

PEOPLE FIRST

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IN THIS ISSUE:

Powerful Self-Help Tool Takes Hold in Pennsylvania

– By Elisa Ludwig

3

Pennsylvania is a leader in adopting and disseminating WRAP® (Wellness Recovery Action Plan), a recovery and wellness tool that transforms lives.

Participatory Dialogues Level the Playing Field for Clients and Providers

– By Elisa Ludwig

7

Allegheny and Chester counties promote SAMHSA's Participatory Dialogues, which create deeper understanding among individuals with mental health conditions, providers and other stakeholders.

Recovery and Little Green Apples – By Brian McLaughlin

10

Recalling his spiral into despair and back, the author – now a certified peer specialist – writes, "Any time someone is able to step outside themselves to help another, healing can take place for both of them."

PEOPLE FIRST

Volume 20, Number 1

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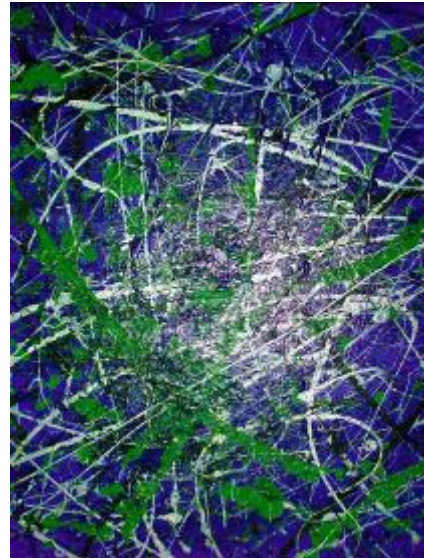
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for the Pennsylvania Department of Public Welfare**

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COVER ART:

"Politically Correct," tempera paint on canvas, by Katherine Redick. (Redick named her painting after it was displayed in the offices of Senator Robert P. Casey.)



The cover features a partial view of the painting, shown here in full.

Redick participates in the Magnificent Minds Project: <http://www.magnificentmindsproject.com>. Featured in "The Arts Inspire Mental Health Recovery" (*People First*, Summer 2011), the Project was created by Syngred D. Briddell-Watts, MSW, an artist and mental health professional. Participating artists have exhibited in galleries such as the Art Association of Harrisburg and the Mantis Collective Gallery, as well as in the Harrisburg Hilton Downtown (as part of the Festival of Hope organized by the Mental Health Association of the Capital Region), at Temple University, at the Dauphin County Music and Wine Festival, and at other sites. "The locations of all Magnificent Minds Project exhibits were spatial donations, made by those in the community who wished to join the fight against mental health stigma," Briddell-Watts said.

An online gallery, <http://www.magnificentminds.net>, solely devoted to displaying the work of Pennsylvania artists at no charge, was recently launched.

Have an opinion to share? Reaction to an article?
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Powerful Self-Help Tool Takes Hold in Pennsylvania

By Elisa Ludwig

When Mary Ellen Copeland developed the Wellness Recovery Action Plan (WRAP®), a tool that helps people work toward mental health recovery, she could not have predicted that, three decades later, it would become a nationally recognized best practice. Yet this past July, WRAP was officially entered into SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP), a list of scientifically proven and reviewed research projects on mental health initiatives.

This latest and most significant recognition for WRAP is based on a

randomized controlled trial, funded by the U.S. Department of Education, the National Institute on Disability and Rehabilitation Research, and the Substance Abuse and Mental Health Services Administration (SAMHSA). For eight weeks, researchers observed a thousand people across the state of Ohio; some of these individuals used WRAP immediately and some were scheduled to adopt it nine months later. A series of tests measured the outcomes, including recovery, empowerment, self-advocacy, social support, hopefulness, quality of life, symptoms, coping, stigma and physical health perceptions. The researchers found that WRAP recipients improved in terms of reduced psychiatric symptoms, increased hopefulness, decreased self-blame, improved quality of life and other factors. In fact, there was a direct correlation between the number of WRAP classes that participants attended and the benefits they saw.

The research supports what those working with WRAP have known for some time – that WRAP can promote real recovery. “We’ve been working on this research for about five years,” said Katie Wilson, director of marketing and special projects at the Copeland Center for Wellness and Recovery in Brattleboro, Vermont. “And for someone

the most important things about WRAP is that it’s a values-based practice and a self-help tool,” said Calhoun. “People can adopt it as they need to, to facilitate their own recovery.”

