Words of Wellness

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Grateful for Friends, Grateful for Health

By Shelly Kaplan

Editor's Note: The following is abstracted from a talk given by Ms. Kaplan as part of the Wellness is Possible! Presentations during our annual Wellness & Recovery Conference.

Peggy Swarbrick asked if I wanted to Participate in this panel. At first, I said nooo!!!! After giving it some thought (a process I learned in my recovery), it seemed like a good opportunity to talk about living.

Last year in April, my doctors told me that I had inoperable lung cancer and that I had about three to four months to live. SO, I am either a ghost or they were wrong." Let's go with the doctors were wrong theory, unless you feel more comfortable with the ghost.

The reasons I am still here are my daughter, my CSP/CEC family, and 10 years of Peggy drumming into my head that wellness is better than ending it all. (It also helped that I gave up smoking).
I discovered that surgery takes a support team. Since I have no family here and my mother was Italian and my father was Jewish, I had to ask the finest Irishman I know, Mark Duffy at CS P, to be my next of kin. Then Eleanor Solieri and Joan Farkas at CEC became my chauffeurs, Rita Carroll at CSP became my chef and Peggy Swarbrick became my car service, picking up friends at the airport and making timely chocolate deliveries.

When I awoke from the surgery I thought I was DEAD because there were so many flowers in my room "from friends". And the phone calls were coming back to back..When you have a mental illness you really don't know how many friends you have.

I also realized how many people's lives were positively affected by my job. They really needed me and they really liked me.

Thank you for insisting that I have surgery and for making me believe that life is good.

The Role Of Families In Physical Health Promotion

It is well known that family members of adults living with mental illness take on many roles associated not only with helping their loved ones to develop skills and supports to attain recovery, but also many things which would be characterized as "case management" or "wrap-around supports" if provided by professional caregivers. Obtaining physical and dental health care are important such supports, and this author is certainly aware of families who have put effort and money into:

1. Making medical and dental appointments
2. Transportation of the person to their medical and dental appointments
3. Helping a person finance and attend a weight loss program
4. Helping a person finance and attend exercise activities
5. Helping a person finance and obtain prescription and over the counter medications
6. Coordinating the complexities of referrals, payments, etc.
7. Providing the person care and a place to live during periods of medical convalescence.
8. Advocating for specific physical health care needs, including attention to medical side-effects, and accommodations for medical issues in dependent psychiatric care settings.

Families of people living with other disabilities, including natural aging, normally take on these kinds of roles. Families of people with or without mental illness also naturally take on health advocate roles, and families play a key role in advocating for positive health behavior change, such as:

1. Reduction/cessation of smoking and other dangerous drug use
2. Weight loss
3. Increase of exercise
4. Diet improvement
5. Initiation, maintenance, and/or resumption of appropriate health screenings

6. Adherence to prescribed treatment of identified health conditions.

The activities of "organized family groups" do seem to take on this natural concern for health. This discussion is anecdotal, with no obvious articles in the peer reviewed literature that are on-point. While there are many family support bodies other than the organizations and affiliates of the National Alliance on Mental Illness (NAMI), and NAMI itself includes many people in recovery[1], it is convenient to consider NAMI as a family group, and the predominant family group for mental health support in North America. Because this author is involved in NAMI NEW JERSEY and one of its affiliates, the following examples are about efforts by these groups that have been aimed at improving the physical and dental health of adults living with mental illness.

1. NAMI's national organization, noting the volume of requests to help advocate for physical health improvement, sought funding and developed the ***Hearts and Minds*** program[2,] which is specifically intended to raise awareness of items 1-4 in the preceding paragraph.
2. NAMI NEW JERSEY built on that model by training and employing part time peer providers to offer the ***Hearts and Minds*** presentations in various group settings.
3. A NAMI local advocate, serving on a county mental health board, surveyed provider agencies about the availability of Automated Electronic Defibrillators (AEDs).
4. NAMI NEW JERSEY, noting hundreds of requests from members for help accessing dental care, created and distributed a guidebook on donated dental services.
5. A local NAMI affiliate started a program to provide access to swimming including pool access, transportation, and new swim suits for those who needed them.
6. That same group worked with a local non-profit comprehensive fitness center to offer several scholarships for local residents.
7. Most notably, NAMI NEW JERSEY has the responsibility to develop and maintain ***The New Jersey State Family Support Plan for Families of Persons with a Serious Mental Illness***[3]. A significant amount of effort is expended to make sure that input from as many people as possible is reflected in that plan. In the appendix of the plan, individual responses from a survey "Health Barriers" reflects families' concerns, including
   - Health consequences of psychiatric medications, including obesity, diabetes, heart disease
   - Heavy smoking and limited access to smoking cessation program
   - Continuity of care is a fragmented or lacking
   - Difficulty in obtaining dental care
   - Limited finances and reimbursement limitations in regards to Medicare/Medicaid
   - Lack of empathy and understanding from primary care physicians; they need to be more involved
   - Physical concerns need to be integrated with mental health treatment
   - Lack of proper nutrition
   - "It is difficult motivating family member to get "check-ups".

