

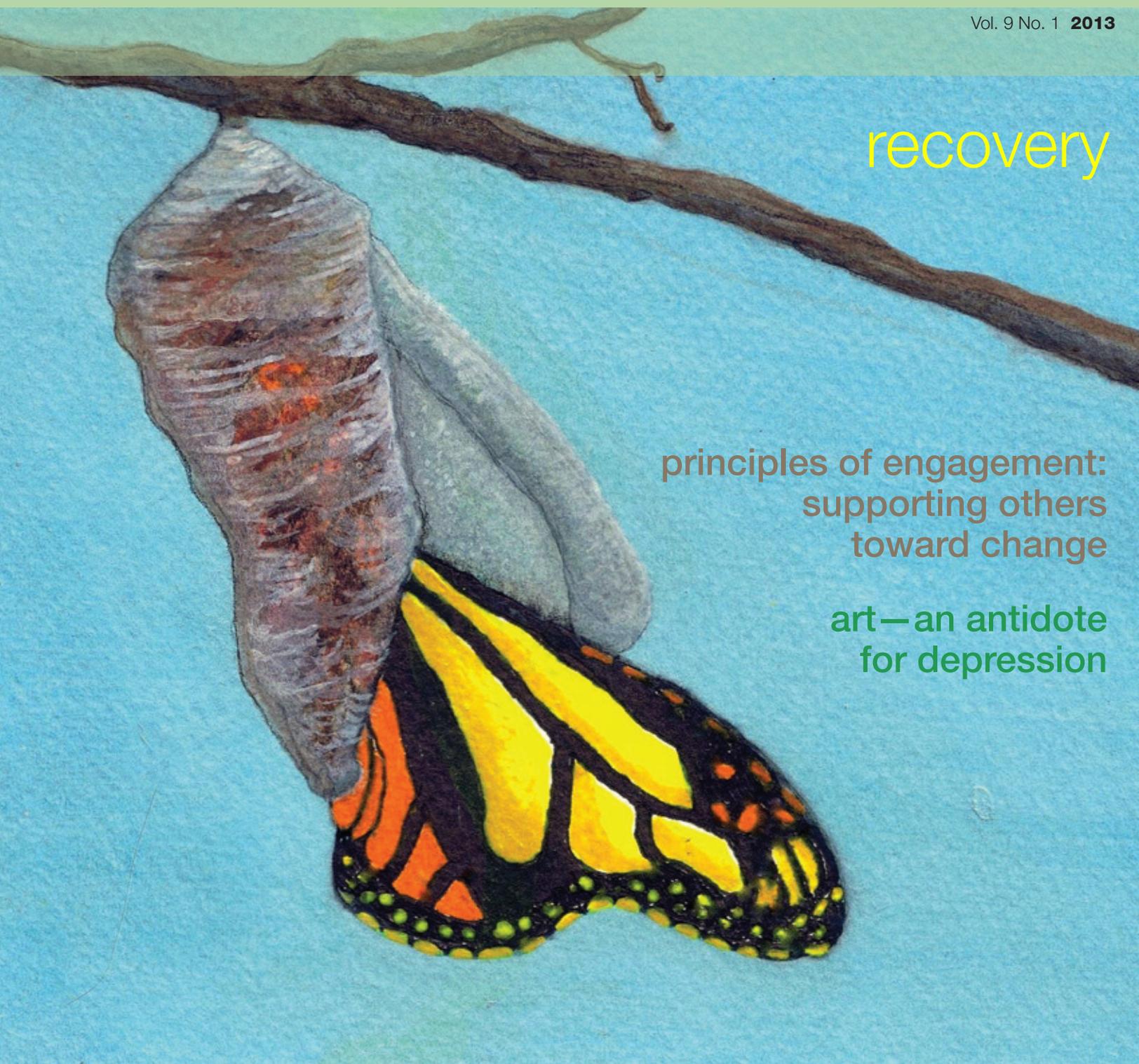
visions

Vol. 9 No. 1 2013

recovery

principles of engagement:
supporting others
toward change

art — an antidote
for depression



visions

Published quarterly, *Visions* is a national award-winning journal that provides a forum for the voices of people experiencing a mental illness or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and addictions issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Addictions Information and funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

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we want your feedback!

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*pseudonym

Our daughter, Elizabeth Bogod passed away on 1st February 2013. Elizabeth contributed to your *Visions* magazine's Borderline Personality Disorder issue with an article called "Don't Call Me Borderline." Please visit a memorial website we've created at www.ebogod.wordpress.com with detailed information, art work, writings and poetry.

— Judy and Philip Bogod, Victoria, BC

I like that you have an issue addressing health literacy. I have looked at pamphlet after pamphlet, and read article after article on the Internet, and none of them describes me. I only know that Seroquel and valproate keep me "stable with side effects." I have also figured out recently a symptom I have and it is that I am incapable of casual conversation. They might ask me a question and I will answer it honestly but they really don't like the answer...Then they storm off in a fit of rage. I certainly am not trying to make the other person upset. I would love to have a casual conversation with them. I'm just not able. I can have a technical discussion, or write, but that's it...As I understand it this can be seen as a symptom of autism. I did pretty well in some subjects at school and not so well in others, such as English, or literature. But fortunately, I was able to fly under the radar. Special attention and help would have only made me feel worse by segregating me from the other kids as different, when my social skills were already totally absent. Thank you for reading my letter. And thank you again for this issue of *Visions*.

