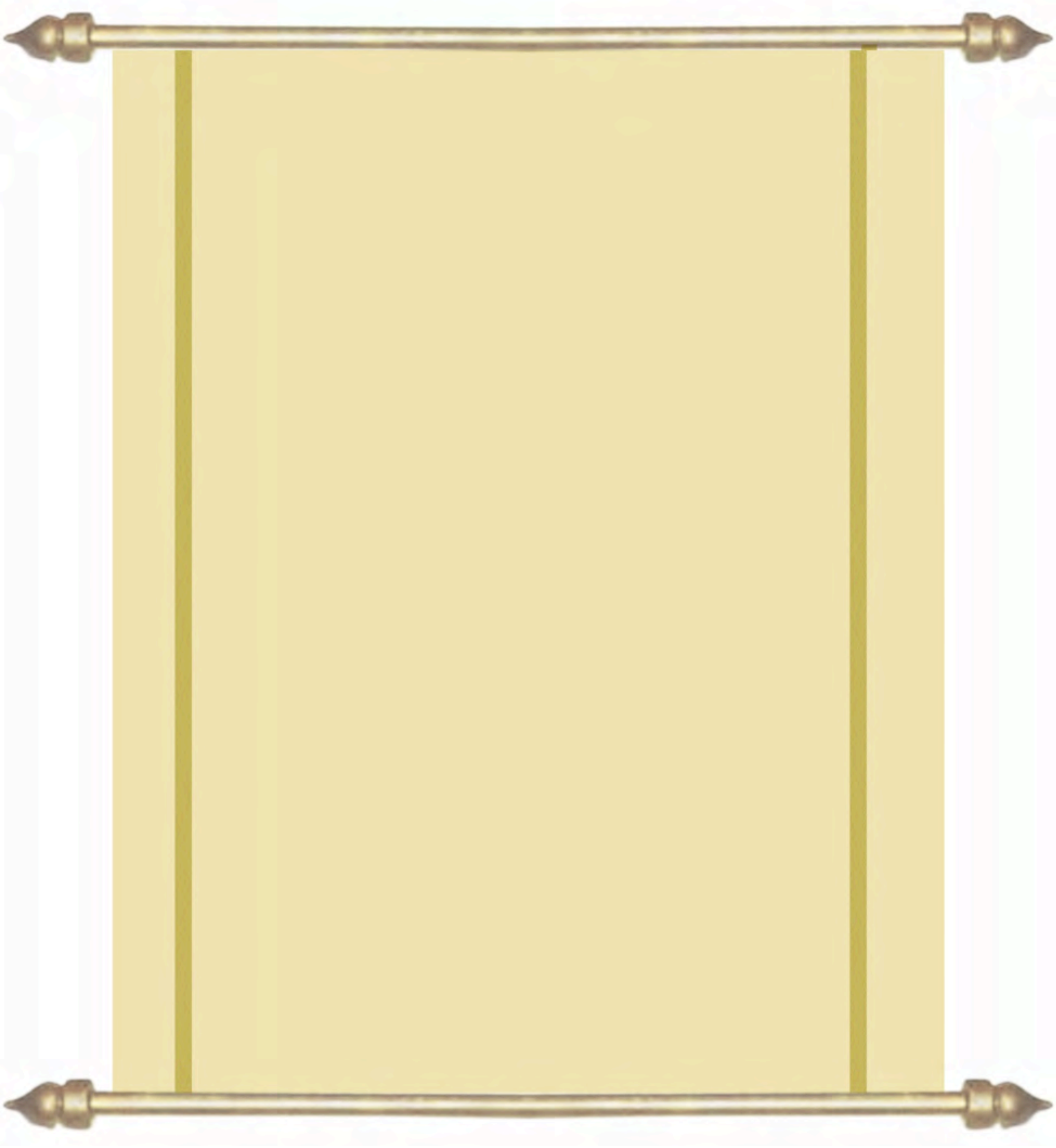
Introduction to Boundaries

What are boundaries?
Boundaries are a set of guidelines or limits that a person creates to help themselves identify safe and permissible ways for other people to behave around them and how they will respond when someone steps outside those limits.[1]

Personal boundaries:
Personal boundaries are built out of a mix of beliefs, opinions, attitudes, past experiences and social learning. Boundaries define who we are as individuals through helping us to create ownership and protection of ourselves. Personal boundaries can be difficult to see and navigate when we consider our relationships and they are crucial to our role as a peer support mentor.

Healthy personal boundaries = taking responsibility for your own actions and emotions, while NOT taking responsibility for the actions or emotions of others. Mark Manson

Personal Bill of Rights



Factors That Influence Our Boundaries[20]

The "perfect peer phenomenon" [20]

The ***perfect peer*** typically tends to blur boundaries; work beyond their skill comfort level; appears to feel uncomfortable saying "no" out of fear of disappointing their peer or supervisor and generally has an unhealthy 'need to please' beyond their scope of work.

Don't take it all on!! Learning how to say NO is an undervalued skill. It is essential to find a balance of life with HIV and outside of HIV…what is your scope of practice? What is my role? [20]

Don't expect to know how to manage and balance new responsibilities in combination with your existing responsibilities right away, it takes time to learn and find a balance that works for you.

Self-care and boundaries:

Self-care is crucial throughout the journey of well-being and in the peer mentor role. When setting boundaries, make sure you are honest with yourself, your peers and the people on your team about your time and limits to how much you are able to take on without overwhelming yourself. Just because you are capable does not mean you need to say yes to every request. Taking on a role where you are supporting others can be stressful. In order to avoid burnout, it's important to learn how to identify and manage stress. It is okay to say no and take necessary steps to ensure your own self-care. Remember that "no" is a complete sentence.

Our boundaries are always changing:

Our boundaries are fluid and may change day-to-day or hour-to-hour. It is important to check in with ourselves because one day we may be uncomfortable with giving a hug, but we may feel totally fine with hugs the next day. Our relationship with people will affect how and when we set a boundary. Our comfort levels can also change on a day-to-day basis. It's okay to change a boundary as long as we are clear and authentic with ourselves and others.

Using "I" Messages[11]

Use "I" not "you" language
Example leader sentences:
When I'm....
When I....
I think that I....
I feel that I....

Refer to the behaviour, not the person
Example leader sentences:
When I'm shouted at I....
When I'm sworn at I....
When I'm pushed around I....
When I think I'm not being heard I....

State how the behaviour affects you
Example leader sentences:
I feel unappreciated when....
My concern is that....
I get really anxious when....
I get really scared when....
I feel hurt when....
I feel tired when....

State what you need to happen
Example leader sentences:
I need to....
I would like....
What I'd like to see happen is....
It would be nice if....

How to put it Together

1. Start by identifying how you feel.

I feel ____

2. State the reason you feel this way or what happened that led you to those feelings.

When ____

3. Try to identify the reason the person's actions led to those feelings for you.

Because ____

4. Let the person know what you want instead.

I would like ____

7a

Module 7a: Mental Health

What to Expect

Module 7a gives a brief overview of what to consider as a mentor when supporting someone who has a mental health diagnosis or is experiencing a mental health concern because of their physical illness. This module will give an overview on how to recognize signs and symptoms and how to support a peer who is struggling with their mental health.

Concepts Covered:

- Mental Health Continuum.
- Mental Health Concerns and What Helps:
    - depression;
    - anxiety;
    - loneliness and social supports.
- Trauma Informed Practice.
- Loss and Grieving.
- Stress and Mindfulness.

Mental Health Continuum[1]

What is mental health?

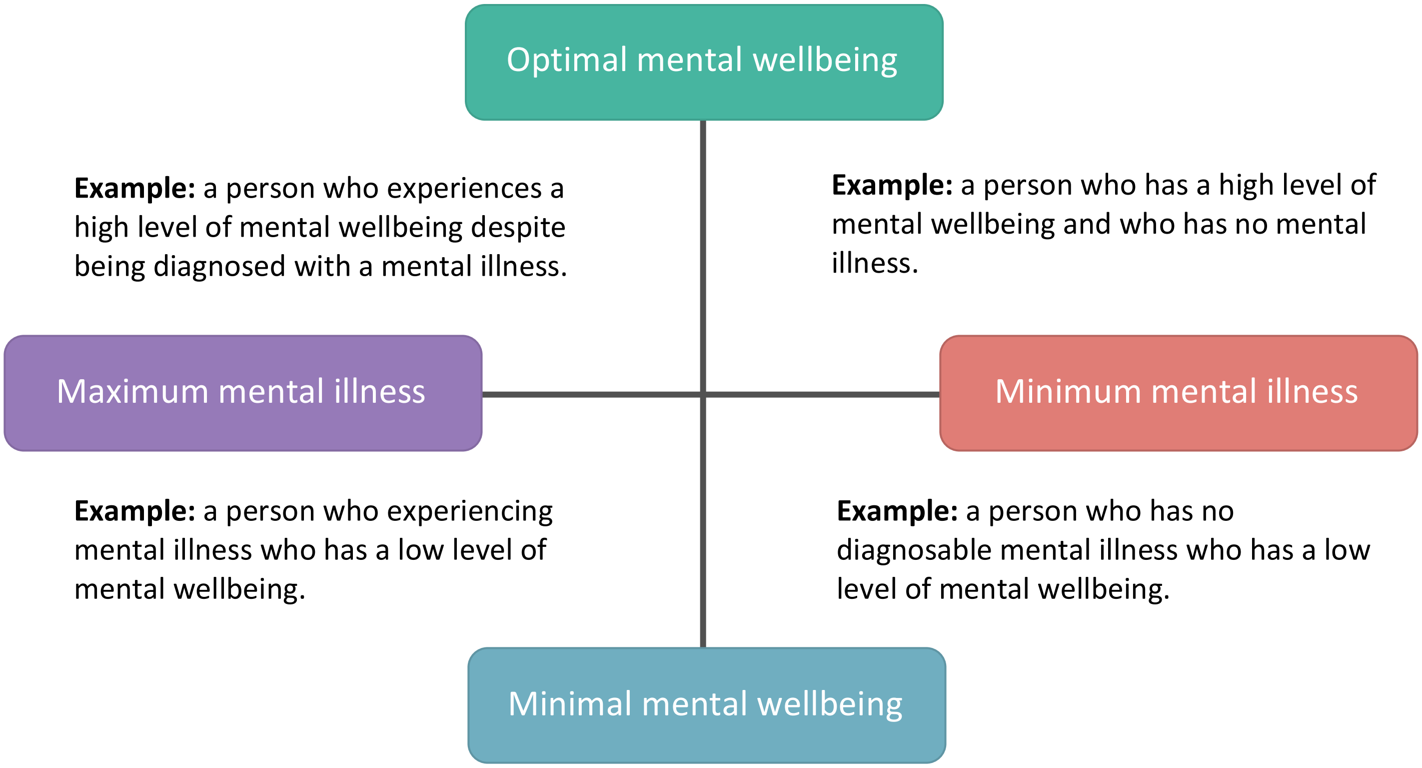
Just as our lives and circumstances continually change, so do our moods, thoughts, and our sense of well-being. It’s natural to feel off-balance sometimes. We have all experienced feeling sad, worried, scared or suspicious but these kinds of feelings may become a problem if they get in the way of our daily lives over a long period. When there are changes in a person’s thinking, mood, and behaviour that cause a lot of distress and make it difficult to do daily tasks, that person may have a mental health challenge.

Who is affected by mental health challenges?

According to the Canadian Mental Health Association [CMHA] (2017), 20% of Canadians will experience a mental illness, which can affect people at any age, socioeconomic status, or education level. It is also likely that people will know someone with a mental illness and will experience the effects of it through family, friends, or colleagues.

Continuum of Mental Health

We all fit somewhere on this continuum. This image illustrates that sometimes we can have a mental illness diagnosis, but be very mentally healthy. There are also folks without a diagnosis who have minimal mental wellbeing for a variety of different reasons. Where we are on this continuum can change day-to-day, week-to-week, and year-to-year, depending on what is happening on our lives.



Example: a person who experiences a high level of mental wellbeing despite being diagnosed with a mental illness.

Example: a person who has a high level of mental wellbeing and who has no mental illness.

Example: a person who experiencing mental illness who has a low level of mental wellbeing.

Example: a person who has no diagnosable mental illness who has a low level of mental wellbeing.

Trauma Informed Practice[21]

What is Trauma?

Trauma is defined as an experience that overwhelms an individual's capacity to cope. Whether it is experienced early in life or later in life trauma can be devastating. Traumatic experiences can interfere with a person's sense of safety, self and self-efficacy, as well as the ability to regulate emotions and navigate relationships. People who have experienced trauma commonly feel terror, shame, helplessness and powerlessness.

Trauma-informed Approaches

A key aspect of trauma-informed practice is understanding how trauma can be experienced differently by refugees, people with developmental disabilities, women, men, children and youth, Aboriginal peoples and other populations. Of note is the increasing understanding of the impact of historical and intergenerational trauma for Aboriginal peoples in Canada and the implications for trauma-informed care for Aboriginal peoples.

Key Principles:

1. **Trauma awareness:** building awareness of how common trauma is; how its impact can be central to one's development; the wide range of adaptations people make to cope and survive; and the relationship of trauma with substance use, physical health and mental health concerns.

2. **Emphasis on safety and trustworthiness**: Physical and emotional safety for peers is key because trauma survivors often feel unsafe, are likely to have experienced boundary violations and abuse of power, and may be in unsafe relationships. Safety and trustworthiness are established through activities such as: welcoming; exploring and adapting the physical space; providing clear information about the role and boundaries; honesty and maintaining trust.

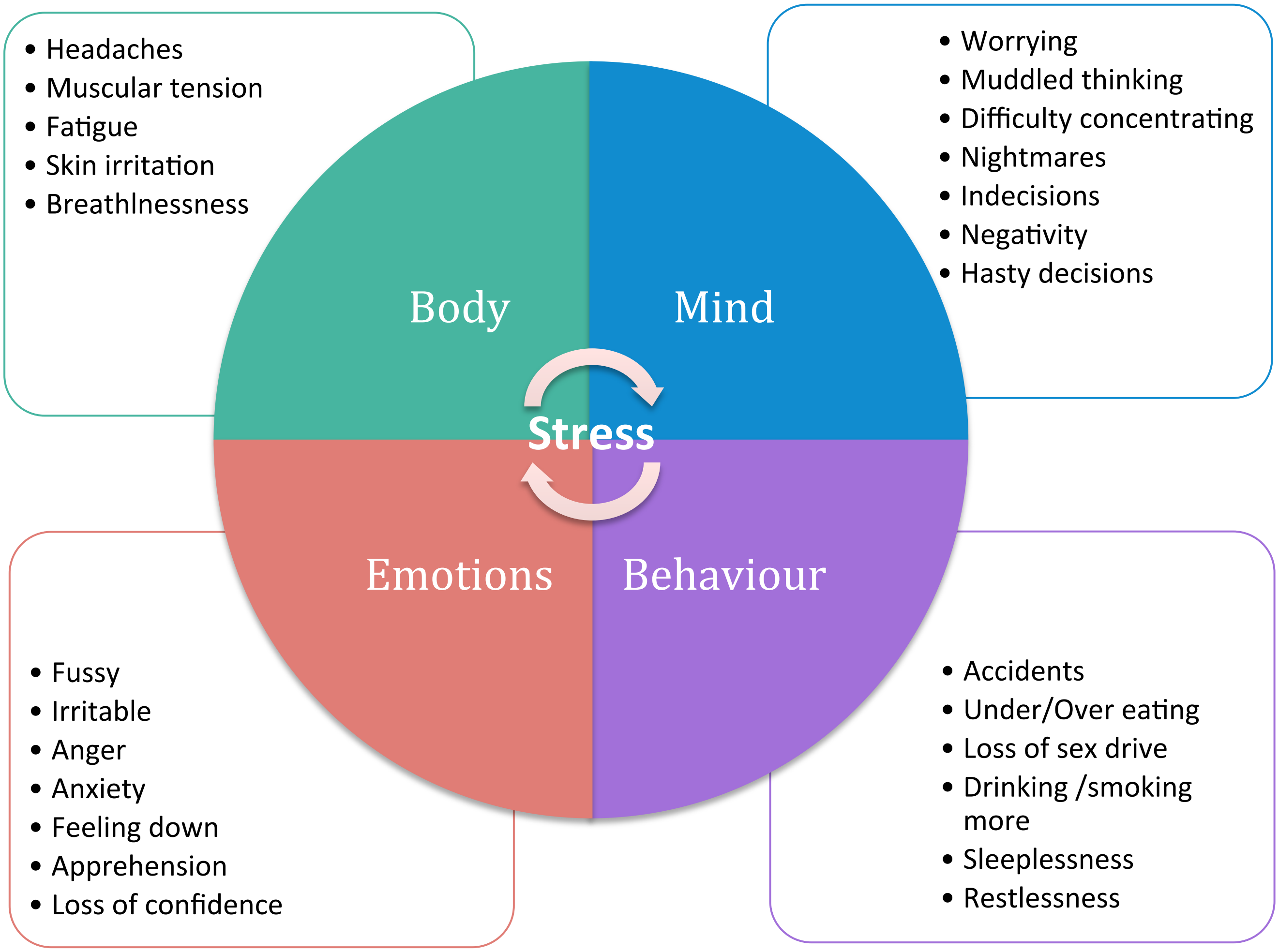
3. **Opportunity for choice, collaboration and connection:** Creating a safe environment that fosters a peer's sense of efficacy, self-determination, dignity and personal control. Mentors should try to communicate openly, equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices, and work collaboratively.

4. **Strengths-based and skill building:** Mentors can assist to identify their peer's strengths and to further develop their resiliency and coping skills. Emphasis is placed on educating and modeling skills for recognizing triggers, calming, centering and staying present.

Self-care and Trauma Informed Practice:

The needs of the mentors are also considered within a trauma-informed approach. Education and support related to vicarious trauma is a key component. Many people have experienced trauma themselves and may be triggered by a peer's responses and behaviour. It's important to be aware of your own triggers, and have supports as well as a self-care plan set up to avoid burnout.

Change in life is unavoidable and we can experience stress even if it's a positive change. People can vary within their tolerance of change. As a peer mentor, it is important to validate the peer's expression of stress as well as recognize when you are personally affected by stress.



Stress

Body

- Headaches
- Muscular tension
- Fatigue
- Skin irritation
- Breathlnessness

Mind

- Worrying
- Muddled thinking
- Difficulty concentrating
- Nightmares
- Indecisions
- Negativity
- Hasty decisions

Emotions

- Fussy
- Irritable
- Anger
- Anxiety
- Feeling down
- Apprehension
- Loss of confidence

Behaviour

- Accidents
- Under/Over eating
- Loss of sex drive
- Drinking /smoking more
- Sleeplessness
- Restlessness

Graphic adapted from: http://www.atokamassagetherapy.com/how-stress-affects-the-body/

Some strategies to manage stress using emotional resillience[22]:

1. **Focus on what you can control, not what's out of your control**. Be solution focused, not problem-focused.

2. **Use events as learning experiences**. Be flexible and open-minded.

3. **Alter your perceptions**. Don't try to change others, practice mindful and rational thinking to try and prevent negativity from taking over.

4. **Limit the hostility factor.** The negativity and anger we harbor for others is more destructive to the one who harbors the resentment.

5. **Strive for goodness, not perfection.** Give up the need to be right and limit defensiveness. Forgive – both yourself and others, accept limitations and let go of "shoulds".

