

## A Comparison of Three ACT Teams in Maine & New Zealand

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May 17, 2012  
ACT Association Annual Conference  
Boston, MA

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## Characteristics of the Clinical Population

- Severe and persistent mental illness
- Co-occurring disorders
- High vulnerability to stress, frequent crises
- Difficulty with interpersonal relationships
- Deficiency in basic life skills
- Dependency on hospitals or family
- Poor transfer of learning from hospital to community

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## Basic Elements of ACT

- In vivo services
- Primary responsibility
- Team approach
- Flexible services
- Emphasis is placed on home visits and interventions in the community
- The team takes ultimate professional responsibility for participants' well-being in all areas.
- All of the staff work with all of the clients
- NOT "one size fits all. Service plans are individualised and client-driven

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## Basic Elements of ACT

- Time unlimited
- 24/7 availability
- Shared Caseload
- Multidisciplinary Staffing
- As long as the need is there
- A conscious effort to help people avoid crisis situations in the first place, and to resolve their crises without going back to the hospital
- Participant to staff ratio is low enough to allow the ACT team to perform all or most services for the majority of clients.

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## ACT Team Members

- Administrative Support Staff
- Social Workers (or MHRT)
- Nurses
- Psychologists (or LCSW, LCPC)
- Vocational Specialist/Occupational Therapist
- Drug and Alcohol Specialist (LADC)
- Psychiatrist
- Peer Support Specialist

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## ACT Team Size

- 8-12 persons, not inc. the secretary or psychiatrist
- For every 50 clients:
  - One half-time psychiatrist
  - One full-time nurse
  - One full-time substance abuse specialist
  - One full time vocational specialist
- Caseload of 10-12 clients
  - Team leader and nurse carry 1/2 caseload
  - Psychiatrist does not have a caseload

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### Treatment Principles & Concepts of Importance to ACT Teams

- Team members cross-train
- Shared responsibility
- Recovery model
- Strengths-based approach
- Stress-vulnerability
- Client-centered treatment planning

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### Principles for Working with ACT Clients

- Engagement - Use an Assertive Approach
- Careful and Continuous Clinical Assessment
- Capitalize on Client Strengths
- Tailor Programming to Individual Needs
- Relate to Clients as "Responsible Citizens"

Note: these principles have also become accepted in standard case management.

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### Principles for Work within the Community

- Use an Assertive Approach
- Use a Wide Variety of Community Resources
- Provide Support and Education to Community Members
- Retain Responsibility for Client Care

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## Principles for Working with ACT Families

- Proactive approach to problem solving
- Psychoeducation
- Collaboration
- Understanding

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## Service Components

- Medication support
- Psychosocial Treatment
- Community Living Skills
- Crisis Stabilization
- Housing Assistance
- Employment
- Family Involvement
- Health Promotion

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## Monitoring ACT Processes

- Fidelity to the Program Model and Program Standards
  - DACT Fidelity Scale
  - INFACT Scale
- Consumer Outcomes
  - Satisfaction Surveys
  - Axis V GAF scores
  - Hospital Admissions, Total Hospital Days (Average/client)
  - % of clients employed

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**Assertive Community Treatment Fidelity Scale**

Program \_\_\_\_\_ Respondent # \_\_\_\_\_ Role \_\_\_\_\_ Interviewer \_\_\_\_\_ Date \_\_\_\_\_