Lives Transformed

In Pennsylvania, WRAP has been adopted by countless individuals, many of whom have seen their lives transformed in the process. It has also been introduced at four hospitals across the state, Calhoun said. “Pennsylvania is one of the leaders in WRAP adoption. We offered voluntary trainings, and at all four hospitals people participating

WRAP has been adopted by countless individuals, many of whom have seen their lives transformed in the process.

who has personally worked with WRAP, it was great to see these positive results – though they weren’t entirely a surprise.”

Gina Calhoun, an advanced level WRAP facilitator and the Copeland Center’s director of wellness and recovery education, agrees: “The beauty of being included in the registry is that now we have the outcome and the evidence to say that it works.”

WRAP is a system for examining one’s own wellness needs and the triggers and early warning signs for the onset of illness. A WRAP plan can include a wellness toolbox, a daily maintenance plan, a crisis plan and post-crisis planning. “One of

in state hospital services, CEOs, doctors, staff and dieticians came. All of a sudden, people were able to step away from their role within the hospital and just be in the room, exploring what they do for wellness. It was a really cool experience,” she recalled.

As more individuals are developing WRAP plans, the mental health system has started to recognize their efficacy – and with that has come the need to address WRAP in policy terms. In December 2010, Sherry Snyder, acting deputy secretary of the Office of Mental Health and Substance Abuse Services (OMHSAS), sent a letter clarifying the agency’s position on

... continued on page 4

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WRAP: that individuals should have the right to choose whether or not to include a WRAP plan in their treatment plan, recovery plan or file. "Making the WRAP mandatory, or even strongly encouraging the development of a WRAP along with the expectation that it must be

aged care organizations and providers that want to effectively implement WRAP. "It is OMHSAS' expectation that every county have peer specialists who are trained in WRAP as well as peers who are trained as WRAP facilitators," the letter stated.

states like Pennsylvania move toward taking a closer look at evidence-based practices, we want to make sure that WRAP is being offered with fidelity," said Calhoun. "That's where the policy statement from OMHSAS comes in. It answers questions about who can actually

"It is OMHSAS' expectation that every county have peer specialists who are trained in WRAP as well as peers who are trained as WRAP facilitators."

included in the person's record, is contrary to the values and ethics of WRAP," the letter states.

However, the letter goes on to suggest possible approaches for counties, behavioral health man-

While WRAP is a self-directed, values-based concept, its effectiveness is also contingent on following certain principles; and, as WRAP grows, the Copeland Center is working to ensure that people have access to quality education. "As

facilitate WRAP and how much training you need." For instance, evidence has shown that people who have gone through five-day WRAP facilitator training were best skilled and able to promote the values of WRAP.



WRAP Around the World Conference, Philadelphia, August 1-3, 2011

(left to right) Gary Andricks, Audrey Garfield, Jean Rogers, Flora Releford, Michelle Maczka, Jane Winterling; (front) Margo McMahon

... continued on page 5

... continued from page 4

The Copeland Center is now offering WRAP refresher courses for existing facilitators, which it recommends they take once every two years. “These courses help people keep up with a growing body of knowledge out there and stay up to date with the new information,” said Calhoun.

International Impact

Celebrating the international impact of WRAP, the Copeland Center sponsored a WRAP Around the World conference, held in Philadelphia last August. The conference offered a wide range of sessions, from WRAP for people with eating disorders to finding funding for WRAP training. “The conference was an excellent time for us to bring together people from around the world who are using WRAP and have adapted it to what’s needed in their local community; people who are working with children or with specific populations could come together and share their experiences,” said Wilson. Judith Cook, Ph.D., the lead investigator of the Ohio research, was on hand to present the

Hospital, I still hadn’t heard the words ‘mental health recovery.’ It wasn’t until I went to Massachusetts and learned about WRAP that the possibility of recovery for my life really began to shine,” said Calhoun. “What was also important was that the facilitator kept telling us it was voluntary. I thought, ‘Man, I haven’t heard that word as it relates to my wellness in a long time.’ To witness people who had written a plan and were now passionate and satisfied within their lives made a huge difference. I sat down and began to write my plan. And just by writing, my brain shifted to wellness thinking. I knew I would implement it.”

