The Peer Model Manual

Consumer Participation in Action

sharc
Self Help Addiction Resource Centre

APSU
Association of Participating Service Users
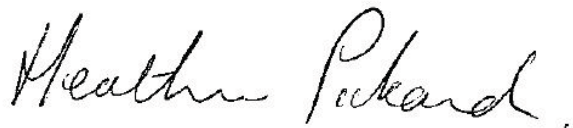APSU is a service of sharc

Acknowledgements

Foreword

In 2008 the Department of Health funded the second round of projects under the Improved Services Initiative (to build an organisations' capacity to respond to service users with co-occurring drug and alcohol and mental health issues). The Self Help Addiction Resource Centre (sharc) was a recipient of this funding and this manual was one of the many projects enabled by this resource.

It was a collaborative project between the Association of Participating Users (APSU) at sharc and the Improved Services Initiative (ISI) at sharc. APSU has delivered the three tiers of this training: Peer Helper Training, Experts by Experience and the Speaker Bureau for many years now but welcomed the opportunity with the ISI project to manualise it and extend its scope to be inclusive of service users with co-occurring drug and alcohol and mental health issues.

In 2012, there is no doubt of the relevance of consumer participation in AOD services, and the benefits of utilising peer support and mutual aid as a positive tool in service delivery. We know this manual will assist APSU at sharc to extend its training further into the sector, and hope also that service providers will utilise sections of this manual to develop skills within their organisations.

The time has come to combine the best of what consumer participation has to offer and health and social sectors knowledge and expertise to support the very best of what we can bring to our service users. The Peer Model Manual is a great example of this and provides a solid framework within which to contribute to paving the future of consumer participation and development of peer support as a credible and effective resource within our sector.

Heather Pickard
Chief Executive Officer
sharc

Contents

Introduction

Welcome to the Peer Model Manual. Contained within this manual are materials that will enable you to deliver all aspects of The Peer Model consumer training. These materials were produced by The Association of Participating Service Users (APSU) in collaboration with the Improved Services Initiative (ISI) at sharc. They are designed to provide training and opportunities for people who experience alcohol and other drug (AOD) issues and want to participate as consumers in the alcohol and other drug sector. As people often experience mental health issues in conjunction with alcohol and other drug use, this model has been developed in such a way that it is suitable for people who experience co-occurring alcohol and other drug and mental health issues.

The Peer Model has three parts: The Peer Helper Training, Experts by Experience Workshops and the Speaker Bureau. Overall, this Model offers training and opportunities for people who want to contribute meaningfully to service provision, policy and research. This is central to the realisation of the mission of the Association of Participating Service Users (APSU). All aspects of this model have been operating successfully for a number of years.

For example, at the end of 2009, when training was last conducted at sharc, out of the 77 participants who had completed Peer Helper Training, over a third had gone on to further education. Out of the 15 people who had completed the Experts by Experience Workshops, at least half of these continued on with volunteer work that involved policy development or governance. There is no doubt that training is essential to the development of skills necessary for users of alcohol and other drug and mental health services to contribute to the development and improvement of the services they use.

The beauty of the Peer Model is that it allows opportunities for service users to exercise the skills and knowledge they obtained during training. For example, part of the delivery of the Peer Helper Training is the 12 hours of Peer Helping. This is working voluntarily for 12 hours, chiefly at a drug and alcohol service. The speaker bureau offers yet another means for service users to exercise their skills. As a member of a Speaker Bureau, the consumer is trained and supported to present at forums or participate on committees. Since 2006 APSU has supported over sixty speaker bureau engagements.

It is with great pleasure that APSU offers this manual specifically to the alcohol and other drug sector in Victoria, and also to any service that is truly interested in ensuring service user participation in their service is effective and sustainable. At APSU we have found that education and training, along with providing opportunities, is the key to such participation.

Self Help Addiction Resource Centre (sharc)

sharc's mission is to provide opportunities for individuals, families and communities affected by addiction and related problems to recover and achieve meaningful, satisfying and contributing lives.

sharc is a Victorian, community-based, not-for-profit, incorporated organisation. sharc is a peer-based service that is made up of a combination of people with lived experience and professional expertise. sharc provides housing, education, advocacy and family support to members of the community who have been affected by alcohol and other drug use with or without mental health issues.

The Association of Participating Service Users (APSU)

The Association of Participating Service Users is a Victorian state-wide consumer participation and advocacy service for people who use alcohol and other drug services. Established in 2000, APSU is a service of sharc. APSU believes that people who use alcohol and other drug services have a wealth of experience and knowledge. Consumers (including family/carers) have a right to contribute to service development, policy, alcohol and other drug research and professional development.

Background

Peer Helper Training

The Peer Helper Training was originally designed for, and run within the Recovery Support Service (RSS) of sharc and funded by The Myer Foundation Community Fund. The first Peer Helper Training was run during 2005. Residents of the Recovery Support Service attended one day a week and used the skills they acquired as mentors for young people who had just commenced residency at the service.

In May 2007, funding for the Peer Helper Training was obtained from Perpetual Philanthropic Services. The Peer Helper Training was revised and opened to the alcohol and other drug sector. Part of the revision of this course was to set up the practice of 12 hours of Peer Helping. This is an opportunity for a Peer Helper graduate to volunteer at a service of their choice.

Peer Helper Training applicants must have lived experience of problematic substance use and/or mental health issues and have achieved recovery or treatment goals. By valuing people's lived experience of problematic substance use, their realisation of treatment goals and recovery, and their desire to be a Peer Helper, you as a service provider are engaging with alcohol and other drug consumers in a way that is different from treatment. Peer Helper Training allows people who have had a disrupted education to 'test the waters', build their self esteem, skill and knowledge level; in this way, the Peer Helper Training is unique.

The value of having Peer Helpers in the AOD sector is immense and often quoted as a necessary part of recovery for alcohol and other drug treatment consumers. Consumers are less likely to feel judged or stigmatise by those who have endured a similar experience. Undoubtedly the peer to peer relationship is built upon common knowledge and shared experiences.

Experts by Experience

The fellowship of 'Experts by Experience' was formed in 2005 (made up of the graduates from the Peer Helper Training), as a participatory mechanism for people who use or have used alcohol and drug services to utilise their expertise in directing alcohol and other drug service provision, policy and research. This initiative includes training service users in advocacy, leadership skills, facilitation and organising skills and learning about the principles of consumer participation and empowerment.

This Experts by Experience four-workshop course was delivered in November of 2007 and aimed to develop a fellowship of those who possess knowledge and wisdom from lived experience, or 'experts by experience'.

Out of the Experts by Experience course in 2007 a lobby group 'Voice for Change' was formed. This lobby group worked on the issue of residential withdrawal waiting times, researching this issue and developing a petition as well as assessing and evaluating a possible media campaign.

The four Experts by Experience workshops are now being used to train consumers, including family, who are achieving treatment goals and are interested in increasing their participation and activism in the alcohol and other drug sector and linking in with a micro community of other participating consumers.

Speaker Bureau

The Association of Participating Service Users' Speaker Bureau provides presentations from people with personal experience of addiction with or without Mental Health issues, conveying the experiential perspective on alcohol and other drug issues. Members of the Speaker Bureau also participate in forums and meetings and act as consumer representatives.

APSU maintains a database that includes speakers and meeting participants, their skills and interests. This information enables APSU workers to select the most appropriate speaker or meeting participant for each occasion. As a result, we utilise the unique experience, ability and capacity of each member of the Speaker Bureau.

Using this manual

APSU has delivered the three elements of the Peer Model Manual for a number of years now. As an organisation, APSU is quite unique in that it is run for consumers by consumers. It is this aspect of APSU that is used not only to inform the development of this training material, but also to deliver it. APSU staff and other presenters facilitate training sessions from a peer perspective. In doing so, APSU values the lived experience of each participant, creating an environment where the sharing of personal experience by the participants is considered essential to the learning process, demonstrating to participants that they have something valuable to offer. It is anticipated that those who use this manual in the future will do the same and treat training participants with the respect due to them and the insight and wisdom they have gained through life's journey.

Peer Helper Training

Peer Helper Training Overview

Introduction

Potentially, the Peer Helper Training can run for 32 hours depending on whether you wish to cover the full range of topics. These include knowledge that is needed to help a peer early in recovery: recovery, recovery capital, first 30 days and knowledge and skills that are needed to help others: consumer care, mentoring, advocacy, the alcohol and other drugs service system, the mental health service system and so forth. The training has been described as a snapshot of the Certificate IV in alcohol and other drugs. Along with the knowledge obtained, the spirit of the Peer Helper training is support and the sharing of experiential knowledge of the participants. This begins with recruitment, continues with the implementation of the course, and ends with the last hours of Peer Helping.

The Peer Helper Training gives an overview and exploration of the different aspects of being a Peer Helper. This training also provides skills and strategies that can be used in every area of life including advocacy and consumer participation in the AOD sector.

Each session builds on the previous one allowing for foundational and sequential learning. After the 32 hours of the Peer Helper Training, participants are then encouraged to complete 12 hours practical Peer Helping at an alcohol and other drug agency, organisation or service of their choice. The training organisation assists in the organisation, support and supervision of this placement for each participant.

Method

Educational Style

The Peer Helper Training has been designed to utilise people's expertise, qualities, strengths and abilities and through bringing these into conscious awareness build participants' self esteem, self awareness, strategies for coping, knowledge of the AOD treatment service system and skills in communication, advocacy and Peer Helping.

Because each training group is so diverse and participants have a wealth of lived experience, insight and skills, a situational teaching style is employed. This invites participants to contribute, share and discuss the topics we cover in each session. It has been our experience that through contributing personal expertise or experience appropriately (each group has guidelines), that the learning objectives and outcomes are achieved in a semi-formal, creative, lateral and respectful way.

The purpose of the Peer Helper Training is to empower participants with a sense of purpose and belonging. We want each participant to have the knowledge, skills and strategies to help themselves through helping others as Peer Helpers and consumer participants.

The Recruitment Process

The recruitment process that APSU undertakes has been one born from review and adjustment. Initially residents from the Recovery Support Service of sharc were recruited to undertake the training in order to act as mentors for new residents. Since the training has grown to include participants from the wider alcohol and other drug sector, APSU recruits with a mail out to our membership, flyers placed in several AOD agencies' waiting rooms and word of mouth. The previously required written response has been replaced with a telephone conversation where the APSU staff member fills out the application form to prevent exclusion of participants with literacy issues. Each training organisation should develop its own method of seeking applicants.

Selection Criteria

To ensure fairness and transparency as well as to increase the likelihood of participants completing the training, selection criteria have been developed. These are:

1. The applicant has reached a stable position in their 'recovery,'
2. The applicant is able to work well in a group,
3. The applicant is able to meet commitments for training and placement.

Applicants who initially appear to meet the criteria are invited to an interview.

Interviews

Interviews are conducted by two staff members. They have proven to be an effective means for the applicants and trainer to become familiar with each other and to resolve any issues around attending the training. Additionally they have proven to be an effective means of weeding out people who change their minds, who are not really motivated or who do not fit the criteria after all. If there is any doubt then applications are discussed in accordance to the selection criteria. An interview form is filled in during the course of the interview by one of the interviewers.

Unsuccessful applicants are encouraged to reapply in the future and offered training opportunities or means of engaging in consumer participation if possible.

Number of Participants

An ideal number of group participants is 10-12; however, APSU has found that several successful applicants usually withdraw before or during the training. APSU therefore accepts up to 16 participants for each training series. If more than 16 applicants are considered appropriate, then those who most fit the selection criteria are offered a place. Numbers selected will also depend on the size of the room the training agency has available.

The Training

Each session of the course runs for approximately 4 hours allowing a ½ hour lunch and two 15 minute breaks. This does not have to be strictly followed as long as all the material is covered and plenty of room for discussion is allowed. It must be remembered that many Peer Helper Training participants have not engaged in study for a long time if ever and may require frequent breaks.

The sessions can be run over few or many weeks. APSU has found that running three sessions per week in consecutive weeks maintains enthusiasm and causes minimal withdrawal from the training. Consideration should be given to what time of day the sessions are best scheduled. This will depend on participant and facilitator availability.

APSU recommends that participants attend a minimum of 8 out of 10 sessions in order for a participant to graduate and proceed to the voluntary 12 hours of practical Peer Helping.

12 Hours of Practical Peer Helping

The practical Peer Helping is a voluntary undertaking. The training agency makes contact with relevant AOD services on behalf of participants. This enables an explanation of the Peer Helper Training and placement requirements and decreases confusion. The training agency recommends specific graduates for particular services depending on placement tasks available, the skills, knowledge and suitability of graduates and their preferences.

For each practical Peer Helping placement suitable tasks and activities are negotiated. The Peer Helper has a clear role during practical Peer Helping and clear boundaries.

Resources

It is preferable to have one coordinator who organises the timetable for the course, recruitment, session facilitators and general resources. The coordinator usually also acts as a facilitator or co-facilitator during sessions.

A large room, sufficient chairs, whiteboard, markers and erasers, PowerPoint projector and laptop, butcher's paper and pens, CD player, session handouts and finally course evaluation forms are required. An A4 size binder and notepaper for each participant is advantageous.

Evaluation

Evaluation of the Peer Helper Training begins on the first day of training. Participants complete a survey prior to training, upon completion of training and two months after training. Responses to these surveys can be used to measure the success of the training. Focus groups could be a further means to evaluate the training.

Suggestions made by participants are incorporated into the next possible training series and have contributed to the Peer Helper Training we have now.

For example, APSU has extended the Peer Helper Training from eight to ten sessions to include more information about advocacy, forensic services, the AOD treatment service system, harm minimisation and mental health. (Note, the session plans for Harm Minimisation and Forensic Services are not included in this manual as external peer presenters are used)

Peer Helper Training Session Objectives

Session One Training Objectives — Orientation and Peer Helping

1. To understand sharc and APSU as a service of sharc & to understand the structure & service of the training organisation.
2. To be familiar with the organisation's complaints procedure.
3. To have a clear outline of the Peer Helper Training sessions and field placement (voluntary practical Peer Helping) requirements.
4. To develop a set of group guidelines agreed upon by the group
5. For participants to have a definition of what 'recovery' means to them.
6. To have a basic knowledge of what Peer Helping is.
7. To understand what a mentor is and the mentoring role.

Session Two Training Objectives — Phases of Recovery

1. To understand the key helping qualities of a Peer Helper and how to apply them.
2. To be familiar with the different phases of recovery
3. To gain knowledge of the 'five main phases model of recovery'
4. For participants to have basic knowledge of how 'recovery' is part of harm minimisation.
5. To recognise where they are on their journey of recovery.