CRITERION	RATINGS / ANCHORS				
	(1)	(2)	(3)	(4)	(5)
<b>HUMAN RESOURCES: STRUCTURE &amp; COMPOSITION</b>					
H1 SMALL CASELOAD: Client/provider ratio of 10:1.	50 clients/clinician or more.	35 - 49	21 - 34	11 - 20	10 clients/clinician or fewer
H2 TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.	Fewer than 10% of clients with multiple staff face-to-face contacts in reporting 2-week period.	10 - 30%.	37 - 63%.	64 - 92%.	90% or more clients have face-to-face contact with > 1 staff member in 2 weeks.
H3 PROGRAM MEETING: Program meets frequently to plan and review services for each client.	Program service-planning for each client usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least 1 time/week but less often than 4 times/week.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.
H4 PRACTICING TEAM LEADER: Supervisor of front-line clinicians provides direct services.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup.	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25% and 50% time.	Supervisor provides services at least 50% time.
H5 CONTINUITY OF STAFFING: Program maintains same staffing over time.	Greater than 80% turnover in 2 years.	60-80% turnover in 2 years.	40-50% turnover in 2 years.	20-30% turnover in 2 years.	Less than 20% turnover in 2 years.
H6 STAFF CAPACITY: Program operates at full staffing.	Program has operated at less than 50% of staffing in past 12 months.	50-64%	65-79%	80-94%	Program has operated at 85% or more of full staffing in past 12 months.
H7 PSYCHIATRIST ON STAFF: There is at least one full-time psychiatrist per 100 clients assigned to work with the program.	Program for 100 clients has less than .10 FTE regular psychiatrist.	.10-.39 FTE per 100 clients.	.40-.69 FTE per 100 clients.	.70-.99 FTE per 100 clients.	At least one full-time psychiatrist is assigned directly to a 100-client program.

DRAFT 2002 ASSERTIVE COMMUNITY TREATMENT FIDELITY SCALE 1

**Assertive Community Treatment Fidelity Scale**

Program \_\_\_\_\_ Respondent # \_\_\_\_\_ Role \_\_\_\_\_ Interviewer \_\_\_\_\_ Date \_\_\_\_\_

CRITERION	RATINGS / ANCHORS				
	(1)	(2)	(3)	(4)	(5)
H8 NURSE ON STAFF: There are at least two full-time nurses assigned to work with a 100-client program.	Program for 100 clients has less than .20 FTE regular nurse.	.20-.39 FTE per 100 clients.	.40-.59 FTE per 100 clients.	.60-.79 FTE per 100 clients.	Two full-time nurses or more are members of a 100-client program.
H9 SUBSTANCE ABUSE SPECIALIST ON STAFF: A 100-client program includes at least two staff members with 1 year of training or clinical experience in substance abuse treatment.	Program has less than .20 FTE SIA expertise per 100 clients.	.20-.39 FTE per 100 clients.	.40-.59 FTE per 100 clients.	.60-.79 FTE per 100 clients.	Two FTEs or more with 1 year SIA training or supervised SIA experience.
H10 VOCATIONAL SPECIALIST ON STAFF: The program includes at least two staff members with 1 year training/experience in vocational rehabilitation and support.	Program has less than .20 FTE vocational expertise per 100 clients.	.20-.39 FTE per 100 clients.	.40-.59 FTE per 100 clients.	.60-.79 FTE per 100 clients.	Two FTEs or more with 1 year voc. rehab. training or supervised VR experience.
H11 PROGRAM SIZE: Program is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage.	Program has fewer than 2.5 FTE staff.	2.5 - 4.9 FTE	5.0 - 7.4 FTE	7.5 - 9.9	Program has at least 10 FTE staff.
<b>ORGANIZATIONAL BOUNDARIES</b>					
O1 EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has used measurable and operationally defined criteria to screen out inappropriate referrals.	Program has no set criteria and takes all types of cases as determined outside the program.	Program has a generally defined mission but the admission process is dominated by organizational convenience.	The program makes an effort to seek and select a defined set of clients but accepts most referrals.	Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	The program actively recruits a defined population and all cases comply with explicit admission criteria.

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Assertive Community Treatment Fidelity Scale

Program \_\_\_\_\_ Respondent # \_\_\_\_\_ Role \_\_\_\_\_ Interviewer \_\_\_\_\_ Date \_\_\_\_\_