Wilson, too, found that the introduction to WRAP was a life-changing experience. “The value was meeting with people who



Gina Calhoun

Director, Wellness and Recovery Education
Copeland Center for Wellness and Recovery

are without judging or pushing them in any specific direction.”

“We’re really witnessing people making changes in their lives.”

results of the study.

“What was neat was that we had people learning about WRAP for the first time alongside people who have been doing it for years,” Calhoun said. “WRAP facilitators were able to refresh their skills, and we here in Pennsylvania could see what other states are doing as far as implementing it into their systems.”

For Calhoun, the belief in the power of WRAP runs deep – and it’s based on her own experience. “Even after leaving Harrisburg State

viewed me with unconditional high regard. It was the first time I was on an even footing with people who were doing well when I was not,” Wilson said. “The fact that they could overcome what they had gone through opened up to me the hope that I could have whatever I wanted for my life. To me, what sets WRAP apart is that you’re meeting people who live by a code of ethics and values, and one of the greatest values is to accept people for who they are and where they

The possibilities for WRAP are just opening up. While WRAP has traditionally been adopted by individuals with mental illness, it can also be viewed as a way to engage communities. “If we can use WRAP not only as a tool for recovery and self-discovery but also as a way for people to be human beings moving toward wellness – whether it’s people participating in mental health services, stakeholders, family members or anyone – WRAP can be universal, and it can be a way to unify

... continued on page 6

“Our group in Ichikawa (Japan) is saying that WRAP is a common language in despite of differences in cultural background and language barriers.”

people,” Calhoun said.

What’s more, WRAP’s application may go well beyond the mental health system. “WRAP provides a framework for people who have challenges; whether it’s a personal or physical or mental health challenge, it gives you a way to help yourself. We’d like to see it used in more hospitals and elementary school settings; there are so many opportunities,” Wilson said.

Calhoun said that in the near future, she is also hoping to introduce WRAP to the children’s mental health system. “As a leader, as the

host of the conference, Pennsylvania is clearly moving forward. I’m looking forward to seeing how WRAP grows in the state from here on out. Being part of WRAP has been empowering – we’re really witnessing people making changes in their lives.”

WRAP in Japan

Others in Pennsylvania are taking WRAP across the world. In 2006, Jeanie Whitecraft of the Mental Health Association of South-eastern Pennsylvania traveled to Japan to teach an introduction to

WRAP. She had been advised that she might have to tailor her presentation to accommodate the natural reserve of the Japanese people. Instead, Whitecraft said, she found that “people were very enthusiastic and very much wanting to participate.” (Whitecraft’s trip was part of a two-year information exchange grant from the Center for Global Partnership of The Japan Foundation.)

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Jeanie Whitecraft on the cover of a Japanese magazine

Participatory Dialogues Level the Playing Field for Clients and Providers

By Elisa Ludwig

Imagine a circle of chairs. The people sitting on those chairs are referred to by their first names only – and although there are equal numbers of medical professionals and individuals with psychiatric diagnoses present, no one knows who is who. Two facilitators introduce a previously agreed-upon topic. Discussion – honest, personal, unedited, surprising – ensues.

In Pennsylvania, two counties have adopted what the Substance Abuse and Mental Health Services

Thompson, now chief medical officer at Recovery Innovations in Phoenix, Arizona, introduced the concept in Allegheny County in 1998, modeling it after a session in New York State that he had participated in. The committee followed suit in 2001.

A Powerful Experience

Recovery consultant Sarah Goldstein attended the first dialogue and found it a powerful experience, one that she immediately wanted to

facilitators to run their own dialogues. Notes from Allegheny County sessions are posted to www.coalitionforrecovery.org.

“In a clinical setting, there’s always a barrier and a power imbalance so people are often intimidated,” Goldstein said. “But in a dialogue, people are speaking from their heart. I think it’s important to learn how to talk to one another. It removes the stigma, it improves communication, and it improves cooperation and collaboration be-

“In a clinical setting, there’s always a barrier and a power imbalance so people are often intimidated. But in a dialogue, people are speaking from their heart.”

Administration (SAMHSA) refers to as Participatory Dialogue, enabling better conversation and deeper understanding among individuals with mental health conditions, providers and other stakeholders within a safe environment. Participatory dialogues encourage healthy conflict – disagreement without disagreeable behavior – and, most importantly, help to erode prejudice by giving faces and voices to mental health conditions.

