Building a Foundation for Recovery

A COMMUNITY EDUCATION GUIDE
ON ESTABLISHING MEDICAID-FUNDED
PEER SUPPORT SERVICES AND A TRAINED PEER WORKFORCE

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Acknowledgments

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Preface

The report of the President's New Freedom Commission on Mental Health (2003) articulated the vision that all mental health consumers can recover. Based on that vision, the Commission called for services that implement recovery and resulting system transformation. This represents a significant shift from the historic mindset that people with serious mental illnesses do not recover, a mindset that resulted in the concentration of funding on symptom reduction and custodial care. Now, however, recovery has been defined as "a journey of healing and transformation" that enables a person with a mental health disability "to live a meaningful life in communities of his or her choice while striving to achieve full human potential or 'personhood'" (National Consensus Statement on Mental Health Recovery, 2005—see Appendix E).

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead Federal agency charged with carrying out government services and research related to mental health and substance abuse issues. SAMHSA, through its Center for Mental Health Services (CMHS), is charged with implementing the recommendations found in the report of the President's New Freedom Commission on Mental Health. SAMHSA's mission is to "build resilience and facilitate recovery" for persons with mental health problems or substance use disorders. In accordance with the Commission's report, SAMHSA has made mental health service transformation a priority. Specifically, Recommendation 2.2 of the Commission report states, "Involve consumers and families fully in orienting the mental health system toward recovery," and, further, "Recovery-oriented services and supports are often successfully provided by consumers through consumer-run organizations and by consumers who work as providers in a variety of settings, such as peer-support and psychosocial rehabilitation programs" (New Freedom Commission, 2003, p. 37).

"Consumers who work as providers help expand the range and availability of service and supports that professionals offer. Studies show that consumer-run services and consumer- providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis. Because of their experiences, consumer-providers bring different attitudes, motivations, insights and behavioral qualities to the treatment encounter" (New Freedom Commission, 2003, p. 37). Recommendation 2.2 concludes with the following statement: "Consequently, consumers should be involved in a variety of appropriate service and support settings. In particular, consumer-operated services for which an evidence base is emerging should be promoted" (New Freedom Commission, 2003, p. 37).

Medicaid-billable consumer-operated services and consumer-providers represent an emerging evidence base, demonstrating cost effectiveness and recovery outcomes that are transforming the system. This publication, *Building a Foundation for Recovery: A Community Education Guide on*

Establishing Medicaid-Funded Peer Support Services and a Trained Peer Workforce, funded by CMHS, provides an overview of information on a new Medicaid-funded service called "Peer Supports" and the training and certification of peer specialists called "Certified Peer Specialists" (CPSs).

In 2004, Georgia billed Medicaid approximately $6 million for peer support services under the Centers for Medicare and Medicaid Services (CMS) Psychiatric Rehabilitation Option. A workforce of more than 200 Certified Peer Specialists promote outcomes of independence and illness self-management by teaching recovery skills that can be replicated and evaluated. Illness self-management and recovery is a federally promoted evidenced-based practice. In Georgia, the practice is called self-directed recovery, promoting the hope of recovery.

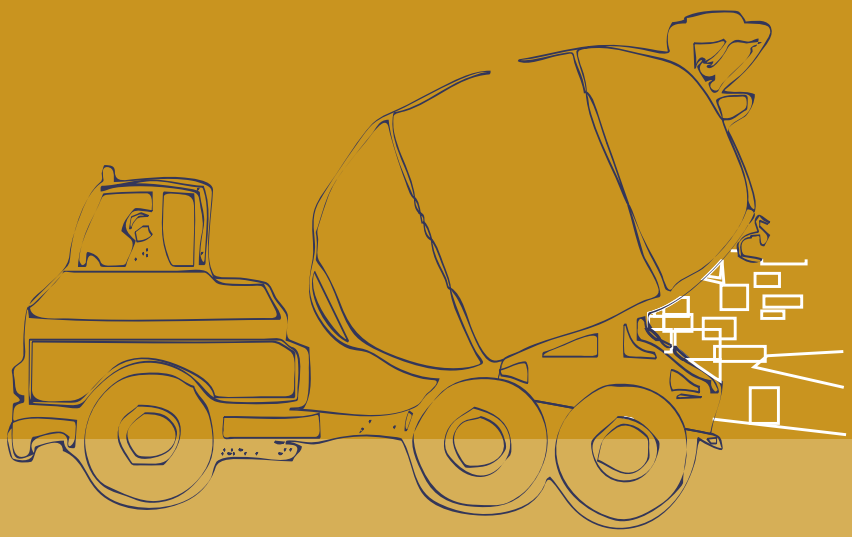
Every State can implement strengths-based recovery in its own unique way. But regardless of the path chosen—whether it be Medicaid-funded peer services, supported employment, or consumer-directed funding (funding that the consumer controls when choosing the services he or she wants to purchase)—transformation leaders will likely encounter powerful resistance to change. Consumers are vital change agents in the effort to transform systems to focus on recovery-based services.

Among the most important resources for transformation is the evidence documented in both *Mental Health: A Report of the Surgeon General* (1999) *and Achieving the Promise: Transforming Mental Health Care in America* (2003), the report of the President's New Freedom Commission on Mental Health. These reports demonstrate that a shift toward recovery is underway, enhanced by peer services and skills taught for self-directed recovery. *Building a Foundation for Recovery: A Community Education Guide on Establishing Medicaid-Funded Peer Support Services and a Trained Peer Workforce* is designed to be another tool for advancing system transformation.

This guide is part of a resource kit that includes *Building a Foundation for Recovery: How States Can Establish Medicaid-Funded Peer Support Services and a Trained Peer Workforce,* a sister publication designed for State authorities, and a colorful fact sheet on peer services and the training and certification of peers. Thinking of the resource kit as a blueprint for implementing federally funded peer support services that help drive recovery and system transformation, each section in the guides represents a component necessary to achieve such a transformed system. To achieve true "transformation," consumers and advocates must learn to "focus on what they want to build, not on what they want to change."

New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America: Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD.

Contents



SECTION 1

CONSUMER VALUES DRIVE THE SHIFT TOWARD SELF-DIRECTED RECOVERY

"Involve consumers and families fully in orienting the mental health system toward recovery" is Recommendation 2.2 of the President's New Freedom Commission Report. This recommendation lays the foundation for the recovery house consumers are building.

The values and leadership of consumers are driving the shift from a system focused on symptom reduction and custodial care to self-directed recovery built on individual strengths. Consumers in each State have the power to form networks that can promote change in their State's mental health system. Grassroots organizations can apply for funds to hold statewide conferences where they can arrive at a consensus on priorities for system change. They can work with State mental health authorities through offices of consumer relations and representation on planning and governing boards. They can even apply for and be awarded grant monies to implement the training and certification of peers for peer support services. The history of the consumer movement in Georgia, described in *Building a Foundation for Recovery: How States Can Establish Medicaid-Funded Peer Support Services and a Trained Peer Workforce,* illustrates how it can be done. Here you will find a summary of the lessons learned that can be applied everywhere. The first lesson learned is to communicate the values of self-directed recovery.

Self-Directed Recovery Values and Beliefs Underlying Peer Supports Services

Actions and behavior are rooted in people's beliefs, assumptions, attitudes, and values. Changing personal beliefs changes individual behavior. People are their beliefs. People protect their beliefs to protect themselves, which is part of their resistance to change. People resist change by seeking evidence that supports their beliefs and finding ways to deny evidence that contradicts their beliefs. Personal growth, i.e., change, always involves creating new ways of thinking and acting which are based on new beliefs.

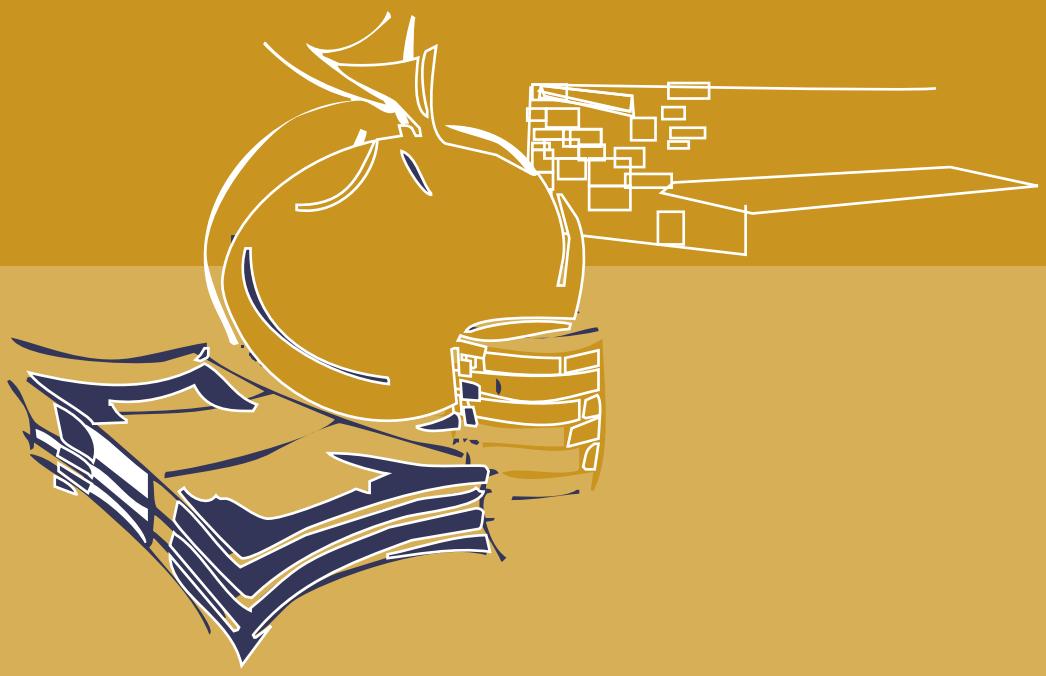
Since people tend to filter out belief-changing messages, how do you change people's beliefs? You need to overload their internal filter system with messages of possibility. You need to send so many messages that they cannot all be filtered out. They have to be surrounded by beliefs that call their personal, restrictive belief system into question.

Provider agencies need to be aware of the values and beliefs upon which they build their services. The following statements, given in no particular order, articulate values and beliefs that support and strengthen the self-directed recovery process. Some of these are more related to mental health than others. No doubt there are more, and they can be stated in many different ways. However, it is important to communicate them directly and indirectly to both providers and consumers of mental health services.

1. What a person believes about him or herself because he or she has a diagnosis of mental illness can often be more disabling than the illness itself. Self-directed recovery involves changing personal belief systems.
2. Self-directed recovery is not the absence of symptoms, but the development of new meaning and purpose as one grows beyond the catastrophic effects of mental illness.
3. When people do not see "recovery" as part of their lives, they need to be surrounded with possibilities of recovery.
4. I am responsible for my own life. I cannot expect anyone else to make my life the way I want it to be. It is up to me to create the life that I want.
5. Everyone has the ability to grow and change; therefore, if I relate to a person's potential, there is the possibility of calling forth greatness.

6. The important thing in recovery is to focus on a person's strengths and not the illness.
7. We tend to see what we are looking for; therefore, I need to help people look for the strengths and beauty in themselves and in others.
8. Whatever you focus your energies on, you give power to. Therefore, focus on what you want to create, not on what you want to change.
9. We all know that for life's most difficult problems, the only real answers come from within. Therefore, the most important thing that I can do for a person who is having difficulties is to ask questions that put him or her in touch with his or her inner wisdom.
10. Although symptoms bring people in for services, the focus needs to shift as soon as possible to wellness.
11. Although treatment plans that focus on decreasing symptoms are crucial for reducing the causes of emotional distress, they seldom motivate people to make major changes in their lives.
12. People are motivated to change the way they think and act (to accept responsibility for their illness and their negative behavior) when they see how their symptoms, thoughts, and actions are preventing them from creating the kind of life that they want.

Those working to support consumer-directed recovery and explain the effectiveness of peer supports include the National Mental Health Association (NMHA). As the oldest mental health advocacy organization in the United States, NMHA has long helped steer the mental health system in new and positive directions. The NMHA board has published a policy statement in support of consumer-directed recovery. It may be found in Appendix D.



SECTION 2

MEDICAID AND OTHER FUNDING OPTIONS FOR PEER SUPPORTS

For peer supports for persons with mental illnesses to become a reality, sources of flexible, targeted funding must be found. One of the agencies in the U.S. Department of Health and Human Services, the Centers for Medicare and Medicaid Services (CMS), have several State plan and funding options for developing peer supports programs. Because Medicaid funds almost 27 percent of all mental health services delivered in the United States (Mark et al., 2005), State and Federal mental health authorities, and the Federal, regional, and State Medicaid authorities wield tremendous influence over decisions about mental health services.

Overview of the Medicaid System

Medicaid was created in 1965 in Title XIX of the Social Security Act. It is funded through combined State and Federal dollars using a formula based primarily on the relative income levels of people residing in each State. The minimum share of Federal Medicaid funding that States receive is 50 percent and the maximum is 83 percent (Social Security Act, 1905(b)(1)). Both the Federal Government and State governments have input into how the program works. Because of this, Medicaid programs vary from State to State within broad Federal requirements.

Medicaid is an assistance program. It serves low-income people of every age. Mental health recipients qualify for Medicaid because of their income or because of the cost of their treatment compared to their income. Based on each State's participation rate, Federal Medicaid contributes a portion of every dollar delivered for Medicaid recipients and the State finances the rest.

Although the primary emphasis of the Medicaid program is on the delivery of medical services and supports, several amendments over the past decade have created options for States to expand services, supports, and eligibility groups, creating highly variable programs across the country. States set their own rates and administer their own programs.