Session Three Training Objectives — Process and Stages of Change

1. To be familiar with the process of change:
2. To be able to compare the models: 'stages of change' and 'processes of change'.
3. Participants can identify what they find helpful about the models 'stages of change' and 'phases of change'.
4. To know what works and what doesn't work when helping people.
5. To recognise the 'stages of change' in their own recovery process.
6. To have knowledge of stages and processes of change for families of people with alcohol or other drugs issues.
7. For participants to have basic knowledge of how and why Families move on.

Session Four Training Objectives — Communication

1. To acquire knowledge of some of the core communication skills.
2. To be informed of what blocks effective communication.
3. To have knowledge of negotiation and assertiveness techniques as conflict resolution skills

Session Five Training Objectives — First 30 Days

1. To explore participants' first 30 days in recovery.
2. To gain an understanding of basic living skills.
3. To adopt strategies for responding to emotions in a helpful way.
4. To recognise the principles of relapse prevention.
5. To gain knowledge of lifestyle interventions including lifestyle change, new coping strategies, problem solving skills and developing supportive networks.

Session Six Training Objectives — Peer Helping and Risk Assessment

1. To comprehend the practical aspects of Peer Helping.
2. To recognise the three main practical aspects of Peer Helping: knowledge, skills & attributes.
3. To have an understanding of ethics and boundaries, roles and responsibilities of the Peer Helping relationship.
4. To have knowledge of substance abuse issues, self-harm, suicide or violence risk assessment.
5. To be informed of the myths and facts surrounding suicide.
6. To adopt strategies for high risk situations.

Session Seven Training Objectives — Advocacy, Service System and Self Help

1. To have an overview of the alcohol and other drug treatment service system in Victoria.
2. To have a basic knowledge of the differences between self help and professional services, groups and organisations.
3. To have a basic understanding of what constitutes a human rights abuse, discrimination and stigma.
5. To have a basic knowledge of whom and how to consult on advocacy issues.
6. To know how to access support and assistance for self or others.

Session Eight Training Objectives — Mental Health and Self Care

1. To be familiar with co-occurring mental health and drug and alcohol issues.
2. To have knowledge of stress reduction and management strategies when Peer Helping.
3. To identify physical, emotional and spiritual self care when Peer Helping.
4. To comprehend confidentiality and duty of care.
5. To identify the key helping qualities of a Peer Helper.

Peer Helper Training Session Plans

Session One Plan: Orientation and Peer Helping

Objective One: To understand sharc and APSU as a service of sharc and to understand the structure & services of the training organisation

RESOURCES: Name labels, pens, A4 notepads and ring binder folders, whiteboard, markers and erasers. Session One Handout 1

METHOD: Discuss sharc and APSU (a service of sharc), as developers of this material and as a peer based service. Discuss the vision and mission statement of the training organisation and give an overview of its structure. Use whiteboard to write up vision and mission statement of the organisation.

OUTCOME: Group participants have knowledge and resources about the organisation.

Objective Two: To be familiar with the training organisations complaints procedure

RESOURCES: Whiteboard, markers and erasers, Session One Handout 2

METHOD: Talk about the information in the handout and the process of lodging a complaint. Generate discussion, answer questions and draw diagrams if necessary.

OUTCOME: Group participants are familiar with the complaint procedure and know the correct process to follow.

Objective Three: To have a clear outline of the Peer Helper role

RESOURCES: Session One Handout 3 and Session One Handout 4

METHOD: Give an overview of the eight-session content. Discuss the information in the two handouts: Encourage questions and facilitate discussion. Encourage thinking about where to do 12 hours of voluntary Peer Helping.

OUTCOME: Group participants have an overview for the entire eight sessions, know the attendance requirements and begin to plan for the 12 hours of Peer Helping.

Objective Four: To develop a set of group guidelines agreed upon by the group

RESOURCES: Butcher's paper and felt pens, whiteboard, markers and erasers.

METHOD: Divide group into threes. Groups to write on the butcher's paper what guidelines they would like for the group. Then ask each group to read out the guidelines they have developed and write these on the whiteboard. Facilitate discussion of group guidelines. Seek agreement regarding the review process of this code.

OUTCOME: To have an agreed code of conduct for the group.

Objective Five: For participants to have a definition of what recovery means to them

RESOURCES: Butcher's paper, felt pens, whiteboard, markers and erasers.

METHOD: Divide group into threes and ask them to write on the butcher paper what 'recovery' means to them individually and generally. Ask participants to read out and discuss what 'recovery' means and write the responses on the whiteboard.

OUTCOME: Group participants have explored and discussed what 'recovery' means to them and how this may differ from other peoples' experience of 'recovery.'

Objective Six: To have a basic knowledge of what peer helping is

RESOURCES: Whiteboard, markers and erasers, Session One Activity Cards.

METHOD: Divide group into threes and hand out mixed bundle of Session One Activity Cards to each group. Ask them to create two columns: one is Peer Helping and one is not Peer Helping. Ask each group what cards they had in each column. Divide the whiteboard into 3 columns: YES, NO, MAYBE and write on the board what each group has decided. Review through discussion and imparting information on what is and what is not Peer Helping and discuss the maybe column.

OUTCOME: Group participants now have a basic knowledge of what is and what is not Peer Helping and what is involved in the Peer Helping role.

Objective Seven: To understand what a mentor is and the mentoring role

RESOURCES: Whiteboard, markers and erasers.

METHOD: Encourage discussion about who participants admire and why. Write on the whiteboard a list of names from the group. Then ask the group what qualities and skills these people have that make them mentors. Discuss what a mentor is and that in fact we often posses some of the qualities we admire in others.

OUTCOME: Group participants can explore who their mentors are and why. To be informed about what is involved in the mentoring role. To become aware that participants posses many of the qualities they admire in their mentors.

The Self Help Addiction resource centre (sharc) is a Victorian community based, not for profit organisation, incorporated since 1997. sharc provides housing, education, advocacy and family support to members of our community who have been impacted by the effects of alcohol and drug use. In some cases this is co-occurring with mental health and sharc also provides help in this area. sharc works with families, individuals, and youth through a peer support model. Our team consists of people with the combination of lived experience and professional expertise. sharc is the umbrella organisation for the following programs:

Recovery Support Service (RSS)

RSS is a peer based residential supported accommodation service. We offer support to young people aged 16-25 experiencing complex and co-occurring needs related to their use of alcohol and other drugs. For example

- Mental & emotional health
- Homelessness
- Legal issues

What we do

At RSS, we offer physical, mental and emotional support to all participants. We provide a homelike, safe and supportive living environment and a community where we create authentic recovery opportunities.

Associated Participating Service Users (APSU)

APSU believes that people who use alcohol and other drug services have a wealth of experience and knowledge to contribute: they have the right to contribute their ideas and opinions to service provision, policy, research and professional development.

APSU works collaboratively with services in the setting-up and the delivery of consumer participation projects. To assist with the sustainability of consumer participation projects we offer the Peer Model as a training and activity model.

The Peer Model includes:

Peer Helper Training: a 40 hour training course that equips people experienced in AOD service use to help others who are just beginning to use AOD services.

Experts by Experience: 4 workshops designed to develop the necessary skills for consumers to participate in the decision making involved in service provision, policy making, research and professional development.

The Speaker Bureau: this is a database of consumers who are willing to offer a consumer perceptive whilst engaged in meetings, forums, or delivery presentations.

Family Drug Help (FDH)

We recognise that alcohol and other drug use within the family can be overwhelming and cause problematic behavior (with or without mental health issues). We offer family and friends support, information, education and inspiration. We don't judge family members because we have been there.

How we can help you

A confidential telephone helpline staffed by trained volunteers with family experience

Family and Friends Support Groups across Victoria where you can gain support and share information and knowledge with others, who are experiencing similar situations in their lives.

A six week family information course ARC to learn strategies in coping with a loved one's addiction.

The Supper Club is a support for people who have lost a loved one due to alcohol & drug use

Free family counseling for extra support

Free booklets and a quarterly newsletter

Mental health difficulties should not be hidden; end the stigma and seek help

At sharc we recognise that young people entering our service for alcohol or other drug recovery can also have co-occurring mental health conditions making recovery more complex. Although anxiety and/ or depression commonly co-occur with alcohol or other drug problems, many people do not recognise or respond to symptoms in themselves or others. Although we provide support and helpful programs we also offer referral to appropriate clinical and non-clinical services as needed. We have collaborative agreements with mental health services to ensure community care and clinical support. Family support is also available.

sharc VISION

We envision a world where all people affected by the impact of addiction can proudly and openly seek help, help each other and demonstrate the living proof that recovery is possible.

sharc MISSION

To provide opportunities for individuals, families and communities affected by addiction and related problems to recover and achieve meaningful, satisfying and contributing lives.

sharc VALUES

PEOPLE: People who have the courage to ask for help have our respect and admiration.

INSIGHT: We believe that people are the experts in their own life.

SELF HELP: We believe in Self Help as mutual healing, passing on the knowledge and skills acquired, as we give and receive help.

RECOVERY: We believe in Recovery – the individual taking ownership of a meaningful and purpose filled life.

LEADERSHIP: We believe in Leadership that is born from direct experience and has the spirit to inspire and advance the wellbeing of all.

COMMUNITY: We believe in Community that includes all members as equal and necessary participants.

ADVOCACY: We believe in Advocacy as a means offered to people to take an essential and active role in a democratic community.

Service User Rights Statement

sharc has developed a statement of Service Users' Rights:

These are some of the things you the service user should expect from health and welfare services:

1. Quality of care as promptly as possible;

2. Considerate care, respecting your privacy and dignity;

3. Adequate information on all aspects of services provided or treatment available in terms you can understand;

4. Participation in decision making which affects your own health care;

5. The right to consent to or refuse care and leave the program;

6. The right to consent to or refuse to participate in educational or research programs;

7. Access to clinical files and to have the confidentiality of records ensured.

Responsibilities

sharc encourages Service Users:

1. To follow a healthy lifestyle. sharc staff can provide information to assist the service user in achieving this goal.

2. To participate in the sharc self help/mutual aid community.

3. To provide complete and accurate information to the worker(s) coordinating care/support.

4. To conscientiously carry out any care plan designed in collaboration with the service user (or to inform the worker of their intention not to do so).

5. To seek out and understand service user rights in other health care institutions.

sharc
Self Help Addiction Resource Centre

Service User Complaints Process

sharc seeks to ensure that complaints and grievances are resolved by negotiation and discussion between the parties. sharc recognises that from time to time service users may have grievances that need to be resolved in the interests of good collaborative relationships.

1. A sharc service user has the right for a grievance to be heard through all levels of management.

2. In the first instance, you can make a complaint on any aspect of sharc services and have that complaint fully and objectively investigated by the Executive Officer or Chief Operating Officer.

3. If the situation is not resolved, you may put the grievance in writing for presentation at a general meeting of the sharc Board of Governance.

4. The service user will be invited to attend the board meeting to clarify the written grievance, but will not be present or have input into the decision-making concerning this grievance.

5. On hearing the grievance, the Board will make a decision and notify the service user of the outcome in a timely manner.

6. If you are not satisfied with the action taken by sharc on your grievance/complaint, you can refer the matter to the Health Services Commissioner and/or to the Ombudsman.

PEER HELPER PLACEMENT

The Peer Helper Project is forty hours of training in 'recovery support' provided to individuals who are in recovery themselves. The training builds on the knowledge and skills already gained from one's own experience. After the training, the Peer Helper spends 12 voluntary hours Peer Helping at an organisation or activity of their choice. Peer Helping is a therapeutic activity with an individual program participant, organisation or agency, provided by a trained Peer Helper.

SUPERVISION:

The Peer Helper will have _____ supervision sessions with training organisation staff.

The Peer Helper will have _____ supervision sessions with _____ from _____ _____ (Peer Helper placement agency).

The Peer Helper will be under the direct supervision of _____ from_____ _____ (Peer Helper placement agency) while completing practical Peer Helping placement hours.

If the Peer Helper breaches the placement agency's Code of Conduct or any other aspect of the placement agreement please contact: the Training Coordinator on_____

TASKS:

The Peer Helper will be involved in following tasks/activities during placement:_____ _____

HOURS:

The Peer Helper will attend placement on _____, starting date_____, between the hours of _____, ending on _____

RESPONSIBILITIES:

The student is responsible to _____ at the agency of placement.

The student is responsible to training organisation's worker _____

The student has signed the placement agency's Code of Conduct, YES/NO

The student has read the placement agency's relevant Policies & Procedures YES/NO

OCCUPATIONAL HEALTH AND SAFETY:

_____ will be responsible for public liability insurance for the Peer Helper. The training organisation will be responsible for insurance relating to the Peer Helpers behaviour whilst on placement at the above agency.

NAME OF PEER HELPER:
Contact Details:

Emergency Contact:

NAME OF AGENCY WORKER:
Contact Details;

NAME OF APSU WORKER:
Contact Details:

DATE:
SIGNED: _____ Peer Helper
_____ Agency Representative
_____ APSU Worker

WHAT IS AND WHAT IS NOT A PEER HELPER?

A counsellor

Although you may use some counselling skills in Peer Helping it's important to remember you are not a counsellor. An advocate – by definition an advocate is someone who 'pleads or speaks for another'. This is part of being a Peer Helper.

A friend

Although some aspects of friendship may enter into the Peer Helping relationship, there are clear differences between friendship boundaries and peer helping boundaries.

A friendly ear

This is part of the Peer Helping role, to provide program participants with a non-judgemental listening space. Someone who remains independent about your problems – the ability to remain independent is a very important part of being a Peer Helper.

An advisor

Peer Helpers may be called upon to give advice but it's important to remember that we don't always know what is best for someone else. Sharing experience rather than giving advice should be the focus in Peer Helping.

A role model

Peer Helpers act as role models through their life experiences and behaviours.

A sympathetic listener

Peer Helpers need to be able to express empathy with program participants rather than sympathy.

WHAT IS AND WHAT IS NOT A PEER HELPER?

A friend	**An advocate**
A counsellor	**An advisor**
A role model	**A sympathetic listener**

WHAT IS AND WHAT IS NOT A PEER HELPER?

Someone who remains independent

A helper

A teacher

A friendly ear

Session Two Plan: Phases of Recovery

Objective One: For participants to be able to identify the key helping qualities of a peer helper

RESOURCES: Whiteboard, markers and erasers, and Session Two Scenario Cards.

METHOD: Divide group into threes and give each group a scenario and ask them to act out each role: Helper, Helpee and Observer. Bring group back together and ask for feedback. Generate discussion about what the key helping qualities of a Peer Helper are. Encourage members of the group to write a Peer Helper quality on the whiteboard. Discuss each quality on the board – is it or is it not a Peer Helper quality?

OUTCOME: Participants can identify the key Peer Helping qualities

Objective Two: For participants to have a clear knowledge of what characteristics the different phases of recovery

RESOURCES: Whiteboard, markers and erasers.