CRITERION	RATINGS / ANCHORS				
	(1)	(2)	(3)	(4)	(5)
<b>02 INTAKE RATE:</b> Program takes clients in at a low rate to maintain a stable service environment.	High monthly intake rate in the last 6 months a greater than 15 clients/month.	13-15	10-12	7-8	Highest monthly intake rate in the last 6 months a greater than 8 clients/month.
<b>03 FULL RESPONSIBILITY FOR TREATMENT SERVICES:</b> In addition to case management, program directly provides psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.	Program provides no more than case management services.	Program provides one of five additional services and refers externally for others.	Program provides two of five additional services and refers externally for others.	Program provides three or four of five additional services and refers externally for others.	Program provides all five of these services to clients.
<b>04 RESPONSIBILITY FOR CRISIS SERVICES:</b> Program has 24-hour responsibility for covering psychiatric crises.	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for program clients.	Program is available by telephone, predominantly in consulting role.	Program provides emergency service (e.g., program is called, makes decision about need for direct program involvement).	Program provides 24-hour coverage.
<b>05 RESPONSIBILITY FOR HOSPITAL ADMISSIONS:</b> Program is involved in hospital admissions.	Program has involvement in fewer than 5% decisions to hospitalize.	ACT team is involved in 5% - 24% of admissions.	ACT team is involved in 25% - 54% of admissions.	ACT team is involved in 55% - 74% of admissions.	ACT team is involved in 75% or more admissions.
<b>06 RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING:</b> Program is involved in planning for hospital discharges.	Program has involvement in fewer than 5% of hospital discharges.	5% - 24% of program client discharges are planned jointly with the program.	25 - 54% of program client discharges are planned jointly with the program.	55 - 74% of program client discharges are planned jointly with the program.	75% or more discharges are planned jointly with the program.

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ASSERTIVE COMMUNITY TREATMENT FIDELITY SCALE

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Program \_\_\_\_\_ Respondent # \_\_\_\_\_ Role \_\_\_\_\_ Interviewer \_\_\_\_\_ Date \_\_\_\_\_

CRITERION	RATINGS / ANCHORS				
	(1)	(2)	(3)	(4)	(5)
<b>07 TIME-UNLIMITED SERVICES (GRADUATION RATE):</b> Program rarely closes cases but remains the point of contact for all clients as needed.	More than 90% of clients are expected to be discharged within 1 year.	From 33-40% of clients are expected to be discharged within 1 year.	From 15-37% of clients are expected to be discharged within 1 year.	From 4-17% of clients are expected to be discharged within 1 year.	All clients are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.
<b>NATURE OF SERVICES</b>					
<b>S1 COMMUNITY-BASED SERVICES:</b> Program works to monitor status, develop community living skills in the community rather than the office.	Less than 20% of face-to-face contacts in community.	20 - 38%.	40 - 60%.	65 - 72%.	80% of total face-to-face contacts in community.
<b>S2 NO DROPOUT POLICY:</b> Program retains a high percentage of its clients.	Less than 50% of the caseload is retained over a 12-month period.	50-64%.	65-76%.	80-84%.	85% or more of caseload is retained over a 12-month period.
<b>S3 ASSERTIVE ENGAGEMENT MECHANISMS:</b> As part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g., probation/parole, OP commitment) as indicated and as available.	Program passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms.	Program makes initial attempts to engage but generally focuses efforts on most motivated clients.	Program attempts outreach and uses legal mechanisms only as convenient.	Program usually has plan for engagement and uses most of the mechanisms that are available.	Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.
<b>S4 INTENSITY OF SERVICE:</b> High total amount of service time as needed.	Average of less than 15 min/week or less of face-to-face contact per client.	16 - 40 minutes / week.	50 - 84 minutes / week.	85 - 119 minutes / week.	Average of 2 hours/week or more of face-to-face contact per client.

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ASSERTIVE COMMUNITY TREATMENT FIDELITY SCALE

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**Assertive Community Treatment Fidelity Scale**

Program \_\_\_\_\_ Respondent # \_\_\_\_\_ Role \_\_\_\_\_ Interviewer \_\_\_\_\_ Date \_\_\_\_\_

