



## Toolkit for the Prevention of Opioid Misuse through Peer Training

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### ABOUT THE PROGRAM

Clinical Scholars is a national leadership program of the Robert Wood Johnson Foundation led by the University of North Carolina at Chapel Hill. Learn more about RWJF's Leadership for Better Health programs by visiting: [rwjf.org/leadershipforbetterhealth](http://rwjf.org/leadershipforbetterhealth)

### ABOUT THE TOOLKIT

This toolkit is designed for anyone who would like to adopt community engaged practices to the fields of substance abuse, addiction recovery, or trauma-informed care. This toolkit uses peer mentoring as a successful model for intervention and prevention. For more information, contact the Office of Community Engagement at the Medical College of Wisconsin: [communityengagement@mcw.edu](mailto:communityengagement@mcw.edu)

# Toolkit for the Prevention of Opioid Misuse through Peer Training

Opioid misuse and opioid use disorder (OUD) is an epidemic that disproportionately affects military Veterans who are more likely than the general population to experience trauma, chronic pain, and post-traumatic stress disorder (PTSD). These interlocking factors are associated with opioid use. Additionally, stigma around opioid misuse contributes to a common resistance to seek care and assistance. These interlocking factors—physical injuries, psychological injuries, PTSD, stigma, and unwillingness to seek care—are some of the reasons OUD is a wicked problem. In the context of opioid misuse, strategies to control pain and strategies to treat trauma have developed within silos. Despite calls to incorporate trauma assessment and intervention into pain treatment, the two approaches rarely have, if ever, been combined as part of a comprehensive, community-based prevention and intervention effort. This lack of integration constitutes a missed opportunity to fully address the psychological, social, and physical aspects of pain experienced by Veterans.

## Helping Veterans who survived the war survive the peace

The Milwaukee Prevention of Opioid Misuse through Disorder with Peer Training (PROMPT) project focused on the prevention of opioid misuse and opioid use disorder in a subset of the Milwaukee Veteran population by seeking to change their knowledge, attitudes, and behaviors related to opioid use through a peer-delivered OUD prevention curriculum. The OUD prevention curriculum was co-created with stakeholder input using a community engagement approach. The team collected focus group data from local peer support providers, Veterans with a history of opioid use disorder, and family members/friends who have supported a loved one with OUD. The data was used to determine topics and skills to emphasize in the crafting of the OUD prevention training modules. These focus groups represent the first step to a comprehensive, community-engaged prevention effort to advance the understanding of the various ways in which peer mentor specialists assist with preventing OUD and OUD-related deaths among Veterans. The research team reviewed the identified themes that emerged from the focus groups to create a peer-delivered training curriculum. The resulting six-module curriculum provides knowledge of key concepts related to substance abuse and recovery as a resource for peer mentor specialists providing peer support for military Veterans with OUD.

The goal of this project was to gain an understanding of the effectiveness of peer mentoring for reducing opioid abuse among Veterans struggling with OUD. The project enrolled military Veterans experiencing OUD into peer mentoring services. Peer mentor services involve building rapport and establishing trust through sharing lived experiences, offering encouragement, and navigating community resources. During their participation in the project, Veterans completed surveys at enrollment, at 6-weeks (mid-point survey) and at 12 weeks (final survey). The computer-based surveys assessed adverse childhood experiences, housing stability, PTSD, depression, and addiction. Veterans were also asked to complete brief weekly surveys online over the course of 12 weeks to gauge their overall well-being such as how they felt about their stress, their cravings, and their sleep.

PTSD and chronic pain are highly correlated, and the prevalence of chronic pain among Veterans with PTSD is estimated to be 80%.



## Planning

Due to the complex barriers Veterans face while recovering from opioid addiction, the project needed diverse expertise and experience. In 2017, an interdisciplinary team assembled: a family physician with extensive experience in community engaged research (CENr) and over 30 years of practice (Syed M. Ahmed); a clinical psychologist with expertise in the impact of trauma and trauma-informed care (L. Kevin Hamberger); an anesthesiologist with expertise in the management of chronic pain (Robert Hurley); and a clinical pharmacist with expertise in pharmacology of opioids and management of chronic pain (Kajua B. Lor).



Collaboratively, they leveraged their partnership with Veteran-serving organization Dryhootch to address this wicked problem. Veteran peer mentoring is what Dryhootch believes to be the foremost factor during a Veteran's recovery from opioid addiction. Veterans are trained to have the back of each other in combat. This unique relationship through shared experiences can move Veterans towards recovery. The team agreed to use a peer-to-peer model to address this complex problem and make a significant impact because it is able to penetrate a hard-to-reach population, has been shown to advance health outcomes, and allows for a sustainable intervention.

In addition to the range of expertise on the team, the project established a Community-Academic Advisory Board (CAAB). The CAAB recognized the community as a source of information and experience and promoted co-learning and capacity building among all partners. It was comprised of academic and community representatives including clinicians, Veterans, and community residents engaged in local work to address Veterans' health issues including: substance abuse, suicide, reintegration, and behavioral health. The CAAB met quarterly during the implementation of the project. It extended the reach and influence of the Milwaukee PROMPT project by connecting project members to additional boards, task forces, and workgroups also working to address opioid misuse across Wisconsin. Each member of the CAAB brought a unique perspective and expertise that built on the strengths and resources found within the community.

## FUNDING

Funding from the RWJF Clinical Scholars program was used by Medical College of Wisconsin to support Clinical Scholars team members' time and effort to plan and implement multiple activities to address the wicked problem of opioid misuse among military Veterans. These activities included engaging in collaborative meetings, partnership development and expansion, development of an OUD prevention curriculum, Clinical Scholar-led trainings for peer mentors about the OUD Prevention Curriculum, research protocol design, and several other activities in alignment with the project logic model.



## TEAM COMPOSITION

- Syed M. Ahmed, MD, MPH, DrPH, FAAFP: Contributed community engaged principles and clinical expertise; oversaw the entire project through development, implementation, evaluation, and sustainability
- L. Kevin Hamberger, PhD: Contributed clinical psychology, curriculum development, and trauma-informed practices; led focus groups and the development of curriculum modules
- Kajua B. Lor, PharmD, BCACP: Contributed clinical pharmacy expertise; was the Big Ideas Talk speaker; led the development of a general education campaign
- Robert Hurley, MD, PhD: Contributed clinical and research expertise in alternatives to opioid treatment and opioid misuse; led dissemination efforts and advised on curriculum modules

## Additional documents

- Logic model (**Appendix A**)
- Full team list (**Appendix B**)



The project subcontracted with:

- Wake Forest University to support the effort of Dr. Robert Hurley, one of the Clinical Scholars fellows with Milwaukee PROMPT.
- Mental Health America of Wisconsin to support project meetings, supplies (including laptops for the research recruitment phase), staff, and organizational efforts at both Mental Health America of Wisconsin and Dryhooch.
- Marquette University UbiComp Lab to license an opioid version of the existing iPeer app to push weekly check-in surveys to the Veteran participants.

### COMMUNITY AND PARTNERSHIPS

The academic institution, Medical College of Wisconsin (MCW), partnered with two local organizations by using a community-engaged framework to conduct focus groups and create a curriculum to train peer mentor specialists on preventing opioid use disorder. These organizations, including Dryhooch and Mental Health America of Wisconsin (MHA), have been essential collaborators. The Milwaukee PROMPT effort leveraged an existing community-academic partnership between faculty at MCW, the Milwaukee Veterans Affairs (VA) Healthcare System, Dryhooch, MHA, and other partners which was in existence for about ten years prior to this project (Franco et al., 2016).

Dryhooch is a non-profit organization founded in 2008 by a Vietnam Veteran with a mission of “helping Veterans and their families who survived the war, thrive in the peace.” Their coffee shop serves as a community rally point to provide a welcoming drug and alcohol-free environment for Veterans, families, and community members. Dryhooch recognizes that peer support empowers Veterans to overcome PTSD and other health issues and has collaborated with MCW for about a decade on health-related efforts for Veterans. MHA is an affiliate of the national non-profit dedicated to helping all Americans achieve wellness by living mentally healthier lives. They have experience operating programs for populations affected by opioid addiction, were the first organization in Milwaukee to have peer mentors and have observed that trauma is almost universal among the people they serve. Dryhooch has offered expertise around providing community-based resources for Veterans and has contributed valuable insight and guidance for project operations, including focus group recruitment and hosting, peer mentor selection criteria, training topics, and other considerations for project implementation. MHA supported this project by providing training and supervision for peer mentor specialists and ongoing project consultation throughout program and curriculum development.



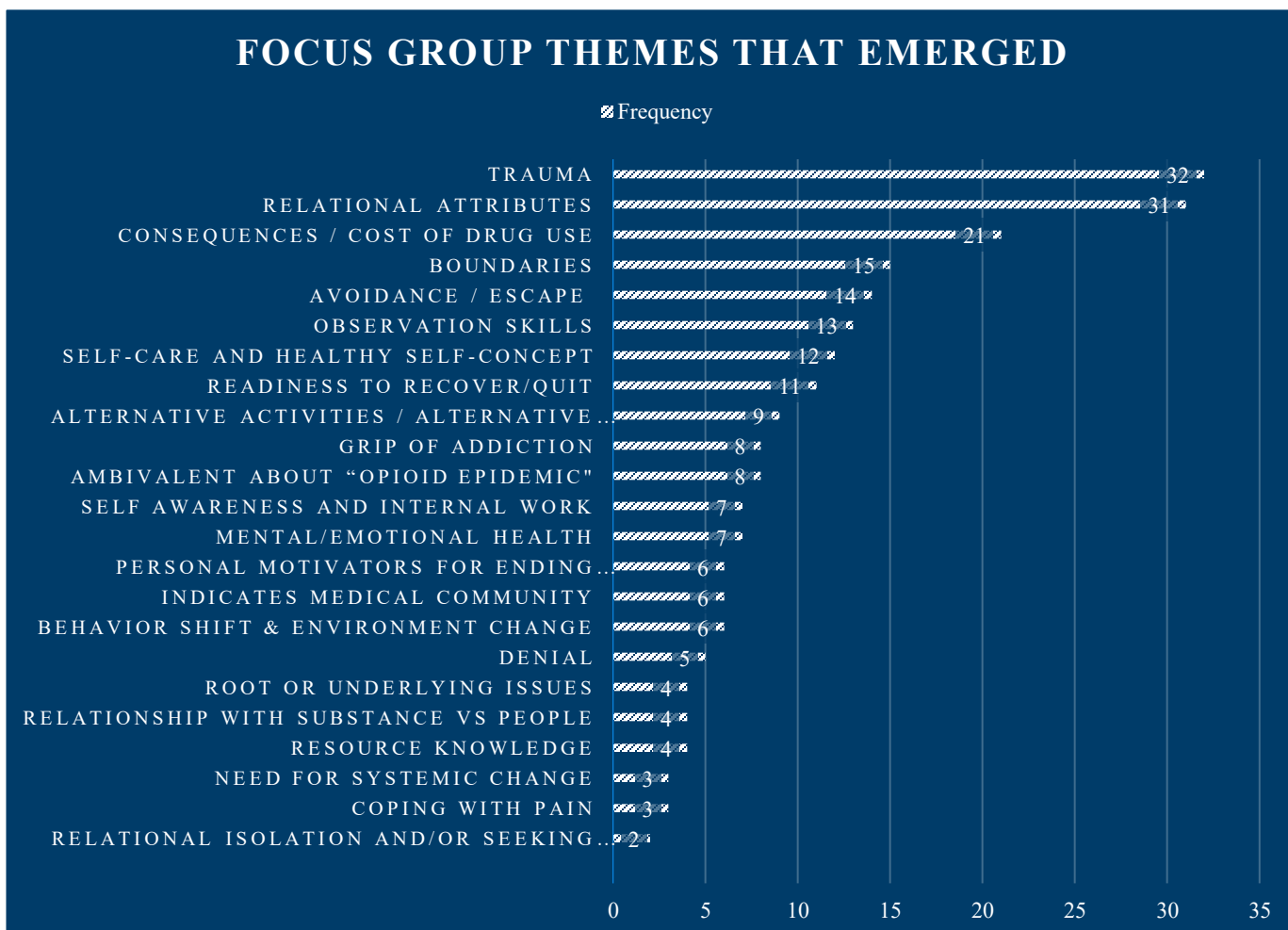


## Project work

The Milwaukee PROMPT effort leveraged the existing community-academic partnership to launch an opioid misuse prevention project designed to equip Veteran peer support specialists to prevent and reduce opioid abuse among military Veterans. The project is a multi-phased project that demonstrates the importance of a community-engaged research approach. We developed a peer-delivered OUD prevention curriculum that was co-created by our partners and the community.

### STEP 1: COMMUNITY VOICE

For the first step of this process, focus groups were held to measure the baseline perceptions that exist with community members. Project partners determined that Dryhooch, a community-based setting, would be an appropriate setting for the focus groups. Community members participated in three audience-specific focus groups targeting: (1) peer support specialists who have worked with people experiencing substance abuse; (2) Veteran peers who experienced opioid addiction; (3) family members/friends who supported such Veterans. Participants of the focus group were contacted by phone for reminders regarding the date and location of the focus groups. The purpose of the focus groups was to obtain input from these three constituencies on what information, resources, and tools would be most helpful to include in interventions for preventing OUD. Focus group questions (**Appendix C**) were developed with community input and asked individuals to share their thoughts and insights about how peer mentors can best support Veterans to reduce or end their opioid use.



Results from the focus groups allowed for nuanced perspectives that fostered a deeper appreciation of the service gaps within the Veteran population by using a CEnR approach. A total of 23 themes emerged from the focus groups. These themes include but are not limited to: (1) peer mentor relational skills, (2) peer mentor referral and resource knowledge, (3) impact of trauma, (4) avoidance, and (5) self-care. Trauma was the most frequent theme discussed during all three focus groups. Peer mentor relational attributes and skills were also highlighted by community members during all three focus groups.

## STEP 2: DEVELOPMENT

After reviewing all the focus group themes, a six-module curriculum (**Appendix D**) was created. The Milwaukee PROMPT curriculum modules provide information about key concepts related to trauma-informed care, chronic stress, influencing positive behavior change, the science of pain and opioids, self-care, and relapse prevention. Focus group participants offered recommendations for training content from the perspectives of peer mentor specialists who have worked with people experiencing substance abuse, Veterans who have experienced opioid addiction, and family members/friends who have supported such Veterans. The training curriculum modules merged community input and clinician expertise.



The research team then trained the peer mentor specialists with the curriculum, which was comprised of the newly incorporated information collected from the focus groups. The resulting training curriculum provides information about key concepts related to OUD and recovery as a resource for peer mentor specialists providing support for military Veterans with OUD.

## STEP 3: VETERAN PEER MENTORING

After completing the Veteran peer mentor specialist training, recruitment for research participants commenced. Flyers (**Appendix E**) were posted in common areas of two Dryhooch locations, MHA, and other community sites identified by our community partners as frequently visited by Veterans. Flyers were also posted online via Facebook and shared online by the community partners. Peer mentors also approached potential participants in-person. MHA screened interested participants with a provided script (**Appendix F**) to determine eligibility to enroll. Participants had to be at least 18 years of age, English speaking, U.S. Military Veterans, and experiencing current or past opioid use. If eligible, the team enrolled the Veteran into peer mentoring services. Enrolled participants were assigned to a Dryhooch peer mentor specialist. During this process, the peer mentors received a refresher course of the OUD Prevention Curriculum during the initial recruitment of participants.



Peer mentors worked with enrolled Veterans to build rapport, establish trust through sharing lived experiences, offer encouragement, and navigate community resources. After participants completed the final survey at 12-weeks (**Appendix G**), they were offered services at Dryhootch and received a certificate.

The peer mentors met regularly with a psychological team with expertise in AODA, self-care, trauma, and Veterans issues to debrief their experiences in their roles. The team was comprised of an AODA (Alcohol and Other Drug Abuse) counselor from MHA, a clinically licensed psychologist from MCW, the PROMPT program coordinator from MCW, and a license-eligible psychologist from MCW.