Although Medicaid rules and policies can be quite complex, the funding opportunities provided by Medicaid provide the first floor in the "recovery house." This floor is essential when working toward recovery goals. Empowered consumers can have a significant role in urging Federal-State partnerships and guiding States to move toward a more recovery-focused mental health system.

CMS Tools for Peer Supports and Self-Determination

First, to qualify for Federal funding for Medicaid programs and receive the Federal Medical Assistance Percentage (FMAP), States must provide a core set of services to all eligible persons under the State plan. Then States have the option of providing additional services and supports using the *rehabilitation services option* under the State plan (see 42 CFR 440.130(d)) and *waiver programs* under 1115 and 1915 authority.

Many States adopting recovery as the model for State-funded programs do so by using the Medicaid Rehabilitation Option (Rehab Option), a program designed for mental health and substance abuse services. Georgia moved toward peer supports and other recovery-focused services using this option. Rules and guidelines associated with the program are very specific and require constant monitoring to ensure that the Federal money continues to support consumer services. In addition to Georgia, a few other States use the Rehab Option to allow reimbursable charges for certain peer-provided services.

Before embracing the Medicaid Rehab Option, Georgia used the Medicaid Clinic Option to provide services. This option was closely aligned with the "medical model." The Rehab Option, on the other hand, allows for consumer-driven values, such as recovery, to be integrated into all mental health services. Not only could Georgia implement consumer-delivered peer support services, but the State could also develop other services that promoted the consumer-owned management of mental illness. As more and more Certified Peer Specialists (CPSs) were trained, it was natural for them to be included in other services that were rehabilitation oriented. Assertive Community Treatment (ACT), Community Support Team (CST), Community Support Individual (CSI), and Psychosocial Rehabilitation (PSR) were all identified as services that could effectively use CPSs.

In addition to Medicaid, CMS administers Real Choice Systems Change Grants for Community Living *(www.cms.hhs.gov/systemschange),* which may be used by States to increase opportunities for people with disabilities who live in the community. Consumers can read more about this option and about using the Medicaid mental health program to pay for needed recovery-focused services in *Building a Foundation for Recovery: How States Can Establish Medicaid-Funded Peer Support Services and a Trained Peer Workforce.* An understanding of Medicaid will strengthen the ability of consumers to push systems toward transformation.

Community Mental Health Block Grants

Another source of flexible funding that can support the development of peer support programs and peer specialist certification is the Community Mental Health Block Grant (MHBG), which is administered for SAMHSA by the Center for Mental Health Services (CMHS). Each State and Territory is eligible to receive a portion of allocated Federal funds based on a formula established by law. To receive funds, each State must develop a State plan and an annual application that defines the strengths and weaknesses of the State system, gaps in services, and State initiatives that will make improvements and close the identified gaps. Each State has an individual who is designated as the State Planner, whose responsibility is to coordinate planning and prepare the MHBG application. A State Office of Consumer Relations and the MHBG State Planner can be very effective allies in many activities that improve services to consumers. Building consumer-directed services into the MHBG State Plan represents a "win-win" for both consumers and the State.

Taken together, Medicaid and other special funding programs present a wealth of opportunities for States that are interested in mounting demonstrations of peer support programs and self-directed care for people with psychiatric disabilities.

SECTION 3

TRAINING AND CERTIFICATION OF PEERS

Change, even for those who are change agents, is difficult. Mental health system providers often resist transformation initiatives that focus on consumer-directed services and may not want to hire consumers as professionals. They often voice many concerns, not the least of which are that they can't identify anyone to hire, would not hire anyone who is being or was served within the agency, or do not know how to advertise for someone who has experienced a mental illness to work for them.

For Georgia, the training and certification of peer specialists was a first step toward achieving acceptance of the new peer support services. Not only did consumers benefit from the support of peer specialists, but through their training and experience, Certified Peer Specialists (CPSs) found new dimensions in their own recovery. With new confidence and certification education, CPSs model recovery to all involved in transforming the mental health system and thus answer the concerns of providers. For a CPS job description, see Appendix A. The following section describes the CPS training program that Georgia developed.

The Georgia Certified Peer Specialist Training Program Progression and Modules

The 42 modules of the 9-day Georgia Certified Peer Specialist Training Program (Table 2) follow the sequence of the recovery process shown in Table 1. Table 1, the Five Stages in the Recovery Process, is based on the work of Dr. Pat Deegan, and it provides the framework for the entire training. **Impact of Illness** brings people to the mental health system. As they struggle to deal with all of the ramifications of illness, they also struggle with the extent to which their **Life is Limited,** in both a real and a perceived sense. When the spark of hope appears, they are able to say **Change is Possible.** At this point the struggle becomes how much **Commitment to Change** they are able or willing to make. Finally, what **Actions for Change** are necessary to move toward independence?

For each stage of the process, the training program modules raise and attempt to answer these three underlying questions:

1. What is the role of services being provided by the mental health system?
2. What is the role of peer support?
3. What is the role of documentation (individual service/recovery plans, goals, objectives, interventions, progress notes, etc.)?

The competencies that the Peer Specialist Certification training develops are listed in Appendix B.

Table 1. The Role of Peer Support in the Recovery Process

Five Stages in the Recovery Process				
Impact of Illness	**Life is Limited**	**Change is Possible**	**Commitment to Change**	**Actions for Change**
The person is overwhelmed by the disabling power of the illness.	The person has given in to the disabling power of the illness.	The person is questioning the disabling power of the illness.	The person is challenging the disabling power of the illness.	The person is moving beyond the disabling power of the illness.
The role of services is to decrease the emotional distress by reducing the symptoms.	The role of services is to instill hope, a sense of possibility, and to rebuild a positive self-image.	The role of services is to empower the person to participate in his/her recovery by beginning to take small steps.	The role of services is to help the person identify his/her strengths and needs in terms of skills, resources, and supports.	The role of services is to help the person use his/her strengths and to get the necessary skills, resources, and supports.

Source: Empowerment Partners, LLC

Following are the 42 modules that make up the Certified Peer Specialist training:

Table 2. Georgia Certified Peer Specialist Training Program

DAY 1	DAY 2	DAY 3	DAY 4
	(4) Is Recovery Really Possible and How Negative Messages Are Sent	(10) Beliefs and Values that Support and Strengthen Recovery	(16) Problem Solving with Individuals
	BREAK	BREAK	BREAK
	(5) The Power of Negative Messages and Creating Recovery Environments	(11) Effective Listening and the Art of Asking Questions	(17) Facilitating Recovery Dialogues
	BREAK	BREAK	BREAK
	(6) Psychosocial Rehabilitation as the Road to Recovery	(12) Dissatisfaction as an Avenue to Recovery	(18) Case Studies and the Individual Service/Recovery Plans
	LUNCH	LUNCH	
(1) Welcome, Introductions, and Overview of Training	(7) The Impact of Diagnosis on One's Self-Image	(13) Combating Negative Self-Talk	
BREAK	BREAK	BREAK	
(2) GA Mental Health System, TRIGRS, and Documentation	(8) TRIGRS and Individual Service/Recovery Plans: Assessment	(14) TRIGRS and Individual Service/Recovery Plans: Goals	
BREAK	BREAK	BREAK	
(3) The Role of Peer Support in Recovery	(9) Telling Our Recovery Stories	(15) Facing Your Fears	
DINNER	DINNER	DINNER	
Free Time	Support Group	Free Time	

Table 2. Georgia Certified Peer Specialist Training Program (continued)

Day 5	Day 6	Day 7	Day 8	Day 9
	(22) Person-Centered Planning	(28) Power, Conflict, and Integrity in the Workplace	(34) Cultural Competency	(40) A Panel of Certified Peer Specialists
	BREAK	BREAK	BREAK	BREAK
	(23) Person-Centered Planning	(29) Power, Conflict, and Integrity in the Workplace	(35) The Five Stages in the Recovery Process: Dangers and Interventions	(41) A Panel of Certified Peer Specialists
	BREAK	BREAK	BREAK	BREAK
	(24) Person-Centered Planning	(30) Supported Employment: How It Works	(36) Recovery: Mind, Body, and Spirit	(42) Reflection, Questions, Evaluation, and Next Steps
LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
(19) Welcome Back and Overview of Week 2	(25) Creating a Wellness Recovery Action Plan	(31) Supported Employment: Peer to Peer	(37) Creating the Life You Want	
BREAK	BREAK	BREAK	BREAK	
(20) The Role and Expectations of the Certified Peer Specialist	(26) Teaching the Wellness Recovery Action Plan	(32) Support Groups and Double Trouble in Recovery Groups	(38) TRIGRS and Individual Service/ Recovery Plans: Progress Notes	
BREAK	BREAK	BREAK	BREAK	
(21) The Role and Expectations of the Certified Peer Specialist	(27) Real Talk: Moving Beyond the Language of Mental Illness	(33) Telling Your Recovery Story Through the Five Stages	(39) Revisiting the Five Case Studies	
DINNER	DINNER	DINNER	DINNER	
Free Time	Support Groups	Free Time	The Soul's Mall	

The Nuts and Bolts of Georgia's Peer Training and Certification

Qualifications. Consumers who are interested in becoming a CPS in Georgia notify the CPS Project Manager, who works for the Office of Consumer Relations in Georgia's Division of Mental Health, Developmental Disabilities, and Addictive Diseases. Candidates are selected for the training based on their employment status and other qualifications. Consumers who are currently employed by a public or private provider of Medicaid billable services are given first consideration. Those who have distinguished themselves as peer leaders and will be sponsored by a Medicaid provider for possible employment within the agency receive second priority. If space is available, consumers who work within a peer service that does not bill Medicaid, or consumers who are seeking certification to improve their marketability are given subsequent priority.

Candidates for certification training must

- Identify themselves as former or current consumers of mental health or dual diagnosis services;
- Be well grounded in their own recovery experience with at least one year between diagnosis and application to the training;
- Hold a high school diploma or GED (including diploma earned in Special Education);
- Demonstrate basic reading comprehension and written communication skills; and
- Have demonstrated experience with leadership, including advocacy and or creation/implementation of peer-to-peer services.

Training. Certification training is conducted over two weeks. Approximately one month after completing the full 40-hour training, trainees are eligible to take the certification exam. The entire test takes approximately 2 1/2 hours, but it is not timed, and thus can accommodate various testing needs and styles. The exam is both written and oral, with each part weighing 50 points. A passing score of 75 percent or above must be achieved. Tutoring/mentoring is available for individuals who wish to retest.

Continuing education. Continuing education is held quarterly to reinforce specific skills or tools and to address issues that emerge from daily practice experience. Emerging issues can lead to the development of additional training modules that strengthen the training curriculum. For example, in Georgia the Office of Consumer Relations held a weeklong training in mediation for CPSs to further develop their communication skills. Afterward, two full-time staff trained in mediation were hired to provide on-site technical assistance to any CPS needing help with conflict resolution.

Code of ethics. As do most professional associations, CPSs have a formal code of ethics. The CPS Code of Ethics (Appendix C) guides consumer providers in how to form productive recovery relationships with the consumers they serve. The niche that the consumer provider occupies is one in which he or she is neither among consumers being served, nor among traditional or nonconsumer staff. If a written allegation of violation of the ethics code is submitted to the Office of Consumer Relations, a tribunal that includes the Director of the Office of Consumer Relations and staff will determine the validity of the allegation and a response. The ultimate response action is to revoke State certification.

The Georgia Peer Support Institute

The Georgia Peer Support Institute is a separate, but equally important, initiative under the Georgia Office of Consumer Relations that identifies, trains, and supports emerging consumer leaders to advocate for quality peer supports and peer support centers in their communities. Twice each year, the Institute selects 35 consumers to attend a 3-day, all-expenses-paid program. The training focuses on the following:

1. What a quality peer supports service is and how it promotes recovery
2. How to advocate for peer supports and recovery projects in your community
3. Tools for self-directed recovery and wellness
4. How to start and sustain self-help/mutual support groups
5. Self-determination or consumer self-direction
6. Supported employment and recovery

Many of the graduates of the Institute go on to apply for CPS training, having gained experience as leaders and developed an interest in being employed to support others in their recovery.

Using Technology for CPS Peer Support

The CPSs are able to go online at any time, day or night, and share knowledge, experience, and support via a special Web site and chat room that only those certified can access. The Web site also provides the latest media articles and research on peer supports and recovery, plus upcoming events including training, and applications to attend the Georgia Peer Support Institute.

Certified Peer Specialists Tell Their Stories

Following are some personal stories that illustrate the impact of the CPS training on individual lives. These experiences of empowerment and recognition of the importance of hope in fostering recovery and the achievement of life goals are both inspiring and enlightening.

Beth Filson

I don't remember how long I worked in a sheltered workshop. I do remember that I had become one of the many who smoked cigarettes on breaks and lined up in the cafeteria at lunchtime for a cheap meal. I sat alone. I worked alone. I did not connect with people. There was too much despair and hopelessness there, or at least in my own mind. I'd crawl into bed slamming into sleeps so deep and dark I wouldn't wake up until night time. I drew on huge sheets of butcher paper until the morning. I used chalk pastels, oil pastels. I can't remember how long I lived like that. I can't remember if I was in the workshop for 6 months or 2 years. I just don't remember.

