Training Peer Mentors: Facilitation Guide

Index – Training Peer Mentors: Facilitation Guide

The times are a guideline, some modules will take longer or shorter depending on your group size and level of engagement. Ensure the group still ends on time each day, the module can be completed the next day if needed.

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Look for this symbol when Peer Mentor Trainees should refer to their *Becoming a Peer Mentor: Participant 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 hepatitis C (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 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 who were members of the Peer Advisory Committee for STOP HIV at the time.

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.

b. Funder: This project would not have been possible without funding and leadership provided by the Interior Health Authority, HIV and Health Outreach Program, Population Health.
c. Authors: Alison Kyte, Jayme Pereira and the Canadian Mental Health Association Kelowna & District Branch.
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.

How to Cite this Document: Kyte, A., Pereira, J. (2018). *Peer support toolkit for people living with HIV and/or hepatitis C: part 2 training peer mentors: facilitation guide*. Kelowna, British Columbia: Canadian Mental Health Association Kelowna & District Branch.

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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.

Materials Needed:

- flipchart paper and markers;
- writing materials: pens and pencils;
- journals (optional);
- facilitator guide and participant guide;
- tent cards and markers for name cards;
- sticky/post-it notes.

Land Acknowledgement

Purpose: A land acknowledgement is an indigenous protocol where a formal statement is made to recognize the unique and enduring relationship that exists between Indigenous Peoples and their traditional territories. It is used to recognize the land and is an expression of gratitude and appreciation to those whose territory we reside on, and a way of honouring the longstanding aboriginal people who have been living and working on the land.

Options: The land acknowledgement can be said once at the start of training or at the beginning of each day of training.

Process:

1. Research your area and learn the name and proper pronunciation of the Nation on whose territory the building sits. Friendship Centres, Aboriginal Student Centres, and local Band Offices are always a good source of information.
2. Be sure you are acknowledging the territory and **not** the reserve.
3. Use one of these options for the land acknowledgement:
    a. "I want to acknowledge the [Name of the territory] that we are on today. This is the traditional territory of the [Name of nation and people]."
    b. "I want to acknowledge the land not ceded [Name of the territory] that we are on today. This is the traditional territory of the [Name of nation and people]."

Example of Syilx/Okanagan land acknowledgement:
"I want to acknowledge the Syilx/Okanagan territory that we are on today.
This is the traditional territory of the Syilx nation and people"

Note to Facilitator: "Land not ceded" means that the First Nations territories in British Columbia never gave up governance of their land on which we reside and work.

Additional Resources –

- https://native-land.ca/ - 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

Housekeeping

Purpose: To give information to the group that allows them to be familiar and comfortable in the space they are using and to inform and clarify other important items prior to the training starting.

Process:

1. Familiarize yourself with the building and area that is being used for the training in order to give accurate information.
2. Review all the housekeeping items applicable for your location. (These items may vary depending on the organization/location).
3. Answer and clarify any questions from the group.

Suggested Items to Review

1. **Hours:** Present the start, break and expected completion times.
2. **Parking:** Review where designated parking areas are and inform if there is a cost, parking pass or a way to have parking validated.
3. **Dress:** Discuss if you have a specific dress code. If it is casual, you can encourage the group to dress comfortably and to let the facilitators know if it is too hot or too cold in the room.
4. **Restrooms:** Note the location and if a key is required.
5. **Smoking Area:** Let the group know if there is a designated smoking area, where it is and how to re-enter the building if applicable (e.g. if doors lock automatically).
6. **Emergency Exits:** Identify emergency exits and a meeting location in case of emergency.
7. **Supplies:** Quickly go over the participant guide and other tools/resources available to assist during training. Let the group know the participant guide is theirs to keep and encourage them to write notes if they choose.
8. **Lunch/Coffee/Snacks:** If your course runs over lunch, discuss the time and duration of the break, where to eat, as well as the location of coffee and snacks if they are provided.
9. **After Hours:** Discuss your availability before and/or after hours for extra support or questions that may arise.

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.

Purpose: Creating a safe environment to review gender pronouns and give an opportunity to have a discussion about why this is important to understand and respect during training as well as in the peer mentor role.

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

Process:

1. Review the preferred pronouns chart in the participant guide on page 7.
2. Have a discussion with the group around using preferred pronouns to ensure everyone's identities are addressed properly and respected.
3. Give the group an opportunity to ask questions and inform them that there will be more information in a later module that addresses identity and inclusion.
4. Tell the group they will be given an opportunity to share their preferred pronoun in their introduction next if they are comfortable disclosing. They can also say "pass" if they prefer not to inform the group.

Introductions of Facilitators and Participants

Purpose: Help build connection through personal introductions of facilitators and participants and an icebreaker activity.

Materials:
- Name tags/tent cards.
- Depends on the icebreaker activity, read the options to determine what is required.

Note to Facilitator: There are 2 icebreaker examples given below, but you can use your own icebreaker activity if you prefer. Ensure you have all the materials necessary.

Process:
1. Begin with an icebreaker before formal introductions to help everyone feel more comfortable with each other (2 options given below).
2. Have everyone introduce themselves by answering the following questions (write the questions on the board for everyone to see). Reminder: They can pass on a question if they are not comfortable answering.
    - **a.** What is your name?
    - **b.** What is your preferred pronoun?
    - **c.** What are your concerns about the training?
    - **d.** What are you hoping to get from the training?

Choose one of the following options:

Option #1: Where the Wind Blows
This activity involves movement. If choosing this activity, make sure you have enough space in the room and that everyone in your group has the ability to get up and move around.

Room Set Up: Chairs set up in a circle, have one fewer chairs than the number of participants (e.g. nine chairs for 10 participants).

Process:

1. Arrange all the chairs in a circle with enough chairs for all participants minus one (facilitators will participate).
2. One person stands in the middle and starts by saying "The wind blows for everyone who…" and then says any characteristic that is true for themselves. For example, "The wind blows for everyone who has traveled outside of Canada." All players who have been outside of Canada must stand and quickly find a new seat. If the player is not able to find a vacant seat, they are the new person who is in the middle saying a "wind blows" statement.
3. Review the rules:
    a. No running.
    b. You cannot pick the chair next to you or sit back in your current chair.
    c. The statement cannot single a person out (e.g. if only one person is wearing blue, your statement cannot be "the wind blows for people wearing blue).
    d. Keep the statement safe/low risk.
4. Play for several rounds, announce when they are on their last round.
5. Lead the group through discussion questions.

Discussion Questions:

1. Did you notice how much you have in common with some of the other group members?
2. Did you start to feel more comfortable with the group after learning more about everyone?
3. Did you notice a sense of relief on some of the more serious questions, knowing that you were not alone?

Option #2: Stand Up/Sit Down

Process:

1. Prepare a series of 10-20 questions/statements to ask the group.
2. Begin with a more general question then integrate a few questions that touch on the purpose of the training.
3. Tell the group that you are going to read them a series of questions/statements. If their answer to the question is yes or the statement pertains to them they should stand up (or raise their hand) If the question does not pertain to them they can remain seated.
4. Continue asking questions until everyone has had a chance to stand/raise their hand.
5. Lead the group through discussion questions.

Sample Questions/Statements:

- How many people like ice cream?
- How many people play an instrument?
- How many people have done public speaking?
- Stand/raise your hand if you have helped resolve a conflict
- Stand/raise your hand if you are willing to work for a better community
- Stand/raise your hand if you live with Hep C or HIV (more general question to get everyone standing and identifying with one another)
- Stand/raise your hand if you have experienced stigma

Discussion Questions:

1. Did you notice how much you have in common with some of the other group members?
2. Did you start to feel more comfortable with the group after learning more about everyone?
3. Did you notice a sense of relief on some of the more serious questions, knowing that you were not alone?

Note: This exercise can be adapted for various physical disabilities. If repeated standing and sitting is difficult people can raise their hand or wave their arms.

Creating a Safer Space Agreement

Purpose: As a group, outline the guidelines that need to be in place to make a safer space for participants to share openly and learn together during the training.

Materials: Flip chart paper, markers, sticky notes.

Note to Facilitator: To allow the participants to feel safe asking questions without fear of judgement or asking a silly/wrong question, introduce the sticky note guideline where participant can write down a question they are not comfortable asking to the group and give it to the facilitators at the end to discuss.

Process:

1. Explain what a safer space agreement is and why it's important (e.g. a safer space agreement consists of guidelines we agree on to help make a safer space for everyone to share, ask questions, and learn).
2. Use the discussion questions provided to help prompt a brainstorm for guidelines.
3. Write the safer space agreement on flip chart paper in point form.
4. Ensure everyone who wants to add something has the opportunity to share.
5. Have the group show their agreement by saying, "I agree".
6. Let the group know they can add items to the list at any point during the training.

Discussion Questions:

1. When you think about a safe group environment for learning and sharing what comes to mind?
2. What helps you establish trust and support in a group?
3. How can we best support each other if there are concerns?
4. How can we be mindful of triggers and respectful language when we are sharing?

Optional Items to Add:
If the group needs help starting the list you can suggest some of the following items:

- Start and end group on time.
- Confidentiality.
- Avoid crosstalk.
- Awkwardness is okay.
- Use "I" statements.
- Thumbs up thumbs down: this is a nonverbal signal for when someone leaves the room. Giving a thumbs up means, "I'm okay and I will be right back". Giving a thumbs down means, "I'm not okay and I need support". This way the facilitators know whether to follow and support.

Next Steps/Reminders:

- Post the Safer Space Agreement somewhere that everyone can see it and make sure it's out for each day of training.
- Read the agreement at the start of each day to help set the tone.
- Add to the agreement as needed.
- If one of the agreements is not respected, refer to the agreement as a friendly reminder.

Journaling and Keeping Track of the Process (Optional) [1]

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 learnings 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.

Materials: Journals for participants to use (optional).

Process:

1. Let the group know that journaling is optional and not mandatory for the training. If they choose to keep a journal throughout training it does not need to be shared with anyone else unless they choose to share it.
2. Facilitators should remind participants that journals can include a variety of pieces such as voice recordings, song lyrics, poetry, or whatever creative endeavors speak to the participant and encourages them to reflect on their lives and the training.
3. Participants can find suggested writing prompts in their participant guide page 8.

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?

Course Outline

Purpose: Helping the participants to feel connected to the program and to be clear about what content to expect from the training and program requirements.

Note to Facilitator: The table of contents is different in the facilitators guide then it is in the participant guide as they do not have all the same documents.

Process:

1. Go through the table of contents and give a brief description of what's involved in each section. Let the group know there is a section for writing notes in their participant guide at the very end of the guide.
2. Discuss requirements of the participants during the training:
    a. expectation for attendance;
    b. contact information for facilitators;
    c. interview process post training.
3. Address any questions or concerns. This is a good opportunity to discuss possible triggering content that is covered and encourage self-care during training.

Pre/Post-Training Evaluations

Purpose: During the training, participants will gain skills in different areas related to peer support. This evaluation will create a baseline of the participants' knowledge and skill level at the outset of training. The same evaluation will be completed again after training to measure participants understanding of the skills taught.

Materials: Pens.

Process:

1. Ask the participants to complete the pre-training evaluation in their participant guide page 9.
2. Discuss the importance of being honest in their answers and assure them they are not expected to know everything already.
3. Collect all the completed evalutations, review them with the co-facilitator at the end of group.
4. Facilitators hold onto these evaluations until the last module, at which time they will be given back for participants to complete the post training section.

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.

Materials Needed:

- facilitator guide and participant guide;
- flipchart paper or whiteboard and markers;
- TV or projector, laptop and internet to show video.

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. [2,3]

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." [4]

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.[5] 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.[5] 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.[6] Contemporary peer support as it is practiced in the mental health field, further evolved in the 1990's and has been growing steadily since.[5]

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.[7]

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. [4]

Presenting “The History of Peer Support”

Purpose: Knowing how peer support began provides context for the impact of shared experience and emotional support.

Process:
1. Review the handouts in the participant guide, pages 11-12, by taking turns reading or highlighting key points.
2. Lead the group through the discussion questions to increase understanding of the material.

Discussion Questions:
1. What parts of the history of peer support do you think has made the biggest impact on how it looks today?
2. How have you seen the role of peer support change over the years?
3. What are some of your hopes for the future of peer support?

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.[4]

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

* Peer Navigators are also a common role in peer support and would fall into the category: community clinical setting peer support.

Figure from *Guidelines for the Practice and Training of Peer Support*[4].

Presenting “Peer Support in Different Settings”

Purpose: To recognize the different settings in which peer support takes place and what the roles entail. This helps us determine where our peer mentor role sits on the spectrum of peer support and brings awareness to the type of support peer mentors will be offering.

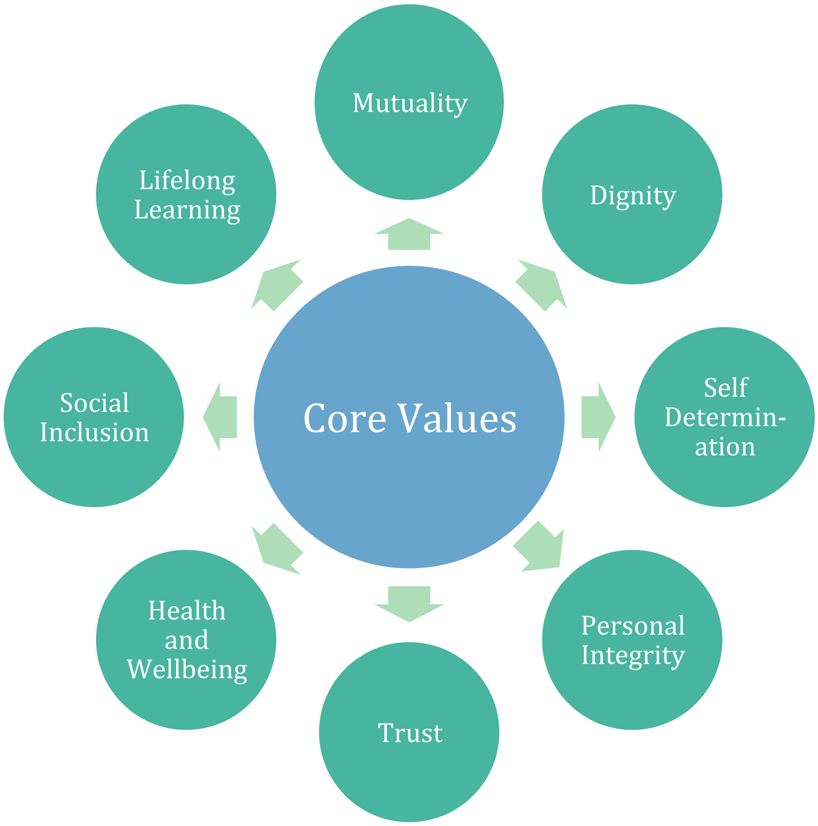
Process:

1. Review the spectrum of types of peer support in the participant guide page 13 and note where they land on that spectrum as far as their role/the organization.
2. Lead a discussion based on the group’s knowledge of different settings within their community that peer support is offered.
3. Ask the discussion questions below.

Discussion Questions:

1. Why do you think it’s important to understand the spectrum of peer support and where your role fits on that spectrum?
2. Have you ever accessed peer support during your care in any of these different settings, and what was your experience like?

Core Values[8]



Mutuality
We value the empathy that comes from shared experience.

Dignity
We honour and respect the intrinsic worth of all individuals.

Self Determination
We honour an individual's autonomy and inherent right to make their own choices as they determine their path to wellbeing.

Personal Integrity
We value interpersonal relationships that honour authenticity, trust, respect and ethical behavior that uphold our Code of Conduct.

Trust
We are honest, reliable and accountable for our actions.

Health and Wellbeing
We value health, wellbeing, and the power of hope for ourselves and others.

Social Inclusion
We respect diversity and value social justice.

Lifelong Learning
We value personal growth through professional and personal development.

Principles of Practice[8]

- 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[8]

- 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.

Presenting “Core Values, Principles of Practice and Code of Conduct”[8]

Purpose: To give context to the ideals, philosophies and rules that are in place for peer mentors and to further explain how to apply these points to their role by reviewing and discussing the handouts on core values, principles of practice and code of conduct.

Process:

1. Review the list of core values, principles of practice and code of conduct in the participant guide pages 14-16.
2. Debrief each point and discuss what they mean and how to apply it in the peer mentor role:
    a. Core values: outline the ideals and ethics of peer support work.
    b. Principles of practice: outline the philosophy and behaviours associated with peer support work.
    c. Code of conduct: outlines the list of rules that a peer mentor agrees too while supporting a peer.
3. Lead the group through the discussion questions.

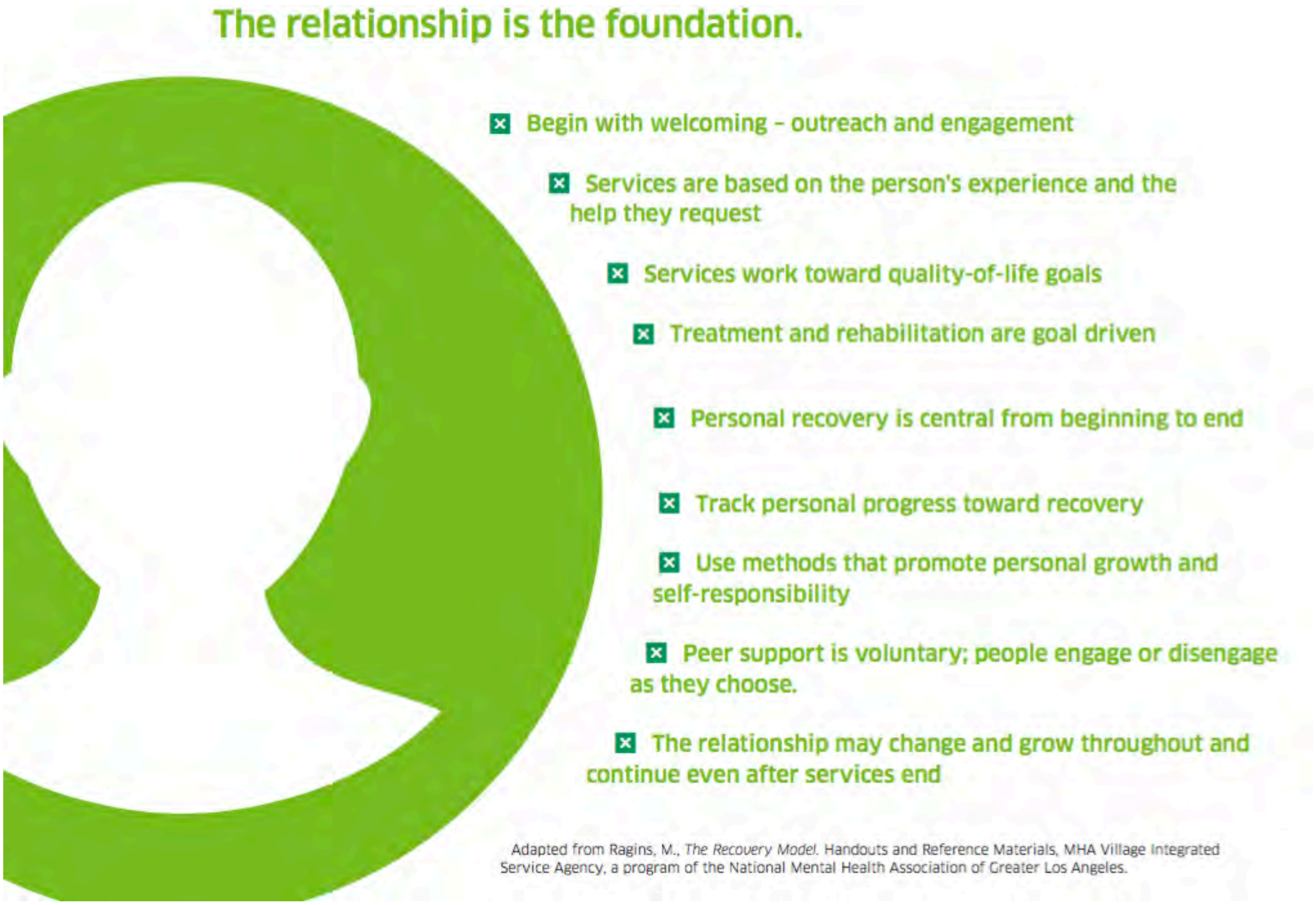
Note to Facilitator: In the principles of practice it discusses taking an active role in connecting peers to resources and partnerships with other agencies. Clarify what this would look like in their role (e.g. giving accurate information if the peer requests it and having an understanding of local resources).

Discussion Questions:

1. How will these values, principles and code of conduct help a peer?
2. How will these values, principles and code of conduct help you as a peer mentor?

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." [4]



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*[4].

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.

Presenting “Person-Centered Approach to Health and Wellbeing”

Purpose: By reviewing the information on person centered approach the participants will recognize that it is not their responsibility to identify the needs of their peer; instead, they will be learning skills during training that help them to support their peer’s ability to identify their own needs.

Opening Comment:
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 peer’s needs change.

Process:

1. Review the handout “Person-Centered Approach” as a group found in participant guide page 17. Discuss the points on the image in more detail and how they can be applied to the peer mentor role.
2. Lead the group through discussion questions.

Discussion Questions:

1. How is using a person-centered approach beneficial in the peer support setting?
2. How do we show our peers compassion, dignity and respect in their choices?
3. How do we support our peers to recognize and develop their personalized approach to health and wellbeing?

Social Determinants of Health

Purpose: To recognize the social factors that can determine/affect one's health. This activity will discuss the social determinants of health and how they are inter-related and their impact on health and wellbeing.

Note to Facilitator: Have the video ready to play before starting the module. Keep in mind that YouTube links are sometimes changed. If possible, download the video and have it saved in a folder on your laptop for easy access. Try: https://keepvid.com/ to download videos.

Materials:

- projector/TV, laptop and internet for video;
- flipchart paper/whiteboard and markers;
- *Determinants of Health* video: https://www.youtube.com/watch?v=DtU_W4FeTno.

Process:

1. Watch *Determinants of Health* video.
2. Debrief the video, discuss key messages and ensure there is an understanding of the meaning of social determinants.
3. Have the group brainstorm what some of the factors are that influence our health and wellbeing, write this on a flipchart or a whiteboard. Some key points to discuss are:
    a. income and social status,
    b. social supports,
    c. education,
    d. employment,
    e. social environment,
    f. physical environment,
    g. personal health practice,
    h. coping mechanisms,
    i. biology/genetics,
    j. health services,
    k. gender,
    l. culture.
4. Lead the group through discussion questions.

Discussion Questions:

1. What are some of the challenges in supporting a peer who is struggling with one or more of the factors listed?
2. How will you bring your knowledge of social determinants of health into your role supporting a peer?
3. What are some of your boundaries/limitation in supporting a peer with these factors?

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.

Materials Needed:

- facilitator guide and participant guide;
- flipchart paper and markers;
- blank paper;
- perception cards (cut out, enough for the number groups you are creating);
- values card sort (cut out, enough for everyone);
- writing material: pens and pencils;
- music (optional for meditation).

Key Concepts for Health and Wellbeing[9]

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.

Purpose: Through discussion, participants will gain an understanding of the key concepts and how to apply them as a peer mentor.

Process:

1. Explain that the origin of the five key concepts come from the Wellness Recovery Action Plan® (WRAP®) course and act as the foundation for effective wellness focused work.
2. Review the key concepts handout in participant guide page 19.
3. Lead the discussion questions.

Discussion Questions:

1. How do each of these key concepts play a role in supporting a peer?
2. How can we apply these concepts to our own wellbeing in order to model it to our peers?
3. How can we encourage our peers to practice these concepts?