“During the PROMPT project, I was able to be honest with myself. That translates to people. Being transparent, whether you like me or not. It allowed me to facilitate better. It allowed me to be a better human being. **That is the key to my growth and being able to model that.** That’s something that I took from it: self-worth. I could not acquire the worth that I have today if I’m not honest with myself. It’s very humbling that I have to accept—as an addict—that people think something of me. Before, I was comfortable with being of no value to anyone. It’s wicked. **It’s okay to accept that you’re okay. You have value. You’re worthy.**” – Otis, Lead Mentor

#### OTIS: VETERAN PEER MENTOR



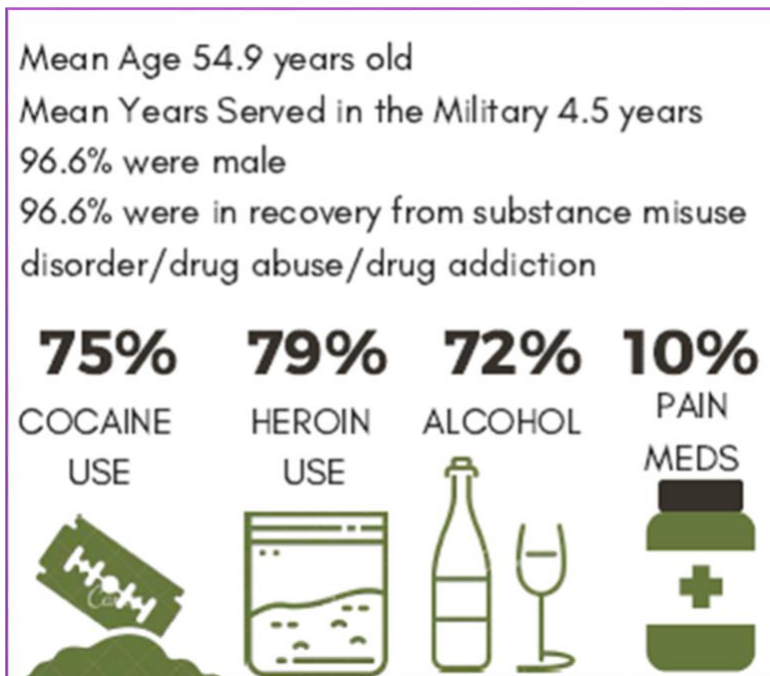
Shortly after his military discharge in 1976, Otis began using heroin and continued to use for over 30 years. He was frequently in and out of recovery centers, VA treatment programs, and private rehabilitation facilities. Otis originally went to Dryhootch looking for a job. At the time, he was homeless and desperate to get his life on track. What initially began as a place to get a job turned into a place where he found a life purpose. As a peer mentor, Otis was able to take a step deeper into his own recovery. He now shares his lived experiences and spreads his message of hope to other Veteran peer mentors and has assembled a team of PROMPT peer mentors to help other Veterans with addiction.



## Evaluation and dissemination

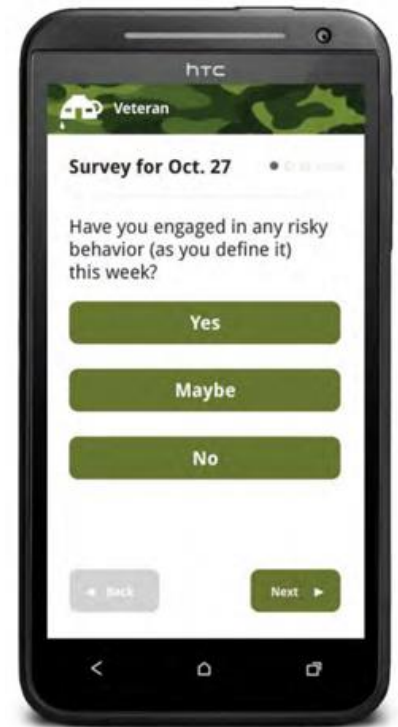
Participants in the project received 12 weeks of peer mentoring. The study team assessed the changes in attitudes, beliefs, and behaviors among military Veterans who received peer support from OUD prevention-trained peer mentor specialists. The project utilized assessment questions from the baseline, mid-point, and final surveys (**Appendix H**). These assessment questions included: PTSD checklist, housing status assessment, addiction severity index, brief trauma questionnaire, core beliefs related to drug use and craving, adverse childhood experience, patient health questionnaire (depression assessment), deployment risk & resilience inventory, and drug-use disorders identification test. Responses to these questions were stored in REDCap, a secure web application.

31 people were screened and 29 people enrolled in the Milwaukee PROMPT project. The recruitment and enrollment phase of the project occurred during the COVID-19 pandemic. In order to comply with public health recommendations during the pandemic, we conducted research activities virtually. This change limited our recruitment efforts and thus affected the total number of participants. The graphic below shows some preliminary descriptions of the 29 enrolled research participants.



Additional levels of analysis consisted of: (a) process measures to ascertain adherence to implementation timelines; (b) a regular review of project artifacts, documenting referrals to Dryhooch for peer support services; and (c) an ongoing log of leveraging opportunities and actions taken to deepen relationships with key stakeholders to engage in advocacy around this issue. During the last month of the Milwaukee PROMPT project, focus groups were conducted with the trained peer mentor specialists. The peer mentor focus group questions (**Appendix J**) were designed to help project partners gauge perceived successes and challenges, and to receive peer mentors' input about the project.

## WEEKLY SURVEYS



Veterans were also asked to complete brief weekly surveys online over 12 weeks (**Appendix I**). There was an option to complete check-in surveys through an opioid version of the existing QRF smartphone app, which was developed by the Dryhooch Partnership for Veteran Health and the Marquette University Ubicomp Lab (Rizia et al., 2015). The Milwaukee PROMPT instance of the app included an opioid-focused question, and it is running on Apple and Android phones.



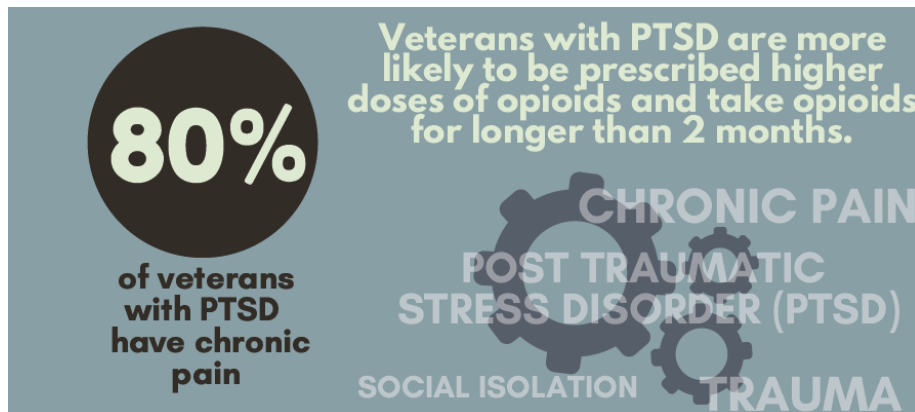
## DISSEMINATION

The resulting peer-delivered curriculum created with the research team's collective expertise and community input provides information about key concepts related to OUD and recovery for military Veterans experiencing OUD. The target population was Veterans experiencing OUD; however, we foresee this framework could serve as a model for engaging with other communities and at-risk populations. The OUD curriculum will be used in the future by Dryhooch as a peer-delivered intervention for Veterans misusing opioids. The curriculum will be delivered as an advanced practice training module after peer mentors have completed the general training.



## KEY MESSAGES

- Self-care is the key to recovery: the Veteran peer mentors trained during this project are in recovery themselves, so we emphasized the importance of taking care of yourself while doing the work.
- Power of influence: Veterans in recovery that surround themselves with a strong circle of influence create a positive behavior change and remain in recovery.
- Meet them where they are: everyone has their own story; for some addicts, the road to recovery is about facing the trauma of what happened before, during, or after military life. The peer mentors support Veterans to get the help they need and connect with clinicians.
- Include the community: we learned to walk alongside Veterans and include the Veteran voice to make a greater impact.



## Challenges, successes, and lessons learned

The Milwaukee PROMPT project faced challenges, achieved success, and gained lessons. We tackled our challenges by being flexible; communicating clearly and effectively; leveraging the team strengths; and staying resilient.

### CHALLENGES

The team was particularly challenged with multiple changes that occurred, including the rapid and necessary changes due to COVID-19. Recruitment and retention of Veterans for this program were challenging during the COVID-19 pandemic. However, Dryhooch has success in implementing programs due to the trusting relationship they maintain with the Veteran community.

Additionally, siloes of different specialties, departments, and organizations presented a challenge. We reduced siloes by maintaining regular communication between team members and seeking input by (1) convening Core Team meetings every four weeks; (2) convening CAAB meetings quarterly; and (3) funding a community coordinator at MHA to maintain a strong partnership with Dryhooch leaders and peer specialists and to provide necessary consultation and training.

### SUCSESSES

While working on this project, we learned many things about Veterans and addiction.

- Regardless of how complicated the program was, we reached all the milestones for the project. COVID-19 impacted recruitment, but all steps that were laid out did work out.
- The team we built was strong and encompassed years of partnerships and trust. Even when staff had left the program and shifted, the project stayed on course, and the team remained focused during crises.
- Consistent with the Trauma-Informed Care principles, we incorporated stigma-reducing language (“opioid use disorder” rather than, for example, “substance abuser”) in all aspects of our program, including the curriculum, trainings, and other written and verbal communication.
- The project impacted the lives of Veterans suffering from complex opioid addiction issues.
- We left our community partner with a training module that will expand the capacity of their organization and will be disseminated across Wisconsin.

### SHIFTS IN THINKING

Our team faced some particularly difficult challenges; however, we were able to develop new mindsets and experiences. As we shifted, we learned the importance of flexibility and the ability to prepare for the unexpected. We knew the work was going to be difficult, which is why we established a clinical supervision group for the peer mentors to review participant progress during the project. However, this shifted to a mix of supervision and a casual check-in for self-care and group reflection. We did these check-ins in person every week and then later shifted the meetings to occur online with the health safety risks of COVID-19. We continued these meetings, despite some technical difficulties, because we found the value in self-care. We consider self-care to be a cornerstone of recovery.



### LESSONS LEARNED

- Community engagement does not move in a linear fashion. Expect the unexpected. For example, COVID-19 threw a curveball, but with our collective strength, we are moving to the finish line successfully.
- Each of us are leaders even without official titles. Leaders ‘brave vulnerability’ and have the courage to take a stand with the community.
- Leadership is flexible. Leadership is NOT about being “the boss” or “the expert.”
- Leadership values diversity in all its forms, including thoughts and ideas, and as such, community partners are accorded respect for being experts on their own situation and how to address it most effectively and in partnership.
- When leaders of the project and of partnering organizations are committed to the project and the partnership, we are able to overcome obstacles, such as staff turnover and recruiting challenges due to COVID-19.



## Recommendations

Partnering with a community-based organization allows the community to amplify their voice and needs. We have found that integrating research with community input and partnerships optimizes the opportunity to address aspects of OUD experienced by Veterans. The Milwaukee PROMPT project offers an important example of how existing community-academic partnerships can serve as platforms for increasingly complex interventions and research as the partnership matures and evolves.

### GETTING STARTED

If you are going to tackle a wicked problem in your community, the first thing you should do is involve the community. Ask the community about their needs, their strengths, and their proposed solutions. Listen to and include them in all aspects.

Second, prepare for the unexpected. Although you cannot prepare for everything, you can create emergency plans to prevent risk. Before recruitment and enrollment began for this project, the team recognized that there was potential for psychosocial risks due to discussing OUD and its association with trauma that could result in feelings of sadness, anger, or other negative feelings. Veterans exposed to trauma may engage in different types of risky behavior, such as impulsivity and aggression. As a precautionary measure, the research team, including experts in mental health and crisis intervention, created an emergency response protocol (**Appendix K**) that included referral contacts and resources at MHA, a partner on the project. The emergency protocol was developed to identify early warning signs that could be displayed by Veterans, the response action that should be taken, and possible signs of relapse. The emergency response protocol was in place during the focus groups and later used for the training facilitation of peer mentor specialists. Licensed mental health counseling staff from MHA were on-site during each focus group to serve as a resource if anyone needed individual support during the session.

### BEST PRACTICES

- Do not come in with a pre-defined solution. Seek input from the community directly involved and work together to incorporate that input into whatever is developed. During our project, focus groups were conducted to measure the baseline perceptions that existed with community members and themes aided the design of the training curriculum. Additionally, the Community-Academic Advisory Board (CAAB) provided regular feedback during the project.
- At the time of a crisis, do not finger point at each other. For us, the most successful ingredient was our team concept. Everyone contributed in a dynamic way to address the challenges we faced, and there was no finger-pointing!
- Don't forget the community voice. Community engagement is about creating relationships to be able to incorporate community in the work being done and support the community in these efforts. We recommend that "leaders" and/or subject-matter experts not assume that they have all the answers. One cannot enter into a community engaged situation with a prescriptive mindset.



**“A positive influence helped me and I was given the ability to talk. As a Veteran, when you leave that stuff bottled inside you, it builds up and you take the wrong path.**

**Peer mentoring helps you open up and talk about the issues and not take the path of using drugs.**

**My peer mentor was not afraid to share his experiences to overcome his opioid addition and this allowed me to share my experiences and work on my own recovery.”**

**– Veteran**

## TEAM REFLECTIONS

- “As much as we were prepared, we could not foresee a pandemic like COVID-19, making many tasks impossible. For example, face to face meetings and interactions are crucial in community engagement. Because of COVID-19, we could only operate virtually. We managed to implement our program, but not to the extent that we could if we had that face to face connection. From this experience, we have learned that we all need to prepare for both small and large crises.” – Dr. Syed M. Ahmed
- “One thing I wish I would have known would be the importance of the relationships created during this experience as a part of the Clinical Scholars. Don’t take the time spent together for granted.” – Dr. Kajua B. Lor
- “I wish I would have known right from the beginning of the application process that this program is much, much more than a funded research opportunity. I was initially surprised that this program is primarily a leadership training program that uses a research/community engagement project as a vehicle or laboratory for trying out lessons learned in the intensives and remote learning sessions. It was a fantastic program that challenges, supports and transforms the clinical fellow. We come into this fellowship with different levels of leadership skill and experience, and we are all changed into champions of advocacy, leadership, and commitment to building a culture of health.” – Dr. L Kevin Hamberger
- “I wish we had known right from the beginning of the project how valuable the weekly debrief sessions were. Peer mentors had time to focus on their own wellness practices, check-in about participant successes/challenges, and talk with project team members with expertise in mental health. Project team members learned about the ins and outs of the project by hearing directly from the peer mentors at the weekly sessions.” – Sarah O’Connor
- “I wish I had realized how past negative experiences in my life could be turned into incredibly positive experiences for my future.” – Otis Winstead
- “I wish I knew how important it was for me to stop and reflect at all stages of the project, not just at the end of the project.” – Myah Pazdera



## ADDITIONAL RESOURCES

- [Dryhootch](#)
- [Dryhootch Partners for Veteran Health](#)
- [Mental Health America of Wisconsin](#)
- [Medical College of Wisconsin, Office of Community Engagement](#)
- [Medical College of Wisconsin, Office of Community Engagement YouTube Channel](#)
- [Medical College of Wisconsin Webinar "From COVID-19 to Action: Community and Clinical Response to Opioids"](#)
- ["A Stranger Comes to Town" by Dr. Syed M. Ahmed](#)
- [Prevent Suicide Wisconsin](#)



## Appendix

### APPENDIX A: LOGIC MODEL

#### LOGIC MODEL / ROADMAP

##### Milwaukee PROMPT: Prevention of Opioid Misuse through Peer Training

Inputs	Activities	Outputs	Objectives	Goals
<ul style="list-style-type: none"> <li>MCW Clinical Scholars team</li> <li>Dryhooch leadership, staff, and peer specialists</li> <li>MHA leadership and staff</li> <li>Community Academic Advisory Board (CAAB)</li> </ul>	<ol style="list-style-type: none"> <li>Seek input through focus groups with Veterans</li> <li>Develop general opioid prevention education campaign</li> <li>Receive advisement throughout the project from an advisory board (CAAB)</li> <li>Develop a peer-to-peer opioid prevention curriculum incorporating TIC strategies and philosophy</li> <li>Train 5 Dryhooch peer specialists in the delivery of the curriculum</li> <li>Deliver the peer-to-peer opioid prevention curriculum via peer specialists to at least 50 Veterans</li> <li>Deliver general opioid prevention education to everyone at Dryhooch</li> <li>Enhance peer support iPeer app-Quick Reaction Force to include questions related to opioid use</li> <li>Collaborate with other organizations and systems with which veterans interact and with whom Dryhooch &amp; MHA partners</li> </ol>	<ul style="list-style-type: none"> <li># veterans in focus groups</li> <li>Input from veterans in focus groups</li> <li>CAAB: # members, # meetings, meeting outcomes</li> <li>Peer-to-peer opioid prevention curriculum</li> <li># peer specialists trained in curriculum delivery</li> <li># veterans who receive curriculum from peer specialist</li> <li>General opioid prevention education campaign</li> <li># veterans exposed to general opioid prevention education campaign</li> <li>Enhancements made to iPeer app to include opioid-related questions</li> <li># referrals received from other partner organizations</li> <li>New practices/policies implemented</li> </ul>	<ul style="list-style-type: none"> <li>Increase # of veterans who request opioid-related treatment or prevention services with peer specialists at Dryhooch</li> <li>Increase # of referrals of veterans to Dryhooch's peer mentoring services from other veteran-serving organizations</li> <li>Positively impact veterans' knowledge, attitudes and behavior related to opioid use</li> </ul>	Prevention of OUD and OUD death among veterans