CRITERION	RATINGS / ANCHORS				
	(1)	(2)	(3)	(4)	(5)
<b>S4</b> <b>FREQUENCY OF CONTACT:</b> High number of service contacts as needed.	Average of less than 1 face-to-face contact / week or fewer per client.	1 - 2 / week.	2 - 3 / week.	3 - 4 / week.	Average of 4 or more face-to-face contacts / week per client.
<b>S5</b> <b>WORK WITH INFORMAL SUPPORT SYSTEM:</b> With or without client present, program provides support and skills for client's support network: family, landlords, employers.	Less than 3 contacts per month per client with support system.	3-4 contact per month per client with support system in the community.	1-2 contact per month per client with support system in the community.	2-3 contacts per month per client with support system in the community.	Four or more contacts per month per client with support system in the community.
<b>S7</b> <b>INDIVIDUALIZED SUBSTANCE ABUSE TREATMENT:</b> One or more members of the program provide direct treatment and substance abuse treatment for clients with substance use disorders.	No direct, individualized substance abuse treatment is provided by the team.	The team variably addresses SA concerns with clients; no formal, individualized SA treatment provided.	While the team integrates some substance abuse treatment into regular client contact, they provide no formal, individualized SA treatment.	Some formal, individualized SA treatment is offered; clients with substance use disorders spend less than 24 minutes/week in such treatment.	Clients with substance use disorders spend, on average, 24 minutes / week or more in formal substance abuse treatment.
<b>S8</b> <b>DUAL DISORDER TREATMENT GROUPS:</b> Program uses group modalities as a treatment strategy for people with substance use disorders.	Fewer than 5% of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.	5 - 10%	10 - 25%	35 - 45%	20% or more of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.

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ASSERTIVE COMMUNITY TREATMENT FIDELITY SCALE

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**Assertive Community Treatment Fidelity Scale**

Program \_\_\_\_\_ Respondent # \_\_\_\_\_ Role \_\_\_\_\_ Interviewer \_\_\_\_\_ Date \_\_\_\_\_

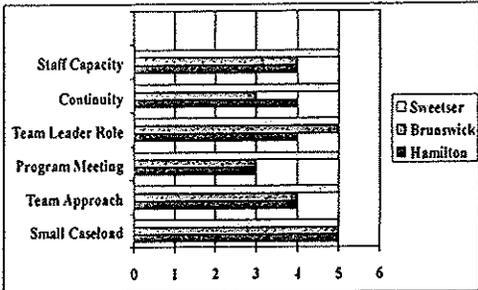
CRITERION	RATINGS / ANCHORS				
	(1)	(2)	(3)	(4)	(5)
<b>S9</b> <b>DUAL DISORDERS (DD) MODEL:</b> Program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence.	Program fully based on traditional model; confrontation; mandated abstinence; higher power, etc.	Program uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for persuasion of clients in denial or who don't fit AA.	Program uses mixed model: e.g., DD principles in treatment plans; refers clients to persuasion groups; uses hospitalization for rehab; refers to AA, NA.	Program uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalize for rehab, nor detox except for medical necessity; refers out some s/o treatment.	Program fully based in DD treatment principles, with treatment provided by program staff.
<b>S10</b> <b>ROLE OF CONSUMERS ON TREATMENT TEAM:</b> Consumers are involved as members of the team providing direct services.	Consumers have no involvement in service provision in relation to the program.	Consumer(s) fill consumer-specific service roles with respect to program (e.g., sefhelp).	Consumer(s) work part-time in case-management roles with reduced responsibilities.	Consumer(s) work full-time in case management roles with reduced responsibilities.	Consumer(s) are employed full-time as clinicians (e.g., case managers) with full professional status.

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ASSERTIVE COMMUNITY TREATMENT FIDELITY SCALE

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### Human Resources Fidelity 1




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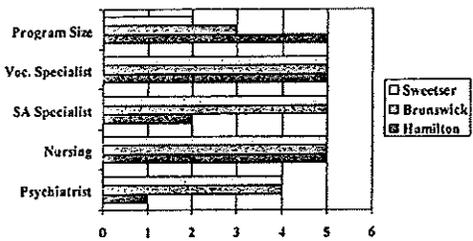
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### Human Resources Fidelity 2