6. **Develop compassion**. Choose kindness over being right. Resist the need to be critical.

7. **Develop good self-care habits.** Allow yourself "mental health breaks" and take care of needs in your mind, body, and spirit. Eat well, exercise, and get enough sleep, pamper yourself, set limits, prioritize, and delegate.

8. **Don't isolate yourself, connect.** Seek to understand – not to only be understood.

9. **Look for the humor in things.** Try not to take all things too seriously. Accept that life doesn't always turn out how we hoped.

10. **Develop mindfulness.** Learn to live in the present, avoid ruminating on events, which can't be changed.

Module 7b: Substance Use

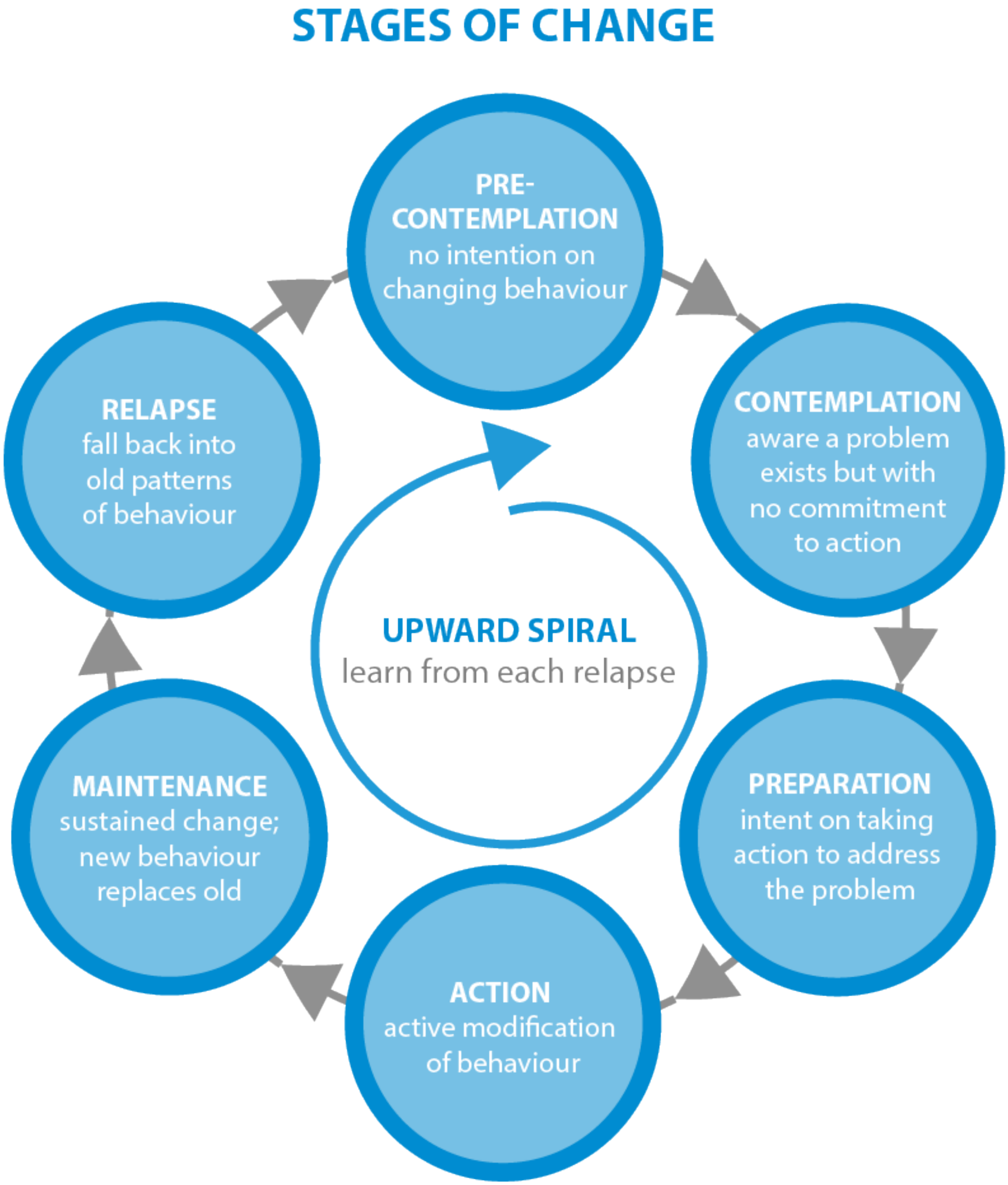
What to Expect

Module 7B will give participants an opportunity to recognize their own attitudes and experiences around addiction as well as how to recognize signs and symptoms and effectively respond to and support a peer who may be struggling with substance use.

Concepts covered:

- Perceptions of addiction and substance use.
- Recognizing and responding to substance use problems.
- Stages of change.
- Harm Reduction.

Stages of Change

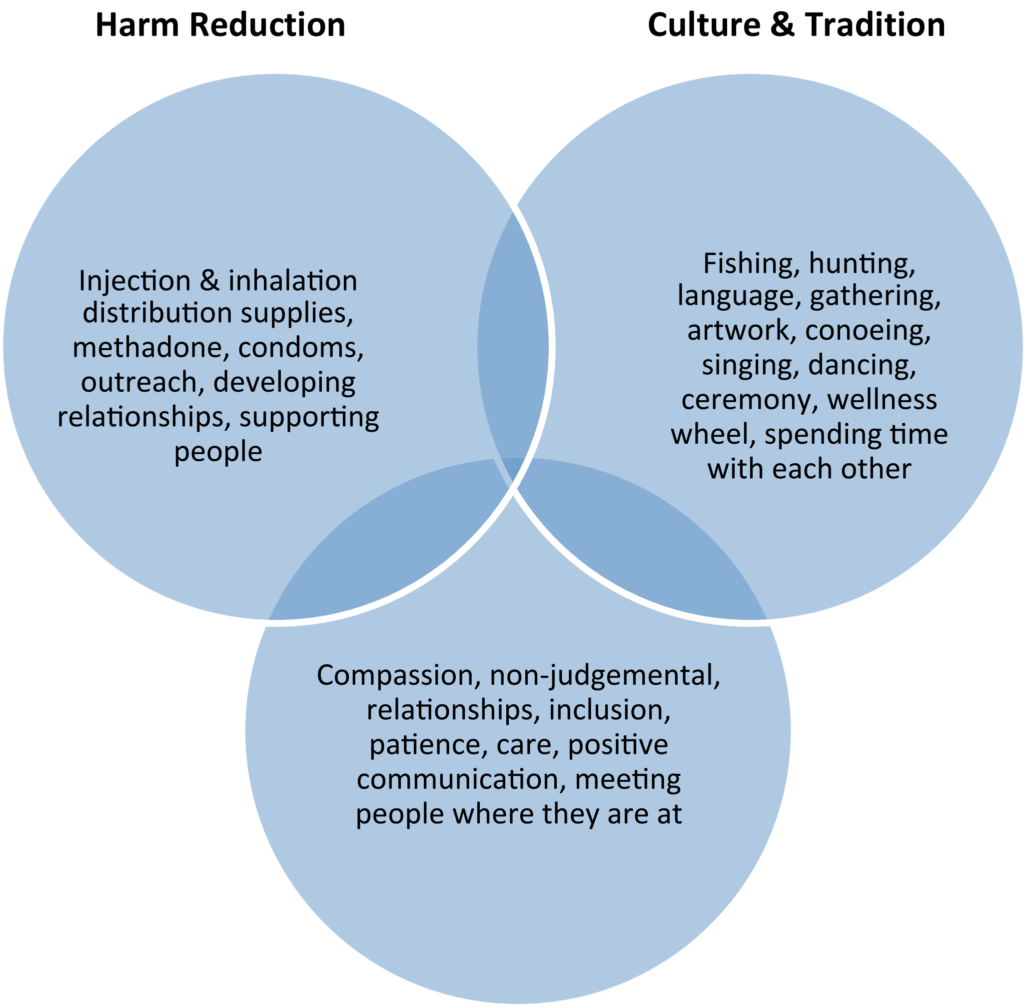


Graphic from: http://homelesshub.ca/sites/default/files/CH-graphics-stagesofchange.png.pagespeed.ce.XVU4farYsj.png

Stages of Change	How to support
Pre-Contemplation	• Validate their feelings and choices. • Remove personal judgements/opinions.
Contemplation	• Help evaluate pros and cons.
Preparation	• Encourage them to explore options. • Offer information/resources if requested. • Help identify supports. • Encourage small steps.
Action	• Support them in whatever resource/step they chose. • Validate feelings and needs. • Continue offering emotional support.
Maintenance	• Help plan for follow up support. • Discuss coping with triggers.
Relapse	• Discuss getting help again if they want. • Encourage learning from the experience. • Help plan stronger coping mechanisms. • Ensure your peer understands that tolerance is lowered after a period of non-use so the risk of overdoes increases.

STAGES OF CHANGE	WHAT HAPPENED	WHAT HELPED
PRE-CONTEMPLATION		
CONTEMPLATION		
PREPARATION		
ACTION		
MAINTENANCE		
RELAPSE		

Harm Reduction[23]



Indigenous Principles of Healing and Harm Reduction

Relationships & Care	Strength & Protection	Knowledge & Wisdom	Identity & Transformation
Healing requires working together as one heart and one mind.	Healing is embedded in culture and tradition.	Healing requires time, patience, and reflection.	Healing involves finding out who you are and accepting who you were.

Module 8: Crisis Situations

What to Expect

Module 8 reviews what to do if a crisis situation emerges while engaging with a peer. Crisis can hit at any time and affects everyone differently. This module will equip the participants with the skills necessary to respond to a crisis in a way that is effective and safe.

Concepts covered:

- Responding to a crisis:
  - supporting a peer through a crisis;
  - de-escalation.
- Suicide prevention.

Responding to a Crisis

What is crisis? A time of intense difficulty, trouble or danger.

Steps to responding to a crisis:

1. Engagement

- Acknowledge the crisis and that you are there to help in whatever way you can; ask for permission first.
- Reassure them that they are not alone.
- Confidentiality: think about level of privacy/distraction.
- Invite the person to sit.
- Maintain a calm presence.

2. Creating Safety and Comfort

- Reduces distress.
- Ensure physical comfort is achieved.
- Practical assistance (e.g. available resources).
- Assess and ensure immediate safety for you and peer (environment).
- Seek medical attention in cases where the peer is unresponsive to communication or there is threat to self or others.

3. Stabilization

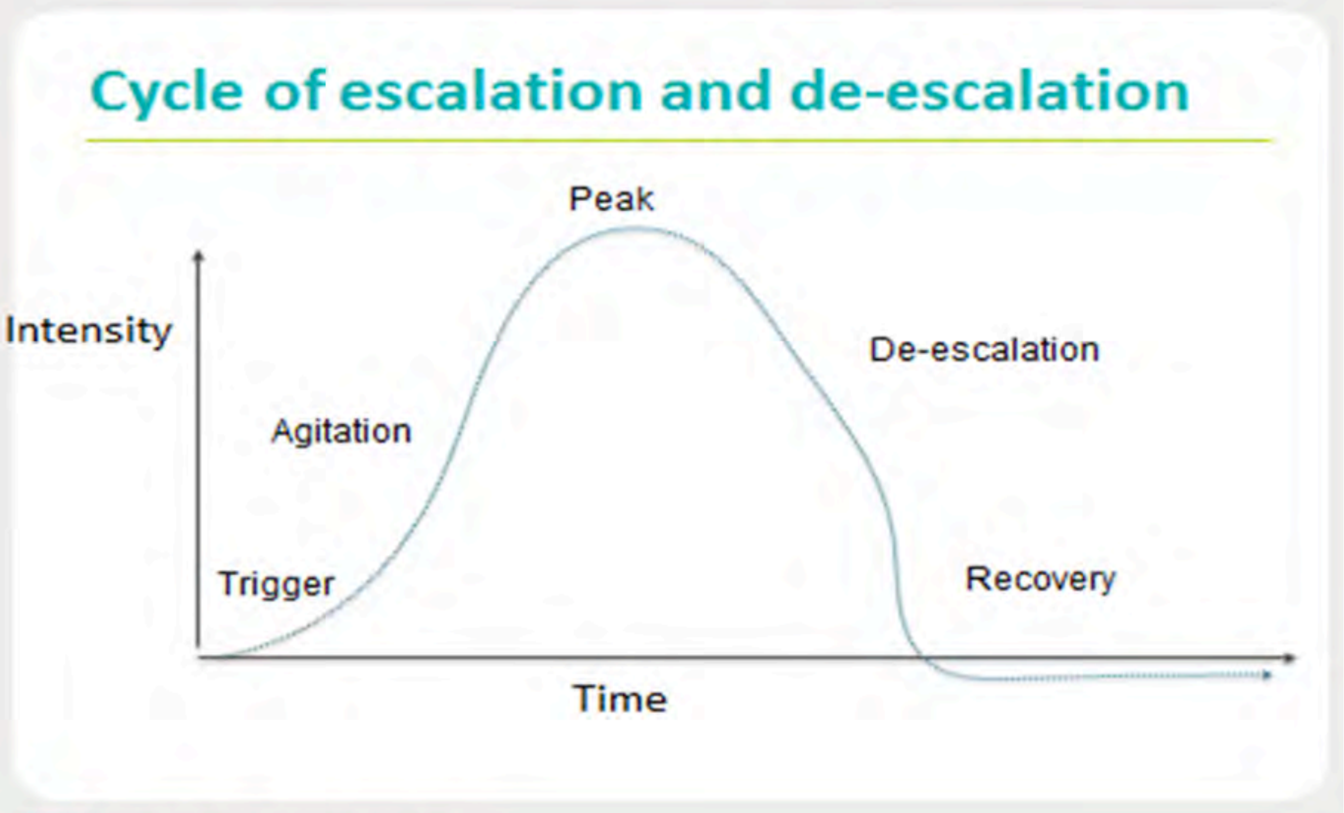
- Individuals may be in a heightened state of distress, disoriented and overwhelmed. You may notice strong emotional responses such as uncontrollable crying or hyperventilation or physical responses such as shaking and trembling. Avoid telling a person to calm down; it won't help, it will agitate them further.
- Normalize and validate their experience.
- Find out what they need. Ask, what would be most helpful for you in this moment?
- Give them time, be available and attentive and show empathy.
- Providing grounding and breathing techniques can be helpful.

4. Information on Coping

- Explore self-care.
- Connection with support system (friends, family, physician, counselor, etc.).
- Adequate rest, nutrition and exercise.

5. Referrals & Resources

- Identify needs and connect to referrals and additional services.
- Plan for follow-up, safe journey home and any further help/questions.



What is de-escalation?

De-escalation is about reducing the emotional intensity of a person, NOT about solving a problem.

What helps de-escalate a situation?

- Patience.
- Work with the person, help them to calm themselves.
- Act calm, even if you don't feel calm.
- Intervene as early as possible, notice warning signs in the trigger and agitation stage.
- Recognize and reflect unmet needs, you may not be able to meet the need but you can acknowledge and validate it.
- Avoid telling the person to calm down.
- Don't take it personally.
- Give the person space to exit the room.
- Practice active listening, especially in the peak stage.
- If you need to set limits, do so in a calm and firm manner.
- Your safety is most important. You can't help anyone if you are hurt. Leave a situation when de-escalation does not work and/or when you start to feel unsafe.
- Discuss next steps once they are in the de-escalation and recovery phase.

Suicide Prevention[24]

"About 4,000 Canadians die by suicide every year. No matter the age of the person or the circumstances surrounding their death, each life lost to suicide painfully and forever alters that person's family, friends and community. **The good news is that suicide can often be prevented.** You don't need to be a healthcare professional to know the warning signs and start an open conversation about suicide."[24]

Who is most at risk?

- The most at-risk group for suicide is men in their 40s and 50s, and men over the age of 80.
- While women are three to four times more likely to attempt suicide than men, men are three times more likely to die by suicide than women. Men tend to use more immediately lethal means and are much less likely to reach out for help.
- Suicide is the second-most common cause of death among young people.
- First Nations, Inuit and LGBT people have higher rates of suicide-related behaviours.
- Up to 90% of people who take their own lives are believed to have substance use problems or a mental illness such as depression or anxiety—whether diagnosed or not—at the time of their suicide.

What are some known risk factors for suicide?

- Having attempted suicide before.
- A family history of suicidal behavior.
- A serious physical or mental illness.
- Problems with drugs or alcohol.
- A major loss, such as the death of a loved one, unemployment, or divorce.
- Major life changes or transitions.
- Social isolation or lack of a support network.
- Family violence.
- Access to the means of suicide.

What can I do to prevent suicide?

- Learn the signs that someone might be considering suicide.
- Learn how to ask someone if you think they are considering suicide.
- Learn how to connect a person at risk of suicide to supports and resources.

What to look for?

A useful tool that outlines key points of what to look for spells "IS PATH WARM":

- **I** Ideation: thinking about suicide.
- **S** Substance use: problems with drugs or alcohol.
- **P** Purposelessness: feeling like there is no purpose in life or reason for living.
- **A** Anxiety: feeling intense anxiety or feeling overwhelmed and unable to cope.
- **T** Trapped: feeling trapped or feeling like there is no way out of a situation.
- **H** Hopelessness or Helplessness: feeling no hope for the future, feeling like things will never get better.
- **W** Withdrawal: avoiding family, friends or activities.
- **A** Anger: feeling unreasonable anger.
- **R** Recklessness: engaging in risky or harmful activities normally avoided.
- **M** Mood change: a significant change in mood.

It's okay to ask:

If someone is displaying any of these warning signs, it's important to ask directly whether they are considering suicide. Even if you're unsure whether someone is displaying these signs, but you are still worried that they may be considering suicide, it's OK to ask. Asking someone about suicide will not give them the idea—talking about suicide with someone who may be considering it reduces the risk that they may attempt and they may feel relieved to be able to talk about it.

How to ask:

- **Do** ask calmly, clearly and as soon as possible. "Are you thinking of suicide?" is the most clear and direct way to ask.
- **Don't** agree to keep someone's thoughts of suicide a secret, even if you think that breaking confidentiality might make them angry. Your priority is to help them keep safe—you can work other things out later.

If they intend to end their life ask them if they have a plan.

- **Do** take all threats or suicide attempts seriously.
- **Don't** minimize any of the person's feelings or try to debate with them.

If they have a plan to end their life soon, connect with crisis services or supports right away.

- **Do** remove any obvious means of suicide from the immediate vicinity.
- **Don't** do anything to compromise your own safety.
- **Don't** leave them alone until help is provided or the crisis line or emergency responders say that you can leave.

Along with asking, listening without judgement is one of the most helpful things you can do.

- **Do** tell them that they are important and that you care about them.
- **Don't** try to fix their problems—simply listening and being there for them is one of the best interventions anyone can give.

Where to get help:

- If someone is at immediate risk, **Call 911.** Stay with them until the emergency responders arrive.
- If someone is not at immediate risk of suicide, you can still help by pointing them to a life-saving resource or service.
    - Your local crisis line.
    - Encourage them to speak with their doctor or psychiatrist.
    - Schools, workplaces, cultural or community mental health or family support services and faith communities can help someone access supports.
- Talk to your supervisor as soon as possible.