## APPENDIX B: FULL TEAM LIST

- **Amy Zosel**, MD, MSCS, Associate Professor, Dept. of Emergency Medicine, Medical College of Wisconsin \*
- **Anne Ruiz**, MS, LPC, counselor, formerly with Mental Health America of Wisconsin ▲\*
- **Anonymous**, PROMPT peer mentor +
- **Bob Curry**, Founder/President, Dryhootch ▲\*
- **Brian Michel**, JD, Director of Prevention Services, Mental Health America of Wisconsin ▲\*
- **Cara Hansen**, Information & Assistance Coordinator, Mental Health America of Wisconsin +
- **Joyce Price**, PROMPT peer mentor +
- **Karen A. Hulbert**, MD, Associate Professor, Dept. of Family & Community Medicine, Medical College of Wisconsin \*
- **Kenneth Schellhase**, MD, President, Wisconsin Academy of Physicians (WAFP); Medical Director, Children's Community Health Plan (CCHP) \*
- **Martina Gollin-Graves**, MSW, President/CEO, Mental Health America of Wisconsin ▲\*
- **Mary-Anne Kowol**, MD, FASAM, Asst. Professor, Dept. of Psychiatry & Behavioral Health, Medical College of Wisconsin, Clement J Zablocki VA Medical Center \*
- **Michael Cegers**, PROMPT peer mentor +
- **Michael F. McBride**, MD, Clement J Zablocki VA Medical Center \*
- **Michael Orban**, DrH, Veteran, Co-founder of The Warrior Partnership \*
- **Milan Alexandra DeLaO**, Bilingual Administrative Assistant, formerly with Mental Health America of Wisconsin +
- **Myah Pazdera**, MS, Milwaukee PROMPT Program Coordinator, Office of Community Engagement, Medical College of Wisconsin ▲\*
- **Otis Winstead**, Executive Director, Dryhootch, lead PROMPT peer mentor ▲\*
- **Praveen Madiraju**, PhD, Associate Professor and Director of Graduate Studies, Dept. of Computer Science, Marquette University +
- **Sa'Aire Salton**, MS, CSAC, LPC-IT, CFS, AODA counselor, formerly with Mental Health America of Wisconsin ▲\*
- **Sarah O'Connor**, MS, Program Manager, Office of Community Engagement, Medical College of Wisconsin ▲\*
- **Shannon James**, MSW, LCSW, SAC-IT, AODA counselor, formerly with Mental Health America of Wisconsin ▲\*
- **Sheikh Iqbal Ahamed**, PhD, Professor of Computer Science and Chair, Dept. of Computer Science, UbiComp Lab, Marquette University +
- **Tiffney Gray**, MS, MA, formerly with the Office of Community Engagement, Medical College of Wisconsin ▲\*
- **Zeno Franco**, PhD, Associate Professor, Dept. of Family & Community Medicine, Medical College of Wisconsin, faculty coordinator of the Dryhootch Partnership for Veteran Health ▲\*

▲ Core Team

\* Community Academic Advisory Board

+ Project support

**Appreciating History: The Veteran facing aspects of the Milwaukee PROMPT project were built on an existing long-term community-academic partnership, the Dryhootch Partnership for Veteran Health. The individuals in the partnership include:**

- **Carletta Rhodes**, MBA, Education Program Coordinator, Medical College of Wisconsin
- **Jeffrey Whittle**, MD, MPH, Professor and staff physician at Clement J Zablocki VA Medical Center, Medical College of Wisconsin
- **Katinka Hooyer**, PhD, MS, Asst. Professor, Dept. of Family & Community Medicine, Medical College of Wisconsin
- **Karen Berte**, PhD, Clement J Zablocki VA Medical Center
- **Leslie Ruffalo**, PhD, Associate Professor, Dept. of Family & Community Medicine, Medical College of Wisconsin
- **Mark Flower**, Veteran, formerly with Mental Health America of Wisconsin and Dryhootch
- **Virginia "Ginny" Stoffel**, PhD, OT, BCMH, FAOTA, Associate Professor, Dept. of Occupational Science & Technology, University of Wisconsin-Milwaukee
- **Zeno Franco**, PhD, Associate Professor, Dept. of Family & Community Medicine, Medical College of Wisconsin, faculty coordinator of the Dryhootch Partnership for Veteran Health

## APPENDIX C: FOCUS GROUP QUESTIONS

### FOCUS GROUP AUDIENCE: FAMILY MEMBERS OF VETERANS IN RECOVERY

1. What knowledge do you now have that you wish you would have known prior to supporting a veteran family member/friend struggling with opioid addiction and abuse?
2. What emotional, physical or other supports did you provide that you feel contributed to successful recovery?
3. What resources would be useful to you in your role supporting a veteran during the recovery journey? What resources do you wish you had at the beginning of the journey?
4. What knowledge or information would be useful to you in your role supporting a veteran during recovery? What knowledge or information do you wish you had at the beginning of the journey?
5. What skills or techniques have been/would be useful to you in your role supporting a veteran during recovery? What knowledge or information do you wish you had at the beginning of the journey?
6. What have you personally learned as a result of supporting a veteran during recovery?

### FOCUS GROUP AUDIENCE: PEER MENTORS

1. What knowledge has been the most helpful for you to have to support recovery from opioid abuse and addiction? Or, another way to think about it might be: what would you have liked to have known about supporting veterans with addiction problems when you were just starting out in your role as a peer mentor?
2. What skills or techniques have been the most helpful to facilitate recovery from opioid abuse and addiction?
3. Imagine a training module for peer mentors designed to help build additional skills to assist veterans in opioid recovery. What training topics would enhance your skill set for this work?
4. What resources do you need to support your work as a peer mentor/peer support provider?
5. What do professionals need to know about preventing opioid abuse and addiction?
6. What skills and techniques do you use now that you might not have when you first started as a peer mentor?
  - a. What strategies do peer mentors use to support recovery that may differ from clinicians' strategies?
  - b. How do you address denial if you feel a veteran isn't being honest with you or themselves about things like relapse?
  - c. How do you build trust with a veteran who has a substance abuse history?
  - d. Do you address trauma's role in addiction with the veterans you work with? If so, what has been the most effective way to explain how trauma and addiction are sometimes related?
  - e. How do you address accountability with veterans in recovery for things like sobriety or keeping agreements they've made with you?

### FOCUS GROUP AUDIENCE: VETERANS

1. What knowledge do you now have that you wish you would have known prior to abusing opioids?
2. What have you learned during your recovery journey that would be useful to another person/veteran in recovery?
3. What interventions (from family member, friend, or professional) do you think would be most helpful in facilitating recovery from opioid abuse or addiction?
4. What knowledge would be most helpful to enable/empower/equip a veteran to end their opioid abuse or addiction?
5. What skills or techniques would be most helpful to enable/empower/equip a veteran to end their opioid abuse or addiction?
6. What might motivate another person/veteran in recovery to end their opioid abuse or addiction?



## APPENDIX D: MILWAUKEE PROMPT MODULES

## ODU Prevention Module 1

### Understanding Trauma, Chronic Stress, and Health

#### LEARNING OBJECTIVES

By the end of this module, peer mentors will be able to:

- Define trauma, normal stress, chronic stress
- Describe how trauma leads to chronic stress
- Describe how chronic stress leads to risky coping behaviors and illness

#### INTRODUCTION

This module introduces the peer mentor to the concept of trauma and how trauma is related to chronic stress and risky behaviors that trauma survivors frequently engage in to cope, including opioid and other drug use and misuse. In addition, the module will provide information that distinguishes between normal stress and chronic stress. Finally, the module will describe how trauma and chronic stress leads to illness and premature death.

#### DEFINITIONS

**Trauma** can be either a single experience or a set of repeated experiences over time that overwhelm a person's ability to cope. When experiencing trauma, a person typically fears death, serious injury, or going crazy. They may feel overwhelmed emotionally, physically, spiritually, and cognitively. Common themes in trauma include betrayal of trust, abuse of power, loss, confusion, and emotional and/or physical pain.

The definition of trauma is broad. There is no one type of traumatic stressor. Rather, trauma is determined by each individual person's experience. There are, however, common themes related to trauma. In general, trauma that is repeated and occurs over time creates more negative impact than one-time traumas. Examples of repeated trauma include the experience of forms of child abuse, growing up in a family witnessing violence between parents, and combat exposure. Trauma that is caused by a human has a greater negative impact than trauma caused by natural disasters such as say, a tornado or a motor vehicle crash. Intentional trauma leads to greater negative impact than unintentional, i.e., accidental trauma.

**Normal Stress** is a person's response to a situation (called a stressor) that is viewed by the person as beyond their ability to adequately cope, but not life-threatening. An example might be having to do a job interview or handle a conflict with a boss. Stress has some aspects that are similar to trauma but differs in terms of overall intensity and response. That is, like trauma, stress is determined by the individual's experience and assessment of their ability to meet the demands of the stressor. When confronting a normal stressor as opposed to a trauma, a person may feel uncomfortable and nervous but rarely feels fearful of death, serious injury or going crazy.

A stress response consists of three main components: the physiological, behavioral, and cognitive responses.

Physiological

Cognitive

Behavioral

### Physiological

The **physiological response** is governed by the brain's centers for emotional arousal, memory for emotional situations, and planning and problem-solving. Together, these and other physiological response centers have been called the "go system" or the "spark plug" by various workers in the field. When a person is stressed, the go system is activated, and this results in the "fight or flight" response. The fight or flight activation allows the stressed person to react more or less automatically, which increases the chances of survival during certain acute stress situations. For example, a person is crossing the street, and suddenly a car appears coming at them at a fast speed. On a physiological level, the person will typically experience some kind of arousal, such as increased heart rate, feeling a rush of adrenaline, trembling, change of temperature, increased muscle tightness, and so on. This physiological activation allows them to run or jump out of the way of the speeding car. Where one feels that increased arousal in their body will differ between persons. For example, one person may notice their heart beating faster, whereas another may notice their muscles tightening up.

### Behavioral

The **behavioral response** component of stress responding consists of the observable actions a person engages in. Typically, a person acts differently when stressed than when not stressed. Examples include talking louder or faster, getting quiet and withdrawing, acting aggressively, such as punching a wall or throwing something or snapping at people. In the case of the speeding car, the stressed individual may yell and curse the oncoming driver and shake their fist. In other situations, such as a stressful relationship or job, a person may engage in other behaviors such as eat more, drink more alcohol, or use prescription or street drugs such as opioids. Sometimes people do less of some behavior when stressed. For example, they may eat less, sleep less, or sleep more and miss work.

### Cognitive

The **cognitive response** refers to the things a person thinks when experiencing stress. Examples include how the person interprets what they are experiencing, such as "This is horrible!" "That person's trying to kill me!" "I can't stand this!" "I'll kill that s.o.b. for driving like an idiot!" The interesting thing about the cognitive response is that, even when we are by ourselves, we can literally talk ourselves into feeling physiologically stressed or relaxed, and we can tell ourselves what to do, behaviorally, whether healthy or unhealthy.

In general, nontraumatic, normal stress responses last only as long as the stressor is present or until the person experiencing the stressor does something to cope with the stress. This could be a few seconds to a few minutes, or even a few days, depending on the situation. In the case of jumping out of the way of the speeding car, once safely out of harm's way, all systems return to a resting state in a matter of minutes. The heart rate and blood pressure go down to normal levels, the trembling stops, temperature

returns to normal, aggression ceases, sociability resumes, and thought processes resume focus on tasks at hand such as walking to the original destination.

**Chronic Stress** is a state of stress responding that never returns to a resting state. With chronic stress, the brain keeps sending signals to the rest of the body that a threat exists even after the original threatening stressor is long gone. The body's physiological, behavioral, and cognitive systems continue to operate at a heightened state of arousal. Some people describe this as feeling as though they are on constant "guard duty" and "high alert." With chronic stress responding, the person is hyperalert to perceived threats to physical and emotional safety. Thus, they may react strongly to unexpected sounds or sights that resemble the original traumatic situation in some way, even if the current situation is, objectively, safe, and not dangerous. At night, they may make frequent checks of the doors and windows to make sure they are locked. Such reactions can be behavioral, cognitive or physiological, or any combination of them, as described above. For example, a person on the street may hear a sudden, loud noise and dive into nearby bushes for cover. Or, with the person in their house, the sudden loud noise may prompt checking the windows and doors several times throughout the night.

People who experience chronic stress do not feel good and frequently feel overwhelmed with their nonstop arousal patterns. They tend to find little relief from their usual coping efforts. For example, if soaking in a warm tub of water once was very relaxing, under conditions of chronic stress, they may feel temporary relief for as long as they are in the tub but revert to the experience of high stress as soon as they get out. Interpersonally, they may respond by alternating lashing out at others and withdrawing from others. They may engage in risky behaviors such as promiscuous, unprotected sex, alcohol abuse, or abuse of prescription and street drugs in an effort to reduce their discomfort or feel something different than the distress. Chronic stress is, by definition, chronic, meaning it lasts for a long time – with little or no meaningful relief.

#### HOW TRAUMA LEADS TO CHRONIC STRESS

As discussed above, trauma, by definition, is overwhelming. As such, the physiological stress component, or spark plug remains chronically activated. It does not turn off when stressors are no longer present. Rather, the spark plug keeps firing. The person feels chronically keyed up. They have difficulty sleeping. They may feel constantly jumpy, irritated and anxious, or tense. Further, because the person is on high alert, they are ultra-sensitive to a wide array of reminders of the traumatic situation. The spark plug keeps firing. The person can't calm down.

On a cognitive level, day-to-day stressors are annoying, but we generally know how to cope with them, and even if we don't, if we wait long enough, they tend to go away on their own, or we can easily learn how to cope. We come to understand that certain things like stressors and hassles happen in life, and we deal with them. With trauma, however, it is usually impossible to make any sense of what happened because trauma is overwhelming and out of the range of everyday experience. As such, it is often impossible to know where the trauma experience fits in one's life and one's identity. Hence, on a cognitive level, the person may develop a tendency to over-interpret a wide array of situations as threatening, leading to the need to take a defensive stance to protect themselves and ward off the threats. That is, the fight or flight response is constantly activated.

A person who has experienced trauma may feel "different" than their peers and alienated from them. Because they have no way to understand the trauma, they have no words to express their experience to



others. Plus, because trauma caused by human action causes loss of trust, they may not believe anyone can truly understand or help them. This, in turn, can lead to difficult interpersonal interactions that include anger outbursts, verbal and physical aggression, or withdrawal from others, including loved ones.

#### HOW CHRONIC STRESS LEADS TO RISKY COPING BEHAVIORS AND ILLNESS

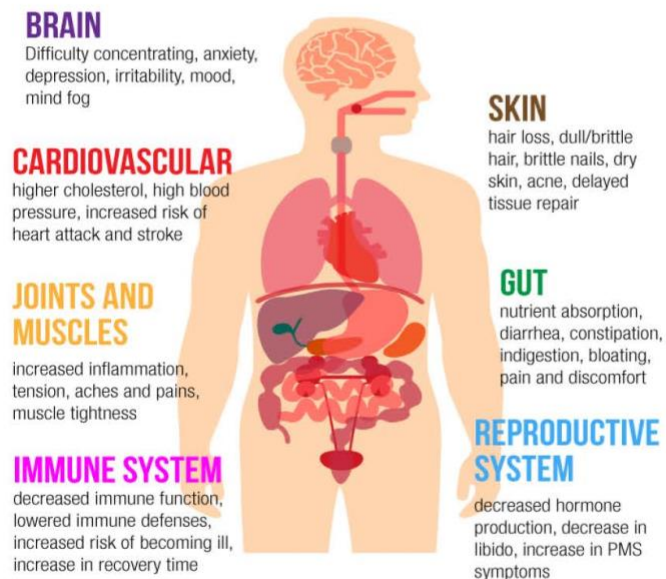
Because the traumatic experience is so painful, the traumatized person spends a lot of energy trying to avoid thinking about it. The avoidance strategies often are the risky behaviors noted above. The person may work exceedingly long hours to minimize downtime. They may abuse tobacco, alcohol, or other drugs in an effort to quiet their system and forget their pain for a while and hopefully get some sleep. The problem is efforts to avoid thinking about the trauma rarely work for long. The effects of alcohol and drugs wear off, and the memories return. Efforts to suppress or “not think about” the traumatic memories are generally futile – much like telling someone to not think of the color red. The more one tries to suppress the thought, the more it appears in consciousness. Thus, the stress continues, sometimes for years.

Chronic stress from traumatic experiences leads to illness. This fact was first demonstrated in a series of studies called the ACE studies. ACE stands for adverse childhood events. The researchers surveyed nearly 20,000 members of an insurance plan about their experiences with child physical, sexual, or emotional abuse, witnessing domestic violence, neglect, parental mental illness, or a parent in prison. The researchers found that the more of these different types of traumas survey respondents experienced, the higher the likelihood of engaging in smoking, alcohol and/or drug abuse, suicidal behavior, depression, and/or anxiety. In addition, the researchers also found that the number of traumas experienced was related to developing medical illnesses such as heart disease, lung disease, stroke, and some cancers.

Chronic stress leads to illness in two different ways. First, years of using risky behaviors to cope with stress takes its toll. Chronic tobacco use, for instance, leads to a number of cancers, heart and lung diseases. Chronic alcohol abuse leads to liver disease and blood pressure problems.

Second, recall the physiological response system is continually activated in chronic stress. This chronic activation results in a number of things happening on a physiological level simultaneously, including lack

## HOW STRESS AFFECTS THE BODY



of sleep, suppression of the immune system, and activation of histamine (a chemical released during stress). All of these factors result in wear and tear on the body systems, resulting in ill health and premature death.

#### MODULE REVIEW

1. Describe the main difference between normal stress and traumatic stress.
2. What are the three main components of a stress response?
3. What are the two main ways that chronic stress leads to illness?

## OD Prevention Module 2

### Trauma Informed Care

#### LEARNING OBJECTIVES

By the end of this module, peer mentors will:

- Understand the philosophy of trauma informed care (TIC)
- Be able to articulate 10 key principles of TIC
- Know key behavioral strategies of TIC

#### INTRODUCTION

This module will discuss what trauma informed care (TIC) is and the key principles that underlie this approach to helping people. In addition, this module will also provide the peer mentor with examples of how to implement TIC when working with peers.