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As a result of this, the ***State Family Support Plan*** contains a specific section with findings and recommendations regarding the need to promote physical health of people served. One indicator identified in the plan is "A smoking cessation program for persons with a mental illness will be available in every county in New Jersey."

We are also aware of individual NAMI members and groups, donating exercise equipment to mental health self-help and treatment settings. In addition, it should be noted that NAMI groups and other family groups which bring in community speakers regularly schedule presentations on topics around physical and dental health care and health promotion.

[1] By some estimates, 15%-25%

[2] Learn about the program, see the video, and download the guidebook at www.nami.org/template.cfm?section=Hearts_and_Minds

[3] Online at www.naminj.org/support/Family_Support_Plan_2006.pdf.

In addition to NAMI, there may be other settings, including Clubhouses[4] and drop-in facilities that may have been formed by family members which offer programming focused on physical health. For example, the Jewish Alliance for the Mentally Ill (JAMI) House in London[5] is one such facility with apparent major family involvement. Their weekly schedule of events includes dance/movement classes and a swimming excursion weekly.

In summary, even though individual family members and organized family groups may ***sometimes*** seem to support ideas counter to physical health promotion (such as urging for medication adherence versus non-adherence due to medical side-affects, or advocacy against smoking cessation in psychiatric hospitals), family members are actively involved in promoting the physical health of their family member, and are doing so on both individual and system levels.

MAKE A "PLEDGE FOR WELLNESS"

In 2007 the Center for Mental Health Services' (CMHS) launched the National Wellness Summit for People with Mental Illness. The heart of this summit is the "10 in 10" campaign, which strives to improve the life expectancy of individuals with serious mental illness (SMI) by 10 years and to achieve this goal within 10 years. Currently, individuals with SMI have a lifespan that averages 25 years less than the general population, due not only to SMI but also various comorbidities, such as diabetes and heart disease. At its summit, CMHS also introduced "The Pledge for Wellness," which includes the goal of the "10 in 10" campaign. All health and mental health provider organizations, individuals and government entities are strongly encouraged to make the pledge. To do so, visit www.bu.edu/cpr/resources/wellness-summit/pledge.html.

EXERCISE: AN ALTERNATIVE AND COMPLEMENTARY PRACTICE

by Libby Bartholomew

As a Wellness Assistant for the Institute forWellness & Recovery Initiatives, I have the opportunity to do a variety of different tasks. In November 2008, I worked on a slide presentation for a training we did on "Alternative & Complementary Practices." We covered several topics, including aromatherapy, meditation, music therapy, supplements, and yoga. This article shares some of the practices that we explored in the presentation.

Did you know that exercise is considered an Alternative & Complementary Practice, and that it can definitely improve one's mental health? Exercise is an "alternative practice" because sometimes people use it to improve their health *instead of* taking medication. Exercise is also a "complementary practice" in that we use it *in addition to* other wellness practices, in order to benefit our health. So, you might take medication, eat a healthy diet, *and* exercise to achieve overall better health.

One of the articles that I reviewed while I was working on the slide presentation reported findings from 11 different longitudinal studies (Donaghy, 2007).[6] These studies indicated four points underscoring the value of exercise[7]:

- First, if a woman gets little or no exercise, then she is twice as likely to develop depression than a woman who gets moderate to high amounts of exercise. Exercise seems very important for women.
- Second, exercise was shown to be protective. That means that you are less likely to develop a mental illness if you exercise. This study was conducted with 2,000 people, who were 50-94 years in age, and they were followed-up at the 5-year time period .
- Third, in a study of over 4,500 adolescents, it was found that adolescents who decrease their physical activity will experience an increase in depressive symptoms. So, for an adolescent who doesn't get exercise, there is some evidence that they may be more prone to depression. It appears that exercise is good for adolescents
- Last, older adults (over age 65) can also benefit from exercise. After 6 months of walking or low-intensity resistance/flexibility training, older adults experienced a decrease in depressive symptoms, which persisted 12 more months to 5 years after commencing the exercise program

As the data show, exercise can work!