Where to find available courses to help you feel prepared:
safeTALK and ASIST: https://cmha.bc.ca/suicide-awareness-training-workshops/

ASIST safeTALK

9

Module 9: Facilitation Skills and Group Dynamics

What to Expect

Module 9 will review how to be an effective facilitator and teach skills on how to understand and manage group dynamics that will help prepare the participants on how to facilitate peer support groups.

Concepts Covered:

- Setting up group structures.
- Facilitation styles and skills.
- Managing group dynamics.

Setting Up Group Structures and Facilitation Skills[6,11]

Setting Up the Structure of the Group:

1. Beginning/Starting
   - Start the group on time.
   - Welcome the participants.
   - Introduce yourself.
   - Create a safe environment.
   - Discuss the purpose of the group.
   - Set expectations.
   - Introduce your topic.

2. Facilitating the meeting
   - Follow an agenda and stay on task.
   - Keep to the time (for the discussion, breaks and check in).
   - Use visual aids where appropriate (make sure it's all set up and working before group).
   - Be authentic and compassionate.

3. Closing the group
   - End on time (unless the group agrees to go longer).
   - Thank the group for sharing and participating.
   - Provide next steps: dates and times of next meetings, other resources if needed.
   - Provide closing remarks: summarize common themes, key messages and reminders of self-care.
   - Ask for help to clean up.

Skills and Characteristics of an Effective Facilitator:

- Interacts informally with participants before and after the group.
- Emphasizes the value and unique perspective of the participants' voice.
- Be well prepared while remaining flexible.
- Think and act creatively.
- Encourage, empower and respect.
- Keep to time without being driven by it.
- Have patience.
- Show understanding.
- Be accepting and inclusive of everyone's knowledge.
- Be sensitive to the needs of others.
- Willing to learn from mistakes.
- Confidence.
- Good communicator.

The Art of Co-Facilitating:
- Keep a unified front.
- Both partners must be active leaders at all times (one is facilitating, the other is observing the groups response and needs).
- Check in with your co-facilitator before and after the group.
- Lead in a way that brings out your partner’s strengths and supports their challenges.

Facilitating Group Discussion:
- Know your purpose; what do you want the group to get out of the discussion?
- Ask open-ended questions that draw on the group’s experience and knowledge.
- Guide the participants to their own knowledge rather than supplying them with facts.
- Use topics the group can identify with or use as part of their well-being.
- Show the group respect and acknowledge the wealth of experience they bring to the group.
- Have a beginner’s mindset (attitude of openness, eagerness and lack of preconceptions).

Facilitating Small Group Check-In:
- Before group starts, review guidelines.
- Manage time by stating how much time there is in total and for each person to share.
- Try to start with a person (maybe yourself) that you know will respect the time and set the appropriate tone for others.
- Ensure everyone has a chance to share and there is respect for all participants.
- Redirect back to the person who is sharing if there is an interruption.
- If someone is going overtime or requires extra support invite them to check in with the facilitator after group for extra support to allow everyone else a chance to share.

Dealing with Difficult Questions:
- Prepare by familiarizing yourself with concept and key points of your discussion.
- Do not be afraid to say you don’t know the answer.
- Bring it back to the group to see if anyone else knows the answer.
- Give information about additional resources.

Managing Group Dynamics

Silent/Shy:

- Acknowledge contribution.
- Encourage them outside of the group.
- Be patient, hold space for their silence.
- Check for understanding.

Aggressor:

- Confront the behaviour when it happens.
- Reminder of group guidelines.
- Support and reinforce positive behaviour.
- Model non-aggressive alternatives.
- Ask them to leave if necessary.

Dominator:

- Reminder of group guidelines.
- Redirect conversation.
- Call on other people for discussion/limit the number of times they share.
- Give them feedback.
- Look for a place to interrupt, summarize and validate what they shared and redirect to someone else.

Empowering Others:

- Be patient.
- Listen to others and show their opinions are valued.
- Be open to learning from the group so that information sharing is multi-directional.
- Encourage the group to discover solutions for themselves and take responsibility for their own learning and recovery.

Managing Conflict:

- Acknowledge the conflict.
- If its related to the topic, help lead the participants to a place of agreement, encouraging mutual respect.
- If its unrelated to the topic and only involves a few group members, encourage them to resolve the disagreements outside of the group setting.

Module 10a: Living with HIV

This module was written by the Positive Living Society of British Columbia.
Website: https://positivelivingbc.org/

What to Expect

This module is an introduction to living with HIV.

Concepts Covered:

- HIV knowledge.
- Transmission.
- Stages of HIV.
- Understanding how treatment works and the importance of medication adherence to prevent disease progression and transmission.
- HIV as a chronic illness.
- Disclosure.

Materials Needed:

☐ flipchart/whiteboard and markers;
☐ writing materials: pens or pencils;
☐ TV/projector for optional video;
☐ participants guide.

Living with HIV

This module has 8 parts.

Purpose of module: Knowing terminology, understanding how treatment and disease progression interact and developing strategies for disclosing our HIV status are the foundation of HIV knowledge.

Time: This module is 165 minutes not including breaks. You should be able to do it in 3 hours with a 15 minute break.

Activity:

- You, the participants, will present this module. This will give you an opportunity to practice the facilitation skills learned in previous module while also learning foundational HIV knowledge.
- If you would like to use a video provided, ask the facilitator(s) for assistance to set up the necessary equipment ahead of time.

Process:

1. Turn to the handouts in your participant guide starting on page 76

2. You will be assigned a partner (co-facilitator) and 1 or more parts of the module to present.

3. Read through your part(s) of the module, discuss with your partner what the key messages are and come up with a way to present the content to the rest of the participants. Be creative with your facilitation style and method! Some options include:
    - role-plays;
    - poster;
    - group discussion;
    - short activity.

4. You have 30 min to prepare and then the group will come back together. Presentations will start with part 1 and continue on in order to part 8.

5. It is important that all the information about HIV in the module is shared with the group. Facilitators will be listening carefully and will bring up any missing points if needed.

Part 1: Terminology (20 minutes)

HIV stands for:

Human **Immunodeficiency** **Virus**

Human

- HIV only affects humans.
- It impacts humans' immune systems – the systems that help our bodies fight infection.
- HIV is a virus, meaning an infectious agent.
- HIV is only transmitted from human to human.
- HIV needs the human body to survive and does not live outside the body.

Immunodeficiency

- Immuno refers to our immune system.
- Immune system is made up of many parts including the white blood cells, the cells that HIV attaches itself to in order to replicate itself.
- Deficiency means that something is lacking or not working properly.
- As the virus replicates itself, white blood cells are destroyed.

Virus

- Microscopic agents capable of infecting living things.
- Viruses require a host cell in order to survive and reproduce.
- This is different from bacteria and fungus, which can reproduce on their own.
- In the case of HIV, since human blood cells cannot live outside the body, neither can HIV.

Things that can kill HIV

In the case of HIV, there are four things that can kill the virus:

- air,
- heat,
- bleach,
- stomach acid.

Unfortunately, due to their own harmful side effects, none of these things can be used to kill HIV inside the body.

Symptoms of HIV infection

- Many people experience no symptoms.
- Some people experience flu like symptoms 2 to 12 weeks after infection, commonly: fever, sore throat, tiredness or lack of energy, swollen lymph nodes, aching joints and muscles, skin rash.
- In this acute infection stage it can be very easy to transmit the virus to others.

AIDS stands for:

Acquired **Immune** **Deficiency** **Syndrome:**

Acquired

- Acquired means to "get" something. AIDS is not an illness that is inherited genetically or occurs spontaneously.
- In order for a person to become infected with HIV, something active has to happen to physically pass the virus on from one person to another.
- Now more commonly referred to as "Advanced HIV".

Immune

- Immune refers to the body's natural defence system against disease and infection.

Deficiency

- Deficiency means the immune system isn't working as well as it should be to fight off disease and infection.

Syndrome

- A syndrome is a collection of symptoms or illnesses that describe a particular condition.
- For example, If the syndrome is a cold, then the symptoms might include:
  - coughing,
  - sneezing,
  - congestion,
  - fever.
- In the case of AIDS, these illnesses are called opportunistic infections.
- Opportunistic infections take advantage of the body's weakened immune system, often leading to very serious health problems.

An AIDS diagnosis is given

- when a person tests HIV-positive AND
- CD 4 count is below 200 AND
- experiences one or more opportunistic infections or indicator diseases such as: candidiasis of bronchi, trachea, or lungs (thrush), pneumocystis jiroveci pneumonia (PCP/PJP), kaposis sarcoma (KS), mycobacterium avium complex (MAC).
- This indicates that the infected person's immune system has become weak enough for them to become susceptible to serious illness.

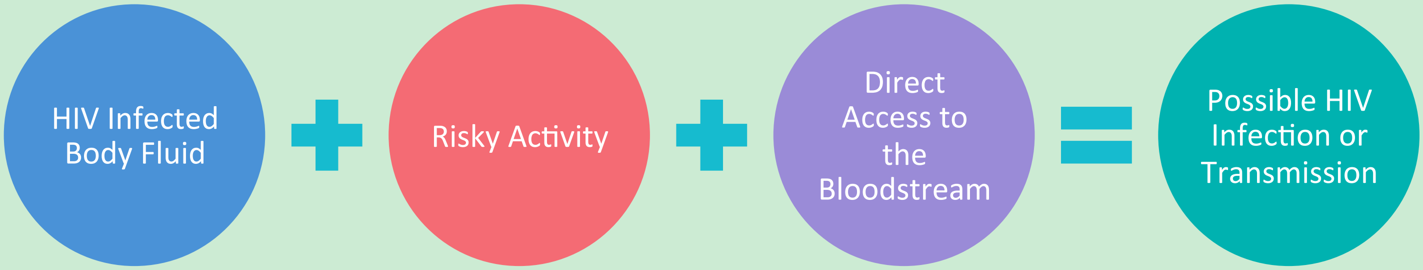
Blood work

- We monitor our immune system's health by doing a blood test to determine our *viral load*, *CD4 count* and other markers effecting the liver and kidneys.

Part 2: Transmission Equation (20 minutes)

Ask your participants: How is HIV Transmitted?

The easiest way to remember how HIV is transmitted is to think of it as an **HIV Transmission Equation:**



- Blood/menstrual blood.
- Semen/pre-cum.
- Vaginal fluid.
- Breastmilk.

- Unprotected sex (vaginal or anal).
- Reusing injection supplies.
- Sharing sex toys.
- Breastfeeding.

- Through vagina, penis or anus.
- Through cuts, tears or sores.
- Reusing injection supplies.

You need at least one piece from all three parts of the equation together to transmit the virus.
Example: Semen + unprotected vaginal sex + through the vagina = possible transmission

Part 3: Preventing Transmission

The medical response**,** also known as **Treatment as Prevention** refers to the use of antiretroviral therapy (ARVs) to stop the spread of HIV. The Centre for Excellence in HIV in BC pioneered the idea that if someone is undetectable they are unable to transmit the HIV virus. The Terence Higgins Trust coined the phrase below as a marketing tool to educate the general public about treatment as prevention.

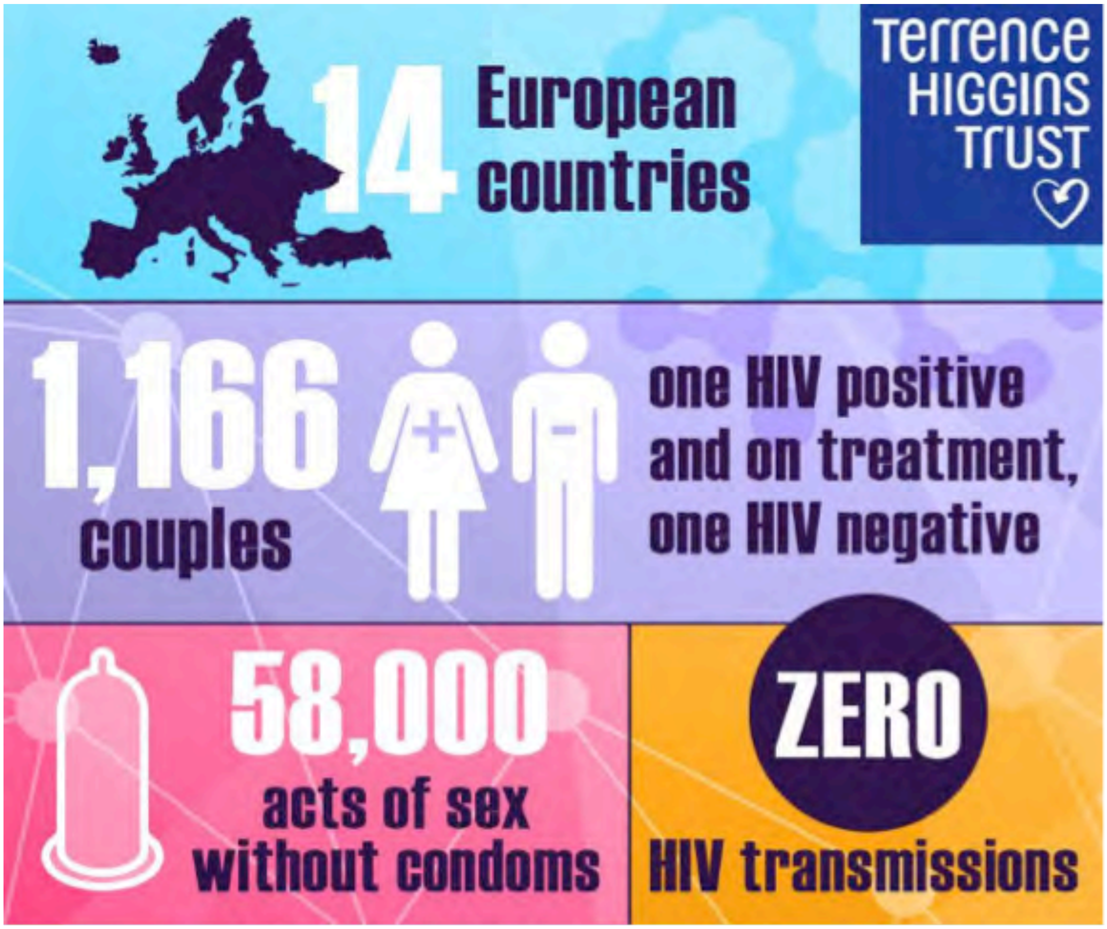
Undetectable = Un-infectious
U = U

This image has become very successful in the HIV community. It needs to be recognized more in the non-HIV community to be more successful.

This new knowledge is the culmination of a number of studies. Chief among them is the landmark PARTNERS Study that followed over a thousand couples where one partner was HIV- and the other was HIV+ with stable undetectable viral load for five years. All couples had previously reached the mutual decision that the risk was acceptable to them and were already having condom-less sex prior to the start of the study. Other studies followed which corroborated the PARTNERS study.

None of these studies found any cases of transmission.

Here is the Terence Higgins Trust poster that summarizes the PARTNERS study:



Pre-exposure prophylaxis (or PrEP) is when people at very high risk for getting HIV take HIV medicines daily to lower their chances of getting infected. PrEP can stop HIV from taking hold and spreading throughout your body. It is highly effective for preventing HIV if used as prescribed, but it is much less effective when not taken consistently. Studies in the UK and Australia have shown a marked decrease in new HIV diagnosis in gay men because of this prevention tool.

Daily PrEP reduces the risk of getting HIV from sex by more than 90%. Among people who inject drugs, it reduces the risk by more than 70%. Your risk of getting HIV from sex can be even lower if you combine PrEP with condoms and other prevention methods. PrEP is not universally available in BC. Health advocates are working to change this. Some people are eligible for a recent research study using PrEP from the Centre for Excellence in HIV here in BC. Some people have started underground vectors to get the medication at a lower cost in the U.S. Health Initiative for Men (checkhimout.ca) can provide more information.

Behavioral Prevention Strategies:
Harm Reduction and its use in preventing HIV transmission:

- Condom use when possible.
- Sero-sorting – only having sex with other people who have HIV.
- Strategic positioning –For men who have sex with men, risk is reduced if the person who has HIV is in the receptive position and the person who does not have HIV is the inserter.
- STI testing – It is believed most new cases of HIV are because someone did not know they were HIV positive, would not be on ARVs and therefore would be highly infectious.
- Viral Suppression with ARV – see above **Treatment as Prevention** at the beginning of Part 3.
- Don't share needles – bleaching the interior of the rig is not an effective solution, as it does not clear Hep C.

New cases of HIV in the intravenous drug community have gone down compared to new transmission rates in the gay community. This is attributed to:

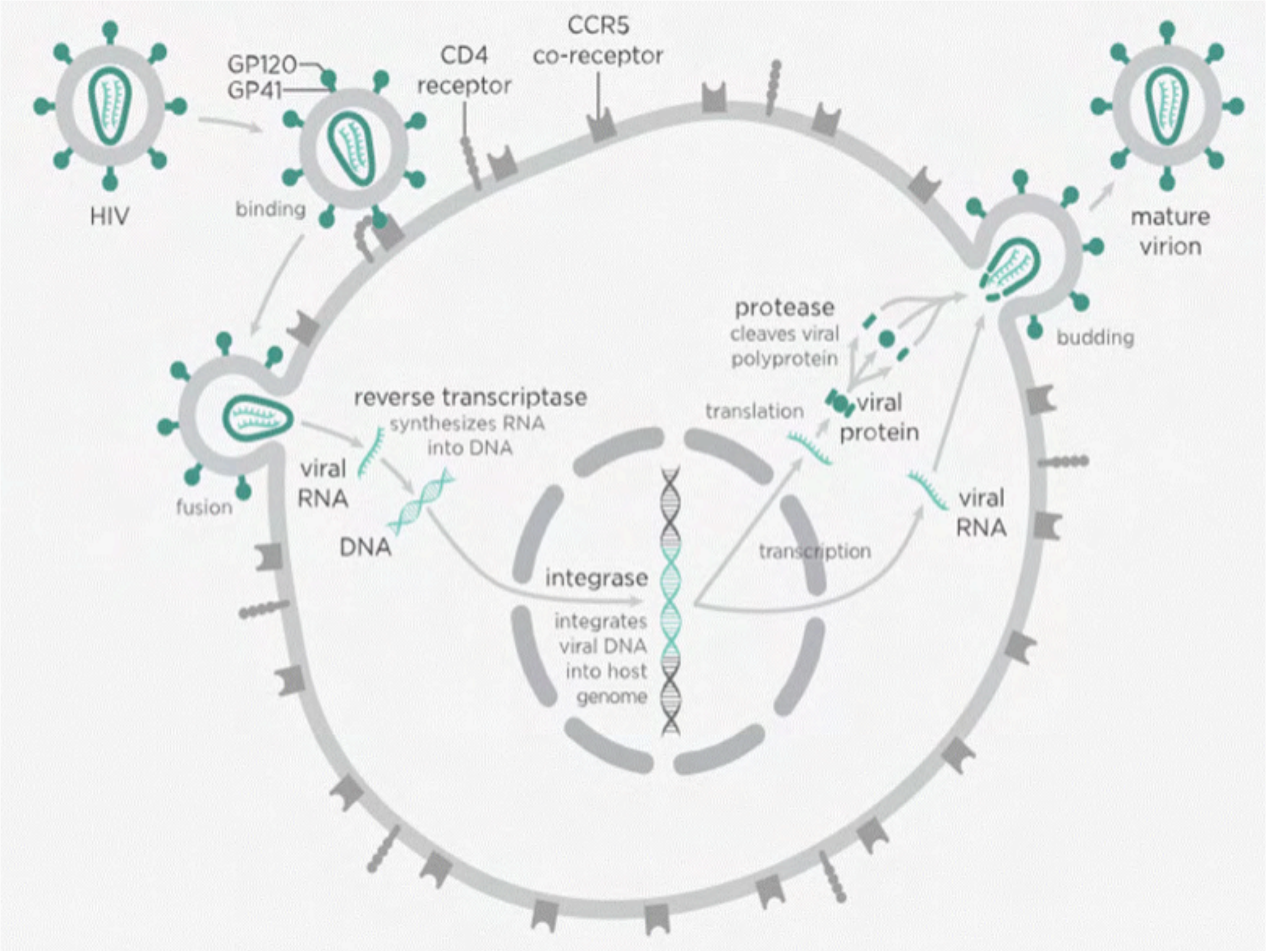
- Needle Exchange.
- Safe Injection Space - Safe injection sites promote access to clean needles, help promote adherence to ARVs and provide overdose safety. The cases of people who use intravenous drugs reaching undetectable viral levels has not increased due to the struggle to stay adherent to ARVs.