#### WHAT IS TRAUMA INFORMED CARE (TIC)?

TIC is both a philosophy of care and an approach to caring for people. As a philosophy of care, TIC recognizes that trauma has a profound effect on the life course of anyone who has experienced it. The impact of trauma was discussed in Module 1: Understanding Trauma, Chronic Stress, and Health. Understanding the impact of trauma on a person's life course is also coupled with the understanding that the very systems or agencies that are designed to help people may have "triggers" that can re-traumatize a person while they are seeking help. Hence, the need for individuals to become "trauma-informed." Sources of re-traumatization can exist within the organization itself or within the behaviors of the helper(s). An example of an organization-based trigger could be a waiting room that doesn't have any privacy or a policy requiring everyone to attend a group session for someone who is very uncomfortable around people. An example of a helper-based trigger could be telling or dictating to the person what they must do rather than providing options and allowing the person to decide for themselves.

As an approach to caring for clients, TIC seeks to reduce environmental and behavioral triggers and thus reduce the likelihood of re-traumatizing the person. From an organizational standpoint, this may involve conducting an assessment to identify potential triggers and change them. From the above example, that would mean changing the waiting area to include a private area and changing the policy from required group meetings to allowing for individual meetings as preferred by the person. From a helper behavior standpoint, using the example above, rather than telling the person what to do, presenting options, and encouraging the person to choose the best one for themselves would represent a trauma-informed approach.

#### KEY PRINCIPLES OF TRAUMA INFORMED CARE (TIC)

Researchers have identified 10 key principles that underlie TIC.\*



1. **Understanding the relationship between prior trauma experiences and present coping.** This material was covered in Module 1. Trauma changes a person's life course. Where they may have trusted easily before, they may not trust now, no matter how trustworthy you think you are. Where they may have been compliant pre-trauma, now they may act in non-compliant and even defiant ways. The importance of this key principle is that rather than wonder and ask, "what is wrong with this person?" it is more appropriate to ask, "what happened to this person?" and think about their behavior as a response to trauma.
2. Until the trauma is addressed, everything else is a band-aid. Therefore, **trauma recovery is a priority.** That doesn't mean that trauma has to be resolved before a person will stop abusing opioids. It also doesn't mean that all band-aids are bad. But it does mean that at some point, trauma, to the extent that it exists, will have to be acknowledged and addressed. Experts in TIC state that trauma treatment and treatment for other issues such as opioid abuse should be coordinated.
3. The peer mentor-peer relationship is a **partnership** based on mutual respect for the knowledge and experience that each brings to the table. Therefore, it is necessary to **design interactions to empower the peer.** Goals should be mutually developed and agreed upon rather than dictated; the peer should feel his or her experiences and choices are validated, leading to an increased sense of competence and self-worth within the peer; the peer should also develop a wider network of resources for support.
4. Trauma, especially human-caused, intentional trauma, robs the survivor of choice. Within a traumatic situation, especially one that is repeated and chronic, victim's rights to make their own choices are stripped away. **TIC emphasizes providing choices and control over one's life, including how and when the peer will accept help.** Healing begins when helpers provide choices and honor decisions made by the peer because it allows the peer to feel respected, affirmed, and in control of their own process.
5. Trauma, especially that which is intentional and human-caused, always involves the abuse of power, with the victim being down. To facilitate healing, helpers are mindful of inherent power differentials between the helper and the peer. TIC seeks to build a **collaborative relationship** between the helper and the peer. A collaborative approach appreciates and validates the equality of persons in the relationship and provides the beginning of safety and trust. This is done by asking the peer for their input and honoring their choices rather than by dictating solutions for them.
6. In TIC, we seek to **create a respectful, accepting environment.** This includes providing a physical environment that is comfortable and safe, both physically and emotionally. In addition, appropriately trained staff provide a welcome and a presence of safety in the situation. Behaviors that signal a respectful and safe environment include listening without judgment, reassuring and maintaining confidentiality, clarifying boundaries and respective roles, respecting the peer's right to control and make choices for themselves.

7. **Emphasis is on strengths and resilience over problems or illness.** It would be easy to view someone's struggle with life and, say, misuse of opioids as stemming from some sort of moral weakness or underlying mental illness. It is important to recognize two things about that. First, the person facing you has survived. This means they have summoned the strength and skills to make that happen. It is important to identify those strengths and validate them. Second, while a superficial analysis of opioid misuse would pass it off as "the problem," a trauma-informed approach would view it as the solution to the person's problem and work from there. Such an approach reduces the tendency to be judgmental, views the peer as capable, and seeks to work with the peer/client's strengths to change.
8. **Emphasis on reducing the likelihood of re-traumatization.** This principle has been discussed previously as the core principle of TIC. It plays out in our work by being mindful of what we say and how we say it to our peers. It involves the recognition that, even without exact knowledge of whether this particular peer has been traumatized in their life, it is important to watch what is said and how it is said. Behaviors to avoid include: aggressive confrontation, judgmental, black/white pronouncements, or making light of a person's concerns.
9. In TIC, we seek to understand the influence of culture and the meanings given to various experiences related to the trauma, its causes, and its healing, as well as different coping efforts. Thus, we strive for **cultural competence and cultural humility**. Although it is not necessary to be educated in all aspects of a peer's culture, it is necessary to be open to listening, learning, and asking questions about the cultural context of the trauma and its healing. Such cultural contexts include race and ethnicity and religion, sexual orientation, social class, and disability status. Each of these represents a community and an intersection between identity and experience.
10. **Seek input and feedback.** Ask the peer for their input into how the process of peer mentoring is working for them, and for recommendations to make it better.

#### KEY BEHAVIORAL STRATEGIES OF TRAUMA INFORMED CARE

Specific trauma-informed behaviors will differ depending on the peer and the particular issues with which they struggle. However, a good resource to start thinking about trauma-informed behaviors is Module 5, Motivational Interviewing. Although we will not repeat that module here, a few highlights from Module 5 are worth mentioning.

- Through **empathy**, we demonstrate a willingness to see the world through the eyes of our peers. By doing so, we create safety and set the stage for developing trust. Empathy goes beyond "I know how you feel" to an actual demonstration of understanding through the spoken word, for example, "What I hear you saying is you feel sad and angry about what happened to you, and you can't seem to shake it." Empathic statements allow the other person to feel heard without judgment or without competition.
- **Acceptance and nonjudgmental orientation.** Whatever the peer is feeling, however, they are presenting themselves, that is who they are at that moment. We accept them as they are without judgment. This can be hard to do, especially if we are dealing with similar issues. In such

circumstances, it may be important to refer to Module 4 and review the material on transference and counter-transference.

- **Curiosity.** Rather than “knowing” the answers for the peer, a trauma-informed approach takes a stance of curiosity, of wanting to understand the peer from their perspective. Thus, asking questions in a sincere attempt to understand your peer is much more important than diagnosing their problem and prescribing a course of action.
- **Provide options.** Trauma strips a person of their right to choose for themselves. Prescribing the “right” way to solve a life problem reinforces the power dynamic that denies the peer to choose for themselves. Where possible, help the peer identify options that they can choose from. This act supports the healing and recovery process.
- **Touch** can be a very healing act. However, from a TIC approach, it is important to recognize that some, and perhaps many people with trauma histories, were harmed through the medium of touch in some way. Thus, a behavior that we might think of as nonthreatening and common say a handshake or a pat on the back, may bring back memories of touch-based abuse in the other person. A trauma-informed approach would be to ask the other person if it’s OK to shake hands or pat them on the back and wait for their response before doing anything.
- **Affirming strengths.** As noted above, people who have lived through trauma are survivors. This means they have done many things “right” in order to do so. Because of the overwhelming pain of trauma, combined with a human tendency, when stressed, to focus only on the negatives and not see any positive qualities, survivors frequently do not appreciate their personal strengths and often have difficulty even naming any positive personal characteristics. It is important, from a TIC perspective, to gently but persistently point such strengths out to the peer. One way to begin implementing a strengths-based affirmative approach is to literally ask the question, “You survived, [the particular trauma]. That kind of trauma would have killed most people. Tell me, what’s your secret to surviving? How did you do that?” This line of questioning allows the peer to begin to describe positive, healthy, and strengths-based behaviors they have used to cope. Another way to affirm strengths is to help the peer “connect the dots” between their positive actions and a good outcome. For example, “Although you’re depressed a lot, you still get up every day and go to work. That’s amazing. How do you do that?” Once strengths are identified, then the task is to see how they can be leveraged to facilitate other changes.

#### MODULE REVIEW

1. What is the philosophical assumption of trauma-informed care (TIC)?
2. In reflecting on the 10 key principles of TIC, what are some common ideas and principles that run through them all?



## ODU Prevention Module 3

### Influencing Positive Behavior Change

#### LEARNING OBJECTIVES

By the end of the module, peer mentors will be able to:

- Identify three key ways to influence individuals
- Describe six sources of influence
- Discuss ways that peer mentors can influence Veterans

#### INTRODUCTION

This module will introduce learners to a process that will help them effectively influence others. The process can help learners to assist Veteran mentees to change negative behaviors. The module will share strategies on ways to influence others and offer case studies that share examples of influence being used to facilitate behavior change.

#### What is influence?

“Who shall set a limit to the influence of a human being?”

-Ralph Waldo Emerson

Influence is the ability to create change in human behavior, and the people who facilitate this behavior change are called “influencers.” As a peer mentor, a component of your work will be to positively influence others. Sometimes “influence” is mistaken for a form of persuasion; that is not the case with peer mentoring. Influence in the context of peer mentorship refers to the continuous application of key behaviors to prompt positive change in Veteran mentees.

#### Three Key Ways to Influence

Scientists have identified three key behaviors to influence others:

- 1) Focus and measure: being clear about the result you are trying to achieve and having ways to measure it
- 2) Find vital behaviors: focusing on 2-3 vital actions that produce the greatest amount of change
- 3) Engage the six sources of influence (discussed later in the module)

You may be asking yourself, how do these behaviors apply to life as a Veteran peer mentor? Here are some specific applications of each key behavior:

*Focus and Measure:* this behavior can occur at both a group and individual level. For example, at a group level, Dryhootch’s peer mentor program may have a goal to reduce opioid use among Veterans in the next year, and they may set up a system to track opioid use among Veteran mentees. On an individual level, a peer mentor may set a goal to reduce opioid use among the 3 Veteran mentees that he/she

serves. Even further at an individual level, the peer mentor will work with the Veteran mentee to identify an individual goal for the mentee.

**Vital Behaviors:** A peer mentor will work with their Veteran mentee to identify vital behaviors that will assist the Veteran mentee in achieving his/her goal. An important step in this process is identifying barriers that are currently keeping the Veteran from positive vital behaviors. Barriers can be personal (e.g., low self-esteem), Social (e.g., relationship challenges), or Structural (Veteran is unable to get mental health when seeking it). Another crucial step to identifying vital behaviors is to identify what are called “crucial moments.” A crucial moment is a time that puts the Veteran at risk for a negative behavior. In the opioid example, crucial moments could be:

1. Before getting hooked on opioids
2. During a crisis moment
3. Lack of understanding and interest in quitting

After barriers and crucial moments have been established, the peer mentor/Veteran duo can work together to select vital behaviors.

**Can you think of some vital behaviors that will help a Veteran overcome opioid addiction?**

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Some possible vital behaviors include: identifying ways for the Veteran to manage pain without opioids, using a crisis moment as an opportunity to quit, and using social/peer support.

#### SIX SOURCES OF INFLUENCE

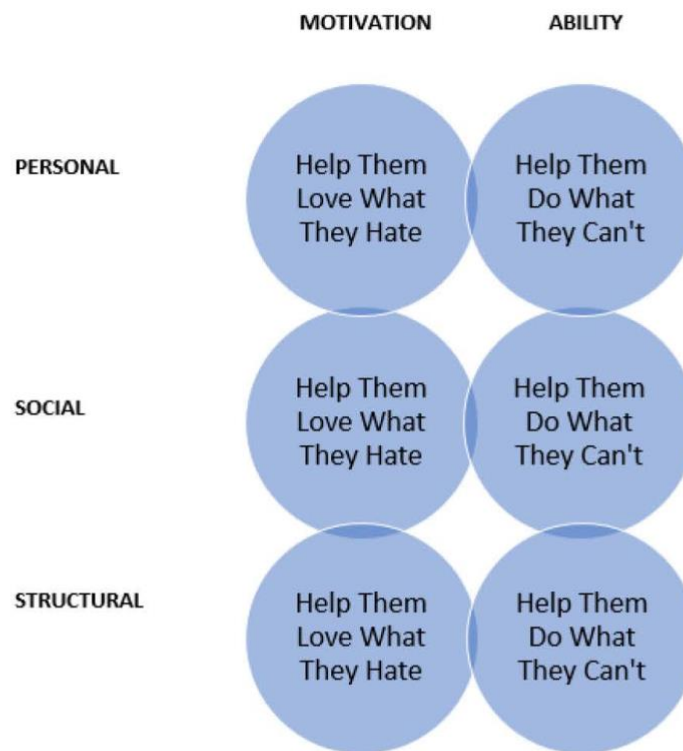
The three behaviors to success outlined above sound simple, right? Philosophically, the behaviors are simple, but in practice influencing behavior change is more complicated. That’s where the six sources of influence come in.

The six sources of influence include:

- **Personal Motivation:** does the Veteran have the personal drive to change behaviors?
- **Personal Ability:** does the Veteran have the ability to make change?
- **Social Motivation:** at a group level, is there motivation to change the culture?
- **Social Ability:** does the group have the knowledge, understanding, and training needed to make change?
- **Structural Motivation:** is the environment conducive to support the Veteran’s change?
- **Structural Ability:** does the group have the resources needed to change?

The illustration below showcases each of the sources of influence:

#### Six Sources of Influence



Grenny, Joseph; Patterson, Kerry; Maxfield, David; McMillan, Ron; and Switzler, Al. *Influencer: The New Science of Leading Change, Second Edition (Paperback)*. US: McGraw-Hill, 2013.

**Think about a time when you helped someone change a behavior.  
What areas of influence did you target and affect?**

	Motivation	Ability
Personal		
Social		
Structural		

The six sources of influence can be helpful in guiding the peer mentor and Veteran towards identifying barriers that might keep the Veteran from engaging in vital behaviors. For example,

*Personal Motivation:* What might be painful, frightening, boring, or uncomfortable about the vital behaviors? In the opioid example,

- Used to opioids for pain
- Used for pleasure
- Does not know how to withdraw
- Does not know how to use alternative treatment
- Frightened about withdrawal symptoms
- Peer pressure

*Personal Ability:* What skill gaps get in the way of doing the vital behaviors (physical skills, knowledge, understanding, social skills)? In the opioid example,

- Lack of knowledge about both short and long-term negative effect of opioids
- Lack of understanding about alternative treatment
- Lack of social skills

*Social Motivation and Social Ability:* What social influence challenges are you up against? How are you or others discouraging the vital behaviors? How are you or others enabling the wrong behaviors? Examples include:

- Lack of adequate care for veterans
- Lack of treatment facilities for opioid treatment
- Peer pressure can continue to make a negative impact
- Negative societal views of people with drug/opioid use/abuse

*Structural Motivation:* Are there costs or penalties for doing the vital behaviors? Are there things that reward people for doing the wrong behavior? In the opioid example,

- DWI
- Drug possession
- Drug selling
  - Earning source

*Structural Ability:* What environmental factors could enable the wrong behaviors (consider space, cues, data, and tools)? In the opioid example,

- Lack of programs to help quit opioids
- Lack of both physical/social support systems



### HOW CAN A PEER MENTOR INFLUENCE VITAL BEHAVIORS?

A peer mentor can use the six sources of influence to identify strategies to help Veterans engage in vital behaviors. Below is a list of practical strategies at each source that a peer mentor can use:

**Personal Motivation:** Tell a meaningful story? Allow for choice?

- Get peer mentors to share their own stories

**Personal Ability:** How can you employ deliberate practice?

- How can they use their own stories to motivate others?
- Use the “learn, do, teach” process

**Social Motivation and Social Ability:** How can you lead the way?

- Think about interdependence
- Build social capital
- Expand social network

**Structural Motivation:** Use rewards in moderation, link rewards to vital behaviors, and use rewards that reward.

- Start with internal satisfaction to change behavior
- Use social support
- Choose a “reward” after the first two ideas
  - A small heartfelt token can be the most powerful

**Structural Ability:** What environmental factors could enable vital behaviors (consider space, data, cues, and tools)?

- The proximity of folks can make them more productive
- Data is important, but don’t overdo it
- A simple change of a space
  - How it looks can speak volumes

This module was influenced by the following reference:

Grenny, Joseph; Patterson, Kerry; Maxfield, David; McMillan, Ron; and Switzler, Al. *Influencer: The New Science of Leading Change*, Second Edition (Paperback). US: McGraw-Hill, 2013.

## OUD Prevention Module 4

### The Science of Pain and Opioids

#### LEARNING OBJECTIVES

By the end of this module, peer mentors will be able to:

- Describe biological changes that occur in the body when pain is experienced.
- Discuss two types of medications used for the treatment of pain.
- Describe how opioids relieve pain.

#### THE SCIENCE OF PAIN

Pain tells you about what's happening within your own body. The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." Pain protects us, so we don't do more damage and is a warning sign of impending or actual injury.

When you suffer an injury, the nervous system is in charge of delivering the news. Imagine that you burn your finger when you accidentally touch a stove. Nerve cells in your finger pick up the signal that something's wrong. A network of nerve cells relays the message to the spinal cord. From the spinal cord, the signal reaches the brain. The brain translates the message and registers the feeling: Ow!