— George Chris Michas, North Vancouver

editor's message

This is the first time *Visions* has looked at the topic of Recovery in more than a decade. And now it's one of our entrenched eight themes. It's both a fascinating topic and a profound one—for both people and systems. There's a lot of overlap with our Wellness theme earlier this year. But there are some differences.

For one, the word 'recover' means to get back. To reclaim. As one of our guest editors notes, there is loss. Even with all the debate around the best words and definitions, it's hard to deny that when someone experiences a mental health or substance use problem or disorder and starts on a journey—and boy, journey is the right word here—to feel better, there is loss that happened along the way. From a clinical point of view, there's loss of functioning and loss of health. But bigger than that, there is often loss of identity, self-worth and confidence, social connections, meaningful roles and activities. I remember when I was ill as a young adult, the words from a song by the band Radiohead always gave me goosebumps. The words were "For a minute there, I lost myself. I lost myself." Because that's how it felt (but for longer than a minute!). I lost myself for awhile. My job, with help, was to get me back. And hopefully a better me.

But this issue isn't really about loss. It's about gain.

I think it's among the most inspirational *Visions* you'll read. If you don't read an issue cover to cover, you may want to start now. We have personal stories in every section this time. And even though the authors have such diverse backgrounds and opinions on recovery, there are common themes. Hope. Persistence. Helping others. A focus on 'can do' not 'can't do.' Creativity. Activity. Social support. Meaning. Journey. Beyond symptoms and treatments. A whole person.

I welcome your thoughts on recovery in a letter to the editor (see page 2 for details). Let's keep the conversation going.



Sarah Hamid-Balma

Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division

footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/visions. If you don't have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 2.

Reflections on Recovery

Guest Editors Renea Mohammed, MLIS and Matthew Denny-Keys, BA

We come from two sides of the recovery services spectrum. Matt is a service provider. Renea is a mental health service user who moved into service provision. This editorial presents some of our reflections on recovery, based on both our personal experiences and our work with others.



What is recovery made of?

Renea: One aspect of recovery that really resonates for me is the notion of hope. I remember, back when I was first diagnosed with paranoid schizophrenia, feeling like it was a death sentence. I thought my life wouldn't amount to much. There was one night I cried for hours over it. But my life has turned out pretty good. I have a good marriage, a meaningful and fulfilling job, a nice place to live in, friends and the freedom to pursue my interests. I have a pretty good quality of life even though I live with schizophrenia.

I wish that, when I was first being told about my diagnosis, recovery stories had also been shared with me. It would have given me something to hope for. It's hard to move forward when you don't have hope. It's times like that when you need someone to hold the hope for you. I'm lucky in that I had people in my life who did hold the hope for me. I don't think I would've reached the point I'm now at in my recovery without them and their belief in me—a belief they held even when I didn't believe in myself.

Matt: I couldn't agree more with the importance of hope in the process of recovery. Renea's inspiring example of the power of hope speaks to how essential it is to have someone looking forward toward a future of potential and light. How this hope is kindled is as important as the hope itself.

As individuals set out on their journey of recovery—many times not yet knowing what that means—they are often met with a series of challenges and obstacles. For people to face these challenges and surmount these obstacles, conditions must be right, internally and externally. Basic physical needs, such as adequate nutrition and safe, affordable housing, as well as a supportive social net are examples of external factors which may support this process. Life experience, a variety of coping skills, wellness techniques, and the holding of hope are internal examples. In order to effectively establish such conditions, the power of decision must rest with the individual themselves.

Renea is Program Coordinator with the Vancouver Mental Health and Addictions Services Peer Support Program. In addition to her master's degree, she has also completed the Douglas College Community Mental Health Worker program. Her introduction to the world of mental health services was as a service user when she developed schizophrenia. She is a recipient of the BC Schizophrenia Society's Calder Cup and Coast Mental Health's Courage to Come Back Award. She sits on the board of directors of the Schizophrenia Society of Canada

Matthew is Assistant Program Manager with Options Community Services' clubhouse program in Surrey. In addition to his bachelor's degree, he holds a graduate diploma in Psychosocial Rehabilitation (PSR) from Douglas College. Matthew is also the Coordinator of BC's first Psychosocial Rehabilitation Advanced Practice and sits on the board of directors of PSR BC

Any time we talk about mental illness or interact with our neighbours, family, friends and even strangers is an opportunity to consider the possible role of recovery.

People who support others in their recovery must be willing to hand control over to each individual and just walk alongside the individual through the beginning stages and later on when they express a desire to be supported. Hope is born of freedom of control, and of belief in oneself and one's abilities, so we must nurture hope by supporting true self-determination.