The Helpful Responses Questionnaire (Pre-Training)[10]

Purpose: To create a baseline understanding of each participant's knowledge and skill level at the outset of training. This questionnaire will be completed again on the last day of training to see how replies have changed and can be used as a measurement tool during post interviews.

Process:

1. Introduce the activity by saying the following scenarios are things that a peer might say to their mentor during a visit. The handout can be found in their participant guide page 20.
2. Give instructions for the activity:
    a. Read each scenario and imagine that it's your peer talking to you, explaining a problem they are having.
    b. In one or two sentences write how you would reply to them.
    c. Print/write clearly as facilitators will be reviewing.
3. Let the group know that there is no expectation for them to have the perfect reply and this is all part of the learning experience. This activity helps facilitators know where everyone's skill level is before and after training.
4. Have everyone hand in their sheet, facilitators will keep them until the end of training.

Perceptions[11]

Purpose: We can sometimes see things differently than others even if we share similar experiences. This activity will help participants discover more about their personal perceptions and how they play a part in a role as peer mentor.

Materials:

- perceptions cards (cut out 1 set for each group, found on page 37);
- flipchart paper or whiteboard and markers;
- pens or pencils;
- blank paper.

Process:

Part One:

1. Write the word "ocean" on the board/flipchart.
2. Have the participants close their eyes and think about the word "ocean", encourage them to see it, hear it, feel it, smell it.
3. Have the group share some words that describe what ocean means to them, write down everyone's different perceptions.
4. Have a group discussion:
    a. Review the words that everyone shared, bring to attention the similarities and differences.
    b. Note how everyone's perception of the same word is impacted by personal experiences and how they filter how we see, hear and feel about things.
5. Divide the participants into groups. Each participant will need a pen/pencil and a blank sheet of paper. Give each group a copy of the perception cards (cut out beforehand).

Part Two:

1. Someone in the group picks the first card and reads it aloud.
2. Each participant takes a minute to write down a few words/phrases that explain their perception of the word.
3. Each participant shares what they wrote.
4. If there is time, participants can ask each other clarifying questions.
5. After approx. 10 min have the group choose another card and repeat the process (there will be enough time for about 3 rounds depending on the length of discussion).

Part Three:

1. Come back to the large group and lead everyone through the discussion questions to help process the activity.

Discussion Questions:

1. How do our personal experiences affect our perceptions?
2. What can help us to look at things from someone else’s perception?
3. Did anyone else’s perception of a word change how you viewed it?
4. Did you find yourself trying to change someone’s point of view or were you able to accept it?
5. What helps to hold space for someone’s perception that is different from yours?

Tolerance	Loss
Community	Wellbeing
Friend	Family
Success	Health
Human Rights	Love
Trust	Treatment
Self-Worth	Discrimination

Activity: Personal Values[12]

Purpose: This activity is intended to help the participants clarify their own core values and consider how these values might influence the decisions they make as well as how they reflect in their relationship with their peer.

Materials: Personal value card sort (cut up, enough for everyone, see pages 40-48).

Process:

1. Begin the activity by explaining that we each hold a core set of values that guide our choices and behaviors.
2. Hand out a complete set of value cards[12] to each participant (cut out before hand).
3. Have each participant sort their cards into 5 piles. The cards are categorized according to importance:
    a. Not important to me
    b. Somewhat important to me
    c. Important to me
    d. Very Important to me
    e. Most important to me
4. Have everyone organize the cards in their "most important" pile in order of importance with 1 being the most important 2 being the next most important and so on.
5. The value of this process is often in the discussion that follows. Lead the group through the discussion questions to help process the activity.

Discussion Questions:

1. How did you choose your core values?
2. Look at the values you put into your most important and very important column, why did you classify these as important to you?
3. Are the values you deemed most important something you personally value or is it something your parents/caregiver valued, something you grew up with and later felt you should also value it?
4. How do your values play a part in your personal wellness journey?
5. Are you currently practicing, promoting and living these values?
6. What is challenging about practicing, promoting and living these values? What makes it easier?
7. When your values differ from your peers, how can you respect both perspectives?

Closing remarks[12]**:**

- This process can strengthen your understanding of yourself and your guiding principles for living. If you choose to do this activity with a peer it can improve your, and the peer's, understanding of their values and how it plays a part in their behaviors and choices as well.
- It's okay to challenge/change our values. As humans, we are always growing and evolving therefore our values can also change. There is nothing wrong with this. It does not mean we do not still value this trait but maybe it has shifted from being "most important" to being "somewhat important" to us.
- This exercise helps us to understand not only what our values are, but also why we have them and how our values impact our communication styles and perceptions that we hold.

PERSONAL VALUES
Card Sort
W.R. Miller, J. C'de Baca, D.B. Matthews, P.L. Wilbourne
University of New Mexico, 2001

IMPORTANT TO ME

VERY IMPORTANT TO ME

NOT IMPORTANT TO ME

ACCEPTANCE

to be accepted as I am

1 9/01

ACCURACY

to be accurate in my opinions and beliefs

2 9/01

ACHIEVEMENT

to have important accomplishments

3 9/01

ADVENTURE

to have new and exciting experiences

4 9/01

ATTRACTIVENESS

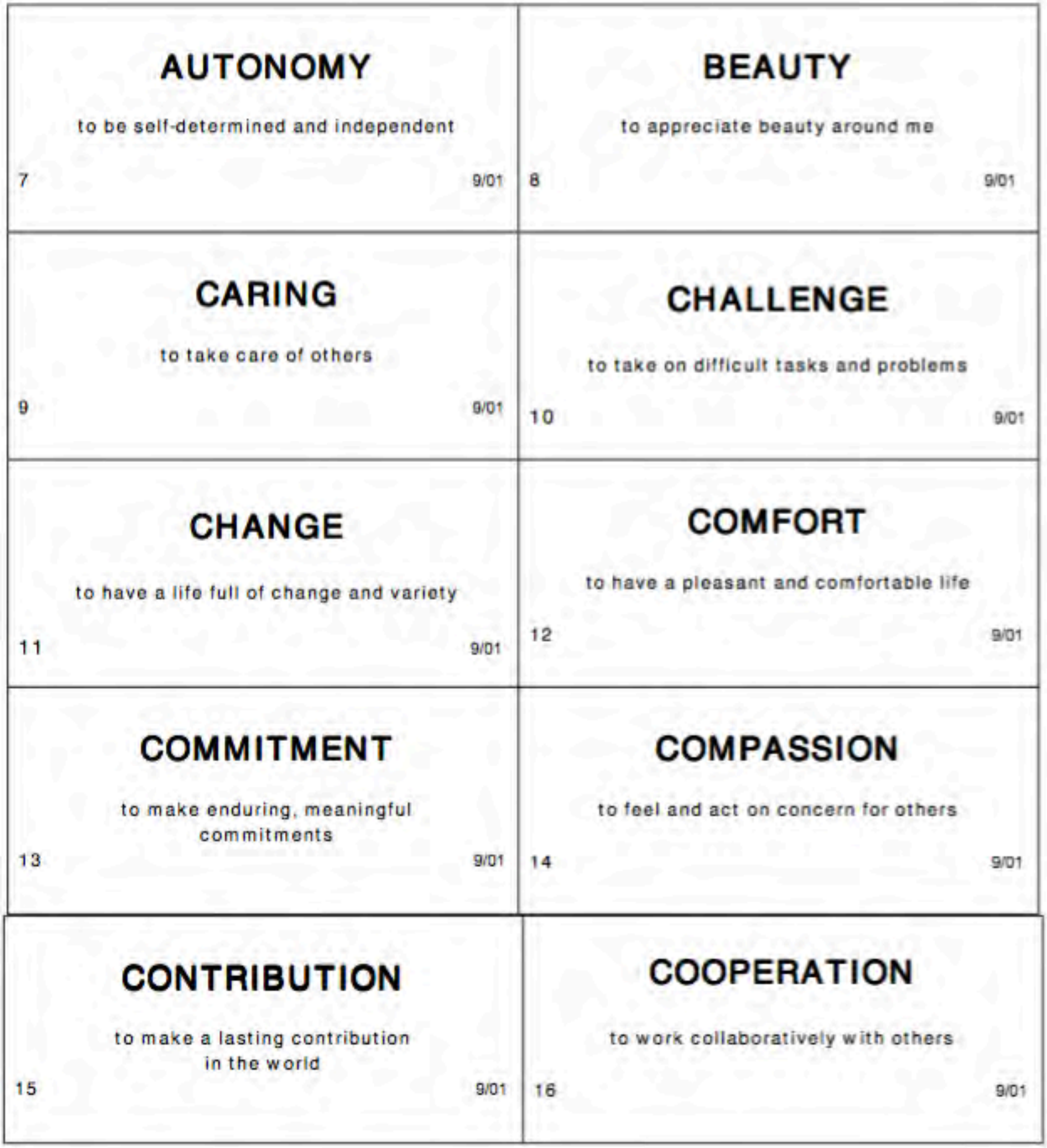
to be physically attractive

5 9/01

AUTHORITY

to be in charge of and responsible for others

6 9/01



AUTONOMY

to be self-determined and independent

7 9/01

BEAUTY

to appreciate beauty around me

8 9/01

CARING

to take care of others

9 9/01

CHALLENGE

to take on difficult tasks and problems

10 9/01

CHANGE

to have a life full of change and variety

11 9/01

COMFORT

to have a pleasant and comfortable life

12 9/01

COMMITMENT

to make enduring, meaningful commitments

13 9/01

COMPASSION

to feel and act on concern for others

14 9/01

CONTRIBUTION

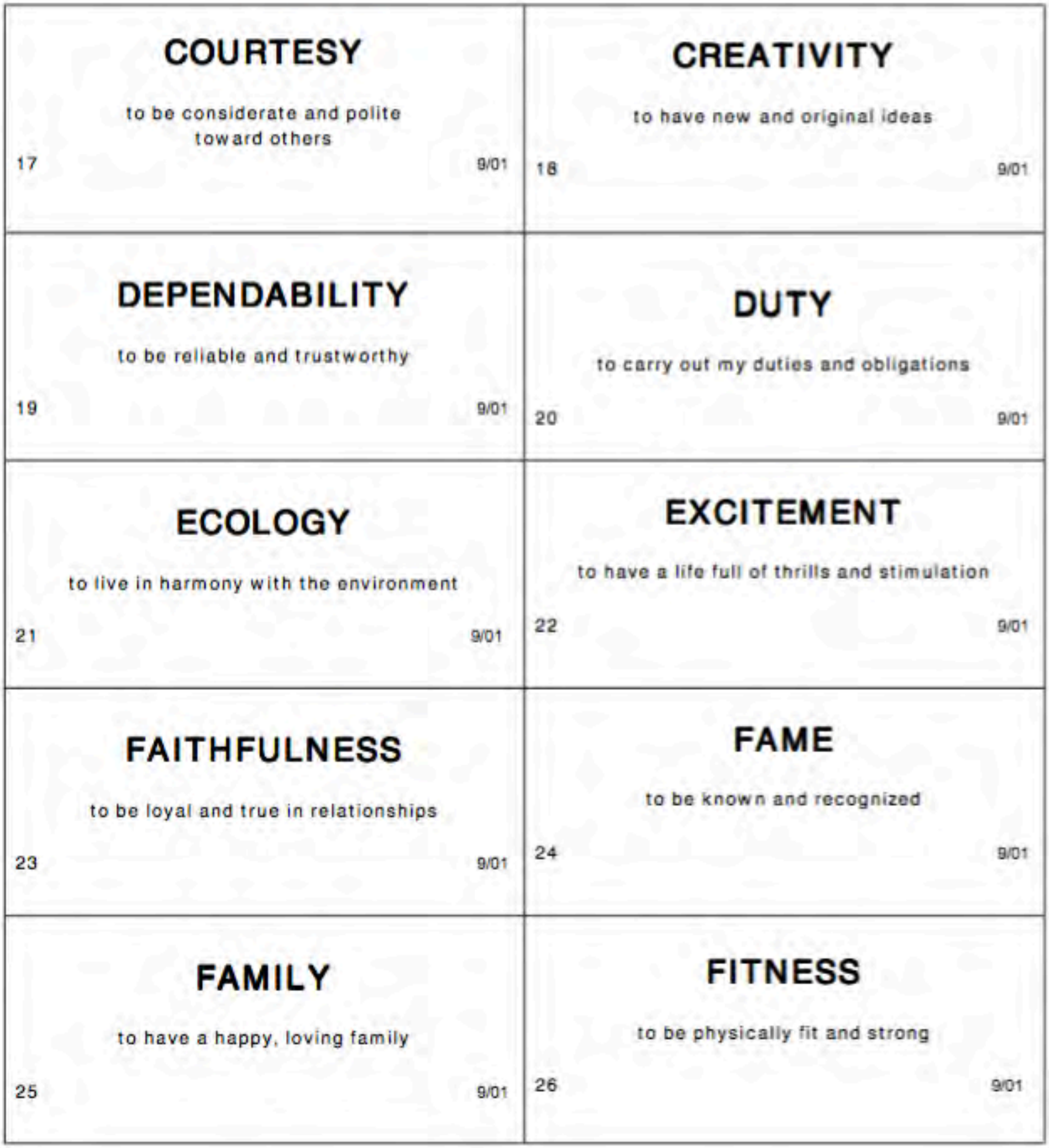
to make a lasting contribution in the world

