



Words of Wellness



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WELLNESS IDEAS FOR MENTAL HEALTH PRACTICE

In each edition of *Words of Wellness* we will highlight things we all can do to improve physical wellness and/or reduce chances of early mortality. Here are a few ideas from our team.

- When offering food or snacks to staff and participants at events, choices should include
 - a. Leafy green vegetables
 - b. Healthy fresh fruit
 - c. Unsalted nuts (peanuts, almonds, cashews, etc.)
- If having an in-service training or board meeting and your group is offering food to attendees; consider making food and bringing it to the meeting. Home cooked food is generally more nutritious and less expensive than ordering fast or convenience food such as pizza or donuts¹.
- Discourage transportation to fast-food locations. Encourage members/service recipients to purchase food at supermarkets and bring food with them to appointments.
- Consider replacing food kept at food banks with healthier alternatives.
- Create partnerships with local farms for reduced prices for service recipients and members to access locally grown inexpensive produce..
- Offer wellness fairs regionally which include health screening opportunities and referrals to local medical providers for those at risk of early mortality.
- Encourage social outings that include physical activity.
- Encourage people to walk (or use public transit) instead of being transported.

THE EXPANDING WORLD OF PEER PROVIDERS

Most of our readers recognize that increasing the proportion of the mental health workforce people who have or have had the experience of living with a mental illness is beneficial and important. Most will agree that there are myriad reasons for expanded peer provider employment, including:

- Increasing overall job opportunities for people with psychiatric disabilities,
- Providing job opportunities for people with a psychiatric disability is an asset, not a liability,
- Providing people served (and all stakeholders) with daily reminders that people with psychiatric disabilities can obtain and maintain meaningful jobs,
- Helping to enlighten provider staff who have negative views of the potential of people with psychiatric disabilities to work, and
- Helping to keep the mental health system focused on a bottom line of assisting people in returning to valued employee roles.

All that said, it is sometimes difficult to identify specific roles where peer providers may be a good fit, and should be integrated into an organization.

¹ While making sure to ensure food hygiene, food safety, and compliance with all applicable laws.

We have outlined five major categories of peer provider employment². We do recognize that there may be others, and that there is significant overlap in these categories.

(1) ***People with psychiatric disabilities who choose to obtain and maintain positions in mental health held generally by people who may not disclose a psychiatric history***, and who get and keep these jobs on the basis of their own educations, certifications, and experience. They may or may not disclose their disabilities during the hiring process (or until years into their tenure). They can bring the empathy and credibility of any peer provider to their roles. We know of people living with a mental illness who are psychiatrists, psychologists, nurses, social workers, case workers, job coaches, benefits counselors, housing search specialists, and professors in a mental health-related academic field. The legal community also plays a role in the mental health system by providing civil or criminal representation for people with disabilities, oversight of the civil rights of people in institutions, and legal advocacy for people facing psychiatric commitments. We know of several people with psychiatric illnesses in paralegal roles in such organizations.

(2) ***People with psychiatric disabilities may choose to obtain and maintain non-mental health jobs in***

² While we are referring primarily to employee positions, these thoughts are equally applicable to contract or consultant roles in the organization.

FINANCIAL WELLNESS NOTES

We all have been talking a lot about *Wellness* and the *Dimensions* (physical, spiritual, emotional, social, intellectual, occupational, environment) of Wellness. We believe that the “Financial Dimension of Wellness” is very important. Financial well-being (wellness) refers to subjective perceptions and objective indicators of individuals’ personal financial status. Objective indicators of financial circumstances include measures such as income, debt, savings and aspects of financial capability such as knowledge of financial products and services, planning ahead and staying on budget. Subjective perceptions include individuals’ satisfaction with their current and future financial situation. An interesting study on Personal Financial Well-being and Performance at Work is reported at www.employment-studies.co.uk/press/project.php?item=N1018&id=hrm. A short quiz on the topic is located at <http://definitionofwellness.com/dimensions-of-wellness/financial-wellness.html>