Let's talk about 'recovery'

Renea: I think there are pros and cons to defining recovery. Service systems sometimes want to define recovery so that everybody is talking about the same thing and so ways of measuring and evaluating services can be identified. But really, if we are truly providing person-centred care, we should be getting our definition of recovery from the individual who is in recovery. And, as many people have acknowledged, it means different things to different people. I once heard a presentation in which international mental health consultant, Ron Coleman,¹ said that if systems were truly person-centred, we'd have a unique definition of recovery for each person being served.² That jives with my thinking.

Matt: As individuals who support others in their process of recovery, it's important to reflect upon how we actually discuss this process. For service providers, what responsibility do we have to this movement outside

of our Monday-to-Friday, nine-to-five jobs? While I'm certainly no advocate of work-life imbalance, I would earnestly argue that those with knowledge and experience that can improve the lives of others should share that whenever possible.

An inspiring mentor once said that the best work he did in mental health services was done at a cocktail party on a Friday night. I see this to be true over and over again. And it extends to all areas of life. Any time we talk about mental illness, any time the media or an artist portrays someone's deepest struggle, any time we interact with our neighbours, family, friends and even strangers—each of these circumstances are opportunities to consider the possible role of recovery, and to promote mental health as a universal human attribute.

Beyond recovery: Looking to the future

Renea: I like the word "recovery." To me, it inspires hope. The word implies that things can get better. That's powerful, because I once thought they never would. It's not about the presence or absence of symptoms for me. It's much bigger than treatment. It includes everything: work, relationships, spirituality, meaningful activity, creative expression—everything. To me, recovery means living beyond your illness, living a life that's satisfying and meaningful, recovering from the effects

of your illness. It's about being happy. It's about the things in life that are important. And if you think of recovery that way, it's something everyone can aspire to—even when there is no cure.

The downside to the word "recovery" is that it links us to a problem, whether it's a mental health issue, an addiction or any of life's other challenges. The word implies that we are always "recovering from" some problem. There are other words, like "wellness," that don't emphasize this link so much, and they may be more universally understood. I've heard people say "recovery" is a journey that never ends—but do we want to be continually living our life in relation to some problem?

Matt: Like Renea, I too appreciate the word "recovery" itself. But I acknowledge that, by discussing recovery, we are also implying loss. For many people engaged in the process, they *are* in pursuit of recovering what has been lost—whether it's something previously held, or potential for the future. But for others, the process has created a shift. Their lives have morphed to one not tied to illness, systemic involvement, and strengths versus deficits—rather, they have realized what Pat Deegan identified as the true goal of recovery: "becoming more deeply, more fully human."³ As service providers—and as members of a fellowship of citizens—*this* must be how we view recovery, whether temporary or lifelong. As people navigate challenges and adversity, we must see their process as a unique, dignified, yet common human experience. We must honour this process as we *all* move through each stage of our lives. ▽

Recovery—It's Broader Than Health Care

Stephen Epp, MCISc OT, BHKin

I want to tell you about Corina.* First, Corina was a client of mine while I was an occupational therapist at a community mental health clinic. She had been referred for rehabilitation following a lengthy hospitalization, with the goal of developing a meaningful daily life.



Stephen is the Occupational Therapy Practice Coordinator for Mental Health and Addictions in Vancouver Coastal Health. He is also an instructor in the post-degree diploma program in Psychosocial Rehabilitation at Douglas College

*pseudonym

We started with goals related to physical fitness and overall wellness. As we achieved these initial goals, the process of rehabilitation opened up more possibilities for change.

Over time, Corina developed many new roles, including becoming a peer support worker, developing skills to start a small business, and ultimately becoming a peer support teacher and facilitator of peer-delivered groups.

Corina continued to have ups and downs, but with each period following stabilization, she was able to return more quickly to her valued roles and identities. And my role and relationship to Corina changed as her situation and recovery changed. During these times, she could be accurately labelled

a patient or a client. However, she could also be labelled as a coworker, since I had hired her as a peer group facilitator; a mother, since she had reconnected with her children; a leader in her community, as she had joined an advocacy group fighting for people living in poverty; and most importantly, to me, an inspiration and role model for recovery.

Despite severe symptoms, with the right support and opportunities, Corina has demonstrated an ability to live a meaningful life and be an active citizen in her community. She is not an isolated example of what is possible in a recovery-oriented system. I regularly witness people with incredible stories of trauma, victimization and severe mental health symptoms who

live beyond their illness. They lead purposeful lives, demonstrating resilience, recovery and humanity.

As we know, mental illnesses can be devastating to the individuals affected and also to their families. These illnesses create serious barriers to quality of life. One way people with mental illness and their family recover is by reclaiming, regaining and recovering the roles in their lives that lead to social inclusion, meaningful engagement in life and participation in their communities.

What gets in the way of recovery?

“Whether you think you can, or you think you can’t—you’re right.”

– Henry Ford

For me as a clinician, this quote demonstrates a central goal of my paid health care work with people with disabilities: instilling hope and a

belief that positive change is possible. I have found that the severity of a mental illness does not seem to predict a person’s ability to make friends, build connections and create a life they are proud of. Hope, belief and an opportunity can have a profound effect on recovery.