(article continues on page 5)

[4] In the formal sense of facilities which closely follow the formal model promulgated by the International Center for Clubhouse Development, www.iccd.org

[5] www.jamiuk.org

[6] Donaghy, M. E. (2007). Exercise can seriously improve your mental health: Fact or fiction? [Electronic version]. *Advances in Physiotherapy*, 9, 76-88.

[7] (See Table 1 of Donaghy, 2007, p. 78) for points two through four.

Factor	Strategy (what you can do to help)
1. Lower air pressure in the aircraft cabin makes breathing difficult for people with lung conditions such as asthma or Chronic Obstructive Pulmonary Disease (COPD).	If you have a health condition that involves your lungs, or can cause acute shortness of breath, get medical clearance before flying.
2. Lower air pressure causes gases in the body to expand (up to 30%). This can cause problems for people who have had recent surgery (including eye surgery).	Get medical clearance to fly after surgery. This may call for special consideration if emergency medical care during travel involves surgery, or when traveling to obtain surgical care.
3. Lower/changing cabin pressure causing discomfort in sinuses and middle ear, including vertigo.	People with significant sinus infections are advised not to fly. Some people chew gum to help relieve the cabin pressure changes, or use specialized earplugs. People dealing with vertigo need to understand how their "kind of vertigo" is affected by air travel, and make appropriate preparations.
4. Sitting in cramped spaces for long periods of time can cause blood clots (emboli).[8] The following people are possibly at an increased risk for such clots: • People who have been diagnosed with deep vein thrombosis (DVT) • Obese people • Smokers • People who have had recent trauma from an accident or surgery (especially to legs) • People with decreased oxygen (see #1) • People on oral contraceptives/ hormone replacement therapy	A NASA article[9] recommends a. Eliminating controllable risk factors (obesity and smoking) b. Discussing possible prevention (medication, anti-embolism stockings) with your doctor. c. Doing the following during flight: • Stand up and walk around at least hourly • Exercise your calf muscles by going up on tiptoes several times while standing • Drink adequate fluids, at least 1 liter per 5 hours of flight time • Avoid alcohol • Avoid crossing legs or prolonged awkward hip or knee positions • Wear loose fitting clothing • Elevate your legs when possible.
5. Recirculated cabin air and close physical contact between passengers leads to increased risk of infection.	A number of interventions to reduce the volume of in-cabin airborne infections include: • cellulose nasal sprays • garlic preparations • probiotics • increasing cabin humidity Travelers can reduce their chances of spreading infections by: • avoiding air travel when they have significant respiratory infections • wearing a mask[10]
6. Very limited access to emergency medical services increases the risk of complications from in-flight medical emergencies. Aircraft medical kits vary widely in their resources.	a. Consider any personal health conditions that have resulted in frequent medical emergencies before flying; get medical clearance if necessary. b. Make sure all medications, including as-needed medications, are accessible.[11] c. People with chronic health conditions should have medical-alert jewelry, especially if traveling alone.
7. For people dependent on medications, any risk of being separated from their medications creates obvious health risks.	Double check medication supplies before travel. Always carry on medications.

[8] Not only has the term "economy class syndrome" become a popular reference for this condition, but some authorities point out that it is just as possible when traveling by care, bus, train, etc.

[9] Available online at http://ohp.nasa.gov/topics/alerts/dvt.html

[10] Some airlines have been known, and are allowed, to require passengers with respiratory infection symptoms to do so.

[11]To understand the Transportation Security Administration's rules regarding both medications and other assets for dealing with health-related disabilities, we suggest that you read www.tsa.gov/travelers/airtravel/specialneeds/index.shtm .

Personally, I started running while I was in college. I found it therapeutic. Running, literally improved my mood. One day my roommate, who was very athletic, asked me if I wanted to accompany her. I had a difficult time keeping up with her. I soon learned that running could really help me with the low bio-rhythms I was experiencing at four in the afternoon. I continued running while I was attending graduate school, and then I started swimming. Swimming helped me to relax, and it also helped me to stay focused.

