

4D

Peer Orientation Packet

WELCOME TO THE 4D PEER MENTOR PROGRAM

The purpose of this Orientation Handbook is to acquaint you with our problem peer mentor program. Being well informed will help you have a more successful experience with the program. Please read this handbook carefully.

Our project staff and peer mentors welcome you to our program. It is our desire to provide the learning experiences and support you deserve and that your experience with the program be personally insightful, educational, and positive. We are here to assist you toward the completion of your recovery goals.

WHAT IS A CERTIFIED RECOVERY MENTOR

A Certified Recovery Mentor (CRM) is an addiction treatment and/or recovery consumer who has been trained and certified to help other consumers identify and achieve self-determined goals of recovery. The CRM cultivates the consumer's ability to make informed, independent choices, and assists consumers in gaining information and support from the community. As a CRM, an individual accepts and agrees that his or her experience as an addiction consumer of treatment or broader recovery community self-help or other recovery oriented services will be known by their colleagues, consumers and others with whom s/he may share that s/he has achieved this certification.

WHAT ARE CERTIFIED RECOVERY MENTOR PEER DELIVERED SERVICES

"Certified Recovery Mentor - Peer Delivered Services" means an array of agency or community based services and supports provided by Certified Recovery Mentors, to individuals or family members with similar lived experience, that are designed to support the needs of individuals and families as applicable. Certified Recovery Mentors must complete an Oregon Health Authority, Addictions and Mental Health Division (AMH) approved addiction training program (peer delivered services) and for the 4D peer mentor program be: A self-identified person in recovery from a addiction disorder who has been free of substance abuse for at least two years.

INITIAL ASSESSMENT

An initial orientation and assessment will mark the formal beginning of our program. The purpose of this orientation and assessment is to give you a brief introduction to the program, inform you of your rights as a program participant, and to complete the necessary paperwork for developing your recovery program.

NOTICE OF PRIVACY PRACTICES (HIPAA/CFR42p11)

**THIS NOTICE DESCRIBES HOW PARTICIPANT INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

PLEASE REVIEW IT CAREFULLY.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive through this program. Your health information may include information created and received by this program, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Federal and State law require your written consent each time we release health information. The Consent will specify who is to receive the information, the purpose of the release of information, and a time period after which the Consent will terminate. You may modify or revoke a Consent at any time.

We may use and disclose health information for the following purposes:

- **For Service Participation.** We may use health information about you to provide you with program services. With your written consent, we may disclose health information about you to doctors, nurses, office staff, or other personnel who are involved in taking care of you and your health. For example, while creating your recovery plan your Certified Peer Mentor might recommend that you address issues regarding grief and loss. The Mentor might share something of your clinical history with your treatment counselor to determine the most effective and appropriate activities for you.
- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive through this program may be billed to a third party. For example, we may need to tell the administrator of the grant that supports these services about your program involvement in order to obtain approval for extended program participation.
- **For Program Operations.** We may use and disclose health information about you with program supervisors and Certified Peer Mentor team leads in order to make sure that you and our other program participants receive quality services.

For example, we may use your health information to evaluate the performance of our staff and contractors in caring for you. We may also use health information about all or many of our participants to help us decide what additional services we should offer, how we can become more efficient, or whether certain new program elements are effective. We may also disclose your health information to

the funding bodies that support the Peer Mentor Program. Our disclosures of your health information to funders and other providers may be for the purpose of helping these agencies and providers improve care, reduce costs, coordinate and manage health care and services, train staff, and comply with the law.

- **Appointment Reminders & Check-ins.** We may contact you as a reminder that you have an appointment and/or for checking in to see how you are doing.
- **Services Alternatives.** We may tell you about or recommend possible assistance options or alternatives that may be of interest to you. These recommendations will be based on your recovery and health information.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations and without your written consent:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state, or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.
- **Military Veterans National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order subject to all applicable legal requirements.
- **Law Enforcement.** We may release health information if required to do so by a law enforcement official in response to a court order, subject to all applicable legal requirements.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your designated emergency contact person in situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as clinical and billing records, that we keep and use to make decisions about your care. You must submit a written request in order to inspect and/or copy records of your health information. If you request a copy of the information, you will be charged a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and/or copy your health information in certain, limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as this office keeps the information. To request an amendment, complete a CLINICAL RECORD AMENDMENT/CORRECTION FORM and submit it to our office. We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
 - We did not create, unless the person or entity that created the information is no longer available to make the amendment.
 - Is not part of the health information that we keep.
 - You would not be permitted to inspect and copy.
 - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures”. This is a list of disclosures we made of clinical information about you for purposes **other** than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions, and law enforcement. The list will also **exclude** any disclosures we have made based on your written authorization.

To obtain this list, you must submit your request **in writing**. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free of charge. For additional lists, we may charge you the costs of providing

the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. To request restrictions, you must complete the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION form and submit it to our office. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Right to Request Confidential Communications.** You have the right to request we communicate with you about clinical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF CLINICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION form and submit it to our office. We will not ask you the reason for this request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for clinical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Eric Martin, Certified Peer Mentor Supervisor at (503) 231-8164, or to Tony Vezina, the 4D Executive Director at 971-703-4623 or Oregon Health Authority, Addictions and Mental Health Division, by calling (503) 945-6187. *You will not be penalized for filing a complaint.*

This is the last page of HIPAA required information.