I am not suggesting that the ability and possibility for change resides solely within individuals or within their perspective. Nevertheless, the matter of the individual’s belief in the possibility for a better life is a central factor in the relationship between health care workers and their clients. As a health care worker, understanding the strengths and limitations of one’s role in the recovery journey is essential to understanding the concept of recovery. Health care cannot be relied on to provide family and community, and family and community cannot be relied on to provide health care.

In the health field, clinical effectiveness is typically defined in terms of “correctness of diagnosis and appropriateness and efficacy of treatment and care provided.”¹ I believe this kind of clinical effectiveness definition is common in our mental health system, but is not necessarily evidence of a “recovery” orientation. For me, a recovery orientation means not only living with an illness, but beyond the illness, extending the boundaries of “client-hood.” Having valued roles in one’s neighbourhood and natural community are examples of living beyond client-hood.

So what is recovery?

The term *recovery* means many things to many people. It is individually defined. One common thread among the people I’ve worked with, though, is the need to be valued and the desire to participate in our world with one’s unique assets.



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In a recovery-oriented system, a ‘successful’ story will include social inclusion, friendships, and purpose in life.

for clinicians

- How could your practice support clients to live beyond “client-hood?” For example, how could your health care practice link directly with valued roles outside of your office or clinic?
- If recovery is broader than health care, who outside of health care workers might need to be involved in informing health care policy?

did you know ?

Occupational therapists are concerned with helping people to engage in their daily lives, on their own terms, in their own communities. Within the mental health system, the role of occupational therapy (OT) could include:

- Assessment—establishing a client’s level of functioning in the community
- Rehabilitation—teaching the life skills and providing the counselling necessary to live as independently as possible
- Care planning—developing a multidisciplinary plan that enables a client to successfully meet their goals

At all times, the client’s values and perspective are honoured and central to the work the OT does together with client.

To understand the concept of recovery for people with mental illness at this time in our society, I believe we can learn from the human and civil rights movement of African Americans in the United States in the 1960s. There were comparable issues with gaining basic human rights, a lack of power and voice, learned helplessness, and frequent misrepresentation in the media. The media often tended to place responsibility for change predominantly on the individual.

John McKnight writes, “Revolutions begin when people who are defined as problems achieve the power to redefine the problem.”² The quote highlights the need for a change of perspective as a society given that the problem of mental illness is also predominantly situated on the individuals with the illness. This idea is also a key aspect of fostering peer leadership and stewardship (i.e., the responsible management of something entrusted to one’s care) as it relates to mental health recovery. For instance, peer leadership and stewardship may include opportunities for people with mental health issues to participate in mental

health system reviews and health care improvement committees. It might also include focusing on positive examples of recovery from mental illness in the media.

Therapists and clients both need to explore how success is defined. In a recovery-oriented system—in contrast to a clinical effectiveness system—a ‘successful’ story will include social inclusion in the local community, friendships within and outside of the mental health system, and purpose in life. In this system, rather than a few select leaders, what will emerge is a collective of citizens who are willing to share and lead via the wisdom in their wounds.

In my experience, a great deal of recovery is “kindled” in the community, person to person. As a health care worker, I have a role with my clients—to teach, to enable possibilities, to inspire and to instill hope. Ultimately, however, this work needs to tie into my client’s goals for valued roles in society and a meaningful life with friends and family. I hope that when my work ends at

5 pm, my clients will have the skills and resource links to connect and be anchored in their community.

I believe I also have a role outside of my job, as a citizen in a society that misrepresents and misunderstands mental illness. I have often said that I do far more for my clients when I elaborate on mental health recovery outside of work—at dinner parties, the gym or just out-and-about in my community, for example—than I do when I’m working within health care. I seize occasions to let people know about health care effectiveness and how change is needed in society for this effectiveness to translate into changed lives. I believe that accepting a personal responsibility to advocate in this way is what provides the fuel, or kindling, that can support the flame of healing in the community to grow. ▼

Psychiatric Rehabilitation

PAST, PRESENT AND FUTURE

Abraham (Rami) Rudnick, MD, PhD, CPRP, FRCPC, CCPE

People with serious mental illness, such as schizophrenia, are often psychiatrically disabled.¹ To facilitate their clinical and personal recovery,² psychiatric rehabilitation has been developed, studied and spread widely.

Dr. Rudnick is an Associate Professor in the Department of Psychiatry at the University of British Columbia and the Medical Director of the Mental Health and Substance Use Services of Vancouver Island Health Authority. He is a Commissioner of the international Commission for Certification of Psychiatric Rehabilitation Practitioners



Psychiatric rehabilitation is a set of value-based and evidence-informed practices used by various professions, such as occupational therapy and nursing, that helps people with mental illness enhance and maintain adaptive skills and supports, such as work skills and social supports. The goal is to help them be satisfied and successful—that is, have personally meaningful and socially valued roles, in their environments of choice—residential, educational, vocational, social and other.³ More traditional psychiatric approaches tend to focus primarily on alleviating symptoms. Psychiatric rehabilitation, however, focuses initially on service users' goals, rather than on their problems. This is particularly helpful for personal recovery, while also being ethically sound, as putting the person's goals

first as a rule (with exceptions, such as to protect the public if needed) upholds self-determination. Self-determination, which involves personal choice, is a fundamental principle of contemporary health ethics.⁴