Part 4: Life Cycle of HIV

- HIV virus uses your body's own infection-fighting-cells as a mini factory by co-opting the CD4 T-Cell to replicate.
- If unchecked, HIV can replicate millions of copies in a short amount of time.

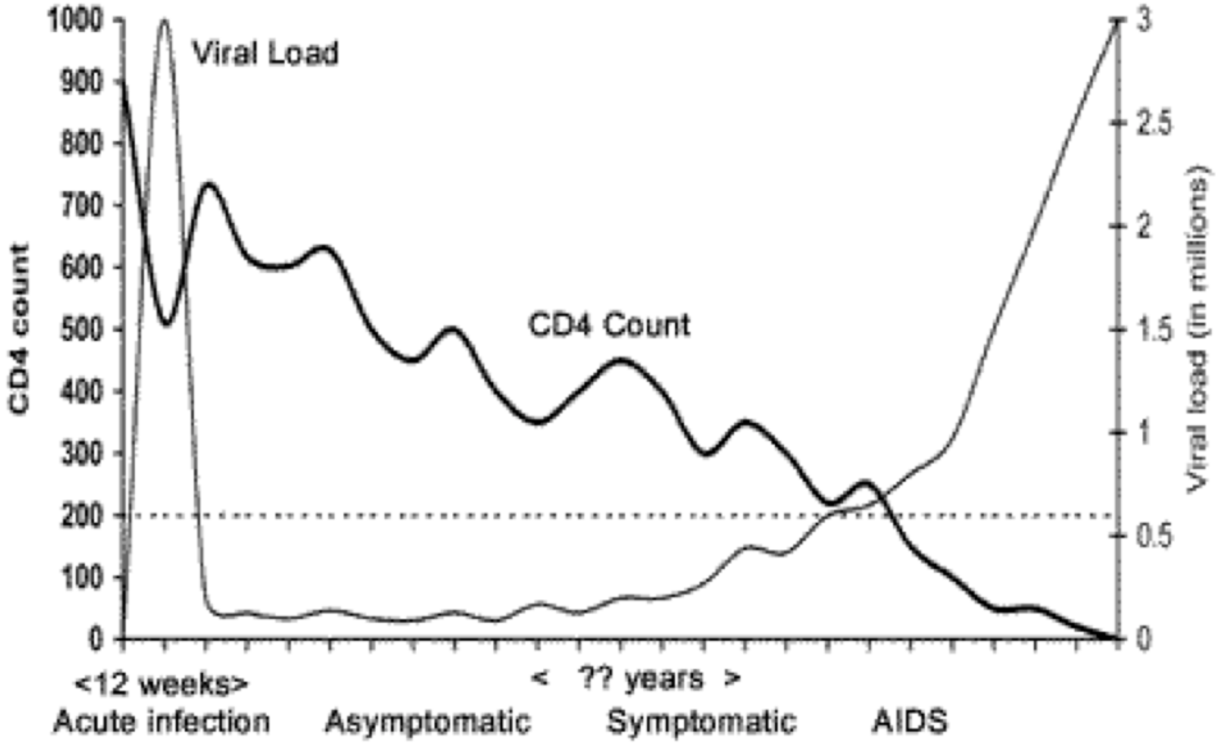
The virus attaches itself to the CD4 cell, called **binding**. It then dumps its internal contents into the CD4 cell, called **fusion**, where it then **synthesizes** the viral RNA with the cell DNA strand. The new DNA strand **integrates** itself into the cell's DNA genome. Viral proteins are added to the mix, called **protease**. Finally, the newly created HIV virus ejects itself from the corrupted host CD4, called **budding**. This new virus moves through the blood stream seeking new CD4s to corrupt while the old CD4 has now become a virus-producing factory creating new viruses at a rapid rate.

Don't get too caught up in the terminology here. The important take away is that the virus enters the CD4 cell, hijacks the CD4 cell and produces more viruses. ARVs stop this process, but it requires at least 3 types of medications. Once people understand how their medications are working, they are more likely to stay adherent.



Part 5: Disease Progression (20 minutes)

Disease progression describes the cascading stages the body's immune system goes through when not on HIV medication.



Seroconversion (acute infection stage): After the initial infection the body develops antibodies to fight the virus, this process is called seroconversion. Following seroconversion the infection goes into an asymptomatic phase and may remain stable for many years.

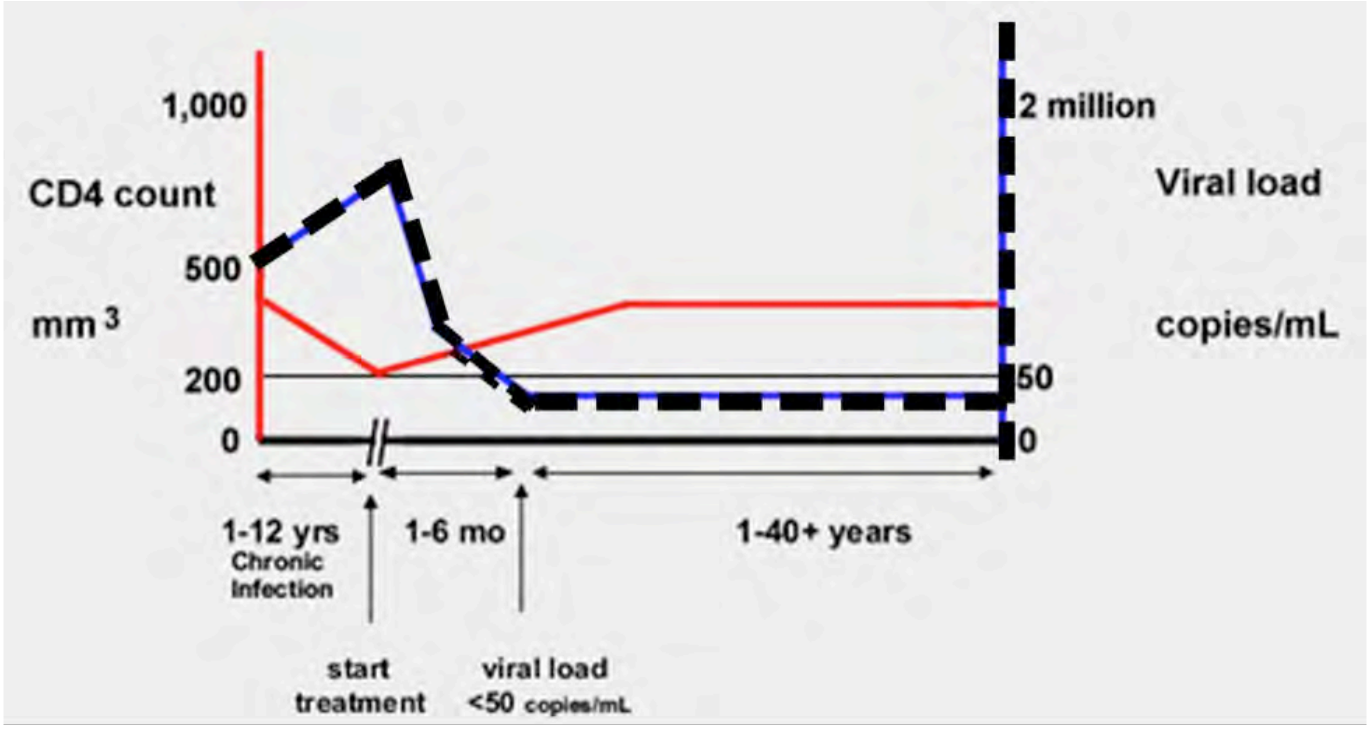
- **Asymptomatic Period:** An HIV+ person is not experiencing any physical symptoms or negative health impacts as a direct result of their HIV infection.
- **Symptomatic Period:** Eventually a person living with HIV will start to experience symptoms related to their HIV infection. Not the same as **opportunistic infections**, but rather are indications that the immune system is weakening and having a harder time fighting off the HIV virus.
- **Advanced HIV or AIDS Diagnosis:** The body's immune system is severely compromised. It's not able to fight opportunistic infections (even mild ones). Depending on length of infection over years and lifestyle, without treatment the majority of cases will eventually lead to the collapse of the immune system and death.

Part 6: HIV Medications & HIV Medication Classes

- HIV Drugs are referred to as antiretrovirals (**ARVs**).
- Requires a combination of 3 or more drugs combined often in 1 or 2 pills.
- Each anti-HIV medication belongs to a class of drugs. Each class attacks HIV, itself, at a particular point within **the lifecycle of the virus**. Currently there are 6 classes of drugs approved with many drugs in each class.

CD4 and Viral Load with ARVs

This graph shows the opposite effect from the previous graph because the person is on ARVs. The viral load is suppressed and the CD4s are holding steady. There is no disease progression happening.



When to start therapy in treatment-naïve individuals
(BC Centre for Excellence HIV Therapeutic Guidelines 2015)

- Patient readiness should be carefully considered and optimized.
- ARVs should be offered on an immediate basis during the acute phase of primary HIV infection, regardless of symptoms or CD4 cell count.
- The HIV-infected member of a **serodiscordant** couple needs ARVs to prevent transmission to the HIV-uninfected partner. **Serodiscordant** means one person has HIV and the other person does not.

HIV Drug Side Effects

- Everyone's experience is different.
- If they occur, generally in the first few weeks.
- More common side effects are insomnia, nausea, lack of energy, gas, diarrhea.
- Often resolve in a few weeks.
- Report symptoms that are not improving to your pharmacist or doctor, occasionally severe drug side effects can occur.

Adherence

- HIV drugs must be taken exactly as prescribed:
  - the right amount,
  - at the right time,
  - in the right way.
- More than **90% adherence** required or drug resistance and/or treatment failure can occur
- If you discover you are having trouble taking your medications, many supports and strategies are available; ask your care team, you don't have to do it alone.

Comparing the image of someone not on ARVs with the image of someone on ARVs side by side, along with the undetectable = un-infectious information and the Life Cycle of the Virus image has proven to be a highly effective way to convince people to go on ARVs and stay adherent.

What is Drug Resistance?

A reduction in the ability of a drug – or combination of drugs – to block HIV reproduction in the body.

Avoiding Drug Resistance

- Tell you your doctor if you miss doses or develop side effects.
- Monitor your blood work, CD4 count and viral load.
- Tell your pharmacist about other supplements you are taking (some can interfere with your ARVs).

Part 7: HIV as a chronic illness: a reframed perspective for people newly diagnosed with HIV

- **Discussion** (*The purpose of this question is to show by experience that everyone's experiences have similarities and differences. Keep the sharing short). What was it like for you to be diagnosed with HIV?*

Presentation:
Getting an HIV diagnosis and living with HIV is experienced differently for each person. A person's HIV status is a hugely important part of their experience. At times it feels like it sets them apart as a person.
Living with HIV can be divided into 3 generations or cohorts.

Generation #1: Before 1996

People were diagnosed with HIV, but mostly AIDS before 1996. Back then, for many, an AIDS diagnosis was a death sentence. Back then, the Gay community experienced an unprecedented number of deaths in a short period of time resulting in an overall cultural trauma and increased stigma. AIDS was the common term used as little was known about the difference between HIV and AIDS at the time.

Generation #2: After 1996

A few people who were diagnosed with HIV before 1996 were able to hang on and get triple combinations of antiretroviral (ARV) medications. The group also includes people who became HIV positive before the year 2000. Adhering to the medication regimes was difficult as the ARVs were complicated to take, toxic and had many side effects including organ damage and physical changes to the body.

Our primary role was to avoid death. For many, AIDS and AIDS activism became their whole identity, almost like a political ideology or a religion. Many of these people experienced long term post traumatic stress syndrome. Today, this group are ageing. We are beginning to see new health complications due to the toxicity of old medications or treatment interruptions that allowed the virus to do more damage.

Generation #3: After 2006

Around 2006 medications became easier to take as they were less toxic, had fewer side effects and could be taken in one or two pill combinations per day. This was a remarkable breakthrough for the HIV community. Now, multiple studies show that antiretroviral therapy has significantly changed the life expectancy of HIV positive individuals. People newly diagnosed with HIV today have every reason to live a long and active life. Although treatments have improved, stigma has not, making HIV disclosure still difficult.

HIV is now considered an "episodic disability". In Canada we define HIV disease as a lifelong, treatable episodic disability, especially for newly diagnosed people who have access to HIV treatments and care.

It is episodic because:

- Periods of good health may be interrupted by periods of illness or disability.
- Often it is difficult to predict when these episodes of disability will occur and/or how long they will last.

It is only a disability when:

- the disease interferes with meaningful, active living.

Having HIV in your body likely means that you might have to take "rest stops" to deal with your symptoms.

Part 8: Disclosure

Knowing how to talk to others about our HIV status is important. Our health information is personal and, in most situations, remains private unless we choose to talk about it. For people living with HIV (PLHIV), this choice can be complex. Being open about living with HIV helps people get the care and support they need. However, the idea of someone knowing about their HIV status can also be dangerous, scary or stressful. The purpose of this section is to help you help others with the disclosure process.

There is no easy way to disclose. The following matrix tool will help guide you and the person you are helping through the disclosure process. People who have completed this matrix and discussed the feelings that come up when doing this matrix have found it to be helpful. Work from left to right first, doing one row at a time. As the process rolls out, people may change their minds about where they put someone in each box. Let them change their mind. It is part of the process.

Pair up and practice this with each other. You don't have to do it all.

Starting a Conversation About Disclosure

	Will Tell?	Might Tell?	Will Not Tell?	Should Tell?	Have to Tell?
Who will I tell?	Mom Sister Friend	Grandparent	Grandparent	Dentist	Sexual Partners
Why this person?					
Where will I tell them?					
When will I tell them?					
What I can do if it doesn't go how I want it to?					

The following are some additional tips to think about. By no means do they cover everything. Talking to a Peer Mentor, a Peer Navigator or Social Worker can help you with this process.

How you give the news is important:

- If you give the news as bad news, that is how it will be received.
- Be informed about what living with HIV is and isn't.
- Try to be hopeful when you tell someone (the medication is better now; I'm going to live as long as I would have if I were HIV-; it's hard to pass on the virus if I'm on HIV medication).
- Try to tell people who have been supportive to you in the past. If, in the past, your parent has not been supportive of you when you shared other parts of your life, HIV is not going to make them suddenly be a different person.

Make sure you are in a safe space (whatever that looks like for you):

- Are you at home?
- Are you in a public place?
- Are you alone or with someone supportive?

Tell a close friend first to see how they respond to the news. This also will give you a supportive person on your side when you start to tell others. Some PLHIV find it helpful to tell two people who know each other. This creates a closed circle of support that gives those who know about your HIV status someone to talk to while still respecting your privacy.

- It may be easier to have a friend with you when you tell others.
- If the disclosure doesn't go well, you will have someone with you that you trust and feel safe with to support you.

Say it out loud in a support group first as practice.

- Meeting with and talking with other people who are HIV positive can be helpful because you can see how other people live with HIV.
- You get to hear what your own voice sounds like when you say it for the first time.
- You can get support.
- You can ask questions.
- You won't feel alone.

Dating and Intimate Relationships

Disclosing your HIV status to current or potential sexual partners is complicated, with different personal, practical, and legal considerations depending on the nature of your relationship (e.g. casual or committed). There is no perfect time for revealing your HIV status, but leaving some space between the act of disclosure and negotiating safer sex (or drug use) allows everyone more time to process their feelings and consider their options. This can be especially important when alcohol and drugs are involved, as substance use can impact a person's ability to make informed decisions or consent to sex.

Criminalization of HIV Non-Disclosure

- *This section provides a brief overview of the applicable Canadian laws on HIV transmission and/or exposure. For more detailed information and a resource kit, go to:* http://www.aidslaw.ca/site/hiv-disclosure-and-the-law-a-resource-kit-for-service-providers/?lang=en *or online to* CATIE at http://www.catie.ca/en/practical-guides/hiv-disclosure *(A legal guide for gay men in Canada).*

With regularity, people living with HIV continue to be criminally prosecuted and convicted for not disclosing their HIV-positive status to sexual partners. As of December 2015, more than 180 people in Canada had been charged for not disclosing their status. Until the law catches up with science (see the PARTNER study mentioned in Part 3) and is changed, criminalization is a reality that the community must live with and respond to despite the confusing contradictions of science and law.

2012 Mabior Legal Decision said people with HIV:

- Must disclose in situation posing a 'realistic possibility' of transmission.
- Decision only for vaginal, heterosexual sex. However, we should assume this applies to anal and oral sex as well.
- Must disclose in situations posing a 'realistic possibility' of transmission.
    - They did not define what a "realistic possibility" is.
- To not disclose, the person must have an undetectable or low (under 200 copies) viral load **AND** a condom must be used.
    - Decision based on vaginal, heterosexual sex. Therefore, any cases involving non-disclosure of HIV and anal or oral sex will have to be tried through the courts as a new case. Worst-case scenario would be a judge who disapproves of anal sex making a new decision (precedence) even more restrictive for anal sex. However, legal experts have advised us that anal sex would likely be treated the same as vaginal sex and disclosure.

- Charges:
  - If someone gets convicted of HIV non-disclosure the charge is aggravated sexual assault.
  - Carries a penalty up to life in prison.
  - Must register as a sex offender for the rest of their life.
  - People can still be charged even if transmission does not occur – 30% = no transmission.
  - If it comes down to a debate whether disclosure happened, the courts tend to side on the side of the complainant.

Negative Implications of this legal decision:

- People who are not living with HIV may make the false assumption the criminal law protects them from getting HIV.
- The onus of disclosure is on the PLHIV.
- No definition of what is 'valid proof' of HIV status.
- People may think the police and public health are working together, therefore people may be fearful to seek out testing or information on HIV/AIDS.
- People living with HIV can be prosecuted for non-disclosure even if they had no intent to harm their partner.

Telling Young Children is Different than Telling an Adult

While some people fear being rejected because of their HIV status, others may legitimately fear for the safety of their children. Often children struggle with family privacy. However, children learn about sex and diseases of any kind in stages best attuned to the developmental stages of their age. It can be helpful to talk to someone who works with children to get some guidance on when and how to tell children.

Work and School

You do not have to disclose your HIV status in your work place or at school unless it is a condition of your Professional Body. If it is a requirement of your Professional Body, check with them first to determine the correct way to tell your employer.