I always resigned from my jobs. I couldn't escape failure. I started every new job projecting competency and collaboration. I met people with a feigned strength that collapsed, always, inevitably, under the weight of my own sense of inferiority and incompetence. It was always only a matter of time before I became what I knew I was inside: Damaged, and the version of me I'd projected to everyone around me disappeared. Even if they never saw the scars on my arms and my wrists and on the back of my hands, I felt marked by the history of an illness. I was afraid of the next time I'd disappear into the hospital and the demoralizing moment I'd have to call a supervisor to report where I was. I never entered into new jobs believing I would succeed and build my life based on this new career, but with the hope that I could last longer than 9 months this time, or a year this time. I was 40 years old. I had never held a full-time job longer than 2 years. Mental illness was not the sole reason. It was a part of the reason as was the lack of skills I had developed to be able to participate in the events important to my community, like work, like relationships, like home. But the significant factor in my constant failure was unquestionably the stress, and the anxiety, and the abject fear I felt in exposing the fact that I carried a mental health diagnosis, and the accompanying belief that it stood between me and all others. Even when an employer was aware that I had been treated for mental illness, I could not overcome my own terror that I would prove myself incompetent at best, truly insane, at worst. I held myself at a remove, too afraid of getting close, of slipping up, of appearing mentally ill. I always left every job before I failed. I felt it best.

This one fact stands out, though. Despite repeated hospitalizations over the course of a decade, there was something in me that refused to give in to the belief that I would never find my way and my place in this world. I remember early on that a psychiatrist told my family that I would die in a State hospital—and even then I did not believe it. Nor did I buy in to the idea that I would never be able to work. There was something in me that said, in fact, that I *must* work. Even though I chose to leave every job I ever had, within days I was searching the papers for the next one.

It was incomprehensible to me to imagine that the visible scars on my arms from shoulder to fingertip were anything less than the most terrible proof of my inability to live and work as others do. The scars signaled to me on a daily basis that I would never be able to form ties and relationships that everyone else seemed to me, looking in from the outside, to take for granted. I knew that there would always be a part of me in hiding, no matter what I did or became, and this knowledge, though seemingly irrefutable at the time, was something I still railed against. Even so, I accepted that it would be a permanent source of separation from all people.

At some point after resigning my most recent job, I found a notice in the want ads. It was a call for a Peer Advocate. It stipulated that this person must have a mental illness. Mental Illness. There it was. I remember the feeling of total resignation blooming in my chest as I stared out of the window where I sat at a small kitchen table in the studio apartment I shared with my sole companion, a bird. I was thinking, well, there you have it—mentally ill. I thought, this is all I am and all I can ever be. I was still going for weekly blood level checks because of the Clozaril I had to take. Wasn't I headed for the hospital again, yet again? I couldn't stop it. It was inevitable. I could know it, but I couldn't stop it. The hospital just came and there I was and there was the sound of the door lock engaging behind me in its absolute certainty that this was my true and only place in the whole world. At that kitchen table I knew there was nothing left but to pick up this terrible mantle of illness I had refused all those years and through all the diagnoses I had ever had and which I'd torn to pieces in hatred and refusal. For a moment I gave up. This is how I met the idea of becoming a consumer provider, and in rebellion I threw away the ad. One day later, however, I spread newspaper on the floor, overturned the trashcan and rooted through the garbage until I found the notice. A soft but persistent voice kept telling me that maybe what the ad was really saying was that my experience with mental illness held meaning. With the flint and steel of my life in that exact moment, hope flared.

I was hired as a Peer Advocate and for 2 years I held on to my part time job facilitating an employment skills group. All I really had to offer was the belief that work had something important to do with recovery. That's all I knew. Everything else that happened in the group was based on shared experiences of defeat and overcoming defeat—not just overcoming it, but making it matter, making it the source of newfound strength, greater insight. Some of the folks who were part of that group went on to claim their status as consumers and spoke of how their experience had caused them to be stronger, more aware of the power of being a team player, more certain of their strengths and how to utilize them. There were successes.

Two years later my boss told me that there was a pilot training that the State was conducting for consumers working in the public mental health system. She wanted me to attend. It was a 6-day training held over a 3-week period—3 days on, a week off, then the last 3 days on. I did not understand what she meant by "the State." I did not comprehend what "pilot training" meant. I did not know that people like me, just like me, worked full time. I did not know to ask about these things. I held an advanced degree. I had worked in Manhattan and Boston. I had taught at the college level. But I lived totally cut off from the world around me, disconnected from any semblance

of citizenship. I could only connect to what I needed to give or to get at any given moment. I was oblivious to the surrounding context of the Consumer Movement.

I remember driving onto the campus of Epworth by the Sea on St. Simons Island. I passed the tiny wooden church on my left under a canopy of live oak where one of my brothers had been married just a few years back—but I did not remember that I had been there before. I lugged my suitcase into my room, a dank cinder block dwelling in the older part of the campus across from the auditorium where the training would be held. I pulled out the material I'd received in my acceptance packet: a small manual called the Wellness Recovery Action Plan and a Xeroxed handout with directions to write down my recovery story. My recovery story? I wasn't sure what that meant. I put it aside. I preferred not to think about it. I would get to it later. I was anxious to start the Wellness Recovery Action Plan I'd been instructed to read and have prepared for my first day of training. My hands shook as I tore open the plastic wrapper on my new sheath of lined paper. I pinched open my new binder. I carefully followed the directions on how to lay out my WRAP folder. I began writing. I headed the first sheet "What I'm Like When I'm Well." It was hard to think. I turned a few pages and headed the next section "Triggers." I referred to the manual for a definition. I jotted down a couple things. I went to the next section, and the next. I went back and forth filling in, scratching out, referring to the WRAP manual, returning with new insight for my own plan. I worked through the night. This made sense.

I stumbled into the training room blinking in the light and that sudden expectancy you have when you walk into a room full of people who don't know who you are or who you are supposed to be. I could start again here. Strong. This was my element—concepts and ideas. I had a chance here. Maybe I could belong. Maybe the faces would not suddenly crack into hatred and disgust when they turned to study my own. I would be careful. I would do it right this time. I wouldn't talk too much. I would be wise and quiet and reserved and silent and not say all that I already knew about what this world feels like to those of us who have had to make a decision about staying.

I remember that I talked too much and that I leapt at the ideas that were presented—like how the impact of diagnosis on one's self image can be more disabling than the illness itself. I tore into discussions about what makes recovery possible pulling from a place inside myself I did not know was full of so many answers. I was moved by the eloquence of Patricia Deegan's statement "when one lives without hope, the willingness to do is paralyzed." I kept nodding my head yes, yes, yes. I struggled to not answer every question that was asked when we were taken through a Recovery Dialogue. I knew all this. We *all* knew this, but maybe it was just that this was the first time we got to know how vital our experience, how key we were to helping a society heal from its own defeat and its own despair over the treatment of the mentally ill. Suddenly I was a wise woman, not damaged. My strength was validated as a human being who had gained great insight by the very experiences that had cut me off from my community. I cried during a small group exercise when one of the group members pinned on my shirt a button while she said out loud, "When I hear your recovery story, I know you are a walking miracle." It was as if I had been brought by strangers to a marvelous table and invited to sit and eat with them and it was huge, that sense of belonging, that realization of new direction in my life, that absolute and final decision that I had found my place and it was here, among my peers in service to others who

did not known they were not alone, who did not know recovery is possible. I knew that from this point on my story would be woven into the stories of all of us who have ever believed that with the diagnosis of mental illness comes the death of all dreams. I chose to make meaning out of the pain and the rage and the hatred and the waste I'd once felt. My life had been one of great meaning, in the end—which was really my beginning.

Soon after becoming certified I was hired as the Project's first full-time manager.

From time to time I have wondered, If I could leave behind the scars on my arms—would I have become a Certified Peer Specialist? If I could shed my skin and walk away—new, glistening—would I do it? The answer is this: I cannot separate my arms from my role as a CPS and I would rather not. I once consulted a plastic surgeon who could offer me only one alternative—to remove the scars by creating the appearance of burns, so great is the stigma associated with self-harm. However, it is because of my work as a CPS and the connections that I have forged in service to my peers, in the work I do with my colleagues, in the community of others who have become role models for the possibility of recovery—that more often than not these are not just scars. They are proof of a life.

We who made up that first class had not "graduated" to some status of normalcy in which we could now be like traditional providers. We were vital because we would work from the perspective of our own experience with mental illness and recovery. The strength of our role was in our very struggle. Our relationships with each other, with our peers, were the conduit for healing. I had tried to be whole and well in isolation. I understood why I kept failing. Failure, for me, was the cost of hiding out.

During the training on St. Simons, I spent a lot of time walking the beach in the late evening. I remember one evening berating myself for saying too much. I'd disclosed too much. I didn't pull back and I should have, like a crab does when you tap on the conch it has pirated and it pulls itself deeper into its stolen whorl. I stilled and studied the sky. The mist was so cold. My slicker wasn't enough against the October wind and rain. Telling anyone I'd been a revolving door patient for years had been at one time incomprehensible to me. Becoming a Certified Peer Specialist was the same as rolling up my sleeves—baring my arms. The times I'd braved short sleeves I'd witnessed the full force of others' disgust, or outrage, or fear. Those reactions had deepened my sense of shame and alienation. I had allowed myself to be stripped of personal power, credibility, authority. Even I, author of my own damage, could not stand the sight of my own arms. This is what stigma does when it is internalized—and does so well: It makes us hate ourselves. My silence had become an accomplice to a world that would rather not look.

Where before I would have looked out over the Atlantic at a furious sea, this time when I did so, I saw a fiery sea, a passionate, raw, full of mystery, powerful, awe-inspiring, fully alive sea. I picked up a rock and hurled it into the sky. I used my whole body to throw it, spinning a little as my feet left the sand.

In that moment I felt a gentling in me, like a deep weariness. I understood that some battle that had been waging in me was finally over. I was finally done. This is how my life and work began.

Jayme Lynch

My caseworker and I were sitting at my dining room table, sipping herbal tea and dodging the jealous swoops of my pet dove. "I am in a void," I said. "I have no goals, no aspirations, and no motivation. I am finally free from all the demanding Web sites I've been maintaining for the last 6 years, and yesterday I got rid of the last one." After volunteering my time to work on fan sites for a rock band, I had finally decided I needed a new direction in my life, though I had no idea what that might be. This was the first morning I had absolutely nothing to do.

"Would you consider volunteering at CFI?" my caseworker asked.

Community Friendship, Inc. (CFI) is a psychosocial rehabilitation center, and I felt I'd already had my share of the mental health system and all its atrocities. I had spent 20 years in and out of hospitals, including a yearlong stay at a State hospital in the early 1980s, and I had been through the whole day-treatment scene as well. I was triggered by the injustices of the system, and those triggers often led me into a crisis situation requiring, ironically, more hospitalization. This was a pattern I had been following most of my life, and it was a vicious, destructive cycle. Thankfully, I had a private therapist who specialized in trauma, and the traumas from all my hospitalizations had been the theme of our sessions for the last several years.

I'd also been a consumer advocate in the 1980s and became disillusioned with that as well. I was basically through with it all, except the basic necessities for my own mental stability.

I remember staring at my caseworker that day, wondering why she would ask such an odd question, and then I felt this strange stirring inside. I know when my spirit is speaking to me, even when it makes no sense at all, and I found myself becoming increasingly inspired. My caseworker and I spent the next hour discussing all the ideas and possibilities, including how awesome it would be for me to teach mental health consumers how to navigate the Internet and make their own Web sites! The more we talked, the more I was ready to get started right away!

I met with CFI's program director the following week. She welcomed me unconditionally, listened attentively to my ideas, and we both felt like I was onto something with this new endeavor. She also mentioned that they had a peer support group I might be interested in, and she gave me the names of the consumers who ran it. I wasn't particularly interested in going to any groups, but I found myself attending peer support twice a week anyway. Driven by a force I did not understand, I decided to simply ride the waves. This included attending the peer support meetings, teaching computer lessons, and assisting in adult education classes. It gave me a feeling that I was making a difference in people's lives, and it also turned into an exercise routine with the 20-minute walk each way to the center. I had found a new structure in my life, and it felt healthy.

One day in peer support, I overheard someone mention Certified Peer Specialist (CPS) training. I had no idea what that was, so I did a search on the Internet for "Certified Peer Specialist." A Web site at **www.gacps.org** turned up, so I called the number and

asked for an application. A few days later, I filled out the application and sent in my $75 registration fee. I was confusing myself, really, and I honestly didn't understand what was driving me to pursue this training, especially to the extent of sending in money! It was making no sense at all, but it was also becoming an adventure just to see what was next.

The following day, I overheard a consumer say that he was going to the CPS training. When I asked him more about it, he said that CFI was paying for his training and all related expenses, including hotel, food, and transportation. I asked the program director if I qualified for a scholarship, and to my surprise she said yes! So in a few weeks, I would be leaving for Milledgeville, Georgia, all expenses paid. It felt so right. It felt so effortless!

Then I learned that the training would be held at Central State Hospital. This was absolutely horrifying! I immediately called the CPS office and asked if I could get a refund because there was no way I was spending one minute at a State hospital, even as a nonpatient. The vibes alone would be intolerable! The woman at the CPS office said yes to the refund, but then she talked me into going. God only knows how she did that. Something much greater than myself was driving me to go to this training in spite of all my fears. This became more and more obvious as the events unfolded.

On a chilly, rainy April morning I rode with three other consumers to the hospital and observed the grounds as we tried to find the chapel. We got lost a few times, so I saw quite a bit. The hospital was spine chilling with all its towering, chipped brick buildings and broken windows. I wondered if I was going to be able to hold it together, and I was getting worried. We finally settled into the training room at the chapel, just in time for the first class to start.

