

RUNNING HEAD: History and Outcomes

History and Outcomes of the Peer Support Project

in Maricopa County, Arizona

Lisa Eman St. George

Arizona State University

Abstract

Alcoholics Anonymous has used peer support as a means to recovery since the 1930's. The idea of peer support for recovery from mental illness began to take shape in the 1990's. The ideas of peer support and recovery along with a lawsuit filed against Arizona for failure to follow state statutes created an atmosphere ripe for change. This is how the Maricopa Model came to fruition. This exploratory study investigates the impact of Peer Support Training on the recovery and wellness of 78 participants. Outcomes reflect perceived increases in family relationships, social supports, activity levels, general wellness and symptom management as well as decreases in crisis service usage and hospitalizations among people who completed the training.

Key Words: Mental illnesses, recovery, WRAP, mental health, serious mental illness, Arnold v Sarn, self-perception, wellness, Peer Support, Maricopa Model, Maricopa County, ValueOptions, META Services, Rehabilitation Services Administration

History and Outcomes of the Peer Support Project
in Maricopa County, Arizona

Every branch of science, art or mechanism—every sect, religious and political, social and moral, seem to have their organs, oral or literary, through which each peculiar tenet or institution is advocated, and guarded against the powerful arms of wrong, oppression and fallacy,--but who ever read or heard a disquisition on or against Mad Houses, Insane Asylums. Such an apostle –such a book, I have never seen or heard of. But you, gentle reader shall not say the same, for the author of this is about to startle the world, and ‘the rest of mankind,’ with a disclosure that shall make the learned Doctors of mad men, and rotten rogues tremble, and gladden the hearts of many a poor, man forsaken, kindred deserted, suffering, perishing, being shut within the walls of the innumerable Bastiles [sic] of our land, ycleped Insane Asylums (Hunt, 1851).

Introduction

Peer Support Training has occurred in Maricopa County, Arizona for 2.5 years at the time of this study. The positive changes in the lives of people who completed the training are examined herewith. The results demonstrate that mutual support and education are important to the recovery process for people with a diagnosis of serious mental illness.

Literature Review

The Arnold v. Sarn lawsuit was filed in 1981 on behalf of mentally ill adults (Johnson, 2001). One outcome of the lawsuit is that Arizona was the first state in which the court ordered that a “comprehensive, community-based system of care for the

chronically mentally ill be developed (Rubenstein & Yohalem, 1987).” In this lawsuit, the “plaintiffs alleged that state and local agencies responsible for providing services to chronically mentally ill Phoenix residents failed utterly to fulfill their responsibilities (441).” This lawsuit continues until now. It has shaped the way that Arizona has attempted to provide services for over 20 years. Arizona was found to be in violation of its own statutory regulations regarding service provision to people with serious mental illness (441). The court ordered that Arizona provide a full continuum of care. Leonard Rubenstein, J.D. and Jane Bloom Yohalem, J.D. assert that it is not just a question of whether someone is not receiving good care, more than that; it is a question of whether people are being denied their civil liberties.

The Arnold v. Sarn lawsuit set the stage for a unique opportunity for a system wide change of service provision. It created a particular set of circumstances that instigated the momentum for change in Maricopa County. However, the change took twenty years to come about. In the book Ethics, Culture and Psychiatry, Professor Norman Sartorius asserts that for any change in a strategy of service provision to become a “self-evident way of proceeding” will take about one working generation...or twenty years. It is interesting to note that it has taken about twenty years for this system change to come to full momentum (9). Peer Support Specialists have been providing services for about 2.5 years at the time of this study.

Part of the change began with a grant issued by the St. Luke’s Charitable Fund. This grant was awarded to begin consumer run businesses. META Services applied for the grant and was chosen as one of the recipients. In addition, META Services responded to a Request for Proposal (RFP) issued by the Arizona State Department of Economic

Security Division of Vocational Rehabilitation. META Services was one of the organizations chosen to create job training to help consumers of mental health services recover by returning to work. META Services began a program they called Peer Support Training. At the same time, a program called the Peer Support Registry created employment for those being trained. These programs were designed to train people who had been given a psychiatric diagnosis of serious mental illness and put them to work as Peer Support Specialists. They would then engage in the recovery process with other people who have a diagnosis of mental illness.

The concept of peer support is not a new idea. The idea gained credibility through its use in Alcoholics Anonymous and similar organizations. In addition, in 1995 Denmark enacted “The Danish Mental Health Act (Okasha, Arboleda-Florez, Sartorius, 2000).” This act addresses the issue of involuntary admissions and the “criteria to be fulfilled in the case of treatment against a patient’s will (75).” There is a particularly interesting twist to this act, and that is the introduction of what are called “patient counselors (75).” These people, who also have a diagnosis of mental illness, are hired by the county and are “independent from any psychiatric institution.” Their particular role is described as follows:

In the case of use of any force, whether related to admission, discharge, or treatment, the psychiatric patient is assigned a patient counselor whose main function is to guide the patient with respect to all conditions related to admission, stay, and treatment on the psychiatric ward. The counselor may also help the patient in the case of a complaint. Patient counselors may be seen as a body that

monitors the use of force in psychiatric institutions, a body that has access to all documents related thereto (75).

In New Zealand, it was found that the indigenous people needed a particular kind of support if they were diagnosed with serious mental illness. The word that is used for people with mental illness in the community is tangata motuhake, which means; people proud to be different. The indigenous community believes that people with mental illness are the experts on what they want and need to help them heal. One of the key elements needed for healing was identified by the tangata motuhake as a “person to walk along side them...a person who has gone through the same journey...who could explain ‘the system’ (Roberts, 2002).”

Edward Knight, Ph.D., a consumer educator who is currently the Vice President for Recovery, Rehabilitation, and Mutual Support for ValueOptions identifies natural supports that occur through peer mutual support groups to be a significant part of developing a recovery oriented service system (Knight, 2002).

In January 2000, the National Council on Disability made ten core recommendations to increase human rights and civil rights of people who experience serious mental illness. The second recommendation the Council makes is that:

People labeled with psychiatric disabilities should have a major role in the direction and control of programs and services designed for their benefit. This central role must be played by people labeled with psychiatric disabilities themselves, and should not be confused with the roles that family members, professional advocates, and others often play when ‘consumer’ input is sought (1). In addition, since the 1980s a consumer movement has been occurring,

which William Anthony, Ph.D. calls a recovery movement. He asserts that the “cronicity that is seen in psychiatric care is a result of the service system itself” and not a result of the disease (Anthony, 2000. p.160). The movement he refers to suggests that recovery from serious mental illness is possible and that it is occurring with or without professional intervention. Studies have shown that up to 68% of all people diagnosed with serious mental illnesses recover (Harding et al., as cited by Knight 2002). Table 1 describes the outcomes for seven different studies of recovery. While the word or idea of recovery, as used in this study, does not mean that people never experience symptoms again or that they will never need medications or supportive counseling again, the criterion of recovery in *these* studies is stringent and described below the chart.

Table 1

Study	Size	# Years	Outcome
Bleuler (1972). Zurich	208	23	53-68%
Huber (1975). Germany	502	22	57%
Ciampi & Miller (1976).	289	37	53%
Tsuang (1979). Iowa	186	35	62-68%
Harding (1987). Vermont	269	32	62-68%
Ogawa (1987). Japan	140	22.5	57%
DeSisto (1995). Maine	269	35	49%
“The universal criteria for recovery have been defined as no current signs and symptoms of any mental illness, no current medication, working, relating well to family and friends, integrated into the community, and behaving in such a way as to not being able to detect having ever been hospitalized...”(Harding, 1992)			

Recovery from mental illness is not a new idea; rather, it is almost a rediscovered idea. In a paper published in the American Journal of Insanity in 1847, author, Amariah Brigham wrote, about Phillipe Pinel, founder of the method of care for the mentally ill commonly referred to as, Moral Treatment. Brigham states, “Pinel...we must regard as the founder of the humane, rational, and now generally adopted system of moral treatment...He is most generally ... known by his bold act of unchaining above fifty

maniacs...at the Bicetre Hospital in 1792 (2-3).” Moral Therapy used tools like companionship, good food, engagement of one’s mind through education, and walks in fresh air as the means of healing a distressed mind. Brigham wrote:

Soon, by this course, their memories will improve; they will become interested in singing or in some particular study, and by perseverance a considerable number will be cured, and many, very many, rendered capable of much enjoyment, and kept from sinking into a state of hopeless dementia(8).

In 1854, the Eleventh Report of the Managers of the State Lunatic Asylum of the State of New York included a table that shows the numbers of recovered patients for the years 1843 to 1853. The table shows percentages of recovered persons in the average population as well as among newly admitted persons. The lowest percentage rate of recovery occurred among newly admitted people during the first year of operation at 19.20%. The highest rate of recovery occurred among newly admitted people in the year 1849 and is listed as 56.07%. Table 2 shows the data presented in this report (American Journal of Insanity, 1854):

Table 2

Year	Average Population	Recovered	Percentage	Admitted	Recovered	Percentage
1843	109	53	48.62	276	53	19.20
1844	236	132	55.93	275	132	48.80
1845	265	135	50.94	293	135	46.07
1846	283	133	50.94	293	153	46.07
1847	415	187	45.06	428	187	43.69
1848	474	174	36.70	405	174	42.96
1849	454	203	44.71	362	203	56.07
1850	433	171	39.49	367	171	46.59
1851	440	112	25.45	366	112	30.60
1852	441	156	35.37	390	156	40.00
1853	423	169	39.95	424	169	39.85

Even in the mid-1800's with few treatment options, and methods of control and coercion like seclusion and restraint, cold showers, and bloodletting commonly in use (Hunt, 1851), people recovered. One described method of control was the "Maniac Bedstead (54)." It is described as:

about two and a half feet square, and long enough for the tallest man. It is a box made of plank, and a cover which is a sort of rack, a little oval, with five strips running lengthwise and hopped across with five hoops of iron, at equal distances apart, and fits upon the top, or the top of the box is sawed off all round four or five inches deep to make the cover, and is fastened on by four hooks and staples near each corner, and when a person is put into it, they will be likely to be found in the morning if it is made strong enough!

Even with harsh and inhumane "treatment," people still recovered. As knowledge of recovery increases and people begin to receive messages of hope for recovery at the time of diagnosis, recovery can become the standard objective of mental health care. A system in which recovery is the goal instead of deterioration or stabilization would necessarily have to undergo a process of recovery itself.

Here are some observations about recovery:

- ✦ *"Recovery is not the privilege of a few exceptional clients (Deegan, 2001)"*
- ✦ *"Since there is no way to predict who will or will not recover, we should approach each person as being able to recover (Deegan, 2001)."*
- ✦ *"Recovery to me doesn't mean denying my problems or pretending that they don't exist (Chamberlin, 2000)."*

- ✦ *“Recent studies by the World Health Organization show that the rate of recovery from severe mental illness is much better in third world countries than in Western industrialized countries (Fisher & Ahern, 2000).”*
- ✦ *“Having someone believe in them translated into hope. Without hope, death can establish a foothold. Hope fights fear and nurtures courage. It inspires vision and the work required to realize the unattainable (Bassman, 2001).”*
- ✦ *“The consumer literature suggests that recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and /or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability (Anthony as cited by Anthony, 2000).*

Key elements in a “Recovery-Oriented System” are described in Table 3 (Anthony, Brown, Rogers & Derringer, 2000).

System Dimension	Recovery System Standard	Example of Current Nonrecovery Standard
Design	<ul style="list-style-type: none"> -Mission includes recovery vision as driving the system -Mission implies recovery measures as overall outcome for system (e.g., empowerment, role functioning) -Core set of needed services are identified for system (e.g., treatment, rehabilitation) 	<ul style="list-style-type: none"> -Mission includes description of service principles (e.g., continuity of care) -Mission implies no measures of recovery outcome (e.g., comprehensive range of services) -Core set of programs or settings are identified for system (e.g., day treatment programs and inpatient settings)
Evaluation	<ul style="list-style-type: none"> -Primary consumer outcomes identified for each service are measurable and observable (e.g., number of crises, percentage of people employed) 	<ul style="list-style-type: none"> -Outcomes for each service are process measures or program quality measures only (e.g., number of people seen in service; time before first appointment)

	-Consumer and family measures of satisfaction included in system evaluation	-Consumer and family perspectives are not actively sought for system evaluation
Leadership	-Leadership constantly reinforces recovery vision and recovery system standards	-Leadership vision is focused on developing specific programs or settings
Management	<p>-Policies insure that a core set of processes (i.e., protocols are described for each identified service</p> <p>-Policies expect programs within each service to have policies and procedures directly related to implementing the service process</p> <p>-Policies insure that MIS System collects information on service process and outcomes</p> <p>-Policies insure that supervisors provide feedback to supervisees on service process protocols as well as on progress toward consumer goals</p> <p>-Policies encourage service programs to be recovery friendly (i.e., procedures are compatible with recovery values)</p> <p>-Policies encourage the assignment of service staff, to greatest extent possible, to be based on competencies and preferences</p>	<p>-Policies do not insure that service protocols guide service delivery</p> <p>-Policies and procedures are about staffing, physical setting, and so forth, and not about service process</p> <p>-Policies focus MIS on collecting information on types of clients served and costs, but not on service processes and outcomes</p> <p>-Policies on supervision do not focus on supervisors providing feedback on protocols and consumer goals; primarily on symptomology and medication</p> <p>-Policies encourage service programs to value compliance and professional authority</p> <p>-Policies direct service staff to be assigned primarily by credentials</p>
Integration	<p>-Function of case management is expected to be performed for each consumer who wants or needs it</p> <p>-Standardized planning process across services that is guided by consumer outcomes</p> <p>-Policies encourage the development and implementation of system integration strategies to achieve specific consumer outcomes</p> <p>-Referrals between Services include consumer outcomes expected of service provider</p>	<p>-Case management function is not expected to be provided to all who want or need it</p> <p>-Planning process varies between services, and is not guided by consumer outcomes</p> <p>-Policies on system integration strategies do not address development, implementation, and evaluation of such strategies</p> <p>-Service referral include consumer descriptions rather than consumer outcomes</p>
Comprehensiveness	<p>-Consumer Goals include functioning in living, learning, working and/or social environments</p> <p>-Consumer goals include functioning in nonmental health environments, not controlled by the mental health settings (e.g., YMCA, religious organization)</p>	<p>-Consumer goals do not include functioning in living, learning, working, and social environments (typically only residential environment)</p> <p>-Consumer goals include adjustment in mental health environments</p>

	<p>-Consumer goals include outcomes from any of the identified services</p> <p>-Policies insure that programs provide an array of settings and a variety of levels of supports within a setting</p>	<p>-Consumer goals include outcomes for only a few of identified services</p> <p>-Policies allow programs to provide a limited array of setting and supports within settings</p>
Consumer Involvement	<p><i>-Consumers are actively sought for employment at all levels of organization</i></p> <p><i>-User-controlled, self-help services are available in all geographic areas</i></p> <p>-Consumers and families integrally involved in system design and evaluation</p>	<p>-Consumers are not actively sought for employment at all levels of employment</p> <p>-User-controlled, self-help services are not available or available in only a few geographic areas</p> <p>-Consumers and families are involved in a token way in system design and evaluation—if at all</p>
Cultural Relevance	<p>-Policies insure that assessments, planning, and services interventions are provided in a culturally competent manner</p> <p>-Policies insure that the knowledge, skills, and attitudes of personnel enable them to provide effective care for the culturally diverse populations that might wish to use the system</p> <p>-Policies insure that settings and programs and the access to them reflect the culture of their current and potential consumers</p>	<p>-Policies with respect to assessments, planning, and services intervention do not take cultural diversity into consideration</p> <p>-Policies related to personnel do not attend to issues of cultural diversity</p> <p>-Policies only insure that settings and programs are compatible with the predominant culture</p>
Advocacy	<p>-advocates for a holistic understanding of people served</p> <p>-Advocates for consumers to have the opportunity to participate in community roles</p> <p>-Advocates for an understanding of recovery potential of people served</p>	<p>-Advocates primarily for particular programs, settings, or disciplines</p> <p>-Advocates for consumers to have the opportunity to participate in mental health programs</p> <p>-Advocates for understanding of recovery potential of people served is lacking</p>
Training	<p>-Policies insure that all levels of staff understand recovery vision and its implications within service categories</p> <p>-Policies encourage selection and training methods designed to improve knowledge, attitudes, and skills necessary to conduct particular service that staff is implementing</p>	<p>-Policies make no mention of recovery vision nor its implications for services</p> <p>-Policies on selection and training based on interests of staff or training coordinator</p>

Funding	<ul style="list-style-type: none"> -Dollars across services are expended based on consumers' expressed needs -Dollars across services are expended based on expected process and outcomes of services 	<ul style="list-style-type: none"> -Dollars across services are expended based on historical, traditional funding -Dollars across services are expended based on historical, traditional funding
Access	<ul style="list-style-type: none"> -Access to service environments is by consumer preference rather than professional preference -Access to service environments is not contingent upon using a particular mental health service -Access to living, learning, working, and social environments outside mental health system is expected 	<ul style="list-style-type: none"> -Access to environments is based primarily on professional decisions -Access to service environments is contingent on participation in certain mental health services -Access to living, learning, working, and social environments outside mental health system is not encouraged

META Services', Gene Johnson, founder of what has been called the "Maricopa Model" of mental health care, created a "recovered" organizational structure and culture within the non-profit agency. Observe how it mirrors the characteristics identified in the above table. A recovered environment has been developed and nurtured. First, the **design** of the agency includes a recovery oriented mission statement that drives the agency culture as a system. The Mission Statement carries a comprehensive recovery vision and is stated as follows: *To create opportunities and environments that empower people to recover, to succeed in accomplishing their goals, and to reconnect to themselves, others, and to meaning and purpose in life.* This outcome study is one of several being conducted to meet the system dimension of **evaluation**, the second dimension. The third system dimension, **leadership**, asks that organizational leaders reinforce the recovery vision. This standard is accomplished through agency wide recovery training. **Management** and team members developed mutual relationships that encouraged interaction. Further, the agency's computer system identifies outcomes and uses treatment plans created to identify the person's goals. Creating a "Friendly customer

service focus which is responsive and respectful to all” became one of twelve service and organizational values. META Services is currently implementing “Creating a Recovery System” which teaches organizations and communities methods for creating a successful recovery oriented system (**integration**), and uses people who have psychiatric symptoms to enhance the learning process.