15 9/01

COOPERATION

to work collaboratively with others

16 9/01



COURTESY

to be considerate and polite toward others

17 9/01

CREATIVITY

to have new and original ideas

18 9/01

DEPENDABILITY

to be reliable and trustworthy

19 9/01

DUTY

to carry out my duties and obligations

20 9/01

ECOLOGY

to live in harmony with the environment

21 9/01

EXCITEMENT

to have a life full of thrills and stimulation

22 9/01

FAITHFULNESS

to be loyal and true in relationships

23 9/01

FAME

to be known and recognized

24 9/01

FAMILY

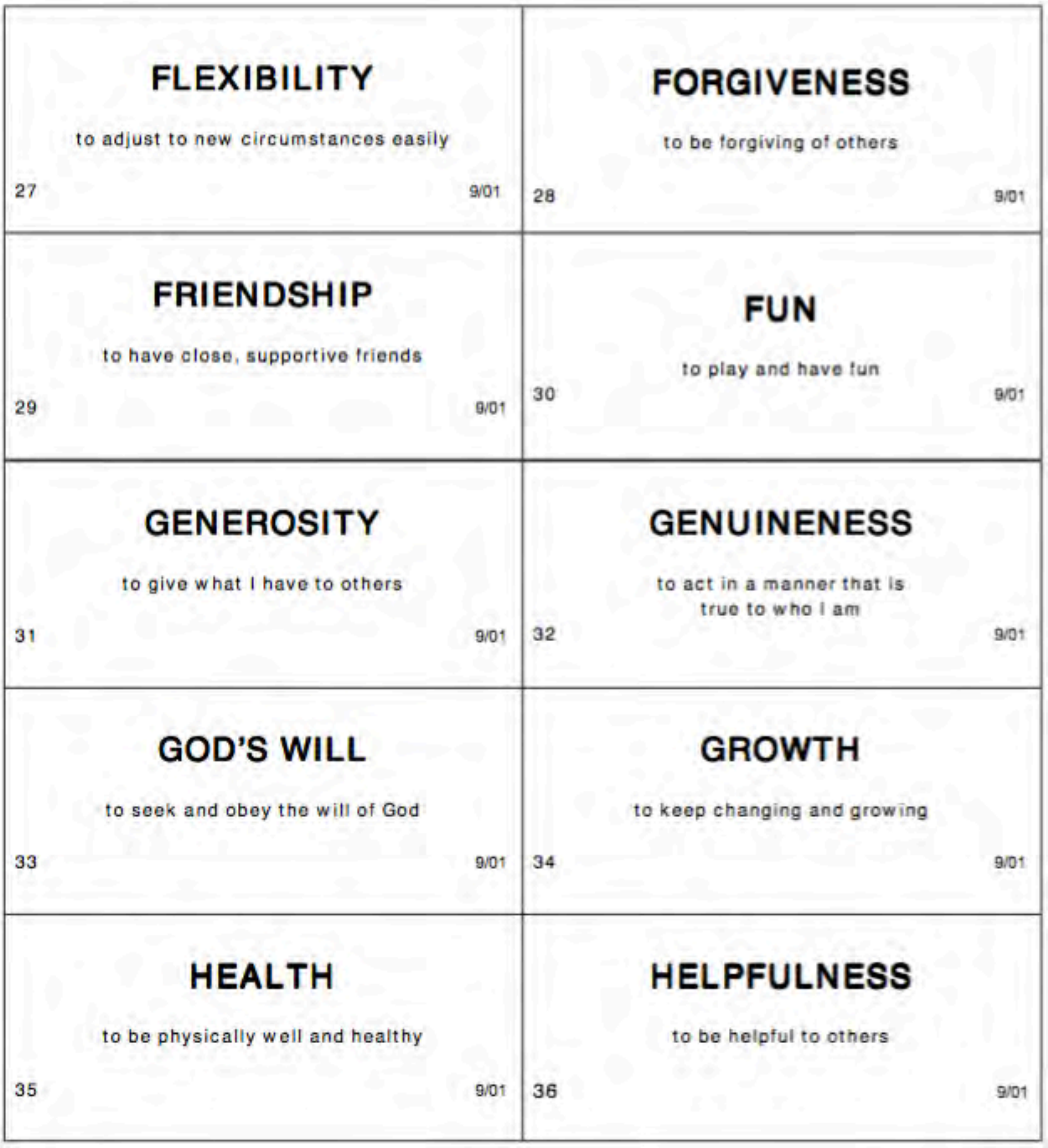
to have a happy, loving family

25 9/01

FITNESS

to be physically fit and strong

26 9/01



FLEXIBILITY

to adjust to new circumstances easily

27 9/01

FORGIVENESS

to be forgiving of others

28 9/01

FRIENDSHIP

to have close, supportive friends

29 9/01

FUN

to play and have fun

30 9/01

GENEROSITY

to give what I have to others

31 9/01

GENUINENESS

to act in a manner that is
true to who I am

32 9/01

GOD'S WILL

to seek and obey the will of God

33 9/01

GROWTH

to keep changing and growing

34 9/01

HEALTH

to be physically well and healthy

35 9/01

HELPFULNESS

to be helpful to others

36 9/01

HONESTY

to be honest and truthful

37 9/01

HOPE

to maintain a positive and optimistic outlook

38 9/01

HUMILITY

to be modest and unassuming

39 9/01

HUMOR

to see the humorous side of myself and the world

40 9/01

INDEPENDENCE

to be free from dependence on others

41 9/01

INDUSTRY

to work hard and well at my life tasks

42 9/01

INNER PEACE

to experience personal peace

43 9/01

INTIMACY

to share my innermost experiences with others

44 9/01

JUSTICE

to promote fair and equal treatment for all

45 9/01

KNOWLEDGE

to learn and contribute valuable knowledge

46 9/01

LEISURE

to take time to relax and enjoy

47 9/01

LOVED

to be loved by those close to me

48 9/01

LOVING

to give love to others

49 9/01

MASTERY

to be competent in my everyday activities

50 9/01

MINDFULNESS

to live conscious and mindful
of the present moment

51 9/01

MODERATION

to avoid excesses and find a
middle ground

52 9/01

MONOGAMY

to have one close, loving relationship

53 9/01

NON-CONFORMITY

to question and challenge authority and norms

54 9/01

NURTURANCE

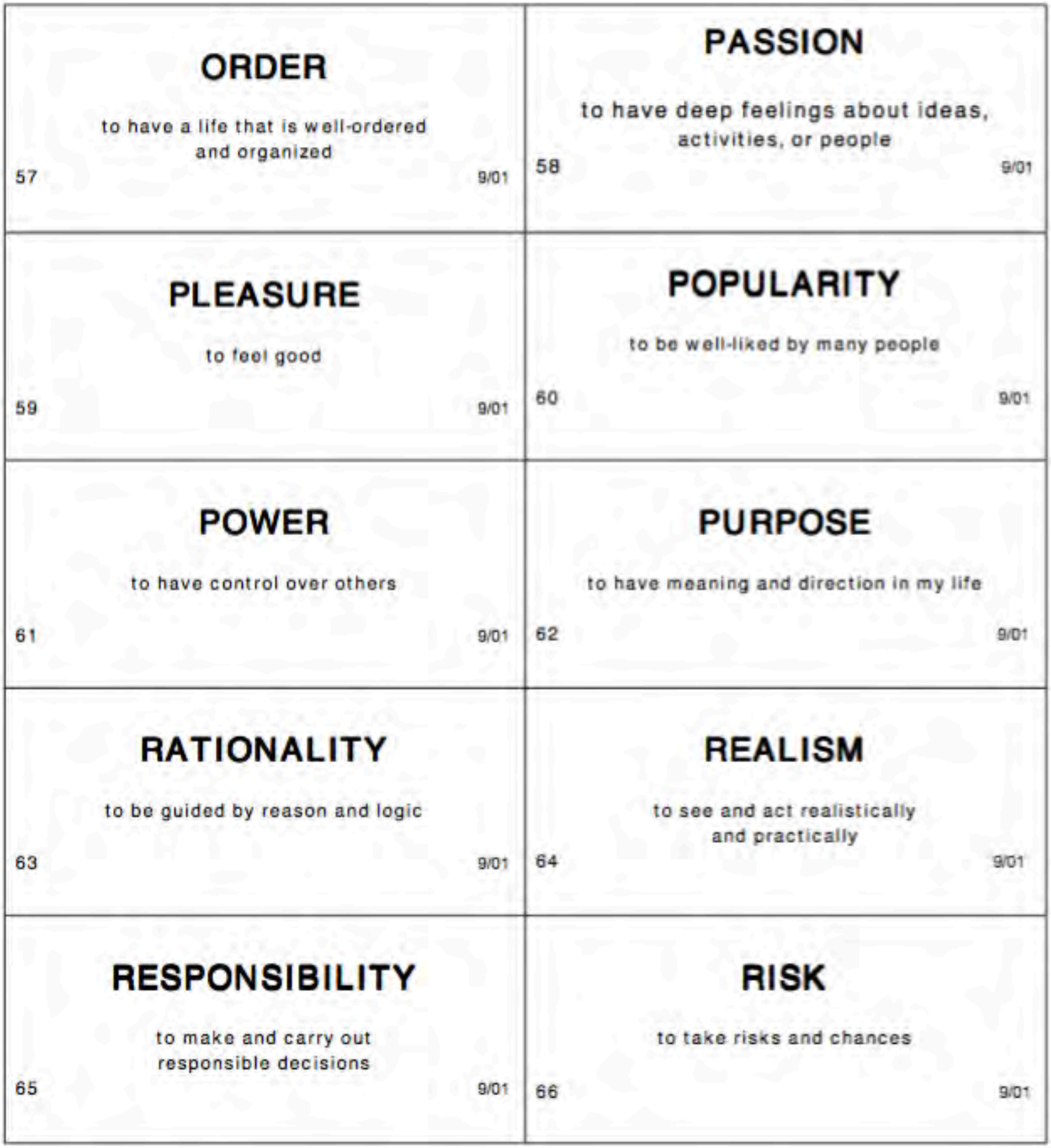
to take care of and nurture others

55 9/01

OPENNESS

to be open to new experiences,
ideas, and options

56 9/01



ORDER

to have a life that is well-ordered and organized

57 9/01

PASSION

to have deep feelings about ideas, activities, or people

58 9/01

PLEASURE

to feel good

59 9/01

POPULARITY

to be well-liked by many people

60 9/01

POWER

to have control over others

61 9/01

PURPOSE

to have meaning and direction in my life

62 9/01

RATIONALITY

to be guided by reason and logic

63 9/01

REALISM

to see and act realistically and practically

64 9/01

RESPONSIBILITY

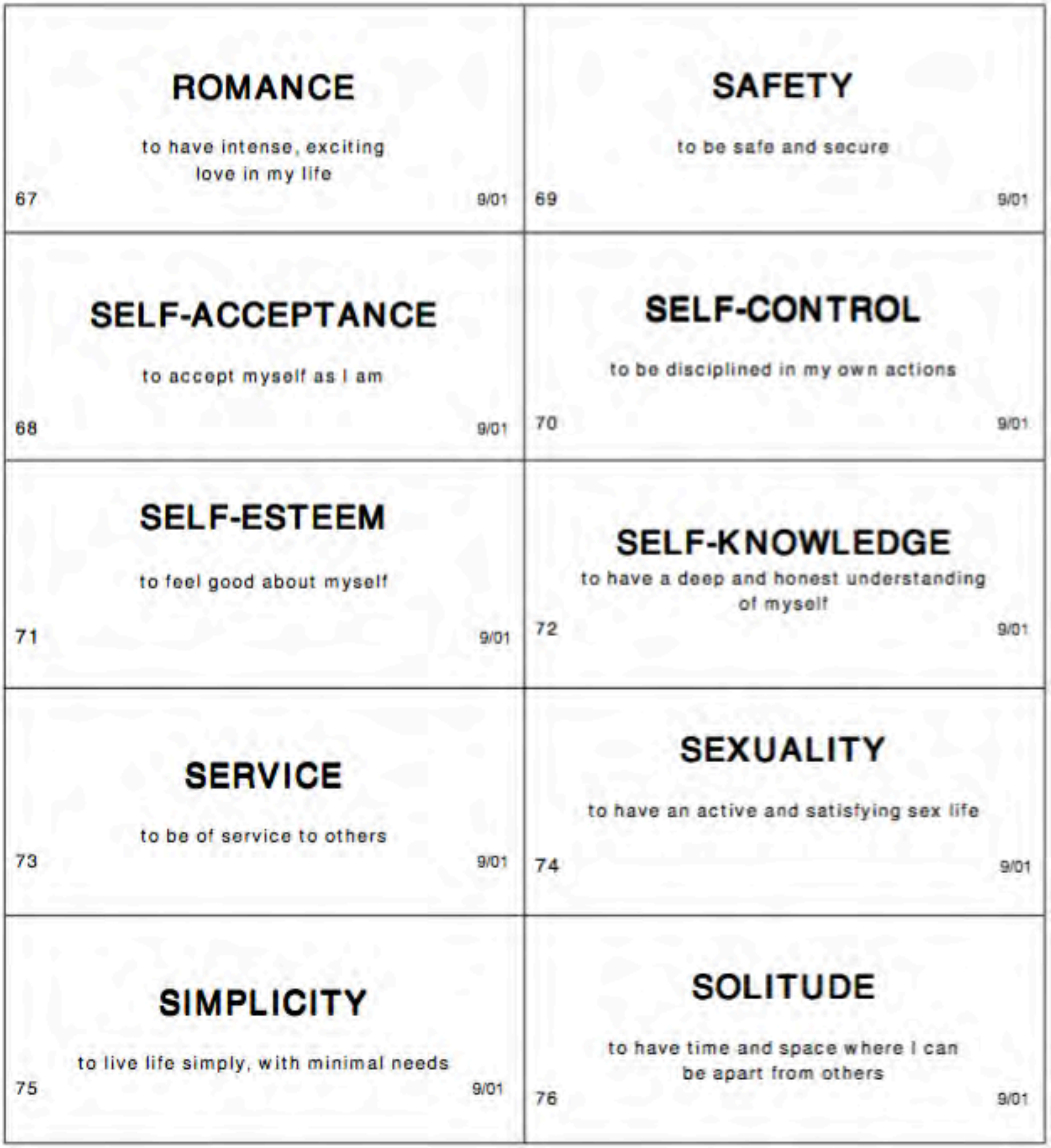
to make and carry out responsible decisions

65 9/01

RISK

to take risks and chances

66 9/01



ROMANCE

to have intense, exciting
love in my life

67 9/01

SAFETY

to be safe and secure

69 9/01

SELF-ACCEPTANCE

to accept myself as I am

68 9/01

SELF-CONTROL

to be disciplined in my own actions

70 9/01

SELF-ESTEEM

to feel good about myself

71 9/01

SELF-KNOWLEDGE

to have a deep and honest understanding
of myself

72 9/01

SERVICE

to be of service to others

73 9/01

SEXUALITY

to have an active and satisfying sex life

74 9/01

SIMPLICITY

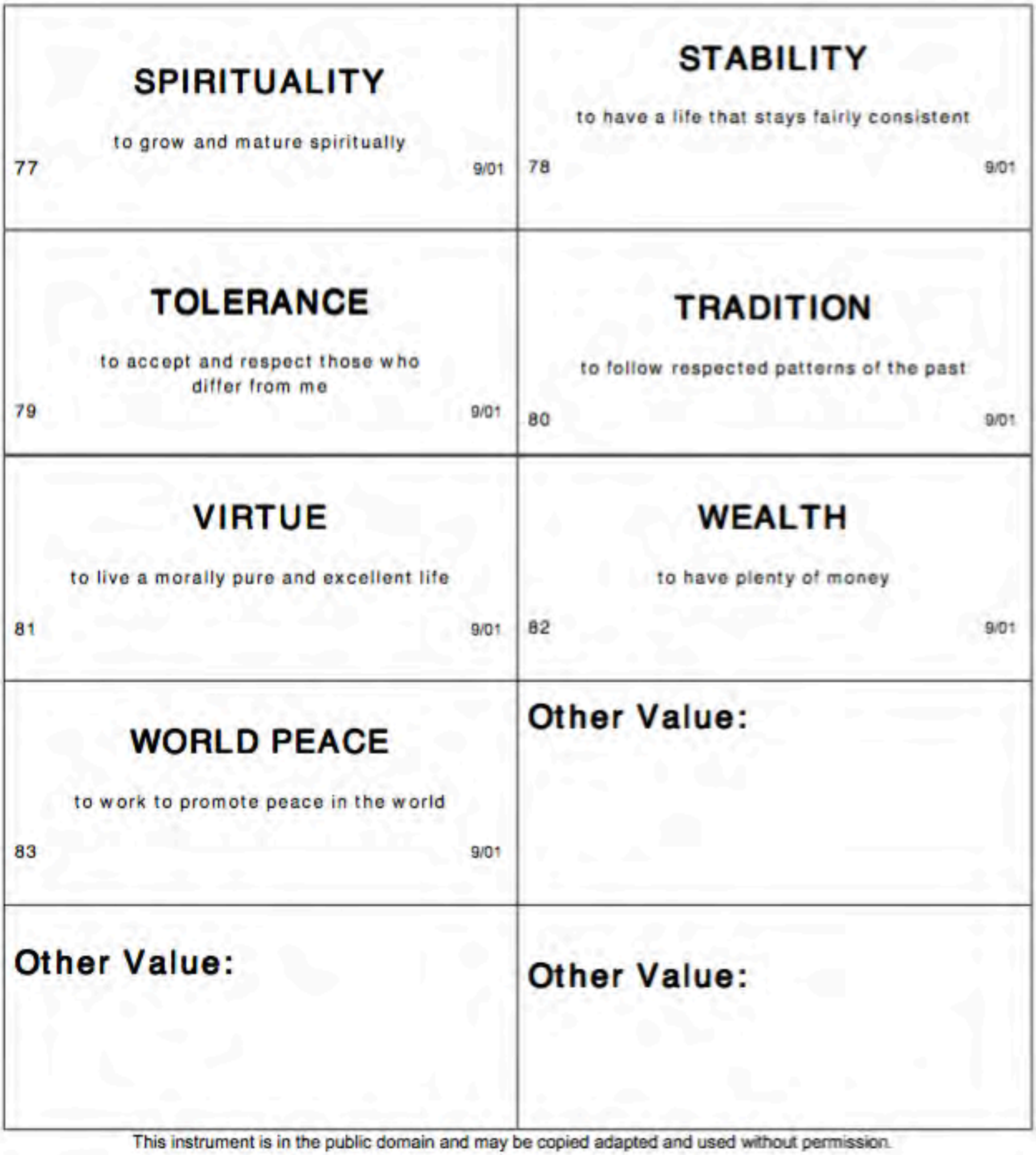
to live life simply, with minimal needs

75 9/01

SOLITUDE

to have time and space where I can
be apart from others

76 9/01



SPIRITUALITY

to grow and mature spiritually

77 9/01

STABILITY

to have a life that stays fairly consistent

78 9/01

TOLERANCE

to accept and respect those who differ from me

79 9/01

TRADITION

to follow respected patterns of the past

80 9/01

VIRTUE

to live a morally pure and excellent life

81 9/01

WEALTH

to have plenty of money

82 9/01

WORLD PEACE

to work to promote peace in the world

83 9/01

Other Value:

Other Value:

Other Value:

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Confidentiality

Purpose: To discuss the importance of confidentiality and provide an opportunity to see how confidentiality plays a role in the relationship with their peer.

Process:

1. Discuss what confidentiality means.
2. Read the following scenario to the group and ask how confidentiality was breached and if the group has other options for responding to the scenario:
    a. Jane is mentoring her peer at a local coffee shop when her friend stops by their table to say hi and asks what she is doing. Jane replies by saying, "I'm volunteering right now; this is my peer Paula and we are just finishing up our visit so I will call you later".
3. Lead a discussion with the group about the importance of confidentiality and explain how it is the cornerstone of trust in a peer support relationship and a big part of building a relationship with the peer.
4. Talk about difficulties that can come up with confidentiality especially within a smaller community and ways to respond.
5. Brainstorm with the group things to be aware of that can break confidentiality.

A few examples:

- Using a person's name when talking to others.
- Giving information that could identify the person to someone else.
- Sharing what was discussed during a visit with someone other than your peer (unless there is a legal duty to report- this will be discussed in the next activity).
- Wearing a name tag with the agency name on you during a meeting.

Duty to Report

Purpose: Through scenarios and discussion, review the situations that require a mentor to break confidentiality.

Process:

1. Review the situations where there is a duty to report and break confidentiality with a peer:
    a. Your peer discloses they are planning to harm themselves.
    b. Your peer has disclosed they are planning to harm someone else.
    c. Your peer has disclosed that a child is at risk and in need of protection.

2. Discuss who the mentor would disclose this information to:
    a. If the peer is at immediate risk, it's a call to 911.
    b. Talk to their supervisor as soon as possible.

3. Read out the scenario questions below and discuss if there would be a duty to report or not.
    a. Your peer tells you that they have been in recovery from drug use for a year now but had a slip last night. They don't want anyone to know and ask you to keep it a secret.
    b. Your peer tells you that their partner is abusive towards them.
    c. Your peer tells you that their partner hit their child the other night while intoxicated.
    d. Your peer tells you that they feel tired all the time and they are planning to end their life so they don't have to deal with their illness anymore.

4. Have the group discuss other possible scenarios that could come up during a visit.

Discussion questions:

1. How do you discuss with a peer the need to break confidentiality?
2. Who do you talk to if you are not sure if it's a situation where you break confidentiality?

Why Peer Support?

> "It is one of the beautiful compensations of this life that no one can sincerely try to help another without helping himself"- Charles Dudley Warner

Purpose: To see the impact that peer support has on the peer as well as the mentor and to give reasons as to why peer support is so important.

Process:

1. Have everyone flip to the Why Peer Support activity in their participant guide page 21 and fill in a few points on what they feel are the benefits for the peer and for the mentor during the relationship.
2. Discuss how it is naturally a give and take relationship. Even though the mentor is giving the support to their peer, it's important for the mentor to benefit as well in order to maintain interest and avoid burnout.

Examples of different benefits (there is a blank copy of this chart for participants in *Becoming a Peer Mentor: Materials and Handouts* or you can make your own chart on a white board or flip chart):

Benefits to the peer:	Benefits to the mentor:
• Support on how to manage the illness	• Experience of training
• Neutral person to talk to	• Sense of accomplishment
• Sense of worth	• Self-esteem builder
• Confidence builder	• Work-type experience
• Hope	• Self-awareness
• Someone who can relate	• Character building
• Better understanding of resources available	• Giving back to the community
• A different perspective	• Helping own wellbeing
• Compassion	• Sharing personal experience with others
• Coping skills	• New friendships/sense of community

Self-Care [Part One][13]

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.

Presenting “Self-Care [Part One]”

Materials:
- Guided meditation script
- Music (optional for meditation)

Process:
1. Review the content in the handout on pages 22-23 of their participant guide.
2. Discuss different ways to practice self-care.
3. Discuss what vicarious traumatization is and ways to avoid/mitigate it.
    - A stress reaction experienced from hearing a traumatic story.
4. Review the list of how to mitigate burn out and discuss what parts fall under the organizations responsibility and what parts fall under personal responsibility.
5. Lead the group through a short meditation as an example of a wellness tool. You can use the one provided or one of your choice [script below].

Guided Meditation Script[14]

[Intro] Have you ever noticed that when we feel stressed or anxious we feel it in different parts of our body? Some of us notice our breath getting faster, some of us may notice our stomachs getting queasy. When we can notice where we feel our stress, it’s almost like an early warning signal. Paying attention to our bodies can help us release the tension and quiet our minds

Make yourself as comfortable as possible in a position that will allow you to be relaxed and still for the length of the meditation.

Now taking a full deep breath in… Hold your breath for a brief moment… And then as you release it let it out with a sigh…Allow your body to completely relax and sink into the support of your position……If you haven’t already, then gently close your eyes.

Focus your awareness on the rhythm of your breath…. Without trying to change the way you are breathing… Just watching the way it moves through your body… Feel how your chest and belly slowly expand and contract back with each inhalation and each exhalation….With each exhalation feel your body slowly loosening…. Becoming softer and more relaxed with each out breath…

Begin to imagine that your body is like a balloon….Each time you inhale, feel it expanding…and on each exhale feel it shrinking down completely….Your body becoming more and more relaxed as you continue to breathe…There is no need to hold any tension…Just allow your body to become relaxed and floppy as though all the air has been released…Feeling completely relaxed….

Focus your attention now onto your right hand….Without moving your hand, become aware of any sensations you can feel here…Perhaps you can feel tingling, tickling, touch or a temperature… They may be pleasant or unpleasant…..Maybe you can't feel anything… That's Ok.

Move your focus up along your right arm… Notice how your arm feels…Can you feel any sensations here?

Now your left hand…. Are there any sensations you can notice in your left hand? … Seeking out even the most subtle tingling sensations…And now move your focus up along your left arm… Seeing if you can notice any sensations here…

Now become aware of how your shoulders and neck are feeling… Are there any sensations that you can feel in these areas? Sometimes it's easy to not even notice sensations until you take your awareness there…

Move your focus up to your head and face…Noticing any sensations that you may be able to feel…

On your lips… Can you feel the contact between your lips…Your eyelids? Any sensations there?

Are there any other sensations you can notice?

Now pay attention to your jaw, your teeth…Are they clenched or unclenched? ….

Now move to your shoulders….Do you notice any sensations here? …

Move your focus down your chest and belly… Noticing if any sensations stand out in these areas?

Scanning over your back….Seeing if you can feel any sensations in these areas…

And then focus on your right leg and foot… Feeling for any sensations you may be able to notice in this area….Switch your focus over to your left leg and foot and feel any sensations you may notice in this area…Does your left leg feel different from your right leg, or do they feel the same?

Become aware of your whole body…And specifically focus on the sensation of touch….

Feel the sensation of your breath as it enters and leaves the tip of your nose….Maybe noticing whether your breath is slightly cooler on the inhalation than on the exhalation….?

Notice if you can you feel the clothes against your body…Perhaps the feeling of your clothing is more obvious in certain parts than others….

Can you feel the air on your skin?

Become aware of the contact between your body and whatever is supporting you….Feel any parts of your body that may be in contact with other parts…

Now, letting go of this awareness of sensations….

(5 second pause)

And slowly begin to deepen your breath…

Slowly start to wiggle your fingers and your toes…And if you like you can stretch out through your whole body… You may wish to gently turn your head from side to side…Just waking your body up after it has been sitting still….In any way that feels comfortable for you…

And when you are ready, you may open your eyes.

Self-Care [Part Two]

Purpose: Discussing the importance of self-care, reviewing ways to monitor their own wellbeing and be aware of their own needs in each area of their wellness including: physical, psychological, social, spiritual and environmental. The group will discuss how to recognize when stress is reaching an unhealthy level and identify the need for focusing on own health, personal growth and resiliency when working as a peer mentor

Note to Facilitator:

- This can be related back to the person-centered care topic in the previous module as it is the individual who is recognizing what areas of their life need more attention and choosing what to do to assist in a more balanced state of wellness.
- Participants can omit questions if they are not comfortable answering, just remind them to change how they score it at the end (if there are 5 questions and they omit 1, they will divide their points by 4 instead of 5).
- The wellness wheel is commonly used for healing among Indigenous cultures. It aligns with the belief in making sure the full circle of mental, physical, emotional and spiritual aspects are maintained in oneself. If you are working with a peer with an indigenous background they may be familiar and comfortable with this concept already. It's important to honor and respect all cultural beliefs.

Wellness Inventory[15]

Process:

1. Have the group open their participant guide to the wellness inventory on page 24.
2. Explain that each statement in the inventory is an indicator of wellness. By completing the inventory and the wellness wheel, the participants can begin to determine the kind of balance they have in their life and be better prepared to design a personal plan for wellness.
3. Read the wellness inventory instructions below and review the "example of a completed table", the "example of colouring in a slice of the wellness wheel" and "how to determine your rating" (also below).
4. After they have responded to all the statements in the inventory, calculate the average points for each section.
5. Transfer the average points from each section of the inventory to the corresponding "slice" in the blank Wellness Wheel (at the end of the questionnaire). Then, draw a curved line between the "spokes" of the wheel.
6. Fill in the portion of each "slice" using different colours.
7. After the wheel is completed, study its shape and balance and reflect on the discussion questions.

Discussion Questions[15]:

1. In which areas of your life are you most/least well?
2. Is there a pattern you see in your inventory? Is your wheel round (would it roll)?
3. What improvements would you like to see in your wheel?
4. What type of action plans/self-care activities can you attach to each section of wheel to either improve or maintain balance?
5. What area of wellness is congruent with your values?

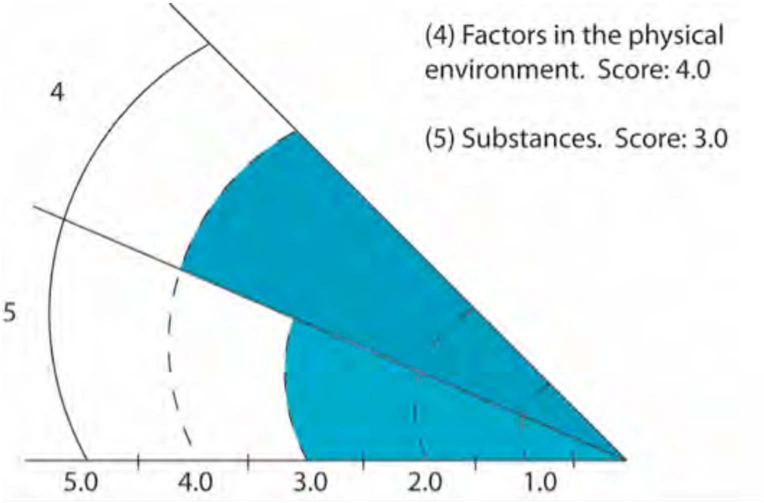
Wellness Inventory Instructions[15]:

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[15]:

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[15]:



How to Determine Your Rating[15]:

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

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.

Materials Needed:

- TV/Projector, laptop and internet to show videos;
- facilitator’s guide and participants’ guide;
- masking tape;
- white board/flip chart paper and markers.

Non-Verbal Communication[16]

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 withdrawn.

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.

Presenting “Non-Verbal Communication”

Purpose: To emphasize the importance of developing and using our nonverbal behaviours to help enhance communication. Body language not only tells us what others might be thinking but it also brings self-awareness into how we present to others.

Note to Facilitator: When referring to the SOLER acronym discuss how you would alter some of your behaviours in the case of escalation, e.g. changing your stance to allow a safe exit, or increasing the space between you and your peer. Note that there will be further discussion on responding to crisis in module 8.

Process:

1. Discuss how our body language makes up a large portion of communication. Body movements can be used to reinforce or emphasize what is being said and can also offer information about emotions and attitudes. It is also possible for body language to conflict with what is being said.
2. Review the SOLER acronym and elaborate on each item
3. Facilitators will give a mini role-play to model the acronym to the participants.

Things to Note:

- These are guidelines, they will learn what is comfortable for themselves and others when they start mentoring and it can look different for different peers.
- Every person is unique and their body language might have a different underlying cause from the ones you suspect. It’s important to check that your interpretation is correct.

Discussion Questions:

1. How do cultural differences affect how we use and interpret nonverbal communication?
2. How do we discover what is comfortable for ourselves and our peers?
3. What are some other types of body language to be aware of?

Active Listening[10]

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.

Presenting “Active Listening”

Purpose: To review and practice the role that active listening plays within communication and discuss the importance of conveying understanding through listening and responding to another person.

Note to Facilitator:

- When introducing the role-play, some participants may feel overwhelmed because they worry they will not remember everything they are “supposed” to do. Reassure them that it takes a lot of practice before feeling comfortable with all the skills learned and there is no expectation to be perfect. These exercises are designed to give the opportunity to practice in a safe space and to learn from one another.
- Have the video ready to play before starting the module. Keep in mind that YouTube links are sometimes changed. If possible, download the video and have it saved in a folder on your laptop for easy access. Try: https://keepvid.com/ to download videos.

Materials:

- *It’s Not About the Nail* video: https://www.youtube.com/watch?v=-4EDhdAHrOg;
- TV/projector, laptop & internet access for video;
- scenario list for role-plays.

Process:

1. Review the content on the active listening handout in participant guide pages 37-38 and clarify each point.
2. Facilitators will role-play some quick examples of the active listening skills.
3. Watch the video: *It’s Not About the Nail.*
4. Debrief the video: although it’s a humorous video there is a message behind it that sometimes we just need to be heard by someone without being given a solution.
5. Split group into pairs or triads to complete a role-play using the active listening skills discussed.
    - If there is a group of 3, one person can be the observer.
    - Participants will take turns being the peer and mentor.
    - They can use the scenario sheets in their participant guide page 115-116 for ideas or come up with their own scenario.
6. Lead the group through discussion questions.

Discussion questions:

1. How does it feel when you know someone is not fully hearing what you are saying?
2. What helps you to stay more mindful when having a conversation?
3. When would be an appropriate time to interrupt a peer and how do we do it respectfully?
4. How did it feel to use the skills discussed in the handout?

Closing Comments:

- Active listening requires a lot of concentration and sometimes it's hard to break our old listening habits, but we can help improve this skill with practice. Be deliberate with your listening and giving yourself gentle reminders to put aside distractions and concentrate on what the other person is saying.
- Note that the first few times they practice these skills through role-play it may feel artificial but in an actual mentoring visit this will feel more natural because it is being used in combination with other skills.

Empathy

Purpose:

Learning to reflect understanding and sensitivity towards a peer's feelings and experiences, whether or not they are able to personally identify with the situation.

Materials:

- TV/projector, laptop & internet access for video;
- *Brené Brown on Empathy* video: https://www.youtube.com/watch?v=1Evwgu369Jw.