METHOD: Generate discussion about the different phases of recovery and write key point of the whiteboard under headings: ACTIVE ADDICTION, CRISIS, EDUCATION, STABILISATION, TREATMENT and MAINTENANCE. You may want to use sub-headings in some of these categories also – under STABILISATION you may have CONTROLLED USING, PHARMACOTHERAPIES and ABSTINENCE.

OUTCOME: Group participants can clearly state some of the characteristics of the different phases of recovery.

Objective Three: For participants to have basic knowledge of the five main phases model of recovery

RESOURCES: Whiteboard, markers and erasers, butchers paper, pens, and Session One Handout 1.

METHOD: Give out the handout and read through it with the group. Divide up the group up into smaller groupings depending on the number of participants and ask them to discuss and draw up on butchers paper what they feel belongs to each phase of recovery. While the groups are engaged in this activity, draw up five phases of recovery headings on the white board in columns. Then ask the group to call out what they have written under each phase. Write these up under the relevant heading.

OUTCOME: Participants now know the five phases of recovery and have the handout to reinforce learning.

Objective Four: For participants to have basic knowledge of how recovery is part of 'harm minimisation'

RESOURCES: Whiteboard, markers and erasers.

METHOD: Generate discussion on harm minimisation; what people think it is, what it is in general terms. Encourage discussion on how 'recovery' fits into harm minimisation. Write up on the board the key themes from the discussion. Write the three pillars of harm minimisation, supply reduction, demand reduction and harm reduction and give the function of each pillar.

OUTCOME: Participants know how recovery is part of harm minimisation and have some knowledge of the three pillars of harm minimisation.

Objective Five: For participants to recognise where they are on their recovery journey

RESOURCES: Whiteboard, markers and erasers, butcher's paper, pens, and Session Two Handout 2.

METHOD: Generate discussion about the handout and using the whiteboard write up the main points. Ask the group to individually write, draw and explore where they are at in their recovery journey. (They don't have to share this with the group).

OUTCOME: Group participants are informed about and able to identify where they are at on their recovery journey.

Five Main Phases Model of Recovery

The benefits of recovery

Moving beyond
the problem

Making the best of it

The struggle begins - Rising to the
challenges of trying to stay clean
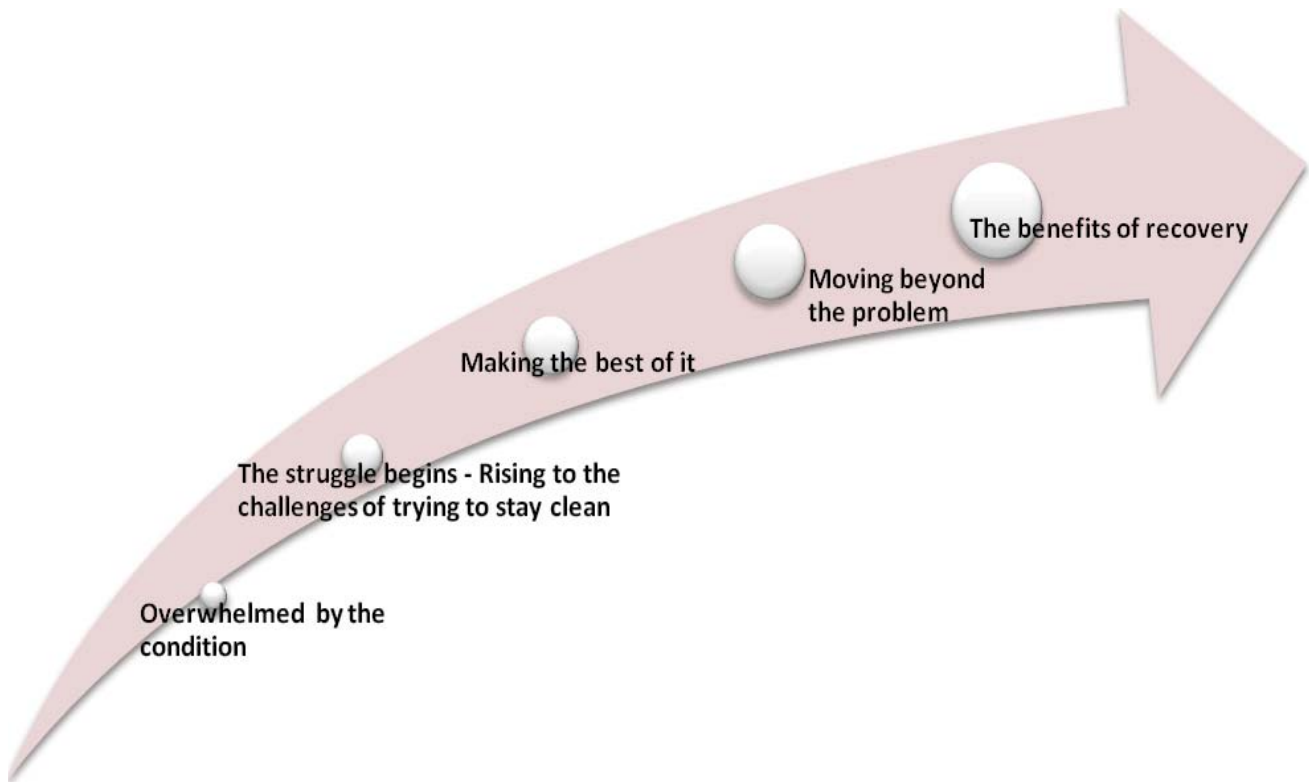
Overwhelmed by the
condition

Phase 1 - Overwhelmed by the condition

'Please help me! I can't go on like this anymore.
I am sick and tired of being sick and tired'
This phase is characterised by:
Chaos, increased negative consequences, confusion. Things are hectic, out of control.
Loss of self respect, friends, home, finances, health, possibly legal, spiritual and social problems.
Wanting the chaos to end, wanting a better life and peace between the ears.
Peer Helper Role: Give hope. Plant 'seeds' and lead by example.

Phase 2 - The struggle begins: rising to the challenges

This phase involves:
Learning to cope in new ways despite the reality of problems, cravings etc.
Much negative self-talk; focusing on what isn't working and 'victim mentality'.
Scared of relapsing and really fearful, focusing on missed opportunities and losses> Self doubt and lack of confidence.
Perseveres anyway, achieves some goals, feels hopeful about recovery, has some positive experiences, a more positive attitude and a growing sense of achievement.
Peer Helper Role: Dare to dream - be a living example. Fun, drug-free activities. Help build networks. Make suggestions.

Phase 3 - Making the best of it: Living with the problems

This phase involves:
Accepting of situation and reality and living well anyway.
Learning new living and coping skills, problems take less space.
Still experiencing problems but using good, effective coping skills.
Peer Helper Role: Help sustain networks.
Be supportive of positive changes.

Phase 4 - Moving beyond the problem

This phase involves:
The problems are now only a small part of our lives and do not interfere with having a decent quality of life.
Feel well connected and quite 'comfortable in our own skin' some of the time.
Working on deeper psychological issues, beginning to change core issues (e.g. feeling better or worse than other people, avoiding helpful things etc).
Peer Helper Role: Reinforce progress. Provide positive reinforcement.

Phase 5 – The benefits of recovery- Self Actualisation

This phase involves:
Authentic self esteem (not dependant on others' approval).
Living independently by our own values.
Openness – absence of hiding our shortcomings.
Honest, genuine, accepting of self and others.
Self motivated - not self-centered but mission oriented.
Peer Helper Role: Celebrate milestones and achievements.

sharc's definition of recovery:

'We believe in Recovery – the individual taking ownership of a meaningful and purpose filled life.'

Roadmap to Recovery

A turning point - stop using

I'll never use again

Recovery begins and the cycle of addiction is broken

Restless irritable and discontent

Use drugs

Scenario 1: The person you are helping is complaining that their partner's drug use makes it impossible for them to stop using. They ask you should they stay with their partner or not?

Scenario 2: The person you are helping can't pick up their methadone does because they are behind in paying for their methadone at the chemist. They have been going to the same chemist for years and they are really angry that their chemist won't give them tick. They ask you for money to pay for it.

Scenario 3: The person you are helping is thinking about giving up alcohol but they have been a daily drinker for years. They have to drink daily or they start to get the shakes and the DT's. They don't think their daily cannabis use is a problem.

Session Three Plan: Process and Stages of Change

Objective One: To have basic knowledge of the process of change

RESOURCES: Whiteboard, markers and erasers, and Session Three Handout 1.

METHOD: Review handout, ask people if they have any questions or comments about the handout, then generate discussion around the process of change. Divide whiteboard into sections and place characteristics of each process of change under the relevant heading.

OUTCOME: Group participants be informed and are invited to discuss the Process of Change model.

Objective Two: To have basic knowledge of the stages of change

RESOURCES: Whiteboard, markers and erasers, and Session Three Handout 2.

METHOD: Review handout, ask people if they have any questions or comments about the handout then generate discussion around the process of change. Divide whiteboard into sections and place characteristics of each process of change under the relevant heading.

OUTCOME: Group participants be informed and are invited to discuss the Stages of Change model.

Objective Three: That participants can identify what they find helpful about the model, stages of change and process of change

RESOURCES: Whiteboard, markers and erasers, and Session Three Handouts 1 and 2.

METHOD: Ask participants to place handouts next to each other and look for the similarities and the differences between the two handouts. Ask the group what is and what isn't helpful in these models. Write the responses on the board under HELPFUL and UNHELPFUL headings.

OUTCOME: Group participants can compare models and discuss and identify what is and what is not helpful in these models.

Objective Four: For participants to have knowledge of what works and what doesn't work when helping people

RESOURCES: Whiteboard, markers and erasers.

METHOD: Ask participants to share their ideas about what has helped and what hasn't. Write the key points on the board under DOESN'T WORK and WORKS headings. Link key helping qualities, processes and stages of change and generate discussion around this.

OUTCOME: Participants' knowledge of what works and what doesn't in helping others has increased.

Objective Five: For participants to be able to identify stages of change in their own recovery process

RESOURCES: Butcher's paper and felt pens.

METHOD: Ask the group to write on their butcher's paper what stage of change they are at. This is to be done individually, participants who want to discuss this with others may, but essentially this is a private exercise.

OUTCOME: Group participants will recognise and explore what stage of change they are at in their own recovery.

Objective Six: For participants to have a basic knowledge of the impact of the processes & stages of change on the families of people with alcohol and other drug issues

RESOURCES: Family Drug Help (FDH) presenter. (Check to see what resources they need).

METHOD: As per presenter.

OUTCOME: Group participants will be informed about and develop a basic knowledge of the impact on, stages and processes of change for families of people with alcohol and other drug issues.

Objective Seven: For participants to have basic knowledge of how and why families move on

RESOURCES: Family Drug Help Presenter, (check to see what resources they need).

METHOD: As per presenter.

OUTCOME: Group participants will be given information about and encouraged to develop basic knowledge of how and why families of a people with alcohol and other drug issues move on.

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PROCESS OF CHANGE

Definition: a process or period in which something undergoes a change and passes from one state, stage, form, or activity to another.

Awareness Raising: Awareness raising is the process you undertake to become aware of your problems and inner-self. This involves looking inward and being honest with yourself. Voluntary sharing can reveal that others have similar difficulties and fears.

Self Re-evaluation: Having increased your awareness of problems and true-selves, change requires that you re-evaluate in light of the new information. Often we have negative self-concepts that need to be eliminated. Assess what you need, what's working and what isn't working for you. You can form a new belief system that is more positive and helpful. Self re-evaluation provides the opportunity to move on from old patterns and habits.

Self Liberation: Having accepted the need for change the self liberation phase involves enhancing our commitment to and belief in the ability to change. The self liberation phase involves the recognition and growing belief that we are capable of change and it is repeatable.

Dramatic Relief: One of the consequences of consciousness raising and self re-evaluation is the recognition of emotional backlog or build up. The process of dramatic relief involves the expression and letting go of previously controlled, denied and/or repressed emotions.

Counter Conditioning: This refers to the process where people develop healthier responses to problems and stop using harmful responses. Counter conditioning involves finding new ways to deal with old situations that better serve the person in the recovery process.

Stimulus Control: This means removing oneself from the circumstances and situations that trigger a desire to use. It's about limiting exposure to dangerous situations and taking responsibility for our own wellbeing.

Reinforcement Management: Gradual and ongoing change requires reinforcement and management. Rewarding ourselves for achieving change is important. Support from a counsellor, GP, group or a friend helps to reinforce the practice towards new ways of being and living.

Helping Relationships: Being involved in helping relationships where each person benefits is an important part of the process for change. Trusting relationships provide both parties with the opportunity to give and receive help resulting in mutual benefits.

Environment and Re-evaluation: This refers to the process of taking a look at how our behaviour and problems impact on the external environment. This change process helps people to focus on taking personal responsibility and step away from self centeredness.

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STAGES OF CHANGE

Each stage of change has a particular change process. This model reminds us that people move through different stages in the recovery process at different times and in different ways.

Pre-contemplation

No intention of change in the near future

Unaware or 'minimising' of the problem(s)

Denial of problem(s)

Contemplation

Aware of the problem(s)

Serious thinking about change

Not committed to making changes, (aware but not ready)

Preparation

Have intent to change

Getting ready to make changes

Still in the decision making process

Action

Strengthening the changes made

Stabilising behaviour

Continuously changing

The Pre-contemplation and Contemplation stages see an emphasis on:

Awareness or consciousness raising

Emotional expression

Impact evaluation

The contemplation and preparation stages see an emphasis on:

Self re-evaluation

The preparation and action stages see an emphasis on:

Self liberation

The action and maintenance stages see an emphasis on:

Reinforcement management

Helping relationships

New coping mechanisms

Self Responsibility

Social liberation

Finding meaning

Session Four Plan: Communication

Objective One: To acquire knowledge of core communication skills

RESOURCES: Whiteboard, markers and erasers, and Session Four Handouts 1, 2 and 3.

METHOD: Play Chinese Whispers by asking each person to repeat a message to the person on their right going around in the circle. Ask the last person in the circle to repeat the message they received, note the differences between the original message and the final one. Discuss SOLER, active listening, asking open and closed questions, asking clarifying questions, not interrupting and relating empathetically. Repeat the Chinese Whispers activity with a different message and ask the last person in the circle to repeat the message that they received – see if there is there is any difference in the accuracy with which the group members listened to, and passed on, the message. Generate discussion around this.

OUTCOME: For participants to gain and improve their communications skills.

Objective Two: To be informed of what blocks effective communication

RESOURCES: Whiteboard, markers and erasers.