Psychiatric rehabilitation in the past

Psychiatric rehabilitation has historical roots in the early 19th century. People with mental illness were liberated from prisons and poor homes and cared for in asylums. These asylums rapidly became large custodial institutions. By the mid-20th century, de-institutionalization had begun—people with mental illness were removed from institutions and integrated into the community.⁵

One of the first formally recognized psychiatric rehabilitation interventions

was social skills training. This was begun in the 1960s and is still used and shown to be effective.⁶

Another early intervention associated with psychiatric rehabilitation is the clubhouse. In the early stage of de-institutionalization, when there were not enough services in the community, people with mental illness self-organized in New York City to establish the first clubhouse—Fountain House. This clubhouse provided social rehabilitation, and later also provided effective residential and vocational psychiatric rehabilitation.⁷

Psychiatric rehabilitation today

There are now many more effective psychiatric rehabilitation practices. These range from illness management and recovery, through supported education, to supported employment, and more.⁸

Recently, the effectiveness of psychiatric rehabilitation has been enhanced by integrating its practices, as well as integrating with related practices. For instance, supported employment has been combined with supported post-secondary education to secure skilled work for people with serious mental illness.⁹ And vocational rehabilitation has been combined with cognitive remediation, which is a set of psychological practices with computer exercises that help people overcome cognitive impairments such as attention and memory problems.¹⁰ This latter combination improves cognitive ability and success in finding, getting and keeping work.¹¹ And psychiatric rehabilitation has also been combined with electronic technology to support effective functioning in independent housing settings, such as by use of a simulated interactive apartment to help

prepare people to cook and clean in an apartment.¹²

Future of psychiatric rehabilitation

What might the future bode for psychiatric rehabilitation? The following scenario may be helpful in conveying possibilities for a person receiving psychiatric rehabilitation services in the future.

Imagine Ray Hope, a 23-year-old man who was diagnosed with schizophrenia after a first psychotic episode at age 18 during his first year of college. That episode lasted a couple of months and was treated effectively at home with antipsychotic medication and cognitive-behavioural therapy.

Ray returned to college with supported education, using his smartphone to download and use cognitive remediation applications for effective schooling. He was guided in this by his psychiatrist and mental health care team, as well as by his college counsellor. Before Ray's college graduation at age 21, the college counsellor collaborated with a supported employment agency to facilitate Ray's transition to the skilled job of his choice.

Ray was offered and accepted a work opportunity in a rural location, where he continued to use his smartphone to

practice cognitive remediation. He also used the smartphone to remain in e-contact with his psychiatric rehabilitation practitioner, who helped him train in social skills with new people. This made it easier for Ray to acquire friends in the rural environment, where such social support is particularly important. Ray is thus satisfied and successful in his rural environment of choice.

In order for such a scenario to become reality, the workforce in the mental health care sector should be further trained in psychiatric rehabilitation; as part of that, psychiatrists should become better informed about and more supportive of psychiatric rehabilitation, which is still lacking in Canada and elsewhere although there is some progress on that.¹³ Also, access of service users to psychiatric rehabilitation should improve, such as in rural and remote communities, likely by using technology such as computer-based secure video.¹⁴ And funding for psychiatric rehabilitation should be obtained and protected, as has been done in a few jurisdictions, such as Israel where it is legislated and regulated separately from other mental health care.¹⁵ ▽

related resources

Two relevant books that I have recently edited may be helpful to readers:

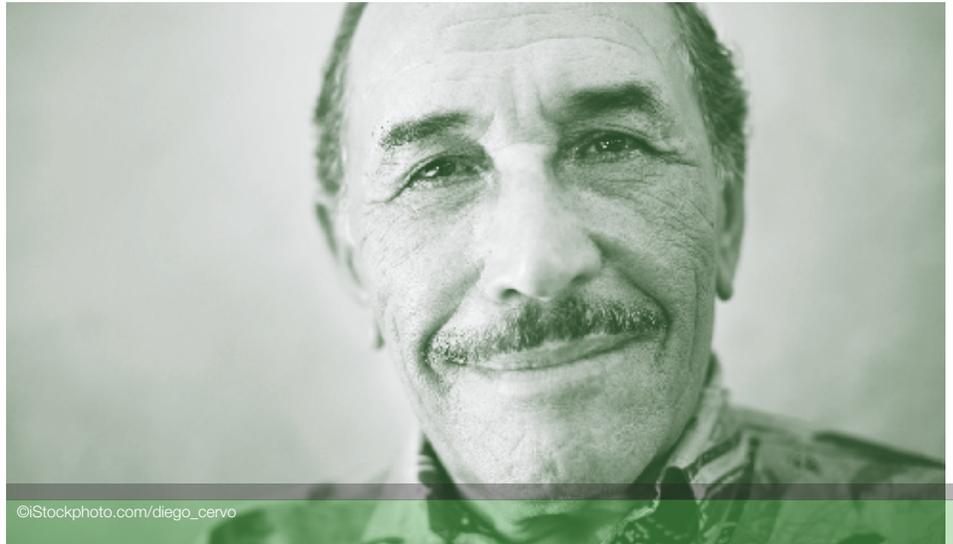
- Rudnick A, Roe D (editors). *Serious Mental Illness: Person-Centered Approaches*. London: Radcliffe, 2011; and
- Rudnick A (editor). *Recovery of People with Mental Illness: Philosophical and Related Perspectives*. Oxford: Oxford University Press, 2012.