Larry Fricks, one of the presenters, was telling us about the hospital cemetery and how the buried patients had had their numbered markers kicked aside for easier mowing. The markers were left scattered around the cemetery, as if the patients never existed in the first place. They were ghosts before they ever died. This was how I saw it, and it was the saddest thing I'd ever heard. I couldn't help but think one of those patients could have been me, or any one of us in that room. I began to cry uncontrollably, which was horrifying, and I hid my head so nobody would notice. With my head lowered, I saw the tears drop to the training manual before me, and I tried to wipe them off. Then I saw written on the manual's cover, "Updated 03/03/03." The number 333 had been my favorite number since childhood, and I had celebrated with friends on that particular date just because of those numbers! Seeing 333 in this context assured me I was doing something right. It was a "cosmic wink," if you will, and I received that wink with much gratitude. I was also able to pull myself together for the rest of the day's training.

The first night in the hotel was especially difficult. It was rough to be away from home, away from my precious dove, away from my computer, and away from my comfort zone. I was scared in that dreary hotel room and I felt so alone. I went to bed early in hopes that the night would go quickly, and I planned to sleep as much as I could the whole week. The first night I woke up and cringed at remembering where I was. A feeling of dread overwhelmed me for a moment, and then I opened my eyes long enough to see the clock. It was exactly 3:33am.

What a relief it is to believe in angels!

The training itself was powerful. I heard groundbreaking concepts about recovery and hope and empowerment. I learned about Medicaid reimbursement for peer support services, which was totally unconventional and unheard of. I attended group sessions and recovery workshops and learned hundreds of acronyms and terms I never knew existed. I learned about the WRAP plan and how to be proactive in my own recovery. I felt like I was gathering all the pieces of a gigantic puzzle that I would eventually put together. I didn't understand everything that week, but I felt a renewed sense of hope and fresh inspiration in my life. I also felt a warm, caring connection with the presenters, and I knew they were all in their elements. It was a gentle, safe feeling. I couldn't believe it, but I felt safe at a State hospital!

After the first 4 days of the training, we were granted a weeklong break at home before returning for the final 4 days. I was thrilled to be home, and I relaxed most of that time. My sister had given me a Norah Jones CD before I'd left because she didn't like it, and I hadn't had a chance to listen to it until then. I ended up playing that CD continuously throughout the entire week. It was soothing and comforting, and it spoke to me in ways that nothing else could at that time. I remember crying a lot, too, mostly from relief that I had made it through that intense first week of training, but also to relieve the stress from having been away from home. I had struggled with agoraphobia off and on my whole life, so that week was quite an accomplishment. I wasn't afraid anymore, and I was ready for the second week of training.

Toward the end of the training, we visited the cemetery. Larry Fricks showed us hundreds of markers that had been gathered from the grounds and placed in beautiful rows as a memorial to all the patients who had died in that dreadful place. Those patients weren't forgotten at all! They were tremendously honored! And it was consumers themselves who made this happen! My heart welled with pride from being a consumer. This was miraculous!

We walked through the gates and further into the cemetery itself. I remember following along the path, taking pictures of a few really old headstones that had weathered the years. I took pictures of my classmates posing near the graves and under trees and all over the well-kept grounds. I remember looking down as I walked, noticing a stray grave here and there and paying tribute in my own silent way. Suddenly I glanced up and saw the most beautiful sight of all. My fellow classmates were climbing all over an enormous bronze angel, hugging it as if it were truly watching out for our late brothers and sisters, smiling from ear to ear at their discovery. We all felt such a kinship with each other at that moment and with all who had died in that hospital. This phenomenal angel rapidly became the defining symbol of true healing. Every one of those patients truly mattered, and we were there to honor them all. I like to believe they were with us in spirit, smiling and perhaps celebrating our discovery. It was such a brilliant moment full of immeasurable hope, and I will never forget it as long as I live.

My life has not been the same since the CPS training. I understand now why I was compelled to volunteer at CFI. I understand why I sent a $75 check to some remote office. I understand how the woman at the CPS office talked me into going. Most of the mystery and confusion is over, and now I work directly with the CPS Project as

the Web master of **www.gacps.org**, as well as the Project's database coordinator. Who would have guessed? It's still hard to fathom that I'm actually getting paid for doing something I love and believe in! I do volunteer work, too, and it has nothing to do with maintaining fan sites for a rock band. I run a national e-mail list called Consumer/Survivor Issues, as well as an online self-help support group for people with dissociative disorders, a writers' forum for consumers to send in personal stories of their experiences with the mental health system, and computer work for the Support Coalition International.

The injustices of the mental health system still trigger symptoms for me, but it no longer means that a setback is inevitable. Instead, I am now growing from these experiences, not destructing. This is what recovery is all about for me. This is what it means to finally live.

What a relief it is to believe in myself!

W. Fred Long

I began my journey into darkness soon after I graduated from high school. I complained to my physician of an inability to think on the level I felt I should be thinking. I also complained of various illnesses that did not really exist. I had seen angels and heard God's voice speaking to me, urging me to do things I was unprepared to do. I felt isolated, alone, and my isolation intensified. My physician referred me to a psychiatrist and my journey into darkness began.

The psychiatrist labeled me with schizophrenia and suggested immediate hospitalization. I could not afford a private hospital so I voluntarily committed myself to the State mental institution. I went there expecting to receive help, but 6 weeks later found myself overmedicated to the point that great amounts of saliva would drool from my lips. One day I fainted from having so much of the medication in my system. A doctor examined me and could find no signs of schizophrenia. I asked to be released and, after a board of doctors examined me, I went home the following week.

I cannot describe to you within the scope of this paper the things I saw at the State mental institution. Besides, the memory of that place only brings bad feelings. I did everything I could during the years I spent in my darkness to keep from ever having to be admitted again. Something within me—even in that darkness—kept me from being institutionalized.

My story includes several years of being in and out of the hospital, receiving shock treatments three or four times, the attempted suicides and the divorces that ensued because of the stigma attached to mental illness. They were years of intense darkness with no hope of recovery. In fact, I had one doctor tell me long ago I would never recover, that I would never function in society again. Yet I tried again and again to blend into society. I faked my life so well that I eventually became a retail store manager with a major retail company. This worked for a while.

Twenty-two years ago, during Christmas rush, I had to be taken to the hospital. I had started having panic attacks. At the time I thought I was having a full-blown heart attack, but this did not prove to be true. I was seen at the hospital by a psychiatrist. This time my diagnosis was severe depression and panic disorder. I tried bravely to return to work, but found I could not manage my depression. The panic attacks returned. After months of treatment, my psychiatrist recommended I quit work and go on disability. That idea was hard to accept. The darkness (which had never left me) now overwhelmed me.

For a long time after I went on disability I did nothing. I existed. I ate and slept. I took my medication. And I never looked back at how successful I had once been because I was now without hope. I was now accepting my mental illness and with it the false belief that I had always been mentally ill and would always be mentally ill. I believed I would never regain any semblance of my former life because now the darkness was so overwhelming. I quit going to church. I had only one friend. I trusted no one, including myself. After all, I was mentally ill and had been told I would never recover.

Years went by as I continued to let the darkness be my master. My wife of that period and I had bought a house. We had two acres of land that were going to ruin. The barn was beginning to collapse. My life had already collapsed. I had to do something. I couldn't continue to feel useless. So I began to tear down the old barn. This was a significant action for me. I knew nothing about building. I knew nothing about how to take my life back. In tearing down that old barn, I began to learn about building. My mind took mental pictures of how the barn had been constructed. When I finished tearing it down, I took on the task of building a new barn. It was hard physical labor. It was challenging and, when I had finished, it was an accomplishment. I felt good about myself, even though I wasn't ready to take on the world yet. But soon even that accomplishment faded. Some more years dragged by. I continued in darkness. My wife divorced me. I attempted suicide again and found myself in the hospital again. I had found the darkest time of my life.

After my hospitalization, I found an apartment and had been living there for a month. I hadn't connected the television. I hadn't unpacked the boxes. I would not sleep on the bed. I did nothing but lie on the sofa and cry. I was in deep, dark trouble. One morning someone knocked on my door. My counselor from the mental health department had sent a caseworker to see me. He listened to me and then told me he would be back the following week. He urged me to have my apartment looking like a home when he came back—and I did.

When he came back, he was surprised. He then told me he wanted me to attend a peer center (back then it was called a day treatment facility). I was reluctant, but he asked me to go as a favor to him for just one day. If I didn't like it, I could come back home and never go back. I stayed in the peer center for 4 years. In 1999, I graduated and there my journey out of darkness begins.

After I graduated from the peer center, I did one of the bravest things I've ever done in my life. I went to Russia to marry a woman I had been writing to for almost 2 years. We married in Russia and I brought her home with me a couple of months later. She has supported me in anything I do or don't do. She accepts me for who I am and she accepts my mental illness. I know she is human, but she is the best thing that has happened to me all my life. When I decided to go to the Certified Peer Specialist training, she was behind me all the way.

I didn't know of the Certified Peer Specialist Project until 2 years ago. I was visiting a privately owned peer center and met a computer technician who was also a consumer. He mentioned the Peer Specialist Project and I was amazed at what he told me. I wanted to become a Peer Specialist that day. I had always wanted to help people and felt this might be the ideal way for me to achieve that goal. However, it took 2 years before I finally decided to become a Certified Peer Specialist. It wasn't because I didn't want to go earlier, it was because of finances, but, when the local mental health system was made aware I wanted to accomplish this task, they provided the financial support.

My awakening came as a result of my becoming a Peer Specialist. During my training, my eyes were opened to a whole new world. My first day of training was one of the most illuminating days of my life. Light began to penetrate the darkness. That first day I began to learn what a consumer who wants to become a Certified Peer Specialist

must learn. I found, too, that this was going to be the biggest challenge of my life. There was so much material to learn, so much to absorb, and I found I would be tested on the things I learned. I knew I had to do it. I wanted to do it, but on the second day I was ready to quit, to give up, because I thought I was stupid. Had it not been for someone who cared—a fellow peer—I might have done just that. This fellow peer offered me her friendship and gave me some good advice. I stayed. I wanted it bad enough that I let my fears subside and pushed the darkness aside. I said "No" to my own darkness for the first time. And I took a little tiny step toward the light without falling down.

The next few days transpired in a blur of intense work. Those of us in that training group began to laugh together and cry together. We shared our experiences as we learned. Before I knew it, the first week of my 2-week training session had ended. I felt sad about this. I had learned to step toward the light by taking little steps and then bigger ones. The content taught was recovery based and recovery oriented and I had been taught I wouldn't recover. Now I was discovering that it was possible. Now I was finding recovery was happening and that it was occurring in me. The few days between training sessions I faced with study and anticipation. I was ready to go back. I wanted to know more of these ideas about recovery. I found myself excited on the day I was to return. I hadn't slept much the night before because of the expectation of what I knew I was about to learn.

When I returned for the second week of my training, I was eager to begin. I was taught a great deal of information those next few days, but the sessions I value the highest were on the Recovery Dialogues. These are scripted discussions done in a group setting and led by a facilitator to get people talking about issues like empowerment, hope, what makes recovery happen, and lead the consumer into the realization that one can recover and that recovery is happening. Another part of this second session was on documentation. I will forever remember the words "If it's not documented, then it didn't happen" for purposes of Medicaid reimbursement.

During my training, I stepped into a different world: A world in which the mental health system is slowly beginning to change, a world in which consumers can now take an active part in their recovery process. I no longer believe the doctor who once told me I could never be part of society again, because I am now an active member in society. I no longer believe that I cannot recover, because I am in recovery. I stepped from a world of darkness into a world full of light and hope. I am still walking in that world of light and hope.

The day of the test for my certification came. I had spent a month avidly studying for what I knew was going to be one of the most significant days of my life. I made notes from the Peer Specialists Training Manual. I correlated those with the notes I had taken in class. I put all those on my dictation recorder. I listened in the morning. I went to sleep listening to my own voice repeating the important notes I had made. I burned a CD of those notes and listened to it in the car. I wanted to make an "A" so badly, but only made a "B." I was a little disappointed until my wife reminded me that I hadn't taken a test since college. (That was in 1974.) So I didn't get that "A," but I did do one thing: I made the change from letting darkness rule me to allowing the light to shine over me. In my embracing of the light, in my saying "No" to my darkness, I have achieved more than a grade. I have found myself.

Each day that has passed since my training I have found new meaning and purpose in my life. There is a reason to live; there is a reason to hope and it was that stirring of hope in me which I received during my training that has caused me to know that mentally ill people do not have to accept what other people think of them and feel constant defeat because of it. We do not have to be a passive part of society; we can be an active part of society. We can make a difference in our world and the world around us.

I find now that I am facing people and new situations with a confidence I never knew I had. Training in the Peer Specialist program has taught me it is important to face new challenges and to have confidence in your own ability—not your disability. In fact, my disability never enters into the picture anymore. I have learned to accept myself as a person with mental illness, yes, but like people with physical disabilities, I have come to realize I can be productive and contribute to society. It is not what we are, but what we do with what we are that can make an impact in our lives and in the lives of those around us.

Now I am in recovery. Now I have hope and confidence and I don't feel ashamed or held back because of my illness. I am a whole person, not just a disease. Now I have goals—something I never had before. My primary goal is to help one consumer discover that recovery is possible. My secondary goal is to work with the Department of Human Resources as part of the Georgia Certified Peer Specialist Project. My primary goal is reachable because I am touching people's lives every day, working directly with consumers, teaching them about recovery. My secondary goal may be a little harder to achieve, but I feel one must set high goals in order to achieve any degree of success.

How has the Peer Specialist Project impacted me? I am not the same person. I am now in the role of giving help to others rather than having to be helped. My perspective about mental illness has changed. I no longer perceive myself as incapacitated. I am alive again.