METHOD: Divide group into pairs, ask each person to find out five things about each other. Ask the group to block communication by interrupting, asking yes or no questions and generally acting disinterested. Then ask each person to state what they learned about their partner and how this exercise felt. Write key points and feelings on the whiteboard under COMMUNICATION BLOCKERS heading. Then ask the group (in the same pairs) to use active listening skills, ask open questions and demonstrate empathy and interest. Then ask the group to relay what they found out about their partner. Ask for feedback and write it up on the whiteboard.

OUTCOME: To gain knowledge of communication obstructions.

Objective Three: To have knowledge of negotiation & assertiveness techniques as conflict resolution skills

RESOURCES:, Whiteboard, markers and erasers, and Session Four Scenario Cards.

METHOD: Write up negotiation skills and assertiveness skills and ask group for input. Divide group into threes – one helpee, one helper and one observer. Ask the group to take turns playing each role. Hand out Session Four Scenario Cards to groups of three to act out one scenario. Generate discussion around this.

OUTCOME: Group participants are informed of, and practice negotiation and assertiveness techniques enabling them to increase their conflict resolution skills.

COMMUNICATION

Communication is the transference of a message between a sender and receiver

WORDS/ TALKING = VERBAL   BODY LANGUAGE = NON VERBAL

BODY LANGUAGE can tell you more about the person and how they are feeling than verbal communication.

What is the message being sent?   How is the message being received?

CORE COMMUNICATION SKILLS

1.   Active listening – Reflecting back
2.   Asking open questions: How, What, Why, When, etc.
3.   Asking closed questions: Where only a yes or no response can be given
4.   Asking clarifying questions: Tell me more…
5.   Learning not to interrupt
6.   Paying attention to body language

Easy Acronym to Remember – SOLER

Sit squarely and face the person
Open posture
Lean forward
Eye contact
Relax

ENGAGING THE CLIENT

Develop rapport by trying to understand what is going on for them and respecting where they are at. Also, use language that they can understand
Repeat key points of what they have said to show that you are listening
Be genuine – 'say what you mean and do what you say'
Be aware of your own body language
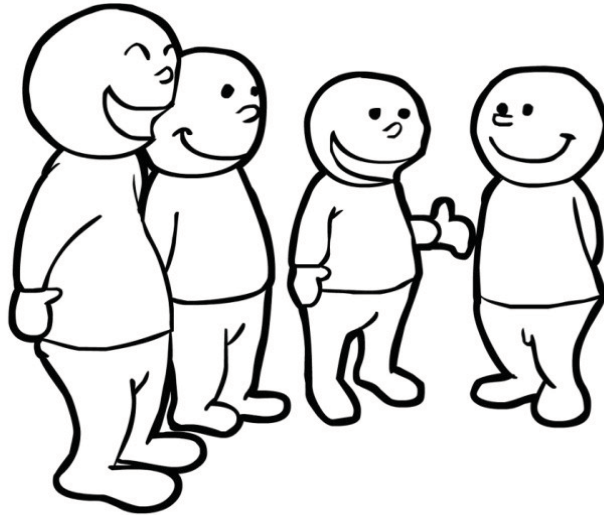
ACTIVE LISTENING

Active listening involves body language, following, and reflecting skills. To practice active listening our body needs to show that we are paying attention to what the other person is saying. This involves eye contact and appropriate body movement. Another aspect of active listening is 'following skills'. This means paying attention to what is being said, asking relevant questions and offering encouragement – such as 'mmm' or 'yes'.

Reflecting involves reflecting back both the content and feelings conveyed to you, summarising and repeating what the person has said to show that you understand them correctly.

Clarifying questions help to focus communication and ensure that the message being received is in line with the message being sent.

WHAT GETS IN THE WAY OF EFFECTIVE COMMUNICATION?

Ordering, directing or commanding

Warning or threatening, giving advice or providing solutions

Persuading with logic, arguing or lecturing

Moralising and preaching, disagreeing, judging, criticising or blaming

Shaming, ridiculing, labeling, interpreting or analysing

Reassuring, sympathising or consoling

Withdrawing, distracting, humoring or changing the subject

CONFLICT RESOLUTION

CONFLICT – violence, disagreement, resentment, drama, anger, silence, gossip, etc.

RESOLUTION – Agreement, compromise, reward, peace, agreeing to disagree, a win-win for both parties.

NEGOTIATION – Actively listening to each party with an open mind is very important; the real issue may not be what is being said. Ask open questions to find out which issues need to be addressed.

Using communication skills can help us to discover what is definitely negotiable, what may be negotiable, and what is absolutely not negotiable for each party.

Once these are clearly defined, role-play can be used as a tool for increasing awareness and decreasing fear and anxiety levels by becoming more familiar with, and practised at, conflict resolution.

ASSERTIVENESS versus AGGRESSION

Aggression involves threatening, offensive or intimidating speech, body language or behaviour.

Assertiveness is getting a message across in a clear non-threatening way, so that the message is more likely to be heard and understood clearly by the other party.

There are many assertiveness techniques, some of which include:

Repeating your statement or request again and again until it is heard.

Repeating what the other party has said then adding your statement or request to it.

Pointing out similarities or common ground and then adding your statement or request to it.

Using legislative, organisational, service and/or agency protocol, policy and procedures to give weight to your statement or request.

Knowing the legal rights, policy and complaints procedures within an agency, organisation or service can greatly empower people by enabling them to use this knowledge assertively.

Scenario 1: The person you are helping is arguing with a pharmacist about the amount of her methadone dose. She believes that she has not received the right dose and the pharmacist is adamant that she has. What do you do?

Scenario 2: You are doing your placement at a detox. Two of the residents are playing cards. One believes that the other is cheating, and they start arguing, things get quite heated. What do you do?

Scenario 3: You are at a café with a person that you are peer helping. They ask you to pay for their coffee, and then ask for your phone number. What do you do?

Scenario 4: You are peer helping a young pregnant woman on Naltrexone. She is thinking about going to rehab and is worried about her baby. What do you do?

Scenario 5: You are peer helping a man who believes that his wife is the cause of all his problems, and who just wants to drink alcohol socially although he has been a very heavy drinker for years. On this particular day his wife is present, and they start arguing. What do you do?

Scenario 6: The person you are peer helping is in rehab for poly substance use. They ask you to bring them some marijuana and pornography. What do you do?

Scenario 7: You are peer helping a young man who thinks that he may be HIV positive, but is worried about being tested, and will only see one particular Doctor who is currently on holiday. What do you do?

Scenario 8: You are peer helping someone who is sexually attracted to you and will not take 'no thanks' for an answer. What do you do?

Scenario 9: The person you are peer helping asks you if you could baby-sit for them, while they score. What do you do?

Session Five Plan: First 30 Days

Objective One: To explore participants' first 30 days in recovery

RESOURCES: Whiteboard, markers and erasers, and Session Five Handout 1

METHOD: Ask each participant to talk for two to three minutes on their experience of their first 30 days. Write up on board what was helpful and what was unhelpful. Generate discussion around this. Review handout

OUTCOME: For participants to be able to identify what is and is not helpful in their first 30 days in recovery.

Objective Two: To gain an understanding of basic living skills

RESOURCES: Whiteboard, markers and erasers.

METHOD: Ask the group what basic living skills are. Generate a discussion around what works and what doesn't work. Write up on the board what the group has identified as basic living skills.

OUTCOME: Group participants can identify basic living skills.

Objective Three: To adopt strategies for responding to emotions in a helpful way

RESOURCES:, Whiteboard, markers and erasers, and Session Five Handouts 2 and 3.

METHOD: Discuss handout. Ask the group for questions and feedback about above. Place in pairs and ask each person to identify which principles they use already and which relapse prevention principles they can use when needed.

OUTCOME: Group participants can develop a relapse prevention plan.

Objective Five: To gain knowledge of lifestyle interventions

RESOURCES: Whiteboard, markers and erasers, and Session Five Handout 4

METHOD: Discuss handout. Divide group into pairs to discuss lifestyle change, new coping strategies, problem-solving skills and developing supportive networks. Ask the pairs to reflect on what lifestyle interventions they have used, or are using, and how they could help others to do the same.

OUTCOME: To gain knowledge of how to help others develop social supports or networks, and promote problem-solving and coping skills.

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The rollercoaster of the first thirty days of recovery/ withdrawal can be a reminder of what it was like, how far we've come, and act as a deterrent when thoughts of resuming old habits arise.

BASIC NEEDS
- Stable accommodation
- Adequate food, water, transport, money to pay bills and live on
- Purpose – family, work, education, employment, creativity

LIVING SKILLS
- Ability to communicate effectively
- Insight/awareness, of one's strengths and weaknesses
- Relationships – personal, family, partner, professional and impersonal, supportive/helpful or unsupportive/not helpful
- Respect for self and others
- Identifying and dealing with emotions

EMOTIONS

It's clear that we can identify heaps of different feelings and ways to deal with them. However, most of our feelings can be classified into four basic groups.

Joy   Anger   Fear   Sadness

The intensity of a feeling is conveyed through body language and tone, volume of voice. Sometimes we have different types of the same feeling i.e. we 'love' our children in a different way to 'loving' sports.

It is important to be able to use a whole lot of different words and labels when we express how we feel to another person because it helps to put feelings into perspective and means that the other person has a better chance of understanding what we mean.

Misunderstanding can make supporting someone difficult. It's important to know how to identify what we are feeling and communicate that effectively to another person. In early recovery it can be hard to distinguish between feelings. We mix them up, ignore them or seek out new ways–apart from using – to run from them. None of these things help us to resolve our feelings and move on. What are the two most commonly confused feelings?

Sadness and Anger

What are some physical and emotional reactions that are similar or different when we get angry or sad?

When we're hurt we wash the wound and put on a bandage, dealing with emotions isn't all that different.

To begin to deal with something first of all we have to know that it's there, and then we need to know what things might make it better or worse.

> The process of recovery is not a single event but rather an unfolding process over time.
>
> Relapse can be a part of this process and can be looked upon as a learning experience in the process of change.

A key to relapse prevention is assessment and self monitoring. This means looking at our past and present experiences, functioning and responses. Relapse prevention is highly individual so it's important to work out individual strategies to prevent relapse.

Assessment: Think about, 'what are the good things about using drugs' and 'what are the not so good things about using drugs.' When you find that the not so good things list is much fuller than the good list, it's difficult to justify using.

Self-monitoring: Another aspect to raising our awareness is learning to recognise triggers, risky situations and costs associated with drug use. Assessment and self monitoring help to keep us focused on our recovery goals and provide information on the kinds of things we need to do to keep ourselves safe.

Ask participants:

What are some of your triggers?

Has anyone recognised a personal relapse pattern?

When, how and where you relapse and things that may have triggered it?

What are some high-risk situations for me?

What triggers me to want to use?

How do I deal with a high-risk situation without using?

Once we've got an idea about our using triggers (situations, feelings and thoughts) we need to think about how we can deal with these situations without using. This is about planning our coping strategies and making sure we have support in place to carry out our plans.

Get participants to note down or discuss with someone else coping mechanisms that work for you.

What can I do in unavoidable high-risk situations?

Repeat motivational statements to yourself (I am ok right now and I don't need to use because of this)

Call someone for support

Practise what you will do 'if' (go through the situation with a friend in advance and plan how you will act)

Get up and go leave the situation

Remember to breathe deeply, use muscle relaxation and focus on the body

Think – are you Hungry, Angry, Lonely, Tired and/or Serious (HALTS)? Did you know that being hungry, angry, lonely or tired can actually alter your mood?

Coping with cravings and urges:

Think about when and where cravings and urges occur and how to deal with them

Distraction. Try to think about other things

Talk it through with someone supportive

Knowing what it is – identification and what triggered it

I don't have to decide right now - (everything passes)

Remember why we wanted to change

Changing thoughts like, 'I have to use', to 'I have a choice'

Writing about cravings and urges – those where we have used and those where we haven't used – can be helpful in identifying what works and what doesn't

Preventing and managing lapses and relapses – what are you guys doing to help prevent relapse?

Back-up planning (what will I do if…?)

Role playing high risk situations with a support person

Imagine you have used or used problematically. What are you going to do to stop the lapse from turning into a relapse?)

Changing thinking (I do matter, people care about me, I have purpose)

Look at lessons learned from a lapse/relapse

Ask yourself:

What are you filing your time with now?

What do you enjoy?

What makes your soul sing?

What do you see as healthy alternatives to problematic/or any drug use?

Lifestyle interventions

It's helpful to think about things other than using that make us feel good. Each person will have various things that they enjoy and can use to fill up their time and stop themselves from using/ problematic drug use.

Exercise

Recreation

Going to the movies

Having 'coffee' with friends

Creating artwork

Computer games

Listening to music

Session Six Plan: Essentials

Objective One: To comprehend the practical aspects of Peer Helping

RESOURCES: Whiteboard, markers and erasers, butcher's paper, and pens.

METHOD: Generate discussion around ethics and boundaries of Peer Helping. Write up the key points on the whiteboard. Divide into groups of three and ask participants to write or draw on butcher's paper some of the things they can do to look after themselves and one another. Ask each group of three to share with the group what they have written and write the key points up on the board.

OUTCOME: For participants to have an understanding of ethics and knowledge of self-care and promoting self-care in others.

Objective Two: To recognise the three main practical aspects of Peer Helping: knowledge, skills and attributes

RESOURCES: Whiteboard, markers and erasers, and Session Six Scenario Cards A.

METHOD: Divide the board into three columns: KNOWLEDGE, SKILLS and ATTRIBUTES. Generate discussion in the group about the differences and similarities between these. Write up key points on the board.

METHOD: Divide group into threes and ask them to act out a scenario with a Helpee, a Helper and an Observer. Encourage awareness of what skills, knowledge and attributes they are using in this scenario. Ask for feedback about this task.

OUTCOME: For participants to be able to identify and practice the three main aspects of Peer Helping: knowledge, skills and attributes.

Objective Three: To have an understanding of ethics & boundaries, roles & responsibilities of the Peer Helper relationship

RESOURCES: Whiteboard, markers and erasers, and Session Six Handout 1.

METHOD: Ask participants what boundaries and boundary violations are and write up key points on the board. Generate discussion around this and ask the group to choose their own STOP phrase.

OUTCOME: Group participants are encouraged to discuss, explore, identify and clarify for themselves what boundaries and boundary violations are and to recognise and develop strategies to avoid boundary violations.

Objective Four: To have knowledge of substance abuse issues, self harm, suicide or risk of violence

RESOURCES: Whiteboard, markers and erasers, Session Six Handout 2 and Session Six Scenario Cards B.

METHOD: Read through handout and generate discussion around substance use, how substances affect people. Introduce the topics of: self harm, suicide and risk of violence carefully as participants may have personal experience of this. Divide group into threes and ask them to act out high risk scenarios – focusing on what they need to do to stay safe.

OUTCOME: Group participants discuss substance use, self-harm and suicide, and risk of violence. Practice strategies to stay safe and know how to make a referral.