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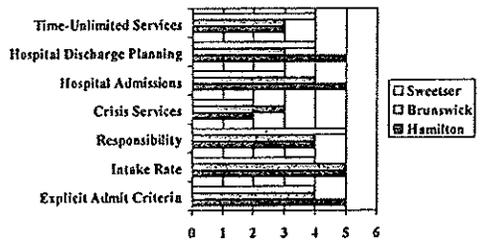
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### Organizational Boundaries Fidelity




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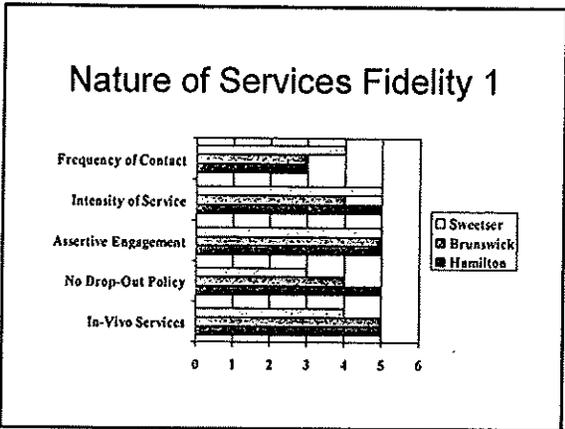
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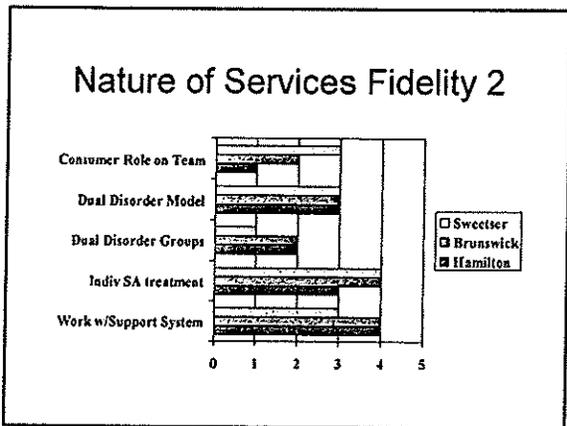
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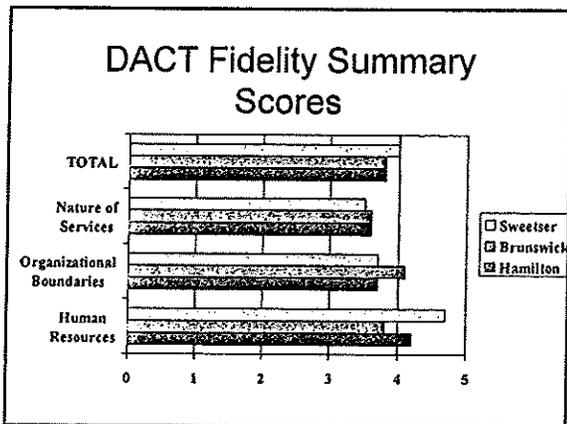
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## 2012: Challenges for ACT Teams

- Maintaining low caseloads
- Recruitment of ACT team clinicians
- Funding – reimbursement for ACT services
- Defining and monitoring outcomes
- Paperwork/documentation requirements
- Fidelity vs. Flexibility: what works best in your community?
- Service integration - collaboration with other providers and other evidence-based practices

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2. Bond GR, Drake, Mueser & Latimer (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on Patients. *Disease Management & Health Outcomes*, 9:141-159.
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4. Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, 68, 216-232.
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## **Intentional Peer Support: What Makes it Unique?**

Formalized peer\* support is springing up everywhere and is currently considered a critical ingredient in a “recovery-oriented” system of care as defined by the President’s New Freedom Commission Report. But peer support has not yet clearly defined itself in terms of its unique contribution. Intentional peer support attempts to actively use reciprocal relationships to redefine help, with a goal of building community oriented (natural) help rather than simply creating another formal service.