A part of my Certified Peer Specialist training included the use of the Wellness Recovery Action Plan written by Mary Ellen Copeland. It is a good self-intervention tool to help monitor your symptoms and to help you stay well. As a result of using this tool, I have experienced no panic attacks and maintain a good degree of mental health. It is a tool well worth learning and using to help in the recovery process. I have even convinced the mental health professionals where I work to do their own WRAP. After all, if we are to teach it to consumers, should we not have a better understanding of it ourselves? I believe in leadership by example.

Emerging from darkness into light is not easy for people with mental illness. Many of us are afraid to cast off our former selves to accept what lies before us. What lies before us is brightness and hope as we support each other in this new endeavor called peer supports.

I want to thank the State of Georgia for its recognition of the Certified Peer Specialist Project as a way to benefit consumers of mental health services. The project is putting people in recovery into key positions within the mental health system to teach and role model the fact that recovery is possible and that it is happening. This is a vast improvement over the old mental health system that I had grown to embrace. Is change good? In the case of the Certified Peer Specialist Project and its impact upon myself and others like me the answer is a definitive **YES**.

Charles Owens

The old saying "it takes one to know one" was never more applicable than in reference to myself. I am a 56-year-old male in recovery from a mental illness for 21 years in April 2004.

My story is not pretty and I did a lot of things I'm not proud of, but I hope my journey can help others. I have behind me 32 hospitalizations, spread out over four different States. Back then I was referred to by the mental health professional as a swinging door. One day once again I was being discharged from the hospital. There was only one catch. There was no one there to take me home. In fact, there was no home. I was transported to the Salvation Army and dropped out front. As I approached the line in hope of getting a bed, with my belongings in a black garbage bag, I was devastated. As I stood there, my mind viewed my whole life. I was a bright and popular boy and young man with goals and dreams. How could I be here? For 13 days every afternoon I was in that line again waiting for a bed and having to leave by 6:00 a.m. and stay in the streets. I sold my blood so I could survive. It was at this time in my life that I made up my mind I would never go back, and I was determined to move on and fight to move into recovery.

Finally, a bed opened up in a halfway house. I was connected to Vocational Rehabilitation and was assigned to a psychiatrist and a counselor. This was the first time that I had seen a doctor and a counselor that were so very caring and nurturing. I totally trusted them, and I began to work hard, listening to them and taking my medication, and my life slowly got better and better. Vocational Rehabilitation did extensive testing on me and decided I could probably work in food service or landscaping. This made me angry, but I accepted this and they found me a job at a hotel on the grounds crew. The hotel manager noticed that I was creative in my designs on the grounds and 6 months later promoted me to assistant banquet and convention director as well as manager of room service. Even though things were going well, I was still angry. I had lived for years in denial and once I moved from denial to acceptance, how was I to know the next phase was so much anger (poor me, why me, where did this come from).

During this period in my life, I broke a lot of hearts and hurt a lot of people. Not only was I full of anger, there was always this horror hanging over me that people would know or find out that I had been in a mental hospital. So not only was I living in anger, I was living in despair, terrified of the stigma that comes with how others in the world perceived people like me. You have no idea how hard it is to live day to day, hiding or basically living a lie, while continuing to maintain recovery and stay out of the hospital.

Eventually, I left the hotel and went to work in the kitchen of a mental hospital with the dream that eventually I could work on a unit with the patients, as we were called back then. After 6 months in the kitchen, my dream came true and I was on a unit with the patients. I felt like I was finally home. I took all the training that was available. I connected with these people. I understood them. I began to have my own caseload and my own office where, when I was behind closed doors with one of my caseload, I began to slowly share about my past. Here I was with someone sitting on the opposite side of my desk looking devastated, angry, in total denial and despair and

then suddenly they are told their case manager is just like them. You wouldn't believe the sudden hope I saw in their eyes. But still I would always say this is just our secret and ask them not to say anything because I was still afraid of the stigma.

Many years passed and I changed jobs and went to a day service program. While interviewing, my soon-to-be new boss told me he identified with the people in the program because he had his own issues in life. For the first time I found myself sitting there telling my story. I was hired and felt free at last, but little did I know that there was more to come.

About a year later, the Certified Peer Specialist project came into my life. This same man came to me and asked me to take the training. Fear set in immediately. I reluctantly agreed, the agency registered me, and then I chickened out and canceled my registration, telling my boss that I did not want to be classified as a "certified nut case." But now everyone knew. About a month or two went by and I realized that most of the other employees weren't acting any differently toward me and I became less afraid of the stigma. I found myself one day sitting in the group room telling my story to the consumers. They were in disbelief. Some of them didn't believe me, but I began to see them become more motivated. They began to get closer to me and show me how much they cared about me. Some of them began saying they wanted what I had. People who would say daily, "I can't work," were coming to me and saying, "I want a job." I knew then that I wanted this training. I made that call and registered and waited for that first day to come.

When I walked in that first day, I was numb and terrified. Each day, I became more and more empowered, sitting and listening to these unbelievable, successful consumers teaching me how to take this training back to my center and use it to empower the consumers I served. It was an amazing 2 weeks. During those 2 weeks, the people in the class began to bond. It was as if we were family. When the training was over, it was so hard to say goodbye. I felt so much love for everyone. There were tears and hugs and off we all went to study for a month for the big test. During that month I found myself calling the people that trained with me and we shared our feelings and fears. Then it was time for the test. Once again, we were all together. We were all afraid of failing, but there were a lot of hugs and support. At the end of the day, I was called in and told I had passed. I was overjoyed beyond words. I felt so empowered that the ride home was one of the most joyous drives I have had in years. When I got home I was on the phone all evening, calling people from the training, and some of them were calling me. We were all experiencing the same joy. That day I realized that I wanted to shout to the world to hell with the stigma. I am a person with a mental disability and look at me now.

My whole life began to change. I was free. My job became better. I was promoted to team leader of Peer Support and got a nice raise. I began to take my training into the program I managed, to utilize it to the best of my ability. Suddenly, I began to see hope in the consumers' faces. Consumers began to go to work. Everybody wanted to work. They wanted a life like I had. Eventually people were graduating and integrating back into the community and working full time. My job duties changed. I began to role model my own recovery every day.

It was very important that I make clear to them that recovery was all about choices. I began to put them in charge. They made the decision of what they needed each day to enhance their own recovery. The first thing I do each morning is to make sure that they all know how much I care about them. Then I ask if anyone is having issues that are bothering him or her that day. If someone does, the entire group decides that we need to focus in on the person and help him or her get past the problem and move on. There is not a day that goes by, but I hear of something that someone feels can't be handled. I immediately remember having been there once myself, so I tell that part of my story and how I got through it. Basically, I share parts of my own story every day.

Out of the program that I run, we now have three more Certified Peer Specialists who have moved back into the community working full time, doing what I do every day of their lives. I serve people who have gotten their GEDs and have gone on to start college. We all have developed our own Wellness Recovery Action Plans and we talk about them almost every day. I have been a CPS for 2 years and in that 2 years there has been so much success in the program that my average daily attendance has gone from 29 consumers to less than 13 consumers a day. The consumers I serve have had 2 years with no hospitalizations. Even though we all have faced occasional crises, through the concept of self-help, we all get past them.

This training has had more impact in my life than I can put into words. I have never been happier. That does not mean that every day is a good day, but you know what, that's okay. I have gained a great deal of recognition in my community. I have people call on me to speak and tell my story. I have opportunities that come my way that I never dreamed would. I serve on different committees. I have had articles written about me. My life has become so powerful since becoming a Certified Peer Specialist. All of my bosses are very caring and supportive of me. The only real barriers that I have faced are that some of the traditional mental health clinicians have difficulty understanding this new concept in mental health. They think I should stop telling the consumers that recovery is all about choice. They still believe that forced treatment is the way to go. But you know what, I just keep on educating them and standing my ground because "I am Charles Owens, I am a mental health consumer in recovery, and I am proud of it! I am also proud of being a Certified Peer Specialist, and there is a lot more work out there to be done."

SECTION 4

MONITORING PROGRESS IN IMPLEMENTING PEER SUPPORT SERVICES

Many factors generally converge within State mental health systems to create climates that foster or promote change or transformation. So, too, in the State of Georgia, many dynamics external to the peer supports program and peer specialist certification contributed to changing traditional treatment to recovery support. One significant partner for Georgia in the movement to strengths- based recovery was the external review organization (ERO), APS Healthcare. The ERO in Georgia is charged with implementing utilization review, utilization management support, provider training, auditing, and prior authorization of Medicaid services.

The primary goal of external review is to ensure that persons utilizing Medicaid Rehab Option services receive the appropriate supports to facilitate individual recovery. The external review of individuals' needs, resources, goals, and recommended service supports allows a more equitable balance of planning between the consumer and providers than traditional provider-driven systems. Unlike traditional managed care models, the Georgia ERO has no financial incentive to recommend fewer services; therefore, they have more freedom to recommend services the recipient needs.

The ERO model has been very effective in facilitating Georgia's transition to a recovery-focused system. Other States will employ different models of service delivery and monitoring. The most important consideration is the necessity of continuous review and quality improvement to ensure that consumers are able to achieve the quality of life they desire. Aspects of the Georgia experience are provided here as examples of ways to foster implementation of quality peer supports and other recovery services. A fuller description of the ERO model of service utilization review is included in *Building a Foundation for Recovery: How States Can Establish Medicaid-Funded Peer Support Services and a Trained Peer Workforce.*

Treatment Plan Review and Quality Improvement

A State has many opportunities to shape and enhance recovery. Critical to effective services and transition to strengths-based recovery is a plan that is logical and based upon identified consumer need. Treatment plan review enables consumers and providers to be assured that those supports best suited to an individual's needs are accessible and potentially added to the plan of care. In Georgia, such review has led to the opportunity to encourage the use and development of peer supports and other recovery-focused services.

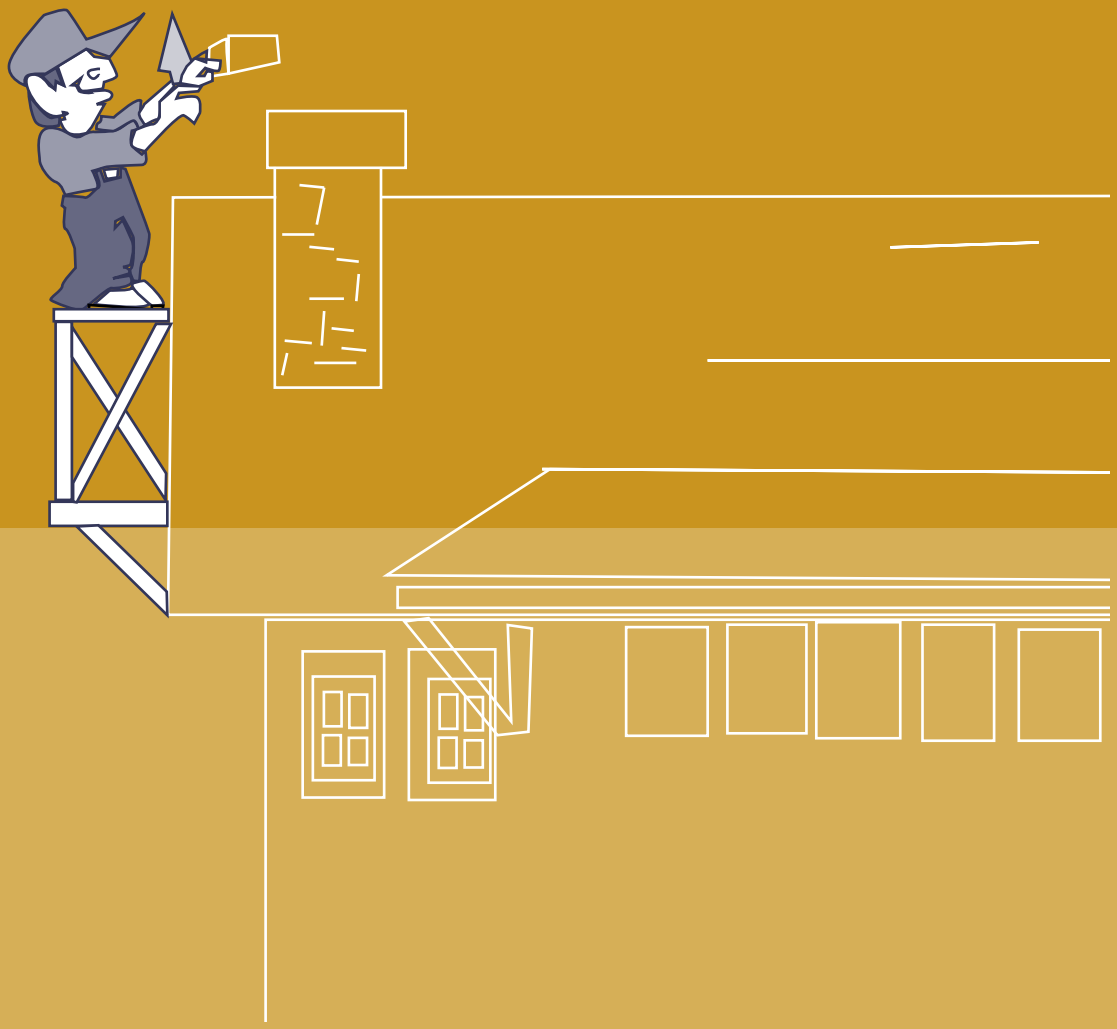
Georgia's ERO has an extensive quality improvement arm consisting of consumers, policymakers, advocates, and providers. The participation of all parties in a comprehensive quality assurance process allows diverse and creative responses to identified needs. However a State chooses to implement quality improvement activities, it is vital to have continuous feedback from consumers on the services being provided. Much of the quality improvement activity of the Georgia ERO has focused on the peer supports program. Through program audits and interviews with participants, factors that impacted quality implementation of peer support services were identified.