Objective Five: To adopt strategies for high-risk situations

RESOURCES: Whiteboard, markers and erasers.

METHOD: Ask the group to state some high-risk situations – What is a high-risk situation for you? How do you know if you are in or approaching a high-risk situation? Write up the group responses on the board. Generate discussion around high-risk situations in general and in relation to Peer Helping and identify the key elements that make a situation high risk. Ask the group to reflect individually on what makes a situation high risk and how they can identify high-risk situations. This part of the session is individual and personal – participants do not have to share this with the group.

OUTCOME: Build on, discuss, and identify high-risk situations and the key elements that make situations high-risk for that person.

RESPONSIBILITIES OF A PEER HELPER

- To work in accordance with the role description and practices outlined in this document and all other program documentation
- To attend all training sessions
- To participate in regular supervision sessions with the training coordinator and/or other training organisation staff members as appropriate
- To ensure the focus of the peer support relationship is on the recovery support needs of those we are peer helping

ROLES OF A PEER HELPER

- Be an active member in the program participant's care and support team
- Advocate for program participants
- Promote & support the program participant's ability to set goals and make informed choices
- Plan & participate in activities with program participants that support the development of an improved self concept for the program participant
- Provide emotional support and companionship
- Teach & model the importance of a daily recovery program
- Assist program participants to develop recovery & crisis plans
- Share recovery experience and assist program participants to realise their own recovery potential
- Suggest & promote effective 'strategies for living'
- To help build the recovery capital of program participants

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Self Harm/ Violence/Suicide

RISK ASSESSMENT

As we know, people in early recovery can be vulnerable. As Peer Helpers we are not counsellors or workers: however we do have a responsibility to be aware and take notice of how participants are travelling. If you think a participant is a risk to themselves or others then there are some simple questions you can ask yourself.

PLAID

Plan – do they have a plan?

Lethality – is it lethal?

Availability – do they have the means to carry out the plan?

Illness – are they ill, mentally or physically?

Depression – do they suffer from depression, past or present?

PALS

Previous attempts – have they attempted to hurt themselves or others in the past? How many times?

Alone – are they alone? Do they have a working support system right now? Do they have any significant relationships?

Loss – have they suffered a loss?

Substance Use – are they using?

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SUICIDE

Myths about suicide

- People who talk about suicide won't commit suicide – suicide happens without warning.
- You can't stop a suicidal person – he or she is fully intent on dying.
- Once a person is suicidal, he or she is suicidal forever.
- Improvement after severe depression means that the suicidal risk is over.
- Suicide is inherited or 'runs in families'.
- All suicidal individuals are mentally ill and only psychotic people commit suicide.
- Suicidal threats and gestures should be considered manipulative or attention seeking behaviour and should not be taken seriously.
- If a client has attempted suicide, he or she will not do it again.

Facts about suicide

- Eight out of ten people who commit suicide give definite clues and warnings about their suicidal intentions. Very subtle clues may be ignored or disregarded by others.
- Most people who are suicidal are very ambivalent about their feelings regarding living and dying. Most are 'gambling with death' and see it as a cry for someone to save them.
- People who want to kill themselves are only suicidal for a limited time. If they are saved from feelings of self destruction they can go on to lead normal lives.
- Most suicides occur within the first three months after the beginning of improvement, when the individual has the energy to carry out the suicidal intentions.
- Suicide is not inherited. It is an individual matter and can be prevented. However, suicide by a close family member increases an individual's risk factor for suicide.
- Although suicidal people are extremely unhappy, they are not necessarily psychotic or otherwise mentally ill. They are merely unable at that point in time to see an alternative solution to what they consider to be an unbearable problem.
- All suicidal behaviour must be approached with the gravity of the potential act in mind. Attention should be given to the possibility that the individual is issuing a cry for help.
- Fifty to 80 per cent of people who ultimately kill themselves have a history of a previous attempt.
  (Information courtesy of Turning Point)

Suicide

Suicide Helpline: for people who are thinking about suicide, for those who are worried about someone else and for those who have been affected by suicidal behaviour.
Call 1300 651 251, 24 hours a day, 7 days a week.

If you need immediate advice and support call:
*	An ambulance – 000
*	The police (for a welfare check, or if the person has a weapon or is in a dangerous situation) – 000
*	SuicideLine – 1300 651 251, or another crisis telephone service, if you are outside Victoria (see below)
*	Poisons Information – 131 126 (if the person has ingested a poison, taken a lot of medication, or consumed alcohol in combination with medication)
*	The person's own doctor, counsellor or psychologist
*	Local Public Emergency Mental Health Service.

For less urgent times call: Suicide Call Back Service 1300 659 467
LifeLine 13 11 14
Salvo Care Line 1300 36 36 22
SuicideLine 1300 651 251

Multicultural Mental Health Australia: A national program in mental health and suicide prevention for Australians from culturally and linguistically diverse backgrounds. This program provides translated brochures for carers and consumers which are accessible via the library and information services section.
SANE Australia provides information about mental illness, suicide prevention and where to get help. It includes factsheets, online bookshop, media releases and a helpline (online and telephone). The site includes research, advocacy and awareness campaigns.

Scenario 1: The person you are peer helping is just out of residential withdrawal & really, really wants to use. Their drug of choice is heroin, but they want to use anything, right now. How do you handle this situation?

Scenario 3: The person you are peer helping is using daily & has a drug habit. They tell you that they want to stop using & that they've had drug free time before. How do you handle this situation?

Scenario 2: The person you are peer helping tells you that they used last night after a few months of total abstinence. How do you respond?

Scenario 1: A program participant thinks her worker picks on her and wants you to sort them out. She is shouting and punching the air.

Scenario 2: A program participant thinks her worker picks on her and wants you to sort them out and has told you that she'll clock her worker if she doesn't stop picking on her.

Scenario 3: A program participant shows you their new knife.

Scenario 4: Can you lend program participant $20? They threaten violence if you don't.

Scenario 5: Can a program participant come to your house because they are feeling suicidal?

Scenario 6: A program participant feels scared in social situations and asks you to sit with them. Do you?

Session Seven Plan: Advocacy, Service System & Self Help

Objective One: To have an overview of the AOD treatment service system in Victoria

RESOURCES: Whiteboard, markers and erasers, and Session Seven Handout 1.

METHOD: Read over handout and draw a simple diagram on the board and encourage participants to ask questions, generating discussion around this. Write up key points on the board.

OUTCOME: Group participants have a handout, diagram of, and have been informed about the drug and alcohol sector in Victoria.

Objective Two: To have a basic knowledge of the differences between self help and professional services, groups & organisations

RESOURCES: Whiteboard, markers and erasers, Session Seven Handout 2 & Session Seven Activity Cards.

METHOD: Divide groups into pairs, hand out Session Seven Activity Cards and ask pairs to put them in piles of 'self help' and 'professional service'. Write on the board the findings and generate discussion and answer questions around this topic. Distribute Session Seven Handout 2

OUTCOME: Group participants discuss and are informed of the differences between self help and professional groups and organisations.

Objective Three: To have a basic understanding of what constitutes a human rights abuse, discrimination and stigma

RESOURCES: Whiteboard, markers and erasers, and Session Seven Handout 3.

METHOD: Ask participants what human rights are and write up key points on the whiteboard. Ask the group what music or other media moves them and to share some of their beliefs or experiences of discrimination and stigma. Generate discussion around human rights abuses. Explain complaints processes. Use Session Seven Handout 3

OUTCOME: Group participants are actively engaged in discussion and have explored what constitutes a human rights abuse, discrimination and stigma. Group participants also develop skills to find information, advocate and pursue complaints processes.

Objective Five: To have a basic knowledge of whom and how to consult on advocacy issues

RESOURCES: Whiteboard, markers and erasers.

METHOD: Generate discussion on whom and how to consult on advocacy issues, answer participants' questions and write key points on the whiteboard.

OUTCOME: Participants are informed and discuss whom and how to consult on advocacy issues.

Objective Six: To know how to access support and assistance for self or others

RESOURCES: Whiteboard, markers and erasers.

METHOD: Generate discussion about what support is. Ask each participant to think of and make a list of the supports and assistance they do access and could access if they need to. Answer questions. Utilise the group's expertise and write key points on the whiteboard.

OUTCOME: Participants discuss, are informed about and reminded of their own affirmative action.

VICTORIA'S SPECIALIST ALCOHOL AND OTHER DRUG AND MENTAL HEALTH SERVICES

Residential withdrawal
Home-based withdrawal
Outpatient withdrawal
Substitute programs (methadone etc)
Counselling Consultancy and Continuing Care
Residential rehabilitation
Supported accommodation
Peer support
Aboriginal services

STATE WIDE SERVICES

Youth Substance Abuse Services YSAS
Ante and post-natal support
Information and support services
Specialist family program
Training and research
Corrections treatment services
Prison programs
Planning and purchasing for community offenders
Intensive post-release program

The peak body for AOD is called Victorian Alcohol and Drug Association (VAADA) and it seeks to raise awareness about AOD issues, provide advice to policy makers and advocate for the rights of people using substances.

Did you know?

Most alcohol and other drug treatment services and programs are funded wholly or in part by the Victorian Department of Health (DH). Some of these alcohol and other drug treatment services and programs are totally government funded.

Other alcohol and other drug treatment services and programs are partly funded by DH, and partly by donation from philanthropic or charitable bodies. These are known as non-government organisations (NGO's).

SELF HELP

Behavioural change
Having a sense of community
Giving and getting help
Consciousness raising
'We feeling'
Improving negative community attitudes
Empowerment
Raising self awareness
Advocacy
Taking action for yourself
Education'
Code of conduct

SELF HELP GROUPS: Help given by those who have experienced the same. Build on the strength of their members. The basis is that you are not alone and can include discussion, education & sharing of information. Groups are open to those who identify as belonging to a particular group.

PROFESSIONAL

Establishing a therapeutic relationship
Observing behaviour
Assessing
Funding
Rules
Regulations
Crisis response
Creating links to services
Following individual case plans
Policy and protocol
Paid workers
Quality cycle

COMPLAINTS

Start directly with the person you have a complaint with, then work your way up the 'Chain of Command'. If the complaint is not resolved contact The Ombudsman, the Human Rights & Equal Opportunities Commission, the Health Services Commissioner or gain support from a friend or worker. You can approach this on your own; however, as peer helpers your organisation is here to support you. Writing down a complaint & keeping a written record can add weight to your complaint & help you keep track of what has happened in more detail. Try to find out both sides of a complaint & work towards a win-win outcome which is positive & effective for both parties involved.

AFFIRMATIVE ACTION

Affirmative action includes creating safe & restricted meeting places, workplaces & reducing the stigma surrounding marginalised &/or disadvantaged people/groups of people.

Affirmative action often begins at a grassroots level.

People we are helping are often in isolation, & as peer helpers it's okay to draw them out of isolation, express boundaries as well as providing support.

Advocacy is a learning curve, we are always learning & we can't afford to be complacent.

Systemic advocacy is changing the system - a systems issue. What is the judgement about?

Rights are something that is due to a person, by law, tradition or nature.

Common sense comes into most decision making processes in an advocacy setting, (ideally).

Counselling	Narcotics Anonymous
Self Help Addiction Resource Centre	WINDANA
Department of Health	Centrelink
Salvation Army	Psycotherapy
Alcoholics Anonymous	New Life

Session Eight Plan: Mental Health & Self Care

Objective One: To be familiar with co-occurring mental health and drug & alcohol issues

RESOURCES: Whiteboard, markers and erasers.

METHOD: Explain the concept of Dual Diagnosis. Explore relationships between alcohol and other drug and mental health issues. Explain the 'No Wrong Door' policy. Write pertinent points on whiteboard. Allow ample time for questions. (This session has previously been conducted by a Mental Health

Service.)

OUTCOME: Participants are familiar with co-occurring AOD and MH issues.

Objective Two: To have knowledge of stress reduction and stress management strategies when peer helping

RESOURCES: Whiteboard, markers and erasers.

METHOD: Discuss general health and stress management, encourage group to ask questions and generate discussion around these topics.

OUTCOME: Group participants are informed about and encouraged to discuss the topics of general health, stress recognition, reduction and management strategies.

Objective Three: To understand the importance of physical, emotional & spiritual self-care when peer helping

RESOURCES: Whiteboard, markers and erasers, and Session Eight Handout 1.

METHOD: Present the importance of physical, emotional and spiritual self care. Ask participants for questions and discuss the topic. Distribute Session Eight Handout 1.

OUTCOME: Group participants are encouraged to discuss and identify physical, emotional and spiritual self care.

Objective Four: To have clear knowledge of confidentiality and duty of care

RESOURCES: Whiteboard, markers and erasers, pens and butcher's paper.

METHOD: Explain confidentiality and duty of care and ask participants for feedback and write the key points on the whiteboard. Generate discussion about this and how to practically apply confidentiality and duty of care.

OUTCOME: Group participants are able to ask questions and discuss and identify what confidentiality and duty of care means for them.

Objective Five: For participants to have knowledge of how to introduce themselves as a peer helper

RESOURCES: Whiteboard, markers and erasers, and Session Eight Scenarios Cards.

METHOD: Introduce topic. Divide group into pairs and ask them to role play the scenarios. Ask groups for feedback and write the key points on the white board. Generate discussion.

OUTCOME: Group participants are able to discuss, identify and practice appropriate self-introduction and building rapport.

Objective Six: To be aware of the APSU's role in providing support and assistance

RESOURCES: Whiteboard, markers and erasers, and Session Eight Handout 2.

METHOD: Explain and discuss the types of assistance and support that training organisation's staff can provide and the guidelines for the relationships between APSU staff and Peer Helpers. Answer any questions and write relevant contact numbers on the whiteboard. Handout Session Eight Handout 2

OUTCOME: Group participants are informed about and invited to discuss and clarify the guidelines between training organisation's staff and Peer Helpers and the kinds of support and assistance that staff can provide.
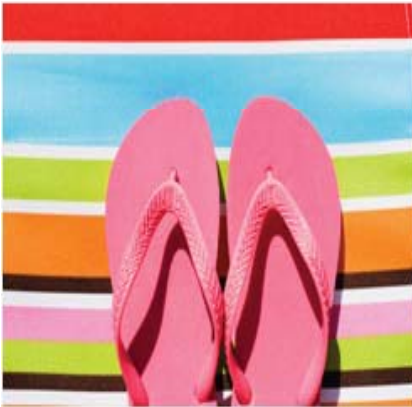
Self care

Self care is about looking after yourself: meeting your physical needs, food, shelter, clothing etc, and about meeting your emotional, social and mental needs, support, de-briefing, fun activities, friendships etc.

Self care includes quiet time for meditation or prayer and doing fun and even challenging activities, treating ourselves like our own best friend.