The programs available through the agency are **comprehensive**. There are programs to help people develop wellness tools like a WRAP (Wellness Recovery Action Plan), which is a self-developed system of symptom identification and management and WELL (Recovery and Empowerment in Life and Living), which helps people develop necessary life skills in a fun and creative atmosphere. In addition, people can develop a “Recovery Planner,” which identifies the goals and objectives the person wishes to achieve, and transfers easily into the ValueOption’s (the current Regional Behavioral Health Authority in Maricopa County AZ) Individual Service Plan. There are programs to help people who are homeless, in supervisory care homes, or in the hospital find housing and develop community and personal living skills. The Urgent Care System has been recently transformed into Psychiatric Recovery Centers that offer comfort and support during psychiatric emergencies. There is also a 23-hour stay unit that is completely peer-run; it is The Living Room. The name is indicative of how the staff creates a comforting friendly atmosphere so that people who come in for care can feel like they are in their own living room. The staff in all programs is completely **integrated** with trained consumer providers, professional staff like counselors, social workers, nurses, and doctors, and administrative staff, consisting of consumer and non-consumer staff, all working side-by-side with no differentiation.

Self-advocacy is taught to the people served by the agency and when it is used, it is supported. A diverse staff that comes from many backgrounds demonstrates cultural sensitivity. **Cultural competency** is taught during New Hire Orientation. In addition, key personnel, including people with psychiatric diagnoses, teach twelve hours of recovery **training** to help insure agency-wide buy-in to the recovery model. In fact, if the four 3-hour trainings are not completed within each employee's first ninety days of employment; they are suspended from work until all four modules are completed. The entire New Hire orientation was redeveloped to include recovery principles and ideas in each of the modules. Again, key staff members act as instructors for the various modules. **Access** to all services is easy and the environments are developed with the customer in mind. META Services went forward with a firm belief that recovery from mental illness can and does occur. This firm belief is demonstrated throughout their system.

When META Services was granted the **funding** for a job-training program and consumer-run organization, the Recovery Education Center was opened. Its mission statement is as follows: **To promote personal growth and recovery for people who experience psychiatric symptoms and/or addiction. Through education, the center will encourage the discovery and development of innate strengths and abilities, to promote self-determination for consumers, supporters and those working in the service system.** Training was developed to teach consumers of mental health services how to use their personal experience as a means of providing hope, as Peer Support Specialists. In addition, the 60 hour training includes modules about crisis intervention, ethics, boundaries, communication, recovery, conflict resolution, substance abuse and co-occurring disorders, resilience, emotional intelligence and more (Rider, 2000).

Two years into the program, 150 Peer Support Specialists are working and providing services throughout Maricopa County, Arizona. This movement is funded by ValueOptions and Arizona Department of Economic Security Rehabilitation Services Administration (RSA) and is helping to create a recovery-oriented service system. Peer Support is an important part of this system-wide change. In fact, Maricopa County, Arizona has the most extensive system of rehabilitation services for people with mental illness in the country (personal interview, Linda Shuttleworth, 2002). This extensive service system is one result of the Arnold vs. Sarn lawsuit.

The Research Question

This study seeks to discover **what is the perceived impact of peer support training on the well-being of participants as measured through given answers to questions posed through a telephone interview, personal interview or assisted completion of the questionnaire using participants who have graduated at least six months prior to the interview.**

Methodology

Sampling

The sample is a convenience sample that consists of people who have completed the training. Eligible participants were those who completed the 60-hour training at least six months before they completed the questionnaire. Candidates were participants in classes that graduated from October 2000 until August of 2002. The total number of graduates eligible for this study was 146. The number of people who completed questionnaires was 78 or 53% of eligible people. Random selection did not occur because the people questioned had all completed the training. However, among those who

completed the training, everyone was called and all but one person who was located agreed to complete the questionnaire.

The population of participants in the training is those referred through an open case with vocational rehabilitation for job training and they must have a diagnosis of serious mental illness. Services are available regardless of a particular diagnostic label. The person never has to reveal their diagnosis. Regardless of the intensity of symptoms, if a person feels ready to take the class, they can take the class. Therefore, the agency does not engage in “creaming (personal interview Lori Ashcraft, 2002).” Creaming occurs when only those who are least symptomatic, highest functioning, or most educated are selected from applicants to a program. Therefore, the population identified for this study is a fairly random sample of people with mental illness by virtue of the fact that anyone who wants to take the training is welcomed.

The longest number of months out of training was 28 months at the time of the interview. 71 of the participants are currently working and 7 are not working. As participants discussed their answers, many expressed that work was an important wellness tool for them. However, the likelihood that the training itself provides participants with a sense of well-being even if they do not work is high. Of the 7 people who are not working, 6 (86%) said that their overall sense of well-being is better since they took the training and one said their sense of well-being remains the same.

Measurement

Some questions use a ten point Likert scale, where ten is the best and one is the worst. Several questions require an answer of yes or no, and some ask that a given number be identified by each participant concerning how many times an event occurred.

Other questions ask for a rating word to identify the answer. In addition, four feedback questions are asked.

Data Collection

Well-being is measured through the answers to a questionnaire administered via a telephone interview or in person. Peer support Specialists who wish to participate are interviewed once. There is no penalty if a person does not want to participate, but the demographics and other information will be compared to those who chose to participate. The passage of six months is expected to give a more valid indication of the long-term outcomes of peer support training. Of the people who participated in the study, 38 completed the training at least twelve months prior to the interview. This is equal to about 49% of the participants. The remaining 40 people completed the training six to eleven months prior to the time of their interview. Interviews were conducted from December 2002 until March 2003. Of the graduates interviewed who completed the first training, 28 months ago, 40% are working or in school. Of all the people who graduated from the first class, 47% are working or going to school. Two are seeking their bachelor's degrees and one is seeking a master's degree.

The participants answered questions in person, by telephone as the researcher interviewed them, or the interviewer assisted them in completing the questionnaire. Each questionnaire was completed with the preface that all information was confidential unless the person expressed a desire to hurt himself or herself or someone else. If this condition occurred, all that was on the questionnaire would remain confidential, but the person's safety and well-being would be paramount. No one expressed any thoughts of harming themselves or anyone else during the interviews. One white male, age 35, refused to

participate in the interview process. He is not working, but was offered a position upon graduation. He chose not to work at that time. People who did not participate either did not have a phone, or the number had changed, or frequently, they were working and their hours were the same as the interviewer. Otherwise, there was a sense of wanting to help spread the idea of recovery. People were excited to talk about their story of recovery. A deep level of trust was conveyed by most participants to the researcher who is well known to them.

Peer support training lasts for five weeks. The training class meets three times a week for 4 hours of training with two fifteen-minute breaks. The entire training encompasses sixty hours. Topics are discussed, studied, and participants take four tests and four quizzes, including a final examination, on which they must score an average of 80% to be considered for graduation according to the agreement with Vocational Rehabilitation. Participants engage in discussion and do extensive reading on topics such as crisis intervention, cultural diversity, ethics and boundaries, advocacy, resilience, emotional intelligence, community building, recovery from mental illness, conflict resolution, communication skills, and substance abuse (Rider, 2002).

In addition to the outcome measurements and discussion of findings, quotes from participants are added so that the reader will not forget that the research subjects are people who have insight and feelings about the training. Therefore, the study is qualitative and quantitative. In addition, it is important to note that the participants in the study will self-report their levels of well-being prior to the training and after the training. This will limit the study to some extent because well-being will not be measured with a pretest and posttest. However, using participant's own perceptions and feelings about

their wellness levels before and after intervention assesses if they identify changes in their well-being.

Marianne Long, BA, RPRP trained the first graduating class. Ann Rider, BA, CPRP, the author of the training manual, trained the next eleven classes. Lisa St. George, BSW, CPRP who is the researcher of this outcome study trained the twelfth class. Currently, Michael Zeeb, BSE, trains the class.

The statistical research uses the Statistical Program for Social Sciences or SPSS. Additional relationships explored are if people who are working perceive themselves to be doing better than those who are not working, if there is any difference in the outcomes for males compared with females or people who are transgender.



Demographics

There were N78 participants in this study. Of those, 91.02% (n 71) are employed. This study had 57 female participants, 18 male participants, 2 transgender participants, and one person who participated did not answer the question of gender. In addition, 62 people consider themselves heterosexual. 20.5 % of participants identified their sexuality as other than heterosexual. The breakdown of these participants is as follows; 6 are lesbian, 3 are gay, 2 are bisexual, 1 identified as asexual and 4 did not identify any sexual identity. Each of these four people asked not to answer this question. Nothing should be assumed about the possible outcome of those four participant's answers because they may have simply refused to answer due to privacy needs.

Many choices were given in the survey for racial or ethnic identity. However, there were people who did not find themselves in the list and did not want to be listed under "other." These participants included a man who is from the Philippines, a woman whose identity was Mexican-American, a woman who is "French, Irish, and Indian" and all of these ethnicities were very important to her. Another female identified herself as a member of the indigenous people who is Hispanic and the first generation born in the United States. This need to be fully recognized, and claim one's heritage can serve as a reminder that people want to be viewed as unique treasures each possessing qualities and culture that comes from their ancestors. The number of participants in this study who were white was 58. There were 6 African Americans who were black; there were 4 people who were Hispanic, and 2 people who were Latino. 2 people identified themselves as members of one of the indigenous people or a tribal member. People identified themselves twice as Mexican-Americans after placing an "X" in the space for other.

Below is Table 4 showing census data regarding race in Maricopa County (according to the 2000 census) compared with racial data from the participants:

Race	Percent in Maricopa County for the year 2000	Percent in Study Participants
African American (Black)	3.7%	7.7%
Hispanic	24.8%	14.1%
Indigenous or Native American	1.8%	2.5%
Caucasian (White)	77.4%	74%
Other	11.9%	1.3%

Table 4

There was no difference in the wellness of one ethnic or racial group over another. Working or not working did not affect the wellness levels of people. While people who work express happiness in their employment, they do not experience a difference in their level of wellness compared to those who are not working. The number of people who are not working is small (n 7), but the training seems to have good outcomes regardless of whether or not the person obtains employment. In addition, sex does not seem to change the outcome of the training. Therefore, the training is suited to males, females, and people who are transgender. In addition, good results occur whether or not the person finds employment, and the training appears to be effective for people of many cultures and races. The Table 5 is an overview of answers to questions on race and ethnicity, employment, and gender as compared to answers to question number 3 regarding overall sense of well-being and question number 7 about skill at symptom management. While these questions will be explored later, this table demonstrates that wellness and symptom management skill frequently increase and sometimes remain the same regardless of gender, employment or race/ethnicity.

Variable	Response Choices	Percentage for Each Answer Choice	Sense of Well-being			Skill in Symptom Management		
			Same	Better	Worse	Increase	Decrease	Same
Working	<i>Yes</i>	91% (n 71)	3	68	0	66	5	0
	<i>No</i>	8.9% (n 7)	1	6	0	7	0	0
Race/Ethnicity	<i>African American (Black)</i>	9% (n 7)	0	7	0	7	0	0
	<i>African from Africa</i>	0						
	<i>African American (White)</i>	0						
	<i>Hispanic</i>	5.1% (n 4)	1	3	0	4	0	0
	<i>White</i>	74.4% (n 58)	3	55	0	54	0	4
	<i>Middle Eastern (including Pakistan and India)</i>	0						
	<i>Latino</i>	2.6% (n 2)	0	2	0	2	0	0
	<i>Asian</i>	1.3% (n 1)	0	1	0	1	0	0
	<i>Member Indigenous People (Native American, Tribal Member, Indian etc.)</i>	2.6% (n 2)	0	2	0	2	0	0
	<i>Other or not on list</i>	6.4% (n 5)	0	5	0	5	0	0
Gender	<i>Male</i>	23.1%	2	16	0	18	0	0
	<i>Female</i>	73.1%	2	55	0	53	0	4
	<i>Transgender</i>	2.6%	0	2	0	2	0	0
	<i>Do not know/no answer</i>	1.3%	0	1	0	0	0	1


 Indicates increase in symptom management and overall sense of well-being

Table 5

Some participants have completed the class with the help of a translator for a Spanish-speaking person. Special equipment was used to assist a person with a hearing impairment. Large print was used to help a legally blind individual complete the class. A tutor assisted an individual who could not read due to a learning disability.

Perspectives on History of Trauma and Abuse in People with a Diagnosis of Serious Mental Illness

Trust is an important part of a therapeutic relationship. Many of the participants have social histories that include abuse and trauma events, which make trusting difficult. Therefore, the issue of abuse in the history of persons with serious mental illness before

or after they receive their diagnostic label deserves exploration. Most movies, newspaper articles, and magazines present a picture of people with mental illness as being out of control, raging, violent, and unable to reason. Because of this perpetuated stigma, people are deprived of their basic civil liberties on a regular basis. People are discriminated against, and verbally abused in the public domain without question. If people were regularly handcuffed and removed from their homes for refusing to take their blood pressure medications or insulin, people would be appalled. If other groups were spoken of in the same terms or similar terms as those, which are used in describing people who wear the label of mentally ill, then there would be great public outcry. Lawsuits would be brought and people would be held accountable for their deplorable behavior. It seems that the mentally ill are one of the few groups left on the fringe of society, cast out, and kept in the realm of “other.”

Careful examination of violence perpetrated against people who have a label of mental illness shows that they are much more frequently the victims of abuse and violence in general, than they are the perpetrators (Hiday, et.al. 2002, Hiday, et. all. 1999, Cascardi, et. al. 1996). This exploration will begin with a discussion about referring to people by their diagnosis. In the September 2001 Phoenix Magazine published an article about the Arizona State Hospital. By the second paragraph, people had been called their diagnosis three times. Patricia Deegan, Ph.D. states that when a person is related to as their disease, our “own capacity to be compassionate” is challenged. In addition, she asserts that it violates the idea of an I-Thou relationship (Buber as cited by Deegan, 1996, p. 8), and as we begin to “relate to the person as if they were a disease then we enter an I-It relationship. The I-It relationship diminishes our humanity (6).” Here are some quotes

from the article written by Peter Aleshire who spent one week visiting the Arizona State Hospital discovering what it means to have a psychiatric label:

“...a destructive, conduct-disordered fellow without a shred of impulse control... (82)”

“...he’s screaming like a banshee... (82)”

“That’s when psyc techs—who come to like their patients, even the ones who might hit them for no particular reason... (82)”

“...his mother is so crazed... (82)”

“...a quiet schizophrenic... (84)”

“..a young, black-haired, good-looking borderline... (84)”

“...predatory psychopaths mingled freely with hapless schizophrenics... (82)”

Is Mr. Aleshire a man without feelings to speak with such lack of empathy about people who are ill? Probably not, but the need to make people with psychiatric labels remain different perhaps comes from a deep fear of the fact that any person could become mentally ill at any time. As long as people are blamed, labeled, and kept in a framework of thought that keeps them far from being like everyone else, there is a perception that these illnesses are for someone else. This treatment of people as a diagnosis, an illness, is inhumane. It creates a setting, which allows and supports coercive treatment like restraints to be used frequently and as a means of social control.

Throughout the above-mentioned article, Mr. Aleshire describes some of the social backgrounds of the people about whom he so despairingly speaks. The person referred to as a destructive, conduct-disordered fellow has been “confined” to the state “hospital for 17 years (83).” “He was molested and beaten with belts, tree branches, and

furniture by his step-father...” for ten years beginning at age two (83). One of the people referred to as a borderline has a history of fetal alcohol syndrome, and was the victim of a reservation boarding school teacher who had molested many of his students. Another person in the article was sexually abused by a person who used “mayonnaise as a lubricant”...the article refers to him as being “obsessed with mayonnaise.” The consistent factor here is that all of these people were victims of abuse. Their perpetrators may be in jail, but they probably do not have a psychiatric label. They are criminals. Shery Mead, MSW, who is a consumer advocate, makes this statement, “Why am I the one who receives a diagnosis of Post Traumatic Stress **Disorder**, when I am having an absolutely normal reaction to someone else’s disorder (personal interview, 2002)?”

There were three questions asked about abuse and sexual abuse in this study. They are:

/“Do you consider yourself to be a person who has experienced trauma and abuse?”

/“Have you experienced sexual abuse?”

/“If yes to any of the above, did it occur as a child, adult, or both?”

The answers to these questions stress the vulnerability of people with mental illness. The results show that a total of 91 % of the people who participated had experienced some form of abuse at some point in their lives. The exact breakdown of when abuse occurred is that 23.9 % (n 17) only experienced abuse as a child. Those who only experienced abuse as an adult were 22.5 % (n 16) and those who experienced some type of abuse as both a child and adult numbered 38 or 53.5 %. Thus, the number of

people who were abused in some way as children is 55 or 77.4 %. This means that 70.5% of the entire group of participants (N 78) experienced abuse as a child.