Note to Facilitator: Have the video ready to play before starting the module. Keep in mind that YouTube links are sometimes changed. If possible download the video and have it saved in a folder on your laptop for easy access. Try: https://keepvid.com/ to download videos.

Process:

1. Watch *Brené Brown on Empathy* and debrief the video afterwards.
2. Explain the difference between empathy and sympathy.
3. Provide examples of empathetic responses. Remind the group that empathy is about recognizing and validating the peer's emotion first and most importantly. Afterwards it can be followed by a statement or question. For example:
   - "I can understand why you would be feeling scared; it's not easy dealing with a new diagnosis."
   - "It sounds like you are feeling frustrated and that's okay, what would help change your perception of this?"
   - "I'm happy to hear you are feeling excited and motivated to make a change. I would love to help you set up some goals if you are ready."

4. Discuss the benefits of empathy:
   - builds a relationship where the peer feels supported and understood;
   - explores the peers' feelings in a non-judgmental way;
   - focuses the attention in a direction that leads to deeper understanding;
   - a way to check perceptions;
   - a way to hold space for emotions;
   - helps keep the mentor from asking too many questions or trying to "fix it".

5. Brainstorm responses to avoid that can get in the way of the helping relationship. Discuss the examples below in more detail:
   - responding with a question before validating feelings;
   - responding with a cliché;
   - responding with your interpretation;
   - responding with advice;
   - responding with pity/sympathy;
   - responding with a solution/rescuing statement.

6. Have the participants split into pairs and practice giving empathic responses. The scenario sheet can be used. Found in participant guide pages 115-116.

Cultural Iceberg[17]

Purpose: To be able to distinguish between the visible and invisible aspects of culture and to be able to explain how the invisible aspects of culture influence the visible ones.

Process:

1. Before beginning the activity explain a bit about culture to the group, covering the following points:
    - It is the set of shared attitudes, values, goals, and practices within an ethnic, religious or social group.
    - It shapes how we see the world, ourselves, and others.

2. Explain that metaphors often help us understand big ideas by relating something we don't know to something we do know. A useful metaphor for culture is an iceberg. Ask the group what they know about the size and shape of icebergs. How much of an iceberg is above the water? How much is underwater?

3. Make the point that only about one-eighth of an iceberg is visible above the water. The rest is below. Culture is similar to an iceberg as it has some aspects that are visible and many others that can only be suspected, guessed or learned as understanding of the culture grows. Like an iceberg, the visible part of culture is only a small part of a much larger whole.

4. Divide participants into groups of 4 and ask them to turn to the worksheet, “Cultural Iceberg” in their participant guide on page 40. Explain that the numbered items on the list are all features of culture.

5. Have them use the outline drawing of an iceberg in their participant guide (page 41) and ask the groups to look at both their outline drawing of the iceberg and their Features of Culture worksheet and review the features one by one and decide as a group if a particular feature belongs above the line (i.e., is "visible") or below the line (i.e., is "invisible") and write the numbers of those features either above or below the line.

6. If needed you can do the first few features with them. Provide examples, e.g., values cannot be directly observed; holiday customs are visible.

7. After the groups are done have them pair with another group and compare their placement of features. They must be prepared to say why they placed a particular feature where they did.

8. **Note:** In the list of features, the numbers that should appear below the water line are #3, #4, #6, #8, #9, #10, #16–18, #22–24, #26–30.

Discussion Questions:

1. Why is it important to know what is visible and invisible within a culture?
2. Do you see any item below the water line that might influence or determine any item above?
3. How will this benefit you and your peer within the helping relationship?

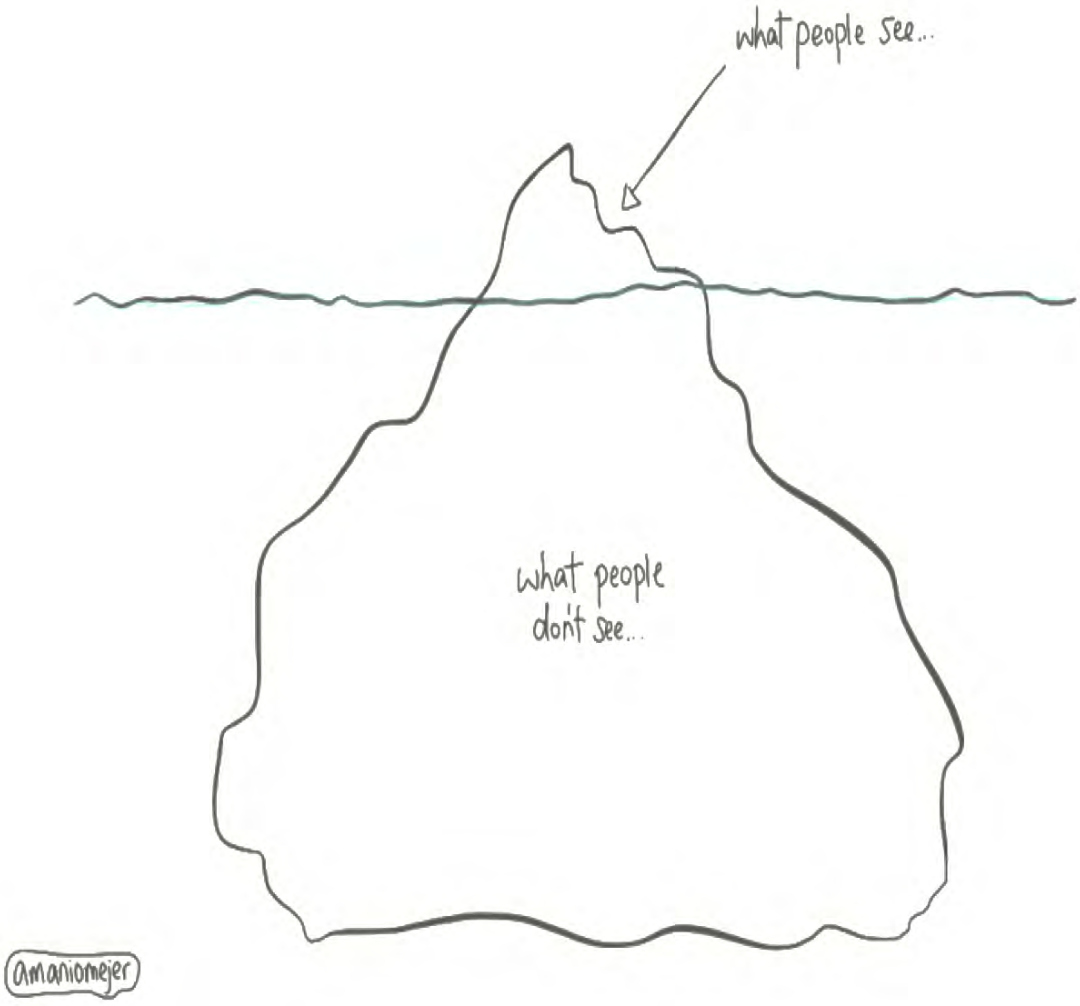


Image source: https://themighty.com/2017/02/emotion-loneliness-of-being-sick/

Communication Blocks and Enhancers

Purpose: To identify and discuss experiences in which communication blocks were a factor during conversations and other interactions where information needed to be shared.

Materials:

- TV/projector, laptop and internet access;
- *Brené Brown on Blame* video: https://www.youtube.com/watch?v=RZWf2_2L2v8;
- whiteboard/flip chart paper and markers.

- **Note to facilitator:** Have the video ready to play before starting the module. Keep in mind that YouTube links are sometimes changed. If possible download the video and have it saved in a folder on your laptop for easy access. Try: https://keepvid.com/ to download videos.

Process:

1. Write the discussion questions on the board and have everyone break into small groups to discuss the questions. Have them choose someone to be the recorder/note taker.
2. After everyone is done ask them to come back together as a large group and have 1 person from each group report back the key points from the discussion they had in their small group. Facilitator will take notes on the whiteboard/flipchart.
3. Watch the video *Brené Brown on Blame* and discuss communication blocks that happened within the video.

Discussion Questions[1]**:**

1. What can block effective communication?
2. What are some examples of conversation enhancers?
3. How can we provide feedback so that our peer is receptive to it instead of defensive?

Examples of discussion question #1 - communication blocks include[1]**:**

- Changing the subject without explanation.
- Advice and persuasion.
- Approval or disapproval on personal grounds.
- Denying their feelings.
- Commands or orders.
- Blaming.
- Status or power imbalance if either party views their position as less or greater.
- Stereotyping by expecting certain behaviours because of your perceptions of a person's culture.
- Strong feelings about the subject or individual.
- Past experiences.
- Pre-occupation.
- Hidden agenda.
- Defensiveness.

Experience Cube[18]

Purpose: To practice effective communication skills in a way that takes conflict and blaming out of the conversation and allows all parties to be heard and give room for more clarity and understanding.

Materials: Masking tape

Facilitator opening comments: If we want to learn from our experiences and we want to help our peers learn from their experiences, then we have to get clear on what experience is. As humans, we are wired to make sense of the happenings in the world around us. When we don't have all the information, we fill in the gaps, we make up stories and tend not to check out our stories with the person about whom it is made up. "Everyone creates their own experience, everyone is having a different experience, and everyone is making up stories about each other's experience"(Bushe, 2009). Gervase Bushe came up with a model called the Experience Cube to help people better understand and learn from their experiences. He says, every experience is made up of 4 elements: observations, thoughts, feelings and wants. The Experience Cube activity will help mentors become aware of their own moment-to-moment experience. It will also prepare mentors to help peers become more self-aware by noticing the 4 elements of their experience.

Note to Facilitator: When the participants share an experience, encourage them to share their experience of the present moment or a very recent experience. Experience only happens in the here and now. People have memories of past experiences, but these are mental constructs that change and not the actual experience. Also encourage participants not to choose something that will trigger them. Keep it light for the purpose of practice. Let the group know there is a handout on coaching questions and feeling words in the participant guide on page 42 that can be used if needed during the practice.

Roles:
In groups of 2, each individual will take turns acting as Person A and B. In groups of 3, add an observer.

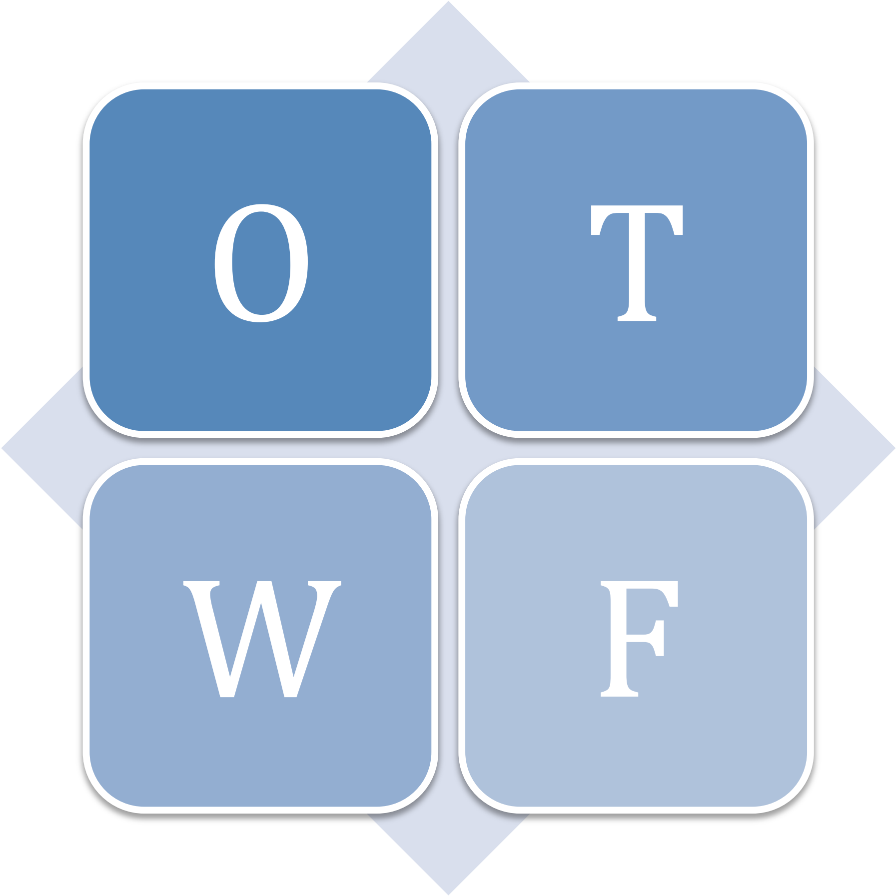
- Person A shares their experience by breaking it down into the 4 elements. Person A starts by standing in the observation square of the cube and shares the observations of their experience (what a video camera would pick up) then moves through thoughts, feelings and wants. The goal is to distinguish observations from thoughts, feelings and wants. This can be quite challenging as often we blend these things.

- Person B practices active listening by summarizing Person A's experience (after Person A is finished talking) in order to clarify Person B's understanding of Person A's experience. Person B can use the coaching questions in their participant guide if person A is struggling to describe their experience or simply to gain more understanding. Person B can only interrupt if Person A is in the wrong square (e.g. "what you are talking about is a feeling, not a thought").

- Observers watch the interaction and share their observations of the exchange between Person A and B.

Description of the 4 elements of experience:

- Observations: What a video recorder would pick up
- Thoughts: Mental constructs, stories or assumptions
- Feelings: Sensations and emotions
- Wants: Motives, aspirations, objectives and desires



Process:

1. Use masking tape to create one experience cube for each group on the floor. Each square will have a different letter that represents an element of the experience cube (see above image). Draw the diagram and legend on the board/flipchart for participants to follow:
    a. O=Observations
    b. T=Thoughts
    c. W=Wants
    d. F=Feelings

1. Arrange the participants into groups of two or three.

2. Groups of two will be assigned a role of Person A or Person B. Groups of three will have Person A, Person B and an Observer.

3. Review the roles with the groups (see above for roles).

4. Person A shares their experience (in the moment or very recent) and will "walk through the cube" by stepping into each square (O, T, W, F). While standing in a square they can only speak to that element of experience represented by the letter in their cube before moving on.

5. Person B summarizes Person A's experiences. E.g., "What I heard was that you observed/ thought/ wanted/ felt ______________" (Person B's paraphrasing Person A).

6. After Person B shares their perspective, Person A can clarify or agree with Person B's summary.

7. Person A talks about how they felt being in that role as they moved through each square and Person B shares how they felt as a listener. Observers can share their perspectives during this time.

8. Switch roles so that Person B is now the speaker and Person A is the listener. In groups of 3, change roles 3 times so each person has the opportunity to practice each role.

9. After everyone has a chance to share their experiences, gather the group together to go over the discussion questions.

Discussion Questions:

1. Did you find that you gained clarity of your experience through this exercise?
2. Were you able to notice when/if you experienced internal chatter and wanted to offer a solution to the person who was sharing their story?
3. When asking questions were you asking for gaining more information or for your own curiosity?
4. How could your motivation for asking a peer a question affect your relationship with them?
5. Were you okay with being silent and not responding until the end?
6. How can we lead ourselves through this exercise if we need to gain clarity on our experiences but do not have anyone to talk to in that moment?

Closing comments:

The stories we tell ourselves about what we think happened can often be worse than what actually happened. Moving through the experience cube helps us to fully understand what we do and do not know about a situation or to clarify what went wrong during a conflict or interaction.

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.

Materials Needed:

- facilitators guide & participants guide;
- whiteboard/flipchart paper and markers.

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.

Presenting “Stages of the Helping Relationship”

Purpose: Setting up the foundation of the helping relationship will ensure that there is a feeling of safety and connection between the peer and mentor throughout the relationship.

Process:

1. Review the three stages in the “stages of the helping relationship” handout found in the participant guide on page 45 and discuss each point.
2. Brainstorm examples of some of the points with the group to help clarify if needed.
3. Lead the group through discussion questions.

Discussion Questions:

1. Why is it important to know what’s involved in each stage of the helping relationship?
2. If it doesn’t feel like a good match for the peer or the mentor what can be done?
3. What are some reasons for a helping relationship to end? What are some signs that there has been a natural end to the relationship?
4. What kind of topics would you discuss in the first couple visits?
5. What are some ways to maintain the relationship if your peer chooses not to set a goal?
6. Why is it important to treat every new helping relationship as unique?

Building a Relationship with Peers

Purpose: Trust is a crucial component of relationship building and is critical to the relationship between peer mentors and peers.

Materials: whiteboard/flipchart**,** markers.

Process:

1. Open by explaining the importance of trust in the helping relationship: When you trust someone, you feel safe with them physically and emotionally. Their actions have shown you that they are reliable and you have confidence that they will be there for you.
2. Brainstorm with the group what helps to build trust. Use the examples below under "What helps build trust?" to help promote discussion and have the group add anything they feel is missing. Write their answers on the board.
3. Lead the group through discussion questions.

What helps build trust?

- Be honest.
- Keep confidentiality (except when you have a duty to report).
- Be genuine and authentic.
- Keep commitments.
- Show consistency in your behaviour.
- Be neutral when placed in difficult predicament.
- Aim to be objective and show fairness.
- Hold space for emotion.
- Be patient and flexible.
- Practice your own self-care.
- Clarify expectations and boundaries.

Discussion Questions[1]

1. What qualities do you look for in someone you trust?
2. What is the role of trust in a peer support relationship?
3. What can get in the way of building trust?
4. What do you think is important for building rapport with a new peer?
5. How will you explain the role of a peer mentor to a peer that you are paired with?
6. How would you integrate confidentiality and boundaries into your relationship building?
7. How can we rebuild trust if it's broken?

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. [19]

When giving information, Egan[19] 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.

Presenting “Giving Information”

Purpose: Giving information can help guide a peer towards resources that they may not be aware of, it also takes pressure off the mentor to feel they should “have all the answers or fix it”.

Process:

1. Review the handout “giving information” found in the participant guide on page 46.
2. Read the following scenario and discuss how a mentor could provide information to the peer:
    - “I have been trying to get off drugs since my diagnosis. I have been to treatment 4 times and it doesn’t seem to work. My friend told me she is on methadone and finds it’s helpful. I’m considering it but I don’t know where to start.”
3. If you know of a community resource information hub (e.g. website) that connects people to resources, show/tell the participants how to access it.
4. Lead the group through discussion questions.

Discussion Questions:

1. How can we avoid letting our own bias get in the way of giving information?
2. What is the difference between giving advice and sharing information?
3. What can we do if we are unsure what type of information to give or unsure if our information is accurate?
4. How do we give information while staying within our scope of practice?

SMART Goals[20]

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 is 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).

Presenting “SMART Goals”

Purpose: SMART is a well-established tool that can be used to plan and achieve goals. When you use SMART, it helps create clear, attainable and meaningful goals and develops the motivation, action plan, and support needed to achieve them.

Materials: flipchart paper/whiteboard and markers.

Process:

1. Review the SMART goal diagram in the participant guide page 47.
2. Brainstorm with the group and pick an example of a goal that a peer may want to set.
3. Write the SMART acronym on the board and work through the example goal with the participants in a way a mentor would with a peer.
4. Lead the group through discussion questions.

Discussion Questions[1]:

1. What are the different areas of our lives that goals can focus on?
2. Why is goal setting important for us to consider as peer mentors?
3. How can we apply goal setting and S.M.A.R.T goals to our peer relationship?
4. When would we need to set limits in goal setting?
5. What’s the difference between empowering individuals to take steps towards their goals versus doing it for them? Can you think of some examples?

Egan’s Helping Model[21]

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 possibilities
- 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

Purpose: This is a model used in coaching/mentoring situations where the hope is to achieve lasting change and to empower our peers to manage their problems more effectively and develop opportunities. This can be used to get to a point of goal setting, giving information or simply offering emotional support depending on what the peer’s needs are.

Materials: flipchart paper/whiteboard and markers.

Process:

1. Review the graphic found in the participant guide page 48 and explain that Egan’s helping model is a useful framework for mentoring that can be broken down into these three section. Write these sections on the board or flipchart paper.
    a. **Exploration -** What is going on?
    b. **Challenging -** What do I want instead?
    c. Action Planning - How might I achieve what I want?

2. Discuss with the group in more detail what the role of the peer mentor is in each of these sections and which of their skills are being utilized.
    a. **Exploration:** Listen to your peer’s experience without judgement and help them identify and clarify their main concerns, areas they would like to work on, opportunities and resources available to them.

Some skills used include (group can add more):

- conversation starters;
- open-ended questions;
- silence;
- active listening.
- empathy;
- paraphrasing;
- summarizing;

b. **Challenging:** Encourage your peer to identify what they want and need, encourage them to consider new possibilities and perspectives, choose goals that are realistic and consistent with their values and resources available to them.

Some skills used include (group can add more):

- goal setting;
- open ended questions;
- empathy;
- active listening;
- coaching questions (as used in experience cube);
- encourage personal responsibility.

c. **Action Planning:** Help your peer to move into problem solving or decision-making methods while providing support and encouragement. Follow up throughout future visits to see if the peer was able to follow through on an action point. **Important note:** Do not judge if they haven't achieved the goal, instead remind them why they stated the goal was important to them and look at if any action steps need to be altered to help with success. If you feel the goal is beyond your skill set to assist with you can give them information and resources to help them achieve their goal.

Some skills used include (group can add more):

- goal setting;
- decision Making;
- problem solving;
- giving information.

3. Have participants practice this model through role-plays.
   - Split into pairs (or triads if there is an uneven number of participants). Each person will get the opportunity to be the peer and the peer mentor. If there is a third person, you can create the role of an observer. The peer can use the scenario sheet or come up with their own scenario. Scenarios can be found in their participant guide pages 115-116.
   - In this role-play encourage them to use the different communication skills they have learned as well as practice SMART goal setting and giving information.

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.

Materials Needed:

- facilitators guide and participants guide;
- whiteboard/flipchart paper and markers;
- TV/projector and laptop and internet access for video;
- pens.

Introduction to Boundaries[1]

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.

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 when we think about 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

Presenting “Introduction to Boundaries”

Purpose: To discuss the boundaries that participants have established in their relationships as well as reflect on what factors contribute to healthy and safe boundaries. Establishing healthy boundaries is essential for all relationships because they keep people safe.

Materials: TV/projector**,** laptop, internet access for video and *Boundaries with Brené Brown* video: https://www.youtube.com/watch?v=xATF5uYVRkM.

Note to facilitator: Have the video ready to play before starting the module. Keep in mind that YouTube links are sometimes changed. If possible, download the video and have it saved in a folder on your laptop for easy access. Try: https://keepvid.com/ to download videos.

Process:
1. Review the “Introduction to Boundaries” handout in the participant guide page 50.
2. Introduce boundaries by watching *Boundaries with Brené Brown.*
3. Debrief the video.
4. Lead the group through discussion questions.

Discussion Questions:
1. How will our personal boundaries show up in a helping relationship?
2. How will role specific boundaries show up in a helping relationship?
3. What are some fundamentals that must be clear to keep you and your peers safe?
4. How do your boundaries look different depending on your relationship with a person?
5. How do we respect our peer’s boundaries when they are not the same as our own?
6. How does culture play a part in boundaries?

Personal Boundaries

Purpose: To have the participants experience what it is like to recognize when they need to set a boundary; what it feels like to set the boundary; and respecting another person's boundary.

Note to Facilitator: You will need space for the first activity. It works well outside or in a room where there is space to walk.

Process:
1. Divide the participants into groups of two and have them stand about 10-15 steps apart, facing each other.
2. Participant A begins walking slowly towards participant B.
3. When participant B feels that participant A has come as close as their boundaries allow, they must put their hand firmly in front of them and say "stop" at which point participant A freezes.
4. Switch roles.
5. After everyone has had a chance, come back as a large group and discuss questions.