Doing the non drug related things that we enjoy like listening to music, playing sport, catching up with like-minded people etc.

When we are kind to ourselves we have more to offer others and we model self care as Peer Helpers by maintaining our own wellbeing, self care and safety.

PEER HELPER RELATIONSHIP WITH TRAINING ORGANISATION

(Training organisation) staff members are available for support, de-briefing, supervision and advocacy. Please get in contact if you have any questions or need support. Staff will support and assist you during business hours throughout the training and while you are on placement. Staff can be contacted on:

Training Coordinator
Phone:
Address:

Scenario 1: You are doing your placement at a rehabilitation centre. How do you introduce yourself to the rehabilitation centre's residents?

Scenario 2: You are starting your peer helping placement at a residential withdrawal service, how do you introduce yourself to the individual detox patients?

Scenario 3: You are introducing yourself to someone that you want to help as a peer. How do you introduce yourself to them & how do you build rapport with them?

Scenario 4: You have decided that you work best as a one to one Peer Helper. How do you introduce yourself to a peer who is much younger than yourself?

Scenario 5: You have decided that you work best as a one to one Peer Helper. How do you introduce yourself to a peer who is a different gender to yourself?

Scenario 6: You are introducing yourself to someone older than yourself, who uses different substances than you did, & that you want to help as a peer, how do you introduce yourself to them & how do you build rapport?

Scenario 7: You are on placement as a Peer Helper at a drop in centre. A person you don't know drops into the centre, & they are drug affected & drowsy. How do you introduce yourself to & build rapport with them?

Scenario 8: You are on placement as a Peer Helper at a detox. A person you don't know comes into the detox and they are drunk. How do you introduce yourself to & build rapport with them?

Experts by Experience

Experts by Experience Training Overview

Introduction

APSU's mission is to facilitate the advancement of consumer participation in the Victorian alcohol and other drug Sector. To this end APSU believes in the power and talents that are inherent in the people who actually use services and see a role for consumers at all levels of policy development, implementation and evaluation through to service provision itself.

The experience of having 'been there' enables people in who have experienced alcohol and other drug use to establish a specific rapport with other people in recovery that is beyond the professional realm of the human services worker. Taking on the roles of a positive role model and educator, transmitting 'reality based' coping strategies, communicating 'lived experience' and relapse prevention strategies have credibility when these are from a peer. In addition, people who have lived or are living the life, have formulated conclusions and consequently want avenues to make these known for the purposes of bettering the services for others. Much of this 'practiced wisdom' is either unknown by service providers or it cannot be delivered with the same impact and authenticity.

We call those who possess this knowledge and wisdom through lived experience 'Experts by Experience.'

This is a major component of the American Recovery Movement which is described by William White, a proponent of the recovery movement in America, as:

"A calling for mutual aid, social communion and political advocacy as a siren call of redemptive "we-ness" to those who have been shamed into isolation or cloistered within subterranean subcultures. "

For Mutual Aid, or as it is known in Australia, peer help, experientialists are needed. Ordinarily, experientialists are shamed into seclusion and silence but with the establishment of 'Experts by Experience' the non-hierarchical support of talents, skills and expertise will enable the participants of this fellowship to be included and respected as 'Experts by Experience'.

Background

The fellowship of 'Experts by Experience' was formed in 2005 (made up of the graduates from the Peer Helper Training) as a participatory mechanism for people who use or have used alcohol and other drug services to utilise their expertise in directing alcohol and other drug service provision, policy and research. A series of four workshops was developed to train service users in advocacy, leadership skills, facilitation and organising skills and the principles of consumer participation and empowerment.

The Experts by Experience workshops were first delivered in November 2007 and aimed to develop a fellowship of those that possess knowledge and wisdom from lived experience.

Out of the Experts by Experience workshops in 2007 a lobby group 'Voice for Change' was formed. This lobby group worked on the issue of residential withdrawal units waiting times, researching this issue and developing a petition as well as assessing and evaluating a possible media campaign.

The Experts by Experience workshops are now well established and are currently expanding to include other

interested people using alcohol and other drug services and families of those affected by alcohol and other drug use. In this way, consumers can link with this micro community and seek a commonality of experience by increasing their participation and activism in the alcohol and other drug sector.

Conceptual Framework

sharc's mission is to build and support mutual self help and peer based approaches to the treatment and care of people with an addiction and their families. The values of empowerment, inclusion, self help, equality and partnership are integral to all operations that come under sharc, The Association of Participating Service Users and the Fellowship of 'Experts of Experience' of course being included.

APSU's mission is:

1. To work collaboratively with key stakeholders to increase service user participation in drug treatment and care provider systems;

2. To increase service user impact on relevant policy development and implementation at the local, state and national levels;

3. To promote, encourage and assist service users in the development of consumer-run programs.

Method

APSU developed a series of four 4 hour workshops. These workshops build on participants' skills, expertise and knowledge and give participants an understanding of meetings, forums, the AOD sector, policy and procedure and advocacy.

A situational teaching style is used as we are teaching adults who have a wealth of experience, insight and expertise to contribute. The facilitation style is flexible with discussions that allow the workshop objectives to be met and for everyone to be heard.

Evaluation

The evaluation for Experts by Experience is a straightforward rating scale evaluation form with room for comments to be completed by participants after each workshop and at the end of the four workshops. These evaluations are then compiled, analysed and findings incorporated into the workshops.

Conclusion

The Fellowship of 'Experts by Experience' naturally branches from our three tier mission of the Peer Model, which is built upon the sound and proven premise that self help enables people with direct experience of addiction to become a helper and thereby better able to advocate for themselves and others to cope more effectively with bureaucratic structures and to develop non-bureaucratic ways of dealing with large-scale problems.

Experts by Experience Workshop Training Objectives

Workshop One Training Objectives — Participation and Service User Groups

1. Inform participants of the benefits of participation of service users in all aspects of alcohol and other drug treatment services development, delivery and evaluation.
2. Teach a particular method of participation.
3. Convey the skills/knowledge and confidence required to participate. Participants will be informed of the Ladder of participation and other materials from Straight from the Source, A Practical Guide to Consumer Participation in the Alcohol and other Drug Sector.
4. Participants will have an understanding of Service User (Community Advisory) Groups and will know how these may be set up.

Workshop Two Training Objectives — The AOD Sector

1. Inform participants of a variety of types of services: who runs them, who pays for them and how they might get involved.
2. Explain AOD policy making and how participants can get involved.

Workshop Three Training Objectives — Advocacy

1. Explore and clarify participants' experiences of and ability to deal with making a complaint and what process to follow
2. Provide participants with information about, examples of and skills in advocacy in varying roles.

Workshop Four Training Objectives — Meetings and Consumer Boundaries

1. For participants to have knowledge of meeting structures and formats
2. For participants to fully participate in meetings and forums with professionals
3. For participants to establish self care plan
4. For participants to know how to have involvement in all aspects of Alcohol and Other Drug treatment services and be able to safely choose their level of participation in the Alcohol and Other Drug sector.

Experts by Experience Workshop Plans

Workshop One: Participation and Service User Groups

Explores why people who use alcohol and other drug services should participate in decision making, various methods of participation and how to set up a Service User Group.

Objective One: To inform participants of the benefit of participation of consumers in all aspects of AOD service development, delivery & evaluation

RESOURCES: Whiteboard, markers and erasers, and Workshop One Handout 1.

METHOD: Discuss the benefits discussed in Consumer Participation Resource Kit for housing and homelessness assistance services. Give examples illustrating current participation in health/mental health and alcohol and other drugs.

OUTCOME: Participants will have an appreciation of the importance of, right to, and various methods of participation.

Objective Two: To teach participants a selection of participation methods

RESOURCES: Whiteboard, markers and erasers, and Workshop One Handout 2 and Straight from the Source: A Practical Guide to Consumer Participation in the Victorian alcohol and other drug sector.

METHOD: Using Straight from the Source, discuss word definitions, levels, and domains of participation. Then work though at least three examples of consumer participation in the AOD sector. Generate discussion around these examples, answer questions and write key points on the whiteboard. Distribute Workshop One Handout 2.

OUTCOME: Participants will be informed about consumer participation and consumer participation projects and at what level of consumer participation these projects sit.

Objective Three: To convey the skills/knowledge required to participate

RESOURCES: Whiteboard, markers and erasers, and Straight from the Source.

METHOD: Using the examples taken from Straight from the Source, tease out communication skills and knowledge that is needed for this level of participation. On the white board draw up a table with the headings SKILLS and KNOWLEDGE at each of two columns and the three examples of consumer participation as headers for the three rows. Fill this out as you tease out discussion points from the participants.

OUTCOME: Participants will understand the personal resources needed when taking part in a consumer participation project.

Objective Four: To create an understanding of consumer (community advisory) groups & how these are set up

RESOURCES: Whiteboard, markers and erasers, and Straight from the Source.

METHOD: Using examples from Straight from the Source work though the process of setting up a consumer advisory council. This would include the development of collaborative relationships between service providers and consumers, using these relationships to develop a plan and timeline, seeking funding, development of purpose of the council, training of its members, development of a TOR, possible barriers and challenges.

OUTCOME: Participants have been informed about and encouraged to contribute, discuss and ask questions about Consumer (Community Advisory) Groups and will know how these are set up.

sharc
Self Help Addiction Resource Centre

BENEFITS OF CONSUMER PARTICIPATION

Much of the material below is adapted from the Consumer Participation Resource Kit for housing and homelessness assistance services.

Benefits to organisations

• Consumers who feel they have a say are more likely to be positive about new proposals and strategies or changes to existing services if they are involved in the planning process. A feeling of ownership creates greater cooperation between the consumer and the service provider.

• Consumers are a (largely) untapped resource who are able to contribute to the growth of an organisation by providing feedback on programs as well as offer solutions or answers to problems.

• Consumers may develop a better understanding about the connection between funding and services and may be less likely to express resentment and suspicion of how resources are applied.

• Trust is built between service users and staff.

• As services improve through the use of consumer participation, staff experience greater job satisfaction.

Benefits to consumers - A better service system

• Higher quality services that are more responsive to consumer needs.

• A service system that is more sensitised to the service users' 'right to be there, to be heard and to hear how decisions that affect them are made.

• Clients learn the value of peer support.

Empowerment and psychological wellbeing

• As service users engage in the participation process they are more able to express their dissatisfaction with services and to offer solutions or ideas for improvement.

• Listening to and valuing a person's experiences and knowledge promotes self-esteem. This is a particularly positive outcome for a person who uses AOD services and may be carrying the shame and stigma of their drug use.

• Participation changes a person's position from that of always needing help to being able to contribute and help others.

• A sense of empowerment contributes to the person's own recovery process. In fact, the very act of participating improves recovery outcomes.

Skills and confidence

• Involvement and participation connects people.

• Service users may gain skills in areas such as how to run meetings, communicate ideas, make decisions, deal with conflict and gain support for a cause. These skills can be transferred to a person's wider life and may eventually lead to employment.

The wider community

Consumer participation in publicly funded organisations provides opportunities for participation in democratic decision making. This can build the capacity of service users to engage as active citizens in other areas of life.

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Self Help Addiction Resource Centre

The Ladder of Participation

Level of Power	Level	Description	Activities
High	Control	All decisions are made by consumers and consumers have control of resources.	• Consumer run organisations • Self help groups
Medium	Partnership	Consumers and providers are joint decision makers.	• Peer workers, educators, trainers • Staff selection panels • Steering committees
Low	Consultation	Consumers are presented with a plan or directive designed by the service provider and invited to give feedback. Control lies firmly with service providers.	• Suggestion boxes • Surveys • Focus groups • Service user groups
	Information	This is not consumer participation but it increases power, enables service users to make decisions about their own treatment and supports consumer participation.	• Information to service users about services and treatment options • Charter of Rights • Complaints systems • Consumer participation policies

Workshop Two: The AOD Sector

The AOD Service System and Policy covers an explanation of services; who runs them and who pays for them, as well as an explanation of AOD policy making and how you might get involved.

Objective One: To inform participants of a variety of types of services; who runs them, who pays for them & how they can get involved

RESOURCES: Whiteboard, markers and erasers, butcher's paper, pens, and Workshop Two Handout 1.

METHOD: Read over and discuss Workshop Two Handout 1. Ask each participant to write on the butcher's paper which services they might like to get involved with and how they could begin that involvement. Write key points and diagram on the whiteboard and answer questions.

OUTCOME: Group participants are informed of the AOD Service System and how they may get involved.

Objective Two: For participants to have knowledge of AOD policy making

RESOURCES: Whiteboard, markers and erasers, and Workshop Two Handouts 2 and 3.

METHOD: Present information on AOD policy and encourage questions and discussions about this. Write key points or a diagram on the board. Ask the group for ways that they may want to be involved, expand on and clarify this. Write key points on the whiteboard. Distribute Workshop Two Handout 2. Briefly discuss governance in organisations and distribute Workshop Two Handout 3.

OUTCOME: Group participants are encouraged to discuss, question and be informed about AOD policy-making and how they may get involved.

VICTORIA'S SPECIALIST ALCOHOL AND OTHER DRUG SERVICES

Victorian Alcohol and other Drug Sector is divided into eight regional areas

• Southern
• North Western
• Eastern
• Grampians
• Barwon South West
• Loddon Valley
• Gippsland
• Hume

Victorian State Wide Youth Specific Services

• Youth Withdrawal Residential and Home-based
• Rehabilitation
• Residential/supported accommodation
• Outreach
• Counselling Consultation and Continuing Care

Examples of Victorian State Wide Youth Specific

• YSAS Eastern and Residential Withdrawal Unit
• Moreland Hall Gwenyth William House for Withdrawal
• YSAS Birribi Residential Rehabilitation in Eltham
• Youth Specific Counsellor at Moreland Hall
• Recovery Support Service at sharc

Victorian State Wide Adult Specific Services

• Withdrawal
• Rehabilitation
• Residential
• Outreach
• Counselling and Continuing Care
• Ante and Post Natal

Examples of Victorian State Wide Adult Specific Services

• Wellington House Withdrawal Service
• The Basin Centre Recovery Service
• Windana Therapeutic community
• Taskforce
• Turning Point
• Women's Alcohol and Other Drug Services

Aboriginal Koori Youth Health Alcohol and Drug Healing Service

• Ngwala Willumbong Cooperative
• Ballarat and District Aboriginal Cooperative Services

Pharmacotherapy

• Referring Doctors
• Dosing Pharmacists
• Primary Health Facilities

Needle and Syringe Program

• Primary
• Secondary
• Mobile outreach

Self Help

• Narcotics Anonymous
• Alcoholics Anonymous
• Windana Peer Support Groups
• New Life
• Action for Recovery

Structures of Policy Making

WITHIN ORGANISATIONS

Each organisation will have its own policy making process, which should be clearly outlined in the policies and procedures manual for that organisation. In each organisation there is a chain of command that allows more input into and responsibility for decision making as the levels progress through clients and general workers, management, steering committees, the Chief Executive Officer and up to the Board of Governance.