This can be shown with a pie chart. Seven people out of the 78 interviewed stated they had no history of abuse of any kind. Figures 1, 2, and 3 show the outcomes of the questions about trauma and abuse:

When Abuse Occurred

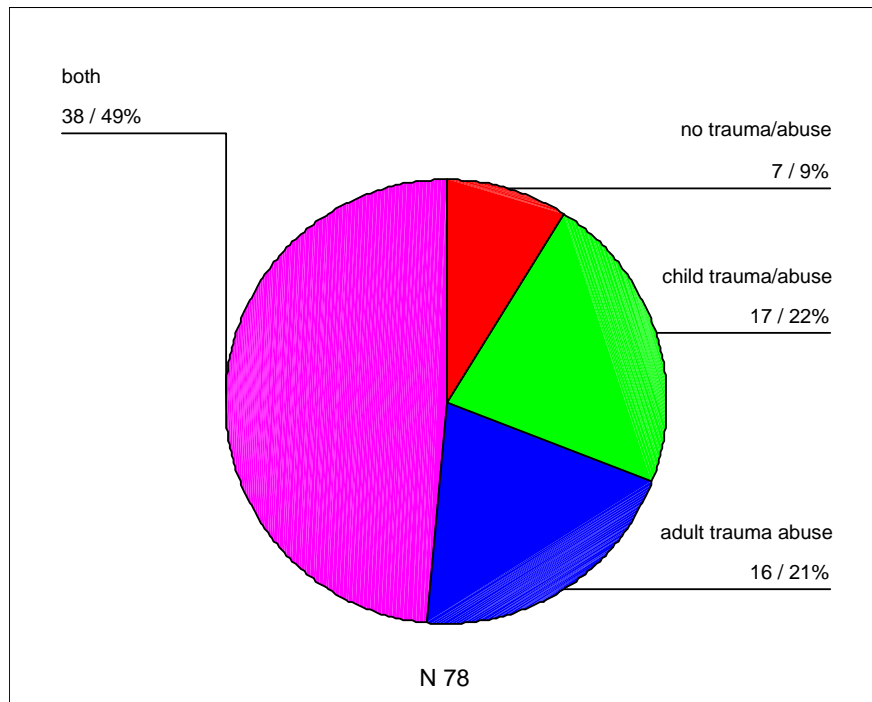


Figure 1

Experienced Trauma and Abuse

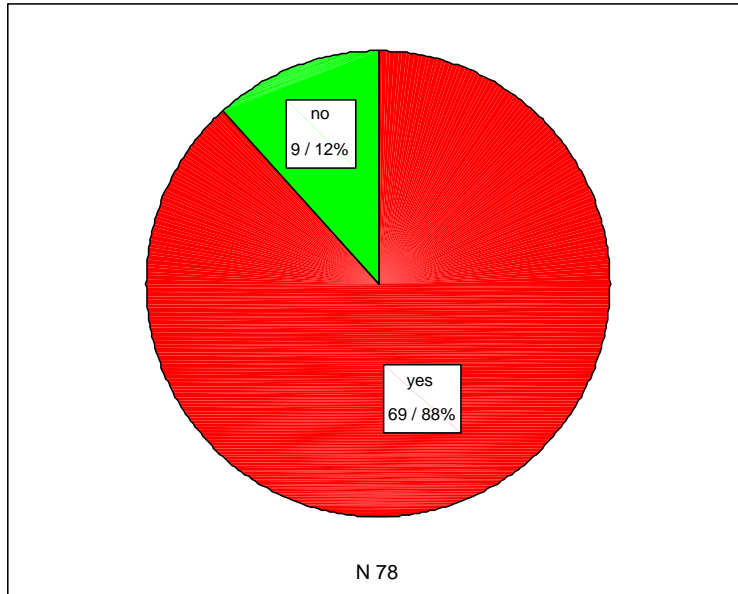


Figure 2

Have you experienced sexual abuse?

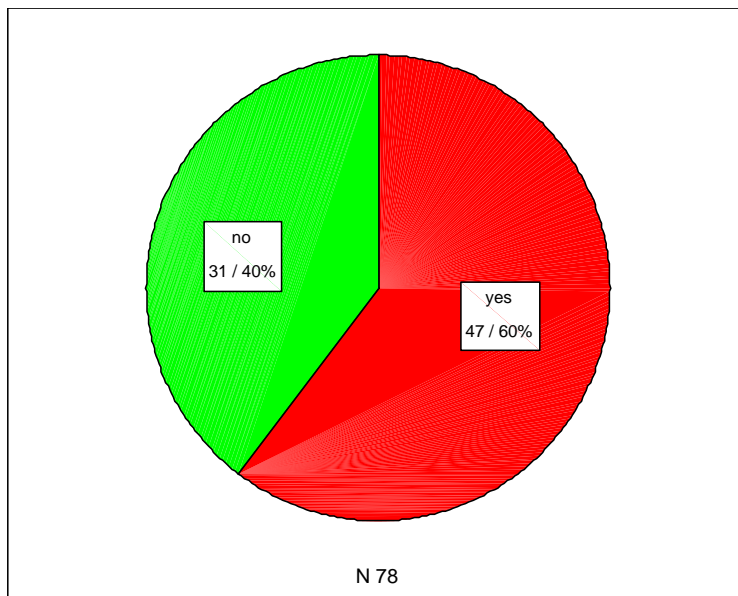


Figure 3

Recall the descriptions of the people that Mr. Aleshire used in his article. The people he describes are symptomatic and have a great deal of difficulty managing their

symptoms. Recall that these people are in the State Hospital and are therefore on medication. In fact, Mr. Aleshire describes one man's pharmaceutical arsenal as consisting of "three anti-psychotics which make him move like a deep sea diver in a 300-pound suit (82)." Medication may help, but there are other influences that are creating the depression, obsession, posttraumatic stress (PTSD), and personality disorders, which are labels given to people who experience sadness, pain, and anxiousness that disrupts their lives. Shery Mead, MSW describes the beginning of her recovery from feelings of self-harm:

It was cathartic when I (S.M.) was able to tell a peer about my experience with cutting (a process I was tremendously ashamed of and secretive about). Instead of labeling it the other person said she had gone through similar kinds of things and had found ways to learn from it and consequently was able to express her pain differently. For the first time, I felt some hope. I felt less of a "crazy person" with bizarre behaviors, and more able to think about gaining new resources toward change. It also allowed me to think about pain in a language that had a relationship to my past history of violence rather than pain as symptomatic. Over time, this knowledge has led me to understand contextually some of the difficult experiences I've had. It has also supported my ability to be in relationship through crisis without falling into the patient role (Mead & Hilton, 2002, p. 6).

The importance of relationship becomes clear through Ms. Mead's description of how she moved from being a person who inflicts self harm (typically referred to with the derogatory reference of "cutter") to a person who experiences pain that is the

expected result of an abuse history and not pathology. Is it possible to depathologize people's experiences with emotional pain?

Explore the issue of physical pain resulting from an accident of some sort. The crisis of the event occurs; the body undergoes violent interaction with an object or physical mass of some sort. The body is injured and a result of the injury is a broken bone, bleeding, bruising, and pain. It would be absurd to imagine that the person involved in this accident would not feel pain. In fact, one of the first measures taken to help someone when he/she experiences the trauma of an accident of some sort is to ease their pain. It is the humanitarian thing to do, the right thing to do, what should be done. After an accident, the person is cared for as a complete entity.

Imagine a person who has experienced the trauma of abuse, physical, psychological, or sexual. The victim is frequently seen as having an injury of the mind. So the mind is medicated, but the wounded body with all of its memories remains uncared for and the injuries of its heart and soul go untended. Therapy is important to help work through the pain of abuse, but having the support of family and loved ones through the injury of abuse is as important. Our culture tends to overlook abusers (Mead & Hilton, 2001) and label children who have been abused as uncontrollable, withdrawn, isolative, aggressive, or depressed and disordered. It is the exceptional family that stands by the child who is abused, especially if the abuser is a family member. Therefore, these children grow into adults who do not trust their perspective on life, they have difficulty trusting, and they internalize the idea that they are somehow at fault. Recall once again, Mr. Aleshire's article and remember the person who was said to be "screaming like a

banshee (82).” The following description presents a common experience among people who experienced abuse as children:

He’s on antidepressants and antipsychotics, which settle him down but do not quite give him control over his gusts of rage. In therapy, he finally detailed the abuse by his stepfather, but his family reacted with outrage and disbelief, so he dropped the issue, saying he has forgiven his stepfather (84).

Here is a man being medicated, which is not having much affect on him, but who must deny his reality or face emotional or physical abandonment by his family. He begins to understand that he cannot trust his understanding of the world, because those whom he loves and trusts the most invalidate his truth. By calling him insane, his stepfather is free from suspicion and his family must only face the world with a child who is not sane rather than with a loved one who is a child molester. If the accusation is true, there is a criminal walking around free while the victim does time in the State Hospital. If it is not true, the victim remains unable to verify truth from falsehood. He never completes the process of understanding how his thinking is faulty and has proof to verify that he must rethink his history. His life hangs in a precarious state of incomplete reality. Therefore, invalidated, frustrated, confused, and in great emotional pain, he is full of “gusts of rage (84).”

However, family can also be a source of support for people who are seriously mentally ill, as this study will show. In addition, religious groups can help build a sense of community and a feeling of belonging. A group assembles that has a similar belief system and that can offer support, friendship and comfort. When asked about spirituality and religion, 72 people said it was very important or important. This number represents

92 % of the people who participated in this study. Twelve step programs have used the strength of spirituality since 1935 to help people recover from addiction.

How important is spirituality or religion to you?

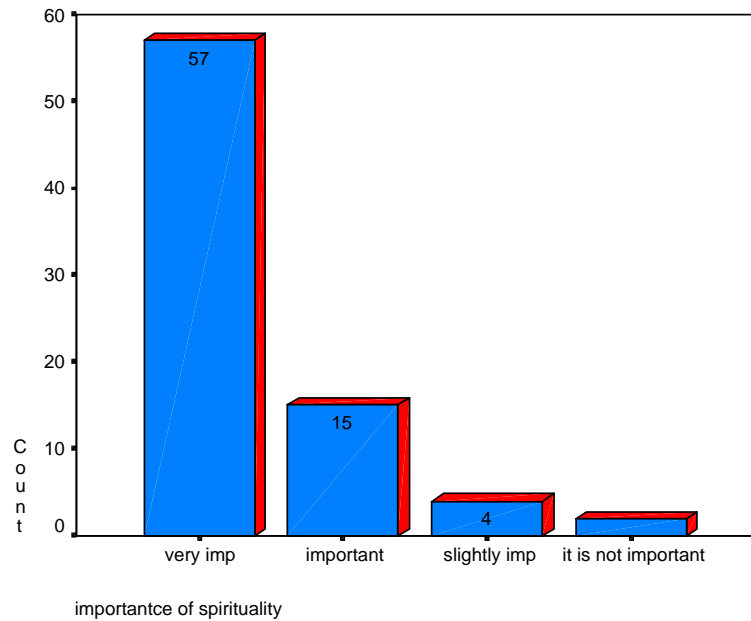


Figure 4

Figure 4 gives visual representation to the level of spirituality or religiousness of people participating in this study. This should not be seen as indicative of all people with mental illness, but because of the nature of the question and the available choices, the results of this study have a high level of validity. It appears that the idea of something greater than one's own experience in life seems to be very important or important to many people with mental illness. Along with work, this spiritual foundation in life could represent a way that people give meaning to their suffering or their life in general.

Therefore, participants in this study were people from diverse backgrounds; they varied in sexual preference, and gender. In addition, 91% of people participating in this study have experienced trauma and/or abuse in their history. Further, over 70% of all

people who participated in this study experienced trauma and/or abuse as a child. Of the people questioned, 72 find that spirituality or religion is a very important or an important part of their life.

Results

There was a consistent degree of positive change in each participant. When asked if their ability to manage their symptoms had increased, decreased, or stayed the same, 93.6 % (n 73) stated that their ability to manage symptoms increased. In addition, 6.4 % (n 5) stated that their skill level remained the same. None of the participants stated that their skill level in symptom management had decreased because of the training experience. Similarly, when asked about their sense of well-being, 94.9 % (n 74) of participants expressed a better overall sense of well-being since the training. Again, no participant indicated a worse sense of well-being, and 5.1 % (n 4) stated that their sense of well-being remained the same as it was prior to the training experience. These outcomes are shown in Figure 5 and Figure 6.

Perception of Ability to Manage Symptoms since Peer Support Training

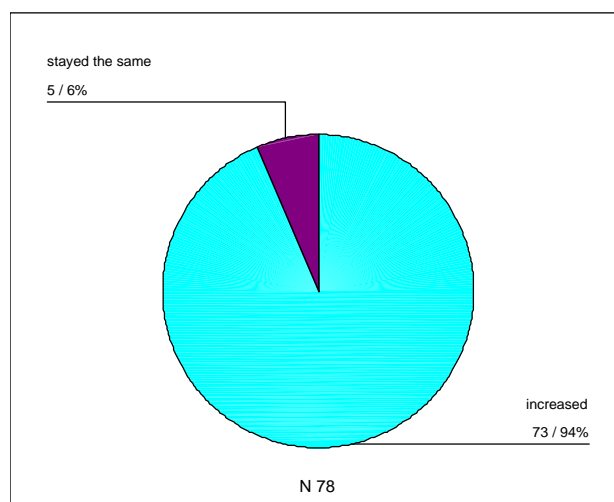


Figure 5

Perception of Well-Being Since Peer Support Training

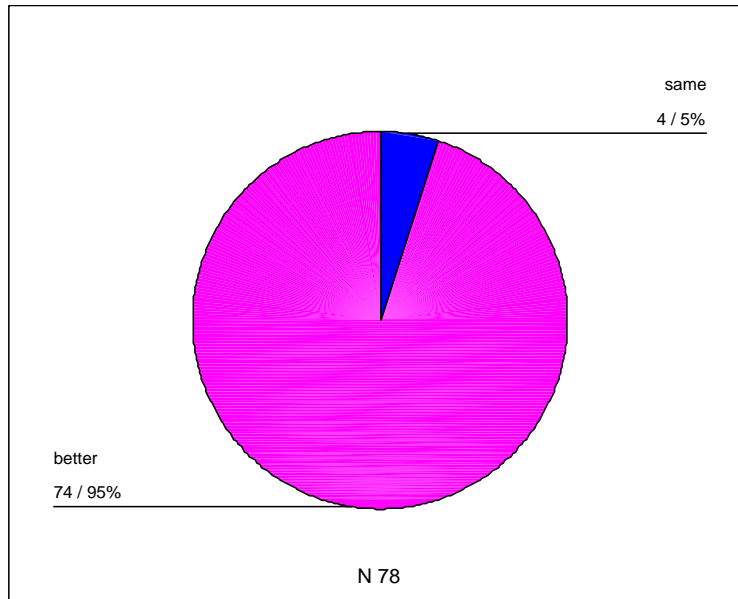


Figure 6

There were positive outcomes in response to the questions regarding service usage before and after training. With the cost of services rising, and decreases in available funding, this particular outcome should be of value to the service system. While use of services is not indicative of a lost recovery, the ability to manage symptoms using wellness tools and a WRAP (Wellness Recovery Action Plan) can prevent high service usage rates (Copeland, 1998). Three people used the crisis phones or urgent care after training when they had not used them before. They stated the usage prevented a hospitalization, or kept them from using substances, which had been an unhealthy means of managing uncomfortable symptoms prior to the training. They indicated they had not known about or felt comfortable using these tools prior to the training. The outcome of the service usage questions appears in figures 7 to 11 and tables 6-10.