Module 10b: Hepatitis C (HCV) 101

This module was written by the Pacific Hepatitis C Network. Website: http://www.pacifichepc.org/

What to Expect

This module will review hepatitis C basics, what it is, how it is (and isn't) transmitted, what it does in the body and how to stay healthy and get treatment.

Concepts Covered

- What is Hep C?
- Transmission risks and prevention.
- Screening and diagnosis.
- Living with Hep C.
- Treatment and cure.
- Resources and support.

HCV/Hep C Module Pre-Session Test

1. Is there a vaccine to prevent Hep C?

- ☐ Yes
- ☐ No
- ☐ I don't know

2. How is hepatitis C passed?

- ☐ Through sweat, saliva or urine
- ☐ By blood-to-blood contact
- ☐ By air (e.g., coughing, sneezing)
- ☐ I don't know

3. Do most people have symptoms when they first get hepatitis C?

- ☐ Yes
- ☐ No
- ☐ I don't know

4. What blood test(s) will tell you if you have ever been exposed to Hep C?

- ☐ Hepatitis C antibody test
- ☐ Hepatitis C virus test (PCR, RNA)
- ☐ Both of the above tests are needed
- ☐ I don't know

5. If someone has hepatitis C, how often should they see a provider?

- ☐ Every month
- ☐ Every 6-12 months
- ☐ Every 2 years
- ☐ I don't know

6. What can alcohol do to the liver?

- ☐ Nothing
- ☐ Clean the liver
- ☐ Speed up liver damage
- ☐ I don't know

7. What is the goal of Hep C treatment?

- ☐ To stop liver damage
- ☐ Prevent transmission
- ☐ Get rid of the virus (cure)
- ☐ I don't know

Total: _____ / 7

The Liver (“hepat”)

A Liver Lesson

Did you know that the liver:

- Stores vitamins and minerals
- Is about the size of a football
- Is the only organ able to regenerate itself
- Secretes bile to help digest food
- Produces plasma proteins essential for blood clotting
- Helps the body resist infection
- Removes waste from the blood
- Is located in the upper right quadrant of the abdomen

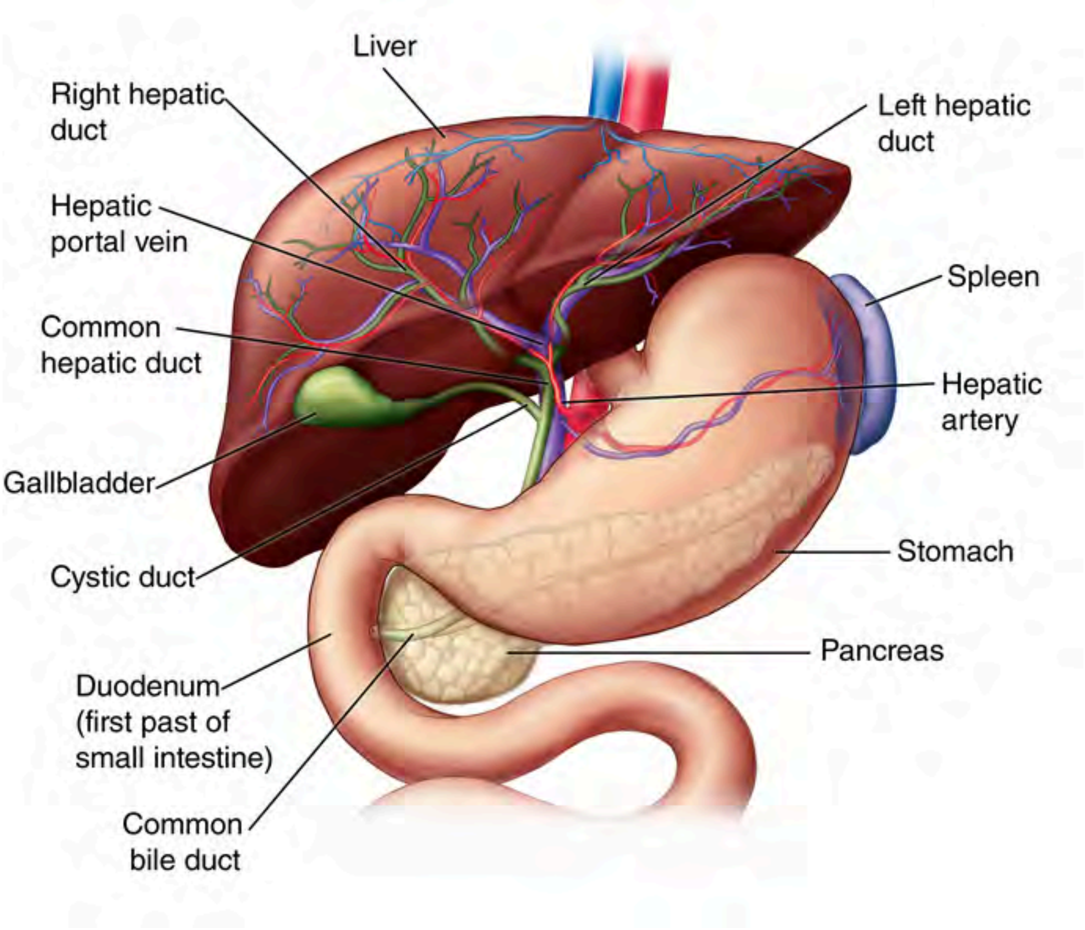


Image from Johns Hopkins Medicine: https://www.hopkinsmedicine.org/healthlibrary/conditions/liver_biliary_and_pancreatic_disorders/liver_anatomy_and_functions_85,P00676

What is Hepatitis?

Hepat = liver
itis = inflammation

Inflammation of the liver – **hepatitis** – can be caused by too much alcohol, poor diet, drug toxicity and viral infections that target the liver.

Viral hepatitis is inflammation of the liver caused by a virus.

3 Main Types of Viral Hepatitis	**Transmission Through**
Hepatitis A*	Fecal-oral
Hepatitis B*	Sexual fluids, blood-blood
Hepatitis C	Blood-blood

*vaccine preventable; there is NO vaccine for Hep C.

What is Hepatitis C?

- Hepatitis C is a virus that, over time, harms and sometimes destroys the liver and can cause additional challenges to overall health and wellness.
- Hepatitis C is spread by blood-to-blood contact—when blood containing the hepatitis C virus gets into the bloodstream of another person.

Symptoms of Hepatitis C:

Early on, most people will have no or few symptoms, but over time, some may experience:

- feeling tired (very tired; exhausted; sleep doesn’t fix);
- muscle or joint pain;
- headaches;
- itchy skin;
- depression.
- anxiety;
- abdominal pain in and around the liver;
- brain fog (having a hard time concentrating and suffering from memory lapses);

Hep C Screening and Diagnosis (Testing)

Hep C *screening* finds HCV antibodies if present.

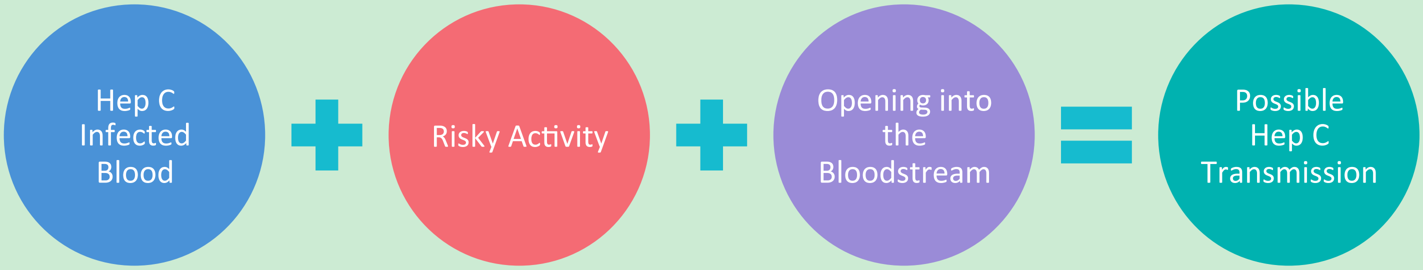
- Positive result means had OR has Hep C (has been 'exposed' to hep C).
- Negative result means have not ever had Hep C virus.
- Doesn't tell if the virus is still present.

Hep C *diagnosis* finds HCV RNA (virus) if present.

- Positive result means person has chronic Hep C (CHC).
  - CAN get liver disease caused by HCV and CAN pass virus along.
- Negative result means person does NOT have chronic Hep C (CHC).
  - CANNOT get liver disease caused by HCV and CANNOT pass virus along.

Hep C Transmission and Prevention

Transmission:



- You can't tell by looking at someone!

- Sharing/reusing injection supplies.
- Needle stick injury.
- Handling blood.
- Unprotected sex.

- Punctures.
- Cuts.
- Tears.
- Open wounds.

Note: The chance of transmitting the virus from mother to baby during pregnancy or birth is approximately 5%. There is no evidence that the method of birth (vaginal vs. caesarian) changes risk of transmission.

Prevention:

Universal Precautions	Harm Reduction
Don't share personal care items (e.g. nail clippers, tooth brushes).	Provide clean supplies.
Proper sterilization always (including tattooing and piercing).	Meet needs and provide accessible services including housing, income, counseling, supports and referrals.
Wear gloves for first aid.	Wear gloves for first aid.

What does Hep C do to the Body?

- Many people have no symptoms when they first get Hep C.
- After 20-30 years living with Hep C, the liver can become scarred.
- You can feel ill even if tests show your liver looks healthy.
- Or, you can feel fine even if your liver has scarring.
- Your doctor and you can monitor how you are feeling and doing over the time you are living with Hep C.

How can you help your liver to stay healthy when you have Hep C?

- Almost everything you eat or drink is handled by your liver. When you have Hep C, your liver may not work as well and you can injure or damage your liver more easily.
- Alcohol makes Hep C worse. Talk to your nurse or doctor about your alcohol use. Ask for help to cut back or stop drinking.
- You don't need a special diet if you have Hep C, but limiting fats and packaged food can help you stay healthy. Talk with a nutritionist about your dietary needs if you have Hep C and especially if you have liver disease.
- Try to exercise (to your ability, not overdoing) regularly.
- Find out what over-the-counter and prescriptions drugs do to your liver. Some supplements can harm the liver. Sometimes different drugs and supplements can do harm when taken together. Talk to your pharmacist about the drugs and supplements you are taking and how to avoid harm.

Should you get regular care for your Hep C?

Yes! Your doctor will do tests to keep track of how your liver is doing.

- Every 12 months if your liver has little or no damage AND you feel fine.
- Every 6 months (or more) if your liver has some damage OR you feel unwell most of the time.

Blood tests

- ALT and AST: liver enzyme tests. Any injury to your liver can cause liver enzymes to rise.
- If your liver enzymes are high 2 times in a row, your doctor will order an imaging test to look at your liver.

Imaging tests

- This could be a biopsy or a fibroscan test.
- These tests will show how much scarring your liver has.
- A score of F0 means no liver scarring and a score of F4 means severe scarring of the liver, also called cirrhosis.

Your doctor should also monitor more often if you have one or more of the following as well as chronic Hep C:

- Co-infection with HIV or hepatitis B virus.
- Post-transplant (liver or other organ).
- Extra-hepatic illness (documentation required).
- Chronic kidney disease (3, 4 or 5 for 3 months).
- Co-existent liver disease.
- Diabetes that requires medication.
- Women who are planning to get pregnant in the next 12 months.

When should you seek treatment?

- This is a personal decision that you make with your physician or specialist.

What is Hep C treatment?

- Current hepatitis C treatments are made up of combinations of drugs called direct-acting antivirals (DAAs).
- DAAs directly target the Hep C virus in different ways to stop it from making copies of itself.
- New DAAs promise treatments with shorter treatment times, much higher cure rates, and fewer side effects.
- Four classes of direct-acting antivirals in various combinations make up different Hep C treatments.

What is the goal of Hep C treatment?

- Hep C treatment has just one goal: to make the virus undetectable in the patient's blood.
    - The liver can no longer be damaged by the Hep C virus.
    - The virus can't be passed along.

- Hep C treatment is a cure!

How do you get treatment?

- Hep C treatment is accessed from BC PharmaCare through an application process.
- An experienced doctor or a specialist must make the application.
- You must have a liver scarring score of F2 or higher or F2 and other conditions that make treatment more urgent (see list of '"other reasons your doctor should monitor more often" above).
- Go to http://www.hepctip.ca/ for further information; see the resources section.

HCV/Hep C Module Post-Session Test

1. Is there a vaccine to prevent Hep C?

- ☐ Yes
- ☐ No
- ☐ I don't know

2. How is hepatitis C passed?

- ☐ Through sweat, saliva or urine
- ☐ By blood-to-blood contact
- ☐ By air (e.g., coughing, sneezing)
- ☐ I don't know

3. Do most people have symptoms when they first get hepatitis C?

- ☐ Yes
- ☐ No
- ☐ I don't know

4. What blood test(s) will tell you if you have ever been exposed to Hep C?

- ☐ Hepatitis C antibody test
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- ☐ Both of the above tests are needed
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5. If someone has hepatitis C, how often should they see a provider?

- ☐ Every month
- ☐ Every 6-12 months
- ☐ Every 2 years
- ☐ I don't know

6. What can alcohol do to the liver?

- ☐ Nothing
- ☐ Clean the liver
- ☐ Speed up liver damage
- ☐ I don't know

7. What is the goal of Hep C treatment?

- ☐ To stop liver damage
- ☐ Prevent transmission
- ☐ Get rid of the virus (cure)
- ☐ I don't know

Total: _____ / 7

Module 11: LGBT2Q+ Peer Support

This module was collaboratively written by the Okanagan Pride Society (http://www.okanaganpride.com/) and Living Positive Resource Centre (http://livingpositive.weebly.com/).

What to Expect

This module emphasizes the importance of creating authentic, supportive and inclusive safer spaces for participants to engage and gain insight. We must ensure the space is mindful and respectful of the diverse voices and lived experience, as well as the social, philosophical, political, religious and global issues impacting the human rights of LGBT2Q+ persons worldwide.

Concepts Covered:

- Introduction.
- History.
- The importance of language.
- Global LGBT2Q+ issues.
- Identity and orientation.

Introduction to LGBT2Q+[A] Peer Support and Education

Gay pride isn’t about celebrating being gay, lesbian, trans or queer, but about our ability to exist without persecution and seeking to bring change via action.

Some key areas of focus to attain this include:

- Understanding the systemic oppression and challenges.
- Creating positive, inclusive and affirming environments and service provision.
- Supporting equal access and fair hiring practices.
- Doing the homework to be an appropriate ally and/or activist.
- Creating trans-positive washrooms and change rooms.
- Addressing issues around name and pronoun changes.
- Supporting an individual who is transitioning.

There is no single route to implementing and sustaining these changes. This module will provide resources and suggestions to assist addressing and preventing discrimination based on sexual orientation, gender identity and gender expression. Gender identity and gender expression are prohibited grounds of discrimination in the *BC Human Rights Code*[B].

It is vitally important that the participants are part of the process of creating the environment for peer support. **First steps include:**

- Recognizing the ongoing oppression LGBT2Q+ people face daily worldwide.
- Creating a Kaupapa[C] or community agreement using strength-based language.
- Providing current and accurate resources and referrals.
- Providing updates as current social climates and human rights shift and change, while being prepared and able to support those distressed, and to celebrate progress and movement.
- Finding neutral meeting spaces identified as LGBT2Q+ inclusive, while avoiding potentially triggering venues such as hospitals or churches.
- Gender neutral washroom facilities.

Affirming environments support people who identify as LGBT2Q+ and allow everyone to bring their most authentic and productive self into an engaging environment. Embracing diversity and cultivating inclusivity creates spaces where human rights and human dignity can thrive and advance in our communities, families, workplaces and policies worldwide.

Understanding the Rainbow

Colour has been used throughout history as a means of identifying gay and queer individuals, from green in Victorian England, purple or lavender representing the lesbian movement and pink and black triangles identifying gay prisoners of war in Nazi concentration camps. The pink and black triangle symbols were reclaimed in the early 1980s as a symbol of surviving oppression.

The first rainbow pride flag was designed by Gilbert Baker in 1978 and following the assassination of Harvey Milk, San Francisco's first openly gay supervisor, the community embraced the flag as a symbol of solidarity in the aftermath of tragedy. The original flag contained 8 stripes (pink, red, orange, yellow, green, blue, indigo and violet); each stripe signifying a strength (sexuality, life, healing, sun, nature, art, harmony and spirit). The pink colour proved too difficult to mass produce and was eliminated along with indigo. The six striped version we use today is recognized by the International Congress of Flag Makers and signifies pride, hope and diversity.

The rainbow is used symbolically in various ways to indicate LGBT2Q+ inclusion and support, such as with parades, crosswalks, stickers, signage and products.

"I love going to cities around the world and seeing the rainbow flag, knowing that it's a safe place where I can be myself." - *Gilbert Baker*

Pride is Political

1,000+ Prides take place internationally every year. Many LGBT2Q+ people experience violence and fear of being caught. Responding to the stigma and isolation faced by our communities helps shape many Pride events as we recognize that many are still facing hatred and discrimination. Whether being outed by media, facing jail time or death sentences, or oppression from hate groups or individuals, it is crucial that our LGBT2Q+ community members have the opportunity to become the politicians of tomorrow and to influence and implement needed policies. This includes getting youth excited and ready to vote and involved in shifting the paradigm of global responsibility with ethical and informed choices.

"Because Pride is about liberation. It's about prioritizing and creating an opportunity for those who are most marginalized in our queer and trans communities to participate. Pride is and should continue to be political." - *QMUNITY news, BC's Queer Resource Centre, July 5, 2017* [D] For more information, visit: https://qmunity.ca/

Critical Dates of Progress [EF]

Since June 2017, The Canadian Human Rights Act and Criminal Code prohibit discrimination based on gender identity or gender expression (bill C-16).

On November 15, 2016, Randy Boissonnault, Liberal MP for Edmonton Centre, was named Special Advisor on LGBT2 issues to the Prime Minister. The role involves protecting LGBT rights in Canada and addressing both present and historical discrimination.

In June 2015, the *Affirming Sexual Orientation and Gender Identity Act* (Bill 77) was made law in the province of Ontario. The act bans conversion therapy on minors and forbids it from being funded under the Ontario Health Insurance Plan[G] public health care for anyone, of any age. As of 2016, other provinces have called for the ban, including Alberta.

Since 2012, transgender identity has been declassified as a mental illness in the new DSM V (diagnostic and statistical manual). However, DSM-IV is still being used across Canada.

In July 2005, the Civil Marriage Act passed, making Canada the fourth country to legalize same-sex marriage nationwide and the first to do so without a residency requirement.

In June 20 1996, the *Canadian Human Rights Act* (CHRA) was amended to include sexual orientation as a protected ground.

Since the 1985 entrenchment of Section 15 of the Charter of Rights and Freedoms, Canadian LGBT people have achieved a range of judicially made gains in most policy areas including immigration, housing, employment, health benefits, adoption, pensions, finances, hate crimes and marriage.

In 1977, Quebec became the first jurisdiction in the world larger than a city or county to prohibit sexual orientation discrimination in the private and public sectors with the Quebec Charter of Rights and Freedoms.

Same-sex sexual activity between consenting adults was decriminalized in 1969 as a result of legislation introduced in 1967 with then-Justice Minister and Attorney General of Canada Pierre Trudeau (who eventually became the 15th Prime Minister of Canada) famously commenting, "there's no place for the state in the bedrooms of the nation".