Generally someone, either a client or a worker, will have an idea and approach a worker, co-worker or manager with the idea. It helps to write down or talk about the idea and clearly think through the idea, how it would work and what the implications of it would be with workers and management.

When making a decision within an organisation you need to consider:

- Does this policy uphold the organisation's Code of Ethics and Code of Conduct?
- Does this enhance organisational policy and procedure?
- What are the possible consequences of this policy?
- Am I authorised to work on this policy or should I discuss it with a worker, co-workers and/or management first?

WITHIN GOVERNMENTS

Local, State and Federal governments have various policy making procedures that they follow. These procedures include:

- Identifying a need to create and/or alter a policy.
- Creating a committee, panel or working group to work on the policy development process.
- Consulting with the relevant groups of people including consumer representatives who are affected by the policy.
- Consulting with their own advisory panels, some of which may have a consumer representative present.
- Analysing the findings of this consultation process.
- Based on the consultation, analysis and objectives, development, implementation, delivery and evaluation plans the policy is derived.
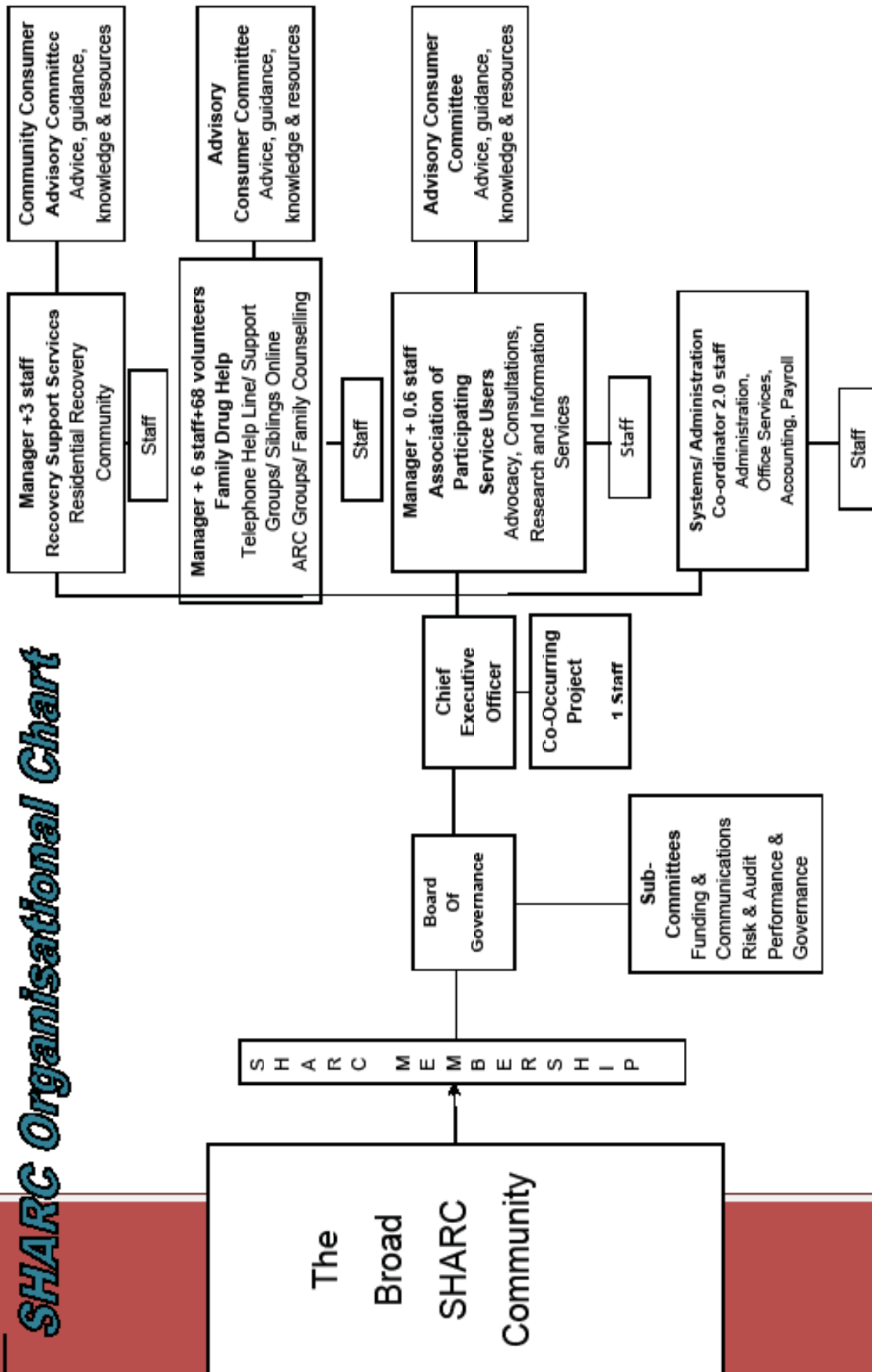
SHARC Organisational Chart

Community Consumer Advisory Committee
Advice, guidance, knowledge & resources

Advisory Consumer Committee
Advice, guidance, knowledge & resources

Advisory Consumer Committee
Advice, guidance, knowledge & resources

Manager +3 staff
Recovery Support Services
Residential Recovery
Community

Staff

Manager + 6 staff+68 volunteers
Family Drug Help
Telephone Help Line/ Support Groups/ Siblings Online
ARC Groups/ Family Counselling

Staff

Manager + 0.6 staff
Association of Participating Service Users
Advocacy, Consultations, Research and Information Services

Staff

Systems/ Administration
Co-ordinator 2.0 staff
Administration, Office Services, Accounting, Payroll

Staff

Chief Executive Officer

Co-Occurring Project

1 Staff

Board Of Governance

Sub-Committees
Funding & Communications
Risk & Audit
Performance & Governance

S H A R C   M E M B E R S H I P

The Broad SHARC Community

Workshop Three: Advocacy

Advocacy and complaints are a means to changing the way things are.

Objective One: To explore and clarify participants' experiences when dealing with making a complaint, and the process to follow

RESOURCES: Whiteboard, markers and erasers, Workshop Two Handout 3 (from previous session), and Workshop Three Handout 1, 2 and 3.

METHOD: Ask participants about their experiences with making a complaint and what helped and what didn't. Write key points on the board. Generate discussion around what resources are required, how to cope with and what processes to follow when making a complaint. Write key points on the board. Include information around organisational structure using sharc's Organisational Structure. Use an example of a complaints process.

OUTCOME: Group participants are encouraged to explore, discuss and identify coping skills in and what process to follow when making a complaint.

Objective Two: For participants to gain insight and acquire information about advocacy and communication

RESOURCES: Whiteboard, markers and erasers, Workshop Three Handouts 4 and 5, and Workshop Three Scenario Cards.

METHOD: Play Chinese Whispers; one person passes a message to the person on their left and that same message is passed around the group in this manner. Observe the differences between the original message and the final message. Generate discussion around this and examine listening skills, body language, asking clarifying questions and other communication skills. Link these communication skills in with advocacy, emphasising that we assist the person with their issue, not do it for them. Generate discussion, encourage questions and divide group into pairs. Give each pair a scenario card and ask them to take turns acting the scenario out. Ask for feedback and write key points on the board.

OUTCOME: Group participants are actively engaged in and encouraged to discuss, question, act out and learn communication skills particularly in relation to advocacy.

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Victorian alcohol and other drug client charter

As a person using Victorian AOD services, you have the right to:

• be provided a service in a safe environment

• be provided a service in a fair, honest and non-judgemental manner

• be provided a service that is friendly and respectful

• be given adequate information on all available services and treatment

• participate in all aspects of service provision

• have information about you kept confidential unless disclosure is otherwise authorised

• be provided with a timely and effective service that responds to your needs

• make a complaint and have that complaint addressed efficiently

• be provided culturally sensitive services that take into account your values and beliefs.

Department of Health

health

Victorian alcohol and other drug client charter

As an advocacy service that upholds the rights of people using Victorian alcohol and other drug (AOD) services, the Association of Participating Service Users (APSU) is happy to introduce this charter of rights and responsibilities. The charter is based on the knowledge and experience of 160 AOD service users who participated in focus groups held across Victoria. The creation of this charter, by people who use Victorian AOD services, has endeavoured to follow a democratic process. The implementation of this charter will contribute greatly to a fairer Victoria.

(Association of Participating Service Users)

Accessibility

If you would like to receive this publication in an accessible format, please phone 9096 5234 or email consumers@health.vic.gov.au

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HOW TO PROCEED WITH A COMPLAINT

- Identify clearly what the issue is
- Gather evidence
- If appropriate speak to the person involved first to try and solve the issue
- There may be time limits in which to complain and you should ask whether there are costs involved
- Explain the problem calmly with as much detail as possible
- Make notes of conversations with the other party straight away – these could be useful later
- You may need to complain in writing and provide your address and other details
- Some organisations may have people to help you make your complaint and help you with this process
- Resolution can sometimes take a reasonable amount of time
- If you need assistance, your local community centre may be able to help you with your complaint
- Most organisations can make interpreters available if asked

PLACES TO GO WHEN YOUR COMPLAINT IS NOT RESOLVED

Human Rights Commission
Level 3, 380 Lonsdale Street, Melbourne Vic 3000
Advice Line Weekdays 9am–5pm (except Wed: 9am–2pm and 4-5 pm)
Ph: 9281 7100 or 1800 134 142 (toll free); 9281 7110 (TTY)
Email: complaints@eoc.vic.ogv.au
Web: www.humanrightscommission.vic.gov.au

Job Watch
Level 10, 21 Victoria Street, Melbourne Vic 3000
Ph: 9662 1933 or 1800 331 617 (country callers)
Hours: Mon-Fri 9am-5pm (except Tues 9am-12noon, 2-5pm and Wed evening 6-8pm
Email jobwatch@job-watch.org.au
Web: www.job-watch.org.au

Ombudsman Victoria
Level 9, North Tower, 459 Collins Street, Melbourne Vic 3000
Ph: 03 613 6222; 1800806 314 (regional Toll Free)
Web: www.ombudsman.vic.gov.au

Commonwealth Ombudsman
Level 10, 2 Lonsdale Street, Melbourne Vic 3000
Ph: 1300 362 072 (complaints line – local call charge)
Web www.ombudsman.gov.au

Victoria Civil and Administrative Tribunal (VCAT)
General List, 7th Floor, 55 King Street, Melbourne Vic 3000
Ph: 9628 9755
Web: www.vcat.gov.au

Pharmacotherapy Advocacy Mediation and Support Service (PAMS)
(A service of Harm Reduction Victoria)
Tel: 1800 443 844(toll free for Victorian callers)
Service hours: 10 am – 6 pm Mon-Fri
Health Services Commissioner (HSC)
30th Floor, 570 Burke Street, Melbourne Vic 300
Ph: 86015200; 1800 136 066(toll free); 1300 550 275 (TTY)
Web www.health.vic.org.au/hsc

Victorian Charter of Human Rights

THE VICTORIAN CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES 2006

- Recognition and equality before the law
- Right to life
- Protection from torture and cruel, inhumane or degrading treatment
- Freedom from forced work
- Freedom of movement
- Privacy and reputation
- Freedom of thought, conscience, religion and belief
- Freedom of expression
- Peaceful assembly and freedom of association
- Protection of families and children
- Taking part in public life
- Cultural rights
- Property rights
- Right to liberty and security of person
- Humane treatment when deprived of liberty
- Children in the criminal process
- Fair hearing
- Rights in criminal proceedings
- Right not to be tried or punished more than once
- Retrospective criminal laws

This Charter was developed by the Victorian Equal Opportunity and Human Rights Commission and is now law in Victoria.

The Universal Declaration of Human Rights

Article 1.
All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2.
Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3.
Everyone has the right to life, liberty and security of person.

Article 4.
No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5.
No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6.
Everyone has the right to recognition everywhere as a person before the law.

Article 7.
All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8.
Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9.
No one shall be subjected to arbitrary arrest, detention or exile.

Article 10.
Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11.
(1) Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.
(2) No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12.
No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13.
(1) Everyone has the right to freedom of movement and residence within the borders of each state.
(2) Everyone has the right to leave any country, including his own, and to return to his country.

Article 14.
(1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.
(2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15.
(1) Everyone has the right to a nationality.
(2) No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16.
(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
(2) Marriage shall be entered into only with the free and full consent of the intending spouses.
(3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17.
(1) Everyone has the right to own property alone as well as in association with others.
(2) No one shall be arbitrarily deprived of his property.

Article 18.
Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19.
Everyone has the right to freedom of opinion and expres-

The Universal Declaration of Human Rights

sion; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20.

(1) Everyone has the right to freedom of peaceful assembly and association.

(2) No one may be compelled to belong to an association.

Article 21.

(1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

(2) Everyone has the right of equal access to public service in his country.

(3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22.

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23.

(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

(2) Everyone, without any discrimination, has the right to equal pay for equal work.

(3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

(4) Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24.

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25.

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness,

disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26.

(1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

(3) Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27.

(1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28.

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29.

(1) Everyone has duties to the community in which alone the free and full development of his personality is possible.

In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

(3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30.

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Scenario 1: You are chairing a meeting when debate between two people becomes quite heated. What can you do?

Scenario 2: You are on a consumer committee at a residential rehabilitation service. There have been several complaints about one of the residents. What can you do?

Scenario 3: You are at a focus group and feel the need to contribute to the discussion but are having trouble getting a word in. How do you go about this?

Scenario Card 4: You and some of your peers have had bad experiences with a particular service. What can you do?

Scenario 5: You have been asked to be part of a presentation at a conference. How can you prepare yourself for this?

Scenario 6: You witness a person being verbally abused by a prescribing chemist. What do you do?

Workshop Four: Meetings and Consumer Boundaries

How to fully participate in meetings with professionals and how to protect yourself when feeling vulnerable.

Objective One: For participants to have knowledge of meeting structures and formats

RESOURCES: Whiteboard, markers and erasers, and Workshop Four Handouts 1, 2 and 3.

METHOD: Read over handout and draw a diagram on the board. Generate discussion, drawing on the participants' experiences and knowledge. Talk about the information in the handout and answer questions.

OUTCOME: Participants are informed of and encouraged to draw on their own experience and knowledge to discuss and question the formats and structures of meetings.

Objective Two: For participants to meaningfully participate in meetings and forums with professionals

RESOURCES: Whiteboard, markers and erasers, and Workshop Four Scenario Cards.