Crisis Phone Use 12 Months before and Up to 28 Months after

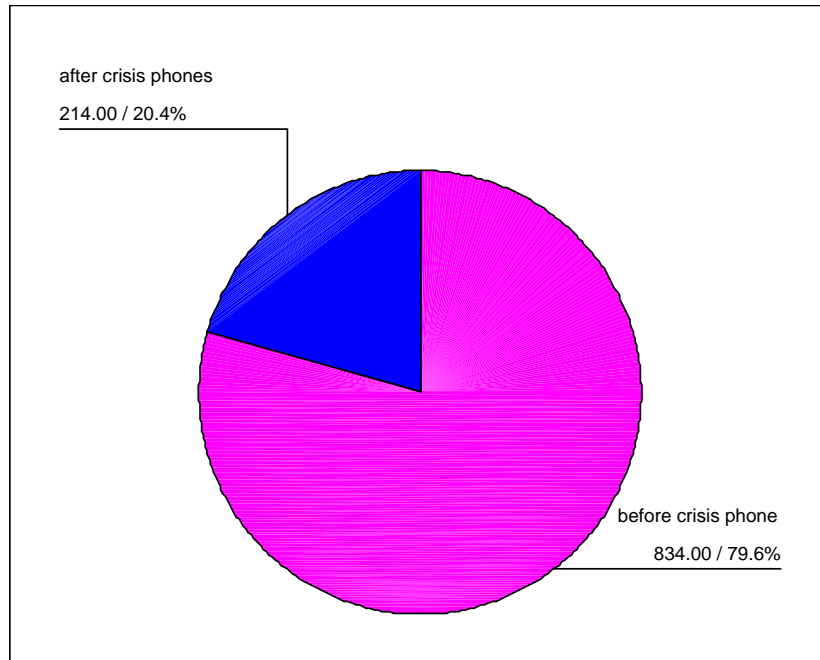


Figure 7

Mobile Team Use 12 Months before and Up to 28 Months after

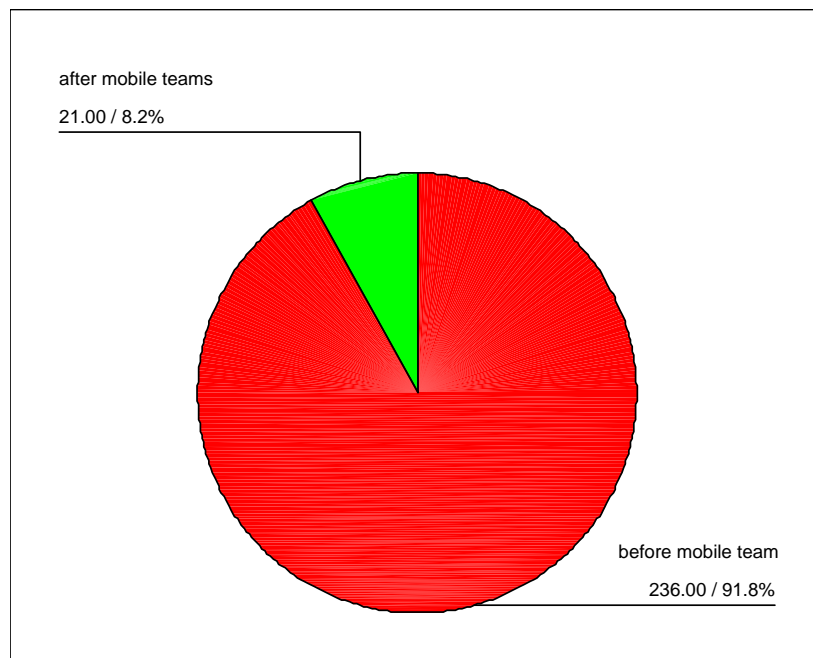


Figure 8

Hospital Use 12 Months before and Up to 28 Months after

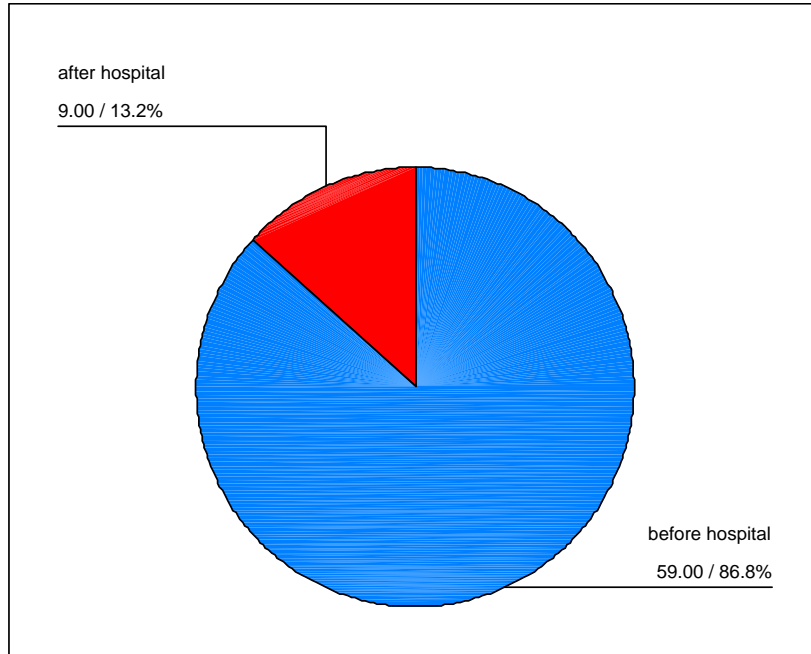


Figure 9

Urgent Care Use 12 Months before and Up to 28 Months after

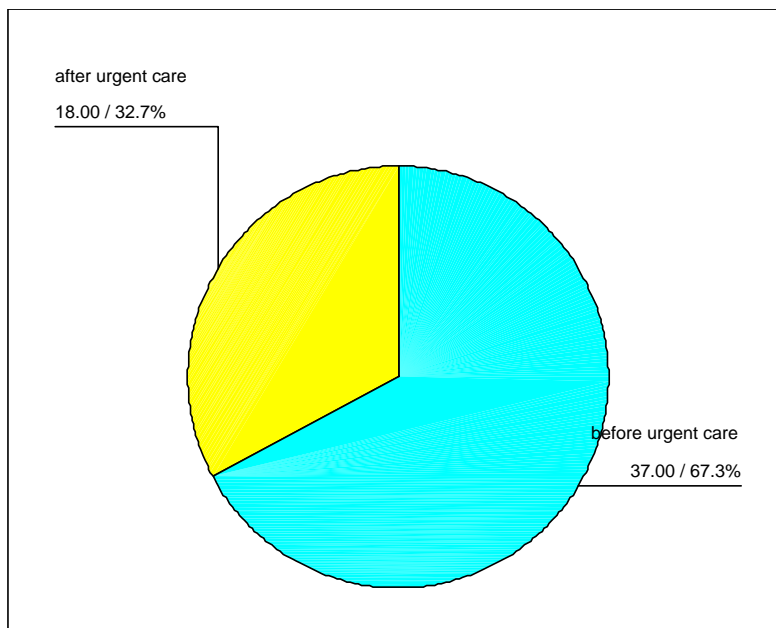


Figure 10

Even with the extended time since training for some of the people who participated in the study, a dramatic drop in service usage occurs by self-report. While this study did not follow individual usage through a computer output, and therefore these numbers are suggestive, people identified a lower service usage. If the number of reported services used 12 months prior and up to 28 months following Peer Support Training is examined, a drop from 1166 uses to 262 uses occurs. The average total usage 12 months before and up to 28 months after goes from 14.94 uses per person to 3.4 uses per person.

Total Service Use 12 Months Before and up to 28 Months after Training

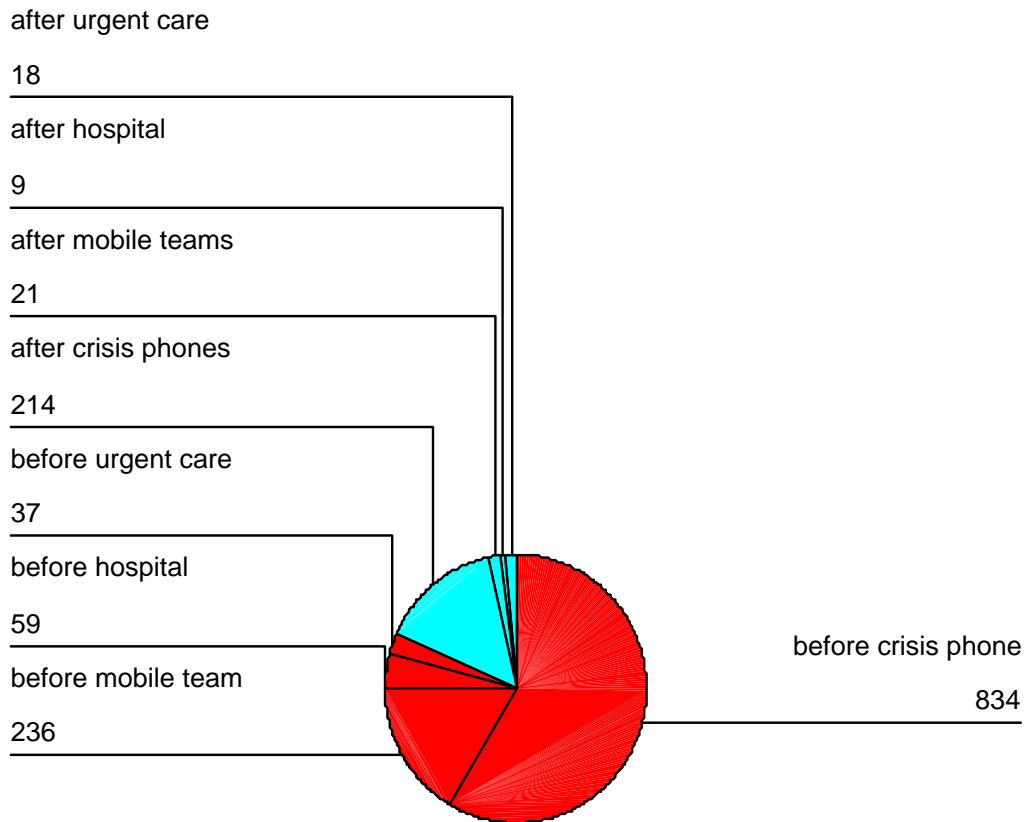


Figure 11

Table 7

Variable	Frequency	Mean	Maximum
Before Training Crisis Phone Use	834	10.6	260
After Training Crisis Phone Use	214	2.74	156
Before Training Mobile Team Use	236	3.03	156
After Training Mobil Team Use	21	.27	5
Before Training Hospital Use	59	.76	4
After Training Hospital Use	9	.12	2
Before Training Urgent Care Use	37	.47	6
After Training Urgent Care Use	18	.23	10

The measurements of service usage are important. However, the person's perception of their well-being in many areas of life can be viewed as markers for wellness, or recovery. As Dr. Anthony suggests, the comprehensive nature of mental health services would reflect a more recovery-oriented system. This comprehensiveness included goals such as "functioning in learning, working, and/or social environments (Anthony, 2000)." It also included "functioning in nonmental health environments" and these settings were akin to places of worship, recreational areas, and could include restaurants, movie theatres, and shopping areas, etc (165). In addition, quality of relationships with family and friends could be included in this measurement of a system that is comprehensive in its service provision. The next set of figures will show perceived changes in people's relationships, activities, support systems, and self-advocacy.



Family Relationships before and after

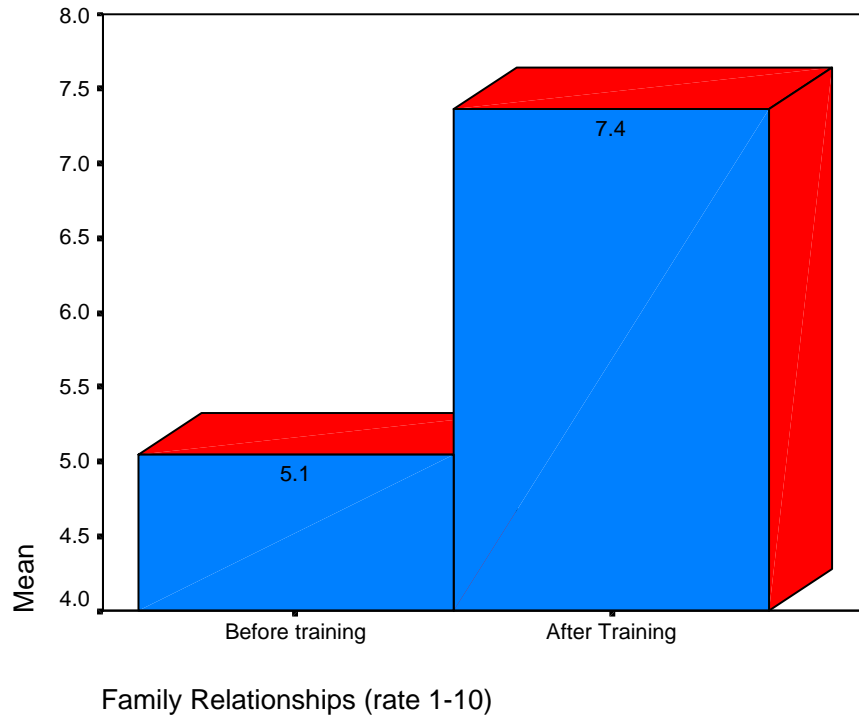
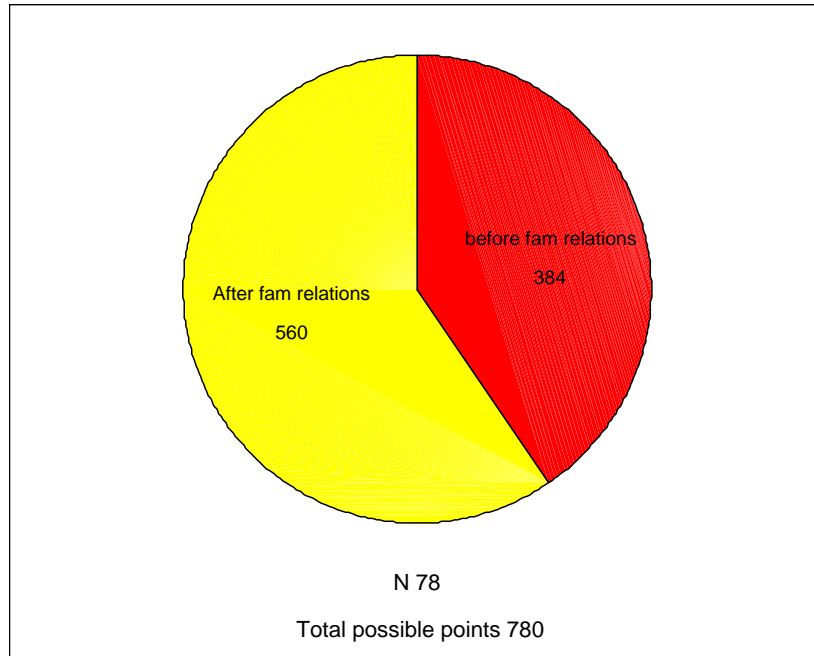


Figure 14

In Figure 14, people interviewed reported family relationships that varied by 176 points before and after. There were 6 individuals who reported the highest quality of relationship with family before training (rating 10). After the training, 31 individuals report they have the highest quality of relationship with their family (rating 10).

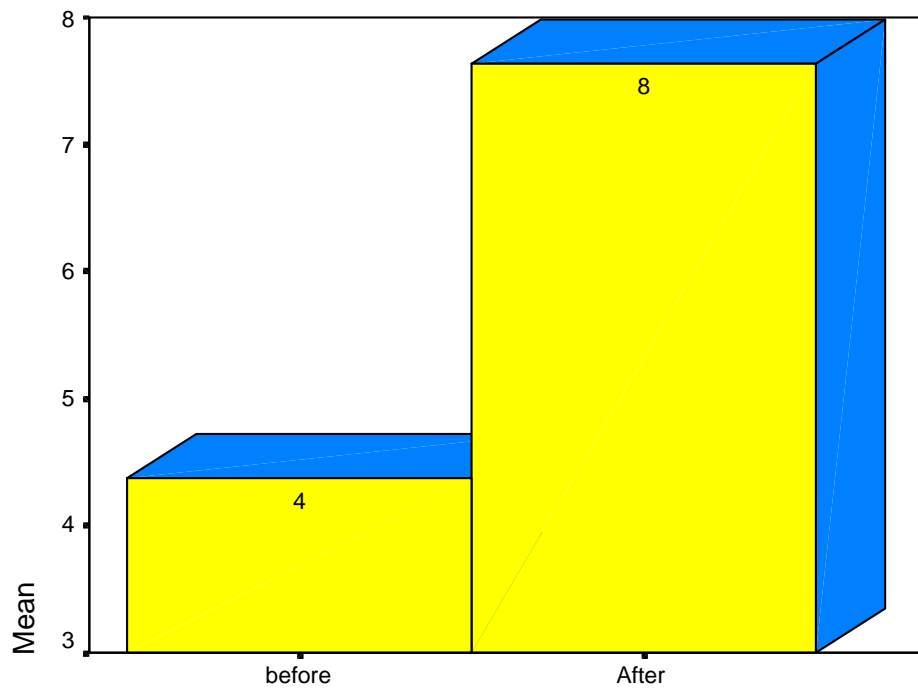
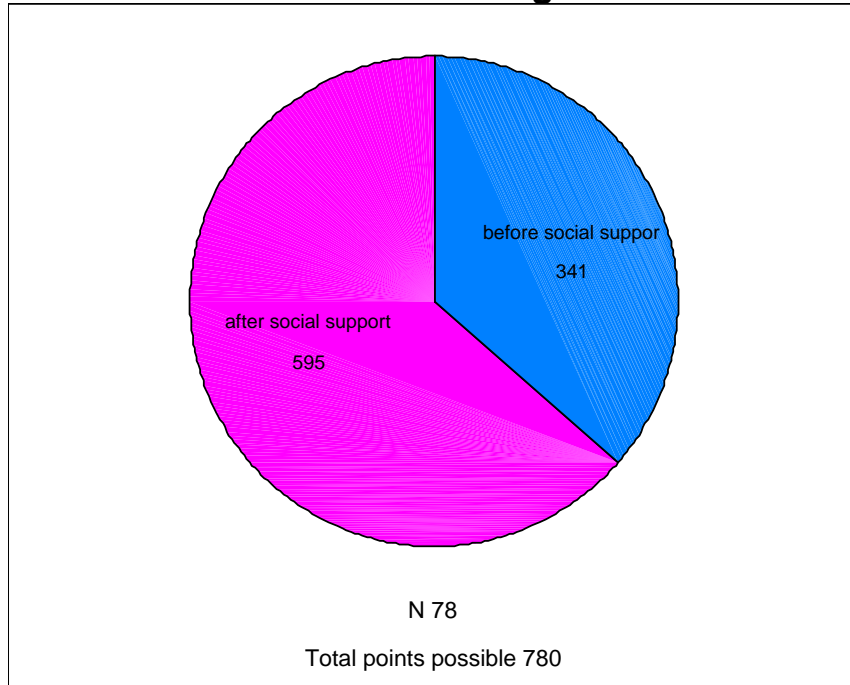
People were told that family means whatever they identify as family. Therefore, if they are living with a partner, and that partner is their identified family, they could fashion their answer around that idea of family. If family meant a large conglomerate of extended family and immediate family, then that system is what they were told to use to rate their perception of the relationship. If their family included one person such as a

spouse or child and the rest of the family was estranged from them, and that was no longer having an impact, then they could use that one person as family. There were many questions about what was acceptable to use to identify family. This demonstrates many variables in the identity of “family” for people. In addition, the concern with using the “correct” group for



family may demonstrate a need to fit in or be accepted. In addition, it may show that people with different types of family groups fear identifying their lifestyles in many settings. Most people expressed a sense of relief when told that “family” was simply whatever it meant to them.