Discussion Questions:
1. Did you say stop at the time you thought you would?
2. How did it feel to set your boundary?
3. How did it feel to respect someone's boundary?
4. If you knew the person, did you let them get closer than you would have if they were a stranger?
5. Did you stop before your partner asked you to stop based on your own personal boundaries?
6. Did you push your own boundary and say stop later than you thought you would because you did not want to offend the other person?

Personal Bill of Rights

Purpose: Reminding ourselves of our personal rights and getting clear about how we deserve to be treated by others.

Materials: pens.

Process:

1. Explain to the group that a bill of rights is another way to recognize our personal boundaries and what is important to us to feel safe and respected.
2. Brainstorm some examples that reflect personal rights:
   - I have the right to ask for what I need;
   - I have the right to say no to requests or demands I can't meet;
   - I have the right to express my feelings;
   - I have the right to change my mind;
   - I have the right to make mistakes;
   - I have the right to say no without explanation;
   - I have the right to be treated with dignity and respect and compassion.
3. Have the group open to the personal bill of rights page in their participant guide page 51.
4. Give everyone time to record their own bill of rights.
5. Ask if anyone wants to share.
6. Encourage the participants to read their bill of rights whenever they need a reminder.
7. Lead the group through discussion questions.

Discussion Questions:

1. How did it feel to establish your personal rights?
2. Did you notice a right that you need to enforce more?
3. Do the rights you wrote down reflect the values you chose in the personal values activity?
4. How can we make sure our personal bill of rights is respected by both ourselves and others?

Factors That Influence Our Boundaries[22]

The "perfect peer phenomenon" [22]
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? [22]

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.

Presenting “Factors That Influence Our Boundaries”

Purpose: To recognize what factors can influence/change the way we set boundaries and to see how our personal accountability and self-care play a role in maintaining boundaries.

Process:

1. Review the handout “factors that influence our boundaries” in the participant guide page 52 and lead the group through the discussion questions.

Discussion Questions:

1. How can we manage our self-care while balancing our mentor responsibilities and other daily tasks?
2. How do we let go of guilt that goes along with the “perfect peer phenomenon”?
3. Can you think of the factors that may influence your boundaries?
4. Why is knowing that our boundaries can be influenced important in our role as a mentor?
5. How can we be clear in how we set boundaries if they look different for different people?
6. How can other people’s expectations of us influence our boundaries?

Setting Limits

Purpose: Boundaries and limits are the foundation of a strong and safe relationship. Boundary violations can be harmful for both a peer as well as a mentor. Through practice and discussion, the participants will learn how to set limits through the skill of gentle refusal.

Note to facilitator: Have the video ready to play before starting the module. Keep in mind that YouTube links are sometimes changed. If possible, download the video and have it saved in a folder on your laptop for easy access. Try: https://keepvid.com/ to download videos.

Materials:

- whiteboard/flipchart and markers;
- TV/projector, laptop and internet for video;
- *3 Boundaries You Must Set in Every Relationship* video: https://youtu.be/sUpZgwLQvSM.

Process:

1. Watch and debrief the video: *3 boundaries you must set in every relationship*.
2. Begin the activity by asking the group the following questions:
    a. Have you ever been in a situation where you were asked to do something you didn't want to do, but didn't know how to say no?
    b. Can you think of a time where you wanted to help out but not to the extent that you became involved?

3. Introduce why you would need the skill of gentle refusal:
    - If during a conversation you find that you need to set a limit, one effective way is through gentle refusal which provides you with a way to say "no" as gently and caringly as possible while still allowing the conversation to continue on a constructive level.

4. Brainstorm when you would use gentle refusal, some examples include:
    - a person makes an unrealistic demand/request of you;
    - a person wants a guarantee;
    - a person demands advice;
    - a person asks personal questions that you are not comfortable answering;
    - you want to end a conversation.

5. Review the model for gentle refusal below by writing the 3 points up on the whiteboard/flip chart paper and work though an example scenario with the group.

Example: Your peer asks to borrow money.

1. Reflection: Let your peer know that you heard their request by reflecting their feelings/needs:
"I know you mentioned feeling scared and struggling financially right now".

2. The Refusal: setting your limit or saying "no": Say as clearly as you can what your limits are and if you choose, your reason. Remember, it is okay to say no without an explanation.)
"No, I'm not able to do that" or "It's against policy to lend our peers money".

3. Offering the invitation: Let the peer know what you can/are willing to do to help.
"However, we can look at other resources you can access to help out until your next cheque".

6. After the discussion, break into small groups have participants discuss the following scenarios as well as role-play setting limits using the gentle refusal model. Explain to the group that there is no "right" or "wrong" way to answer these questions and some of the questions may have different answers depending on your comfort level or agency policy. The goal is to have a good sense of personal boundaries.

- Your peer is feeling overwhelmed and doesn't want to leave the house, they ask you to come to their place to have the visit.
- Your peer is asking personal information about yourself.
- Your peer is asking you for a hug.
- Your peer has phoned you late at night 2 times in a week requesting support.
- Your peer has asked if they can add you to Facebook.
- Your peer asks to have the meeting at a pub/bar in town.
- Your peer asks you to attend their doctors visit with them to help advocate.
- Your supervisor phones and asks you to cover peer support group because another mentor cancelled but you are not feeling up to it.
- Another mentor on your team phones you to talk because they had an awful day, they have been supportive to you in the past but you also had a bad day and don't feel like you can be there for them.

Using "I" Messages[10]

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 ____

Presenting “Using ‘I’ Messages”

Purpose: To be able to state your needs without arousing the defences of the other person. The effectiveness in communication lies in stating your perception and needs rather than saying what the other person should or shouldn't do.

Note to Facilitator: Let the group know that this may feel uncomfortable or scripted when they first start to practice but they will eventually find their own way to use “I” language in an authentic way that doesn’t sound scripted. This is just a chance to practice different useful language that promotes personal accountability and to break the habit of blaming.

Process:

1. Discuss the purpose of using “I” statements.

2. Brainstorm times when they would use an “I” statement:
   - when confronting others about their behavior;
   - when we feel others are not treating us right;
   - when we feel defensive or angry;
   - when others are angry with us.

3. Review the handout on using “I” messages in their participant guide page 53 and discuss how to use the leader sentences to piece together an effective “I” statement.

4. As a group discuss the scenarios below and have the participants practice using the leader statements in their handout.
   - A peer is insisting that you should share their religious beliefs.
   - A peer is using language you find inappropriate and uncomfortable to listen to.
   - A peer is continuously asking you out on a date.

Discussion Questions:

1. How do we know when our boundaries need some work?
2. How do we know when our boundaries are not being respected?
3. How do you know when you may be crossing someone else’s boundary?

Self-Disclosure[10]

Purpose: Self-disclosure issues are complicated and multi-faceted for peer mentors. The skill of self-disclosure involves knowing how, what and when to share personal information with their peer.

Process:

1. Discuss the following things to keep in mind when using self-disclosure with a peer.
    - Only disclose what is relevant to the peer.
    - Self-disclosure should not be used as a means of unburdening your own issues.
    - Avoid self-disclosing too early or too often.
    - Keep it “other orientated”, remember this is your peer’s time to share.
    - Know your purpose in self-disclosing and make sure it’s to benefit the peer.
    - Be aware of personal triggers; do not disclose things that will upset you or take away from your own well-being.
    - Relay the importance of personal choice. What worked for you may not work for them.

2. Lead the group through discussion questions.

Discussion Questions:

1. Have you used self-disclosure in the past in a way that was beneficial?
2. When does self-disclosure become unsafe?
3. How can you set limits with self-disclosure?

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 illness 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.

Materials Needed:

- TV/projector, laptop and internet to show videos;
- facilitators guide and participants guide;
- whiteboard/flip chart and markers;
- writing materials; pens and pencils;
- *Here to Help* PDF’s (print 1 of each);
- approx. 12 small soft balls for stress activity (enough for 6 per group, depends on your numbers).

Mental Health Continuum[1]

What is mental health?

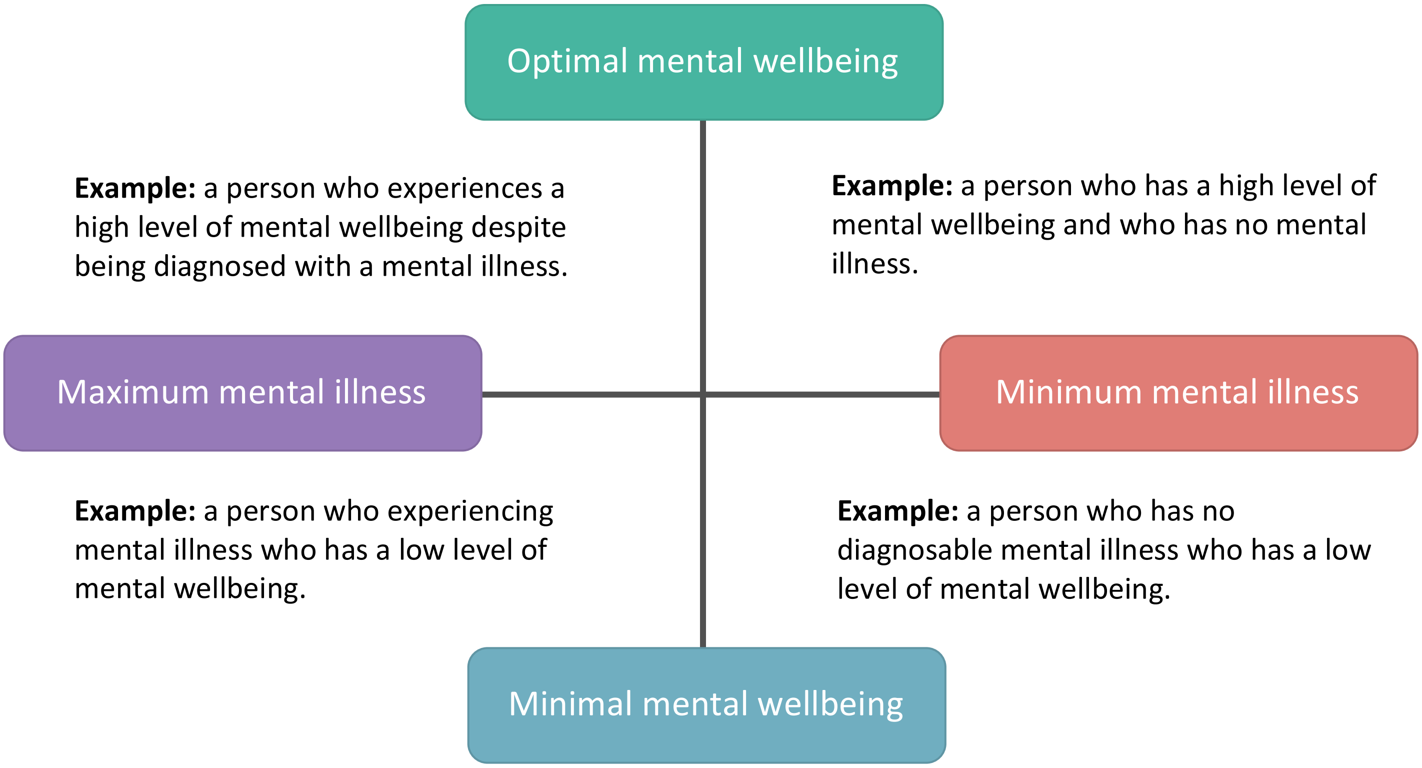
Just as our lives and circumstances continually change, so do our moods, thoughts, and our sense of well-being. It’s natural to feel off-balance sometimes. We have all experienced feeling sad, worried, scared or suspicious but these kinds of feelings may become a problem if they get in the way of our 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.

Mental Health Concerns and What Helps

Purpose: Depression and anxiety are commonly seen mental health concerns among people living with HIV and Hep C, knowing how to recognize signs and symptoms will help us to provide the most effective type of support.

Materials:

- whiteboard/flip chart and markers;
- print PDF version of *Here to Help* fact sheets (1 of each)
  http://www.heretohelp.bc.ca/factsheet/depression
  http://www.heretohelp.bc.ca/factsheet/anxiety-disorders
  http://www.heretohelp.bc.ca/wellness-module/wellness-module-3-social-support.

Process:

1. Have participants turn to the mental health continuum handout on page 55 in their participant guide, review it together and discuss the handout and continuum image.

2. Split into 3 small groups, assign one of the topics below and distribute assigned *Here to Help* fact sheet. Each group will review their fact sheet and decide on the most important information to present to the group. They can present it in any manner they want. The topics include:
   - depression;
   - anxiety;
   - social support.

3. After everyone is ready, come back as a large group and have each small group share what they learned from their fact sheet and how it can be applied to their role as a mentor.
4. Discuss risk and protective factors that influence our mental health. Brainstorm as a group and write them up on the whiteboard.
5. Discuss other local resources that a mentor can refer their peer to if the mental health concern requires more support than the peer mentor is able to offer.
6. Lead the group through discussion questions.

Discussion questions:

1. Why are depression and anxiety commonly experienced by people living with HIV and/or Hep C?
2. Where do our assumptions of people who have mental health challenges come from?
3. How can we challenge our assumptions/bias around mental health?
4. How does isolation and loneliness affect mental health?

Trauma Informed Practice[23]

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.

Presenting “Trauma Informed Practice”

Purpose: Being aware of the impacts of trauma and how using trauma-informed practices will help a peer mentor be less likely to unintentionally re-traumatize a peer and more likely to support healing.

Note to Facilitator: It’s important to discuss with the group how to best support someone who has experienced trauma without moving outside of their scope of practice. If you choose to watch the video, have it ready to play before starting the module. Keep in mind that YouTube links are sometimes changed. If possible, download the video and have it saved in a folder on your laptop for easy access. Try: https://keepvid.com/ to download videos.

Process:
1. Review the handout “Trauma Informed Practice” in the participant guide page 56 and discuss ways to implement the key principles in their role.
2. Discuss the role of a peer mentor where trauma is concerned. Emphasize that they are not counselors and should not be probing into a traumatic experience.
3. Provide a list of local resources that specialize in trauma that they can give to a peer if needed.
4. Optional: watch and debrief the video *Me Too* by Stephen Epp (start at 1:20): https://www.youtube.com/watch?v=zRsgL__Pxuc&feature=youtu.be

Discussion Questions:
1. What could be considered a traumatic event?
2. What are some possible and common effects of trauma?
3. How does trauma show up within different cultures?
4. How does trauma show up within people living with HIV/Hep C?
5. How do we manage our own triggers if trauma is disclosed?
6. How do we recognize vicarious trauma and practice self-care in those situations?
7. How can we apply the key principles in the handout to our role as a mentor?
8. How can we be aware of our communication style when our peer has experienced trauma?
9. Can you think of ways that individuals may cope with trauma?
10. How does recognizing that our peer has trauma impact the way we support them?

Loss and Grieving

Purpose: Grief and loss can be big parts of living with HIV/and or Hep C. By understanding the grieving process, a mentor can better support a peer through their grief journey as well as be aware of their own grief.

Materials: whiteboard/flipchart and markers.

Process:

1. Write the following definition of grief on the board and discuss with the group: *Grief is the natural, expected reaction to a loss. It's the emotional suffering you feel when something or someone you love is taken away.*
    - ***Natural-*** Universal in human experience
    - ***Expected-*** Grief is inevitable
    - ***Reaction***- it is dynamic- reaction of the heart, physical etc.

2. Brainstorm different types of loss that can be grieved for, some examples include:
    - death of a loved one or friend;
    - end of a relationship;
    - loss of health;
    - losing/changing jobs;
    - loss of a dream/goal;
    - loss of safety after a trauma.

3. Review some common myths about grief and loss below and ask how they could help their peer through these types of thoughts:
    - it's important to be strong for ourselves and others when faced with a loss;
    - if you don't cry it means you are not upset about the loss;
    - grief should only last for a year or less;
    - you can only grieve a death;
    - moving through grief means never thinking about the loss again.

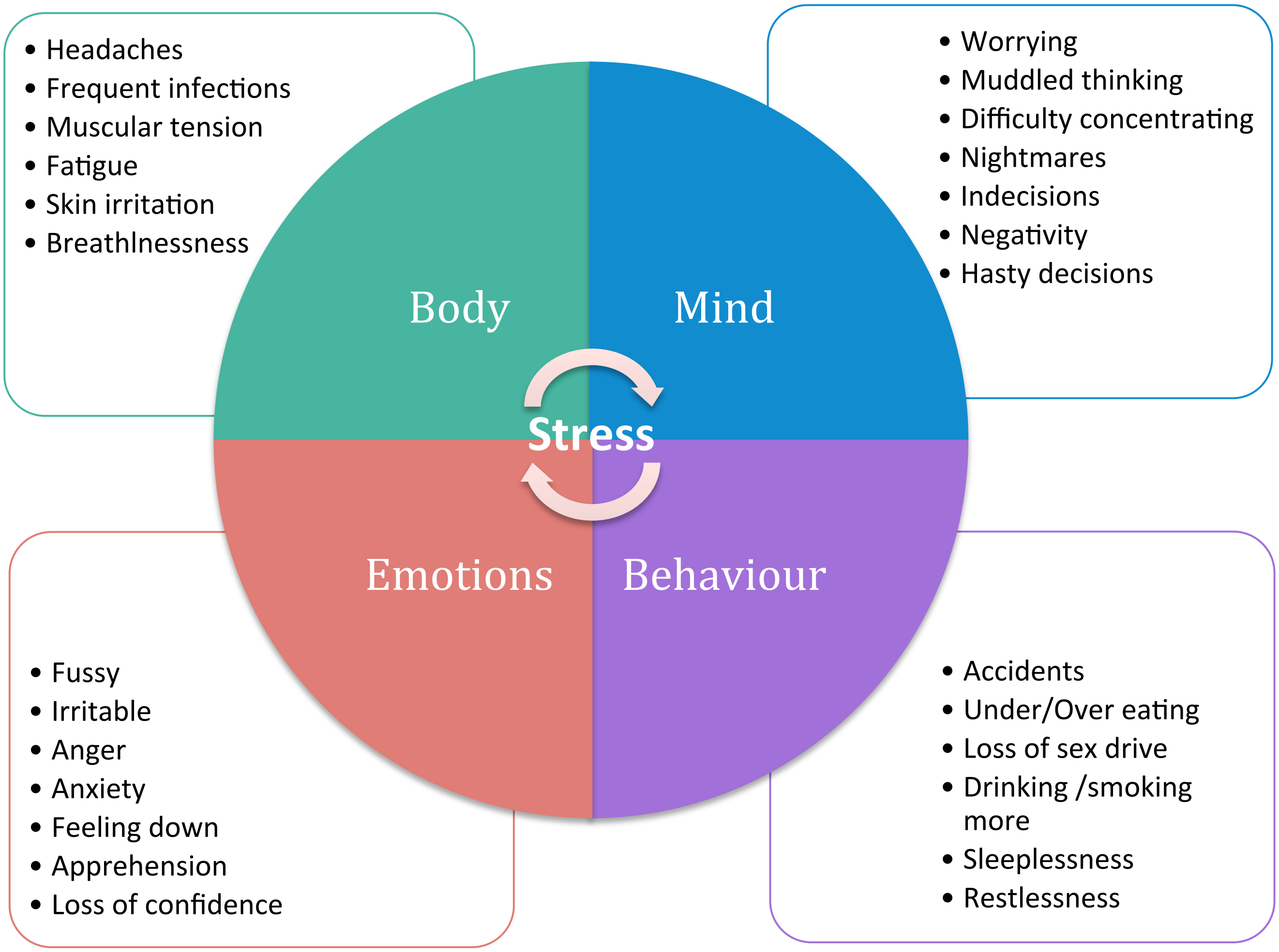
4. Introduce the 5 stages of grief and loss by Dr. Kübler-Ross and discuss what's involved in each stage.
    1. Denial.
    2. Anger.
    3. Bargaining.
    4. Depression.
    5. Acceptance.

Points to discuss for stages of change:

- There are responses to loss that many people experience, but there is not one typical response to loss. We grieve in individual ways.
- There is no order to the stages, we can move back and forth through the stages and will not necessarily experience every stage.

5. Discuss ways that a peer mentor could support a peer who is grieving.
    - Hold space for their emotions and validate them. You do not have to have an answer.
    - Withhold judgement. What seems like a minor loss to you can be devastating to them.
    - Recognize when they may need more support than you can offer and give information on an appropriate resource.

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.



- Headaches
- Frequent infections
- Muscular tension
- Fatigue
- Skin irritation
- Breathlessness

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

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

- 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[24]:

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.

Presenting “Stress and Mindfulness”

Purpose: To discuss how stress is a natural part of life, although it can look different for everyone there are coping strategies available to ensure that the stress does not take over and lead to negative consequences.

Materials: whiteboard/flipchart and markers.

Process:

1. Review the “Stress and Mindfulness” handout found in participant guide page 57 and the “Emotional Resilience” handout found in the participant guide page 58 as a group. Ask the group if they have ever used any of the emotional resilience tips.
2. Ask the participants to think about a time when they were stressed. Ask them to note the ways in which stress presented in their mind, bodies, emotions and behaviors (relate to the diagram in the handout).
3. Brainstorm a list of stressors that might be present in their peer’s life. For each example, ask the group how they would respond to their peer in a way that would help with the stressor.
4. Have the group brainstorm tools they use to manage their own stress.

Additional Activity for "Stress and Mindfulness"[25]

Purpose: This activity provides an opportunity to experience both the benefits and challenges of stress. The group is encouraged to use some of the emotional resilience tips including humor and mindfulness as tools to manage the stress.

Materials: small soft balls (6 per group) and a space big enough to have 1 or 2 groups standing in a circle.

Process:

4. Ask the participants to stand and form circles of about five to eight people. Give each group one ball to begin. Have the first person throw a ball to someone else and instruct everyone to remember who they threw it to since they will be asked to continue the same pattern.
4. Each person throws the ball to someone who has not yet received it. The last person sends it back to the original person who "keeps the ball rolling" a little faster than last time but in the same order.
4. Once they have the pattern down, introduce another ball, then another and then another. In the balls drop, encourage them to pick them up and continue. With five or six balls going at a time, it becomes quite busy/stressful but also very humorous and fun.
4. After a few rounds with all the balls, have everyone sit down and lead them through the discussion questions to help process the activity.

Discussion questions:

1. What did you learn had to be done in order to be successful?
2. How did you manage your stress through the activity?
3. How many of you found you had time to be distracted by other thoughts during this activity? E.g. did you think about what you are having for dinner tonight?

Closing comments:

This is a great lesson on mindfulness as the participants are totally focused on the present moment. Point out that life is like the activity—we all juggle many things at one time and if we are not focused, things get dropped. If we focus too much on the past or present, the balls will bombard us and we can feel overwhelmed if we are not alert and practicing our stress management skills.

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.

Materials needed:

- TV/projector;
- laptop and internet access for video and website;
- facilitators guide and participants guide;
- whiteboard/flipchart and markers;
- cue cards;
- permanent markers;
- masking tape;
- 4 pieces of blank paper;
- substance use resources list.

Perceptions of Addiction and Substance Use

Purpose: To get an idea of the participants' knowledge and perceptions about addiction/substance use as well as what some misconceptions might be.

Materials: cue cards, permanent markers, category topics written on paper and masking tape.

Note to Facilitator: Write the following categories on paper ahead of time and stick them to the walls with space between and below them.

Categories:

- Myths.
- Misconceptions.
- Hurtful/disrespectful language.
- Factual information.