Leading the charge in Pennsylvania is the Consumer-Provider Collaborative Committee, based in Allegheny County. Dr. Kenneth S.

help recreate for others. “From there, we worked toward developing more dialogues on a regular basis. In 2005 we joined the Allegheny County Coalition for Recovery,” said Goldstein, now the Consumer-Provider Collaborative Committee’s co-chair, along with Dr. Wesley Sowers, medical director of the Allegheny County Office of Behavioral Health.

Since 1998, there have been 40 dialogues in the county, generally between clients and providers, although family members are sometimes invited to participate. Goldstein has trained three groups of fa-

cause it helps you understand the other person’s role by hearing them speak about it. It breaks down the barriers.”

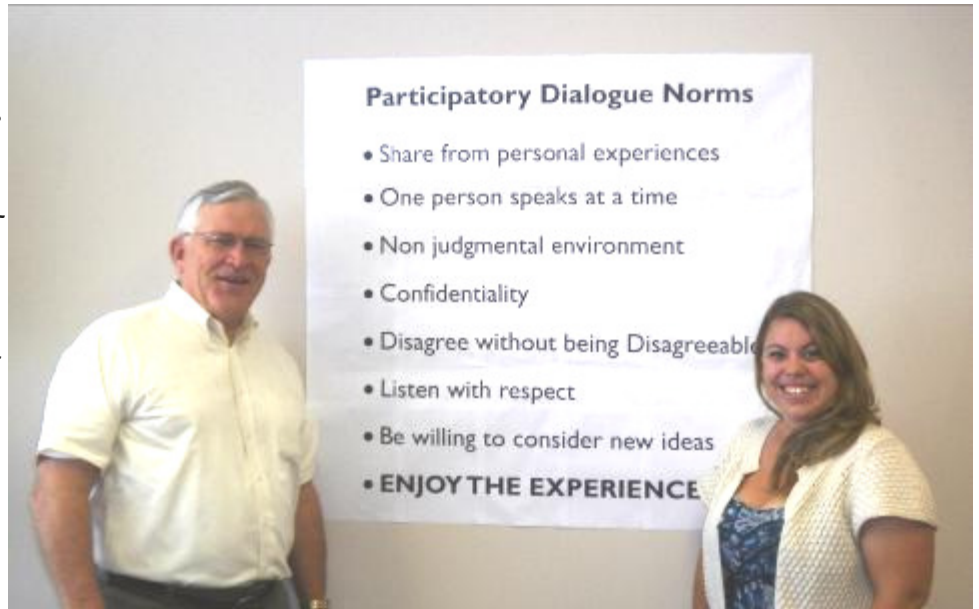
Goldstein is also quick to point out the difference between a dialogue and a meeting or focus group that might bring together clients and providers: “This is not about making repairs, or fixing what has been broken.” Yet dialogues can also lead to real change by encouraging partnerships between participants and helping to change attitudes and practices throughout the behavioral health care system and beyond.

... continued on page 8

Chester County

In 2006, Chester County followed Allegheny County's example, adopting participatory dialogues with training from Goldstein and Sowers. An initial Dialogue Committee supported by Community Care Behavioral Health and Compeer Chester County (a program of the Mental Health Association of South-eastern Pennsylvania) was convened, with 14 members – seven providers and seven clients – representing various agencies.

Largely responsible for Chester County's interest in the model, Compeer Chester County founding program director Rob Chisholm recalls that a fair amount of preparation went into the process, including staging a mock dialogue before opening the sessions up to guests. "We practiced internally before we held our first official dialogue," he said.



Rob Chisholm, founding director, Compeer Chester County (left), and Jamie Messersmith, care manager, Community Care Behavioral Health

spectrum can get together and discuss issues very candidly and respectfully," said Karl Schatz, who first attended a dialogue when he

In Chester County, an initial group of 40 to 50 people is divided into two smaller groups. There are two separate dialogues and then the

“People from different walks of life and different parts of the service spectrum can get together and discuss issues very candidly and respectfully.”