Social Supports before and after Training



Social Support (rate 1-10)

Figure 15

A larger change occurred in social support systems from before to after the training. People had a perceived social support system before training that is about half of their perceived rating after the Peer Support Training. A rating of 4 is interpreted as demonstrating a high level of social isolation among people with psychiatric disabilities. DeLisi (2003) identified adequate community support as being “the best preventive measure” against suicide among people labeled with schizophrenia. In addition, DeLisi states, “From my own experience with first-episode patients with schizophrenia who have committed suicide, I found them to be somehow lost to follow-up care (121-122).” This follow-up care could be support given by a good social network of supporters or peer support specialists. Patricia Deegan, Ph.D., who is also a person who bears the label of schizophrenia, describes the social isolation that occurs as follows:

I turn my gaze back over the years. I can see her yellow, nicotine-stained fingers. I can see her shuffled, stiff, drugged walk. Her eyes do not dance. The dancer has collapsed and her eyes are dark and they stare endlessly into nowhere...she forces herself out of bed at 8 o'clock in the morning. In a drugged haze she sits in a chair, the same chair every day. She is smoking cigarettes. Cigarette after cigarette. Cigarettes mark the passing of time. Cigarettes are proof that time is passing and that fact, at least, is a relief. From 9 a.m. to noon, she sits and smokes and stares. Then she has lunch. At 1 p.m. she goes back to bed to sleep until 3 p.m. At that time she returns to the chair and sits and smokes and stares. Then she has dinner. She returns to the chair at 6 p.m. Finally, it is 8 o'clock in the evening, the long-awaited hour, the time to go back to bed and to collapse into a drugged dreamless sleep.

The same scenario unfolds the next day, and then the next, and then the next until the months pass by in numbing succession marked only by the next cigarette and then the next... (Deegan, 1993, p. 8, as cited by Deegan, 2001, p. 9-10).

Whether imposed by the caregivers, the medications, or by the person in the midst of their symptoms, isolation has been the social experience of many people with mental illnesses throughout history. Read this description of isolation that appeared in The Springfield Union on December 8, 1966. Neil Perry wrote this account of Josiah Spaulding, Jr., son of Rev. Josiah Spaulding. Josiah (Si) Spaulding died in 1867:

For Josiah Spaulding Jr., ... was a 'raving maniac' and was confined to a small wooden cage for 57 years. Naked, except for a woolen blanket wrapped protectively around him, Si sat for decades on the cage floor, his knees drawn up to his breast, waiting to die. The townspeople waited with him...

The following accounts were written by Ronald Bassman, Ph.D. and describe his experiences with "treatment" while coping with psychiatric symptoms (2001, p. 1):

The seclusion room was empty except for a mattress covered in black rubber on the concrete floor. They lowered me onto the mattress and turned me on my side. I fought their grip on my ankles and wrists, but they were too strong and experienced. I quit struggling and stared at the wire-encased ceiling light. I couldn't see the nurse when she came in aide, "Get him ready." They quickly pulled my pants and underwear down to my knees. I winced at the violent thrust of the needle. I tried to prepare myself to fight the onslaught to the thought-dulling, body numbing Thorazine.

They waited for the drug to take effect before they stripped me of my clothes. I was left naked in the seclusion room, and no explanations were given. They did not tell me how long I would stay there...

Dr. Bassman writes further:

When I was discharged from the hospital I was told I had an incurable disease called schizophrenia. The doctor told my family that my chances of being rehospitalized were very high. is [sic] medical orders were directed at my parents, not me, and stated wit [sic] an absolute authority that discouraged any challenge. He predicted a lifetime in the back ward of a state hospital if his orders were not followed.

He will need to take medication for the rest of his life. For now, you need to bring him to the hospital weekly for outpatient treatment and he must not see any of his old friends.

I was devastated.

The hospital doctor put me into a coma five days a week for eight weeks by injecting me with insulin. Those 40 insulin treatments combined with electroshock blasted huge holes in my memory, parts of which have never returned. I ballooned from 140 to 170 pounds; I appeared the clown in clothes that no longer fit. My already damaged self-image had plummeted to an unrecognizable depth...Not see my old friends? How was I going to face them and explain what had become of me? Did anyone really think that I was capable of making new friends? I was sure that they would have nothing to do with me.

Dr. Bassman and Dr. Deegan have fought their way back from the spirit crushing experiences of psychiatric treatment. They have given voice to the devastation and horror that was predicted to be indicative of the way they would live for the rest of their lives. Both have proved this untrue. So have many others. In spite of the treatment imposed isolation or illness imposed isolation, they eventually reconnected to the world around them. Recovery is not an easy task or a task that happens in any specified time frame. Recovery does not mean a person never experiences symptoms again, it means they manage their symptoms and live a full life. For both Dr. Deegan and Dr. Bassman, companionship and support were important factors in their recovery. Dr. Deegan discusses her support:

The first truly proactive step I took in my recovery process occurred at the prompting of my grandmother. Each day...she would ask me if I would like to go food shopping with her and each day I would say "No"... For reasons I cannot account for, one day after months of sitting and smoking, I said "Yes" to her invitation. I now understand that "yes" and the subsequent trip to the market where I would only push the cart, was the first active step I took in my recovery. Other small steps followed such as making an effort to talk to a friend who had come to visit or going for a short walk (10).

Dr. Bassman writes:

It isn't one person or incident or clinical intervention that is critical for change to occur. Instead, it's a complex process. One essential factor is keeping the spirit alive. Connecting with others helps: Receiving respect and warmth breaks through the isolation and helps you feel worthy and alive (2).

Therefore, family and social support are important factors that help a person achieve recovery. Peer Support Training and the experience of that training increased the positiveness of people's relationship with their families, which were already providing strong support in most instances. In addition, perception of an increase in social support doubled and this is viewed as a very positive outcome of the training experience. These outcomes are shown in Figure 15.

The other supportive entity for a person with a serious mental illness is their treatment team. They may receive case management services, nursing care and psychiatric services as well as counseling through the community mental health provider. The better the relationship that exists between the person and their service team, the better the care and communication that occurs among members. Team, as used in this document, means all treatment team members and most important, the person receiving services and any supporters that person designates to be on their team. In the past, the treatment team was viewed as having all the answers and the person receiving services was viewed as having little knowledge about what might be best for them. Judi Chamberlin, a well-known consumer advocate, writes in an article entitled, Confessions of a Non-compliant Patient, (2000):

It was clear that my thoughts, feelings, and opinions counted for little. I was presumed not to be able to take care of myself, not to be able to make decisions in my own best interest, and to need mental health professionals to run my life for me. For this total disregard of my wishes and feelings, I was expected to be appreciative and grateful. In fact, anything less was tacked as a further symptom of my illness, as one more indication that I truly needed more of the same (1).

Figure 16 shows the people’s perception of their relationship with their provider team since the training. In addition, the figure 17 shows people’s perception of their ability to advocate for themselves. When a person can advocate for their needs, they are able to present what they need in a manner that helps their treatment team “hear” what they are saying. While advocacy may be very assertive at times, more often it is speaking out as soon as a need or problem is recognized and not waiting for problems to increase before requesting help or change.

**Responses to Question:
Has your relationship with your provider team
gotten better, worse, or stayed the same?**

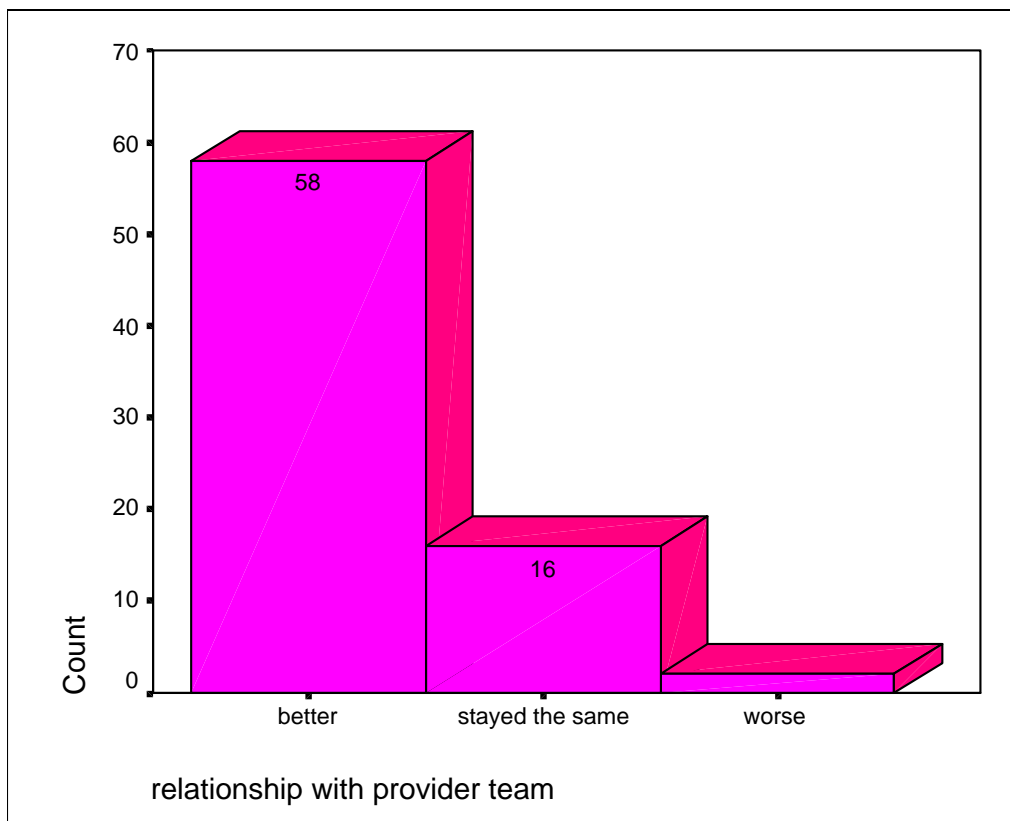


Figure 16

Self-advocacy Scores before and after Training

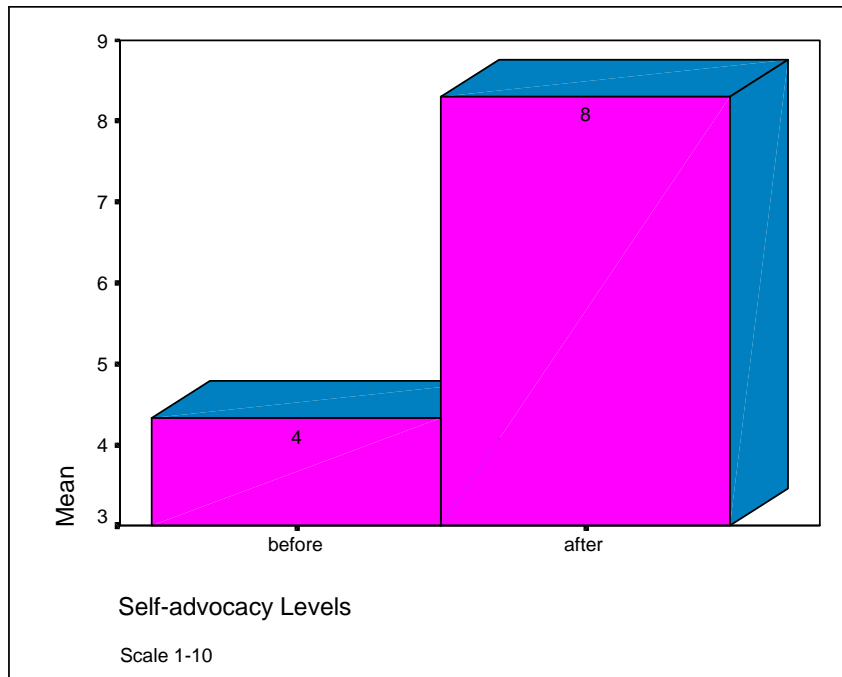
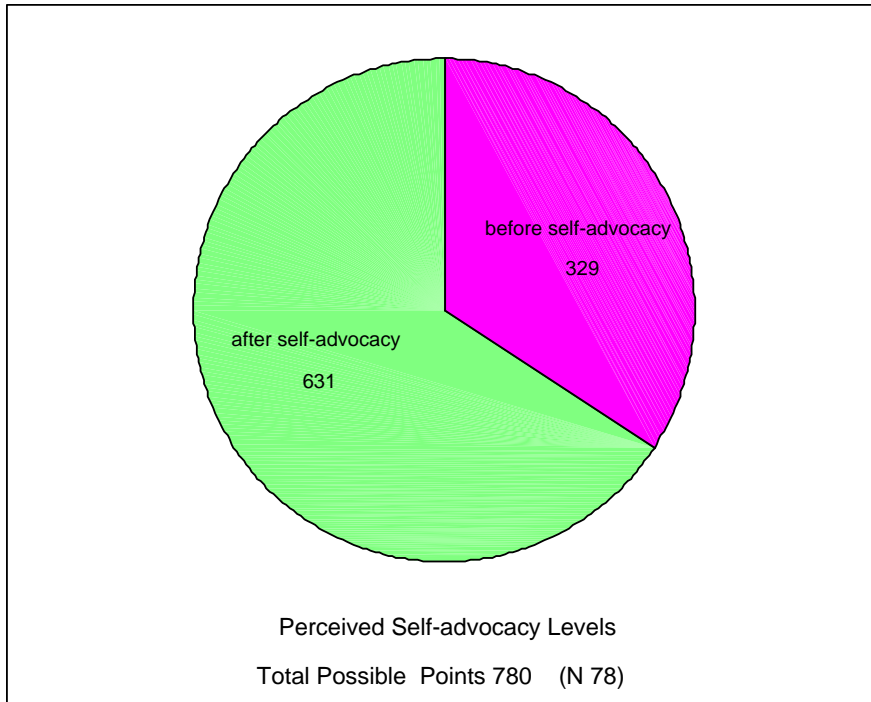


Figure 17

Figure 16 shows that 74 % (n 58) of the people interviewed answered that their relationship with their provider team was better since they took the Peer Support Training. One person said their relationship had worsened. A change in the case management provider was the cause for the diminished relationship. Several did not answer that question and 21 % (n 16) said that their relationship with their provider team had not changed. Most respondents made statements like, *“We get along much better now.”* *“I am able to advocate for myself now and they listen.”*

Figure 17 reflects people’s responses to the question about changes in their level of self-advocacy before the training and after the training. The mean level of self-advocacy before the training was 4. After the training, people rated their level of self-advocacy had doubled. When people do not feel heard, they feel defeated. When people are able to talk about what they need, they feel empowered. A strengths based perspective always looks for what is working for people, no matter what their circumstance. A strengths based perspective on helping looks for how the people being served have coped with difficulties in the past and draws on those skills. Therefore, the strengths based perspective of care, a recovered perspective of care wants the people being served to share their expert knowledge of what works and what does not work as a full member of their treatment team.

Sadly, after decades of making choices for people and controlling their lives in institutions, we learned that denial of personal choice leads to a syndrome called **“learned helplessness.”** This syndrome is marked by profound depression, apathy, indifference, cognitive deterioration, and loss of a sense of self and self-esteem. Researchers also found that the apathy, depression, cognitive

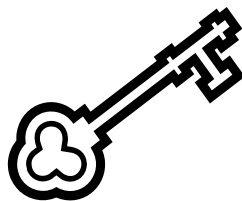
deterioration and loss of self that are the hallmarks of learned helplessness, were perhaps even more disabling than the original mental illness. We now know that *denying people the opportunity to make choices results in harming people rather than helping* them as was once thought (Deegan, 2001, p. 1).

Self-advocacy is important and people must have the opportunity to engage in self-advocacy. In 1996, Dr. Deegan gave a speech in Brisbane, Australia. In the speech, she makes it clear that not allowing people to make choices and decisions is robbing them of their humanity. She said:

We recognize that within each one of us there is a person and that, as people, we share a common humanity with those who have been diagnosed with mental illness. We are here to witness that people ... are not things, not objects to be acted upon, are not animal or subhuman life forms. We share in the certainty that people labeled with mental illness are first and above all, human beings. Our lives are precious and of infinite value. And as we progress ... we will be learning that those of us with psychiatric disabilities can become experts in our own care...(3).

There are five key concepts in the recovery process (Copeland, 1998). Mary Ellen Copeland developed the Wellness Recovery Action Plan. This tool, mentioned previously, helps people identify the specific things they know about how their symptoms progress. When Ms. Copeland began work on the WRAP, she identified five tools that help people recover. These became the *Five Key Concepts* they are as follows:

Hope Personal Responsibility Education Support Self Advocacy



As people develop a WRAP, they gain even more expertise about the illness as they experience it. WRAP is being taught throughout Maricopa County by Peer Support Specialists to help people create a Wellness Recovery Action Plan for themselves. People have been required to complete a WRAP since the inception of the Peer Support Training. As classes to learn the WRAP became more widely available due to funding by ValueOptions, more people came to the training with a WRAP already prepared. People who came with a WRAP were more aware that recovery could occur. This knowledge made it easier to begin to learn that people with serious mental illness can recover. In addition, they missed fewer days of class. Therefore, since July of 2002, all participants must complete a WRAP plan before they may enter the class. There is no cost to this process and it is easily accessed throughout the county. In addition to ValueOption sites, WRAP is taught at other agencies by Peer Support Specialists and at the Recovery Education Center.

People were asked about WRAP in five ways on the questionnaire. They were asked if they had a WRAP, if they used it, and if it was helpful. In addition, they were asked to report if they made it before, during, or after the training. Next, they were asked if they had any comments about the WRAP.

While the answers to these questions will be discussed, it is important to compare the level of perceived wellness, and symptom management by those with a WRAP.

WRAP

Do you have a WRAP?