In 1993, I was hospitalized for bipolar disorder and schizo-affective disorder. I found it impossible to get the exercise I needed, and soon I started gaining weight. I found I needed to look at alternative ways to exercise. I decided become a member at the YWCA in Princeton so that I could swim. I then started to swim 3-4 times a week for the next 8 1/2 years. Not only did I feel invigorated afterward, but I often forgot about my problems and it helped me out to fall asleep at night. Sometimes, I would have days where I was just overwhelmed and felt like I couldn't manage. I would make a concerted effort to go to the YWCA and swim, and I would feel totally better, after a 30-minute swim.

As I started to take on more work, exercise became something I needed to fit in to my schedule. I found I often missed the times when the pool was open, so again I had to plan. Currently, I have supplemented my routine with a membership to a gym. I work out on a circuit and get strength training by using the machines. When the weather is nice, I make an effort to walk from my house to the gym, do the circuit routine, and then walk back home. It takes me an hour and a half, but I get my strength training in along with my cardio workout. With the higher risk of heart disease and diabetes among people living with mental illness, exercise is an important complementary practice. Exercise has helped me to stay positive, especially when life just seems to give me more than I can handle. When my thoughts seem to "heat up," getting a workout seems to release the steam pressure and makes me feel better. I know that I am more productive when I exercise, and I feel my mood is more stable.

Exercise is an important practice that has helped me to stay focused and helps me to continue to enjoy life. I find that because I have established a routine, I have more control over my life. I feel I know what it takes for me to feel "good." I now exercise several times a week, more in the summer and less in the winter. In addition, I have worked with my doctor to lower my medication. I also continue to work on eating right and socializing with my friends. It's a total package!

Air Travel

There are a wide variety of reasons why air travel is something many of us need to do (work, education, family obligations) or want to do (vacation). All of these, of course, link directly to areas of wellness. Unfortunately, for a small number of us, air travel can have a negative impact on one or both of the dimensions of physical and emotional wellness.

The primary negative physical health effects of air travel result from seven primary factors. Those factors, and ways to deal with them, are presented in the table on page 4. Despite the negative impacts, it needs to be emphasized that

- Air travel is very safe, compared with most other ways of traveling long distances.
- Medical emergencies in-flight are rare, and airplanes do have resources, including medical kits and telemedicine support, to deal with emergencies that may arise.
- Deaths due to in-flight medical emergencies are exceedingly rare. An older comprehensive study of this phenomenon[12] found that these few deaths were due to sudden cardiac incidents. A more recent review of the subject[13] noted that "most airlines now carry … automatic external defibrillators" and that a physician is likely onboard on the majority of flights.

The emotional challenges of air travel are just as real and significant to those who deal with them as are the physical challenges. Some people may have the diagnosable and treatable psychiatric condition known as aviophobia (fear of flying), or may have related fears such as fears of heights (acrophobia) or fear of enclosed spaces (claustrophobia). A variety of professional interventions ("systematic desensitization" and other forms of talk therapy, hypnosis, and medication), as well as self-help tools and groups are available to help people deal with those conditions. Others may have fears of air travel accidents or terrorist activities, despite the extreme rarity of such occur-

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[12] Cummins RO, Chapman PJ, Chamberlain DA, Schubach JA & Litwin PE (1988). In-flight deaths during commercial air travel. How big is the problem? *Journal of the American Medical Association;* Apr 1;259(13):1983-8.

[13] DeHart RL (2003). Health issues of air travel. *Annual Review of Public Health; 24:*133-51.

rences.[14]

Other people, while not having the specific conditions mentioned above, may experience anxiety during air travel as a result of other things such as:

- rushed preparations for travel;
- highly visible security provisions;
- highly visible safety precautions, such as in-cabin announcements and warnings;
- concerns regarding connections;
- changes in routine, including sleep and eating patterns;
- interrupted access to fresh air; and
- interrupted access to nicotine (for smokers).

Ideas for coping with some of these emotional challenges of air travel include:

- dealing with the existing and underlying personal conditions through the use of one's own wellness, mental self-help, and mental health treatment approaches;
- dealing with nicotine deprivation, if necessary, by having a nicotine replacement (patch, gum) in place;
- expecting temporary discomfort (such as cramped seating), and planning around it;
- expecting the worst, but hoping for the best;
- considering the length of flights and layovers. People who feel "cooped up" in an airplane might not be good candidates for a long non-stop flights;
- working with seasoned travelers and travel professionals to look for reduced-anxiety travel times. Some flights may have better on-time records. Others may have typically smaller crowds, fewer children, etc.;
- planning suitable healthy distractions from known anxieties. Many people carefully stock up on good reading, music players, puzzles, etc., sufficient for the trip, including possible delays; and
- isometric exercises can be done in airline seats.