CSP-NJ, along with our subsidiary, Community Enterprises Corporation, offers a variety of services to help people achieve financial wellness through savings, skill building, direct consultation, and educational programs. Introductory and advanced lectures can be scheduled for self-help centers and groups around the state. For more information about our array of services that address the financial dimension of wellness contact: Peter Stahl, pstahl@cspnj.org or Zoraida Reyes, zreyes@cspnj.org

include human services technician, psychiatric technician, or nurse’s aide. In-community roles include van driver, shopper/driver, travel trainer, and residential shift worker. Part-time “assistant” jobs, such as “assistant case manager” or “assistant job coach” are also included in this category.

mental health organizations. They may be writing computer programs, fixing vehicles, negotiating with health insurers, balancing the books, planning and cooking meals, tabulating and assessing quality improvement data, or any other job the organization needs done. They may or may not have significant contact with service recipients, and if they do, their presence has the value of bringing employment optimism to persons served and staff throughout the organization.

(3) ***People with psychiatric disabilities who choose to obtain and maintain mental health jobs that require limited training and experience*** typically have low pay and status. It makes sense to use affirmative action to make these positions available primarily to people with psychiatric disabilities. It is also important to ensure that people who get these jobs have access to career ladders so they do not get stuck in dead-end positions. The prime example of such positions in state and other psychiatric hospitals are the entry-level patient care roles. Some of these roles

(4) *People with psychiatric disabilities who choose to obtain and maintain jobs that can not reasonably be performed by someone who has not lived with mental illness.* These include:

- Facilitator and other jobs inside of mental health drop-in centers, self-help centers, or self-help groups,
- Workers on peer-support “warmlines,” and
- Speaker/recovery educator roles such as the presenters for NAMI’s *In Our Own Voice: Living with Mental Illness* program. Few of these roles are likely to be full-time, and many may be much closer to a volunteer role rather than paid employment. A more limited number of opportunities exist “up the chain of command” from these roles, serving as program coordinators or trainers.

(5) *People with psychiatric disabilities who choose to obtain and maintain jobs that could be done by someone without a psychiatric disability, can do these jobs as effectively.*

The jobs *may* be specifically adapted to be performed by people without the academic preparation required for people performing most other jobs in the organization, and/or performed on a part-time basis, as many people returning to the workforce with a psychiatric disability may choose to take part-time work before making the commitment to full-time. This group provides a wide range of opportunities, including all of the following:

- **Peer outreach worker.** Whether working in general mobile support, specialized mobile support such as Programs of Assertive Community Treatment (PACT), homeless outreach³, boarding home outreach, “inreach” to jails and prisons, or outreach to people who have opted out of

traditional services, peer providers can offer a special level of empathy. And credibility.

- **Crisis Worker.** The presence of peer providers in traditional mental health crisis settings is steadily expanding, due in part to the recognition that peer providers can bring a higher level of empathy and client focus. Peer providers are also able to bring that empathy to less traditional crisis programs, such as warmlines, mobile response, crisis “living rooms,” and “crisis diversion houses.”

- **Mental Health Educator.** Peer providers may bring higher credibility to teaching recovery skills to people, using programs such as Wellness Recovery Action Planning (WRAP), Illness Management and Recovery Education (IMR) or CSP-NJ Recovery Network peer

educator. There is also a growing body of research that having “peer faculty” teach mainstream mental health staff about the lived experience and recovery concepts improves the empathetic performance of staff, and has some positive effect on people’s perceptions of the recovery orientation of a program or agency.