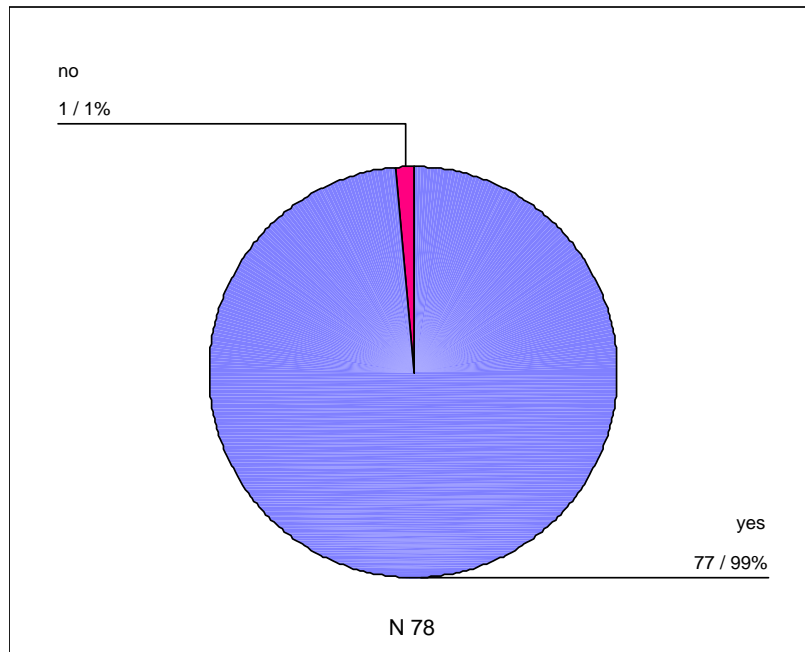


Figure 18

Is your sense of well-being the same, better or worse?

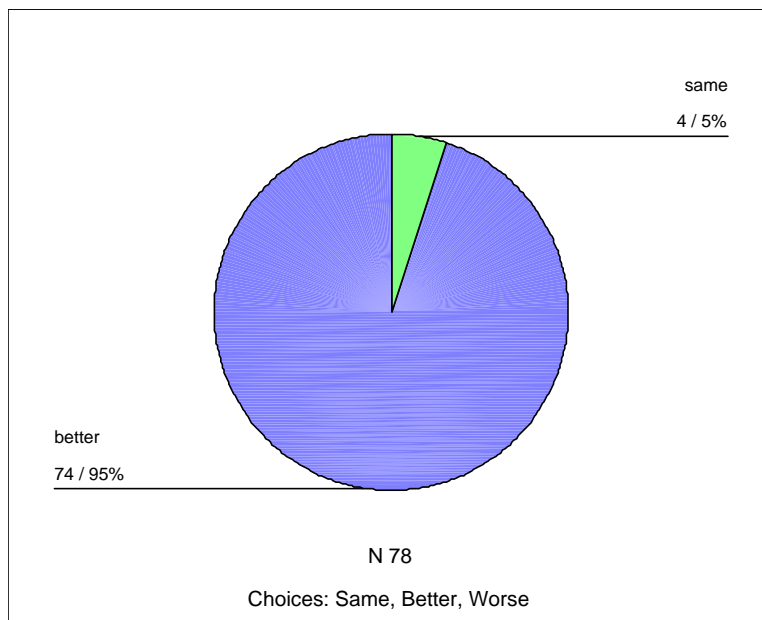


Figure 19

Did your level of symptom management skill increase, decrease, or stay the same?

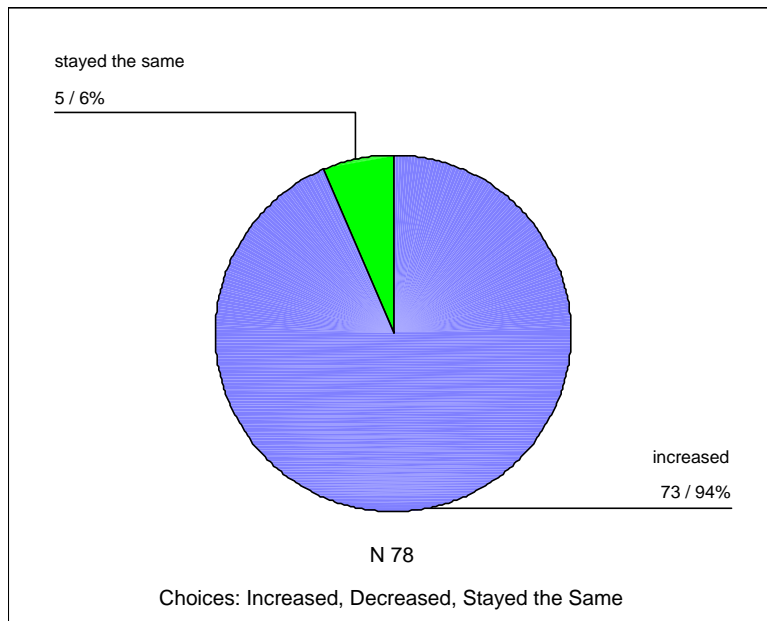


Figure 20

Do you use your WRAP?

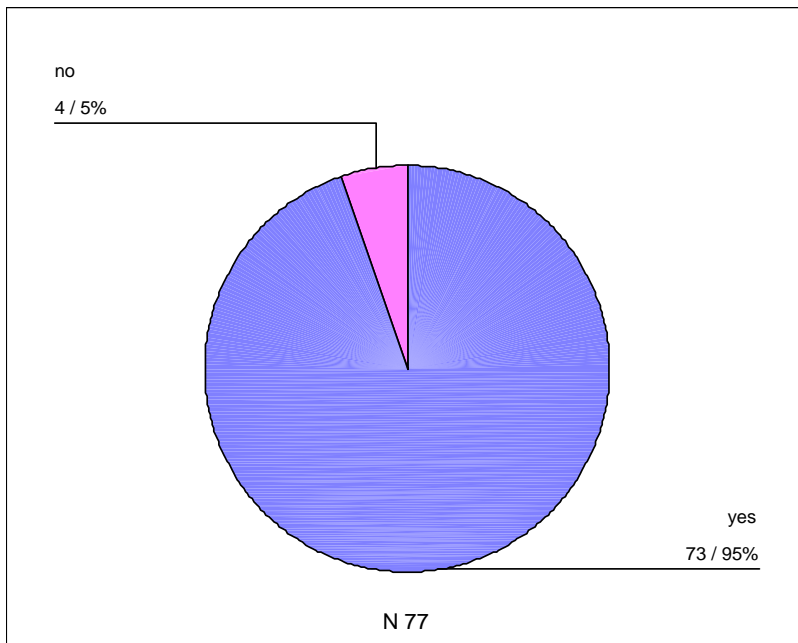


Figure 21

Does WRAP help?

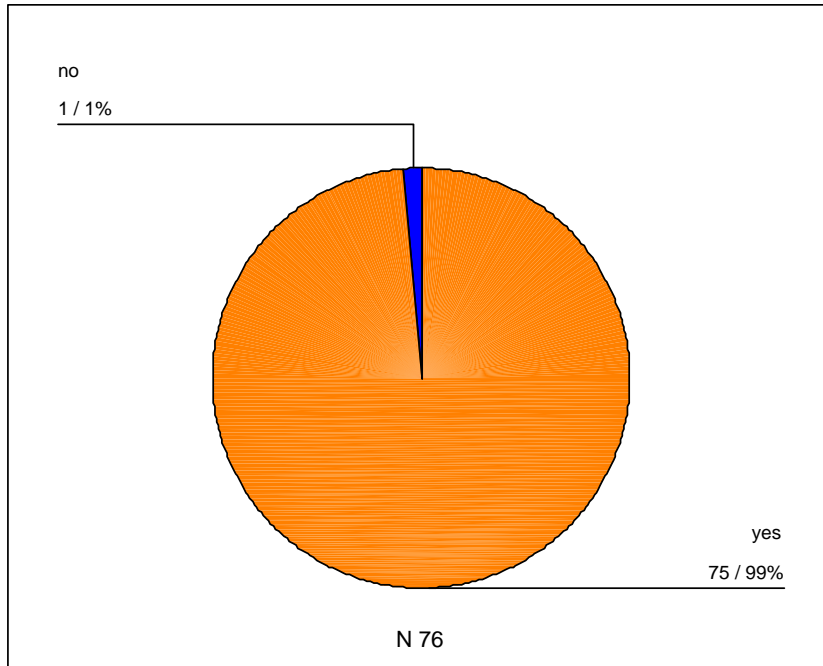


Figure 22

When did you complete your WRAP?

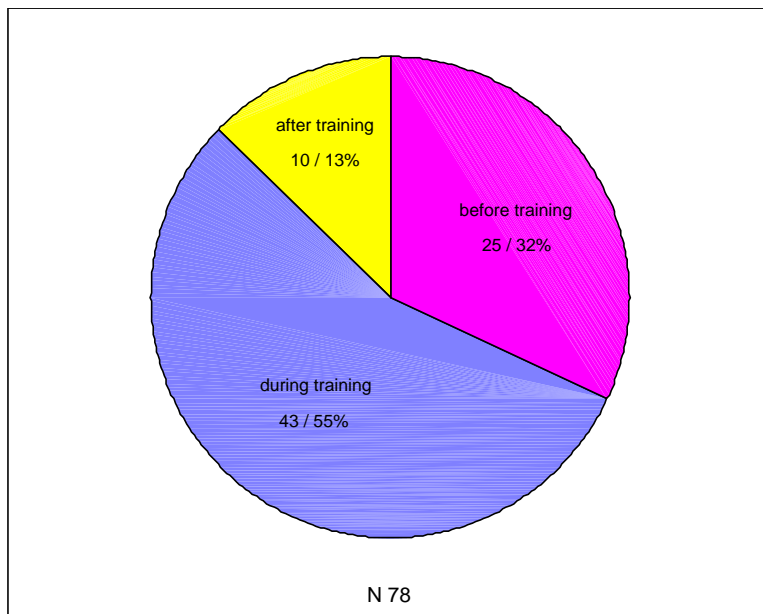


Figure 23

These outcomes from the questions about WRAP, wellness, and symptom management skills show that almost everyone reports that they completed a WRAP. In fact, 77 out of 78 people said they completed a WRAP. Interestingly, the charts match almost exactly when symptom management skills and wellness are compared with use of WRAP. Out of 78 people interviewed, 74 reported an increase in sense of well-being. Four people reported no change. In response to the question, “Do you use your WRAP?” 73 people said, “Yes” four people responded that they do not use it and this leaves one person who did not respond. Out of 78 people, 73 reported an increase in skills for symptom management. The remaining 5 reported no change. To the question about whether or not WRAP helps, 75 people said it does, one person said it does not help and 2 people did not respond. 68 people completed their WRAP before or during the Peer Support Training and ten people completed it when the class was over. The reliability of these questions is high because they require an answer that is either yes or no. Even the question about WRAP completion time requires the person to answer with one of three choices. While the answers about well-being and skill in symptom management are less valid and less reliable, they are still important in that the self-report of wellness is valid for that person if they are considered the expert. This paper takes the position that people are the experts and therefore all of their reports and perceptions about their lives, wellness, symptoms, and experiences are valid and respected.

Wellness Recovery Action Plan

When asked if they had any comments about WRAP, here are some of the comments:

Y “*It’s too simple to work, but it certainly does!*”

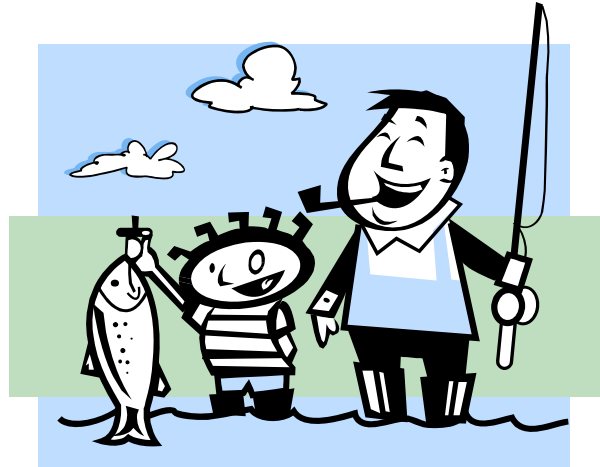
- Y “I’d like...a WRAP for physical illnesses.”
- Y “It helps me manage my symptoms.”
- Y “Very good, helped me come out of my shell and be a human being instead of an animal, just existing.”
- Y “Everyone whether they have a diagnosis or not could benefit from it. It enhances your life, it’s simple.”
- Y “It’s a spectacular tool, one of the most intelligent ways of helping people deal with their symptoms. I love personal responsibility!”
- Y “Really good thing, if I’d have known about it before, I think I would not have been hospitalized as many times in the past.”
- Y “Greatest thing that ever happened to me. I learned to know myself and that I don’t have to give in to these symptoms, I can handle them.”
- Y “It’s a good program that has helped me with recognizing my weakness. So, that when I see them I can get the help I need before it gets to the crisis level.”
- Y “WRAP is an excellent tool to learn and use. It doesn’t do any good if you don’t use it. It gives you hope.”
- Y “Saved my life, gave me hope, Godsend to my life. I am grateful for it.”
- Y “WRAP has taught me how to carry on in spite of symptoms. Used to be everything would go to hell when I was depressed. No mail, no sleep, no bathing. I learned to ask for help and support.”
- Y “I believe so much in WRAP. I could have avoided some of my hospitalizations.”
- Y “It’s a life changing opportunity and process. It made a phenomenal difference in my life. Helps me notice early symptoms. I don’t let things snowball.”

- Y' *“Update your WRAP regularly.”*
- Y' *“It is totally wonderful. The people at the urgent care that I gave WRAP to helped clear their heads.”*
- Y' *“Need it in Spanish.”*
- Y' *“It’s helped my whole life, family, smoking, substance abuse.”*
- Y' *“WRAP is one of the best things since sliced bread.”*
- Y' *“Wellness Recovery Action Plan promotes self-awareness, education to others and a written journal promoting self-advocacy and empowerment in our lives.”*
- Y' *“I had a relapse and was able to use WRAP tools to stay out of the hospital.”*
- Y' *“It works if you work it. It helped a lot to give my therapist a copy so she can recognize my symptoms. Also to give my supporters.”*
- Y' *“It makes a lot of sense. I never realized how many triggers I have or had but now I not only recognize them but know what to do in the event of having a lot of triggers.”*
- Y' *“WRAP taught me how to save my own life.”*
- Y' *“The five key concepts are a powerful force to recovery.”*

While there were other comments not included in this list, all of them were positive statements about WRAP. Many people wanted to tell others the WRAP must be used in order for it to work. People want to be responsible for their wellness and when they have the tools to help themselves they feel empowered. Note the third statement, “It helps me manage my symptoms.” This hardly reflects the common stigmatized view of people with mental illness. This person wants to be able to take care of himself/herself. The statement immediately following demonstrates the isolation and loss of hope typical of many individuals with mental illness, however, this individual has found his/her way

out of “just existing”, like an animal. This person is working and making significant contributions to the lives of others, now that they have “come out of their shell.” Several people spoke about enjoying the ability to manage symptoms, to take personal responsibility and to keep themselves out of the hospital. These statements certainly contradict the idea of “hapless schizophrenics” and people “screaming like a banshee (Aleshire, 2001). One of the most powerful statements was simply, “WRAP taught me how to save my own life.” Implicit in this statement are several ideas. First, this person has been in a place where the taking of their life has occurred to them at least once. Life has been painful enough that leaving life seemed a viable alternative to continuing to live in pain. This person has tools to help himself/herself now. Life is something worth saving. Those nine words contain hope for the future and demonstrate a willingness and desire to live and be in charge of one’s destiny. Perhaps in this person’s experience there is now the knowledge that he/she is able to be in control and help himself/herself instead of feeling and acting on “gusts of rage (Aleshire, 2001).” The person who made that statement is engaged in a process of making the world a safe and comfortable place for them to be even though this was not always the case.

It is likely that people who have experienced their world as unsafe and confusing would feel uncomfortable being out in the world. They might find it difficult to trust others, especially if their trust in those people who were there to protect them was shattered. Therefore, in addition to social supports, family supports and perceived wellness increasing as a result of recovery, one would expect to find an increase in social activities. The following graphs and charts show the kinds of changes in activity levels that people experienced following the Peer Support Training.



With 10 being the best and 1 being the worst, how would you rate your activity level?