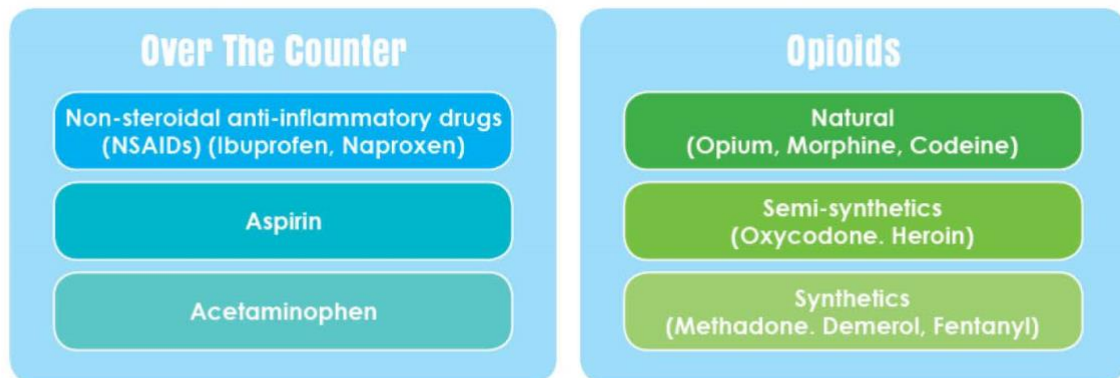
Burning your finger when you touch a hot stove. Throbbing from a broken foot. Pulling a muscle from carrying heavy furniture. The short-term effect is called acute pain and is typically related to tissue damage. Other pain that lasts months or years is called persistent or chronic pain. There is no easy explanation for the causes of chronic pain. Some common reasons for chronic pain are inflammation, nerve damage, and others.

**Inflammation** is a way that the body responds to cellular injury and triggers swelling, redness, and heat. For example, arthritis is a disease that causes painful joint inflammation.

**Nerve damage** can be a second source of pain. Diabetes is a disease that can damage the nerves in the hands and feet. The damage leads to pain, tingling, and numbness.

#### FIVE WAYS TO HELP WITH PAIN

- 1) Medications help but only in a limited way. (see Figure 1. Medications for Pain)
- 2) Thoughts and emotions (see QRF Volume 1 | Module 14 | Health and Well-Being)
  - a. Stress reduction
  - b. Emotional wellbeing
- 3) Nutrition and lifestyle (see QRF Volume 1 | Module 14 | Health and Well-Being)
- 4) Life Story (see QRF Volume 1 | Module 2 | Trauma-Informed Care)
  - a. Step back and reflect on what happened to the veteran when the pain started
- 5) Physical Activity and Function (see Module 14 | Health and Well-Being)
  - a. Get moving as the Veteran feels comfortable

**Figure 1. Medications for Pain****Over the Counter (OTC) Medications**

- Non-steroidal anti-inflammatory drugs (NSAIDs) block pain
  - Ibuprofen
  - Naproxen
- Aspirin (extracted from willow bark) metabolizes into salicylic acid
- Acetaminophen relieves pain and fever but doesn't reduce inflammation
  - Mostly metabolized in the liver

**Opioids**

- Don't kill pain
- Relieve pain by blocking the transmission of pain signals to the brain
- Massage the brain's opioid receptors to alter the perception of pain
- Side effects: nausea, drowsiness, constipation, the chemistry of addiction

**Table 1 Opioids and Example Commercial and Street Names**

OPIOIDS	
<u>Name</u>	<u>Street Names</u>
<b>HEROIN</b>	Brown sugar, China White, Dope, H, Horse, Junk, Skag, Skunk, Smack, White Horse, With Over-the-counter cold medicine and antihistamine: Cheese
<b>CODEINE</b>	Captain Cody, Cody, Lean, Schoolboy, Sizzurp, Purple Drank With glutethimide: Doors & Fours, Loads, Pancakes and Syrup
<b>MEPERIDINE, DEMEROL®</b>	Demmies, Pain Killer



<b>HYDROCODONE, VICODIN<sup>®</sup>, LORTAB<sup>®</sup>, LORCET<sup>®</sup></b>	Vike, Watson-387
<b>OXYCODONE, OXYCONTIN<sup>®</sup>, PERCODAN<sup>®</sup>, PERCOCET<sup>®</sup></b>	O.C., Oxycet, Oxycotton, Oxy, Hillbilly Heroin, Percs
<b>METHADONE, DOLOPHINE<sup>®</sup>, METHADOSE<sup>®</sup></b>	Amidone, Fizzies With MDMA: Chocolate Chip Cookies
<b>FENTANYL, ACTIQ, DURAGESIC, SUBLIMAZE</b>	Apache, China Girl, China White, Dance Fever, Friend, Goodfella, Jackpot, Murder 8, Tango and Cash, TNT
<b>OPIUM</b>	big O, black stuff, block, gum, hop

- **Acute Effects:** Euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feeling of heaviness in the body; slowed or arrested breathing
- **Health Risks:** Constipation; endocarditis; hepatitis; HIV; addiction; fatal overdose

#### OPIOID USE DISORDER (OUD)

What is OUD?

**About 2.1 million Americans had opioid use disorder in 2016.**

- A problematic pattern of opioid use leading to clinically significant impairment or distress
- OUD was previously classified as Opioid Abuse or Opioid Dependence
- OUD has also been referred to as "opioid addiction"

**Here's what we know about opioid misuse: (CDC, 2018)**

- In 2016, 11.5 million people self-reported that they had personally misused prescription opioids during the previous year
- The most commonly-reported reason that opioids were misused was to relieve physical pain (62.3 %)
- The misused prescription opioids were obtained:
  - From a friend or relative (53.0 %)
  - Through prescription(s) or stealing from a healthcare provider (37.5 %), typically through one doctor
  - From a drug dealer or stranger (6.0 %)

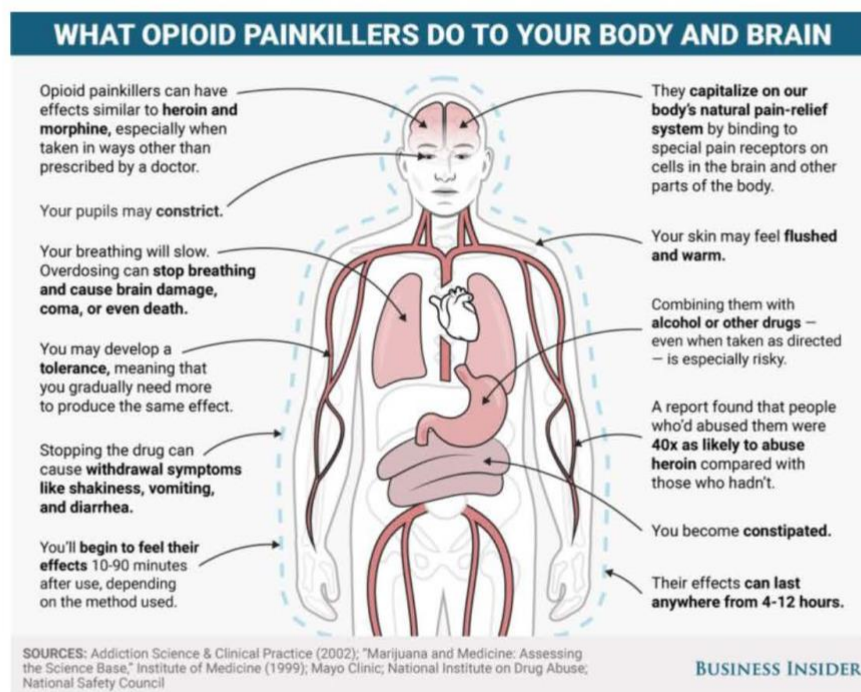
**What is Tolerance?**

Tolerance is defined as either: 1) a need for increased amounts of opioids to achieve intoxication or desired effect, or 2) a diminished effect with continued use of the same amount of an opioid.

#### What is Withdrawal?

- A. Either of the following: 1) Stopping (or reducing) opioid use that has been heavy and prolonged (several weeks or longer), or 2) taking a substance that opposes the opioid
- B. Three (or more) of the following, developing within minutes to several days after stopping or reducing opioid use: dysphoric mood; nausea or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloerection, or sweating; diarrhea; yawning; fever; or insomnia

#### OPIOIDS HAVE VARIOUS EFFECTS ON THE BODY



#### HOW A PEER MENTOR CAN HELP

Peer mentors can...

- Listen to the Veteran's challenges with managing their pain
- Help the Veteran reflect on what they would like to be able to manage
- Help the Veteran with health resources in the community that explain and/or assist with the condition

- Encourage the Veteran to set realistic goals for their situation (see QRF Volume 1 | Module 5 | Motivational Interviewing)

#### MODULE REVIEW

1. Compare and contrast acute pain vs. chronic pain.
2. Describe how you can support a Veteran experiencing chronic pain.

#### VIDEO RESOURCES

- Why we have pain, & how we kill it by Sci Show: <https://youtu.be/GmHGUTNoL-I>
- Understanding pain in less than 5 minutes, and what to do about it!  
[https://youtu.be/C\\_3phB93rvI](https://youtu.be/C_3phB93rvI)
- What we lose when we undertreat pain | Kate Nicholson | TedxBoulder  
<https://youtu.be/u4vHSLeTe-s>

#### WEBSITE RESOURCES FOR OPIOID USE DISORDER

- Wisconsin - <https://www.dhs.wisconsin.gov/opioids/find-treatment.htm>
- National - <https://www.samhsa.gov/treatment/substance-use-disorders>
- National - <https://www.psychiatry.org/psychiatrists/education/signature-initiatives/model-curriculum-project-for-substance-use-disorders/medication-assisted-treatment-for-opioid-use-disorder>
- National - <https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction>



## ODU Prevention Module 5

### Self-Care & Wellness Activities

#### LEARNING OBJECTIVES

By the end of this module, learners will be able to:

- Define what is meant by “self-care”
- Understand the levels at which a veteran peer mentee may need support in initiating self-care strategies (e.g. Tier 1, Tier 2, or Tier 3)
- Discuss self-care and wellness strategies with peer mentee
- List strategies to avoid burnout and maintain personal wellness as a peer support provider

#### INTRODUCTION

This module is designed to provide an overview of self-care and wellness strategies to support peers in recovery from opioid use disorder (OUD). The module provides peer mentors with examples of self-care strategies (across several domains such as physical, emotional, and intellectual wellness) that may help veterans on their road to recovery. Finally, the module reviews strategies that peer support providers can use to maintain wellness. This form of professional self-care can help to increase peer support providers’ resilience and maintain sustainability in this role.

#### WHAT IS SELF-CARE?

Self-care is any activity that we do deliberately to take care of our mental, emotional, or physical health. Self-care is a demonstration of respecting and valuing oneself that can be practiced through engaging in activities, practices, and habits that promote one’s health and well-being. We view self-care as the cornerstone of recovery as it is the opposite of self-destructive or self-harming behavior. A self-care activity is one that refuels or recharges us, rather than drains or depletes us. Self-care can be considered across eight (8) domains of wellness:



Each of these eight (8) domains falls within a tier, or degree of intensity, depending on where the veteran peer is in his/her recovery journey. Tier 1 includes *basic* activities to help gain personal stability. Tier 2 includes *intermediate* activities to maintain stability and develop strength. Tier 3 includes *advanced* activities to help peers thrive and maximize personal wellness. For example, self-care at Tier 3

of the physical domain might include a healthy diet and nutrition and vigorous, or hard, physical activity; however, at Tier 1, self-care in this domain might include meeting very basic physical needs such as eating at least one meal a day. The following table illustrates possible self-care activities to support wellness. Peer mentors are encouraged to develop individualized Self-Care & Wellness Plans early in the peer support relationship, specifically within the first three meetings with their mentee. Note: these plans may be dynamic and subject to regular updates, based on the unique needs of the Veteran peer mentee.

	Tier 1	Tier 2	Tier 3
Physical	<ul style="list-style-type: none"> <li>Bathe</li> <li>Shave</li> <li>Haircut</li> <li>Eat Daily</li> </ul>	<ul style="list-style-type: none"> <li>Keep doctor's appointments</li> <li>Healthy Food Choices</li> <li>Sleep well</li> <li>Light Exercise (walking, cycling, swimming)</li> </ul>	<ul style="list-style-type: none"> <li>Nutrition supplements</li> <li>Exercise (running, cycling, boxing)</li> <li>Meditation, yoga</li> <li>Massage, acupuncture</li> </ul>
Intellectual	<ul style="list-style-type: none"> <li>Drawing, painting, coloring</li> <li>Journal your thoughts</li> <li>Listen to calming music</li> </ul>	<ul style="list-style-type: none"> <li>Art therapy</li> <li>Take a class</li> <li>Read inspirational books</li> <li>Find creative niche</li> </ul>	<ul style="list-style-type: none"> <li>Build self confidence in thinking ability...</li> <li>Create Sculpt/paint</li> </ul>
Environmental	<ul style="list-style-type: none"> <li>Secure safe housing/shelter</li> <li>Obtain clean clothing</li> <li>Enjoy nature</li> <li>Get fresh air</li> <li>Visit positive/inspiring settings (library, church, coffee shop, museum)</li> </ul>	<ul style="list-style-type: none"> <li>Clean your home or living space</li> <li>Organize personal space</li> <li>Maintain clean clothing</li> <li>Regularly visit the zoo or museum</li> </ul>	<ul style="list-style-type: none"> <li>Welcome positive people in your personal environment</li> <li>Decorate home</li> <li>Create peaceful and serene spaces at home</li> <li>Create a meditation space in the home</li> </ul>
Emotional/ Mental	<ul style="list-style-type: none"> <li>Develop a Self-Care &amp; Wellness Plan</li> <li>Take medication, if applicable</li> <li>Maintain counseling appointments</li> <li>Journaling</li> <li>Listen to inner voice (notice and record patterns)</li> <li>Identify/name/label emotions (anger, sadness, hurt, disappointment)</li> <li>Express emotions</li> <li>Take a walk/Get fresh air</li> </ul>	<ul style="list-style-type: none"> <li>Practice journaling and reflection</li> <li>Recognize emotional triggers (painful memories)</li> <li>Practice gratitude</li> <li>Don't rehash the past</li> <li>Counter negative thoughts with positive statements</li> <li>Enjoy nature</li> <li>Get fresh air</li> <li>React to emotions in a healthy manner (i.e. use coping skills to replace</li> </ul>	<ul style="list-style-type: none"> <li>Respond to emotions in a healthy manner</li> <li>Nurture one's self through positive self-talk</li> <li>Practice gratitude</li> <li>Engage in health-promoting rituals</li> </ul>

	Tier 1	Tier 2	Tier 3
		negative or harmful expressions of emotions)	
Financial	<ul style="list-style-type: none"> <li>• Apply for relevant public benefits (e.g. food stamps, housing)</li> <li>• Connect with job training providers (e.g. Department of Vocational Rehabilitation)</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a resume</li> <li>• Secure employment</li> </ul>	<ul style="list-style-type: none"> <li>• Read articles/listen to podcasts about personal finance and saving</li> <li>• Develop a savings plan</li> </ul>
Social	<ul style="list-style-type: none"> <li>• Uphold weekly contact with Peer Mentor</li> <li>• Cut ties with past co-users</li> <li>• Participate in self-help groups</li> <li>• Find and create positive peer groups</li> </ul>	<ul style="list-style-type: none"> <li>• Join activity-based social groups (bowling team, book club, hobby group)</li> <li>• Participate in cultural enrichment (plays, art shows, live music)</li> <li>• Leave toxic relationships</li> <li>• Develop positive social relationships</li> <li>• Participate in positive peer groups</li> </ul>	<ul style="list-style-type: none"> <li>• Participate in cultural enrichment (plays, art shows, live music)</li> <li>• Join a book club</li> <li>• Serve on a committee or board</li> </ul>
Spiritual	<ul style="list-style-type: none"> <li>• Prayer or meditation</li> <li>• Daily quiet time</li> <li>• Enjoy nature</li> <li>• Find a spiritual counselor or advisor/pastor</li> </ul>	<ul style="list-style-type: none"> <li>• Prayer or meditation</li> <li>• Practice gratitude</li> <li>• Help someone through volunteering or mentoring</li> <li>• Listen to inspirational lectures/messages</li> </ul>	<ul style="list-style-type: none"> <li>• Read scripture or inspiring writing</li> <li>• Listen to inspirational lectures/messages</li> <li>• Find purpose and meaning</li> </ul>
Professional/Occupational	<ul style="list-style-type: none"> <li>• Be on time</li> <li>• Meet deadlines</li> <li>• Keep your word</li> <li>• Be accountable</li> <li>• Connect with job training providers (e.g. Department of Workforce Development/Vocational Rehabilitation)</li> </ul>	<ul style="list-style-type: none"> <li>• Volunteer</li> <li>• Know your strengths</li> <li>• Complete a resume</li> <li>• Get interview coaching</li> <li>• Apply for jobs</li> <li>• Read free content on personal development</li> </ul>	<ul style="list-style-type: none"> <li>• Complete a communications style assessment</li> <li>• Take professional development courses</li> <li>• Read books and other content on leadership, personal development and success</li> </ul>

As you reference this table, consider how the menu of strategies may apply to veteran peer mentees with whom you are working. Remember, each peer mentee may occupy varying tiers depending on the domain in question, as well as their individual goals for growth and recovery. As a peer support provider,



also keep in mind community resources and referral sites that may be relevant and/or helpful to the achievement of the peer's goals (see QRF Modules 1-3 and QRF Manual pages 21-22).