Jamie Messersmith, care manager at Community Care Behavioral Health, was an early convert to the power of fair and open exchange. "I was working in the mental health field as a coordinator of residential programs for adults, and I was invited to participate in the first dialogue," she said. "I was so enthused about the experience, about the fact that I could sit in a circle with clients and providers and have a conversation about a topic, that I knew I wanted to join the committee."

Another World

Dialogues can offer a rare glimpse into another world. "People from different walks of life and different parts of the service

was leaving a step-down program. "And all of these people who wear different shoes and hats when they walk out of the door become very similar during the time they're talking to each other."

In 2007, Messersmith joined the committee and was later elected to be its co-chair along with Karl Schatz. The committee meets monthly and plans topics for the semiannual dialogues, which sometimes emerge from a previous dialogue. Topics might include misconceptions about mental health recovery or what constitutes decent, affordable housing. Only invited participants can attend the event. Participants are chosen by the committee and invitations are delivered in person.

groups reunite for feedback and a wrap-up discussion.

Personal Transformation

"The common denominator is that most people walk away feeling that they have experienced something very unique," said Chisholm. "Whether it's a provider or a consumer, the takeaway is personal transformation. People walk away and go back to their roles changed in some way. It's the ultimate form of recovery, changing how we conduct ourselves in relationships."

"The idea is to have a genuine conversation without filtering yourself, without trying to be politically correct," Messersmith said. "It takes away the hierarchy. What we've found is that someone might come

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from their workplace as a doctor but when they're here they might share an experience that's personal, or from a family member."

In 2009, Messersmith and Chisholm introduced a new change to the Chester County program: while in the past dialogues had taken place only between mental health consumers and providers,

a crisis situation." In both cases, participants came away from the experience more open to others' points of view.

A Different Tone

Whereas police and other people who regularly encounter individuals with mental health conditions receive sensitivity training and

see the children's system involved in participatory dialogues, particularly at the age when youth transition into the adult system.

For his part, Chisholm would like to see more counties adopt the model, which he said is out there for the taking. "The dialogues really give people in recovery a new sense of recognition about their unique

"All of these people who wear different shoes and hats when they walk out of the door become very similar during the time they're talking to each other."

they decided to branch out and invite other members of the community. "We wanted to include community mental health stakeholders who don't necessarily provide mental health services but who are in some way impacted by the system, such as probation [and] hospital staff and police," Messersmith said.

Sometimes the idea of leaving a professional identity behind can be difficult, as in the case of a local police chief who was invited to attend. "He physically could not do that because he came dressed in full uniform," Messers-

smith recalled. "I asked him to put on a nametag and he said he didn't need one. But he came up to me at the end of the experience and said he saw great value in it. It was the first time he was able to speak to a mental health client in recovery; typically, people in law enforcement encounter clients when they're not in a healthy place. It was the same for the clients: it was the first time they'd spoken to a police officer when they weren't in

seminars, the tone is very different from a participatory dialogue. "In fact, the police chief asked us to do two mini-dialogues with his department so they could have that experience," Messersmith said. "In the end, he has become a community stakeholder beyond what we could imagine."

She said they had a similar experience with a probation officer who works with reentry for people coming out of the justice system. "He is now trying to get more peo-

role, and a neutral territory to come together," he said.

Allegheny County is still working on developing tools to measure outcomes and find out how participants are using what they glean from the dialogues. In the meantime, Sarah Goldstein has noticed the impact of dialogues in her own relationships with providers. "I have learned how to talk to my doctor better: listening to how other people communicated with their doctors allowed me to learn how to do it,"

Goldstein noted. "We have a good relationship, and part of that is just learning

"It's important to learn how to talk to one another. . . . It breaks down the barriers."

ple from the legal system involved because he believes the dialogues are a new way for the systems to collaborate for future growth and transformation. The amazing thing is that changes might not come up right away but you see things develop."

Messersmith said it has sometimes been challenging to get psychiatrists to attend, but they are working on strategies for making that happen. She would also like to

that doctors are people, too."

For Schatz, the power of the concept is in the exchange of ideas.

"In a dialogue, there is no right and wrong. Everyone is entitled to their opinion and everyone has the freedom to express it."