One clearly identified need was training for both providers and consumers. A significant training initiative targeted at consumers and frontline staff was most effective in improving the quality of peer support services. After being educated on the true intent of peer supports, consumers became empowered to advocate for what they need and want in their own peer support services. A comprehensive training on recovery and the value of peer supports was also developed and implemented for supervisors, provider CEOs, and State hospitals. It is vital that all levels of the organization understand what is required for effective implementation of recovery-based services.

Consumer Involvement and Individualized Service Plans

The most critical opportunity for improvement identified through the quality improvement process and training experiences was the absence of real consumer involvement in service planning and goal setting. Historically, Individualized Service Plans (ISPs) have been the domain of the clinical team. Consumers have been only marginally involved in the development of these plans and the goals on which they are established. "Noncompliance" with the ISP has been frequently cited as the reason for retention in higher intensity services and treatment "failure." In most instances, consumers are unable to articulate their treatment goals or to describe what a life in recovery would be. In Georgia, as Certified Peer Specialists began working with individuals receiving services, they began to recognize the disconnect that existed between consumers and their treatment goals. System transformation to strengths-based recovery cannot be achieved until consumers are empowered to articulate their own goals and to have them included in their ISPs.

To change this dynamic in Georgia, two initiatives were implemented. First, the CPS training curriculum was changed to focus on recovery goal setting and teaching consumers how to "own" their goals and outcomes. Those CPSs who had already completed their certification training received intensive continuing education to enable them to become "recovery coaches" for the individuals whom they served. Next, the name of the ISP was changed to encompass the recovery goal, and the name "Individual Service/Recovery Plan" (IS/RP) is now being implemented. States seeking to implement more recovery-focused services will need to determine the level of consumer partnership in the development of the Individual Service/Recovery Plan, and undertake an improvement process if the level of consumer involvement is lacking.



SECTION 5

GAINING SUPPORT FOR RECOVERY-ORIENTED PEER SUPPORTS

Monitoring the system to determine progress in implementing the new service followed the establishment of CPS training in Georgia. However, it became clear that this was not enough to foster system change. States must first determine the extent to which their system is recovery ready. Consumers and advocates can help States to evaluate their level of readiness for recovery services and system transformation.

Resistance to system transformation has myriad causes. For many years, graduate school programs have trained providers to promote "compliance." The Medicaid and mental health systems have required documentation that individuals coming into services have deficits in order to be served, and financing has been geared toward services provided by persons with the highest academic credentials.

In the past, Georgia's services focused on long-term (if not lifetime) maintenance. The State system did not offer adequate incentives for recovery services such as employment. Therefore, as peer supports were introduced, the system responded with the reactions: "We can't do this." "We don't know how to do this." "This won't work." The staff at the State mental health authority office and members of the consumer community began brainstorming potential strategies for the survival of peer supports.

One result of the brainstorming was a training initiative called "Thinking Outside the Box: Implementing Recovery Based Services" that was delivered to both line staff and program managers. Its impact was felt at both top and bottom. The process and activities that led to acceptance of the recovery philosophy, the "Outside the Box" training, and the role of consumers and advocates in making it all happen are further detailed in *Building a Foundation for Recovery: How States Can Establish Medicaid-Funded Peer Support Services and a Trained Peer Workforce.*

In addition, consumer recovery itself plays a tremendous role in changing attitudes. The following observation of a clinician in the Georgia system demonstrates recognition of the value of the shift to recovery that is made possible through consumer-led services.

A Clinician's Perspective on the Peer Support Movement

by Joseph Handman

I am currently employed in a day program that provides Peer Support and PSR services. I began working in mental health in 1980. At that time, and for a significant time following, the resounding word in the mental health arena was "stabilization" and the key statement was "keep folks out of the hospital."

It wasn't until the late 1990s that the long awaited new word lifted off the horizon: RECOVERY. This word has stirred and shifted the mental health paradigm. Our collective goal is no longer to help an individual "remain out of the hospital," "stabilize," or return to "baseline." Our goal is to aid them in their RECOVERY. Although recovery means something a bit different to all, the thread of what has been consistent is the recovery of a life. Things that were previously thought impossible are now achievable. Hopes, dreams, relationships, and activities that brought joy and satisfaction are being reclaimed. Although I do not specifically know the individuals responsible for this change, I do know that we are deeply indebted to them.

For me personally, it all began in 2001 with the announcement that Day Program managers needed to begin to transfer "traditional staff" out of Peer Support Programs and hire consumers (Certified Peer Specialists) in their place. Initially, many of us "traditional staff" looked at this new directive with suspicion, amazement, and wonder. Our consumers were to be self-governing, without our assistance and leadership? If the medical model was to be thrown out and with it a primary focus on the "problem" or illness, what would we have to talk about with our consumers? How could the "traditional staff" begin the move from identifying the consumer as the patient to joining with them to form a unified "we"?

This vacancy of "traditional leadership" in Peer Support created a vacuum and therefore offered increased chances of leadership and growth for our people. Consumers are now coming up to the plate by arranging their own appointments and transportation, leading groups of interest and value, and volunteering, supporting, and helping one another. They have become more independent and, in doing so, have made the Peer Support program uniquely theirs.

It has been wonderful to watch Peer Support take off with the leadership of newly hired Peer Specialists. As the bar was raised on Peer Support, energy levels and motivation went up and folks became more engaged in their treatment and recovery. Through the use of WRAP plans and other peer-facilitated techniques, Peer Support consumers began moving into lesser restrictive environments, monitoring their own medications, and obtaining employment at a much higher rate than before. In addition, consumers no longer allow the fact that they have a mental illness to stop them from reaching for goals and have increased their self advocacy by asking for what they need or want, heightening their awareness of the injustice of

> discrimination, and increasing energy for educating family and members of the greater community about mental illness. Peer Support consumers are demonstrating an increased level of volunteerism and enthusiasm for helping others. As consumers are learning to expect more from themselves in a spirit of self-kindness, traditional staff are learning to expect more and give up our old ways of spoon feeding and fostering dependence. The glass ceiling continues to lift as evidenced by more of an "I can" attitude. To have increased independence modeled by a peer, to be walked with in partnership, and in concert with the adoption of the 12-step model, the shift in the mental health paradigm has begun.
>
> This is a very exciting time in mental health. Folks who had been told that they would never get out of the group home are buying their own homes. Consumers who were told they would never work again have given up disability benefits and accepted full time employment. Consumers who were isolated and rarely spoke are now leading dynamic groups. Consumers are self-empowered and are empowering each other by the accelerated rate of growth in areas of addiction, employment, lesser restrictive residences, joy, and overall quality of life.

Evidence of the effectiveness of peer supports is perhaps the ultimate tool for overcoming resistance to peer supports. Provider agencies remain challenged to change the attitude they hold toward consumer providers, and it takes honesty and courage to achieve that change. Accepting consumer-providers as persons first, and not a collection of symptoms, and allowing for flexible work schedules and environments are both necessary for system transformation.

Barriers and challenges will never be entirely eliminated, nor should we expect them to be. Problems that arise must be seen as opportunities to change the system. Dealing with barriers and challenges directly and finding ways to overcome them strengthen the system as a whole and help it become more recovery focused and, therefore, more effective in meeting the needs of the individuals being served.

SECTION 6

EVALUATION AS A TOOL FOR SYSTEM CHANGE

Lives reclaimed through peer supports demonstrate that recovery is real. Evaluation of peer supports demonstrates the positive fiscal impact the service can make. Consumers and advocates can and should demand rigorous evaluation of services that will demonstrate effectiveness and eliminate the resistance to recovery-focused services.

Anecdotes of success are no longer enough to show that a program is managing its resources well and is producing intended results. Peer support is undergoing dramatic changes, and those programs with access to good data are proving to be the most influential leaders in promoting promising new practices. Architects of system change are demanding solid evidence demonstrating which community programs are safe and effective in meeting consumer recovery needs.

Peer support programs have to be able to show what services are being delivered, the quality of those services, and how well the services are meeting program goals. Consumers and advocates should ensure that the critical ingredients of a peer service are systematically identified and the level of program implementation measured. Ultimately, peer support program evaluation can have an instrumental role in helping people who use peer supports thrive in a future driven by the values of evidence-based practices.

The Role of Data in Georgia Peer Supports

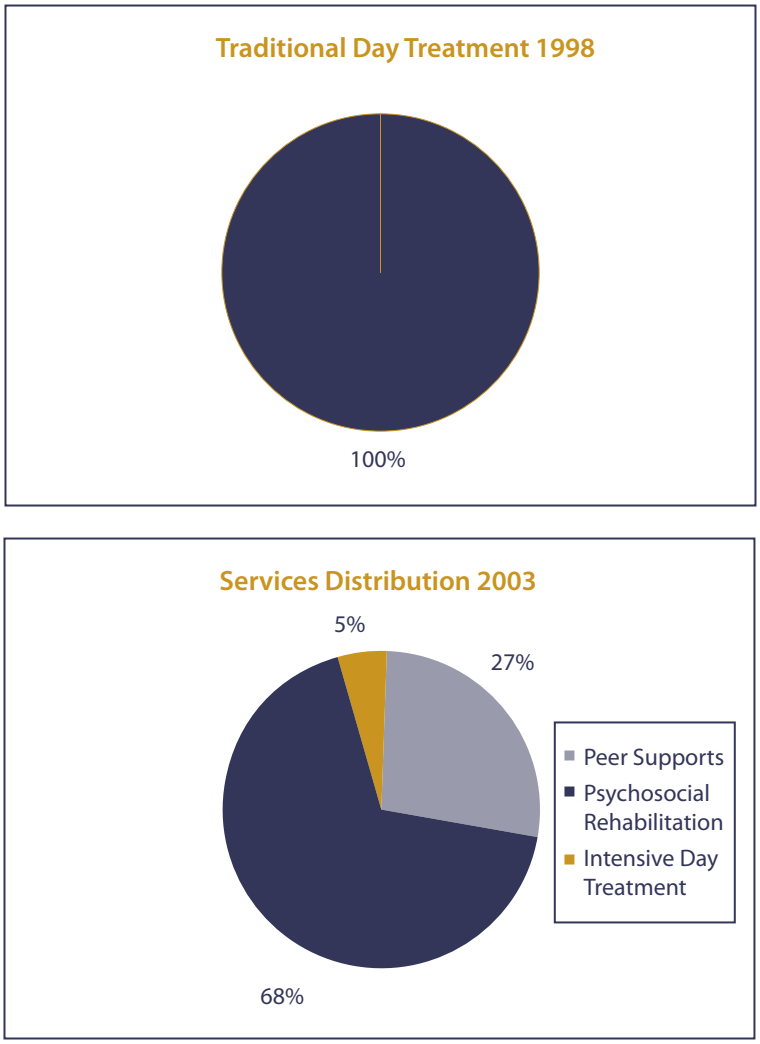
The following sections contain the charts and graphs that illustrate how the Georgia Peer Supports initiative began to use available program data as a means to change the hearts and minds of administrators and overcome resistance to program innovation within the continuum of community care.

From the beginning, the Georgia system was interested in evaluating the peer supports program implementation as well as the related outcomes of the supports. Two factors posed a challenge to conducting a good program evaluation, however. One factor was that only limited human and financial resources were available for major evaluation studies. The second factor was that no tools to assess the critical ingredients of the peer specialist program and its implementation (e.g., a measure of fidelity to the peer specialist model) had been developed, because Georgia was the first State to try a peer supports program. Subject to these limitations, a variety of evaluation methods based on what data were already available were employed. Although none of the methods used have been comprehensive, all aimed at demonstrating the value of the initiative and acquiring information that promotes the improvement of the service design. As additional evaluation tools are developed, more meaningful and useful data can be generated. Operating in a continuous quality improvement environment makes this possible.

Financial Outcomes

The first evaluation efforts were the analysis of financial outcomes. Because the State Medicaid authority was considering whether to dismantle day treatment services, they wanted to know the financial and utilization trends created by alternative service options. Prior to 1999, nearly all services offered were related to a day treatment model. After the reconstruction of the services design to a more recovery-based approach, the Medicaid funds in Georgia were distributed as shown in the chart on the right.

Table 3. Services Paid for by Medicaid in Georgia



One financial outcome was that services were delivered at a lower cost. The rate for peer support services was set at a fraction of the reimbursement rate for other day services. Since Medicaid authorities use program budgets as one of many means for ascertaining usual and customary rates, the fact that many Certified Peer Specialists did not have college degrees led to low cost-setting indicators. When the program began, the peer supports rate was only 45 percent of the rate set for the more traditional day treatment model. After 2 years, the rate was raised to 55 percent of the traditional day service. Although there is some concern that this rate is significantly less than adequate, the outcome of cost efficiency is evident in the reimbursement rate analysis alone.

Certified Peer Specialist Demographics and Outcomes

A second data-driven effort was to look at the Certified Peer Specialists as a specific and new cohort of professionals with the unique qualifications of recovery experience. The following peer specialist demographics are available for analysis:

Table 4. Demographics of Certified Peer Specialists

Approximately 200 peer specialists were certified over 3 years.
CPSs support over 2,500 unique consumers in a given year.
The average CPS class size is 31.
The average dropout rate is 1 person/per class.
75% of CPS candidates pass the exam on their first try.
98% of CPS candidates have passed by their second try.
47% of CPSs self-report their primary diagnosis is "depression."
26% of CPSs self-report their primary diagnosis is "bipolar disorder."