### **How does it work?**

Over and over we hear from people that when they’ve met someone who’s had a similar life experience, they feel an immediate sense of connection (e.g. she/he “gets it”). When there’s no assumption of power over, or expert/recipient many people become willing to hear/think/see in new ways. However, because peer support in some cases is part of a service team (even as its own organization), it is not uncommon for peers to quickly default into traditional roles (one person is there to help another). We hear this in the language of “role modeling, peer support specialist, recovery specialist etc.” Intentional peer support is about relational change; a commitment to mutuality, negotiation, noticing power dynamics, and a transparent agreement that both people are there to learn through the process of their relationship. This starts with the very first contact and is carried through by an on-going process of self/relational assessment.

### **What specifically is the intention?**

The first task of intentional peer support is to consider how we’ve each “come to know what we know.” In the absence of this awareness (of how we have learned to think about our experiences, develop our beliefs, create our assumptions), we don’t have real choices. Because many of us have learned to understand our experiences as something that simply happens to us, we have become afraid of our own feelings/thoughts. Only when we can see that there are many ways to interpret our experiences do we have a choice about what to do and what’s possible.

With intentional peer support we share our stories in ways that help others consider how their beliefs and assumptions have created their reality, understanding, choices, and even their relationships. Although we may have had similar experiences, we listen for how people have learned to tell that particular story and ask questions that create space for reflection and awareness. We explain that we are not there to provide “help,” but rather to contribute to a conversation and a process where we actively challenge each other, and where “recovery” becomes a mutual, dynamic relational process and outcome.

The second task, mutuality, seems obvious, but in fact is quite difficult, especially when one person is getting paid. Mutuality, however, is a critical component and one that gets

*\*In this context, a peer refers to an individual who is receiving or has received services and supports related to the diagnosis of a mental illness and who is willing to self-identify on this basis with peers and in the community.*

frequently undermined. For example, mutuality should not be confused with feeling good just because you were helpful to someone else.

Many of us have spent a long time in the role of recipient. Our relationships have focused on our problems and our feelings, and other people in our lives have been there to listen, provide feedback, and even to offer answers. We have lost our ability to negotiate in meaningful ways and we have forgotten how to see ourselves as having value to someone else. Through the process of direct, honest, communication and dialogue, intentional peer support builds on a creative process; one in which both people learn and grow while continuously negotiating the terms of the relationship (and have responsibility for making it work).

The third task then becomes meaningful and fairly easy; helping each other move towards what we want, as opposed to away from what we don't. Intentional peer support is not a problem-focused relationship. When we begin to challenge our beliefs, understandings and assumptions, we open up to the possibility that we've spent entirely too long focusing on coping with problems and much less time envisioning what it is that we truly want. It is through this intentional process that we support and challenge each other to try on new ways of thinking and perceiving.

### **Isn't this an awful lot like professional services?**

No, actually it's more like a really good friend with whom you have a "coaching" relationship. In clinical relationships, even when there is collaboration, there can be no real mutuality. Most professions have specific boundary guidelines that prohibit the disclosure of any personal information, and all mental health professions have a treatment paradigm with pre-determined individual outcomes often defined by a person's illness. In intentional peer support, there is a commitment to relational outcomes that ultimately benefit both people. This focus on relational outcomes offers the possibility of personal but also social recovery.

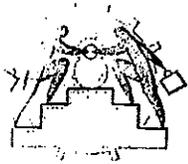
### **Aren't there a lot of possible risks with peer support?**

When people get together, there are always risks. That's why in intentional peer support it's important to negotiate relational safety early on. In other words, instead of waiting for a crisis to happen and then reacting from a position of power, responses are negotiated proactively. Both people, then, continue to place responsibility in the relationship rather than on each other. This idea has important implications for other systems involved in crisis response.

So all in all, intentional peer support is a way of life; a way of communicating that honors individual experience as well as relational growth. It is a system of giving and receiving that ultimately helps us build healthier communities all the way around.



*Developed and published by the Office of Consumer Affairs,  
Office of Adult Mental Health Services in consultation with  
Shery Mead with funding from Center for Medicaid  
Services June 2006*



# Maine



## Certified Intentional Peer Support Specialist

### Requirements for Earning and Maintaining Certification

#### 1. Intentional Peer Support Specialists Training

- Peer Support 101
- Application Process
  - Reviewed by consumers
- Web Training
  - Includes learning styles assessment
- 9-days classroom training
  - Must not miss more than five hours of classroom time.
- Completion of final test (six-weeks)
  - If test is not completed – entire training must be repeated.