#### SPOTLIGHT ON EMOTIONAL WELLNESS

Coping with painful emotions associated with past hurts or adverse events is a challenge commonly cited by individuals in recovery. Some people have referred to their substance misuse as a harmful means of escaping or avoiding unrequited emotional pain. Listed below are some activities that may help a person counter intensely painful emotions or negative mood. ***As a peer support provider, you are not a clinician or therapist.*** However, you can point peer mentees to these kinds of strategies to cope with painful emotions or feelings that may arise—until they are able to connect with their clinical provider and/or as a complement to formal mental health or counseling services.

### Triggers

Triggers of past adverse events may include, but are not limited to sights, sounds, or smells.

#### Strategies:

- Get up and physically move (e.g. go for a walk, jog in place, perform jumping-jacks, ride a bike, etc.)
- Open the windows; allow plenty of sunshine in the room
- Inhale fresh, clean air
- Take a hot shower, or a bubble bath using aromatic oils
- Focus on a task like naming all the objects in your visible environment that have a specific shape or color (e.g. items that are yellow such as paintings, pencils, markers, folders, flowers, food containers, socks, etc.)
- Talk to a friend

### Painful Emotions

Painful emotions may include, but are not limited to feelings of worthlessness, sadness, guilt, or regret.

#### Strategies:

- Identify the thoughts or memories behind the painful emotion. It may be helpful to write them down (e.g. "I am feeling guilt because...")
- Replace the thought of a painful memory with an out-loud statement of gratitude (e.g. "I am grateful for...")
- Halt/arrest the painful thought and focus on another task or object
- Don't replay or rehearse the past; don't stew or marinate in negative memories
- Counter negative thoughts with positive statements. Rehearse positive affirmations and positive self-talk.
- Separate painful memories, feelings, or emotions from your intrinsic value
- Express emotions in a healthy way, not in a harmful way. Love yourself; don't harm yourself
- React to emotions in a healthy manner (i.e. use coping skills to replace harmful expressions of emotions)



- Call a friend to talk
- See your counselor or therapist to talk about concerns
- Practice positive self-talk

### SELF-CARE & WELLNESS PLAN

A Self-Care & Wellness Plan is a useful resource to visualize individual goals for personal growth and development as well as maintaining overall wellness and sobriety. This tool can also help with tracking progress during regular check-in meetings with peer mentees. Additionally, a self-care & wellness plan may be helpful for personal use. As a peer mentor, you might remember to be **both mindful and protective of your personal recovery journey**. It is a good idea to have a Self-Care & Wellness Plan on file for yourself, even as you have similar plans on file for the peer mentees which you support. You will find a blank Self-Care & Wellness Plan template at the end of this module.

### SELF-CARE AS A PEER SUPPORT PROVIDER

*What can you do for yourself as a professional, to bring your best self to the table? What are self-care strategies for peer support specialists?*

Burnout can be a challenging issue for peer support specialists. Characteristics of burnout can include loss of interest at work, tardiness, disorganization, emotional exhaustion, physical fatigue, irritability, and relapse thoughts. In order to protect against burnout, you may wish to evaluate your workload and assess your personal satisfaction from your work as a peer support provider. **Peer support providers are also encouraged to recognize what emotional triggers may exist within the peer mentor-peer relationship and interactions.** It's a good idea to regularly reflect on your personal and professional stressors and share your thoughts and impressions with other peer support providers through case consultation and other professional development opportunities. The table below lists some strategies that may be used in personal and professional contexts to support peer mentors' self-care.

### Taking Care of You

- Sleep well
- Exercise regularly
- Eat a balanced diet
- Meditate, practice yoga
- Reflect on and continue to use strategies that you use to maintain your sobriety
- Be aware of your triggers
- Find a safe person to share your thoughts and feelings
- Balance your workload
- Set boundaries, don't be afraid to say "no"
- Advance your education and training
- Network with others doing similar work

### MODULE REVIEW

1. Define "self-care"

2. Name two self-care activities that support *physical* wellness for veteran peer mentees
3. Name two self-care activities that support *emotional* wellness for veteran peer mentees
4. Name two self-care activities that support *environmental* wellness for veteran peer mentees
5. What are two ways you can engage in self-care as a peer support professional?
6. Interactive Exercise: Think about how you would develop a ***Self-Care & Wellness Plan*** with a veteran peer mentee. Take a few minutes to draft a personal ***Self-Care & Wellness Plan*** as a peer support provider.

## OUD Prevention Module 6

### Relapse Prevention

#### LEARNING OBJECTIVES

1. Explain the cycle of addiction
2. Identify the road to relapse
3. Explain the importance of mood management in early recovery and sobriety
4. Compose a relapse prevention plan
5. Explain ways that peer mentors can facilitate continued recovery

#### INTRODUCTION

This module addresses relapse prevention as an important continuation of ongoing recovery work. The module discusses effective coping strategies to assist veterans in maintaining desired behavioral changes.

#### BACKGROUND

##### *Addiction cycle:*

Addiction is often described as a chronic remitting and relapsing illness. This means that people go from active “using” stages to stages of recovery back to “using” again, possibly even after years of recovery. Even though most people don’t want to go back to using substances or engaging in addictive behaviors, relapses are the rule and not the exception.

It may take many of those cycles for a person with an addiction to grow into solid recovery.

Men and women have different relapse risk factors. Men seem to seek the intoxicating effect and are more vulnerable when confronted with previous drug-using environments. Women are more sensitive to stress and prone to “use” when experiencing negative emotions. They are also more vulnerable to relationship tensions or losses. Keep in mind, however, that each person has their own specific vulnerabilities.

#### DEFINITIONS

##### *Lapse:*

Initial episode of use of a substance after a period of abstinence. There is a major difference between having one slip and having a relapse. A lapse represents a temporary slip or returns to a previous behavior that one is trying to control or quit. This is usually a one-time occurrence. When a lapse can be accepted as part of the path to recovery, it is much more likely to not develop into a relapse.

*Marlatt, G. A., & Donovan, D. M. (Eds.). (2005). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. Guilford press.*

##### *Relapse:*

Continued use after the initial slip. A breakdown or setback in the person’s attempt to change or modify any target behavior. “An unfolding process in



which the resumption of substance use is the last event in a long series of maladaptive responses to internal or external stressors or stimuli.” It often involves a disengagement from recovery activities.

*Mee-Lee, D. (2016). How to deal with relapse, continued use and continued problems: working together to promote recovery. The Change Companies.  
[https://pscourts.nmcourts.gov/uploads/FileLinks/870ac93bc7364ff292617d318fd9f1c0/HO.1.5h.Breakout\\_Session.How\\_to\\_deal\\_with\\_Relapse\\_\\_Cont.Use.Problems.DavidMee\\_Lee.SheratonAlbuquerqueUptown.11.3.1610.pdf](https://pscourts.nmcourts.gov/uploads/FileLinks/870ac93bc7364ff292617d318fd9f1c0/HO.1.5h.Breakout_Session.How_to_deal_with_Relapse__Cont.Use.Problems.DavidMee_Lee.SheratonAlbuquerqueUptown.11.3.1610.pdf)*

#### *Recovery:*

A long-term and ongoing process rather than an end point. Recovery is more than just not using. “It is a **process of sustained action that addresses the biological, psychological, social, and spiritual disturbances inherent in addiction**. Recovery aims to improve the quality of life by seeking balance and healing in all aspects of health and wellness while addressing an individual’s consistent pursuit of abstinence, impairment in behavioral control, dealing with cravings, recognizing problems in one’s behaviors and interpersonal relationships, and dealing more effectively with emotional responses.”

*Strategies to Strengthen Recovery: A Pathway Forward. (2018). British Columbia Centre on Substance Use. <https://www.farcana.org/app/uploads/2018/07/Report-Strategies-to-Strengthen-Recovery-in-British-Columbia-The-Path-Forward.pdf>*

#### *Shame and Addiction:*

People with addiction are often highly shame sensitive. It means that they see themselves and not their actions as “bad.” They feel like a hopeless failure and ultimately unlovable. When shame becomes too much of a part of an individual’s life, it can be highly destructive. When an individual becomes troubled by the shame, they may turn to substance use for solace. Overwhelming shame can lead to heavier “use” when lapsing and therefore lead to a full-blown relapse much quicker: “If I am an addict, I may as well act like one, and I don’t deserve to have a good life.” After using, the shame returns of “I can’t do anything right.”

The best way to overcome shame is to engage in mental health services, to learn that one’s mistakes do not define an individual, and to build self-esteem by engaging in meaningful activities. Relapse and Recovery are mediated by the severity and damage caused by the substance use, the presence of other psychiatric or medical illness, and the individual’s coping skills, motivation, and support system.

#### **Relapse Determinants**

Relapse prevention has been shown to decrease individual’s risk for relapsing and to strengthen recovery. Like learning any new behavior, changes in behavior may not appear immediately. It is important to stay consistent in the messages and advice given to the veterans.

Relapse prevention focuses on “high-risk” situations, situations in which it may be very hard to not use. In order to learn how to avoid or deal with high-risk situations, we first have to think about what makes for high-risk situations:

Factors within and around the person with addiction interact with each other and increase or decrease the risk for relapse. Most often, those different factors influence each other substantially. No one single

factor can easily be “blamed” for a relapse. However, the driving force behind a relapse may be traced back to an individual’s vulnerability to relapse.

Example: Phil has been in recovery for a few months now. He has a co-worker who used to share pain pills with him. Phil has learned to avoid that co-worker and has blocked the phone number. However, one day after an argument with his significant other and getting reprimanded for being late to work even though there was an accident and he had called his job, Phil saw the co-worker and could not deal with the cravings that had built. He asked the co-worker for pills and used them immediately in the bathroom.

### **Intrapersonal Determinants of Relapse**

Self-efficacy: The Veteran’s own belief in his or her ability to complete a certain task or achieve his/her goals. These beliefs shape the goals, the persistence in reaching the goals, and the effectiveness of problem-solving activities.

Outcome expectancies: A person might relapse because they expect a relief of a negative mood state.

Craving/urges: To predict a relapse it’s not as important if a person craves a substance but if the person who has cravings/urges has other risk factors. (low trust in oneself to be able to cope, comorbid depression, low fulfillment in life)

Motivation: The commitment for self-improvement. Treatment might not always be the initial motivation during recovery and high motivation does not automatically predict good outcomes. Good coping skills can assist with motivation when faced with challenges.

Coping: Critical predictor of substance use treatment outcomes. Can entail learning to avoid triggers, distraction skills, or learning to tolerate negative emotions, “urge surfing,” actively changing a situation.

Emotional states: Substances are often used to change mood states. Especially negative affect (anger, frustration, sadness, loneliness) has a strong link to relapse.

### **Interpersonal Determinants of Relapse**

Social support:

- Positive factors: size (more is better), quality, and level of support from non-substance users
- Negative factors: Conflict, social pressure

## RECOGNIZING WARNING SIGNS

**Post-Acute Withdrawal Symptoms (PAWS).** Although not part of the “medical” language of addiction science, PAWS is well recognized among both professionals as many people with addiction describe those symptoms while trying to be in recovery. PAWS are withdrawal symptoms that occur after the acute phase of withdrawal is over; for some, this is after medical/inpatient detox. The symptoms can last anywhere from a couple months up to two years. Recognition of PAWS is important as these can be “triggers” to use due to urge to rid of symptoms.

*Post-Acute-Withdrawal Syndrome (PAWS): An In-Depth Guide. (2020). American Addiction Centers. <https://americanaddictioncenters.org/withdrawal-timelines-treatments/post-acute-withdrawal-syndrome>*

### Symptoms of PAWS Include

- Difficulty thinking clearly
- Difficulty managing emotions such as anger or depression
- Increase in impulsive behavior
- Short term memory problems
- Inconsistent sleep
- Problems with physical coordination, motor skills decline, may not be able to walk straight.
- “Feeling off,” irritability, on edge kind of feeling

## RELAPSE PREVENTION STRATEGIES

1. **Help Veterans understand relapse as a process and event and learn to identify warning signs.** Explaining the cycle of addiction can decrease shame and stigma. Warning signs are the links in a relapse chain. Review with the Veteran their relapse history (consider using a calendar) in order to plot or map out the connections between thoughts, feelings, events, or situations and relapse. Discuss which attitudes, emotions, thought processes, and behaviors seemed to change before the relapse.
2. **Recognizing the return of denial – the inability to see the truth in reality.** It is said that relapse happens before a person goes back to picking up the substance of abuse or problematic behavior. It is comparable to people developing tunnel vision, only focusing on one part of the problem and therefore excluding other parts that could help sustain recovery.

### Projecting

“The Army is the reason I’m an alcoholic. If I didn’t go into the Army, I never would have been an alcoholic.”

### Minimizing

“I can have just one beer while watching the game.”

### Rationalizing

“Alcohol is my problem. A little pot helps my anxiety, and it’s legal in some places.”

### Comparing

“I’m not as bad as him/her. She has been in rehab 5 times this year. I’ve never had to go to rehab.”

3. **Recognizing addiction grief.** Grieving one’s addiction is much like grieving the loss of a loved one. Grief is a normal and healthy way to get through the loss; the substance was such a big part of one’s



life; grief is to be expected. One can get through the grief by not isolating, asking for help, remembering you are not alone, and investing your time and energy into healthier lifestyle choices.

**4. *Help Veterans identify their high-risk situations and develop effective cognitive and behavioral coping.***

Recognize and manage high-risk factors which involve intra- and interpersonal situations in which a veteran feels vulnerable to relapse. People make “mini-decisions” over time, each of which brings people closer to creating a high-risk situation. Veterans can benefit from role-playing refusal skills, assertiveness practice, engaging in meditation, exercise, and relaxation.

**Management of PAWS**

- Sobriety
- Talk to professional (to rule out medical issues)
- Education to keep PAWS symptoms in perspective
- Self Care: nutrition, exercise, relaxation, balanced living
- Spirituality

- 5. *Help Veterans enhance their communication skills to develop relationships and social networks that support recovery.*** Ask the veteran if there are family members, significant others, or non-substance using friends who can be a support network. Offer an opportunity for them to ask questions, learn coping, and support strategies. Veterans can be encouraged to engage in self-help groups. Practicing with the veteran asking for help and support can build confidence and prepare for both negative and positive responses from the person asked.

**Social Networking:  
People, Places, and Things**

- Find new sober friends
- Spend time at sober facilities such as Dryhooch and 12 Step Meetings
- Identify new hobbies: “What did I like to do before my addiction?”

- 6. *Help Veterans reduce, identify, and manage negative emotional states.*** Emotional states like anxiety, depression, anger, and loneliness can weaken relapse defenses. Discussing how to reach out or what activities have helped in the past, listing them, and practicing them can decrease those negative emotional states and thereby strengthen relapse resistance.
- 7. *Help Veterans identify and manage cravings and cues that precede cravings.*** Cues can be in the environment or within the veteran. They can be sights or smells of the substance, prior co-users or dealers, certain areas of town. They also can be stressful memories, painful emotions, or other mood states in which the veteran previously used. Once exposed to the cue, the person with addiction may feel a strong urge or develop intrusive thoughts of wanting to use. Learning to challenge the positive expectation (“the drug made me feel good but only for a short while and then I again lost everything I built for myself”), recalling the negative consequences, learning to leave or change a situation can be powerful experiences that increase a person’s self-confidence and resolve. Another way to manage cravings is to acknowledge those thoughts and feelings without judging them and waiting for them to pass without dwelling on the thoughts or feelings.
- 8. *Help Veterans understand and recognize Post-Acute Withdrawal Syndrome.*** PAWS often causes veterans to be concerned. They might assume having PAWS means “something is wrong” or that they don’t do what they need to do for recovery. Once veterans understand that PAWS is commonly encountered after stopping to use any substance or problematic behavior, they can reassure themselves that those symptoms won’t last forever.



9. **Help Veterans identify and challenge incorrect thoughts.** Warning signs can be certain thought patterns: black and white thinking (“relapse can’t happen to me”), overgeneralization (“I’ll never use drugs again”), catastrophizing (“I’ll never get better”), jumping to conclusions (“a few pills won’t hurt”). Asking veterans to write those down and learning how to counter those thoughts when they arise can be powerful tools to not relapse.

### Self-Management and Motivation

#### HELPING IDENTIFY CONSEQUENCES OF SUBSTANCE MISUSE: COST/BENEFIT ANALYSIS

##### What do I enjoy about my addiction/What does it do for me?

- Temporarily reduces mental health symptoms
- Reduces anxiety
- Social

##### What are the consequences? What do I dislike about my addiction?

- Financial Stress
- Relationship Stress
- Be as specific as possible

##### What do I think I won’t like about giving up my addiction?

- What will you hate, dread or dislike about giving up substance?
- Not hanging around my friends
- Having to confront problems

##### What do I think I will like about giving up my addiction?

- What good things will happen when you stop your addiction?
- Better relationships
- More money
- Helps long term physical health and mental health

#### HOW A PEER MENTOR CAN HELP

Every person has their own story, and no two veterans will obtain recovery in the same way. However, most veterans will benefit from additional support for recovery.

*Recognize that some veterans may be prescribed medications in combination with psychosocial treatments.* Some veterans benefit from medications for cravings and or other mental health diagnoses. Support regular visits to talk about the benefit or side effects. It can be very helpful to talk about what

resources the veterans have in terms of formal treatment. The level of care depends on how severe the addiction is. Not everybody needs detox or rehab.