Don't Give Up—Things Do Get Better

Barry

In July 1949 I made my debut into this cruel world on Canada's east coast, in a very small village. Unwanted and unplanned for, born to a single mom who was only 18.

Barry has worked as a health care provider for over 30 years, earning Licensed Practical Nurse equivalency. He loves people and loves his work, and recently completed the coursework for the Vancouver Coastal Health peer support worker training. Barry lives in Richmond with his life partner of 29 years



Long before the words date rape were even invented. When having a child out of so-called wedlock was worse than catching the bubonic plague. Mother and child bore and wore discrimination as their yoke and cloak, while the father left town the week I was born.

The only thing worse than poverty and being illegitimate was having a mental illness and being gay. Who would have known that curses can become one's blessings!

Mom and I had no choice but to live with my grandfather, a chronic alcoholic, and my grandmother, a hypochondriac. They fought verbally from the time they opened their eyes in the morning until closing them at night.

Starting school was no reprieve—I was the fat, gay, punching-bag kid. High school wasn't any better—a broken tailbone, my front tooth knocked out, and pushed down a flight of stairs. But what hurt me most wasn't the physical abuse; it was the mental cruelty of the other kids.

After grade eight, I left school for a couple of years. The stepfather who was on the scene by then all too eagerly gave me a one-way ticket to relatives in Ontario. When I returned to my hometown school as an older student, things were no better.

In 1969, the summer after grade 10 when I decided I'd had enough of high school, my body and mind gave out.

*Homosexuality was listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* until 1973.

I lost all sense of reality and started hearing voices. I attempted suicide, and after having my stomach pumped in the ER, I ended up in a psychiatric hospital 175 miles from my small-town home. I spent my 21st birthday there.

I was diagnosed with manic depression (what is now called bipolar disorder). With heavy doses of medications, plus 21 electro-convulsive therapies (ECT) sessions, I started responding. It was seven long months before I got out of hospital.

Don't ever accept 'never'

"Recovery" wasn't a word I heard back then. And there certainly wasn't much support for my dreams.

Ironically, this was the same hospital I'd been accepted at to start nursing school in the fall. A neighbour woman—my main support—had helped me apply for the practical nursing training. But now this hospital wouldn't honour the letters of confirmation they had sent me. I was super sad and cried uncontrollably.

Doctors and nurses and social workers asked me repeatedly: "What do you want to do once you're released from hospital?" I kept telling them I wanted to work with people in health care, but it was like they didn't hear what I was saying at all. Their replies were always the same: "no way" and "impossible for you to do that now that you've gotten ill" and "you won't be able to stand the pressures and stress of working in health care."

But this only gave me more determination. I had a dream of being able to help others. Finally, I told them: "Got three words for you—watch me go! I will find the way to do just that."

It took me a year and half to land a job working with mentally challenged children, back when jobs were a dime a dozen. Stigma! I always answered the employers' questions about what I'd done over last year honestly, because I knew my stay in the psych hospital would eventually be found out.

Finally I was accepted for a child care worker job in a residential facility, on the condition that I give the administrator a signed letter releasing my hospital file to her. (Today, this would clearly be a violation of my human and privacy rights.) As soon as this administrator read my file and saw I was gay,* I found myself on steady graveyard shifts. I tolerated this punishment for two years, then quit.

I moved to Ontario and landed a job as an orderly (male attendant) and counsellor with mentally challenged adults in an institution. Three years later I was working in residential group homes, also with adults with mental challenges.

Levelling the 'yo-yo effect'

In Ontario and on the east coast, the drug therapies weren't continued long enough after being released from hospital, so I was seeing GPs who put me on tranquilizers. I kept telling them this wasn't working, and they'd just

increase one drug, delete another and/or add something new. I lived a "yo-yo effect"—hypermania, fidgeting, endless restlessness medicated down so I could sleep at night; then meds to get me up for the day.

When I moved out to the west coast in 1976, at age 27, I was determined to find a doctor who would listen—and hopefully know how to deal with my condition.

I found an excellent doctor in psychiatry at Vancouver General Hospital, after a couple of referrals by my new GP. I'll always remember the day that this doctor not only confirmed my diagnosis, but prescribed lithium and told me to get rid of all the tranquilizers. (I found out in the medical library that tranquilizers are useless for treating a bipolar condition.) I skipped down the street like a kid—people looked at me as if I'd lost my senses, but I didn't care. Deep down, somehow I knew I was finally on the right pathway.

In just three to four weeks my highs-to-lows mood swings levelled off for the very first time. Before that, I was almost resigned to feeling forever out of control. I had spent six years properly diagnosed, but hadn't been on the right medication!