#### 2. Quarterly Co-Supervision

- Co-Supervision 1 time per quarter - may attend more frequently.

#### 3. Continuing Education

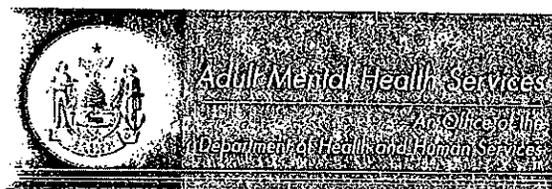
- Two continuing Education Classes Per Year

#### 4. 72-hours of Peer Support per year

- Documented quarterly.

#### 5. Certification is issued upon completion of all requirements.

- Requirements must be met within one year of completion of Peer Support Specialists Training.
- Co Supervision, Continuing Education and 72-hours Peer Support requirements must be met each year to maintain yearly certification.



# Intentional Peer Support

## The Four Task of Peer Support

1. Building Connection
2. Worldview – Helping each other understand how we've come to know what we know
3. Mutuality – Redefining help as a co-learning and growing process.
4. To help each other move Towards what we want rather than away from what we don't want.

(Be With Me Today!)

### Listening Differently

1. Listen from a position of not knowing. (Make no assumptions)
2. Listen for the untold story.
3. Validation/Reflection vs. Problem Solving. (Avoid "Fixing")
4. Ask questions that open up the story.
5. Share relevant personal change story, if need be.

### Remember: Stay Peer

- What I am feeling right now?
- Whose need am I trying to meet?
- What's making me uncomfortable?
- Am I doing assessments or evaluations?
- Am I being honest and owning my part?
- Am I listening for the "larger story"?

## Mutual Responsibility

1. Consider Worldview
2. Say what you see
3. Check it out
4. Say what you feel about it
5. Say what you need (for you, not from him or her)
6. Request it from the other person

To achieve Mutual Responsibility, I need to:

- Have an awareness of my worldview
- Understand the worldview of the other person
- Verbalize both and hold them as equally valid
- Discuss what we see, feel, and need
- Move to where we both take responsibility

Here are some questions, words and catch phrases that may help open up the story:

- I wonder...
- Help me understand...
- How did you learn...
- What makes that so... (Hard, scary...)
- How would you like it to turn out?
- What can we do to get there?

## *Giving and Receiving Critical Feedback*

### *Giving:*

1. *Ensure Connection*
  - \*Ask Permission*
2. *Strive for Mutuality*
  - \*Awareness of Power*
  - \*Frame around observation rather than judgment*
  - \*Check it out*
3. *Consider both of your worldviews*
  - \*Ask "Is this a reflection of my privilege or bias?"*
4. *Move Towards...*
  - \*Focus on Positive*
  - \*Agree on "Where to go from here"*

### *Receiving:*

1. *Be Aware of your defenses*
2. *Remember there is a grain of truth in all critical feedback*
3. *Be open to the other's worldview*
4. *Ask "In the light of this feedback, is there something for me to move towards?"*

# OPENING UP THE STORY

I WONDER...

- I wonder how that feels...
- I wonder why she/he did that...
- I wonder how they felt...
- I wonder what you would tell a friend in the same situation?

HELP ME UNDERSTAND...

- Help me understand what that feels like...
- Help me understand how that might look...

HOW DID YOU LEARN...

- That when things get loud, someone's gonna get hurt
- That when things get hectic I want to kill myself
- When I get overwhelmed, I need to go to the ED

~~WHAT MAKES THAT SO...~~

HARD or SCARY or HURTFUL or DISAPPOINTING?

HOW WOULD YOU LIKE IT TO TURN OUT?

WHAT WOULD YOU LIKE TO SEE HAPPEN?

WHAT CAN WE DO TO GET THERE?

WHAT WOULD YOU HAVE TO BELIEVE TO BEGIN?