*Let the veteran decide on their goals.* They may decide to stay completely abstinent, or they may decide to first reduce their level of drug use. Remind them of safety-related issues, like obtaining a Narcan rescue kit, and of the treatment options available to them. Keep them engaged in talking about their personal goals. It is more helpful to talk about what to do than about what not to do. It will help veterans to increase their self-confidence and eventual desire to lead a life without drugs. Invite significant others or people who the veteran identified as a positive support to be part of the conversation. Never give up.

*Help Veterans work toward a more balanced lifestyle.* A healthy lifestyle helps to reduce stress by increasing health, providing enjoyable activities, and creating an increased sense of fulfillment. Evaluating tasks by “do I want to do this or do I need to do this” and balancing effort and time between the two can reduce sources of stress within a person with addiction and in their relationships.

*Establish a relapse prevention plan.* Having a relapse prevention plan helps one stay on the alert, become aware of one’s warning signs and symptoms, helps one avoid pitfalls that may lead to relapse and provides one with a strategy to implement if one finds themselves slipping into a relapse.

1. What are my triggers?	
2. What will I do to avoid high risk situations?	
3. What will I do to safely cope with high risk situations that I cannot avoid? What are my coping skills?	
4. Who can I call for support?	
5. What meeting can I attend if I am having an urge or a craving?	
6. What actions can I take when twelve-step meetings begin to feel boring or unimportant?	
7. What immediate actions can I take when I'm feeling frustrated? Resentful? Angry?	

### Tips to Avoid Relapse

- Cravings will eventually pass, distract yourself in the meantime
- Avoid complacency or overconfidence: “I don’t need to attend meetings, I got this.”
- Establish sober relationships
- Don’t view relapse as a failure, falling back into old patterns will only make the situation worse

#### Handling a Slip

- Don’t panic, one slip does not have to lead to a full return to substance abuse
- Understand that relapses can be a chance to change things, relapses don’t equal failure.
- Be aware of wanting to give up
- Renew your commitment, think back as to why you started recovery in the first place; return to review cost/benefit analysis
- Decide on a course of action to get out of the situation, take a time-out and engage in a healthy activity
- Talk to a supportive person or sponsor

#### MODULE REVIEW

1. What are two symptoms of post-acute withdrawal syndrome (PAWS)?
2. Name two tips to avoid relapse
3. What are two social networking strategies to support recovery?

## APPENDIX E: RECRUITMENT FLYER



**CURRENTLY ENROLLING VETERANS**

# PREVENTING OPIOID MISUSE THROUGH PEER SUPPORT

Seeking military veterans experiencing Opioid Use Disorder (OUD) or Opioid Addiction to volunteer and participate in a research study to evaluate the effectiveness of peer support.

You may qualify for this study if you:

- Are a U.S. Military Veteran
- Are age 18 or over
- Struggle with or are recovering from opioid addiction (including Oxycodone, heroin, and fentanyl)

For more information or to see if you qualify:  
Call 414.336.7972 or Email [milan@mhawisconsin.org](mailto:milan@mhawisconsin.org)



MEDICAL COLLEGE OF WISCONSIN



dryhooch



MHA Wisconsin  
Mental Health America of Wisconsin

Preventing Opioid Misuse Through Peer Support 414.336.7972	Preventing Opioid Misuse Through Peer Support 414.336.7972	Preventing Opioid Misuse Through Peer Support 414.336.7972	Preventing Opioid Misuse Through Peer Support 414.336.7972	Preventing Opioid Misuse Through Peer Support 414.336.7972	Preventing Opioid Misuse Through Peer Support 414.336.7972
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## APPENDIX F: RECRUITMENT SCRIPT

### SCRIPT

- ➔ Phone Rings
- ➔ Standard Office Greeting
- ➔ *If the person is calling in response to a Milwaukee PROMPT recruitment flyer, then proceed as follows*

#### Greeting

Thank you for calling today. Yes, I can provide you with additional information about the Milwaukee PROMPT Project: Preventing Opioid Misuse Through Peer Support.

#### Study Information

The ***Milwaukee PROMPT: Prevention of Opioid Misuse through Peer Training*** project is a research study aiming to reduce opioid abuse and opioid-related deaths among Military Veterans in Milwaukee. We are seeking volunteers to participate in the study with Peer Mentor Specialists from Dryhooch, who will provide peer mentoring for veterans.

#### Information about Participation

If you decide to participate, you will be asked to complete an intake questionnaire and engage with a peer mentor who will provide peer mentor services to veterans through lived experience, offering encouragement, and navigating community resources. You must have access to either a smartphone or a computer with internet connectivity on a regular basis to respond to weekly surveys. Data from this study will only be available to Dryhooch (a community-based veteran services organization) and researchers at the Medical College of Wisconsin/Froedtert Hospital, and Marquette University.

#### Compensation

You will receive up to three \$25 gift cards (up to a total of \$75) depending on your participation. The gift cards will be distributed after the completion of the baseline survey, at 6 weeks after responding to the mid-point survey, and at 12 weeks when you complete the final survey. There are no costs associated with this study, but you must have access to either a smartphone or a computer with internet connectivity on a regular basis. You can access a computer at Dryhooch if needed.

### CALLER INFORMATION

#### Introduction

I need to ask you a few questions to make sure you meet the age and eligibility requirements to participate.

Eligibility – need to answer “YES” to all boxes below	YES	NO
• Are you at least 18 years of age or older?		
• Are you a U.S. Military Veteran?		
• Are you willing to receive peer mentor services from DryHooch?		
• Have you struggled with opioid abuse or addiction?		

#### Person is Not Eligible = DO NOT GET FURTHER INFORMATION

Thank you for answering those questions. Unfortunately, you do not meet the eligibility requirements for this study. If you need resources related to opioid or other addiction(s), [refer to MHA's list of community-based mental health resources]. Thank you for your time.

### **If they ask “Why” they are not eligible**

For this project, participants for this study must be a U.S. military veteran at least 18 years or older who has struggled with opioid misuse or addiction. I appreciate your time today. Have a good afternoon.

### **Person is Eligible = COLLECT INFORMATION and ENTER TO REDCap**

Great! Thank you for answering those questions. You meet the eligibility requirements for the study. I will need to ask you for some contact information. [refer to Participant Screening Log]

### **After REDCap is Completed**

I will connect you to a Dryhootch peer mentor specialist who will contact you about next steps.

*THE INFORMATION BELOW IS NOT A PART OF THE VERBAL SCRIPT*

### **DEFINITIONS**

- (1) **Struggled with Opioid Abuse or Addiction:** This phrase is used to describe an individual who has previously misused, abused, or been addicted to opioids (including hydrocodone, methadone, fentanyl, and heroin) and *is attempting or has attempted to stop*. In this instance, “struggle” suggests “effort” and dissonance or conflict about engaging in opioid use.
- (2) **In Recovery:** This phrase is used to describe an individual who has previously abused opioids, has attempted to stop, has sought resources (e.g. 12-step program, counseling, etc.), and has been sober for any amount of time.
- (3) **Active Addiction:** This phrase refers to an individual who is in active addiction and has not demonstrated interest in discontinuing opioid abuse, (i.e. has not attempted to discontinue use or asked for help to stop).
- (4) **Disclaimer:** This study does **NOT** involve therapy. If an individual needs assistance, please refer them to MHA's list of community-based mental health resources.

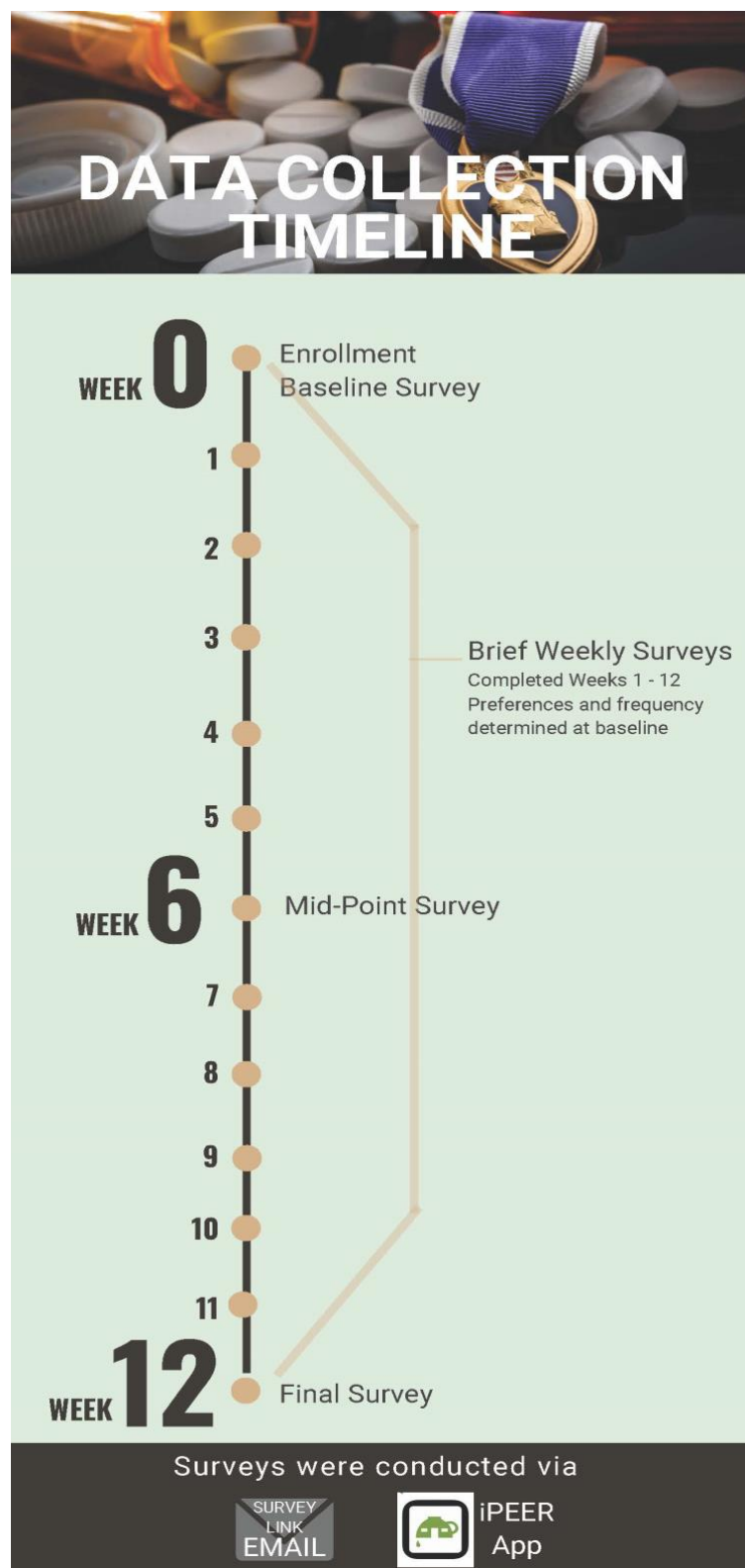
### **List of Prescription Opioids**

- codeine (only available in generic form)
- fentanyl (Actiq, Duragesic, Fentora, Abstral, Onsolis)
- hydrocodone (Hysingla ER, Zohydro ER)
- hydrocodone/acetaminophen (Lorcet, Lortab, Norco, Vicodin)
- hydromorphone (Dilaudid, Exalgo)
- meperidine (Demerol)
- methadone (Dolophine, Methadose)

### **SCREENING PROCESS**

The information collected in the Participant Screening Eligibility Log will be inputted to REDCap, and an email will automatically be generated to alert the Dryhootch contact of a potential research participant.

## APPENDIX G: PARTICIPANT DATA COLLECTION TIMELINE



## APPENDIX H: BASELINE SURVEY

<i>Demographic Questions</i>	
1. First name	Open ended
2. Last name	Open ended
3. Age	Will have range options
4. Marital status	Options: Single (never married); Married, or in a domestic partnership; Widowed; Divorced; Separated
5. Phone number (mobile)	Open ended
6. Email address	Open ended
7. How do you prefer to receive your weekly surveys?	a. Send the survey link to my email every week b. I will take the survey every week on the iPeer app on my smartphone
8. What is the highest degree or level of school you have completed? (If you're currently enrolled in school, please indicate the highest degree you have <i>received</i> .)	c. Less than a high school diploma d. High school degree or equivalent (e.g. GED) e. Some college, no degree f. Associate degree (e.g. AA, AS) g. Bachelor's degree (e.g. BA, BS) h. Master's degree (e.g. MA, MS, MEd) i. Professional degree (e.g. MD, DDS, DVM) j. Doctorate (e.g. PhD, EdD)
9. To which gender identity do you most identify?	M; F; TgF; TgM; Gender Variant/non-conforming; Not listed, prefer not to answer
10. Military Branch	US Army, US Navy, US Marine Corps, US Air Force, US Coast Guard
11. Combat era	a. Operation Iraqi Freedom (OIF; March 2003 - November 2011) b. Operation New Dawn (OND; September 2010 - December 2011) c. Operation Enduring Freedom (OEF; October, 2001 – December, 2014) d. Persian Gulf War (1991) e. Vietnam War (1962 - 1973) f. Korean War (1950 - 1953)
12. What is your current employment status?	a. Employed full time (40 or more hours per week) b. Employed part time (up to 39 hours per week) c. Unemployed and currently looking for work d. Unemployed and not currently looking for work e. Student, Retired, Homemaker Self-employed f. Unable to work
13. Do you have a valid driver's license?	g. Yes, no
14. Do you have a personal vehicle?	h. Yes, no
15. Do you have the resources to prepare/eat a meal at least once a day?	a. Yes, no
16. Have you received VA healthcare services in the past 6 months?	b. Yes, no

*Homeless Screening Clinical Reminder Tool*

In the past two months, have you been living in stable housing that you own, rent, or stay in as part of a household? (“No” response indicates Veteran is positive for homelessness).



### *Housing Status Assessment Guide for State TANF and Medicaid Programs*

1. Where did you stay last night? [Please select the one response that best describes where you stayed last night]
  - a. Emergency shelter, including hotel or motel voucher paid for by a social service or charitable organization
  - b. Transitional housing for homeless persons
  - c. Permanent supportive housing for formerly homeless persons
  - d. Psychiatric hospital or other psychiatric facility
  - e. Substance abuse treatment facility or other detox facility
  - f. Hospital (non-psychiatric)
  - g. Jail, prison or juvenile detention facility
  - h. Half-way or three-quarter-way home for persons with criminal offenses
  - i. Room, apartment or house that you rent
  - j. Apartment or house that you own
  - k. In a friend's or family member's room, apartment or house
  - l. Hotel or motel paid for without emergency shelter voucher
  - m. Foster care home or foster care group home
  - n. Group home or other supervised residential care facility
  - o. Place not meant for human habitation (street, car, park, etc.)
  - p. Other (please describe): \_\_\_\_\_
  - q. Don't know
  - r. Refused
2. How long have you stayed in the place you stayed last night? [Please select the one response that best describes how long you have stayed there]
  - a. One week or less
  - b. More than one week, but less than one month
  - c. One to three months
  - d. More than three months, but less than one year
  - e. One year or longer
  - f. Don't know
  - g. Refused

### *Addiction Severity Index*

1. With whom do you spend most of your free time?	<ol style="list-style-type: none"> <li>a. Family</li> <li>b. Friends</li> <li>c. Alone</li> </ol>
2. Are you satisfied with spending your time this way?	<ol style="list-style-type: none"> <li>a. No</li> <li>b. Indifferent</li> <li>c. Yes</li> </ol>
3. Have you been detained/arrested or incarcerated?	<ol style="list-style-type: none"> <li>a. In the past 30 days</li> <li>b. In the past 6-12 months</li> <li>c. In the past 2-4 years</li> <li>d. 5 or more years ago</li> <li>e. Never detained/arrested or incarcerated</li> </ol>

### Brief Trauma Questionnaire (BTQ)

1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? (Note: By sexual contact we mean any contact between someone else and your private parts or between you and someone else's private parts)
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? (Note: Do not answer "yes" for any event you already reported in Questions 1-9)

### PTSD Checklist for DSM-5 (PCL-5)

Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. In the past month, how much were you bothered by:

1. Repeated, disturbing, and unwanted memories of the stressful experience.	Not at all A little bit Moderately Quite a bit Extremely
2. Repeated, disturbing dreams of the stressful experience?	Not at all A little bit Moderately Quite a bit Extremely
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	Not at all A little bit Moderately Quite a bit Extremely
4. Feeling very upset when something reminded you of the stressful experience?	Not at all A little bit

	Moderately Quite a bit Extremely
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	Not at all A little bit Moderately Quite a bit Extremely
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	Not at all A little bit Moderately Quite a bit Extremely
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	Not at all A little bit Moderately Quite a bit Extremely
8. Trouble remembering important parts of the stressful experience?	Not at all A little bit Moderately Quite a bit Extremely
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	Not at all A little bit Moderately Quite a bit Extremely
10. Blaming yourself or someone else for the stressful experience or what happened after it?	Not at all A little bit Moderately Quite a bit Extremely
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	Not at all A little bit Moderately Quite a bit Extremely
12. Loss of interest in activities that you used to enjoy?	Not at all A little bit Moderately Quite a bit Extremely
13. Feeling distant or cut off from other people?	Not at all A little bit Moderately

	Quite a bit Extremely
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	Not at all A little bit Moderately Quite a bit Extremely
15. Irritable behavior, angry outbursts, or acting aggressively?	Not at all A little bit Moderately Quite a bit Extremely
16. Taking too many risks or doing things that could cause you harm?	Not at all A little bit Moderately Quite a bit Extremely
17. Being “super alert” or watchful or on guard?	Not at all A little bit Moderately Quite a bit Extremely
18. Feeling jumpy or easily startled?	Not at all A little bit Moderately Quite a bit Extremely
19. Having difficulty concentrating?	Not at all A little bit Moderately Quite a bit Extremely
20. Trouble falling or staying asleep?	Not at all A little bit Moderately Quite a bit Extremely

***PTSD Questionnaire of Core Beliefs Related to Drug Use and Cravings for Assessment of Relapse Risk***  
***Addiction***

1. Drinking alcohol is the only way to increase my creativity and productivity.
2. Using opioids is the only way to increase my creativity and productivity.
3. I cannot work without drinking alcohol.
4. I cannot work without using opioids.