For more LGBTQ history in Canada visit: http://davievillage.ca/about/lgbtq-history.

The foundation of human rights is human dignity. Inclusion cannot stop at our "queerness". Knowledge is a way forward for inclusion; knowing that there is something that connects us to everyone. This involves challenging the status quo, imagining the future that we want and transforming ourselves to transform the world. Injustice against one is injustice against all.

The Importance of Language [H]

Using respectful and inclusive language is a powerful way to demonstrate a commitment to creating welcoming spaces. It is crucial to provide people with the spaces and opportunities to speak openly and honestly about the terms (such as pronouns) that reflect their identity and then to use those terms accordingly.

Heteronormativity

Heteronormativity refers to the commonplace assumption that all people are heterosexual and that everyone accepts this as "the norm". The term *heteronormativity* is used to describe prejudice against people that are not heterosexual, and is less overt or direct and more widespread or systemic in society, organizations, and institutions. This form of systemic prejudice may even be unintentional and unrecognized by the people or organizations responsible.

"__________"ism

Harmful beliefs, behaviours or institutional practices by a group or person with power directed against specific groups, rationalized by an underlying belief that certain people are superior to others. Examples include: ageism, anti-semitism, audism, cis-sexism, classism, ethnocentrism, heterosexism, racism, sexism, ableism, sizeism.

"__________" phobia

A learned dislike, aversion or an extreme, irrational fear and/or hatred of a particular group of people. It is expressed through beliefs and tactics that devalue, demean and terrorize people. Examples include: biphobia, homophobia, Islamophobia, transphobia, xenophobia and others.

Heterosexism
The assumption that everyone is heterosexual and that heterosexuality is superior and preferable. The result is discrimination against bisexual, lesbian and gay people that is less overt and which may be unintentional and unrecognized by the person or organization responsible for the discrimination.

Cissexism
A system of oppression that considers cis people to be superior to trans people. It includes harmful beliefs that it is “normal” to be cis and “abnormal” to be trans. Examples include scrutinizing the genders of trans people more than those of cis people or defining beauty based on how cis people look.

Allyship and Understanding Privilege
Allyship involves compassion, empathy, active listening, providing support and facilitating frank and upfront discussion. For example, a trans ally will learn about cisgender privileges and maintain an openness and willingness to learn about the drastically different lived experiences a gender non-conforming or trans person faces daily worldwide. The more you know, the more effective an ally you can be. When you witness transphobia and/or heterosexism, being an ally means you say or do something about it (without putting yourself at risk). Oppressions intersect, so you can also address instances of racism, classism and sexism, for instance.

Mental Health and Suicidality

Imagine knowing at a young age that you are different. Imagine that you see your difference contrasted every day in the relationships you grow up around. Imagine that your peers hurl insults defining how you are different. Imagine that the social and cultural institutions inform you that your difference is not acceptable. Imagine that you long to be with others who are also different, but don't have a way to connect with them. [I]

In today's society, coming out about your sexual or gender identity can still be a daunting process as homophobia, transphobia and discrimination are still pervasive within our culture.[J]

Research shows that LGBT people have higher rates of mental health challenges than the general population. LGBT people often struggle with depression, anxiety, trauma and self-acceptance as a result of facing ongoing discrimination over their lifetimes. LGBT youth are about three to four times as likely to attempt suicide as their peers.[K]

Addictions and Substance Use

Research indicates that LGBTQ people use some substances, such as tobacco, alcohol and other drugs, at a rate 2-4 times that of the broader population. LGBTQ substance use must be understood within the context of the stigma, prejudice and discrimination to which LGBTQ people are constantly exposed. *The Centre for Addiction and Mental Health* notes that, "isolation, alienation and discrimination from a homophobic society is stressful" and that escaping from these feelings is one of the main reasons why LGBTQ people use substances.

Substance use is often viewed as a source of harm. While this can be true, it is also important to recognize substance use as a way to reduce harm and suffering in people's lives as well. Use may mitigate emotional or physical pain or it may enable people to socialize with others and find a community of support and acceptance. For this reason, it is important to understand substance use in the context of an individual's social and personal life. This is especially true of LGBTQ people who experience high rates of discrimination and stigma.[L]

LGBT youth report elevated suicide risk and also have high rates of substance use (Marshal et al., 2008; Haas et al., 2010). Elevated suicidal behaviour among LGBT youth has been associated with substance use disorders (Fergusson et al., 2005).[M]

Social Determinants of Health and Wellness

LGBTQ people's identities also extend beyond sexual orientation and gender. They are also members of other social groups, based on status and relationships of race, ability, class, language, place of origin and beliefs. These groups occupy a range of privileged and marginalized locations in society. It is the totality of social identities and social locations that influence people's well-being and affect our health care experiences.

Peer based wellness education programs, such as Mary Ellen Copeland's WRAP® Wellness Recovery Action Plan(www.mentalhealthrecovery.com/) and PeerZone International Peer-Led Workshops (www.peerzone.info/), can provide excellent evidence-based wellness and healing frameworks and support, which have been proven to increase positive health outcomes.

Community networks can also provide timely and specialized support, in the form of youth, gender identity, parent, seniors, education and outreach services. Look for a list in your area, such as Okanagan Pride Society[N] Community page at www.okanaganpride.com / www.kelownapride.com.

Youth Homelessness

150 thousand young people experience homelessness. Trans, non-binary and non-conforming are especially at risk due to the segregated nature of shelters; they are often rejected and face more discrimination and transphobia. Steven Little, of *The 519 Education Team and Senior Manager, Diversity & Inclusion at Scotiabank* in Toronto provided these statistics on LGBT2Q+ Youth Homelessness in 2017.

- 67% self harm
- 25% run away
- 55% housing related difficulty

Vulnerability

- 77% considered suicide
- 45% attempted

Risk decreases 93% with family support

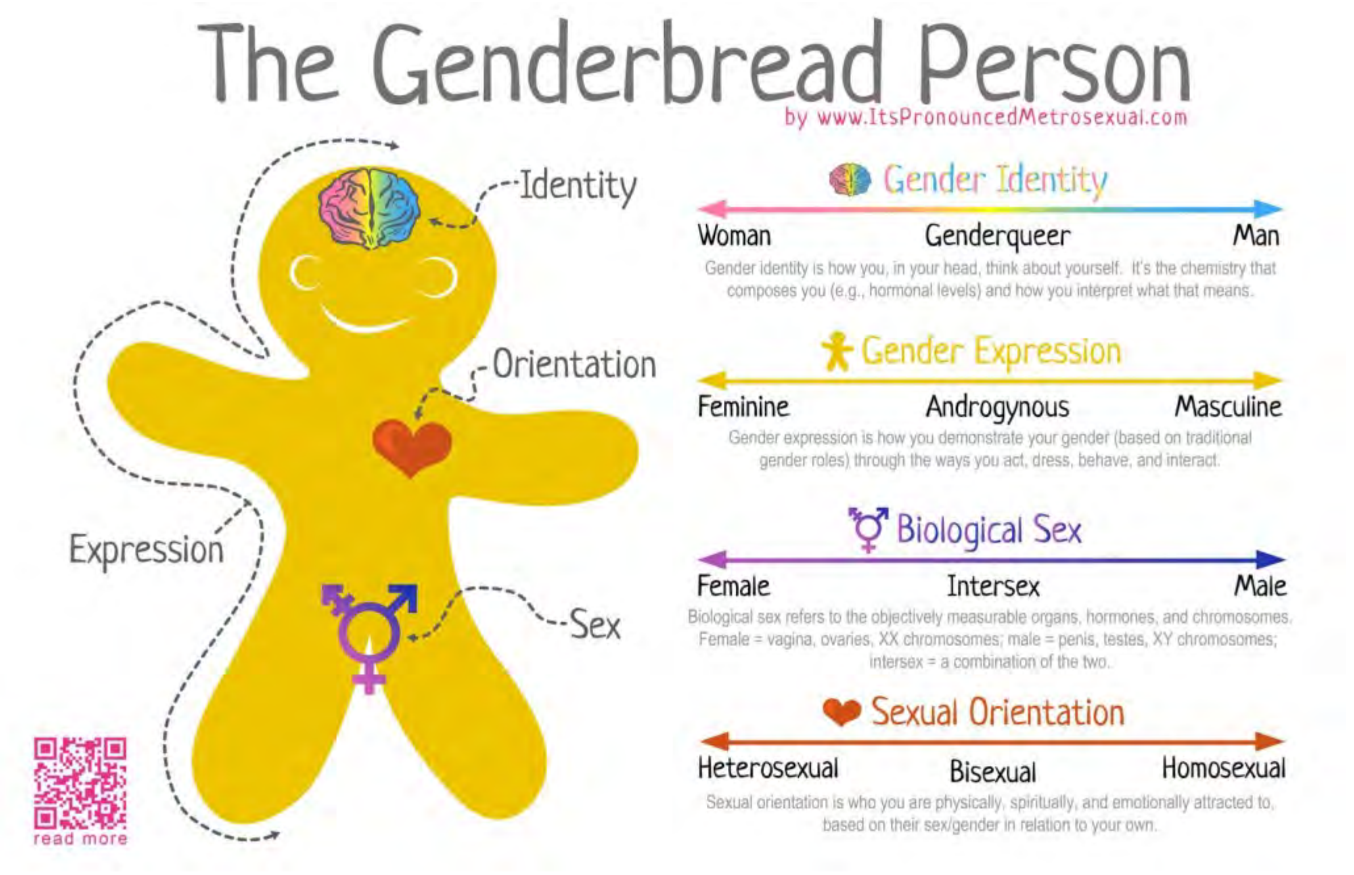
LGBTQ2S young people do not have to become homeless and to experience poverty, despair and fear. We work to advance human rights and to ensure legislation is enacted in a way that creates real safety and inclusion for queer and trans people and where no one experiences isolation, violence or discrimination because of who they are.[O]

Immigration and Refugees

Canada is generally considered to be a "safe" country for sexual minority groups; however, the settlement challenges of LGBT immigrants and refugees are often overlooked. [P]

LGBT2Q+ is the term used by Okanagan Pride Society to describe members of our community, representing Lesbian, Gay, Bisexual, Trans, Two Spirit and Queer, plus other sexual orientations, gender identities and expressions. LGBT is the most widely used term, but letters may be added such as A (asexual, agender), I (intersex), Q (queer, questioning) or may indicate specific groups needing inclusion such as QTIBPOC - Queer, Trans, Indigenous, Black & People of Color.

Sex and Gender – The Genderbread Person[Q]



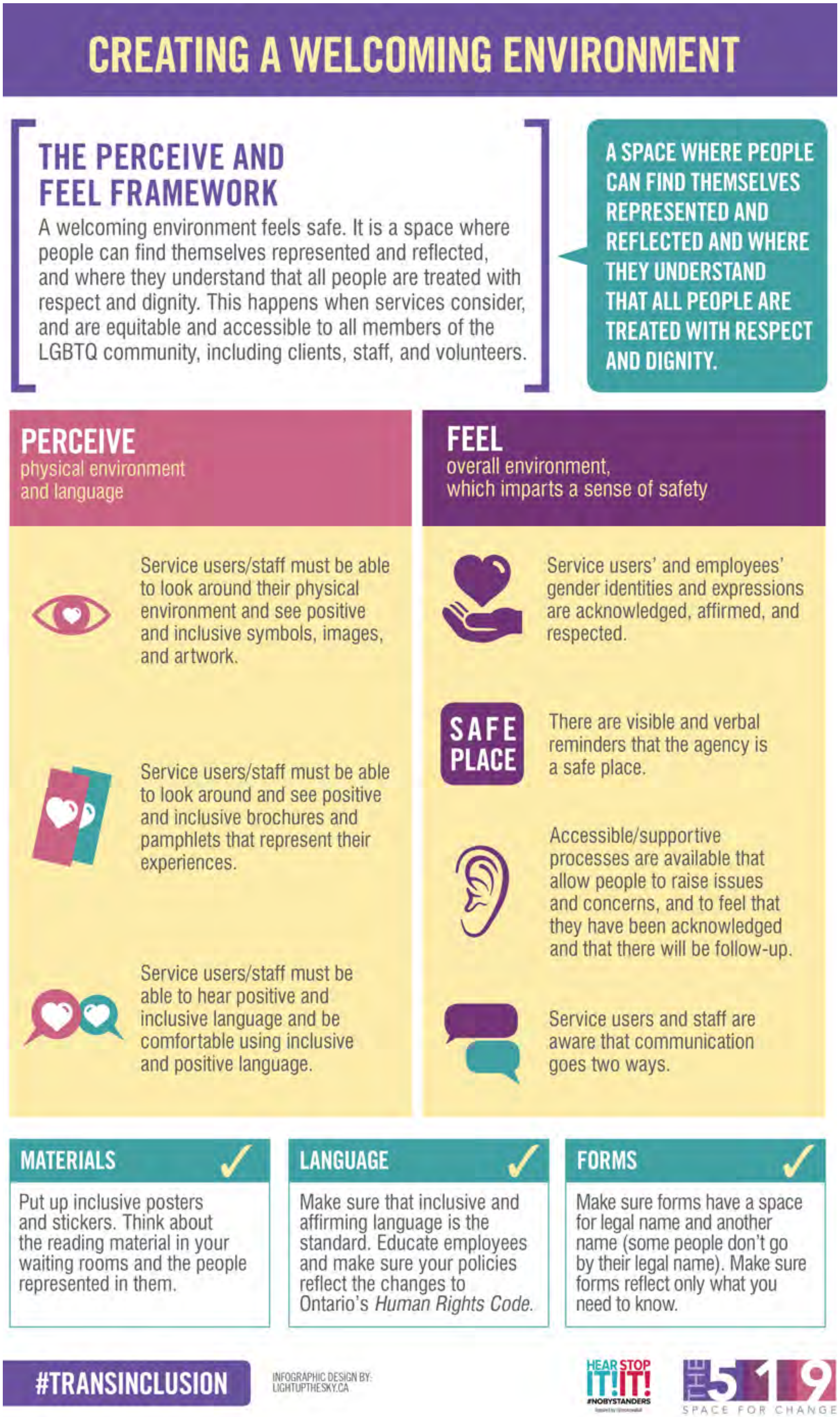
Gender identity is how you, in your head, think about yourself. It's the chemistry that composes you (e.g., hormonal levels) and how you interpret what that means.

Gender expression is how you demonstrate your gender (based on traditional gender roles) through the ways you act, dress, behave, and interact.

Biological sex refers to the objectively measurable organs, hormones, and chromosomes. Female = vagina, ovaries, XX chromosomes; male = penis, testes, XY chromosomes; intersex = a combination of the two.

Sexual orientation is who you are physically, spiritually, and emotionally attracted to, based on their sex/gender in relation to your own.

R



CREATING A WELCOMING ENVIRONMENT

THE PERCEIVE AND FEEL FRAMEWORK

A welcoming environment feels safe. It is a space where people can find themselves represented and reflected, and where they understand that all people are treated with respect and dignity. This happens when services consider, and are equitable and accessible to all members of the LGBTQ community, including clients, staff, and volunteers.

A SPACE WHERE PEOPLE CAN FIND THEMSELVES REPRESENTED AND REFLECTED AND WHERE THEY UNDERSTAND THAT ALL PEOPLE ARE TREATED WITH RESPECT AND DIGNITY.

PERCEIVE

physical environment and language

- Service users/staff must be able to look around their physical environment and see positive and inclusive symbols, images, and artwork.
- Service users/staff must be able to look around and see positive and inclusive brochures and pamphlets that represent their experiences.
- Service users/staff must be able to hear positive and inclusive language and be comfortable using inclusive and positive language.

FEEL

overall environment, which imparts a sense of safety

- Service users' and employees' gender identities and expressions are acknowledged, affirmed, and respected.
- SAFE PLACE — There are visible and verbal reminders that the agency is a safe place.
- Accessible/supportive processes are available that allow people to raise issues and concerns, and to feel that they have been acknowledged and that there will be follow-up.
- Service users and staff are aware that communication goes two ways.

MATERIALS ✓

Put up inclusive posters and stickers. Think about the reading material in your waiting rooms and the people represented in them.

LANGUAGE ✓

Make sure that inclusive and affirming language is the standard. Educate employees and make sure your policies reflect the changes to Ontario's *Human Rights Code*.

FORMS ✓

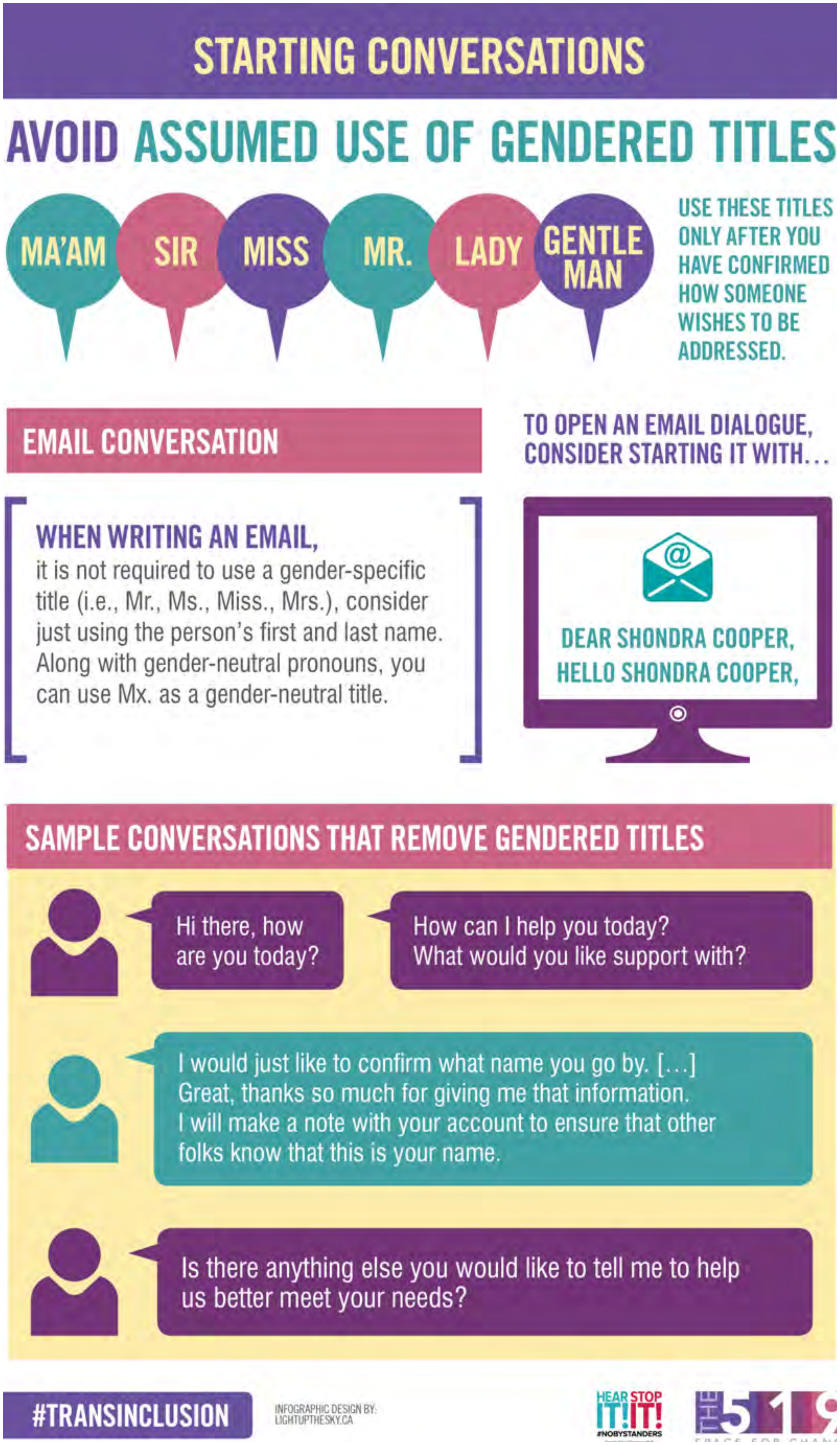
Make sure forms have a space for legal name and another name (some people don't go by their legal name). Make sure forms reflect only what you need to know.