Process:

1. Ask the participants to think about the first things that come to mind when they hear the words substance use and addiction (their answers are anonymous so encourage them to be honest).
2. Get them to write down as many thoughts as they can on cue cards (make sure it's only 1 word/sentence per cue card as they will be categorized afterwards). Facilitators can add their own cards to help promote discussion.
3. Once everyone is done writing, have them hand in their cue cards to the facilitators.
4. Facilitators will shuffle them to help with confidentiality.
5. Read out each cue card and as a group, discuss which category it belongs under and stick the card on the wall under that category.
6. Once all cards have been placed under a category address all the comments by validating truthful facts, demystifying myths and addressing fears and misconceptions.
7. Lead the group through discussion questions.

Discussion Questions:

1. Where do misconceptions and myths come from?
2. Why is it important to be aware of our own bias about people who use substances?
3. What is the difference between substance use and addiction?
4. What are some reasons that people use substances?
5. How does our knowledge of substance use/addiction affect how we support a peer?
6. How does believing myths help promote stigma?
7. What are some risk and protective factors for substance use problems?

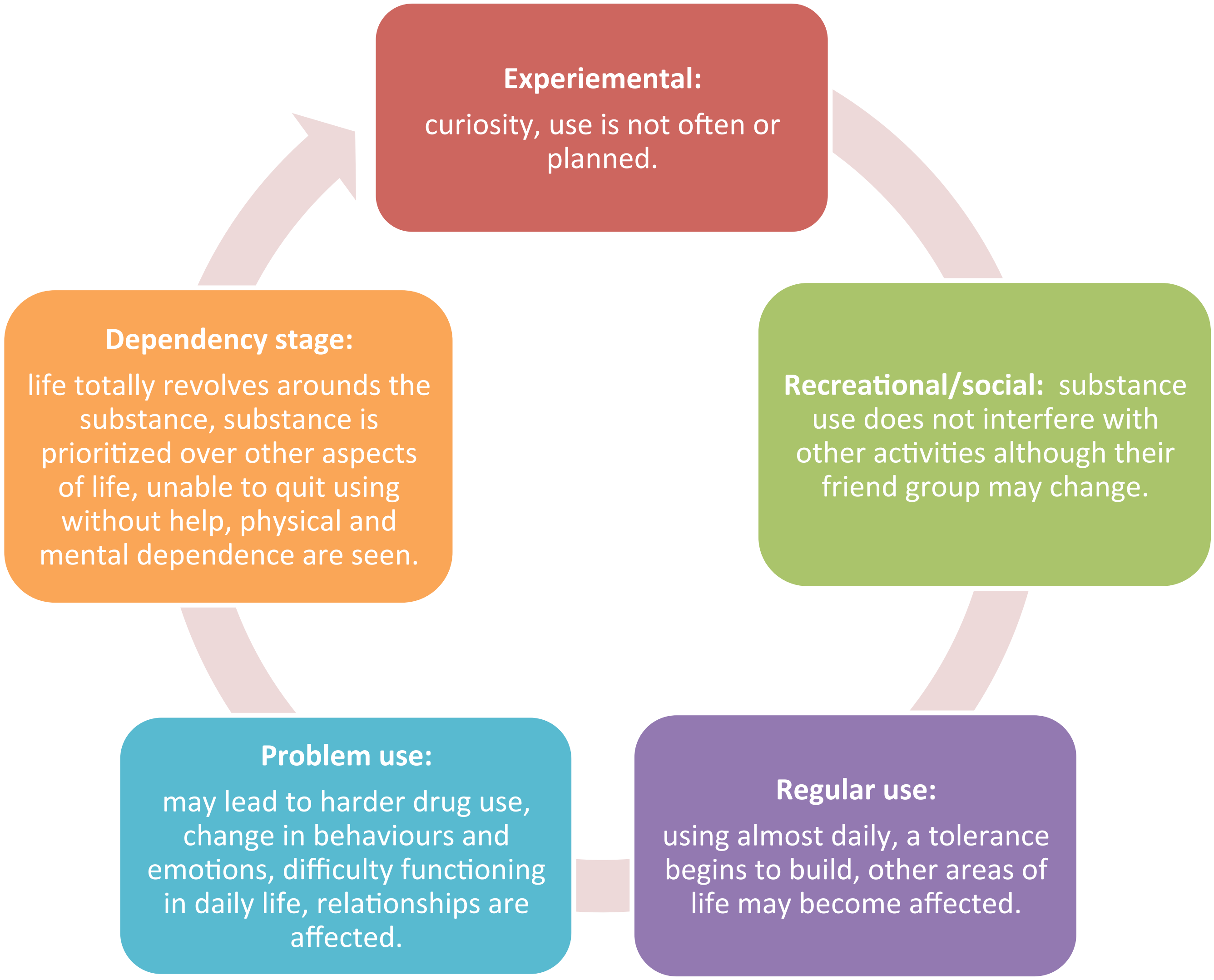
Recognizing and Responding to Substance Use Problems

Purpose: As a peer mentor, it is possible to be matched with a peer who uses substances. Through discussion and practice the participants will learn how to respond in a supportive way and offer their peer support and resources if needed.

Materials: whiteboard/flip chart and markers.

Process:

1. Write the different stages of substance use on the board and discuss what each one entails:



Experiemental:
curiosity, use is not often or planned.

Recreational/social: substance use does not interfere with other activities although their friend group may change.

Regular use:
using almost daily, a tolerance begins to build, other areas of life may become affected.

Problem use:
may lead to harder drug use, change in behaviours and emotions, difficulty functioning in daily life, relationships are affected.

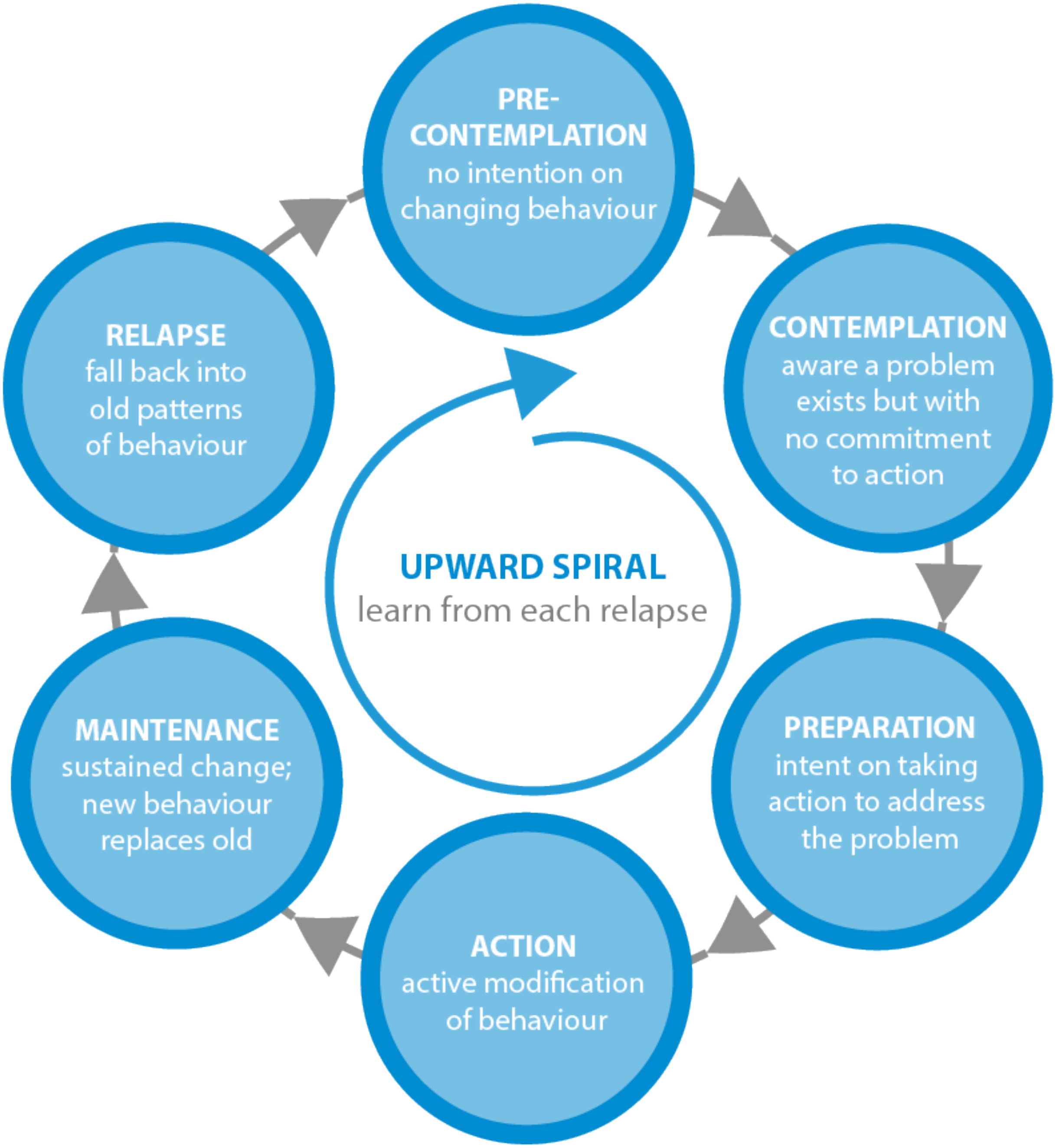
Dependency stage:
life totally revolves arounds the substance, substance is prioritized over other aspects of life, unable to quit using without help, physical and mental dependence are seen.

2. Mention to the group how substance use and addiction can look different for everyone. Discuss questions 1 & 2.
3. Stigma around substance use can stop our peers from being honest or asking for help. If they perceive you as non-judgmental or relatable they may feel more comfortable opening up. Discuss questions 3&4.
4. Not everyone will be ready/willing to get help for a substance use problem; they may not even see it as a problem. It is important as a mentor to meet our peer where they are at and not to push our own beliefs onto our peer. Only offer resources if they have asked for them. Discuss question 5&6.
5. Brainstorm how to ensure personal safety if a peer is actively using. E.g. not meeting if the peer is under the influence and meeting in safe places. Discuss question 7.

Discussion Questions:

1. What are some signs that substance use has started to impact a peer's life in a negative way?
2. What factors influence what substance use and addiction look like?
3. How can you let your peer know that you are a safe person to talk to about their struggles without prying or assuming?
4. How can you use self-disclosure in a safe and helpful way?
5. How do we support our peer if they are not ready for/wanting help?
6. How do we give information/resources to a peer without overstepping?
7. How can we be aware of our own triggers if we are in recovery and supporting a peer who is using?

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.

Presenting “Stages of Change”[1]

Purpose: Understanding the Stages of Change Model allows us to recognize that people tend to move through the five stages in their way. Knowing the stages that a peer may go through helps us to know how to best support them towards making changes.

Materials: resource list**,** TV/projector, laptop and internet for the video *Nuggets*: https://www.youtube.com/watch?v=HUngLgGRJpo.

Note to Facilitator:

- Create a list of local resources that help with substance use/addiction problems that can be distributed to the participants.
- Keep in mind that YouTube links are sometimes changed. If possible, download the video and have it saved in a folder on your laptop for easy access. Try: https://keepvid.com/ to download videos.

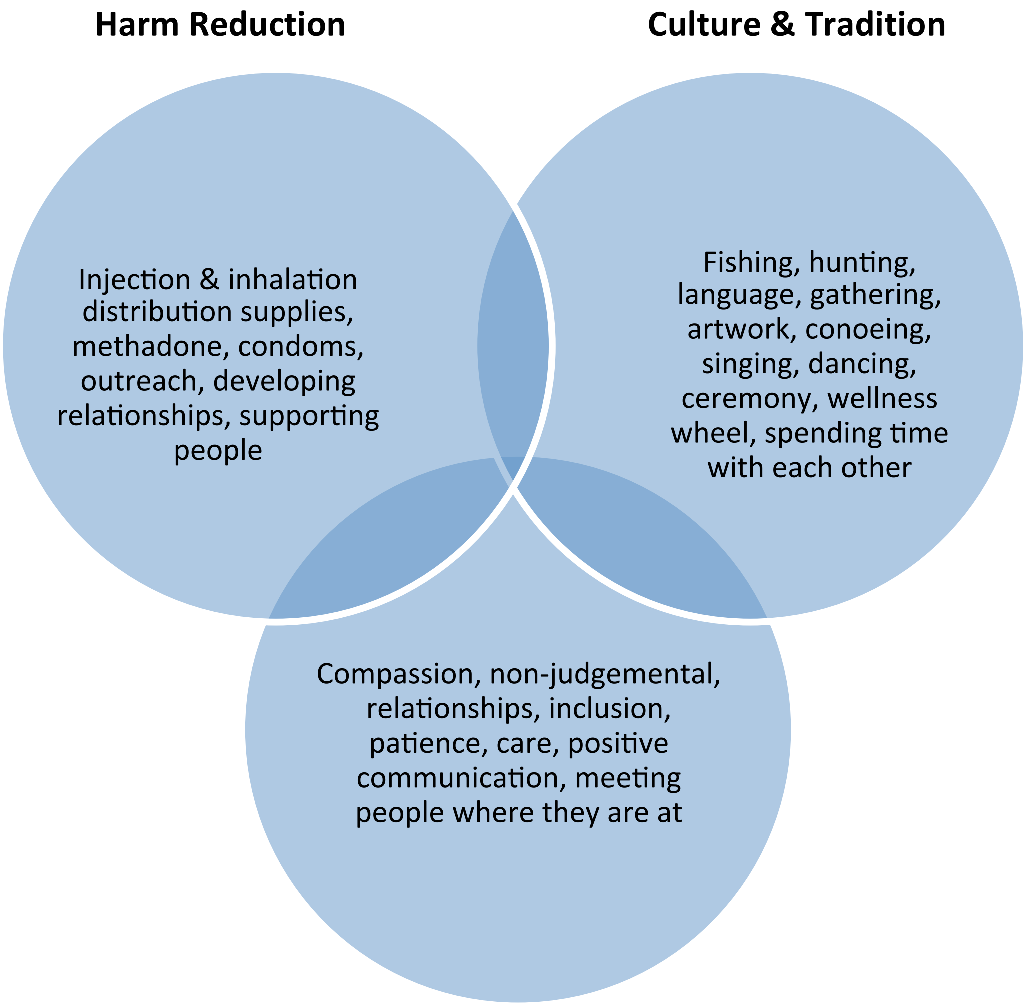
Process:

1. Have the participants open to the stages of change handout in their participant guide page 60 Review and discuss the handout.
2. Show the video *Nuggets* and debrief how it relates to the stages of change.
3. Ask the participants to think about something in their life that they wanted to change (it does not have to be related to substances).
4. Have them use their example and move through the stages of change using the blank table in their participant guide page 62 and consider what happened and what helped during each stage.
5. Explain to them that this activity is not about using this model on their peers. The goal is to understand the process of change. It also helps build empathy because the process of change is difficult for everyone.
6. Lead the group through the discussion questions.
7. Distribute and review the list of substance use resources available in your community.

Discussion Questions:

1. Why is understanding the Stages of Change important to our work as peer mentors?
2. How can you as a peer mentor support someone to get connected to resources in the community?
3. What helps change happen?

Harm Reduction[26]



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.

Presenting “Harm Reduction”

Purpose: Harm reduction is a way to promote health, prevent sexually transmitted infections and blood borne infections, and improve life conditions using a philosophy with an empowerment approach.

Materials: TV/projector and laptop to review the “Toward the Heart” website http://towardtheheart.com/naloxone.

Note to Facilitator: Review the website a head of time so you know where to access the information on harm reduction, signs and symptoms and responding to overdose.

Process:

1. Define what harm reduction is with the group: “*Harm reduction is a response that focuses on keeping people safe and minimizing death, disease and injury associated with higher risk behaviour, while recognizing that the behaviour may continue despite the risks. At the practical level, the aim of harm reduction is to reduce the more immediate harmful consequences*” www.healthgov.bc.ca
2. Discuss how harm reduction is a concept that can be related to any high-risk behavior including substance use and sex.

3. Brainstorm what is available to assist in a harm reduction approach.
   Examples:

- injection & inhalation distribution supplies;
- methadone prescription;
- safe injection/overdose prevention sites;
- distribution of condoms;
- outreach services;
- education;
- naloxone training.

4. Discuss the importance of recognizing and responding to an overdose. Explain that naloxone is a medication that quickly reverses the effects of an overdose from opioids such as heroin, methadone, fentanyl and morphine. Pull up the “Toward the Heart” website and review the information on how and where to receive a naloxone kit as well as how to recognize and respond to the signs of an overdose.
5. Review the diagram in the participant guide on page 63 on harm reduction and culture/tradition and discuss the importance of recognizing and integrating culture and tradition into harm reduction and healing.

Discussion Questions:

1. How can you support a peer even if your beliefs do not align with a harm reduction approach?
2. What are the harm reduction services you could refer your peer to?

8

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.

Materials Needed:

- facilitator guides and participant guides;
- whiteboard/flipchart and markers.

Responding to a Crisis

What is crisis? A crisis is 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.

Presenting “Responding to a Crisis”

Purpose: Knowing how to respond in a crisis situation helps to keep both the peer and mentor safe and allows the mentor to feel prepared.

Materials: whiteboard/flipchart and markers.

Process:

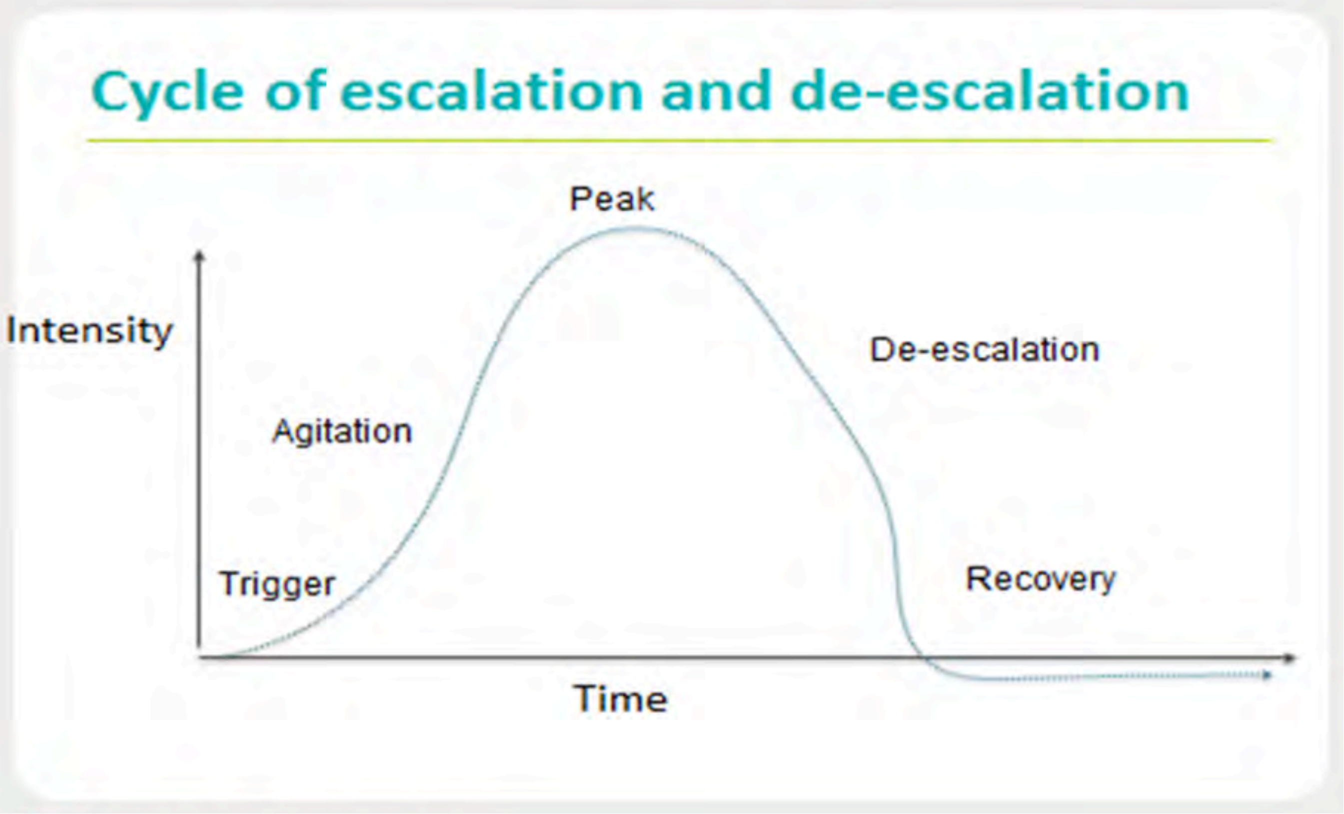
1. Review the “Responding the Crisis” handout as a group, found in participant guide page 65.
2. Ask the group what some different responses to crisis are (cover fight, flight and freeze).
3. Discuss how empathy plays a big part in responding to crisis. Write this empathy formula on the board: **Empathy = reflection of feeling + reflection of content** and discuss how to put it into practice.
4. Refer back to the communications module as many of those skills are helpful when responding to a crisis situation. Review the following skills quickly and discuss how they apply:
    a. empathy;
    b. open ended questions;
    c. summarizing/clarifying;
    d. validation;
    e. reflection;
    f. paraphrasing;
    g. silence;
    h. non-verbal communication.
5. Brainstorm a list of coping strategies that can help stabilize someone who is feeling overwhelmed.
6. Practice the 5 senses exercise with the group; this is something they can use to help a peer or themselves in the future.

Instructions for 5 Senses Exercise

1. **Sit in a comfortable upright position** with your feet planted flat on the ground.
2. **Notice your breathing.** Bring attention to each part of the breath, the inhale, exhale, and space in between.
3. **Bring awareness to each of your 5 senses.** One at a time, for about one minute each. The point here is to focus on the present moment and how each sense is being activated in that moment.
    a. **Hearing: Notice 5 things you hear in the moment.** Notice the sounds around you. Try not to judge the sounds, just notice them.
    b. **Sight: Notice 4 things you see in the moment.** Observe your surroundings and notice the colors, shapes and textures.
    c. **Touch: Notice 3 things you feel in the moment.** Bring your attention to the sensations of skin contact with your chair, clothing and feet on the floor, temperature etc.
    d. **Smell: Notice 2 things you smell in the moment:** Shift your attention to notice the smells of your environment. Maybe you smell food, trees or plants, books or paper.
    e. **Taste: Notice 1 thing you can taste in the moment.** You can do this one even if you don't have food in your mouth. You may notice an aftertaste of a previous drink or meal or a taste that is linked to smell.
4. When finished, have everyone pause to notice how their body feels in the moment. Have them compare it to how they felt 5 minutes ago. Ask, what has changed?

Discussion Questions:
1. What are some triggers for crisis?
2. What are some signs that our peer may be experiencing a crisis?
3. What are some helpful resources we could refer our peer to?
4. What has been helpful for you in the past while experiencing a crisis?
5. What is our role in supporting a peer through crisis?
6. What do we want to avoid doing in a crisis?
7. How can you keep yourself safe?

De-escalating a Crisis Situation



What is de-escalation?
De-escalation is about reducing the emotional intensity experienced by 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.

Presenting “De-escalating a Crisis Situation”

Purpose: It can be stressful for the person who is experiencing and responding to a crisis. Learning skills on how to de-escalate some of the intense emotion can help the peer and mentor get to a place of strategizing coping skills and additional resources.

Note to Facilitator: Ensure the group knows their role as a mentor is to understand the situation, appreciate the perception of the peer, recognize the severity of the problem and respond in an appropriate manner. It is important to stay within their scope of practice.