I lived in a "yo-yo effect"—hypermania, fidgeting, endless restlessness medicated down so I could sleep at night; then meds to get me up for the day.

Look at the total person and not just their labels or diagnoses or challenges, because we are all much more than our diagnoses.

Blessings

I have now worked in health care for well over 30 years. I've worked in emergency, psych and extended care, and with clients in sheltered workshops, group homes, palliative care and detox. My experience earned me the equivalent of a licenced practical nurse (LPN).

Meeting patients and clients and their families has always been a blessing. Most patients and clients aren't out to judge or discriminate; they just see me as person who shows kindness and who's willing to go the extra mile. Most people don't care if staff are gay or straight or polka-dotted in their private life.

I love people of all walks in life. By sharing, we all learn what's most important. I talk with people at malls and bus stops or grocery stores. When I'm not working, I visit seniors and volunteer—I did bell ringing to help the Salvation Army raise funds at Christmastime, for instance.

I believe we receive our blessings in life from what we're willing to give to others. Over the years, I have received so much more than I could ever have given. Good comes back to us tenfold.

The best teacher of compassion and empathy, and of understanding for self and others, has been my own struggles with mental and emotional illness, having come from that locked ward as a patient, to being a competent staff member and team worker. The curse that has become a blessing!

Fortunately, I've also had family and friends who believed in me—even when I wasn't able to believe in myself. Over the last 29 years, I've shared my life with my soulmate, who accepts me as I am and encourages my hopes and dreams.

Wellness and recovery, to me, means focusing on what I can improve on, rather than just focusing on what I can't do. This can include diet, exercise, setting personal goals and cultivating hope.

In January I finished taking the peer support worker courses with Vancouver Coastal Health, and I'm about to start my practicum. I've been out of the workforce for the last four years and want to get back. I'm 63 (age is only a number), but still want to work with people and help others with their journeys toward wellness.

I wish this peer support program had been available during my roughest

years—not just as a training possibility, but it would have been wonderful to have had support from a peer.

Recently, someone at school asked me what I thought was the most important aspect of working with people. I must say it's being able to look at the total person and not just their labels or diagnoses or challenges, because we are all much more than our diagnoses.

We are not defined by our income or where we live, our jobs, our diagnoses, or our sexual-preference identity. Other people will always try to define us, but it's our own inner self that defines what kind of person we want to be. If I'd listened to the professionals, I'd have accepted an \$80 monthly pension at 21 years of age and been hospitalized for the rest of my days.

I have bipolar disorder—but bipolar doesn't have me! I can choose to be a victim—but I choose to be a survivor. ♡

Phoenix

Doreen Marion Gee

I have done my time in hell. But after a lifetime of living with mental illness, I know that hope and recovery always shine like starlight—even in the blackest pit of despair. Years ago I was sick and broken, standing in the rubble of my own ground zero.



©Orange Frog Studios

Doreen raised a beautiful son, Stephen; was nominated for a 2006 Courage to Come Back Award; earned second place in creative non-fiction with the Victoria Writers' Society contest in 2009; and attended the 2012 Together Against Stigma conference in Ottawa. She is a professional writer, photographer and social media manager

This photo of Doreen Gee was taken when she was shortlisted for the 2012 Victoria Leadership Award. Doreen's message of hope: You can recover from mental illness and have a good life!

I could never have imagined that one day I would be dancing in sunbeams, short-listed for a 2012 Victoria Leadership Award for my work in challenging the stigma about mental illness. I turned the tides around. So can you.

At 33, I was diagnosed with a chronic anxiety condition called obsessive-compulsive disorder (OCD), with secondary depression. As serious as any psychosis, OCD completely took over my life. I was tormented by terrible thoughts about my worst

fears: getting some incurable illness, being broke and penniless, setting my apartment on fire or leaving it open to burglars. The obsessive thoughts were so alarming, I was desperate to get rid of them. Mental and physical rituals gave me momentary relief: I checked my stove, my body, my bank account and my front door lock continuously until I was exhausted. At my sickest, the rituals took up every waking minute and I felt like I was losing my mind.

My lucky break was getting sick during the early '80s, when mental health

services were well funded. I entered a full-time cognitive-behavioural therapy program at Shaughnessy Hospital in Vancouver, which used “exposure” and “response prevention” approaches. Instead of trying to shut down the thoughts and anxiety, I learned how to tolerate them without doing the rituals. For example, if I wasn’t sure if the door was locked, I forced myself to walk away without checking. At first the anxiety was crushing, but it eventually dissipated.

This simple procedure worked miraculously: by not doing the rituals, I taught myself that no matter how anxious and worried I was, it still did not make the thoughts true. And every time I walked away and nothing happened, I knew the thoughts were false and harmless. As the rituals slowly diminished, I gained control of the OCD. That early intense therapeutic intervention is the main reason I’m doing so well today; I learned the tools that I use every day of my life.

With mental illness, the best defence is a good offence. After I finished my treatment in Vancouver, I moved back to Victoria and returned to university. I used my new skills to manage my OCD, and at UVic I got support from a doctor and peer counselling.