#TRANSINCLUSION

INFOGRAPHIC DESIGN BY:
LIGHTUPTHESKY.CA

HEAR IT! STOP IT!
#NOBYSTANDERS

THE 519
SPACE FOR CHANGE



STARTING CONVERSATIONS

AVOID ASSUMED USE OF GENDERED TITLES

USE THESE TITLES ONLY AFTER YOU HAVE CONFIRMED HOW SOMEONE WISHES TO BE ADDRESSED.

EMAIL CONVERSATION

WHEN WRITING AN EMAIL, it is not required to use a gender-specific title (i.e., Mr., Ms., Miss., Mrs.), consider just using the person's first and last name. Along with gender-neutral pronouns, you can use Mx. as a gender-neutral title.

TO OPEN AN EMAIL DIALOGUE, CONSIDER STARTING IT WITH…

DEAR SHONDRA COOPER,
HELLO SHONDRA COOPER,

SAMPLE CONVERSATIONS THAT REMOVE GENDERED TITLES

Hi there, how are you today?

How can I help you today? What would you like support with?

I would just like to confirm what name you go by. […]
Great, thanks so much for giving me that information.
I will make a note with your account to ensure that other folks know that this is your name.

Is there anything else you would like to tell me to help us better meet your needs?

#TRANSINCLUSION

INFOGRAPHIC DESIGN BY:
LIGHTUPTHESKY.CA

HEAR IT! STOP IT!
#NOBYSTANDERS

THE 519

Asking the Right Questions
Several factors contribute to self-disclosure:

- feelings of safety, non-judgmental and non-heterosexist/genderist attitudes, advertising of a service in LGBTTTIQ publications and communities, LGBTTTIQ-positive stickers and posters, use of non-biased, inclusive language, confidentiality, those who are knowledgeable of LGBTTTIQ specific issues.

The following factors enhance the experience of services for LGBTTTIQ people:

- availability of specialized programs/services, composition of treatment/counselling groups based on sexual orientation and gender identity, anti-discrimination policies, LGBTTTIQ-positive materials in waiting areas, access to LGBTTTIQ-positive therapists/counsellors. [T]

Indigenous and Two Spirit Inclusion [U]
Because of the spiritual**,** cultural and historical component, being Two-Spirit is different than identifying as LGBT2Q+ and indigenous. Before colonization, Two-Spirit people were often highly revered in their communities, taking on the role of healers, match-makers, counsellors, among many others.

The term *Two-Spirit* is only to be used by indigenous people, due to the cultural and spiritual context; however, not all indigenous people who hold diverse sexual and gender identities consider themselves Two-Spirit.

Module 10: LGBT2Q+ References

A. The term LGBT2Q+ is used throughout this document, unless pulling directly from source material that publishes under a variation (LGBT, LGBT2, LGBTQ, LGBTTTIQ, LGBTTI2QQ).

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C. Kaupapa: Kaupapa means principles and ideas, which act as a base or foundation for action. A kaupapa is a set of values, principles and plans which people have agreed on as a foundation for their actions. Source: https://teara.govt.nz/en/papatuanuku-the-land.

D. Qmunity. Source: https://qmunity.ca/news/pride-is-political/.

E. https://en.wikipedia.org/wiki/Timeline_of_LGBT_history_in_Canada.

F. https://en.wikipedia.org/wiki/LGBT_rights_in_Canada.

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Q. Genderbread Person. Source: http://itspronouncedmetrosexual.com.

R. Creating a Welcoming Environment. Source: http://www.the519.org/.

S. Starting Conversations. Source: http://www.the519.org/.

T. ARQ2 Asking the Right Questions. Source: http://www.camhx.ca/Publications/Resources_for_Professionals/ARQ2/arq2_resources_glossary.html.

U. THiPTransgender Health Information Program. Source: http://transhealth.phsa.ca/trans-101/two-spirit.

V. Tasheka Lavann. Source: http://www.huffingtonpost.ca/2016/08/25/tasheka-lavann-lgbtq-caribbean-canada_n_11455258.html.

W. http://www.the519.org/education-training/training-resources/trans-inclusion-matters/creating-authentic-spaces/gender-specific-and-gender-neutral-pronouns.

The Helpful Responses Questionnaire[11]

1. Your new peer has been feeling extremely isolated and has finally contacted you. You have been connecting well and she's been responsive to your care and concern and wants to hang out more. You feel like you need to set boundaries so that the relationship remains as a peer mentor and not as a friend.

Your response:

2. Your peer discloses that they are struggling with the shame and stigma surrounding their (HIV/Hep C) diagnosis. They state feeling helpless and just wanting to give up on life completely

Your response:

3. Your peer tells you, “I'm having a problem that's tearing me apart. I don't know how to tell my family that I am (HIV/Hep C) positive, I have been able to tell my best friend, and after the initial shock, they were able to accept me. I don't think it will be like that with my family, especially my parents - they are pretty 'old school'. I fear that they will judge me and maybe reject me. What should I do?”

Your response:

4. A newly diagnosed peer tells you that she's in an abusive relationship. She's concerned that if she discloses to her partner she could be at risk for more violence, and yet if she doesn't disclose and continues having unprotected sex while on medication she could be charged with sexual assault, even if she does not infect her partner.

Your response:

Appendix 1: Practice Scenarios for Training Role-Plays

These are conversation starters to use for role-plays based on situations that a peer might disclose to their mentor. An HIV or Hep C diagnosis has been included in brackets for each scenario; choose one or both diagnoses for the role-play.

1. I don't know how to tell my family that I am (HIV/Hep C) positive. I'm afraid they won't understand and might never speak to me again. I also have not told them I'm gay due to the same fear. If I tell them about one will I also have to tell them the other?

2. I have just been diagnosed with (HIV/Hep C). I was in such a state of shock when the doctor told me that I don't understand what the diagnosis means or what to do about it.

3. My family is very supportive of my diagnosis and they want to be involved in my treatments and be a part of my care, but sometimes it can feel overwhelming and as supportive as they are, they will never fully understand what it's like to live with (HIV/Hep C). I want to be able to include my family, but keep parts of my journey separate.

4. I feel like I am not being heard by my GP. When I discuss my (HIV/Hep C) related issues during an appointment, they seem distant and lack basic knowledge about living with (HIV/Hep C). Very often I have to do the educating. I also get the feeling that they are judgmental about my sexuality and lifestyle. Do you have any advice?

5. Since my diagnosis my partner is afraid to touch me and is not comfortable being intimate. I feel hurt and rejected but I also understand where their fear is coming from. I just miss how it used to be before I got sick and I don't want them to be afraid of me.

6. I want to meet someone and people are attracted to me, but I am afraid to get close because I don't want them to reject me and even worse tell others in my small town about my diagnosis.

7. I have been living with (HIV/Hep C) for several years and haven't even told my own daughter. I am terrified that she and my son in law and his family will judge me.

8. I have been living with (HIV/Hep C) for the past 10 years and I’m going to be starting my interferon treatment next week. I’m anxious about what side effects to expect. I haven’t told anyone at work about my diagnosis and I don’t know what to say to them if I feel sick and need time off during my treatment.

9. I live in a small community. I was diagnosed with (HIV/Hep C) and it was difficult to talk about my diagnosis with friends and neighbors, partly because of judgements, misinformation and fear of rejection. My family were immediately notified and fortunately they were very supportive and non-judgmental, but I don’t know if I feel prepared to let others know.

10. I have a personal friend of mine who was recently released from a drug addiction treatment program at the same time as I received my HIV diagnosis. He disclosed his situation to me and it felt good about disclosing my diagnosis to him. He has been a great support person. I feel like he is the only one I can talk to.

11. I have been meeting with an Outreach Nurse. We have had a few meetings and she has been great with providing information and support for many of my concerns, but she told me she is moving and I will be getting a new nurse. I’m afraid this will impact all the improvement to my health. I have a hard time trusting new people.

12. I just started a new relationship. We are not intimate yet because I’m not ready to disclose my status to them. I’m struggling with what to do.

13. I’m pregnant and I’m afraid of passing the virus to my baby. I’m not sure where to go for support. My husband died and his family was my only support, but they don’t talk to me anymore. Where can I go for help?

14. I’m currently living at home with my family who is supportive, but I really want to find work and move out on my own. This is a small town; I’m worried no one will want to hire me.

15. I can’t live with this feeling of shame anymore, I have some friends who are supportive, but some days it doesn’t feel like enough and I’m lonely. I’m not sure if it’s worth living anymore.

16. I’m feeling tired and depressed. I keep feeling more and more sick, but I can’t afford my medication. I don’t know what to do.

Appendix 2: Peer Mentor Training Evaluation

Please help us by taking a few minutes to answer some questions about the peer mentor training. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We welcome your comments and suggestions as they help us improve the quality of the program.

Areas to be Considered	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Not Applicable**
The information provided was relevant, informative and helpful.					
I have increased knowledge around the topics presented and discussed.					
Based on what I have learned, I feel more equipped to continue in a role as a peer mentor.					
The facilitator(s) were professional and delivered a quality service.					

What was most helpful about the peer mentor training?
Comments:

What areas of the training could be improved on?
Comments:

Appendix 3: Additional Resources

Module 1:

Land Acknowledgement:

https://native-land.ca/- details on territory and language in your area
https://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-BC/STAGING/texte-text/inacmp_1100100021016_eng.pdf - details about FN communities
https://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-BC/STAGING/texte-text/fnmp_1100100021018_eng.pdf - broader territory map

Journaling:

Creative writing prompts:
http://thinkwritten.com/365-creative-writing-prompts/

The benefits of keeping a journal:
http://lifehacker.com/why-you-should-keep-a-journal-and-how-to-start-yours-1547057185

Module 2:

Understanding peer support Mental Health Commission of Canada guidelines for the practice and training of peer support:
https://www.mentalhealthcommission.ca/English/document/18291/peer-support-guidelines

History of peer support:
http://peersforprogress.org/pfp_blog/a-brief-history-of-peer-support-origins/
http://www.catie.ca/en/pc/program/peer-navigators?tab=why

Social determinants of health video:
https://www.youtube.com/watch?v=DtU_W4FeTno

Module 3:

Wellness Recovery Action Plan:
Key Concepts: http://mentalhealthrecovery.com/wrap-is/

Module 4:

Active Listening

University of Glasgow: Egan's Skilled Helper Model:
http://www.gla.ac.uk/services/humanresources/employeeandorganisationaldevelopment/developmentaltoolkits/mentoringtoolkit/

Nail in the Head video: https://www.youtube.com/watch?v=-4EDhdAHrOg

Brené Brown video: *Empathy vs Sympathy:*
https://www.youtube.com/watch?v=1Evwgu369Jw
Brené Brown video: *Blame:* https://www.youtube.com/watch?v=RZWf2_2L2v8

Module 5:
N/A

Module 6:
Brené Brown video: *Boundaries, Empathy and Compassion:*
https://www.youtube.com/watch?v=xATF5uYVRkM

Oprah video: 3 *Boundaries you must set in every relationship:*
https://youtu.be/sUpZgwLQvSM

Module 7:
Nuggets video*:* https://www.youtube.com/watch?v=HUngLgGRJpo

First Nations Health Authority *Indigenizing Harm Reduction:*
http://medfomlearningcircle.sites.olt.ubc.ca/files/2017/02/IndigenizingHarmReductionApril6FINAL.pdf

Naloxone & overdose prevention website:
http://towardtheheart.com/naloxone

Module 8:
Further information on suicide: http://www.cmha.bc.ca/ask-about-suicide/

Finding Safe TALK and ASIST courses in your area: http://www.cmha.bc.ca/suicide-awareness-training-workshops/

Module 9:
Deep Dive: Philadelphia Guidelines for facilitating peer run groups, pg 216-220:
http://dbhids.org/wp-content/uploads/1970/01/PCCI_Peer-Support-Toolkit.pdf

Module 10a:
Videos on criminalization of HIV: http://www.youtube.com/AIDSLAW
Impact of non-disclosure of HIV on women: http://positivewomenthemovie.org

Module 10b:
Hepatitis C treatment information project: www.hepctip.ca
Help 4 Hep BC: www.help4hepbc.ca
Pacific Hepatitis C Network: www.pacifichepc.org
Hepatitis Education Canada: www.hepatitiseducation.med.ubc.ca
CATIE Hep C Resources: www.catie.ca/en/hepatitis-c
Toward the Heart (BC Centre for Disease Control): www.towardtheheart.com

Module 11:
Glossary of Terms: www.qmunity.ca/resources/queer-glossary
Okanagan Pride: www.okanaganpride.com/community
Kelowna Pride: www.kelownapride.com

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heretohelp
Mental health and substance use information you can trust

Canadian Mental Health Association
British Columbia
Mental health for all

learn about depression

info sheets **2013** www.heretohelp.bc.ca

People can't just snap out of depression. It's a real illness, and the leading cause of suicide.

After years of working hard at your job each day, you've just been laid off. You feel sad, tired and emotionally drained. The last thing you feel like doing is getting out of bed in the morning. This sadness is a natural part of being human and feeling this way for a few days is normal. In fact, many people hear people say "I'm depressed" in their day-to-day life when they are talking about that low feeling that we can all have from time to time. But if these sad feelings last for more than a couple of weeks and you start noticing that it's affecting your life in a big way, you may be suffering from an illness called depression.

What is it?

Depression, also known as clinical or major depression, is a mood disorder that will affect one in eight Canadians at some point in their lives. It changes the way people feel, leaving them with mental and physical symptoms for long periods of time. It can look quite different from person to person. Depression can be triggered by a life event such as the loss of a job, the end of a relationship or the loss of a loved one, or other life stresses like a major deadline, moving to a new city or having a baby. Sometimes it seems not to be triggered by anything at all. One of the most important things to remember about depression is that people who have it can't just "snap out of it" or make it go away. It's a real illness, and the leading cause of suicide.

Who does it affect?

Depression can affect anybody; young or old, rich or poor, man or woman. While depression can affect anyone, at anytime, it does seem to strike most

could I have depression?

- ☐ I feel worthless, helpless or hopeless
- ☐ I sleep more or less than usual
- ☐ I'm eating more or less than usual
- ☐ I'm having difficulty concentrating or making decisions
- ☐ I've lost interest in activities I used to enjoy
- ☐ I have less desire for sex
- ☐ I avoid other people
- ☐ I have overwhelming feelings of sadness or grief
- ☐ I'm feeling unreasonably guilty
- ☐ I have a lot of unexplained stomachaches and headaches
- ☐ I feel very tired and/or restless
- ☐ I have thoughts of death or suicide
- ☐ I'm feeling more tearful or irritable than usual

If you agree with five or more of these statements and have been experiencing them for more than two weeks you should talk to your doctor.

often when a person is going through changes. Changes can be negative life changes such as the loss of a loved one or a job, regular life changes such as starting university or a big move, or physical changes such as hormonal changes or the onset of an illness. Because depression can be linked to change, certain groups of people are at risk more often than others:

- **Youth:** More than a quarter of a million Canadian youth—6.5% of people between 15 and 24—experience major depression each year. Depression can be hard to recognize in youth because parents and caregivers often mistake a teen's mood swings and irritability for normal adolescence, rather than depression. Studies have shown that gay, lesbian, bisexual or transgendered youth have higher rates of major depression.
- **Older adults:** Around 7% of seniors have some symptoms of depression. This can be brought on by the loss of a spouse, a shrinking circle of friends or the onset of an illness. It's also much more common among seniors living in care homes or who have dementia. Depression in people 65 and over appears to be less common than in younger groups, but researchers aren't sure if this is a real difference or an issue with the research questions. It's likely that depression is at least somewhat under-recognized in seniors. Some symptoms like changes in sleep or activity levels may be mistaken as signs of aging instead of depression.
- **Women:** Depression is diagnosed twice as much in women as it is in men. Some reasons for this difference include life-cycle changes, hormonal changes, higher rates of childhood abuse or relationship violence, and social pressures. Women are usually more comfortable seeking help for their problems than men which likely means that depression in men may be highly under-reported. Men generally feel emotionally numb or angry when they are depressed whereas women usually feel more emotional.
- **People with chronic illness:** About one third of people with a prolonged physical illness like diabetes, heart disease or a mental illness other than depression, experience depression. This can be because a long term illness can lower your quality of life, leading to depression.
- **People with substance use problems:** There is a direct link between depression and problem substance use. Many people who are experiencing depression turn to drugs or alcohol for comfort. Overuse of substances can actually add to depression in some people. This is because some substances like alcohol, heroin and prescription sleeping pills lower brain activity, making you feel more depressed. Even drugs that stimulate your brain like cocaine and speed can make you more depressed after other effects wear off. Other factors, like family history, trauma or other life circumstances may make a person vulnerable to both alcohol/drug problems and depression.

- **People from different cultures:** Depending on your cultural background, you may have certain beliefs about depression that can affect the way you deal with it. For example, people from some cultures notice more of the physical symptoms of depression and only think of the emotional ones when a professional asks them. Attitudes from our cultures can also affect who we may ask for help. For example, in one BC study Chinese youth were twice as reluctant to talk to their parents about depression as their non-Chinese counter parts. Aboriginal people, on and off-reserve, may also have higher rates of depression, from 12–16% in a year, or about double the Canadian average.

What can I do about it?

Depression is very treatable. In fact, with the right treatment, 80% of people with depression feel better or no longer experience symptoms at all. Some common treatments, used on their own or in combination are:

Counseling: There are two types of counseling that work best for people with depression.

- **Cognitive-behavioural therapy (CBT):** A health professional who uses this approach can teach you skills to help change your view of the world around you. They do this by coaching you to break the negative patterns of depression including the thoughts and actions that can keep the depression going.
- **Interpersonal therapy (IPT):** Often when you are depressed your relationships with other people suffer. A health professional who uses IPT can teach you skills to improve how you interact with other people.

Medication: There are many different types of effective medication for depression, and different kinds work in different ways. Talk to your doctor to find out if medication is right for you, and if so, how to take it properly.

Light therapy: This treatment has been proven effective for people with seasonal affective disorder. It involves sitting near a special kind of light for about half an hour a day. Light therapy should not be done without first consulting your doctor because there are side effects to this treatment. It is being researched for use in other kinds of depression as well.

Electroconvulsive therapy (ECT): This is a safe and effective treatment for people with severe depression or who can't take medications or who haven't responded to other treatments. ECT is a treatment done in hospital that sends electrical currents through the brain.

Self-help: For mild depression, or when moderate or severe depression begins to improve with other treatments, there are some things you can do on your own to help keep you feeling better. Regular exercise, eating well, managing stress, spending time with friends and family, spirituality, and monitoring your use of alcohol and other drugs can help keep depression from getting worse or coming back. Talking to your doctor, asking questions, and feeling in charge of your own health are also very important. Always talk to your doctor about what you're doing on your own.