We encourage our readers to think through their preparations and wellness considerations, and enjoy the flight!

[14] In calendar years 2002 and 2007, for instance, zero people died in or as a result of any accidents by US airliners.

AVERAGE MIRACLES… AND LAUGHTER

Average Miracles (www.averagemiracles.org) is a program developed by some individuals pursuing psychiatric recoveries intended to raise "awareness of alternative methods of healing and energy medicine as a practical, valuable and effective means toward general wellbeing and the recovery from mental illness."

A major aspect of the group's current activity is laughter yoga/laughter therapy. Several research links are provided, as well as "instructions for laughing."

Laughter Therapy is by no means limited to Average Miracles, and a Google search for "laughter therapy" yields 125,000 hits of this worldwide phenomenon. Some of the "mainstreaming" of laughter therapy started after Norman Cousins used laughter therapy (applied by the use of Marx Brothers films) for pain management during his recovery from a disabling form of arthritis, and then wrote about it in the widely read ***Anatomy of an illness as perceived by the patient : reflections on healing and regeneration***[15].

Laughter Yoga International (www.laughteryogas.org) indicates that there are thousands of laughter clubs worldwide. A small number of clubs are running in New Jersey (Barnegat, Pomona, and Warren), and several certified leaders and trainers are listed for the garden state.

In a closely related area, The Turn-a-Frown-Around Foundation (www.frowntosmile.org) is a program developed by individuals pursuing psychiatric recoveries here in New Jersey aimed at reducing the loneliness of people who are in psychiatric hospitals or nursing homes or who are homebound. Among various activities, Turn-a-Frown-Around brings entertaining shows (comedy, music, and more) into psychiatric hospitals and nursing homes.

A recent development at Turn-a-Frown-Around is a formal training, known as "Introduction to Humor and Joke-Telling as a Social Skill." The training is Co-presented by Turn-a-Frown-Around's founder, charismatic comedian Drew Horn, along with a Certified Psychiatric Rehabilitation Practitioner. It can be provided to people pursuing recoveries, or used as a staff in-service training. Contact jyudof@hotmail.com for further information.

[15] New York, Norton, 1979.

PEER CONNECTIONS NEWSLETTER LAUNCHED

Peer Connections is a new monthly e-newsletter that is designed to connect people in recovery, public and private mental health provider agencies, government officials, and policy makers to issues surrounding the creation of a peer workforce and its impact on the transformation of the mental health service delivery system. This e-newsletter will highlight training and certification options, models of peer-delivered services, expanding roles for peers in all phases of mental health, and research on peer models. In addition, we will foster an open discussion of issues facing employers and highlight best practices necessary for cultural change.

Peer Connections is being produced by the **Mental Health Association in New Jersey, and Collaborative Support Programs of New Jersey**, each nationally recognized for their peer-delivered services, training, and advocacy. Our main focus will not only be on the issues facing New Jersey, but also share information, program models, and resources from across the county.

Peer Connections is a work-in-progress, and we welcome our readers to help us to offer new information, and to identify resources that we can share. Our goal is to make this newsletter of value to the entire mental health community during the transformation of the mental health service delivery system to include a strong peer workforce as an essential component.

Peer Connections understands that there are a number of terms used to describe persons in recovery who are employed in peer-designated and traditional roles. Terms include "peer provider," "consumer provider," and "persons in recovery as providers," and we will use these terms interchangeably.

Free e-subscriptions are available at http://visitor.constantcontact.com/manage/optin/ea?v=001hDXaORE2PUTwk7UsmrnYeQ%3D%3D ,

PEER WELLNESS COACH EDUCATION PROJECT

A collaboration between NJDMHS[16], the UMDNJ[17] Department of Psychiatric Rehabilitation, and a national funder is allowing a unique pilot project aimed at:

1. Improving the physical health and wellness of people living with mental illness in New Jersey,
2. Creating a new valued role for peer providers,
3. Conducting research to validate the effectiveness of this role, and
4. Establishing infrastructure (including a training curriculum and billability) so that this service, if successful, can persist and be expanded.

Trained peer wellness coaches will receive sixteen full days of training from UMDNJ on topics which will include:

1. Overall wellness
2. Awareness of health resources which can be of value to people
3. Application of the coaching model to assist people in identifying and reaching personally valuable goals to improve their health or other aspects of wellness.