Recovery and Little Green Apples

By Brian McLaughlin

I like to say that God gifted me with an average mind. University was a mighty struggle; however, I made grades and finished up with a master's degree. My early career was marked by some great successes and some equally great failures. But, as time passed, my moods became ever more extreme. At some level, I knew what was happening: I was cycling. However, the thought of being mentally ill was too frightening, too terrible. I engaged in magical thinking: I would say to myself, a person with my education should be immune from mental illness. It is often said that depression is "anger turned inward," and that describes my experience. I wasn't diagnosed with clinical depression until age 30, when my life so overwhelmed me that I began expressing that anger by suicidal thoughts, self-injury, and periodic substance abuse. It always seemed dark outside and, obsessed with violent thoughts and images, I became convinced that everyone was out to get me.

As I lingered in denial, my mental illness became more disruptive. I never was fired from a job – because I would quit first. Thoughts of suicide led to hospitalizations, and my secret was out.



Brian McLaughlin, MS, has worked in the public mental health system much of his adult life. For the past 16 years he has served as a mental health advocate at the mental health base service unit now named Erie County Care Management. Brian was in one of the first classes of certified peer specialists trained in northwestern Pennsylvania; he completed his CPS training in spring 2006.

Despite confidentiality regulations, word of my illness traveled swiftly through the system that had once employed me. When I applied for a job stacking dog food, the manager informed me that one of my previous employers in the mental health arena said that they "would not hire me under any conditions." So my parents helped me apply, successfully, for disability benefits.

A year passed and I grew bored and angry. I remember sitting in the dark for hours, thinking and praying. I finally said, *God, you know how hard I've worked at the university; but if this is all you want for me, so be it.*

Then the phone rang. An old friend who knew of my situation told me that the local base service unit – jargon for a community mental health center – was looking for a new mental health advocate. I was hired shortly thereafter. That was 16 years ago; today I am both an advocate and a certified peer specialist (CPS).

Being a CPS has helped me make sense of my life; it gives me the structure that for a time was painfully missing. And I firmly believe that being a CPS helps me better control my symptoms. Any time someone is able to step outside themselves to help another, healing can take place for both of them.

Winning Hearts and Minds

Stigma can be a barrier to healing. And, unfortunately, despite the fact that the mental health system I found myself in (in northwestern Pennsylvania) was and is deemed progressive, stigma is still rampant – and a progressive leadership and public policy do not always ensure a progressive line staff.

Initially, I aggressively confronted professionals whom I found prejudiced. This approach was met with resentment, anger, and a general failure to be persuaded.

Then I discovered that, to be heard, I needed to be more subtle, gentle, even humorous. For example, once in a meeting, a master's level professional remarked, "Well, her apartment is clean . . . for a consumer." To which I replied, "I am a consumer and my house is spotless." There was dead silence. The professional blushed with anger, or embarrassment. I quickly added, "Maybe that is just because I am unnaturally close to my mother." Everyone laughed, including the offending professional. Because she was not threatened, she heard my message loud and clear – and changed.

I made another mistake when first I carried the title of advocate: I became, as the poet said, "an island onto myself." Instead of becoming a member of the team, I made myself an adversary, ready to pounce on every issue. I found myself shunned and ineffective.

I quickly adopted a new style and looked for ways to support the team. If I uncovered a problem, I learned to bring it to the team – armed with several creative solutions and a willingness to pitch in.

... continued on page 11

... continued from page 10

I also made it a point to let the professionals I worked with get to know me – and I got to know them. Together, we found common ground. This led to frequent invitations to lunch and other social gatherings. I went from being “that crazed manic-depressive zealot” to being Brian.

Even now, I still make mistakes. Like my professional colleagues I am not perfect and, on occasion, mishandle things. On these occasions, a sincere apology, coupled with a visible effort to reform, is strong medicine.

As pioneers of a new healing profession, we must demonstrate our unique ability to help our peers attain ever greater levels of recovery, self-determination, and health. In the end, our paths as peer specialists will be as unique as the paths we took towards our personal recovery.

Little Green Apples

Although my personal path has led me to feel secure in my recovery, sometimes I find myself in transition from mania to depression. Mania is wonderful as it makes me fearless and removes all limits. Mania is also terrible as it makes me fearless and removes all limits. Mania is like listening to the Rolling Stones with the speakers blown, and is as bright as a sunflower painted by Van Gogh. Depression is as silent as the grave, and just as dark.

But I am blessed with parents who love me to a degree that surpasses my comprehension. They have been with me through all the suffering.