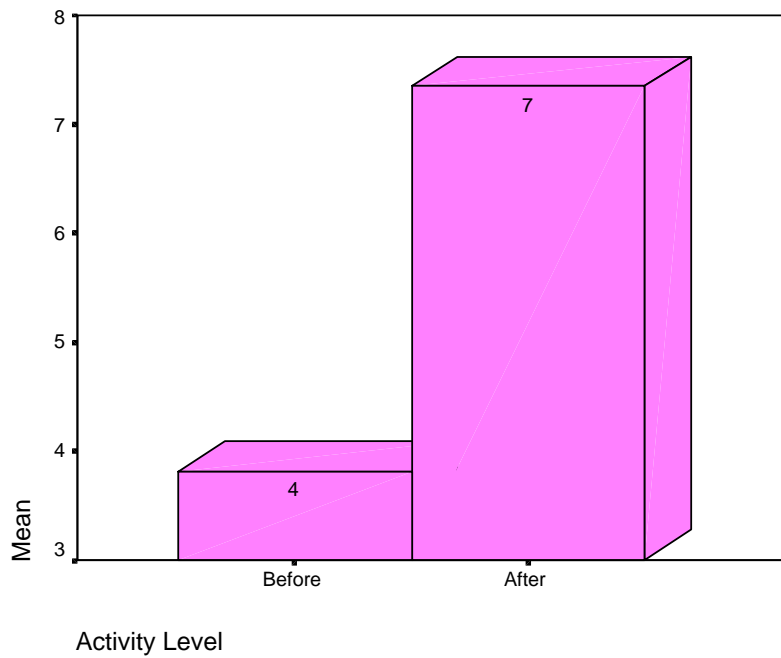


Figure 24

Perceived Activity Level Total Number of Points before and after Training

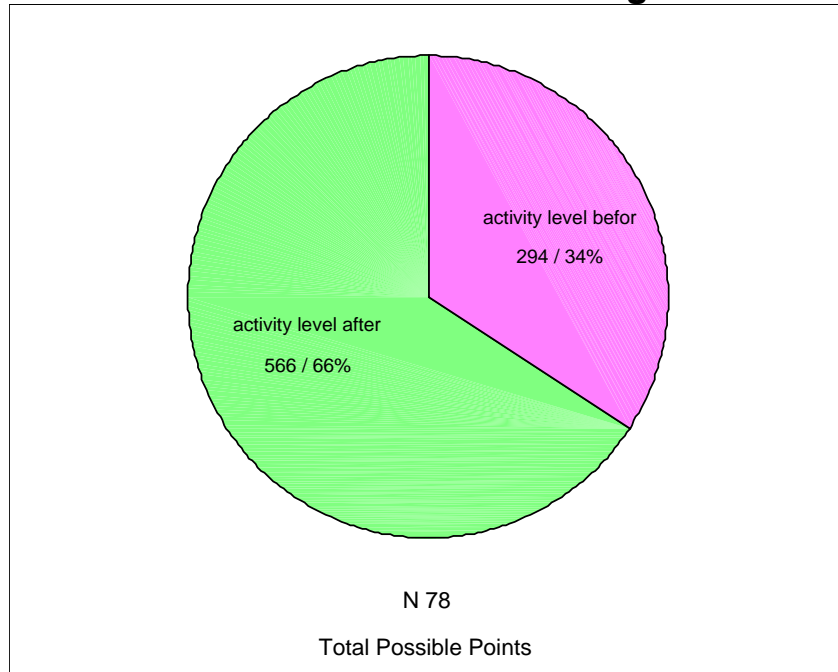


Figure 25

Again, a positive increase is seen. This time it occurs with the perceived activity level of people who completed the Peer Support Training. Overall, the number of rated points increased 272 points with mean ratings of 3.8 before the training and 7.3 following the training. The number of respondents was 77 in the question about activity level before training. Even when it was explained that the lowest possible rating was a one, this person felt that they could not even give their activity level a one because they had been so isolated and alone prior to the training. He/she spoke of going out in the middle of the night to do grocery shopping. The person said that they did not want others to see them, because they believed they “looked crazy” and it was painful. Two other respondents discussed shopping in the middle of the night to avoid being seen as a crazy person.

Two more questions were asked about activities. People were asked if they were doing any fun things now that they were not doing before and if so, what those activities are. They were asked what activities they are engaging in now that they were not engaged in before only if they said that they **were** doing fun things. Examine the graph and discussion about activities that follows.



Are you doing any fun things now that you were not doing before you took the training?

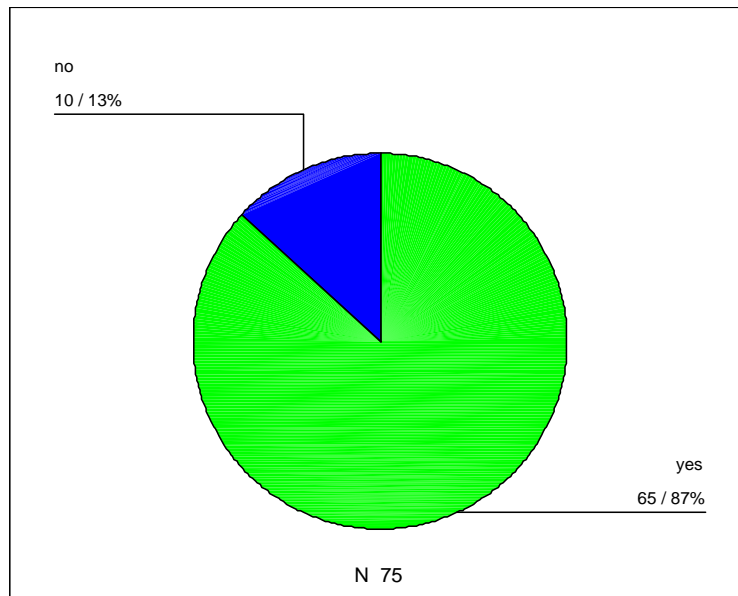


Figure 26

As Figure 26 demonstrates, 65 people said they were doing fun things that they were not doing before the training. Three people did not answer and ten people said they

were not doing any fun things. One person who answered, “No” stated they were in the process of transitioning to living on their own, they stated that they needed to increase their outside activity level. Another who said no, expressed that work takes up a lot of time.

Many people said that working was fun for them. A female reported that it is easier to talk to people now. One male said that work was fun, but that he also went to the movies and was generally more relaxed. One female stated that she is now exercising, working, reading a lot, and watching videos. People frequently expressed that they find it easier to be around others now. Many are exercising, walking, going out to movies, going out to eat with friends and co-workers. One male responded that he calls his kids, goes bowling, and to the movies. He stated that he is able to be out in crowds now. He always dreamt of going to a ball game, he never did because he thought he was crazy and that everyone knew it, now he has gone to the ball game more than once. His activity level increased 4 points since he took the training. One person expressed that they had gone out one night to see Christmas lights, and that they had gone out of town for the weekend. These folks are enjoying concerts, plays, dinner parties and having fun with their children. These things are adventures for many of the people in this study. Activities that most people take for granted, that people consider the activities of life, are gifts for many of the people in this study. Repeatedly, people expressed thanks for these gifts, gifts that should have been theirs all their lives. Engaging these people in this study, was like watching butterflies emerge from their cocoon. It was as if they had been buds until they took the training, and then they burst forth ready to let the sun shine on them, to let rain fall on them, and to grow into the beautiful flowers they were meant to be.

Some people who have a serious mental illness also have substance abuse problems. When people have co-occurring disorders (mental illness and substance abuse), they are at an increased risk for unnatural death due to homicide, suicide, or overdose. In a recent study in Demark, Hiroch, Appleby, Mortenson, and Dunn (2001) found that people with mental illness during the years 1973-1993 had a 25% higher risk of dying of unnatural causes (suicide, homicide, and accidents) than did the general population. They also found that people who use illegal substances have a higher risk of suicide, and that risk is increases further if the person is in active psychosis. Therefore, if people could manage their substance abuse or recover from it altogether, it would decrease those risks to life. There were two questions about substance abuse in the survey. The first question asked, “In addition to psychiatric symptoms, have you had substance abuse issues?” The second question asked, “Has the training increased, decreased, or unchanged your ability to manage your substance abuse?” Here are the results of those questions:

In addition to psychiatric symptoms, have you had substance abuse issues?

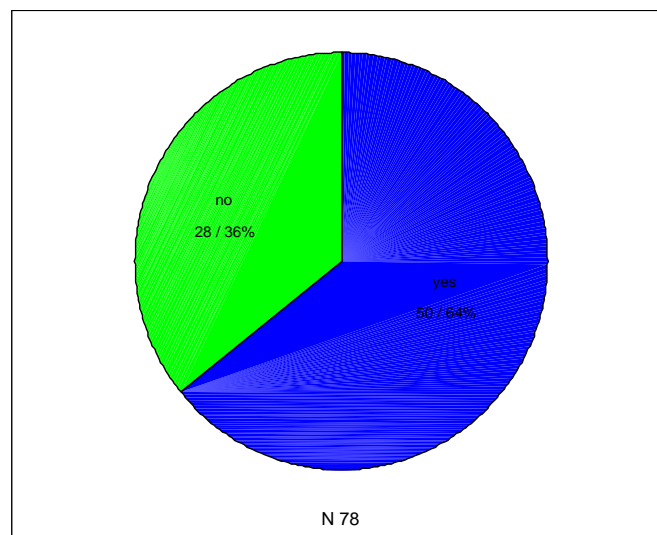


Figure 27

The results of this question show that 64.1 % (n 50) of the participants in this study had a history of substance abuse. Abusing substances, while taking psychotropic medications, is dangerous. The next graph shows if people perceived the training as helpful in managing substance abuse.

Has the training increased, decreased, or unchanged your ability to manage your substance abuse?

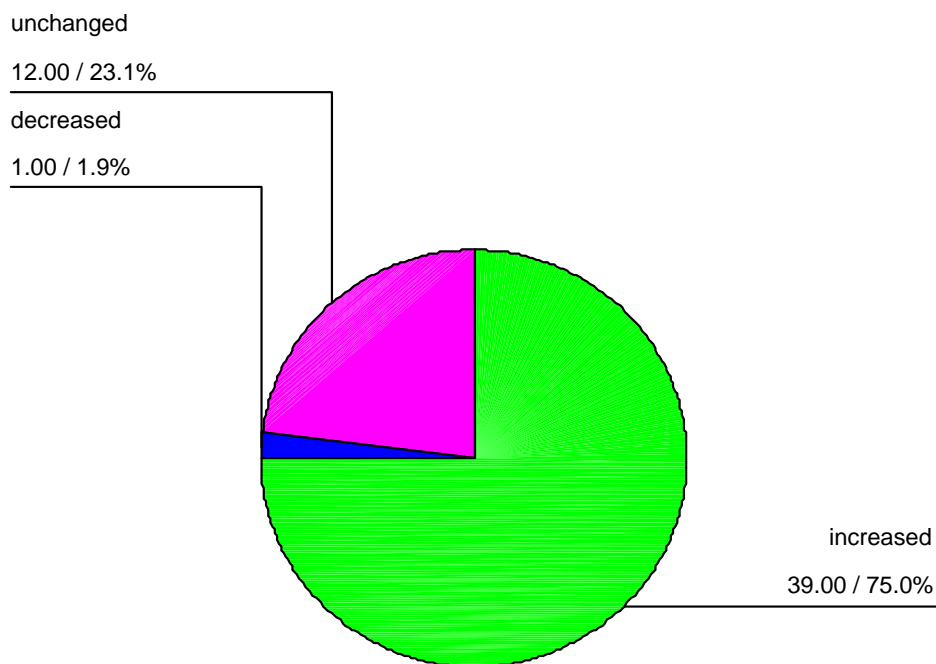


Figure 28

Of those who stated they had substance abuse issues, 73.1 % stated that their substance abuse management skills increased because of the training. Those that stated it remained unchanged were exclusively people who had been clean and sober for many years and felt that they had developed very good tools for managing their substance abuse issues prior to the training. One person stated that since the training their substance abuse

management had decreased. That person stated that the reason they were having difficulty was the stress in their life and not the training itself. They were instructed to report what was valid in their life and right now, they are struggling. However, they also stated they are receiving support from friends with this problem and now know how to ask for help. These results are reliable because of the nature of the question. Most participants, who have been clean and sober for long periods, follow a 12-step program. These types of programs often offer a spiritual component and a community support component. The high ratings of spirituality and religiousness among the participants in this study would indicate that those people who use substances would feel supported by that system.

Analysis

The Peer Support Training appears to have a healing effect on the people who attend the class. This study finds that people's perception of their wellness improves after they attend Peer Support Training. The improved sense of well-being appears in many areas of the participant's lives. While this wellness is not demonstrated by the lowering of the exact numbers of times services were used, but rather by people's perceptions about their wellness and service usage, it must be viewed as an important demonstration of the results of the training. This importance is derived from the self-report of individuals whose perception and understanding of their lives, their symptoms, their experiences are considered expert. META Services is currently engaged in outcome studies with Boston University to provide scientific measures of people's change over time as they experience many programs provided by the agency.

It is important to discover why the training has a positive affect on the participants. While the resilience of the human soul and spirit is full of endless possibilities, the training seems to provide an important framework for self-discovery and healing. The training curriculum is written in an interesting and compelling manner. “The manual is not written ‘down’ to the people who take the class but at a level that expects effort and attention to be given to the materials and information presented therein (Rider, 2000).” The class occurs in a short period of time. There is intense interaction and self-exploration occurring during each meeting. Every time the participants meet, they are learning skills to help them work with people in a helping role. The same tools they are learning to use to help others, they soon discover will work to help themselves. As they discuss using these new tools, they are encouraged to move forward in their experience of life. They are coached to move away from the way things have always been and to look at how they can use their life experience as a gift that will be important in helping others increase their wellness.

However, all of this is done with gentle guidance; there is no forced movement forward. Each participant must make his/her self-discoveries in their own time. Two things are happening during this journey. Meaning is given to their life experience and a purpose is given to the pain they suffered. Developing understanding and mastery of their life’s journey transforms their story from one of hardship and pain to one of strength and courage. Each person sees how much he or she has come through and how amazing he or she is, just as they are. There is acceptance of self.

Many rituals occur during training. These rituals do not happen repeatedly, they each occur only once, but they help participants make the transformation from seeing

themselves as “unemployed mental patients (Jacobs, 2001)” to capable, valuable, and helpful human beings and workers. They begin to take on their new roles during the class. “The major task then in recovering from mental illness is to regain social identities which are recognized as valid by oneself and the people in one’s community (Fisher & Ahern, 1999). Students emerge from their role as patient and taker, to new roles as friends, classmates, supporters of classmates, students, knowledgeable givers of information, and especially to people who can help. As they participate in class activities and discussions, they see that they have valuable information to share and contributions to make. They see that classmates, who in a sense are mirrors of themselves, also have valuable information to share. This knowledge helps them value their own knowledge and experience as they value it in their classmates.

In addition, their reality is confirmed and validated. Each person shares their story during one day of class. They are asked to share their story in a way that can be used to provide hope to others. This helps them find their own strength and courage in a story, which may have been, until that day, a story of helplessness and despair. The day for story telling is strategically planned to occur at a point when relationships and trust have begun to appear among the group. People are given a specific amount of time to share and they may not go over that time. As each person finishes, feedback from classmates must be positive and help the storyteller understand why their story created hope. The use of story as a tool for providing hope is a critical skill that Peer Support Specialists must develop. Story can never be used as a means for “one-upping” of pain and suffering. Therefore, while story-telling day is full of great emotion, change, and support, it is also a

day in which one of the fundamental tasks of peer support is observed repeatedly, hopefully to the point of mastery.

Peer Support Specialists learn about themselves and others during the class. They learn how to help and listen to others. In addition, through interaction with the instructor, they begin to see that they are valuable and important members of their learning community. The instructor plays an important role in the training. The instructor should be a peer to the class participants. He/she must be intensely focused on the learning community members each day they are together. When a member speaks, the instructor must provide unwavering attention. The person speaking must see that the instructor/facilitator is listening with their whole heart to what they are saying. The instructor must also be the guide that helps the class find the way to becoming a learning community and not just participants in a class. Rogerian-like interactions that provide unconditional positive regard must occur each day, all day, and with every member of the class.

There is a key factor in all the work that occurs at META Services. That intangible yet crucial component of care is...love. People must be willing to love of their work, and love and caring for the people served within the agency. This love is not romantic love; it is love for a fellow human being, simply because they are a human being and love for work that accepts all people wherever they are in their recovery. While intangible and not usually listed in the skill base of most providers in the mental health system, it is an invaluable and indispensable tool. Remember that only seven out of the 78 people who participated in this study had had lives that did not include abuse. Therefore, many of the people served will have internalized messages about themselves,

others and the world around them that include being unlovable or bad. Being able to demonstrate a love and caring for each person served will help them learn and believe that they are loveable and important people.

Within this group, there is a goal. That goal is to learn a skill that will help each person find work. This end goal helps members focus on moving forward, sometimes through uncomfortable realizations, painful triggers, and personality conflicts with learning community members, to the end goal of going to work. Keeping focused on that goal and the fact that there are always people whose personalities clash in a work environment, people can, as a team, move past these conflicts, and not become mired in the recreation of previous life dynamics. Therefore, the job training aspect is important to keep the community members moving forward and focused on the future and developing new ways of being with others.

In addition, the frequency and duration of meeting times is important. The classes are four hours in length with two fifteen minute breaks added, so that members are together 13.5 hours a week. Each day the learning community meets, the first fifteen to twenty minutes are spent checking-in and discussing any questions from the readings, or concerns about upcoming tests or quizzes. This brief introduction helps members settle in and reconnect with each other. Following this interaction, tests or quizzes occur or the day's discussion topics begin. Participants can begin to develop relationships due to the length of class time. They develop trust as they share experiences related to the topic at hand. They begin to create new roles as they help and support each other through difficult learning experiences. However, from the start of the training, everyone is given continuous spoken or unspoken encouragement and they begin to overcome their fear of

failure. As the learning community members and the facilitator continuously support each person, they begin to believe they can complete the class.

Because no “creaming” takes place, members of the class are often symptomatic, or highly medicated. People are supported to pace, to color, to manage their symptoms as is necessary. While participants may not leave during class to smoke, breaks are timed so that they occur every 1.5 hours. Support is available to class members if they become triggered or upset by a discussion topic. They are encouraged to address their concerns immediately and most often, just having someone listen validates their experience and they are able to return to class within fifteen minutes.

Therefore, the important components of the training include, education and job training, mutual support, building community, facilitator interaction, frequency and duration of interactions, reframing life experience in a way that is hopeful and demonstrates strength and courage, the ample provision of love and encouragement, and the resilience of the human spirit. When the class is completed, a ceremony, which is one of the rituals that occur during training, takes place. This ceremony is the Peer Support Graduation. This experience for members of the learning community is sometimes, a celebration of the only thing they have completed for many years. It is a ceremony that is full of hope, wonder, and joy. It is such an experience of hope and recovery that META Services and The Recovery Education Center have each arranged for it to count as training hours for their staff members. Graduations give class members time to speak about their experiences before an audience and to invite family and supporters to celebrate their accomplishment. It is the symbolic ending of their life as a mental patient and the beginning of their life as a participant in as many roles as they choose.