An initial class of trainees is being recruited by UMDNJ. They are seeking peer providers who are currently working in supportive housing or residential service programs anywhere in the state. Their employer must be willing to cover their labor for an 8-week (2-day per week) course, and commit to expanding their current duties to include peer wellness coaching. The initial course will be conducted in Scotch Plains beginning in June. At the completion of the course, trainees will be certified as peer wellness coaches, and will receive six college credits. Tuition and all course materials will be paid for by NJDMHS.

The registration deadline is May 6. To obtain information and a registration packet, contact Assistant Professor Ann Murphy at 908-889-2734.

PEER PROVIDERS - QUO VADIS

By some measures, the opportunities for peer providers have increased greatly over the past quarter century. Individuals who disclose having a mental illness are being accepted into roles in peer-operated services (POS), in hybrid services, and in traditional mental health roles. People are filling these roles in ways in which their experience living with a mental or emotional imbalance is viewed as an asset or strength. In some – but not all cases, peer providers are able to advance from entry-level posi-

[16] the New Jersey Division of Mental Health Services
[17] University of Medicine and Dentistry of New Jersey

tions. In some – but not all situations peer providers are seeing parity of compensation with people who were able to achieve academic preparation by not having spent a portion of their lives dealing with mental illness and its after-effects.

The opportunities for disclosed peer providers who lack academic preparation are profoundly limited. Many remain in minimum-wage[18] positions, with limited career paths. Many have worked into peer designated or set-aside roles and funded by the SMHA[19], but are not likely to be considered for "mainstream" roles. In some places, entire peer-operated services are pigeonholed by the SMHA. In some of those cases, a lack of competition makes it difficult for the SMHA to extend the reach of POS. There is no clamorous outcry by service recipients, family members, SMHAs, federal authorities, or insurers to see the roles of peer providers and POS increased. We are not aware that any affirmative programs exist to help disclosed peer providers obtain careers in psychiatry or psychiatric nursing. We are also not aware of any effort by SMHAs – with their large entry-level workforces in psychiatric hospitals – to use affirmative action to steer a large proportion of such jobs to peer providers.

One of the brightest hopes for peer providers and POS is the trail blazed by the addiction community in terms of peer delivered service models. From radical beginnings in 1935, Alcoholics Anonymous alone has grown to nearly two million members worldwide. The success of this self-help group clearly influences the perception of peer support as a valuable ingredient in addiction treatment. Referral to Alcoholics Anonymous is a standard of medical care for addiction in many circles; we rarely see a comparable trend of referrals to self-help in mental health. As one aspect of that, the addiction treatment community itself, starting with Hazelden in 1950, has a long history of using its own peer providers in roles which benefit both the provider and recipient.

Another bright spot is the prospect of supporting research initiatives to solidify the perceptions of the "niche" roles in which peer providers may well be more effective than people who are not disclosed peer providers. It seems likely that, in addition to positions in POS, those niche roles include:

- Outreach to individuals who are frequently homeless or otherwise hard to engage
- Providing comfort and initial engagement in traditional crisis settings, alternative crisis/diversion services, and "warmlines"
- Supported Parenting services
- Participatory Action Research in mental health services.

A final pair of "quo vadis" questions is:

- How high can peer providers rise in the mental health service system, and
- What do we need to do to make that happen?

It is completely usual to see state authorities which serve people who experience other disabling conditions (such as hearing or visual impairments or mobility issues) having directors and leadership teams who have the disability which the organization services. We are not aware of any SMHAs led by people with disclosed psychiatric disabilities. In fact, there are probably very few people with disclosed psychiatric disabilities managing psychiatric hospitals or large mental health provider agencies. If we assume that these would be good outcomes, it makes sense for the peer advocacy community to chart a course towards making such leadership happen.

WORDS OF WELLNESS

As part of its broad array of services to foster wellness and recovery for individuals with disabilities, the Institute for Wellness and Recovery Initiatives at Collaborative Support Programs of New Jersey (CSPNJ) offers this monthly newsletter, *Words of Wellness*. This publication features valuable information and resources, including details about educational events, to help people to achieve and maintain wellness. The purpose of this newsletter is to bring useful information to all of our readers, whether pursuing recovery themselves, supporting recovery in clients or family members, helping to administer and change our mental health and related services system, or researching the field and educating future practitioners. *Words of Wellness* co-editors are Jay Yudof and Peggy Swarbrick.

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[18] or below-minimum-wage "stipended"
[19] State Mental Health Authority