Process:

1. Open the discussion by stating, “anger happens when there is a perception of threat or the person believes something is beyond their ability to cope. We may not see or understand the threat but for the agitated person it’s real and it’s important to acknowledge that.”
2. Review the de-escalation image found in their participant guide page 66 and further discuss the tips on what helps.
3. What can help us as responders is to be aware of our own triggers. When we feel triggered by an event it alters how we react and can lead to an unhealthy approach to communication. Awareness of what our triggers are can help us to not fall into this trap. Discuss volcano and heart string triggers.
    a. **Volcano Trigger:** ”Hot button issues”. Things that set us off with a strong emotional reaction where we feel we have to do something about it.
    Note: we may be at risk of adding fuel to the fire or becoming escalated ourselves when our volcano trigger has been activated.
    b. **Heart Strings Trigger:** Things that appeal to our emotional side, these triggers can get us to overstep our own boundaries to fix things/rescue others.
4. Brainstorm with the group what their volcano and heart string triggers are and how they can cope with them in a crisis situation.

Discussion questions:

1. How can we set limits without escalating our peer further?
2. What are some effective de-escalation techniques you have used or seen or tried?
3. What are some signs of escalation?
4. What are some signs that someone is starting to de-escalate?

Suicide Prevention[27]

"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."[27]

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/

Presenting “Suicide Prevention”

Purpose: To help the participants feel prepared in assisting someone who is at risk of suicide by learning warning signs, how to ask and how to connect them to an appropriate resource.

Notes to Facilitator:

- If you have access and funds available to bring in a safeTALK instructor to facilitate, book them ahead of time to facilitate this section. It is a half day course that reviews:
    - How to recognize a person with thoughts of suicide.
    - Connect a person at risk of suicide to resources and supports that can further intervene.
    - Use the simple and effective TALK steps: Tell, Ask, Listen and Keep Safe. Check out this link for courses in your area: http://www.cmha.bc.ca/suicide-awareness-training-workshops/

- If you are in the Okanagan, you can give the participants the resource for the Community Response Team at Interior Health at 250-212-8533; they are available 7 days a week between 11:30am - 9pm. They will come to assess the individual in community to help determine the next point of action. Research your area to see if there is a similar service available.

Process (if you don’t bring in a safeTALK instructor):

1. Review the handout as a group, found in participant guide on pages 67-69.
2. Provide a list of local resources and phone numbers that can assist such as: crisis line, 911, community response team, etc. **(facilitators to create ahead of time).**
3. Facilitators will role-play a scenario where they respond to a peer who is at risk of suicide, modeling the proper steps to take.
4. Have the group split into pairs and role-play how to help a peer who is feeling suicidal. Remind them that it’s important to be direct and clearly ask, “Are you thinking about suicide?”.
5. Review the following myths about suicide and discuss the truth/facts for each statement:
    a. Once someone decides on suicide, they cannot be stopped.
    b. Talking about suicide gives people the idea.
    c. People who talk about suicide never actually go through with it.
    d. If someone has attempted suicide in the past they are less likely to try again.
    e. There is a “typical” type of person who will attempt/die by suicide.
    f. Once someone feels suicidal they always will.
    g. Most suicides happen without warning.
6. Lead the group through discussion questions.

Discussion Questions:

1. How can you support yourself if someone you know dies by suicide?
2. Who can you debrief with after a situation where you assist someone who is feeling suicidal?
3. Why is it important to be direct when asking if someone is feeling suicidal?
4. How can you keep yourself safe?
5. How can we respond if our peer asks us to keep their suicidal thoughts a secret?
6. How can we show a peer we are a safe person to talk to?

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.

Materials Needed:

- facilitator guides and participants guides;
- whiteboard/flipchart and markers.

Setting Up Group Structures and Facilitation Skills [5,10]

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.

Presenting “Setting Up Group Structures and Facilitation Skills”

Purpose: There are many skills involved in facilitating a peer led support group, this information will provide tips on how to lead a peer support group and manage group dynamics.

Process:

1. Read through the handout in participant guide pages 71-73 and provide examples and clarification where needed, use examples that the group will have witnessed during the training.
2. Discuss the definition of facilitating and brainstorm how facilitating and teaching are different.
3. If possible have a couple of current peer mentors come in and lead the group through an example of how a peer support group is run (if no mentors are available, facilitators will do this).
4. Have the participants split into groups of 5 where they will practice leading a group using the skills learned.
5. Encourage a couple group members to play a role using one of the difficult dynamics listed above to give the facilitator a chance to practice managing those dynamics using the tips provided.
6. Come back as a large group once everyone has had a chance to play the role of a facilitator and lead the group through the discussion questions.

Discussion Questions:

1. Why is it important to set up the structure of the group?
2. What has stood out as the most important or effective skill a facilitator has used during a group you have attended?
3. How can you remain genuine and at a peer level while facilitating?
4. What would help you feel more comfortable as a facilitator?
5. How do we practice our own self-care before, during and after leading a group?

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 and pencils;
- TV/projector for videos.

Living with HIV

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

Notes to Facilitator:
- Explain that this module provides information on living with HIV and also gives the opportunity to practice the facilitation skills they learned in previous module.
- If one of the groups would like to use a video provided, make sure you have the necessary equipment set up for them before they present.

Materials:
- flipchart paper/whiteboard and markers;
- pens.

Process:
1. Have participants turn to the handouts in their participant guide starting on page 75. The first handout provides basic instructions on how the module will be presented.

2. Split everyone into pairs and assign them a part to read and present (depending on the number of participants some groups may be assigned 2 parts).

3. Ask the groups to read through their part(s) and discuss with their partner what the key messages are and to come up with a way to present the content to the rest of the participants. Encourage them to be creative in how they facilitate, some options include:
   - role-plays;
   - poster;
   - group discussion;
   - short activity.

4. Give the participants 30 min to prepare, then bring everyone back as a large group. Starting with the group who is presenting part one and continuing on with each group.

5. It is important that all the information about HIV in the module is shared with the group. Facilitators should listen carefully to the participant presentations and bring up any missing points if needed.

Part 1: Terminology

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.

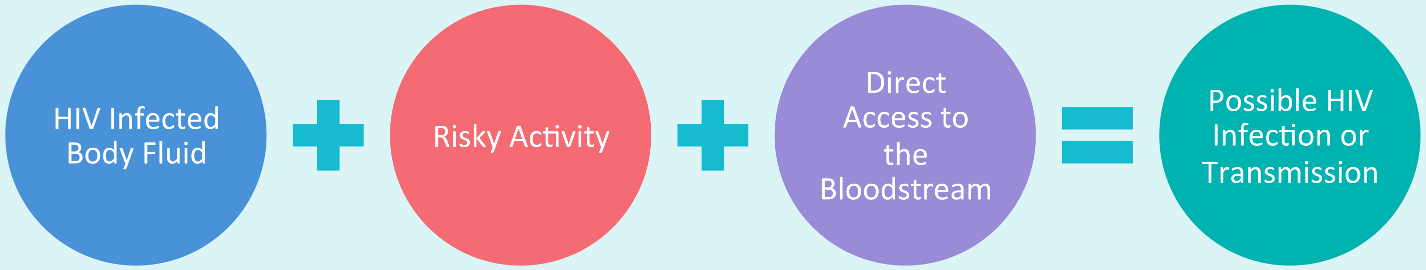
Blood work

- 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

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.

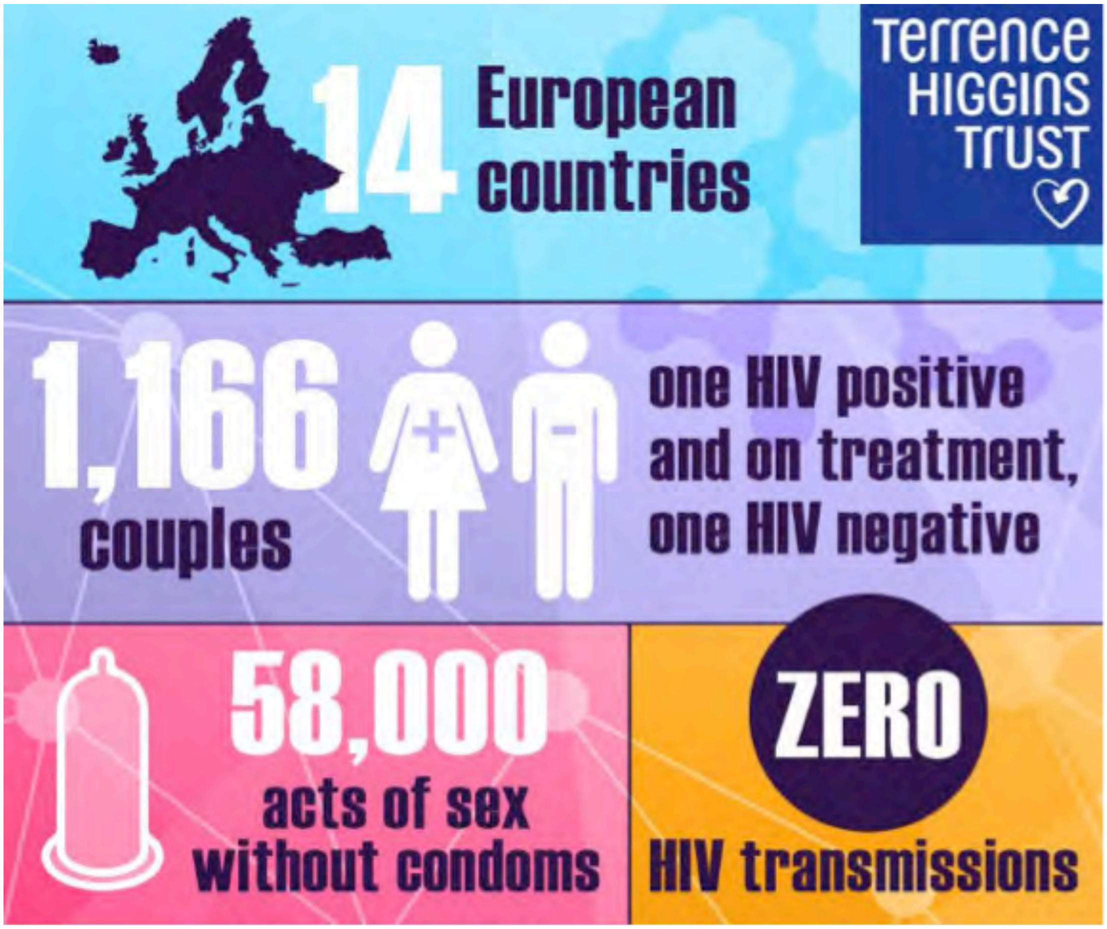
Undetectable = Un-infectious
U = U

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:

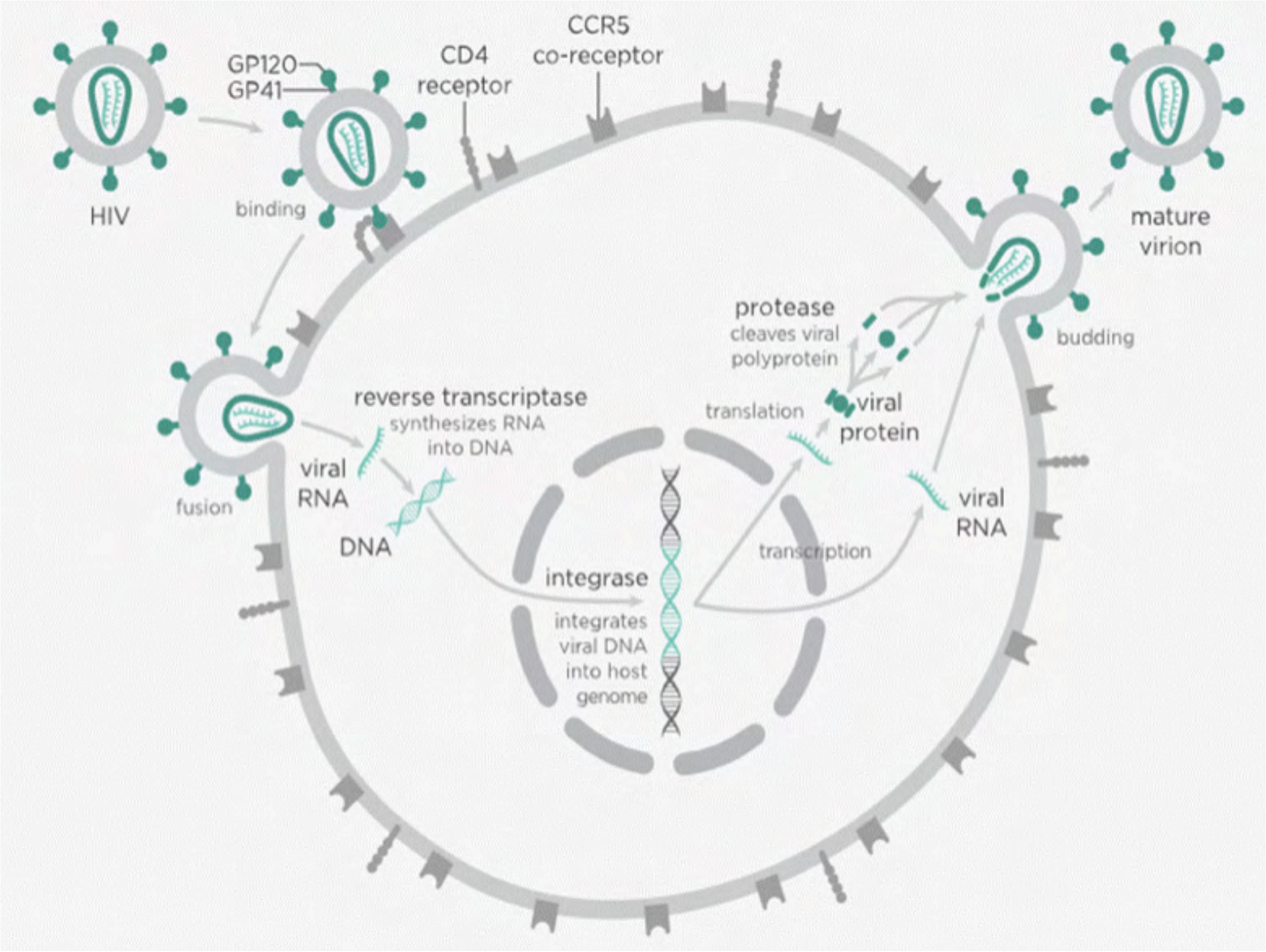
- Needle Exchange.
- Safe Injection Space - Safe injection sites promote access to clean needles, help promote adherence to ARVs and provide overdose safety. The cases of people who use intravenous drugs reaching undetectable viral levels has not increased due to the struggle to stay adherent to ARVs.

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.

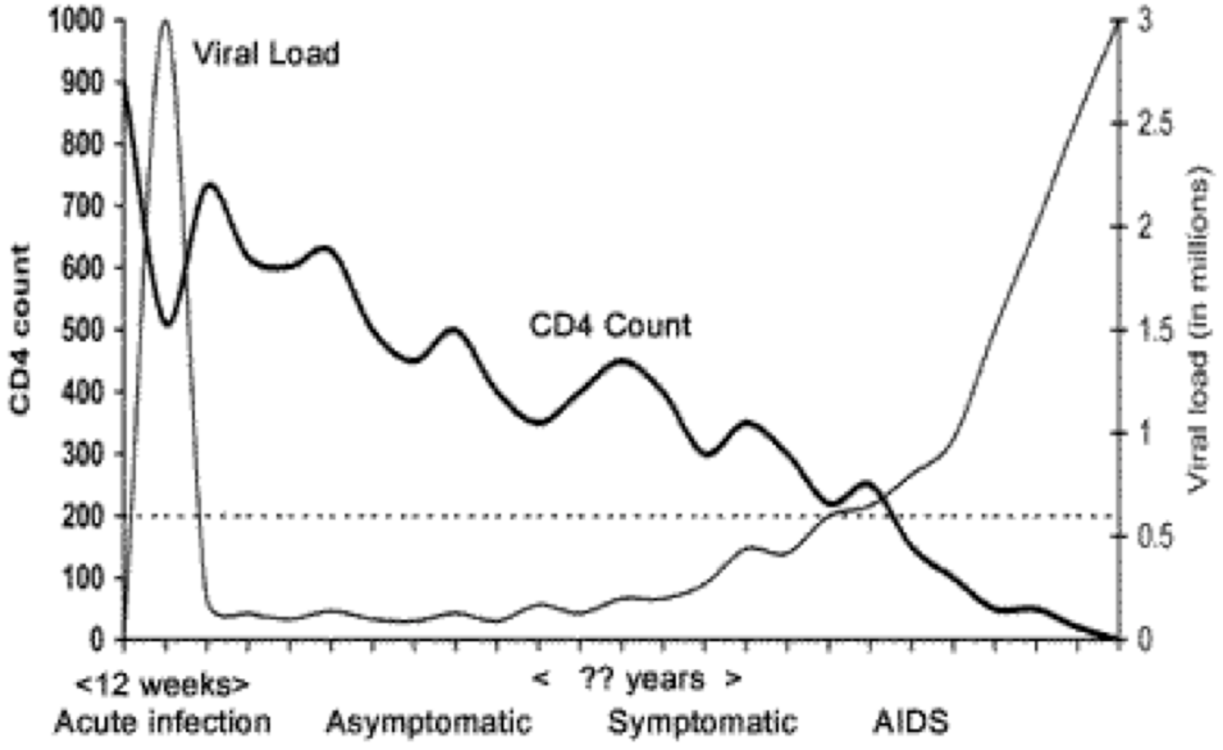
The virus attaches itself to the CD4 cell, called **binding**. It then dumps its internal contents into the CD4 cell, called **fusion**, where it then **synthesizes** the viral RNA with the cell DNA strand. The new DNA strand **integrates** itself into the cell's DNA genome. Viral proteins are added 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

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.

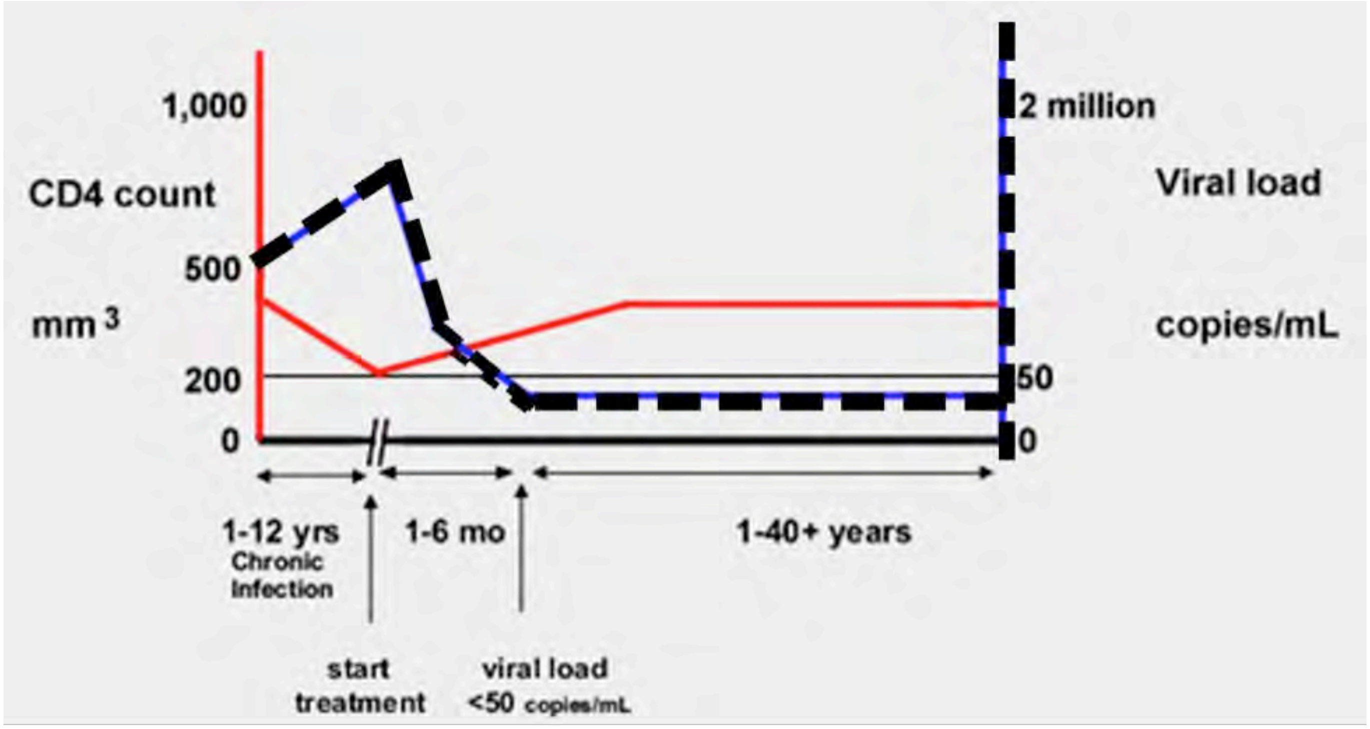
- **Asymptomatic Period:** An HIV+ person is not experiencing any physical symptoms or negative health impacts as a direct result of their HIV infection.
- **Symptomatic Period:** Eventually a person living with HIV will start to experience symptoms related to their HIV infection. Not the same as **opportunistic 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 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 so participants will know 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.

Materials Needed:

- TV/projector, laptop and internet for video;
- facilitators guides and participants guides.

Presenting “Hepatitis C 101”

Purpose: To provide basic information about hepatitis C (Hep C), also known as HCV or hepatitis C virus, in order to prevent transmission, maintain health, get support, engage in care and access treatment (cure).

Materials:

- Pre-and-post session questionnaires (can be completed individually or as a group);
- TV/projector, laptop and internet to show video;
- *Dr Evan Adams - World Hepatitis Day Message* video: https://www.youtube.com/watch?v=9D-h1Svkn1g.

Notes to Facilitator:

- Depending on the size of your group and timing, you can choose to include this module with module 10A, in which case participants will prepare and present the content. Alternatively, the facilitators can present the content using the process below.
- Keep in mind that YouTube links are sometimes changed. If possible, download the video and have it saved in a folder on your laptop for easy access. Try: https://keepvid.com/ to download videos.

Process:

1. Have participants complete the pre-session test on page 92 of their participant guide.
2. Cover points in each topic.
3. Show and debrief *Dr Evan Adams - World Hepatitis Day Message* video.
4. Allow time for questions and discussion after each topic.
5. Allow time at the end for any remaining issues or questions.
6. Have participants complete the post-session test on page 99 of their participant guide.

Things to Note:

- Stigma related to Hep C is compounded by the stigma and discrimination that people who use drugs face as well as by the association with HIV and other communicable diseases (and vice versa).
- There are two main groups impacted by Hep C:
    - those that have had the virus for a long time and are now facing advanced liver disease and
    - those who are most at risk for contracting the virus, passing it along to others and of dying from drug-related harms.
- Both groups experience stigma and discrimination directed towards people who use drugs, as well as other forms of discrimination.

Discussion Questions:

1. How is Hep C transmitted?
2. What is the purpose of treatment for Hep C?
3. Why is Hep C a concern?

Hep C Module Pre-Session Test

Answer key below. Blank quiz can be found in participant guide for pre- and post- 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

*A bit of a trick question: the first two are benefits of treatment. For a woman considering pregnancy, preventing transmission could be her main goal, which is awesome. But, the clinical goal of treatment is to reach 'sustained virologic response' (SVR) of 'undetectable' viral load = cure.