METHOD: Generate discussion about meaningful consumer participation in meetings and forums. What does this mean? How can we achieve full participation? What is 'the consumer perspective'? Write key points on the board. Divide into threes, give each triad a scenario card and ask them to act out participation skills in turns. Ask group for feedback about this task. What did the participants find difficult? What was easier for the participants? Write key points on the board.

OUTCOME: Participants are encouraged to explore, discuss, question and practice meaningful participation in meetings and forums with professionals.

Objective Three: For participants to establish consumer boundary skills

RESOURCES: Whiteboard, markers and erasers, butcher's paper, pens, and Workshop Four Handout 4.

METHOD: Discuss with group how participating in meetings as a consumer, i.e. an expert by experience, differs from participating as a professional. What are some of the things that might happen in meetings and what to do about them? What boundaries do consumers need to have in place to protect themselves? Use Workshop Four Handout 4 to remind participants to also take care of themselves.

OUTCOME: Participants understand how to present themselves when participating and how avoid being vulnerable.

Objective Four: For participants to know how to be involved in all aspects of AOD treatment services

RESOURCES: Whiteboard, markers, erasers, butcher's paper and pens.

METHOD: Give each participant a piece of butcher's paper and pen. Ask them to divide sheet into three columns – YES, NO, MAYBE. Ask the participants to write what they can, won't and are unsure of being involved in under the relevant heading. Encourage the participants to ask questions. This is a personal exercise and does not have to be shared with the group. Discuss as a group how to become involved in the AOD sector as a service user or 'consumer representative'. Write key points, strategies and skills on the board.

OUTCOME: Group participants are encouraged to explore and identify what type of requirements and level of participation they as an individual want to have in the AOD sector as a service user and how that might be achieved.

Meetings Definitions

AGENDA – a formal list of things to be done in a particular order, especially a list of things to be discussed at a meeting and the order that they will be discussed.

CHAIRPERSON – somebody who presides over something, the presiding officer of something such as a committee, board, or meeting. (The person who runs the meeting, is in charge of who gets to speak, keeping the meeting focused on the items on the agenda, keeping the meeting to time etc)

MINUTES – Record of meeting proceedings, an official record of what is said and done during a meeting.

MOTION – Proposal, a proposal put forward for discussion at a meeting. (e.g. I propose that we send a letter to…) The proposal (motion) is usually voted on after discussion.

SECOND – A second person agrees with the proposal that something be discussed or voted on. (e.g. I second the proposal (motion) that we send a letter to ….)

SECRETARY – Officer of club, society or committee, somebody elected or appointed to keep the records of the meetings (minutes) of an organisation such as a club, society, or committee, and to write or answer letters on its behalf.

QUORUM – Minimum number required for a valid meeting, a fixed minimum number of people or percentage of members of a committee who must be present before the meeting can conduct valid business, especially voting.

Types of Meetings

Focus Groups

A small group of people who are affected by a particular issue are asked to give their opinions on the issue. The small group is intended to be a representation, or a reflection of a larger group of people. The group's discussion and comments are then fed back to the person/organisation that wanted this information. Focus groups are used especially in market research or political analysis. In AOD, focus groups are a great way to gauge service user opinions and ideas on specific topics.

Working Group

A group of people working together temporarily until some goal is achieved; "the working group was supposed to report back in two weeks". A working group differs from a focus group because the participants of a working group are chosen with diversity aimed at forming an effective team with a range of complementary skills and resources so that a task can be completed. A working group may be formed to investigate a particular problem and come up with a solution. The group is appointed by a committee or board and would report back to them.

Types of Meetings Cont.

Conference

Most conferences are put on by a single organisation. They may run for half a day up to several days. Usually in the AOD sector the peak bodies or the larger organisations hold the conferences. The DH also has a one day conference every 3-4 months. The conferences are designed to share information with the whole sector, to keep everyone up to date with issues, research and requirements.

Board Meeting

A Board meeting is a meeting of the members of the Board of an organisation. Board members are usually elected, are often from the community and/or have expertise in the type of services that are being delivered. There is usually a member with accountancy experience. Board members serve a specified term (e.g. one year) and then must be re-elected. In community organisations, board members are often unpaid. Boards have the final say in all important matters.

Committee

A special group delegated to consider some matter. A committee is generally a formal working group within a larger organisation, often formed by election, often having authority or legitimacy of some specific kind. A committee may exist within an organisation often for the purpose of running certain aspects of the organisation. The committee is responsible to the board. For example Management Committee which would be made up of senior managers from within the organisation. Other committees may be set up from time to time to manage a particular project or aspect of service delivery and then disbanded when project is completed. A committee may also exist between organisations in order to plan or coordinate a particular type of service or activity e.g. Needle and Syringe Programs, Conference planning.

A Steering/Advisory Committee

An advisory committee is a group of people, usually elected, who give direction to part or the whole of the organisation. The committee often gives feedback directly to that part of the organisation. The board would have the final say on controversial matters.

Strategic planning

A strategic plan is a document used by an organisation to align its organisation and budget structure with organisational priorities, missions, and objectives.
This plan documents who an organisation is, where they are going, and how they are going to get there. All organisations hold planning days where those involved (board members, managers, staff, and members) help plan the organisation's future and what activities the organisation will undertake. From this type of meeting, a strategic plan can be formulated.

Meetings – How to Run a Meeting

Name of Meeting:

Date:

Open the Meeting: Chairperson welcomes everybody and introduces any new people or guest speakers/visitors.

Apologies: Members pass on any messages to say that people couldn't attend.

Last meeting's minutes: Decide whether the minutes of the last meeting are an accurate record of the last meeting or if they need to be changed in any way. Either way, this is then put to a vote or the minutes will be (eventually) accepted when a majority agrees they are accurate.

Matters arising from last meeting's minutes: Briefly discuss what actions were decided upon in the last meeting and if these have been done yet. Don't spend too long on this, especially if these items are covered in general business.

Correspondence (inwards and outwards): Has any communication been received/sent?

Reports: This is an opportunity to find out new information or more detailed information.

General Business: These items are usually decided upon before the meeting and meeting members are informed of them via an agenda which states what will be discussed at the next meeting.

Item 1 –

Item 2 –

Item 3 –

The items 1-3 should be voted upon or action to be taken decided upon if possible.

Arrange Next Meeting: set a time and date for next meeting

Close Meeting: Chairperson thanks everybody for attending

Self care and stress

Self care

Self care means to take care of ourselves; it's like the advice to parents on a plane with young children. In the event of an emergency oxygen masks will drop down, and parents are advised to put their own masks on first before going to the aid of their children. We are not able to be good workers if we are not able to look after our own needs.

Why do we need to do it?

- Nobody else will
- Self preservation
- Relapse prevention
- Part of being a responsible adult

There are 3 areas of self care: Physical, Emotional and Spiritual

Stress

Common causes

Life!, finances, using thoughts, dealing with authorities, relationships

Some signs of stress

Anxiety, restlessness, obsessive thinking, feeling tired, lethargic or pressured

Some things we can do to prevent stress

Attend to our physical needs

Take time out to relax

Scenario 1: You are asked for your opinion on residential withdrawal waiting times at a service user group. What do you do?

Scenario 2: You are nominated to chair a service user group meeting, how do you do that?

Scenario 3: As part of a service user group, you are discussing ideas about drug-replacement programs at your service. What are some of the issues, solutions and ideas the group may discuss?

Scenario 4: You have been invited to attend a conference as an AOD treatment service user (this is known as being a consumer representative), what sort of things would you feel comfortable talking about in that setting?

Scenario 5: What are some of the things that could make you feel safe in meetings?

Scenario 7: What sort of group guidelines would you like for a service user group?

Scenario 6: How would the chairperson and the secretary deal with conflict in the service user group?

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| 1 = poor | 2 = fair | 3 = good | 4 = very good | 5 = excellent |

Please circle your answer

1.   Were the topics of the session relevant?

1   2   3   4   5

2.   Were the topics of the session clearly explained?

1   2   3   4   5

3.   How would you rate the helpfulness of these sessions' activities?

1   2   3   4   5

4.   Was the facilitator helpful and approachable?

1   2   3   4   5

5.   How useful to you was this session?

1   2   3   4   5

COMS:_____

_____

_____

_____

_____

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Self Help Addiction Resource Centre

1 = poor	2 = fair	3 = good	4 = very good	5 = excellent

Please circle your answer

1.   Were the topics of the workshops relevant?

1   2   3   4   5

2.   Were the topics of the workshops clearly explained?

1   2   3   4   5

3.   How would you rate the helpfulness of the workshops activities?

1   2   3   4   5

4.   Was the facilitator helpful and approachable?

1   2   3   4   5

5.   How useful to you were these workshops?

1   2   3   4   5

COMS:_____

_____

_____

_____

_____

_____

Speaker Bureau

Speaker Bureau Guidelines

The Association of Participating Service Users' Speaker Bureau provides presentations from people with personal experience of addiction that convey the experiential perspective of alcohol and other drug issues. Members of our Speaker Bureau also participate in forums, meetings and service user representations. APSU maintains a database that includes speakers and meeting participants, their skills and interests. This information enables APSU workers to select the most appropriate speaker or meeting participant for each occasion. As a result, we utilise the unique experience, ability and capacity of each member of the Speaker Bureau.

Purpose

As experientialists, rather than paid professionals, it is recognised that those sharing from the perspective of their personal experience are putting themselves in a potentially vulnerable position. It is imperative that people are adequately prepared and supported. Therefore, this protocol has been written to provide guidelines in the recruitment, training, support and payment of speakers in order to ensure that their welfare, dignity and recognition of their expertise remain paramount. When other organisations provide a similar service it is hoped they will follow these guidelines.

The consumer perspective

Both speakers and meeting participants are advised to share from their own and other consumers' personal experience. However, when speaking to an audience of 'professionals', speakers are encouraged to use their own and others' personal experiences to shape ideas and opinions about the topic being discussed rather than 'tell their story' in great detail. The use of in depth storytelling for an audience of professionals is firstly unnecessary as most professionals will have become familiar with the journeys of people with addiction issues in their day to day work and secondly can leave the individual feeling vulnerable and exposed. APSU therefore recommends that service users present a consumer perspective based on their own and their peers' experiences.

Sometimes though, especially in front of audiences of peers or the community, personal stories can be powerful. For example, when a school requests a young person talk to their students about alcohol and other drug issues, a personal story may have more impact than a series of 'lessons learnt'. Similarly, when speakers are talking to family groups, the personal story, especially one that contains a portion of recovery, may not only inform but also convey a message of hope.

Recruitment, training and support

APSU accepts speakers and participants with personal experience of addiction (with or without mental health issues) from Flipside readership and its APSU membership base and networks. Also, people are invited to join the Speaker Bureau after completing the Peer Helper Training. Other organisations would need to develop their own method of recruiting service users that is appropriate for their service.

The initial interview

Conduct an initial interview or workshop with each participant to determine that:

- The individual understands the purpose and functioning of the Speaker Bureau
- The individual will be suitable for public speaking without experiencing personal duress
- The speaker or participant has thought through the implications for themselves and others of 'going public' with their personal experience of addiction
- The speaker has thought through which parts of their story will be disclosed in what circumstances and which parts will remain private

Assess the individual's experience, knowledge, skills and interests, taking into account:

- The experience the speaker has with certain aspects of addiction (and mental health) that they are willing to share publicly
- The knowledge the speaker has about certain aspects of addiction (and mental health) that is broader than their own experience
- The interests and passions of the speaker
- The speaker's current experience and confidence with public speaking
- The participant's experience of committees

Determine the individual's need for training, support and access to resources with consideration of:

- The extent to which the speaker or participant needs assistance/training in research skills, preparation of talks and public speaking
- The resources needed by the speaker to fulfil their role

Inform the speaker that:

- The speaker will be briefed before each occasion including what the presentation will be about, the length of presentation required and the size and type of audience
- The speaker will be presented with a list of questions that may be asked, and given the opportunity to develop appropriate responses for them prior to the presentation
- The speaker will decline answering questions they would rather not answer
- The meeting participant will understand what is expected of a service user representative and will be given sufficient information and support to meaningfully participate prior to attending

And also that:

- Speakers or participants will have access to two preparation /workshop sessions with one of the APSU team prior to a speaking engagement
- A staff team member will accompany the speaker or participant to the event if required, and meet with them afterwards to provide support, feedback and debriefing as needed
- The staff member will phase out this support when members are participating in ongoing committees/ meetings
- Speakers will not be expected to undertake talks or presentations unless they feel comfortable doing so

The event

- An outline of content required or questions asked are provided to the speaker at least a fortnight before the event

- For a meeting, background information, terms of reference with clear objectives are provided

- Speakers are informed of known services and individuals attending the event

- Event organisers are informed of parameters of questions and that questions do not have to be answered, nor painful events recalled, if this causes emotional distress for the speaker

- Remuneration, payment method and date are negotiated.

Support

Presenting from a personal perspective rather than from learned knowledge adds to the experience of speaking in front of an audience whether it is a large or small one. APSU, as part of a peer organisation, having both professional and personal experience of this, is best placed to provide support for people undertaking this potentially vulnerable activity.

In addition, a conflict of interest may occur when people with personal experience participate in service provision or policy development and are supported by the organisation they are participating in.

It may be a challenge for the organisation to support the service user because:

- input received from the service user may or may not complement a worker or organisational point of view but be valid nonetheless

- the particular experience of taking part in a forum, meeting or conference when you are not a paid professional requires expert and impartial support.

- where practical it is advised that APSU or another relevant consumer body be involved in supporting the speaker or participant. If this is not possible, the organisation should keep the above mentioned conflicts in mind when providing support.

Remuneration

- Event organisers will pay for the speaker's travel and accommodation costs as well as registration for the event. APSU will pay speakers or participants who are not employed an amount of between $40 to $150 depending on the amount of preparation required. This payment is dependent on current funding capacity. In the absence of funds, other avenues of remuneration will be sought.

- There are other ways to remunerate. These may include: access to training provided by the organisation or organisations involved, assistance with securing employment including references, assistance with resume and application development and access to the organisation's computers and printers. Non-financial remuneration should be negotiated prior to the engagement or commencement

Conclusion

Performing in public can be a daunting task, especially when one is doing so from one's own life experience and indeed from experiences that have stigma attached to them. Over the past years, APSU has successfully managed the Speaker Bureau with little or no distress to its participants and a resounding approval from audiences. This has largely been due to the care and attention paid by APSU Staff to the principles inherent in these guidelines. APSU suggests that these or similar guidelines be followed when consumers are asked to present the consumer perspective to the AOD sector.

HAVE YOU WALKED THE WALK? WE'D LIKE TO HEAR ABOUT IT.

Association of Participating Service Users (APSU)

140 Grange Rd
Carnegie Victoria 3163
Phone 03 9573 1778
Fax 03 9572 3498

A service area of the Self Help Addiction Resource Centre (sharc)