- **Peer Mentors.** Peer providers often are viewed as having empathy, are in a good position to help others who are pursuing recoveries in a non-clinical one-on-one capacity. Some mentors have added training in coaching concepts, including rehabilitative diagnosis and motivational enhancement. Some mentors have specific education and skills in “peer wellness coaching,” helping fellow mental health service recipients make positive changes in the areas of diet, exercise, smoking reduction/cessation, or use of medical and dental services. The Medicaid plans

PETS AND SECOND HAND SMOKE

The damaging effects of second-hand tobacco smoke are well known and have led to the expression of a universal right to smoke free workplaces and public places. Even before this trend, people recognized the impact of second-hand smoke on youngsters and got in the habit of not smoking around their children. There is also a longstanding body of research that second hand smoke can be dangerous to pets as well. Articles in the peer-reviewed literature identified tobacco smoke exposure as a contributing factor to:

- Nose cancer in dogs
- Mouth cancer in cats
- Lung disease in dogs, birds, and hamsters.

The obvious recommendation for people who have pets or service animals in their home is to stop smoking in the house and in outdoor spaces where their pets are often found. *It’s a point worth passing along!*

³ Including the federally funded Projects for Assistance in Transition from Homelessness (PATH) programs around the country

in a growing number of states have language that supports the billability of peer mentors, thereby creating financial viability for the service.

- **Specialized peer mentoring for people dually diagnosed with a mental illness and a co-occurring substance disorder.** This is another area where lived experience and empathy may be able to help service recipients make positive changes.
- **Program Evaluator/Participatory Action Researcher.** The whole field of *Participatory Action Research* (PAR) is one where people who are involved in a problem, service, or system take on the planning and implementation of research about that topic as the leads of the effort, or as full equals with academic or other researchers. Therefore, people pursuing psychiatric recoveries are a mandatory component of PAR about personal experience seeking services. Also, peer providers outside an organization are in a better position to come into that organization and conduct credible surveys of service recipients than the agency's own staff. Finally, people receiving mental health services play an important role in most states in assessing licensed or contracted mental health programs.
- **Systems Advocacy.** There is a long-standing tradition of people in general who live with a mental illness in general, as the **key** stakeholder, being involved in helping to change the system by participating in the boards, committees, or workgroups of the system, and by presenting advocacy issues to lawmakers and others. Because of their unique dual perspective, peer providers are often at the forefront of such efforts. Peer providers also get involved in grass-roots advocacy efforts, such as organizing voter registration drives.

In summary, there is a wide and increasing range of roles for peer providers, and the increased presence of peer providers in the mental health system is beneficial and essential. We are always interested in hearing from our readers on opportunities and challenges in this area and encourage you to email us at nleditor@cspnj.org.

WHAT IS MENTAL HEALTH RECOVERY?

The need to define what constitutes mental health recovery has been bouncing around in the mental health community for some time. The need to define recovery seems to come from several different but related causes, including:

- The difference between recovering *from* something and recovering *with* something. With a time-limited medical condition, such as a broken foot, the flu, or appendicitis, people often limit or suspend their day-to-day activities until the condition has passed. With the “ups and downs” of mental health recoveries, people need to live their lives and pursue their life roles while recovery is taking place.
- The increased recognition that most people live long periods when they are symptom-free, and/or not significantly impacted by troubling symptoms. Research of the past twenty years has dispelled older thinking to the contrary.⁴ Increased recognition that recovery is commonplace raises the need to quantify and qualify it.
- Increased roles for and power in the “person-survivor” movement. By supplanting some of the authority of medical practitioners with those of people living with the conditions, a “less medical” definition seems necessary.
- Increased recognition of the role of non-medical treatments in helping people pursue recoveries. If services as diverse as job coaching, illness management education, family education, and peer mentoring lead to improved ability for people living with a mental illness to function, they are obviously recovery services, although they may not be “medical treatment.”

⁴ Many people would consider the “turning point” article on this to have been Harding CM, Brooks GW, Ashikaga T, Strauss JS & Breier A (1987). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry*; Jun;144(6):727-35

- The need to define characteristics of recovery so that individual services, and a service delivery system, can be structured to maximize recovery.