5. Drinking alcohol is the only way to deal with the pain of my life. 6. Using opioids is the only way to deal with the pain of my life.
7. The only way to handle my anger is by drinking alcohol. 8. The only way to handle my anger is by using opioids.
9. I could not be social without drinking alcohol. 10. I could not be social without using opioids.
11. Craving and impulses will not disappear unless I use.
12. I cannot relax without drinking alcohol. 13. I cannot relax without using opioids.
14. I cannot control my anxiety without drinking alcohol. 15. I cannot control my anxiety without using opioids.
16. I cannot have any fun in my life unless I drink alcohol. 17. I cannot have any fun in my life unless I am using opioids.
18. Someday I'll use in a controlled fashion again.
19. I think that I can use once a day and not go on.
20. Someday, I may use even if it's only once.
21. I hope to be able to learn controlled drinking. 22. I hope to be able to learn controlled use of opioids.
23. When I am ready, I will be able to drink alcohol in a controlled way. 24. When I am ready, I will be able to use opioids in a controlled way.
25. If I feel physically good, nothing should happen if I use.
26. If I feel psychologically good, nothing should happen if I use.
27. This disease is transient. When I am well, I will be able to drink alcohol without abusing. 28. This disease is transient. When I am well, I will be able to use opioids without abusing.
<u>Cravings...</u>
1. I feel like using when I feel bad physically.
2. When I get the idea of using, I cannot avoid it.
3. I feel like using when I feel good.

4. I feel like using when I have problems with someone.
5. It is difficult for me to cope with craving.
6. I feel like using when I feel bad psychologically.
7. I feel like using when I have money.

### *Adverse Childhood Experience (ACE) Questionnaire*

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often... Swear at you, insult you, put you down, or humiliate you? <b>or</b> Act in a way that made you afraid that you might be physically hurt?	Yes No
2. Did a parent or other adult in the household often... Push, grab, slap, or throw something at you? <b>or</b> Ever hit you so hard that you had marks or were injured?	Yes No
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? <b>or</b> Try to or actually have oral, anal, or vaginal sex with you?	Yes No
4. Did you often feel that... No one in your family loved you or thought you were important or special? <b>or</b> Your family didn't look out for each other, feel close to each other, or support each other?	Yes No
5. Did you often feel that... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? <b>or</b> Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes No
6. Were your parents ever separated or divorced?	Yes No
7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? <b>or</b> Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? <b>or</b> Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	Yes No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes No
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	Yes No
10. Did a household member go to prison?	Yes No

### *Patient Health Questionnaire-9 (PHQ-9)*

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things	Not at all Several days More than half the days Nearly every day
2. Feeling down, depressed or hopeless	Not at all Several days More than half the days Nearly every day
3. Trouble falling or staying asleep, or sleeping too much	Not at all Several days More than half the days Nearly every day
4. Feeling tired or having little energy	Not at all Several days More than half the days Nearly every day
5. Poor appetite or overeating	Not at all Several days More than half the days Nearly every day
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	Not at all Several days More than half the days Nearly every day
7. Trouble concentrating on things, such as reading the newspaper or watching television	Not at all Several days More than half the days Nearly every day
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	Not at all Several days More than half the days Nearly every day
9. Thoughts that you would be better off dead, or of hurting yourself	Not at all Several days More than half the days Nearly every day
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all Somewhat difficult Very difficult Extremely difficult

### *Deployment Risk & Resilience Inventory-2 (DDRI-2)*

The statements below are about your combat experiences during your most recent deployment. As used in these statements, the term "unit" refers to those you lived and worked with on a daily basis during deployment. Please mark how often you experienced each circumstance.

- Never = 1
- Once or twice = 2
- Several times over entire deployment = 3
- A few times each month = 4
- A few times each week = 5
- Daily or almost daily = 6

#### *During deployment...*

1. ...I went on combat patrols or missions.
2. ...I took part in an assault on entrenched or fortified positions that involved naval and/or land forces.
3. ...I personally witnessed someone from my unit or an ally unit being seriously wounded or killed.
4. ...I encountered land or water mines, booby traps, or roadside bombs (for example, IEOs).
5. ...I was exposed to hostile incoming fire.
6. ...I was exposed to "friendly" fire.
7. ... I was in a vehicle (for example, a "humvee", helicopter, or boat) or part of a convoy that was attacked.
8. ...I was part of a land or naval artillery unit that fired on enemy combatants.
9. ...I personally witnessed enemy combatants being seriously wounded or killed.
10. ...I personally witnessed civilians (for example, women and children) being seriously wounded or killed.
11. ...I was injured in a combat-related incident.
12. ...I fired my weapon at enemy combatants.
13. ...I think I wounded or killed someone during combat operations.
14. ...I was involved in locating or disarming explosive devices.
15. ...I was involved in searching or clearing homes, buildings, or other locations.
16. ...I participated in hand-to-hand combat.
17. ...I was involved in searching and/or disarming potential enemy combatants.

Next are statements about your exposure to the consequences of warfare during your most recent deployment. Please mark how often you experienced each circumstance.

- Never = 1
- Once or twice = 2
- Several times over entire deployment = 3
- A few times each month = 4
- A few times each week = 5
- Daily or almost daily = 6

#### *During deployment...*

1. ...I saw people begging for food.
2. ...I saw refugees who had lost their homes or belongings.
3. ...I observed homes or communities that had been destroyed.



4. ...I took care of injured or dying people.
5. ...I saw civilians after they had been severely wounded or disfigured.
6. ...I saw enemy combatants after they had been severely wounded or disfigured.
7. ...I saw Americans or allies after they had been severely wounded or disfigured.
8. ...I saw the bodies of dead enemy combatants.
9. ...I saw the bodies of dead Americans or allies.
10. ...I saw the bodies of dead civilians.
11. ...I interacted with detainees or prisoners of war.
12. ...I was exposed to the sight, sound, or smell of dead or dying animals.
13. ...I was involved in handling human remains.

The next set of statements refers to social support from family or friends at home DURING YOUR MOST RECENT DEPLOYMENT. Please mark how much you agree or disagree with each statement.

- Strongly disagree = 1
- Somewhat disagree = 2
- Neither agree nor disagree = 3
- Somewhat agree = 4
- Strongly agree = 5

#### During deployment...

1. ...family members and/or friends at home were sincerely interested in hearing what was going on with me.
2. ...I had family members or friends at home I could talk to when I had a problem.
3. ...I could count on my family members or friends at home for good advice.
4. ...relatives or friends at home could be counted on to look out for the well-being of my family or other dependents (including pets).
5. ...relatives or friends at home could be counted on to take care of my finances, property, or belongings if needed.
6. ...I was happy with the amount of communication I received from people at home.
7. ...I was happy with the amount of support I received from people at home.
8. ...people at home did things to show they cared about me.

You have completed the questions about your deployment. The next set of statements refers to events you may have experienced SINCE RETURNING FROM YOUR MOST RECENT DEPLOYMENT. These questions are similar to the questions you've answered previously about events before your deployment. Please mark "Yes" or "No" for each question

- Yes, this happened
- No, this did not happen

#### Since returning...

1. ...I was robbed or had my home broken into.
2. ...I experienced unwanted sexual activity as a result of force, threat or harm, or manipulation.
3. ...I went through a divorce or have been left by a partner or significant other.
4. ...I had problems getting access to adequate healthcare.

5. ...I experienced a natural disaster (for example, a hurricane), a fire, or an accident in which I or someone close to me was hurt or had serious property damage.
6. ...someone close to me has experienced a serious illness, injury, or mental health problem (for example, cancer, alcohol/drug problem).
7. ...I have witnessed someone being seriously assaulted or killed.
8. ...I lost my job or had serious trouble finding a job.
9. ...I have been emotionally mistreated (for example, ignored or repeatedly told I was no good).
10. ...I have experienced serious financial problems.
11. ...I have experienced serious physical or mental health problems.
12. ...I have experienced stressful legal problems (for example, being sued, suing someone else, or being in a custody battle).
13. ...I have been seriously physically injured by another person (for example, hit or beaten up).
14. ...someone close to me has died.

The next set of statements refers to social support AFTER YOUR MOST RECENT DEPLOYMENT, as well as current social support. Please mark how much you agree or disagree with each statement.

- Strongly disagree = 1
- Somewhat disagree = 2
- Neither agree nor disagree = 3
- Somewhat agree = 4
- Strongly agree = 5

*Since returning...*

1. ...the American people made me feel at home.
2. ...people made me feel proud to have served my country in the Armed Forces.
3. ...my family members and/or friends make me feel better when I am down.
4. ...I can go to family members or friends when I need good advice.
5. ...my family and friends understand what I have been through in the Armed Forces.
6. ...there are family and/or friends with whom I can talk about my deployment experiences.
7. ...my family members or friends would lend me money if I needed it.
8. ...my family members or friends would help me move my belongings if I needed help.
9. ...if I were unable to attend to daily chores, there is someone who would help me with these tasks.
10. ...when I am ill, family members or friends will help out until I am well.

The sentences below refer to family experiences AFTER YOUR MOST RECENT DEPLOYMENT. Please mark how much you agree or disagree with each statement. If you spend time in more than one family setting, please answer these questions about the family in which you spend the greatest amount of time.

- Strongly disagree = 1
- Somewhat disagree = 2
- Neither agree nor disagree = 3
- Somewhat agree = 4
- Strongly agree = 5

Since returning...

1. ...my input is sought on important family decisions.
2. ...I feel like I fit in with my family.
3. ...family members know what I think and how I feel about things.
4. ...I feel like my contributions to my family are appreciated.
5. ...I share many common interests and activities with family members.
6. ...my opinions are valued by other family members.
7. ...I am affectionate with family members.
8. ...I play an important role in my family.
9. ...I spend as much of my free time with family members as possible.
10. ...family members tell me when they are having a problem.
11. ...I can be myself around family members.
12. ...I get along well with my family members.

***Drug Use Disorders Identification Test (DUDIT)***

Here are a few questions about drugs. Please answer as correctly and honestly as possible by indicating which answer is right for you.

1. How often do you use drugs and alcohol? (See list of drugs on back side.)	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often
2. Do you use more than one type of drug on the same occasion?	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often
3. How many times do you take drugs on a typical day when you use drugs?	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often
4. How often are you influenced heavily by drugs?	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often
5. Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often
6. Has it happened, over the past year, that you have not been able to stop taking drugs once you started?	Never Once a month or less often 2-4 times a month

	2-3 times a week 4 times a week or more often
7. How often over the past year have you taken drugs and then neglected to do something you should have done?	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often
8. How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often
9. How often over the past year have you had guilt feelings or a bad conscience because you used drugs?	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often
10. Have you or anyone else been hurt (mentally or physically) because you used drugs?	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often
11. Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?	Never Once a month or less often 2-4 times a month 2-3 times a week 4 times a week or more often



## APPENDIX I: MILWAUKEE PROMPT WEEKLY SURVEY

## Brief Weekly Survey

Participants have the option to receive the weekly survey on the QRF (Quick Reaction Force) Smartphone app or to be sent a link through their email with the results stored in REDCap. This preference is asked during the baseline survey.

1. Are you feeling good about yourself overall this week?	Choices: Yes, No, Maybe
2. Have you engaged in any risky behavior (as you define it) this week?	Choices: Less, Same, More
3. How strong were your cravings this week?	Choices: Less, Same, More
4. How stressful has this week been?	Choices: Less, Same, More
5. Has your health changed this week?	Choices: Better, Same, Worse
6. How well did you sleep this week?	Choices: Better, Same, Worse
7. Did your Dryhooch peer mentor talk to you this week?	Choices: Yes, No  If Yes, we talked: Face-to-Face, Phone, Text, Social Media

\* These questions are adapted from the existing iPeer app in order to push weekly check-in surveys to the veteran participants. The app has been updated with an opioid-focused question and it is running on Apple and Android phones.

**APPENDIX J: PEER MENTOR FOCUS GROUP GUIDING QUESTIONS**

1. How has your understanding of peer mentoring changed during the PROMPT project?
  - a. How did you think about peer mentoring when the project started?
  - b. How do you think about peer mentoring now?
  - c. What has changed?
2. What different type of strategies did you use in your work with participants?
3. How/did your prior life experiences help you related to people in recovery?
4. How would you describe your relationships with your peer mentees during the mentoring process?
5. How did peer mentoring impact your own journey of recovery?
6. What was challenging and what went well with the protocols and procedures of the PROMPT project?
  - a. Consent
  - b. Computers
  - c. Redcap weekly surveys
  - d. Gift cards
  - e. Other project team members who you occasionally interacted with
  - f. Other
7. What stood out to you as particularly useful in the OUD training manual? What was missing or needs improvement? What aspects of the training program worked best or did not work best?
8. What do you feel you did well during the PROMPT project?
9. What do you feel you need to improve on for future peer mentoring?
10. Was there ever a time when you were afraid or unsure in the program?
11. What was your proudest moment in the program?
12. What would you like to see different about this program if anything?
13. Can you give an example of a time that you felt you had an impact on someone during the PROMPT project?
14. Is there anything else you want to share about your experience with the PROMPT project?

## APPENDIX K: EMERGENCY RESPONSE PROTOCOL

Mental Health Category	Early Warning Signs	Response Action	Signs of Relapse	Resources to Provide
<b>Normal</b>	<ul style="list-style-type: none"> <li>• Calm</li> <li>• Attentive</li> </ul>	N/A	N/A	Meeting with peer mentor specialist
<b>Elevated</b>	<ul style="list-style-type: none"> <li>• Rapid breathing</li> <li>• Clenching fists</li> <li>• Grinding teeth</li> <li>• Feeling hot or flushing</li> </ul>	<ul style="list-style-type: none"> <li>• Redirect conversation</li> <li>• Refocus on a different topic/object</li> <li>• Prompt person to use coping skills</li> </ul>	<ul style="list-style-type: none"> <li>• Poor self-care</li> <li>• Isolation</li> <li>• Uncomfortable Emotions/H.A.L.T (Hungry, Angry, Lonely, Tired)</li> </ul>	MHA staff have emergency cell phones which can be utilized by individuals at risk 24/7.
<b>Escalated</b> (Alert Stage 1)	<ul style="list-style-type: none"> <li>• Negative talk</li> <li>• Fidgeting</li> <li>• Yelling</li> <li>• Throwing object(s)</li> <li>• Storming out of the room</li> </ul>	<ul style="list-style-type: none"> <li>• Validate feelings</li> <li>• Offer to take a break/step outside</li> <li>• Go outside with veteran if he/she leaves the room</li> <li>• Offer post-session debrief or follow-up</li> </ul>	<ul style="list-style-type: none"> <li>• Talk of new difficulties such as sleep, finances, weight loss</li> <li>• Talking about cravings</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Assessment with MHA First Step Detox</li> <li>• Recovery Village Hotline</li> </ul>
<b>Exacerbated</b> (Alert Stage 2)	<ul style="list-style-type: none"> <li>• Negative talk</li> <li>• Yelling</li> <li>• Pacing</li> <li>• Throwing object(s)</li> </ul>	<ul style="list-style-type: none"> <li>• Validate feelings</li> <li>• Offer to take a break/step outside</li> <li>• Offer post-session debrief or follow-up</li> <li>• Inquire about person's supports</li> <li>• Schedule appointment with therapist</li> </ul>	<ul style="list-style-type: none"> <li>• Flu-like symptoms</li> <li>• Talking about drug use</li> </ul>	<ul style="list-style-type: none"> <li>• MHA Treatment</li> <li>• Level of Care Assessment</li> <li>• Day Treatment</li> <li>• IOP/Outpt Treatment</li> </ul>
<b>Emergent</b> (Seek Emergency Care)	<ul style="list-style-type: none"> <li>• Panicked</li> <li>• Aggressive</li> </ul>	<ul style="list-style-type: none"> <li>• Inquire about person's supports</li> <li>• Schedule emergency appointment with therapist</li> <li>• Seek nearby assistance</li> <li>• Call crisis line</li> </ul>	<ul style="list-style-type: none"> <li>• Slurred speech</li> <li>• Shallow breathing</li> <li>• Uncontrollable craving</li> </ul>	Use of Narcan and/or call 911
<b>Crisis</b> (Eminent Danger)	<ul style="list-style-type: none"> <li>• Belligerent</li> <li>• Combative</li> <li>• Violent</li> </ul>	<ul style="list-style-type: none"> <li>• Exit the room and get to safety</li> <li>• Call family and/or support person</li> <li>• Call 911</li> </ul>	<ul style="list-style-type: none"> <li>• Chest pain</li> <li>• Confusion</li> <li>• Overdosed</li> </ul>	Use of Narcan and/or call 911

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