Please continue reading for other information vital to your success in our program.

YOUR SPECIFIC RIGHTS AND PROTECTIONS AS A PEER MENTOR PROGRAM PARTICIPANT

PARTICIPANT RIGHTS

Informed Consent: Participation in the 4D Peer Mentor Program shall be voluntary. Participants will be informed of this right and asked to sign a Participant Consent Form as acknowledgement of their informed consent to program participation.

Informed Participation in Recovery Planning: The participant and others of the participant's choice shall be afforded an opportunity to participate in an informed way in planning the participant's receipt of and involvement in services, including significant procedures, and the review of progress toward recovery goals and objectives which shall include the right to be free from retaliation for exercising such right.

Civil and Human Rights: Each participant shall be assured the same civil and human rights as other persons.

Participant Privacy and Dignity: Participant privacy and dignity will be respected and protected to the fullest extent possible.

Adequate Services: Each participant is entitled to adequate service and care to include participation in his/her recovery planning, timely processing of records and reports, and that program participation not inflict unreasonable hardship, whenever possible.

Services Refusal: Each participant shall have the right to refuse service, or any specific procedure. If adverse consequences may result from refusing service, the participant will be notified verbally and, whenever possible, in writing what those consequences might be.

Access to Records: Participants have the right to obtain a copy of their records within five (5) business days of receipt of the written request and after making payment for the cost of duplication (\$5.00 plus \$.10 per page). Participant shall have reasonable access to their own record except: (a) when the Clinical Supervisor determines that disclosure of records would be detrimental to the participant's recovery; or, (b) if confidential information has been provided to the program on the basis that the information not be disclosed.

SPECIAL PROTECTIONS

Physical Punishment or Physical Abuse: Physical punishment or abuse **will not be tolerated**. Any such incident should immediately be reported to the Clinical Supervisor, Eric Martin 503-231-8164 or the 4D Executive Director, Tony Vezina at 971-703-4623.

Sexual Abuse or Contact: Sexual abuse or Sexual Contact between participants and staff.

Allowable Restrictions: No participant shall be denied services or discriminated against on the basis of age or diagnostic or disability category unless predetermined program criteria for service restrict the service to specific age or diagnostic group or disability group.

Barriers to Services: When there is a barrier to services due to culture, language, illiteracy, or disability, we shall develop to the best of our ability a holistic service approach including support services available to address or overcome those barriers including: (a) providing individuals to assist (*e.g.*, interpreters); (b) translation of materials to the appropriate language or method of communication; (c) providing assistive devices which minimize the impact of the barrier, to the degree possible (*e.g.*, sign language interpreter); acknowledging cultural and other values, to the degree possible, which are important to the program participant; (e) not charging participants for the cost of the measures, such as the provision of interpreters, that are required to provide nondiscriminatory treatment; (f) referring a program participant to another provider if the individual requires services outside our specialization.

Program Participant Work & Gift Policy: No program participant labor toward 4D activities will be required. Certified Recovery Mentors are not allowed to accept problem participant (mentee) labor or gifts that benefit the Certified Recovery Mentor.

NONDISCRIMINATION POLICY

We do not discriminate against any person on the basis of race, color, national origin, handicap, or age. This program operates in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1975, the Age Discrimination Act of 1975, and regulations of the U.S. Department of Health and Human Services. If you have questions about the accessibility of our programs or facility, need more information about this policy, or if you believe that discrimination has occurred, please contact our Operations Manager or the U.S. Department of Health and Human Services Office for Civil Rights: 1-800-368-1019 TTY: 1-800-537-7697.

DESCRIPTION OF SERVICES PROVIDED

INITIAL ASSESSMENT AND ORIENTATION

At the time of your first appointment, you will be asked to complete initial paperwork, after which you will meet with your Certified Recovery Mentor. At that time, the Certified Recovery Mentor will go over your paperwork with you, give you an overview of the program, and schedule your next meeting.

RECOVERY PLANNING

You will meet with your Certified Recovery Mentor who will talk over your recovery plan with you and discuss way the Peer Mentor Program can assist you with your recovery efforts. The length of your involvement with the Program will depend on your individual needs and desires along with the availability of program funding and/or any service restrictions placed by the program's funders.