However, something once happened that at first I found troubling and, later, I came to understand. Depressed, I called home. My dad answered and I told him that, once again, I was cycling down into a depressed state. Dad paused and then handed the phone to my mother. I repeated what I had told my dad. My mother also paused and then said, “There is a sale on Granny Smith apples; would you like me to get you some?” Confused, I said yes, thank you; and we politely said goodbye.

What had happened to my loving and supportive parents? Then I understood: they still loved me but simply had no more to give. My dad had to hand me off. My mom had to talk of little green apples.

I did get my little green apples, and I put them in a bowl on my kitchen table. They remind me that I am loved and that even the worst depression will pass in time.

Praise and Criticism

The idea of training individuals with psychiatric histories as paraprofessionals actively engaged in the care of their peers has received both praise and criticism. Supporters assert that mental health consumers are naturally qualified to help their peers. Critics suggest that persons with serious mental illnesses are

so compromised that they cannot possibly fulfill the role of paraprofessionals.

Here is a story that proves the critics wrong.

In my mid-20’s, I experienced a dark depression that led to my first psychiatric hospitalization. I chose what I thought was the most modern inpatient unit in my small northwestern Pennsylvania community.

I was admitted on the weekend, so I didn’t get to see a doctor; instead, I was given a room and a pair of blue-and-white-striped pajamas to wear out on the floor. I quietly took my place on one of the many couches and, with my peers, stared at the big-screen TV. The hours passed slowly as we sat in silence, alone with our suffering. The nurses and technicians seemed to power-walk through the room once an hour; the rest of the time the staff peered at us through a window.

Then came Shawn, whom I had once looked after in a community outpatient treatment program and group home. We had attended the same high school, where he had struggled through special ed. He had been diagnosed with early onset schizophrenia, and his symptoms were profound and disabling. He also was strangely brave and, most of all, caring.

Shawn knelt in front of me. With a deeply concerned expression, he said, “Brian, what happened? What is wrong?” I slowly replied that I was having a little trouble with depression – holding back some because I was worried that I would upset him. Still, it felt wonderful to be given the opportunity to talk to a genuinely concerned person.

Shawn responded, “Brian, it’s going to be okay. I will pray for you.”

Just then a nurse approached and sharply told Shawn, “Leave him alone.” Shawn hung his head and retreated to his room. The nurse got her wish: I was left alone with my illness for the next 48 hours: no medication, no therapy, no interaction with the staff – except at the end of each shift, when the mental health technicians ordered me to the front desk and, in front of the whole floor, loudly interrogated me about my symptoms. I soon realized this was born of their need to fill up the log with something before their shift ended.

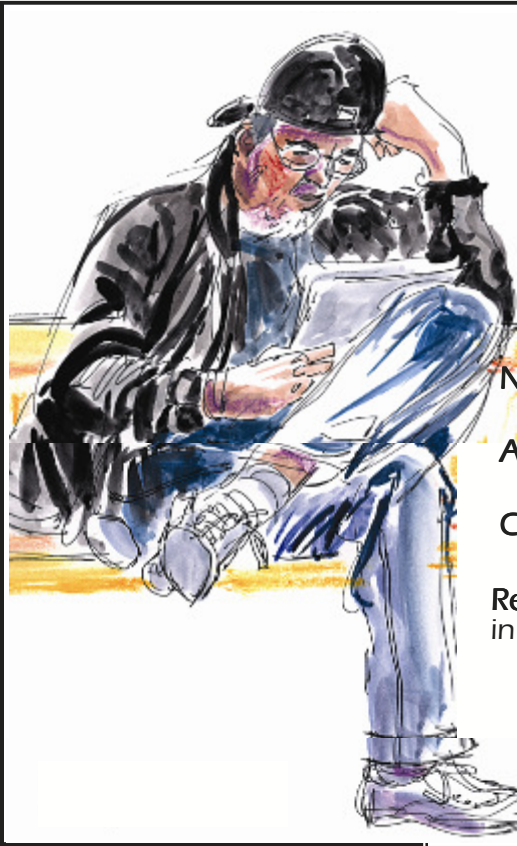
In short, the greatest healer I have encountered in my 20 years of experience working in the public mental health system was another peer. Sadly, Shawn has tragically passed away. God speed, Shawn; I am going to be okay, just like you promised.



“My little green apples remind me that I am loved and that even the worst depression will pass in time.”

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