Here is what one class was told at the time of their graduation:

As you begin the newest part of your life today, remember this:

All that you need to be is already inside you. META did not cause you to become something new; it helped you find the treasure that was already inside you...Like the seed that holds the promise of a beautiful blooming flower, you held the wonder that you see in yourself today...all the time.

It is your time to bloom and grow, to unfold into the glorious person you were always meant to be. People encourage and support you, but you take the step and make the choice to...Recover (St. George, 2002)

The last question in the survey asked for any comments that people might want to make about their experiences in or after Peer Support Training. Here are some of those statements. They are important reminders that all of the numbers and measurements contained within this study represent real people, people who have struggled and worked hard and have overcome many obstacles in their lives, please read on:

- ☞ *I enjoy work and meeting new people.*
- ☞ *I am glad my case manager introduced WRAP to me. So glad to be with META and be able to help people. I love what META is doing.*
- ☞ *The different instructors that taught us were helpful and kind.*
- ☞ *I wish we were nationwide. I wish people could go to their local META office and get help.*
- ☞ *Absolutely the happiest I have ever been, I know who I am, where I am going. I am a lot more spiritual. Life is great.*

- ☞ *The course increased my self-esteem. Peer Support Training, WRAP and getting a job is one of the best things that happened in my whole life. It gave me a reason to live and go on not just exist. Wish I could have learned it long ago. Really wonderful.*
- ☞ *The programs here have helped me a lot in being able to walk away from the victim level of my life. And see a chance at a better life. The possibilities now seem endless, even though I am still going through changes.*
- ☞ *META Services has changed my life. It has given me a life back. Getting through Peer Support Training gave me such courage and respect for myself. Now working as a Team Leader is such a challenge and I do fall down but I have such tremendous support and am learning so much my life has become valuable to me. I have real respect for myself.*
- ☞ *I'm fortunate to be part of META. It's a great program.*
- ☞ *Thank you so much for being the caring wonderful people you were for instructors. I found out how much my life means to others.*
- ☞ *Of all the things made available to me to get into a recovery place to learn, grow, relapse, re-grow and feel like today that tomorrow brings hope, it has been the concepts, examples, modules I have had through the Peer Support Training at META. I'm feeling connected for the first time in years. Things are much better with family.*
- ☞ *Thought my life was over before the Peer Support Training. I have a whole new life.*

- ☞ *This survey was good to ask me. This clarifies how much growth has occurred. I can gage the change.*
- ☞ *I have my life back.*
- ☞ *Introduction to META and all of its principles is the best thing that ever happened to me. I have been in substance abuse recovery for 12 years but META was the miracle.*
- ☞ *I think working is a great tool.*
- ☞ *Training is priceless. I can't thank the trainers enough. It's helped me improve my quality of life. Before this, I had no quality of life.*
- ☞ *I feel genuinely hopeful for the first time. That scary stuff of feeling my whole life that I couldn't take care of myself, I am walking beyond that now and trying to decide on a career goal and looking beyond what I ever dreamed I could do. Even while I was psychotic, I was working and I was able to keep working and this made me proud and **that** overcame the haze.*
- ☞ *WRAP and Peer Support Training has changed my life and since I started, I don't have time to be ill. I can handle stress that comes up. I am grateful and happy. I have a social experience when I come to meetings.*
- ☞ *Going through Peer Support Training has helped me be more confident. I am out of the hole; I haven't been out of the hole for a long time. I only see myself going forward not backward anymore, it is a positive thing.*
- ☞ *I feel like that I can now do almost anything that I want to.*
- ☞ *I love my job, thank you all.*

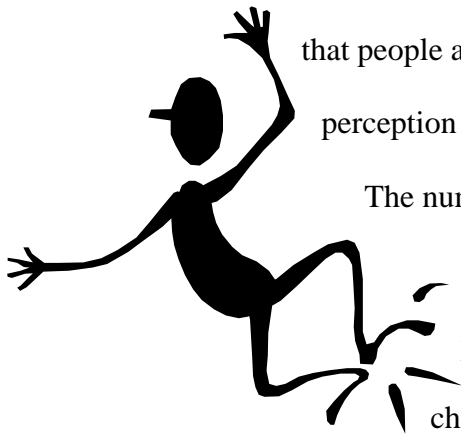
These statements are full of hope and growth. They reflect a willingness to work hard to increase wellness and improve quality of life. However, many of the statements reflect the hopelessness and despair that many have felt and now moved past. They talk about progressing, moving forward, being in control, and having hope. Read the statements about self-esteem. Read the statements that discuss building dreams and creating goals. As people see that they can take care of themselves, get their lives back and that they are valued, they can risk mistakes, and hope for the future, they can “reconnect with meaning and purpose in life (META Services, 2000).”

Conclusion

Transformation takes place during Peer Support Training. For each unique individual it is a journey toward recovery. It is clear that people’s perception of their wellness, as measured by many factors, increases following the training. There may be many factors contributing to the increase in wellness. However, people questioned for this study perceived their wellness as connected to the training. This paper takes the stand

that people are the experts about themselves therefore that perception is viewed as valid.

The number of persons affected by trauma and abuse was high. This is cause for concern, as is the number of persons who experienced trauma and abuse as children. Freud named abuse as a causal factor in psychological distress long ago. Forced by the disbelief of colleagues to retreat from this theory, victims have since been labeled with psychiatric disorders rather than simply comforted and supported through their trauma responses. The relationship between



trauma and abuse and interaction with mental health institutions, must be explored.

Methods must be found to disengage trauma responses from pathology and diagnosis.

The human community must make a commitment to begin to understand and correct the devastation resulting from violence perpetrated on individuals, especially children.

Arizona Department of Vocational Rehabilitation and ValueOptions must continue its commitment to support recovery oriented programs. Maricopa County stands as a model of a recovering system. The wellness that is evident in the people who participated in this study is a testament to the importance of education and support in the recovery process. In addition, creating environments that allow intense interaction for long periods of time with an end goal seems to provide a setting that supports recovery. Healing and recovery occur through relationship. Relationship develops during time spent together. Policies that support recovery environments must be written and proposed to governmental entities. The mental health system must move away from coercive, disempowering methods of care. Creating environments that value individuals and treasure them, that recognize their humanity and their right to choice will create atmospheres that help people take personal responsibility and take chances that help them move forward and grow.

Finally, recovery environments must contain two things that will create a hopeful atmosphere. The first is respect for those individuals seeking help and the second is an intangible ingredient that must be developed within people working in the system and must be felt by the people being served. That ingredient is *love*...Mother Teresa once said, "We can do no great things, we can only do small things with great love." Let the mental health system move forward with great love.

Appendix A

Questionnaire for Peer Support Specialists

The caller will say HI! this is your name . I am calling to talk to you about a project I'm working on. We're doing some follow-up with people who have taken the peer support training class. We are calling people who have graduated from peer support training to ask them how the training has affected their recovery so far. Do you have time to help me out with this? Could you answer a few quick questions? There is no penalty attached if you do not want to participate in this study so feel free to say "no." We will not be using your name in our report; we just need your comments. If this isn't a good time to talk, when can I call you back? _____

***If you begin and we come to a question you do not want to answer, you do not have to answer. Everything is confidential unless you say you want to harm yourself or someone else.

What is your graduation date? _____

Do you have a hire date? _____ (if applicable)

These first few questions just give me some general information about the people who participate: What is your age? ____ Are you male or female, or transgender? _____

Are you: African American (Black) _____

African from Africa _____

African American (White) _____

Hispanic _____ White _____

Middle Eastern (including Pakistan and India) _____

Latino _____ Asian _____

Member of indigenous people _____ other _____
(Native American, tribal member, Indian etc) (Explain)

Do you consider yourself to be:

Heterosexual _____ gay _____ lesbian _____ asexual _____ Bisexual _____

Do you consider yourself to be a person who has experienced trauma and abuse?

Yes _____ No _____

Have you experienced sexual abuse?

Yes _____ No _____

If yes to any of the above, did it occur as a child or adult or both?

Child _____ Adult _____ Both _____

How important is spirituality or religion to you?

Very important _____ Important _____

Slightly important _____ Not very important _____ It is not important _____

The next questions will ask you to use a rating scale.

1. How would you rate your family relationships on a scale of 1-10, with 10 being the best and 1 being the worst,
 - A. Before you completed the training? _____
 - B. After you completed the training? _____

2. With 10 being the best and 1 being the worst, how would you rate your social support systems (friends, religious groups, recreational groups etc):
 - A. Before you took the Peer Support Training? _____
 - B. After the Peer Support Training? _____

3. After the training, has your relationship with your provider team gotten:
 - A. Better? _____
 - B. Worse? _____

C. Stayed the same? _____

These questions are about your fun, leisure, and/or social activities:

4. With 10 being the best and 1 being the worst, how would you rate your activity level:
- A. Before you took the Peer Support Training? _____
- B. After the Peer Support Training? _____

5. Are you doing any fun things now that you were not doing before you took the training? What are they?
- _____
- _____
- _____

6. With 10 being the best and 1 being the worst, how would you rate your level of self-advocacy:
- A. Before you took the Peer Support Training? _____
- B. After the Peer Support Training? _____

The next six questions are about symptom management; do you know what I mean by managing your symptoms? (Just to make sure they know what you are talking about. If they do not understand, tell them you are referring to how they identify and use things like relaxation, deep breathing, distraction, journaling, and other wellness tools to help them get through difficult periods when they may have strong symptoms.)

7. Has your level of symptom management increased, decreased, or stayed the same since you took the Peer Support Training?
- Increased _____ Decreased _____ Same _____

8. Would you say that your overall sense of well-being is the:
- a. Same _____
 - b. Better _____
 - c. Worse _____
9. In the year before you went through Peer Support Training, how many times did you use:
- a. Crisis phones: _____
 - b. Crisis mobile teams: _____
 - c. Hospitalization: _____
 - d. Urgent Care Centers: _____
10. After you went through Peer Support Training, how many times did you use:
- a. Crisis phones: _____
 - b. Crisis mobile teams: _____
 - c. Hospitalization: _____
 - d. Urgent Care Centers: _____
11. In addition to psychiatric symptoms, have you had substance abuse issues?
- Yes _____ No _____
12. Has the training increased, decreased, or unchanged your ability to manage your substance abuse?
- a. Increased _____
 - b. Decreased _____
 - c. Unchanged _____
13. If you could come back to a class for more information, what would it include?
-

14. Are there things we could add to the peer support training class that you find you need to know or that would have been helpful to you?

Do you have a WRAP? _____ Do you use it? _____ Does it help? _____

Did you complete your WRAP:

Before training? _____

During training? _____

After training? _____

Do you have any comments about WRAP?

Is there anything you would like to say or add at this point?

Lisa St. George, BSW

DATE (Must be filled in)

Other Interviewer (Please print)

Signature of interviewer

References

- Aleshire, P. (2001). Inside the asylum. *Phoenix Magazine*, 81-87.
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. American Psychiatric Association, Washington, DC, 2000.
- Anthony, W. (2000). A Recovery Oriented Service System. *Psychiatric Rehabilitation Journal*. Vol. 24 No. 2 (159-167)
- Anthony, W. et. al., (2000). A Supported Living/Supported Employment Program for Reducing the Number of People in Institutions. *Psychiatric Rehabilitation Journal*, Volume 24, Number 2.
- Bassman, R. (2001). Overcoming the impossible: My journey through schizophrenia [Electronic Version]. *Psychology Today*. Retrieved April 27, 2002.
<http://www.ect.org/selfhelp/pschtoday.html>
- Brigham, A. (1847) The moral treatment of insanity. *American Journal of Insanity*. (Para 14-16). [Http://www.disabilitymuseum.org/lib/docs/1246.htm?page=print](http://www.disabilitymuseum.org/lib/docs/1246.htm?page=print)
Disability Museum, www.disabilitymuseum.org Retrieved September 29, 2002.
- Cascardi, M., Mueser, K. T., DeGiralomo, J., Mirrum, M. (1996). Physical aggression against psychiatric inpatients by family members and partners. *Psychiatric Services*, 47: 531-533.
- Chamberlin, J., (2000). Confessions of a non-compliant patient. *National Empowerment Center*. Retrieved July 9, 2001 from www.power2u.org

Copeland, M.E., Harris, M., (2000). *Healing the trauma of abuse, a woman's workbook*.
New Harbinger Publications, Oakland, CA.

Copeland, M. E., (1998) *Wellness recovery action plan*. Vermont: Peachtree Press.

Deegan, P., (2001). *Intentional Care: Employee Performance Standards for Client*
Choice, Retrieved April 4, 2002 from www.advocatesinc.org,1-18.

Deegan, P. (1996). Recovery and the conspiracy of hope. *Paper presented at the Sixth*
Annual Mental Health Services Conference of Australia and New Zealand. Retrieved
April 27,2002 from http://www.namisc.org/newsletters/February02/Pat_Deegan.htm

Deegan, P., (2001). *Recovery as a self-directed process of healing and transformation*.
Retrieved April 4, 2002 from www.intentionalcare.org

Deegan, P., (1995). *Coping with voices: Self help strategies for people who hear voices*
that are distressing. National Empowerment Center.

DeLisis, L. (2003). Introduction to current controversies in schizophrenia research.
Current Opinion Psychiatry. 16(2) 121-122. Retrieved from www.medscape.com
March 8, 2003.

Dubin, W. & Stolberg, R., (1981). *Emergency psychiatry for the house officer*. SP
Medical & Scientific Books, New York.

Eleventh Report of the Managers of the State Lunatic Asylum of the State of New York,
(1854). *American Journal of Insanity* Vol. 11, no. 2, Pages 188-191.

<http://www.disabilitymuseum.org/lib/docs/1302.htm?page=print> Disability History
Museum, Retrieved September 29, 2002 from: www.disabilitymuseum.org

Fisher, D. & Ahern, L., (1999). People can recover from mental illness. *National*
Empowerment Center. (1-4) Retrieved April 27, 2002 from www.power2u.org

- From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves*, Paper Presented at the National Council on Disability, January 20, 2000. Washington, DC. www.connix.com, (4/27/2002).
- Gutheil, T., Bursztajn, H., Brodsky, A., Alexander, V., (1991). *Decision making in psychiatry and the law*. Baltimore: Williams & Wilkins.
- Hiday, V. A., Swartz, J. W., Borum, R., Wagner, H. R. (2002). Impact of outpatient commitment of victimization of people with severe mental illness. *American Journal of Psychiatry*. 159: 1403-1411.
- Hiday, V. A., Swartz, M. S., Swanson, J. W., Borum, R., Wagner, H. R. (1999). Criminal victimization of persons with severe mental illness. *Psychiatric Services*. 50: 62-68.
- Hiroch, V., Appleby, L. Mortenson, P.B., Dunn, G., (2001). Death by homicide, suicide, and other unnatural causes in people with mental illness: A population based study. *The Lancet* 358: 2110-2112.
- Hunt, I. H. (1851). *Astounding disclosures! Three years in a madhouse*. Unpublished manuscript. <http://www.disabilitymuseum.org/lib/docs/736.htm?page=print>, (paragraph 5), Disability History Museum, www.disabilitymuseum.org (April 27, 2002). Patricia Deegan Collection.
- Jacobs, R., (2001). *Real stories of recovery*. Director: Gene Johnson. Producer: META Services. Video Recording.
- Johnson, G., 2001. Home page. *META Services*. Retrieved from <http://metaservices.com/history.htm> on October 5, 2002.
- Knight, E., (2002). Recovery, self-responsibility (empowerment) and self-help. Retrieved from www.nccbh.org/chicago-htm on April 13, 2003.

- Lawsuit's History, (2001, November 27). *The Tucson Citizen*, pp.1-2. Retrieved from http://www.tucsoncitizen.com/local/archive/01/mental/11_27_01mental_side4.html on September 28, 2002
- Mead, S., Copeland, M.E., (2000). *What recovery means to us: Consumer perspectives*. Community Mental Health Journal, Vol. 36, No. 3, June, 2000.
- Mead, S. & Hilton D., (2000). *Peer Support: A theoretical perspective*. The Journal of Psychiatric Rehabilitation. Boston University Press.
- Mead, S. & Hilton, D. (2002). *Crisis and connection*. Unpublished manuscript.
- Mother Teresa, (date unknown), Unknown Source.
- Okasha, A., Arboleda-Florez, J., & Sartorius, N. (Eds.), (2000). *Ethics, culture and psychiatry: International perspectives*. American Psychiatric Press, Inc., Washington, DC.
- Perry, N., (1966, December 8). Raving maniac of Buckland spent 57 years in a cage. *The Springfield Union, Springfield, Illinois*. (para 5). <http://www.disabilitymuseum.org/lib/docs/935.htm?page=print> Disability History Museum, www.disabilitymuseum.org Retrieved September 9, 2002.
- Rider, A., (2002). *Peer support training manual*. META Services, Inc. Phoenix, AZ
- Roberts, V. (2002). *The buddies proposal: Tangata whaiora/tangata motuhake for consumers by consumers*. Kites Proposal. Wellington, New Zealand.
- Rubenstein, L., & Yohalem, J., (1987). The Courts and psychiatric disability. In A. T. Meyerson & T. Fine (Eds.), *Psychiatric disability: Clinical, legal, and administrative dimensions* (pp. 437-448). Washington, D.C.: American Psychiatric Press.

St. George, L. (2002). *Graduation class number 12*. Video Production. Gene Johnson,
Director and META Services, Producer.