Employment data also holds promising information about the peer specialist professionals. The data sets below were gathered at two separate 2004 continuing education events for Certified Peer Specialists and do not include date on all Georgia CPSs.

Table 5. Employment Status of CPSs (N=80)

Full Time	71%
Part Time	22%
Contract	2%
Volunteer	1%
Unemployed	6%

Percentages only represent CPSs present at survey event

Table 6. Employment Tenure of CPSs (N=49)

0-3 Months	30%
3-6 Months	24%
6-12 Months	15%
> 1 Year	21%
Not Applicable	9%

Percentages only represent CPSs present at survey event

Another study revealed the impact of CPS certification on the employed specialists' own recoveries. It was found among the first class of specialists certified that consumers who completed the training realized a greater sense of personal empowerment than they had experienced prior to training.

Program Implementation Outcomes

The external review organization in Georgia provides a tremendous amount of information to State planners through its auditors who visit programs on a quarterly basis. For one quarterly audit, the State asked the ERO to focus on the programmatic integrity of peer support programs. Without validated measurement tools, most of the review was subjective, yet it was important to State officials in structuring continued educational outreach to provider agencies and peer specialists. The following are data provided by APS Healthcare, the ERO in Georgia:

Table 7. Does the program promote recovery?

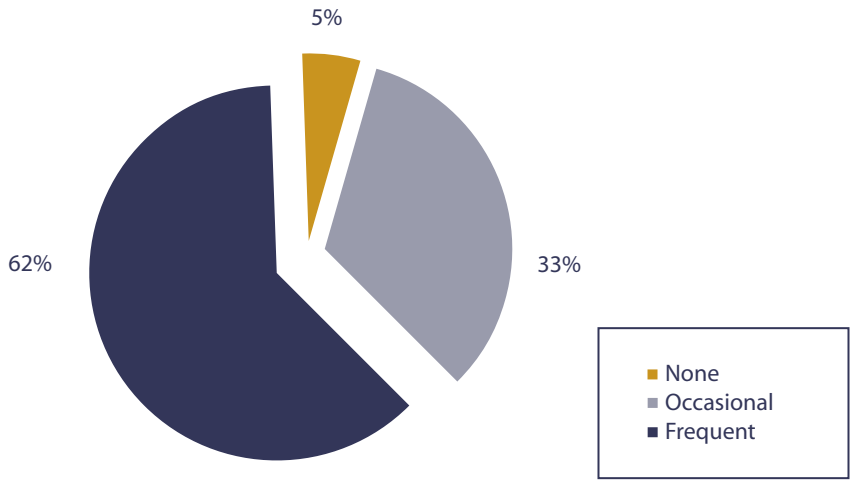


Table 8. Are programs led by consumers?

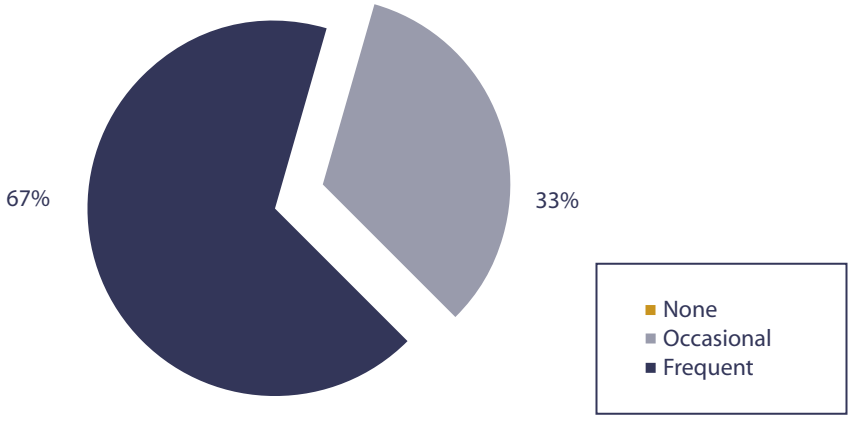
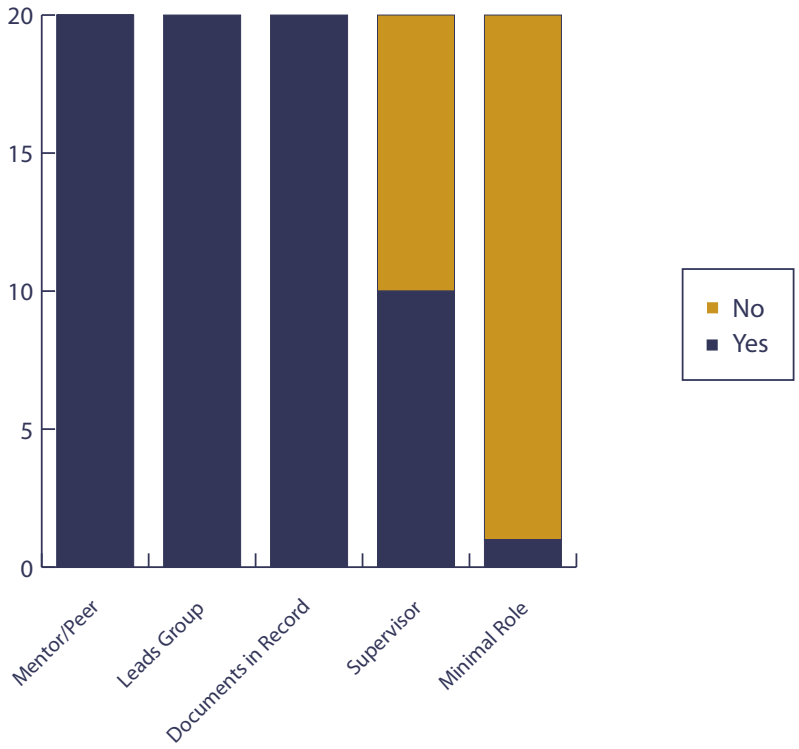


Table 9. Roles of Peer Specialists in Peer Support Program



This table was derived from a random sample and audit of Georgia peer support programs by APS Healthcare. In 2002, 20 Certified Peer Specialists were asked about their roles in the programs.

Recovery Outcomes

The State of Georgia system also wanted to ascertain improvements in recovery outcomes for persons participating in peer support services. To that end, a research design was created utilizing treatment information housed in the State's external review organization's data system, which includes data from the Treatment Request and Integrated Georgia Reporting Survey (TRIGRS) that is completed by providers as part of the Medicaid service authorization. The goals of the analysis were to document improvement over time for consumers enrolled in peer supports and to evaluate effectiveness of peer supports by comparing individual-level service outcomes with outcomes produced by other programs. A cohort of consumers served/enrolled in peer supports in State fiscal year 2003 with a subsequent reauthorization that included peer supports, was reviewed. The reviewed group was limited to those identified as "seriously and persistently mentally ill" with diagnoses of schizophrenia, bipolar disorder, and/or major depression. The number of persons reviewed was 160, with an average of 260 days between a first TRIGRS submitted and any subsequent TRIGRS.

A control group (N=488) with an average of 247 days between TRIGRS, composed of those with an enrollment in a generic day supports service during State fiscal year 2002 with a subsequent reauthorization that included the same service, was used for comparison. The day supports service was a remnant of the traditional day treatment program that was left operational only for a transition period that ended in State fiscal year 2003. Therefore, it provided an excellent contrast control. Consumers who were simultaneously or subsequently enrolled in peer supports were excluded from this group. The same diagnostic categories were used for both groups.

Specific items from TRIGRS were used for a noncomparative analysis of outcomes based on initial TRIGRS to subsequent TRIGRS. Grouping of items focused on three areas: (1) current symptoms/behaviors; (2) skill deficits; and (3) available resources/needs. Response items are Likert-type, 4- or 5-point scales. Outcomes for purposes of this analysis were changes in scores over time. Overall, peer support consumers showed improvement in each of the three outcomes groups over an average of 260 days between assessments. For each outcome, impact of peer supports is positive and small, but statistically different from zero (using effect size = Cohen's d with adjustment for paired observations).

When looking at the comparative analysis of peer supports to day supports, between group effects were estimated through OLS regression. For each of the three outcome measures—symptoms/behavior, skills, and needs/resources—the level of improvement for consumers enrolled in peer supports was greater than day supports, and the difference between the groups was statistically significant at the $p<.05$ level of confidence.

In 2005, Georgia let a contract with the Medical College of Georgia to develop an evaluation protocol to evaluate the delivery of peer support services, identify the key elements in promoting successful peer centers, evaluate the CPS training curriculum, and publish the findings.

Many more steps still need to be taken to establish an evidence base for the peer specialist model. The development and use of a measure of the fidelity and implementation of the peer specialist model may show whether increased recovery outcomes are linked to particular administrative and/or philosophical approaches. In the meantime, using available data and finding innovative ways to monitor and improve quality service delivery systems will support increased recovery outcomes for consumers.

SECTION 7

EXPANDING THE USE OF CERTIFIED PEER SPECIALISTS

Always critical to improving and expanding services in a transforming system is the ability of policymakers, providers, consumers, and advocates to identify new ways to utilize and expand effective programs. Some new initiatives and other models from States that have followed Georgia's lead in introducing peer supports are described in ***Building a Foundation for Recovery: How States Can Establish Medicaid-Funded Peer Support Services and a Trained Peer Workforce.*** *South Carolina and Hawaii, where consumers and advocates have partnered with State mental health agencies to begin system transformation, show how Georgia's successful model can be adapted for developing recovery-focused services in States across the Nation.*

The implementation of consumer-directed services utilizing Certified Peer Specialists can challenge State mental health systems to "think outside the box" for additional roles and opportunities for consumers seeking to help others on the recovery journey. For example, Certified Peer Specialists could be trained for these two roles:

1. A workforce for the implementation of self-determination, also known as consumer direction, whereby the consumer is empowered to choose the supports and services necessary to address his/her personal needs through an individual budget.

2. Hospital Certified Peer Specialists (HCPSs) that help transition consumers out of institutions to a meaningful life in the community of their choice with supports that promote freedom and independence.

Certified Peer Specialists and Self-Determination

Using funds from Real Choice Systems Change grants awarded by the Centers for Medicare and Medicaid Services (CMS), Georgia is now piloting the training of Certified Peer Specialists for the implementation of self-determination in one region of the State. The project offers the service of a CPS who is trained in supporting both self-directed recovery and employment. Under Georgia's newly implemented Rehabilitation Option, Medicaid cannot be billed for teaching the actual skills needed for employment. However, billing is authorized for helping a consumer develop skills to get and keep a job if that is a goal in his or her Individual Service/Recovery Plan, and for providing the support services necessary to assist the individual in managing illness-related barriers to employment. Individuals participating in a "self-determination" model could select a CPS as one of their providers, to assist them in making the necessary connection to natural supports in their communities that promote independence and recovery. This initiative supports the President's New Freedom Commission Report, Goal 2: "Mental Health Care is Consumer and Family Driven" (New Freedom Commission, July 2003).

Hospital Certified Peer Specialists

Georgia also has completed curriculum development and training for the new role of Hospital Certified Peer Specialist (HCPS) described above. In the early 1990s, for the first time ever, Georgia employed mental health consumers to work within the mental health system. These consumer pioneers worked in State psychiatric hospitals, to provide a role model for those individuals receiving inpatient services and to offer them hope for life beyond the walls of the hospital. With vague job descriptions and limited understanding of the potential of their positions, the consumer specialists brought appreciation for the consumer viewpoint into treatment in the Georgia system for the first time. After the success of the CPS training program, it was felt that the consumers working in hospitals would feel more empowered and become more effective if they had the benefit of similar training. It is significant that this training curriculum adds modules on Person Centered Planning (PCP). Other States may wish to explore the use of peers within inpatient services to facilitate the introduction of concepts of hope and recovery for consumers in these settings.

The Role of Peer Centers

In Georgia, consumer-operated peer centers, referred to in the State Medicaid guidelines as *Peer Support Centers,* have been operating since 1999. With the implementation of the Medicaid Rehab Option, these peer centers could operate as special providers offering just peer supports services. The fundamental principles for establishing peer centers were these: They must be 100 percent consumer staffed, be noncoercive, rely on user participation to direct program goals and services, promote recovery and self-determination, and develop leadership from within the program.

The principles listed above also serve to direct the growth of peer centers. To bill for reimbursable services, peer centers must pay careful attention to Medicaid guidelines. However, peer centers may provide additional programming that falls outside the realm of Medicaid reimbursable services. These programs might include recreation, social time, or unstructured drop-in activities. In this way, a peer center is able to capture some of the values of peer supports and choice that may never be supported with Medicaid funding.

Although peer centers share common beliefs, each peer center is unique because of the needs and influence of its community and membership. Addressing the uniqueness of the larger community in which the program operates is one of the biggest considerations when developing a peer center. Is your community rural, urban, or suburban? Is there access to public transportation? Answers to questions like these will determine the model you choose. In the Georgia system, peer centers may operate within a comprehensive public provider agency, or may operate as "freestanding" private provider agencies. Following are examples of both models of peer center operations in Georgia.

Crossroads

Crossroads opened in November 1999 by taking advantage of the Medicaid Rehab Option that provides for reimbursable peer support services. Crossroads started with one peer specialist, three supported employment counselors, and 7–12 member consumers.

In February 2003, Crossroads had a total membership of over 80 consumers. The staff consisted of two Certified Peer Specialists, two full-time supported employment counselors, one part-time job development counselor, a full-time case manager, an occupational therapist, and a psychiatrist who visited weekly.