In an effort to help define recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA) and several other Federal agencies convened the *National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation* in December of 2004. With 110 expert panelists participating in the conference, the group created the following consensus statement:

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

Based on this definition, the group outlined fundamental components of recovery. A brochure about the consensus statement at fundamental components is available for download at www.ncadi.samhsa.gov/ken/pdf/SMA05-4129/trifold.pdf. Among many authors on the topic, Bellack wrote an interesting article that went beyond the consensus statement to explore three questions: (1) What is recovery? (2) Is recovery possible? and (3) What are the implications of a recovery model for a scientific approach to treatment.⁵

One can encounter the consensus statement in many contexts today, ranging from state and

DID YOU KNOW?

That the state of New Jersey offers 4 specialized helplines for emotional issues (all operated by UMDNJ University Behavioral Healthcare).

- 866-COP2COP, for NJ law enforcement officers and their families
- 866-NJFD-EMS, for firefighters/emergency medical service workers and their families
- 866 VETS-NJ4, for veterans returning from service in Southwest Asia and their families
- 800-328-3838, for women/families dealing with post-partum depression.

county policy documents to the guiding documents of individual provider agencies and facilities. Recently, the New Jersey Division of Mental Health Services has embedded the consensus statement in various requests for proposal (RFPs). The RFPs now state that services must be designed and implemented in a manner that reflects recovery as

an overarching value as well as an operational principle, and refer to the ten fundamental components of recovery. This inclusion potentially results in agencies identifying specific adherence to the consensus statement in their proposals, which then become part of the contract between the agency and the state. We can hope and expect that future RFPs will continue this trend, and also that contract monitoring efforts take these proposed adherences into consideration.

The Ten Fundamental Components of Recovery, as quoted from the national consensus statement, appear in the table on pages 7-8. In keeping with our “person-first” editorial policy, all references to “consumer” have been replaced with “person.” Also included for each are ideas of what should be done at the person, program, and system levels to maximize adherence to this component.⁶

In addition, we believe that all ten components require that every program must **ENSURE** that all staff

- have meaningful understanding of recovery and each of the components,
- have training in specific modalities and skills needed to apply the components of recovery, and
- work in a culture where their active efforts to promote these tenets is valued and rewarded.

⁵ Bellack AS (2006). Scientific and person models of recovery in schizophrenia: concordance, contrasts, and implications. *Schizophrenia Bulletin*; 32(3):432-442. Available online at <http://schizophreniabulletin.oxfordjournals.org/cgi/content/full/32/3/432>.

⁶ Regular readers are aware that we often see issues applying at these three levels.

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. Free e-mail subscriptions are available from nleditor@cspnj.org. We also welcome submissions and feedback at that address.

LATE-BREAKING CALENDAR INPUTS

The following **FREE** training opportunities reached us too late for our June 1 calendar edition, and will take place during the month of June.

- The New York State Office of Mental Health will conduct a one-day conference on June 22, *Peer Specialists In New York City - A Change we Can Believe In*, at the New York University Kimmel Center. Over 20 workshops have been scheduled. Registration/details at www.coalitionny.org/the_center
- UMDNJ's Department of Psychiatric Rehabilitation will host two colloquia featuring John Fossella, Ph.D. presenting on "Brain Mechanisms and Psychiatric Rehabilitation." On June 25, from 6-8pm, Dr. Fossella will discuss "An Overview and Review of the Literature." On June 26 from 10am-noon, Dr. Fossella will discuss "Hypothesis Development and Study Design." spagnoam@umdnj.edu