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

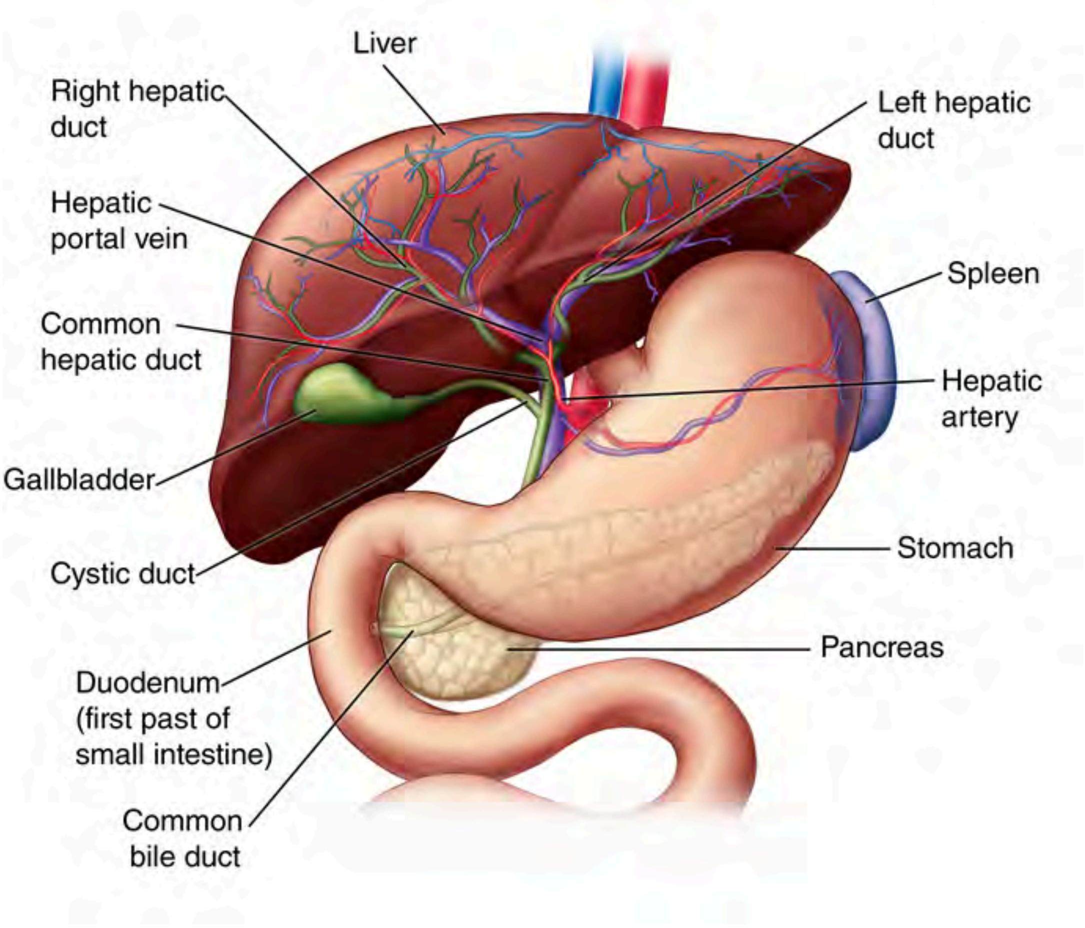


Image from Johns Hopkins Medicine: https://www.hopkinsmedicine.org/healthlibrary/conditions/liver_biliary_and_pancreatic_disorders/liver_anatomy_and_functions_85,P00676

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:

Hep C Infected Blood + Risky Activity + Opening into the Bloodstream = Possible Hep C 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.

Hep C Treatment and Cure

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.

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.

Note to Facilitator: An important consideration when delivering this module is engaging a facilitator who has lived LGBT2Q+ experience, critical thinking skills, and can provide appropriate and reassuring language to participants. If possible, invite someone or an organization with LGBT2Q+ experience from the community to facilitate or co-facilitate this module.

Concepts Covered:

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

Materials Needed:

- TV or projector and laptop to show video;
- facilitator guide and participant guide;
- glossary of terms www.qmunity.ca/resources/queer-glossary (if using alternative quiz activity);
- cue cards with terms and definitions written on them (if using alternative quiz activity).

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.

History and Context

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

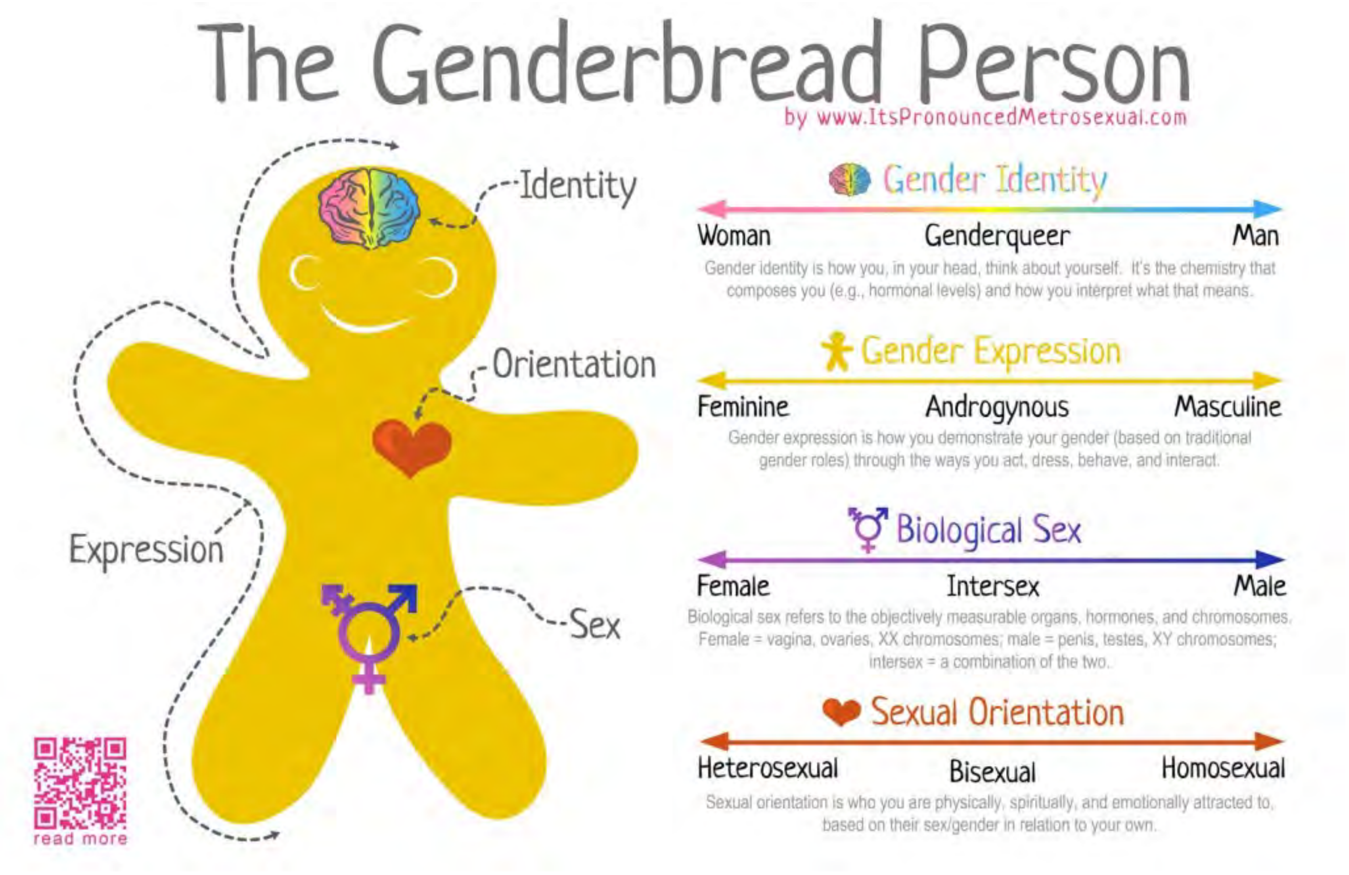
LGBTQ2S young people do not have to become homeless and to experience poverty, despair and fear. We work to advance human rights and to ensure legislation is enacted in a way that creates real safety and inclusion for queer and trans people and where no one experiences isolation, violence or discrimination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

Identity and Orientation

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 Colour.

Sex and Gender – The Genderbread Person [Q]



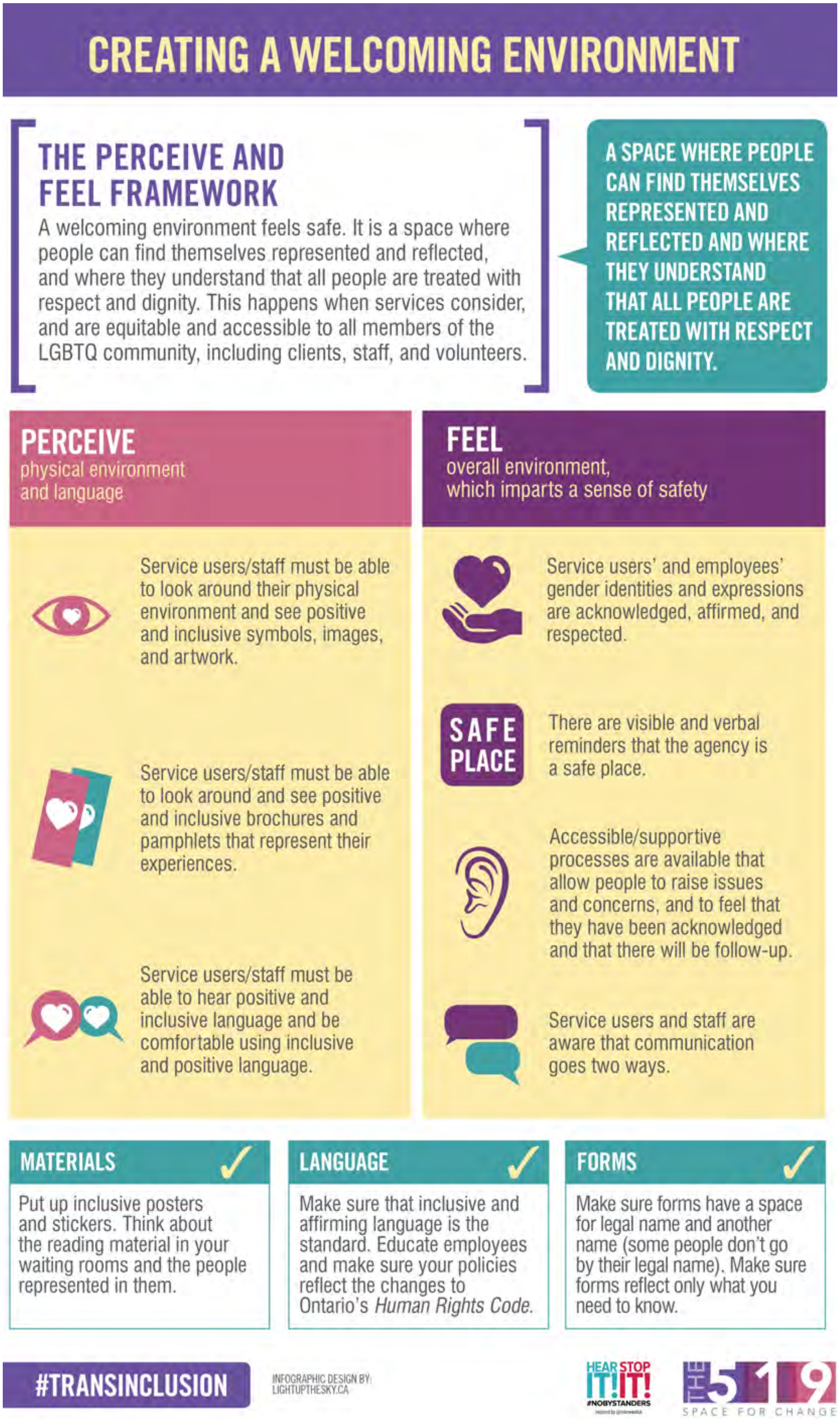
Gender identity is how you, in your head, think about yourself. It's the chemistry that composes you (e.g., hormonal levels) and how you interpret what that means.

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.

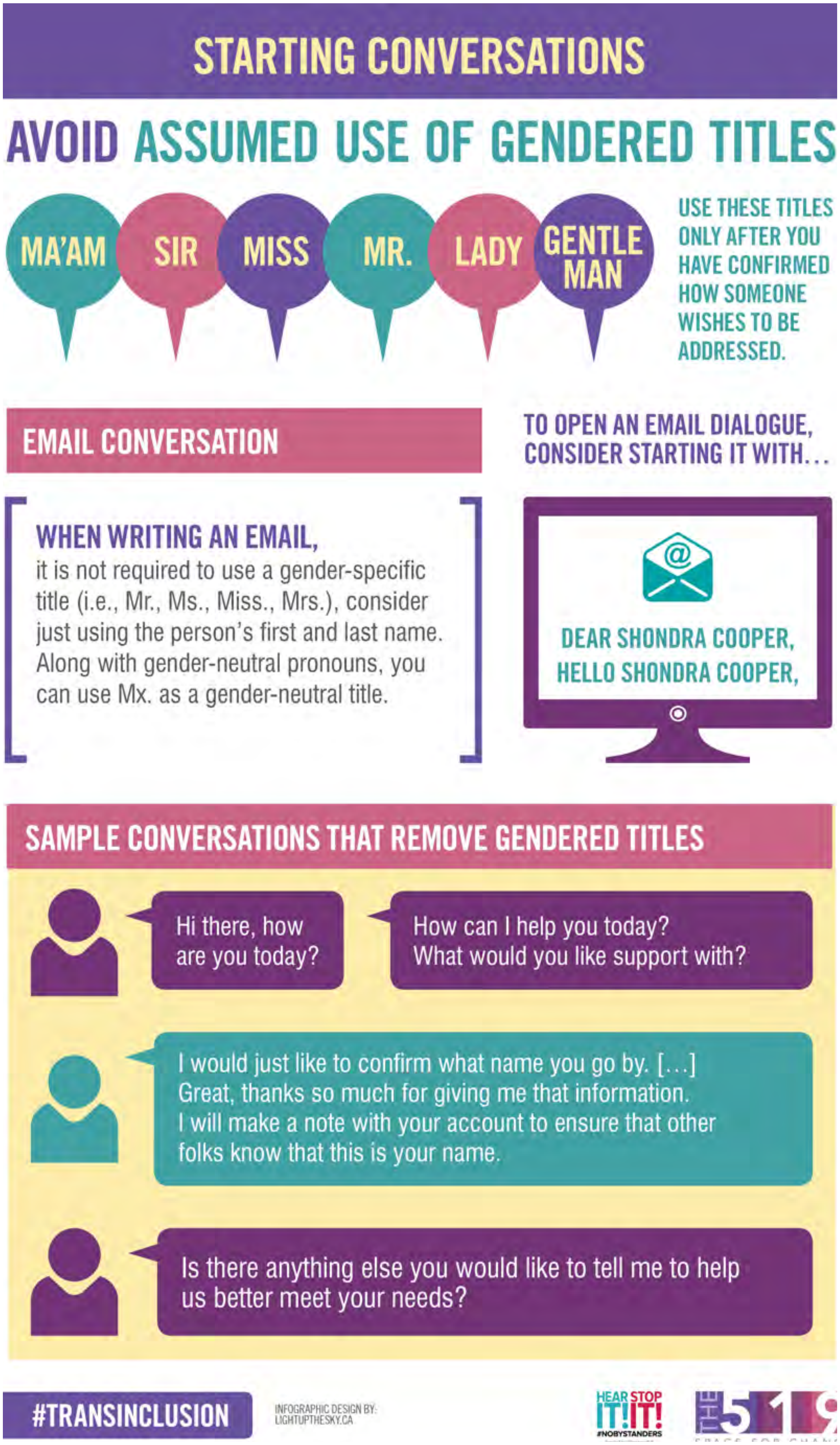
#TRANSINCLUSION

INFOGRAPHIC DESIGN BY:
LIGHTUPTHESKY.CA

HEAR IT! STOP IT!
#NOBYSTANDERS

THE 519
SPACE FOR CHANGE

s



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

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.

Presenting the LGBT2Q+ Module

Purpose: The following activities can be included to generate ideas and start conversations.

Materials:

- TV or projector and laptop and internet to show video;
- glossary of terms (if you use alternative quiz);
- cue cards (if you use alternative quiz).

Notes to Facilitator:

- Have the video ready to play before starting the module. Keep in mind that links are sometimes changed, if possible download the video and have it saved in a folder on your laptop for easy access.
- Note/reference A explains the term LGBT2Q+ is used throughout this document, unless pulling directly from source material that publishes under a variation (LGBT, LGBT2, LGBTQ, LGBTTTIQ, LGBTTI2QQ).

Process:

1. Review the handouts with the group found in the participant guide starting on page 100 to ensure understanding and discuss how the information will benefit them in their role as a peer mentor.
2. Read through the activity options below and choose one or more to facilitate.
3. Video and discussion[v]:
    - Tasheka Lavann left the Caribbean for Canada to escape homophobia and save her own life. Watch the video to learn more about her story. Discuss http://m.huffingtonpost.ca/2016/08/25/tasheka-lavann-lgbtq-caribbean-canada_n_11455258.html.

4. Practice – Gender Neutral Storytelling[w]:
    - Get into pairs, or take turns in a small group, to practice using gender neutral terminology. Think of an important loved one in your life and practice describing them to others without indicating gender. This is accomplished by using "they, them and their". If participants challenge this (for example, "no that would be plural"), remind them that these terms have been historically used in the singular for many years (Chaucer, Shakespeare). Speaking naturally and with correct terminology takes practice and patience.

5. Quiz – Sex, Gender, Gender Expression and Sexual Orientation
   - Divide group into smaller teams of 2-4. Place the following 4 categories on a wall to create a continuum:
     - sex,
     - gender identity,
     - gender expression,
     - sexual orientation.
   - Using the glossary of terms, write out 20-30 words on small cards, randomly give each team 5-7 words under the category they believe is best suited. For example, pansexul - sexual orientation; transgender - gender identity; androgynous - gender expression. Remind participants that the categories are fluid and some terms can be accurate across the spectrum (e.g. queer).

6. Alternative Quiz
   - Using the glossary of terms, write out terms on white cards, with the description on separate cards. Give 5-7 sets to each team and have them match the term and the description. Read out a term to the whole group and have participants take turns reading the term and the description they think best suits it. Allow participants to give feedback and how they might adjust or add nuance based on their identities and lived experience. For example, some gender non-conforming, gender fluid and genderqueer people do not identify as trans and some do.
   - Ultimately, it is the person who chooses the description of their own self-identity; having a current understanding of these terms and language can validate and support LGBT2Q+ peers in our families, communities, workplaces and government.

Additional Resources:
Okanagan Pride: www.okanaganpride.com/community.
Kelowna Pride: www.kelownapride.com.

Module 11: LGBT2Q+ Notes and 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).
B. BC Human Rights Protection. Source: http://www2.gov.bc.ca/gov/content/justice/human-rights/human-rights-protection.
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.
G. https://en.wikipedia.org/wiki/Ontario_Health_Insurance_Plan.
H. Glossary of Terms. Source: The 519 Glossary of Terms http://www.the519.org/.
I. LGBT People and Mental Health. Source: "LGBT" issue of Visions Journal, 2009, 6 (2), pp. 10-11).
J. PRISM Services. Source: http://www.vch.ca/public-health/health-topics-a-z/topics/lgbt2q+.
K. LGBT Mental Health. Source: http://www.heretohelp.bc.ca.
L. Rainbow Health Ontario. Source: https://www.rainbowhealthontario.ca.
M. Substance Use and Suicide among Youth. Source: Prevention and Intervention Strategies Robyn J. McQuaid, Research and Policy Analyst. March 9, 2017. www.cclt.ca.
N. Okanagan Pride Society Resources. Source: http://www.okanaganpride.com/community/, www.kelownapride.com.
O. Steve Little,Senior Manager, Diversity & Inclusion at Scotiabank. Source: https://www.linkedin.com/pulse/519-education-team-supporting-10000-people-2016-create-steven-little?articleId=6221783969743065088#comments-6221783969743065088&trk=prof-post.
P. Migration Matters. Source: http://www.amssa.org/resources/quicklinks-resources/resources-to-support-lgbtq-newcomers/.
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.

Training Wrap-Up

Purpose: To summarize the content learned during the training and allow an opportunity for participants to ask questions. This is also a time to celebrate the time spent learning and growing together.

Materials:
- helpful questionnaire;
- post evaluation (same that was given at the start);
- "Peer Mentor Training Course Evaluation" (in participant guide);
- certificate of completion;
- snacks, plates, cutlery, napkins.

Note to Facilitator:
- Print the certificates before the last day.
- If it's in your budget, purchase snacks ahead of time for the group celebration.
- Let the participants know there will be a post-training interview scheduled for everyone to review their skills learned during training and discuss fit and interest in continuing on as a peer mentor. Let them know how you will be reaching them to schedule interview if you have not scheduled them already.

Process:
1. Have the participants complete the helpful responses questionnaire in their participant guide page 114 (this is the same one they did at the start). This will give an idea of how their skills have improved post-training.
2. Announce that everyone has completed the training program. Give a brief overview of the topics that have been discussed and ask if anyone has any questions before wrapping up.
3. Hand back the pre-training evaluation form that was completed on the first day of training and have the group fill out the post-evaluation section.
4. Ask everyone to complete the Peer Mentor Training Course Evaluation found in their participant guide pages 117-118 to evaluate the training and facilitators.
5. Present the participants with a certificate of completion.
6. Put out snacks and have a social celebration to wrap up the training.

Organization Logo Here

FIRSTNAME LASTNAME

has completed the Peer Mentor Training course presented by [Organization Name].

Organization Slogan/Motto

Instructor:

Date:

Signature:

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.

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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.

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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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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Canadian Mental
Health Association
British Columbia
Mental health for all

learn about
anxiety disorders

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

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

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.

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:

*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.

heretohelp
Mental health and substance use information you can trust

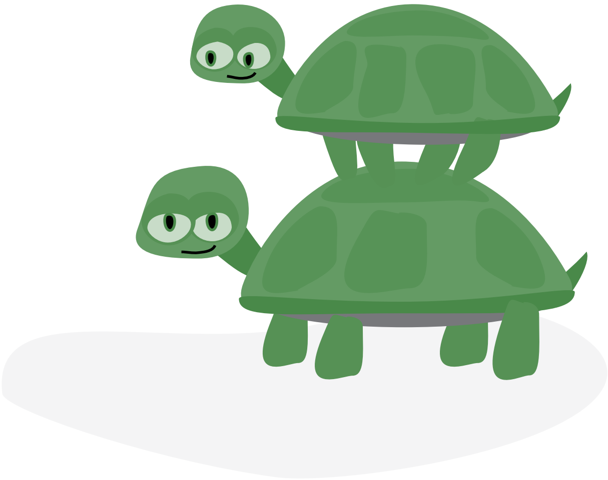
HeretoHelp is a project of the BC Partners for Mental Health and Addictions Information. The BC Partners are a group of nonprofit agencies working together to help individuals and families manage mental health and substance use problems, with the help of good quality information. We represent Anxiety 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.

SOCIAL SUPPORT

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.

types of social support

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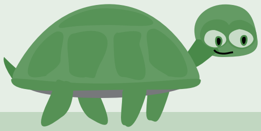

Sharing points of view: Some people help by sharing their point of view on a particular situation, or sharing how they might handle a situation. When you share points of view, you can develop a better understanding of a situation and the best way to handle it. For example, if you tell a friend about 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.