The Crossroads philosophy states that people with mental illnesses can and do recover and lead fully productive lives, even if the mental illness persists. Consumers can work, live independently, and have meaningful relationships. The program promotes consumer leadership and ownership in several different ways. One aspect of the program is consumer-run groups. Some of the groups, which have been and are currently led by key members, are these:

1. The WRAP (Wellness Recovery Action Plan) Series—based on the work of Mary Ellen Copeland;
2. Creative Expression Group—where members teach each other ways to use the arts as a means of communication;
3. Current Events Group—where members take turns researching and reporting the local, national, and world news; and
4. Employment Support Group and Women's Support Group—where members take ownership by leading weekly self-help groups.

Members of Crossroads report that it is an excellent full-service recovery-oriented program.

AmericanWork, Inc.

An alternate model of a peer center is a private, for-profit provider called AmericanWork, Inc. This provider operates multiple sites in small towns, and each program is unique to the community it serves. The consistent theme for all of the sites is the focus on vocational success for all of its members. This is made abundantly clear even in the name of the program—*Amer-I-can-work!*

AmericanWork, Inc. is owned by a consumer and staffed by consumers, including several who are CPSs. The program utilizes wraparound services to enhance its vocational focus. Supported living, day services, supported employment, transportation support, and financial planning all serve to ensure that each consumer is employed as quickly as possible. The driving philosophy of AmericanWork is *work first, recovery follows.*

These models do not exhaust the ways that peer centers can be realized. They simply provide an example of how peer centers can be similar in philosophy and different in structure. The above-cited programs are examples of successful peer centers doing different things. What they have in common is a firm commitment to recovery, an approach that is noncoercive, reliance on user participation to direct program goals and services, the promotion of self-determination, and the development of leadership from within the program.

Collaboration for Building a Stronger Workforce

Georgia is also partnering with the Medical College of Georgia, Department of Psychiatry and Health Behavior (Augusta). In addition to incorporating an opportunity for scientific evaluation of the CPS training and implementation and the peer supports service, this project will develop training for psychiatry residents. Initial discussions centered on preparing psychiatrists to incorporate Certified Peer Specialists in their private practice as support for individuals in treatment to foster recovery and encourage active participation in treatment planning. This initiative will move the concept of consumer-directed services beyond the public mental health system into the field of private practice psychiatry.

For Certified Peer Specialists to gain credibility as a professional discipline, their training and competencies must be recognized. To that end, collaboration is underway with the Annapolis Coalition on Behavioral Health Workforce Education. The Coalition has as its mission to build a national consensus on the nature of the behavioral health workforce crisis and to promote improvements in the quality and relevance of education and training by identifying and implementing change strategies. With a strong emphasis on improving workforce education, identifying strategies to overcoming obstacles to education reform, and disseminating information on best practices and change strategies, this SAMHSA-sponsored coalition is becoming a valuable ally in establishing credibility for the CPS workforce.

In May 2004, an expert panel was convened to focus on furthering the use of competency-based approaches to building a stronger workforce. As a member of the panel, the Director of the Georgia Office of Consumer Relations discussed the competencies identified for consumer-providers and the training needed to develop and maintain those competencies. Collaboration with the Annapolis Coalition is expected to strengthen the training of CPSs while building national recognition of the value and credibility of this component of the behavioral health workforce.

In memory of Vicki Cousins,
a contributor and member
of the Editorial Board for this resource kit
who pioneered peer support services in South Carolina.
February 25, 1957 – June 28, 2005
In deep gratitude
for her leadership and service to consumers nationwide.

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Appendix A

CERTIFIED PEER SPECIALIST JOB DESCRIPTION

Under immediate to general supervision, the Certified Peer Specialist (CPS) provides peer support services; serves as a consumer advocate; and provides consumer information and peer support for consumers in emergency, outpatient, or inpatient settings. The CPS performs a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. The CPS will role model competency in recovery and ongoing coping skills.

1. Using the 10-step goal-setting process the CPS will

a. Assist consumers in articulating personal goals for recovery.
b. Assist consumers in determining their individual objectives in order to reach recovery and/or life goals.

2. The CPS will document the following on the Individual Service Plan (ISP) by

a. Assisting consumers in determining "Problems."
b. Assisting consumers in identifying recovery Goals.
c. Assisting consumers in setting Objectives.
d. Determining Interventions based on the individual consumer's recovery and/or life goals.
e. Observing progress consumers make toward meeting objectives.
f. The CPS will understand and utilize specific interventions necessary to assist consumers in meeting his or her recovery and/or life goals.

3. Utilizing the CPS' specific training, the CPS will

a. Lead as well as teach consumers how to facilitate Recovery Dialogues through the use of the Focus Conversation and Workshop methods.
b. Assist consumers in setting up and sustaining self-help (mutual support) groups.
c. Assist consumers in creating their own Wellness Recovery Action Plan (WRAP).
d. Teach problem-solving techniques with individuals and groups.
e. Teach consumers how to identify and combat negative self-talk.
f. Teach consumers how to identify and overcome fears.
g. Support the vocational choices consumers make and assist them in overcoming job-related anxiety.
h. Assist consumers in building social skills in the community that will enhance job acquisition and tenure.

i. Assist non-consumer staff in identifying program environments that are conducive to recovery and lend their unique insight into mental illness and what makes recovery possible.
j. Attend treatment team meetings to promote consumer use of self-directed recovery tools.

4. Utilizing his/her unique recovery experience, the CPS will

a. Teach and role model the value of every individual's recovery experience.
b. Model effective coping techniques and self-help strategies.

5.Maintain a working knowledge of current trends and developments in the mental health field by

a. Reading books, journals, and other relevant material.
b. Developing and sharing recovery-oriented material with other CPSs at the continuing education assemblies and on the CPS electronic bulletin board.
c. Attending continuing education assemblies offered by the CPS Project.
d. Attending relevant seminars, meetings, and in-service trainings whenever offered.

6. The CPS will serve as a recovery agent by

a. Providing and advocating for effective recovery-based services.
b. Assisting consumers in obtaining services that suit the individual's recovery needs.
c. Assisting consumers in obtaining decent and affordable housing of their choice in the most integrated, independent, and least intrusive and restrictive environment.
d. Informing consumers about community and natural supports and how to utilize these in the recovery process.
e. Assisting consumers in developing empowerment skills through self-advocacy and stigma busting.

Appendix B

CPS COMPETENCIES

1. An understanding of their job and the skills to do that job

-understand the basic structure of the State mental health system and how it works
-understand the CPS job description and Code of Ethics within the State mental health system
-understand the meaning and role of peer support
-understand the difference in treatment goals and recovery goals
-be able to create and facilitate a variety of group activities that support and strengthen recovery
-be able to do the necessary documentation required by the State
-be able to help a consumer combat negative self-talk, overcome fears, and solve problems
-be able to help a consumer articulate, set, and accomplish his/her goals
-be able to teach other consumers to create their own Wellness Recovery Action Plans
-be able to teach other consumers to advocate for the services that they want
-be able to help a consumer create a Person Centered Plan

2. An understanding of the recovery process and how to use their own recovery story to help others

-understand the five stages in the recovery process and what is helpful and not helpful at each stage
-understand the role of peer support at each stage of the recovery process
-understand the power of beliefs/values and how they support or work against recovery
-understand the basic philosophy and principles of psychosocial rehabilitation
-understand the basic definition and dynamics of recovery
-be able to articulate what has been helpful and what not helpful in his/her own recovery
-be able to identify beliefs and values a consumer holds that work against his/her recovery
-be able to discern when and how much of their recovery story to share with whom

3. An understanding of and the ability to establish healing relationships

-understand the dynamics of power, conflict, and integrity in the workplace
-understand the concept of "seeking out common ground"
-understand the meaning and importance of cultural competency
-be able to ask open-ended questions that relate a person to his/her inner wisdom
-be able to personally deal with conflict and difficult interpersonal relations in the workplace
-be able to demonstrate an ability to participate in "healing communication"
-be able to interact sensitively and effectively with people of other cultures

4. An understanding of the importance of and having the ability to take care of oneself

-understand the dynamics of stress and burnout
-understand the role and parts of the Wellness Recovery Action Plan (WRAP)
-be able to discuss one's own tools for taking care of oneself

Appendix C

CERTIFIED PEER SPECIALIST CODE OF ETHICS

The following principles will guide Certified Peer Specialists in their various roles, relationships, and levels of responsibility in which they function professionally.

1. The primary responsibility of Certified Peer Specialists is to help individuals achieve their own needs, wants, and goals. Certified Peer Specialists will be guided by the principle of self-determination for all.
2. Certified Peer Specialists will maintain high standards of personal conduct. Certified Peer Specialists will also conduct themselves in a manner that fosters their own recovery.
3. Certified Peer Specialists will openly share with consumers and colleagues their recovery stories from mental illness and will likewise be able to identify and describe the supports that promote their recovery.
4. Certified Peer Specialists will, at all times, respect the rights and dignity of those they serve.
5. Certified Peer Specialists will never intimidate, threaten, harass, use undue influence, physical force, or verbal abuse, or make unwarranted promises of benefits to the individuals they serve.
6. Certified Peer Specialists will not practice, condone, facilitate, or collaborate in any form of discrimination on the basis of ethnicity, race, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental or physical disability, or any other preference or personal characteristic, condition, or state.
7. Certified Peer Specialists will advocate for those they serve that they may make their own decisions in all matters when dealing with other professionals.
8. Certified Peer Specialists will respect the privacy and confidentiality of those they serve.
9. Certified Peer Specialists will advocate for the full integration of individuals into the communities of their choice and will promote the inherent value of those individuals to those communities. Certified Peer Specialists will be directed by the knowledge that all individuals have the right to live in the least restrictive and least intrusive environment.
10. Certified Peer Specialists will not enter into dual relationships or commitments that conflict with the interests of those they serve.
11. Certified Peer Specialists will never engage in sexual/intimate activities with the consumers they serve.

Appendix D

National Mental Health Association

THE ROLE OF PEER SUPPORT SERVICES IN THE CREATION OF RECOVERY-ORIENTED MENTAL HEALTH SYSTEMS

Statement of Position:
NMHA believes that peer support is a unique and essential element of recovery-oriented mental health systems. Peer support programs provide an opportunity for consumers to direct their own recovery and advocacy process, and to teach one another the skills necessary to lead meaningful lives in the community.[1] Peer support services have demonstrated effective outcomes such as reduced isolation and increased empathic responses to consumers.[2] Research has also shown that outcomes improve when consumers serve as peer specialists on case management teams.[3]

The final report from the President's New Freedom Commission on Mental Health states, "studies show that consumer-run services and consumer providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis."[4] The report goes on to describe how persons with psychiatric disabilities, because of their experiences, bring different attitudes, motivations and insights to mental health services.[5] The provision of mental health support services by persons who have experienced mental illnesses is the epitome of empathy, empowerment and, ultimately, recovery.

Peer support services are part of the array of services necessary for a culturally competent, recovery-based mental health system. Peer support services are equal partners to quality clinical care. However, NMHA recognizes that peer support should not be used as a cost-saving substitute for clinical services, especially during the current era of budgetary constraints. As means of insuring quality care, peer services should implement a credentialing process similar to that of clinical services. Both Georgia and New Jersey have been successful in developing credentialing programs for peer support workers.

NMHA recognizes that while the majority of peer support programs today are funded through State revenue, there is an opportunity and incentive to utilize Medicaid funds as a way to implement peer support services. Given the current fiscal crises that states are experiencing, Medicaid is increasingly being viewed as a means to fund mental health services. Georgia was the first State to implement successfully an independent peer support services program that bills Medicaid directly; approximately 9 other states reference peer support services in their Medicaid rehabilitation rules. It should be noted that NMHA prefers Medicaid funding without the extensive documentation requirements of other Medicaid programs. Many of these requirements can prove onerous to small agencies, consumer run or not.

NMHA urges Mental Health Associations, mental health service provider organizations and other advocates to make peer support an integral part of mental health service delivery and to insure that consumers are involved at multiple levels of planning and implementation of peer support services, including senior management positions in service programs. The President's New Freedom Commission on Mental Health recommends that local, State and federal authorities encourage consumers and families to participate in planning and evaluating treatment and support services.[6] NMHA supports the work of states and communities to incorporate peer support services into community-based mental health services, both as stand alone entities and in conjunction with other mental health services. Such activities will pave the way for implementation of recovery-oriented mental health systems.

NMHA recommends that each State set aside a substantial percentage of State funds for peer support programs.

Notes

[1]Sabin, J., & Daniels, N. 2003. Strengthening the consumer voice in managed care: VII. The Georgia Peer Specialist Program. *Psychiatric Services, 54,* 497-498.

[2]Powell, 1994, Kurtz, 1997, Mowbray et al., 1996 as cited in *Mental Health: A Report of the Surgeon General*. (1999). Rockville, MD: U.S. Department of Health and Human Services.

[3]Fenton et al., 1995 as cited in *Mental Health: A Report of the Surgeon General*. (1999). Rockville, MD: U.S. Department of Health and Human Services.

[4]New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services.

[5]New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services.

[6]New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services.

Appendix E

NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY

The President's New Freedom Commission on Mental Health, in its final report entitled *Achieving the Promise: Transforming Mental Health Care in America,* called for recovery to be the "common, recognized outcome of mental health services."

To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004.

Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings:

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.

The 10 Fundamental Components of Recovery

- **Self-Direction:** Consumers 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.
- **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.

- **Empowerment:** Consumers 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 consumers 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.
- **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 consumer access to these supports.
- **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 consumer to move on to fully engage in the work of recovery.
- **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, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect:** Community, systems, and societal acceptance and appreciation of consumers—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 consumers in all aspects of their lives.

- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **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.