RANGE OF SERVICES

Certified Recovery Mentors serve as a:

- motivator (exhibits bold faith in individual/family capacity for change; encourages and celebrates achievement)
- ally and confidant (genuinely cares, listens, and can be trusted with confidences)
- truth-teller (provides a consistent source of honest feedback regarding self-destructive patterns of thinking, feeling and acting)
- role model and mentor (offers his/her life as living proof of the transformative power of recovery; provides stage-appropriate recovery education and advice)

A RECOVERY MENTOR IS A:

- problem solver (identifies and helps resolve personal and environmental obstacles to recovery)
- resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support)
- advocate (helps individuals and families navigate the service system assuring service access, service responsiveness and protection of rights)
- community organizer (helps develop and expand available recovery support resources)

A RECOVERY MENTOR IS NOT A:

- sponsor (does not perform AA/NA step work)
- therapist (does not diagnose, probe undisclosed trauma/"issues"; does not refer to their support activities as "counseling" or "therapy")
- nurse/physician (does not make medical diagnoses or offer medical advice), or a
- priest/clergy (does not respond to questions of religious doctrine nor proselytize a particular religion/church)

EDUCATION

The educational process is a vital component of your recovery experience and a cornerstone of any successful recovery plan. Gathering accurate information and learning new perspectives about recovery, relapse prevention, and resources will be a large part of your program experience.

USE OF MOOD ALTERING DRUGS

It is necessary to be mentally, emotionally, and physically available to make successful changes in behavior and habits. The use of mood-altering drugs significantly hinders that process. I understand that I will not be allowed to participate in program groups or obtain other Certified Peer Mentor services while under the influence of alcohol or drugs that are not medically managed. If it is determined that the use of mood or mind-altering drugs are a source of problems in your life and negatively impacting your recovery from addiction problems, you will be referred for substance use treatment and supported in your recovery.

BUILDING YOUR RECOVERY CAPITAL

Recovery Capital is the sum total of all the personal, social, and community resources a person can draw on to begin and sustain his recovery from addiction problems. Recovery capital, or recovery capacity, differs from individual to individual and differs within the same individual at multiple points in time. Recovery capital also interacts with problem severity to shape the intensity and duration of supports needed to achieve recovery. This interaction dictates the intensity or level of care one needs in terms of professional treatment and the intensity and duration of post-treatment recovery support services. Persons with high problem severity but very high recovery capital may require few new resources to initiate and sustain recovery than an individual with moderate problem severity but very low recovery capital. Where the former may respond very well to outpatient counseling, linkage to recovery mutual aid groups and a moderate level of ongoing support, the latter may require a higher intensity of treatment, greater enmeshment in a culture of recovery (e.g., placement in a recovery home, greater intensity of mutual aid involvement, involvement in recovery-based social activities), and a more rigorous level of ongoing monitoring and support. To build your recovery capital, you will be encouraged and assisted in finding new “People, Places, and Things” to practice new recovery behaviors with. You will be encouraged to attend community support group sessions as a way to encourage new, healthy, drug-free relationships among like-minded individuals, in new situations, living without using.

Your Certified Recovery Mentor will offer assistance and support to you in building your recovery capital.

CLIENT GRIEVANCE

It is our goal to provide a program process in which misunderstandings and disagreements can be resolved during discussions based upon mutual respect and understanding. However, there may be occasions when a program participant feels that a policy or practice has been misinterpreted and the relationship with the Certified Recovery Mentor has become strained. If a participant wishes to file a grievance, the following steps should be followed for resolution:

Step 1

The program participant should always begin by discussing the situation with the Peer Mentor involved. Often there is simply a misunderstanding and this clarification step resolves the problem. The Peer Mentor will document this discussion in the program participant’s file.

Step 2

If a disagreement still exists following Step 1, the program participant may report the grievance to Eric Martin, Certified Peer Mentor Supervisor at (503) 231-8164, or to , the 4D Executive Director, Tony Vezina, at 971-703-4623. The program participant may be asked to file a written grievance during this phone call. This written grievance should be as concise as possible and include the exact details of the disagreement and specific objectives the program participant may have. Documents should be provided when appropriate.

Step 3

If the program participant is not satisfied with 4D response or has a grievance directly with 4D then they should contact the Oregon Health Authority, Addictions and Mental Health Division, by calling (503) 945-6187. OHA will contact the 4D Board and request a formal inquiry and resolution plan. The resolution plan will include follow-up discussion with the program participant by 4D’s executive staff and/or a representative. The outcome

of this meeting will be documented and will be the final resolution of the grievance. If your grievance is specific to the protection of your private health information subject to HIPAA regulations, you are entitled to further measures in the grievance process. Please refer to the HIPAA documentation included in this handbook.

OFFICE HOURS

4D Certified Recovery Mentors do not keep regular office hours. If you need to reach your Recovery Mentor email and they will get back to you as soon as they can. Speak with your Recovery Mentor to set up regular check-ins, appointments, or other activities.

EMERGENCY CONTACT

If you have a life crisis emergency and have a professional counselor, use them as your first resource. You can also contact your Recovery Mentor and if they are not immediately available then , please call the 24-hour, 7 days-a-week, Helpline at **800-923-4357**.

ACKNOWLEDGEMENT OF RECEIPT OF PARTICIPANT RIGHTS AND ORIENTATION INFORMATION

Please read the following statements, sign the Consent Form, acknowledging receipt of this orientation packet.

- ❖ I acknowledge receipt of the 4D Peer Mentor Program orientation information.
- ❖ I accept responsibility for reading and for complying with the requirements set forth therein.
- ❖ I understand that I am responsible for familiarizing myself with the requirements of this program.
- ❖ I understand that it is my responsibility to ask my peer mentor for clarification on any of this information I do not understand.