	Definition	What this might include at the Person level	What this might include at the Program level	What this might include at the System level
Self-Direction	People lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.”	MAKING choices at all levels regarding life, treatment or services and QUESTIONING other people’s recommendations suggesting reducing self-direction, such as getting a payee or living in a place that handles your medicine.	OFFERING recipients full control of choices regarding their assets, persons, or services along with the information they need about services offered to help them maximize self-direction. It might also include ENSURING that recipients are a mandatory player on their own treatment/service planning teams at all levels.	OFFERING recipients meaningful choice of services through a combination of a payment voucher system and accurate information about the resources in the system on which to base <i>meaningful choices</i> .
Individualized and Person-Centered	There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.	TAKING a leading role in the process of planning the services and supports for your recovery and QUESTIONING other people’s recommendations when they seem to be standardized, or designed more for someone else’s benefit than yours.	OFFERING recipients the time and energy needed to go through a meaningful service planning process.	ENSURING that the system has the range of appropriate general and specialized services needed to make individualized planning meaningful.
Empowerment	People have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other people to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.	BECOMING AWARE of peer organizations, legal advocates, and similar resources that can assist you in self-advocacy.	ENSURING that all recipients are provided regular information about advocacy resources via a variety of means, such as speaker sessions and public bulletin boards.	MOBILIZING organizations that provide individual and systems advocacy, and COLLABORATING with those organizations for systems monitoring and change efforts
Holistic	Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for person access to these supports.	BROADENING the scope of ones thinking about recovery, <i>away</i> from the natural tendency to think about treatment.	HELPING all participants think in the same broad holistic scope of recovery. This seems especially challenging, and therefore especially important, in settings such as hospitals that naturally have a very medical focus.	FUNDING programs that reflect the broader picture of recovery, and EMPHASIZING those programs that seem to do a good job of breaking down old separations.
Hope	Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.	THINKING intensely about your hopes and dreams, where you stand in terms of your own hope, and what you may need to do to improve your sense of hope.	ENSURING that every action of the program is built around the expectation of recovery and PROVIDING staff and people with daily reminders of successful recoveries.	REQUIRING regular measurement of recovery attitudes and hope as part of contracts and program evaluation, and ELIMINATING programs that do not demonstrate consistent high levels of sustaining hope.

	Definition	What this might include at the Person level	What this might include at the Program level	What this might include at the System level
Non-Linear	Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the person to move on to fully engage in the work of recovery.	ENGAGING in crisis planning and wellness planning, with the honest recognition that setbacks can occur.	ASSISTING recipients in wellness/crisis planning, and in developing the personal tools and resources they need to deal with possible setbacks.	FUNDING programs that raise awareness of wellness/crisis planning and HONORING people's individually developed plans, DEVELOPING and IMPLEMENTING services that give people access to continuity of care, so that they do not need to re-establish relationships when setbacks (or positive changes) occur.
Strengths-Based	Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, people leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, or employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.	REGULARLY EXAMINE your strengths, especially those in the domains of living, learning, working, and socializing.	ENSURING that all services assist people in identifying their strengths, and avoid the risk of becoming disability-oriented or narrowly focused.	PROMOTING programs which are strengths-based, MINIMIZING or STOP FUNDING programs that do not fit such criteria, and ASSISTING people in finding and using programs whose own strengths match their current needs.
Peer Support	Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. People encourage and engage other people in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.	ENSURING that you are aware of, and make maximum use of, both casual support from peers and formal support such as self-help groups and programs.	PROVIDING people both good opportunity for casual interaction and awareness of organized peer support. It can also include PARTNERING with peer support organizations for marketing, space, etc.	ENSURING AWARENESS so a variety of peer support options can flourish.
Respect	Community, systems, and societal acceptance and appreciation of people — including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of people in all aspects of their lives.	EXAMINING your own level of self-respect, as well as your attitudes towards peers in recovery whose diagnoses, or personal backgrounds vary from your own.	ENSURING that every action or publication of the program models ultimate respect for every individual.	ELIMINATING programs that do not demonstrate consistent high levels of respect for every individual in their language and actions, as well as ENSURING that system-level actions and documents show that same high level of respect.
Responsibility	People have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. People must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness. CONSIDERING all decisions from a framework of personal responsibility.	ENSURING that all people are aware of and actually hold the power to make their own decisions on a responsible basis, and ELIMINATING policies and practices that seek to minimize people's responsible decision making.	PROVIDING people with the power to make responsible decisions about their own care and services, rather than using them towards a restrictive linear continuum or restricted set of choices.	PROVIDING people with the power to make responsible decisions about their own care and services, rather than using them towards a restrictive linear continuum or restricted set of choices.