Some people find that herbal remedies, such as St. John's Wort, help with their depression symptoms. Remember that even herbal remedies can have side effects and may interfere with other medications. Dosages can also vary depending on the brand you use. Talk about the risks and benefits of herbal or other alternative treatments with your health care provider and make sure they know all the different treatments you're trying.

depression

where do I go from here?

The best first step is always to talk to your doctor. They can help you decide which, if any, of the above treatments would be best for you. They can also rule out any physical explanations for your symptoms. In addition to talking to your family doctor, check out the resources below for more depression information.

Other helpful resources available in English only are:

Your Local Crisis Line

Crisis lines aren't only for people in crisis. You can call for information on local services or if you just need someone to talk to. If you are in distress, call 310-6789 (do not add 604, 778 or 250 before the number) 24 hours a day to connect to a BC crisis line, without a wait or busy signal. The crisis lines linked in through 310-6789 have received advanced training in mental health issues and services by members of the BC Partners for Mental Health and Addictions Information.

Mood Disorders Association of BC

Visit www.mdabc.net or call 604-873-0103 (in the Lower Mainland) or 1-855-282-7979 (in the rest of BC) for resources and information on mood disorders. You'll also find more information on support groups around the province.

Canadian Mental Health Association, BC Division

Visit www.cmha.bc.ca or call 1-800-555-8222 (toll-free in BC) or 604-688-3234 (in Greater Vancouver) for information and community resources on mental health or any mental illness. You can also learn more about two helpful programs:

- Bounce Back is a free program for adults experiencing mild to moderate depression, stress, or worry, using self-help materials and telephone coaching: www.bouncebackbc.ca
- Living Life to the Full is a fun and engaging mental health promotion course that helps people learn skills to deal with the stresses of everyday life: www.llttf.ca

BC Partners for Mental Health and Addictions Information

Visit www.heretohelp.bc.ca for info sheets and personal stories about (illness). You'll also find more information, tips and self-tests to help you understand many different mental health problems.

Resources available in many languages:

*For the service below, if English is not your first language, say the name of your preferred language in English to be connected to an interpreter. More than 100 languages are available.

HealthLink BC

Call 811 or visit www.healthlinkbc.ca to access free, non-emergency health information for anyone in your family, including mental health information. Through 811, you can also speak to a registered nurse about symptoms you're worried about, or talk with a pharmacist about medication questions.

This fact sheet was written by the Canadian Mental Health Association's BC Division. The references for this fact sheet come from reputable government or academic sources and research studies. Please contact us if you would like the footnotes for this fact sheet. Fact sheets have been vetted by clinicians where appropriate.

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Mental health and substance use
information you can trust

HeretoHelp is a project of the BC Partners for Mental Health and Addictions Information. The BC Partners are a group of nonprofit agencies working together to help individuals and families manage mental health and substance use problems, with the help of good quality information. We represent Anxiety Disorders Association of BC, BC Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health, Jessie's Legacy Program at Family Services of the North Shore, and Mood Disorders Association of BC. The BC Partners are funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

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British Columbia
Mental health for all

learn about

anxiety disorders

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Anxiety becomes troubling when it lasts weeks or months, develops into a constant sense of dread and begins to affect your everyday life.

Suddenly your heart is racing, palms are sweaty, stomach's churning. Your muscles are tense and your senses alert. Your mind is flooded with worries and fears that something bad will happen. This is anxiety; and we have all had it. When faced with a threatening event such as a physical attack or a natural disaster, most people feel anxiety or fear. Our bodies give us a surge of adrenaline and our instincts take over. This gives us the strength we need to get out of the situation and survive. Anxiety is our body's response to stress and danger, but in today's world most of the 'dangers' we face day to day are not ones we can fight with our fists or run away from easily. These modern 'dangers' are many and can be anything from a heavy work load at your job to family conflicts, aggressive drivers or money troubles. Some anxiety from time to time is normal and healthy; it can help motivate us and help get us out of tough situations. But when anxiety lasts for weeks or months, develops into a constant sense of dread or begins to affect your everyday life, you may have an anxiety disorder.

anxiety disorders

could I have an anxiety disorder?

☐ I've had panic attacks and worry about having more and about what will happen if I do

☐ I frequently have trouble concentrating or sleeping because I worry about work or home or money or my family's health

☐ I go out of my way to avoid objects or situations that make me anxious

☐ I feel anxious about things more often and more intensely than other people around me do

☐ I feel I can't move on with my life after a trauma and keep reliving it over and over again

☐ I have a deep worry of being embarrassed in public

☐ I often find myself repeating a behaviour like hand washing, organizing, re-checking or mental acts like counting or repeating words in my head

☐ I'm experiencing one or more of the above symptoms and it's impacting my life and causing me distress. I also know it's unreasonable but I can't seem to stop it.

If this last item plus one or more of the others sounds like you, talk to your doctor about it. You may also want to try our online self-tests* which can be printed out and taken to your doctor. See www.heretohelp.bc.ca/screening-self-tests

**available in English, French and Traditional Chinese*

What is it?

Anxiety disorders describe a group of related mental illnesses. A very common myth is that anxiety disorders are the same thing as problems with stress. Anxiety and stress problems can have a lot in common. The difference is that in an anxiety disorder, the symptoms are extreme and don't go away once the stress is over. There are several different types of anxiety disorders:

- **Generalized anxiety disorder**—is when someone has unusually high levels of anxiety and worry about aspects of daily life like health and well-being, finances, family or work.
- **Panic disorder**—is when a person has panic attacks and is afraid of having more panic attacks. A panic attack is a sudden, unexpected rush of intense anxiety symptoms that can last anywhere from a few seconds to several minutes. Not everyone who has panic attacks has panic disorder.
  - Panic disorder can also exist with agoraphobia. Agoraphobia is a strong fear of and urge to avoid being in places where escape may be difficult or embarrassing (like crowds and public places).
- **Post-traumatic stress disorder (PTSD)**—is when someone is a part of or witnesses one or more traumatic events. This can be harmful to their mental health. Some examples of traumatic events are war, assault and other crimes, accidents and natural disasters. In addition to other symptoms, a person suffering from post-traumatic stress disorder can relive these events long after they're over, through nightmares and flashbacks.
- **Social anxiety disorder**—is when a person is terrified of social settings because they feel other people are judging them and they fear they'll embarrass themselves. This is also known as social phobia.
- **Separation anxiety**—is when a child or teenager experiences extreme anxiety when they are separated or expecting to be separated from their parents or caregivers.
- **Specific phobias**—is when a person experiences extreme or unreasonable terror when confronted with a certain object, situation or activity. This terror can lead to a strong need to avoid that object or situation. The objects of phobias are diverse and can include fear of dogs, flying, enclosed spaces, water, and blood among others.
- **Obsessive-compulsive disorder (OCD)**—is when a person has recurring, unpleasant thoughts (these are called obsessions), like thinking their hands are always dirty. As a result, they may develop repetitive and time-consuming behaviours to try and reduce anxiety or distress (these are called compulsions), like washing their hands hundreds of times a day.

anxiety disorders

Who does it affect?

Anxiety is the most common type of mental disorder affecting 12% of BC's population, or one in eight people, in any given year. There are a number of things about who you are that can put you at greater risk of developing an anxiety disorder:

- **Gender:** Women are twice as likely as men to be diagnosed with an anxiety disorder. There are a number of reasons for this including women's hormonal changes, caregiving stress, and greater comfort seeking help than men.
- **Age:** Anxiety disorders most often appear in youth, with phobias and OCD showing up in early childhood and panic disorders and social phobias in the teen years. An estimated 6.5% of BC youth have an anxiety disorder.
- **Personality factors:** Children who are shy and worrisome are more likely than other children to suffer from an anxiety disorder later in life. People who tend to be perfectionists are also more prone to anxiety disorders.
- **Family history:** Anxiety disorders run in families. In addition to possible genetic influences, the role a child may play within their families can also be a factor in developing an anxiety disorder in the future.
- **Social factors:** People with a lack of social support are more likely to develop anxiety disorders.
- **Occupational risks:** One kind of anxiety disorder, post-traumatic stress, can be linked to people's jobs. For example, emergency personnel and military personnel are at high risk.
- **Chronic illness:** People who have chronic mental or physical illnesses often worry about their illness, their treatments and the effect the illness has on their lives and the lives of those around them. This constant worry can sometimes lead to the development of an anxiety disorder.

What can I do about it?

Anxiety disorders are among the most treatable mental illnesses. There are a few different things you can do that have been shown by research to help the most:

Counselling: Many people with anxiety disorders benefit from a special form of counselling called cognitive-behavioural therapy or CBT. A mental health professional trained in the CBT approach can help you work through the thoughts, emotions, behaviours and triggers contributing to your anxiety problems. They can also teach you coping skills. Part of CBT may involve slowly introducing you to things that you may have been avoiding or extremely afraid of until you feel more comfortable with them. CBT is a short-term treatment and requires you to practice the skills during and after treatment.

Medication: Anti-anxiety medications can be used in combination with counselling to reduce your body's response to anxiety.

Support groups: You are not alone. Anxiety disorder support groups are a great way to share your experiences and learn from the experiences of others.

Self-help: There are some things you can do on your own to help keep you feeling better. Regular exercise, eating well, managing stress, spending time with friends and family, spirituality, and monitoring your use of alcohol and other drugs can help keep anxiety from getting worse or coming back. Talking to your doctor, asking questions, and feeling in charge of your own health are also very important. Always talk to your doctor about what you're doing on your own.

am I having a panic attack?

☐ I feel like something terrible is about to happen
☐ I'm having trouble catching my breath
☐ My heart is pounding
☐ My body/hands are shaking
☐ I'm breaking out into a sweat
☐ I feel lightheaded or dizzy
☐ I have goose bumps or 'chills'
☐ I feel tingling in my hands and feet
☐ I feel disconnected from reality
☐ I feel nauseous

If the first symptom plus several or more of the others come on suddenly, you may be experiencing a panic attack. Panic attacks usually peak within a few seconds or a few minutes. Talk to your doctor about your attacks and work together to figure out ways to prevent and treat them.

It's important to know that having a panic attack doesn't mean you have panic disorder. A third of adults will experience a panic attack in their lifetime and most of them will not develop panic disorder. Panic attacks can also be part of other anxiety disorders.

anxiety disorders

where do I go from here?

If you think you have an anxiety disorder, it's important to see a doctor first to rule out other explanations for your symptoms. In addition to talking to your family doctor, check out the resources below for more information on anxiety disorders.

Other helpful resources available in English only are:

Your Local Crisis Line

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AnxietyBC

Visit www.anxietybc.com or call 604-525-7566 for information and community resources.

BC Partners for Mental Health and Addictions Information

Visit www.heretohelp.bc.ca. See our section on anxiety disorders including our Anxiety Disorders Toolkit. The Toolkit is full of information, tips and self-tests to help you understand your anxiety disorder.

Resources available in many languages:

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SOCIAL SUPPORT

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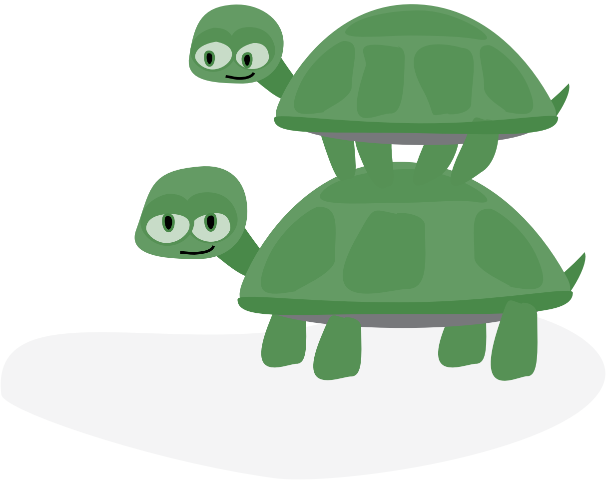
are there people in your life you can turn to when you need to talk to someone?

someone to help when your basement is flooded or when you need someone to watch the kids?

or maybe just someone you can call when something really great happens and you want to share the news?



social support is the physical and emotional comfort given to you by your family, friends, co-workers and others. It's knowing that you are part of a community of people who love and care for you, value you and think well of you.

Types of social support

Support can come in many different forms. There are four main types of social support:

Emotional support: This is what people often think of when they talk about social support. People are emotionally supportive when they tell you that they care about you. For example, if you separated from your partner or lost your job, a close friend might call every day for the first few weeks afterwards just to see how you are doing and to let you know that they care.

Practical help: People who care about you might give you practical help such as gifts of money or food, help with cooking or child care, or help moving house. This kind of support helps you complete tasks in your daily life.

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CANADIAN MENTAL HEALTH ASSOCIATION
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
BC DIVISION

AnxietyBC®

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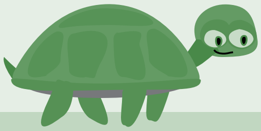

Sharing points of view: Some people help by sharing their point of view on a particular situation, or sharing how they might handle a situation. When you share points of view, you can develop a better understanding of a situation and the best way to handle it. For example, if you tell a friend about difficulties you are having with your teenage son, she may offer a point of view you hadn't considered. This may help you to better address the situation with your child.

Sharing information: It can be very helpful when family, friends or even experts give factual information about a particular situation. For example, a friend who recently married might provide information on the cost of their wedding, or a cancer survivor might provide information on different types of cancer treatments.

Getting your support needs met

Many of the people in your life can provide social support. These can include your parents, spouse or partner, children, siblings, other family members, friends, co-workers, neighbours, health professionals and sometimes even strangers.

Different people in your life may provide different kinds of support, so it's unlikely that one person can provide all the support you need. For example, your parents may be great with childcare, and your best friend may give great relationship advice.

The best support often comes from the people you are closest to in your life. Receiving support from the people you are close to may be more beneficial to your physical and emotional health than support from people you don't know well.

What is so important about social support?

Research shows that social support provides important benefits to our physical and emotional health. Stress may be related to a number of health concerns, from mental health problems to chronic health problems like heart disease and migraines. However, social support can help protect people from the harmful effects of stress. When dealing with a stressful situation, people are less likely to report stress-related health problems when they feel like they have support from others.

How much support do you have? Take our online quiz at **www.heretohelp.bc.ca**

Select sources and additional sources

- Visit **www.heretohelp.bc.ca** to read the Social Support issue of *Visions: BC's Mental Health and Addictions Journal.*
- Visit **www.bccf.ca** for information on healthy families from the BC Council for Families.
- Visit **www.takingcharge.csh.umn.edu** for the social support section of Taking Charge of Your Health, a project of the University of Minnesota.
- Cohen, S., Underwood, L.G. and Gottlieb, B.H. (2000). *Social Support Measurement and Intervention: A Guide for Health and Social Scientists*. London: Oxford University Press.
- Gottman, J. and DeClaire, J. (2001). *The Relationship Cure: A 5 Step Guide to Strengthening your Marriage, Family, and Friendships*. New York: Three Rivers Press.

when might I want to change my social support network?

While some people maintain the same set of friends, co-workers and contact with family members over their entire adult lives, many others make shifts to their support networks. Here are some of the reasons why.

- **Not enough support:** You may wish to bring new people into your support network if you find that you need more people in your life who can provide you with support, or if you're missing people in areas that are important to you. For example, you may have good emotional support, but you may want to meet more people who share your interests.

- **Change in lifestyle:** People often make changes to their support network when they experience important life changes. Here are just a few examples of changes that may require a shift in support:
    - **Parenthood:** People often change their social life significantly when they become parents. They may spend more of their time with other parents.
    - **Divorce or death of a spouse:** Married people often socialize with other married people. Following divorce or the death of a spouse, your usual social network may no longer be a good fit for your needs.
    - **Change in behaviour:** People who smoke, drink or use drugs on a regular basis may socialize with others who do the same. When you cut back or quit, you may decide to make a new friends to help you maintain your goals.
    - **New hobby or activity:** When you take up a new activity, like running or painting, you may want to find others who share your interests.

- **Need for a like-minded community:** You may wish to join a community or communities that you identify with, or make friends with people who share your values.

- **Need for specialized knowledge or expert opinion:** You may wish to seek out extra help when you experience something that your existing support network isn't familiar with. People with lived experience may be better able to provide empathy, support and understanding. The knowledge that we aren't alone can also help you cope with feeling of blame or shame.

  Formal support, like an education group or professional, may be helpful when you need highly specialized or technical information. For example, you may need specialized information if you or a loved one is diagnosed with a health problem.

social support and mental illness

Social support plays an important role in mental health and substance use problems. For example, people living with depression report lower levels of social support than others. Specifically, people living with depression tend to report fewer supportive friends, less contact with their friends, less satisfaction with their friends and relatives, lower marital satisfaction and confide less in their partners.

It's likely that lack of social support and feelings of loneliness make people more vulnerable to mental health or substance use problems like depression. However, many people pull back from others when they're experiencing mental health or substance use problems. In this way, mental health or substance use problems can lead to problems with social support and aggravate feelings of loneliness.

Reconnecting with others in healthy, supportive ways is often an important component of managing most mental health or substance use problems.

how do I improve my social support network?

1. Don't be afraid to take social risks

Seeking out new people and introducing yourself to them may be a useful way to meet others. For example, you may decide to go to a party, even though you won't know anyone else at the event. Informal gatherings, community centres, recreational courses or clubs, volunteer positions, schools and workplaces are also common places to meet people.

2. Get more from the support you have

It's easy to assume that other people know what you need, but this usually isn't true. You may need to tell others what you need. Be as specific as possible in your requests. However, be careful not to overwhelm your support providers.

3. Reach out

Ask the people you know to help you broaden your networks. If you have recently become single, ask your friends to introduce you to other single people your age. If you have recently come out, ask your friends to introduce you to others in the community.

4. Create new opportunities

You may create new opportunities to meet others when you step outside of your usual activities. For example, you may meet new people when you join a club or group or get involved in an organization.

5. Let go of unhealthy ties

Walking away from any relationship is painful—even when the relationship is causing harm—but it may be necessary. For example, if you're trying to quit drinking and your friends only ever want to spend time in bars and clubs, you may decide to let them go. Use your judgement, though. It may be possible to spend less time with certain people without fully abandoning the friendship.

6. Make a plan

Figure out what supports you need and figure out how you might find it.

7. Be a joiner

Sometimes, the best way to find the support you need is through a support group. If you need support for a highly specific problem, like managing a health problem, a formal support group may be the best option. See our fact sheets on finding help and support at **www.heretohelp.bc.ca**.

8. Be patient

Making new friends can take time. You may need to meet many new people to make just one new friend. Building intimacy also takes time. It can take several months to feel close to someone and feel like you can count on their support.

9. Avoid negative relationships

Negative relationships are hard on your emotional health. Some negative aspects may be obvious, such as abuse. Other times, they may be more subtle, such as excessive dependence or control issues. You aren't responsible for the other person's behaviour, but it can still take a toll on your own well-being. You may find yourself dealing with the problems in unhealthy ways. It can be hard to avoid certain negative relationships, especially when these relationships are with family members. In this case, it may be best to limit the amount of contact with these people (or buffer that contact with other helpful supporters), and avoid relying on them for support.

10. Take care of your relationships

You're more likely to build strong friendships if you are a good friend, too. Keep in touch with your support network, offer support to others when they need it and let them know that you appreciate them.

Notes