My symptoms abated, and here’s why: at school, I actually did something well. I felt successful, good about myself. As I felt better, my depression lessened. Since my depression ignites the OCD, my OCD symptoms diminished. And distracting myself with challenging work requiring mental focus kept my mind off the OCD treadmill. I graduated in the top 7%, earning a Bachelor of Science and three scholarships.

I’ve always been a rogue, a maverick—refusing to believe that I am ‘less than’ because I have a mental illness, and knowing that I have the same right as anyone to the good things in life. Years ago I decided that my mental health conditions, though they may have posed challenges, would never impose limits on me or my life. That mental “will” came from knowing that I was better than my illness and that I had skills and strengths despite my mental health challenges. I engaged in activities that helped me feel valuable—self-esteem building courses, volunteer work, making friends, art and writing. As I felt stronger, I knew with more certainty that OCD and depression did not define who I was.

My recovery is always up and down, good days, bad days. In the winter of 2004/2005, my mood was very low. I felt worthless, with no motivation to do anything. But a free creative writing course being offered at a local newspaper sparked my excitement, so I pushed myself to sign up. That course turned into volunteer writing for the newspaper, a paid job at a magazine and a career in journalism and social media.

Tapping my creative side has facilitated and fuelled my recovery from mental illness. Writing gave me a voice and power when I felt I had neither. Since anger, pain and frustration inflame my anxiety, being able to express those feelings on paper—at a safe distance—gives me tremendous inner peace. Writing is my anti-anxiety drug.

When I engage my mind on creative outlets, I forget about my OCD and tap into the part of me that is healthy, productive and positive. This can apply to anyone, with any interest. It helps to get away from the illness sometimes and do whatever makes you feel good—perhaps walking, swimming, cooking. I think recovery is all about focusing on what you can do rather than on what you can’t do.

Using my lived experience to help others turned my pain into something positive and hopeful. In 2011 and 2012, I was a peer support worker with a local non-profit, being a supportive friend to clients with mental illness, and I gave community presentations about my recovery. I loved mentoring young people with psychoses in a 10-session workshop that I co-facilitated, Your

Writing gave me a voice and power when I felt I had neither. Writing is my anti-anxiety drug.



Nowadays, I am enjoying my own starry “Everest,” having climbed back up from the abyss. Who knows when I will scale the top, but I am miles above rock bottom.

Recovery Journey. In all these roles, my message was hopeful: recovery is possible.

With the youth, I encouraged them to focus on their strengths, what they did well, and how to take care of themselves to avoid relapse. The self-stigma about mental illness can limit people. So I helped the young people to see themselves in a new, positive light. This gave them more confidence and hope about their future. One young man said that I helped him see that recovery was possible, and he felt stronger about taking on new challenges. He now has a full-time job plus an exciting new business enterprise.

My illness peaked in 1983 when I was defenceless: stressed out and worn down from a bad relationship. Building my resilience back up was a big part

of my recovery. For every person, that process will be different. But, basically, it's simply doing what makes us feel good, valuable and important. For me, it was school and work, but for someone else it could be building friendships, getting fit or helping their neighbour next door. Taking caring of our health, getting support, eating well, being with people who treat us well—all of these things build our resilience and help us recover from mental illness. Medication is also a very effective tool in my wellness.

Nowadays, I am enjoying my own starry “Everest,” having climbed back up from the abyss. Who knows when I will scale the top, but I am miles above rock bottom. Years ago, OCD thoughts and rituals desecrated my life and my sanity 24/7. Now they affect a mere 20 minutes of my day at most. I have

a good life, stable housing, work and friends. My goal is to teach Mental Health First Aid through the Mental Health Commission of Canada.

Mental illness will never have the final say in my life; I will. To those of you who are discouraged: I offer you hope for the future! ▼

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For Better Or For Worse

Jane*

I grew up in a very happy home and married my husband Larry* when I was 21. Both his parents were alcoholics, but none of his six siblings is an alcoholic, nor was Larry for the first nearly 30 years of our marriage.

Jane is a happily retired former teacher who volunteers on a committee to educate others about mental illness

*pseudonyms



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When our son was diagnosed with schizophrenia at the age of 24, however, my husband dealt with the devastation of that diagnosis by drinking. I, on the other hand, went to the BC Schizophrenia Society support meetings, joined an Alanon group (self-help recovery group for people affected by someone else's alcohol addiction), and had my faith in God to fall back on.

Why is it that Larry ended up drinking rather than dealing with our son's illness in a positive manner? I'm sure it was insidious—it just crept up on him. He didn't 'choose' to become an alcoholic, though with alcoholism in his genes, he could have been more careful.

The fact that Larry suffers from depression hasn't helped. His

depression was diagnosed about 29 years into our marriage, after our son's schizophrenia diagnosis. When our son became ill and I became more educated about mental illness, I realized Larry had been depressed our whole marriage.

After one winter of feeling completely miserable because of him—he blamed me for everything that went wrong, never wanted to have anyone over, and whatever I did was unsatisfactory—I threatened to leave if he didn't see the doctor about his mental health. So finally he got diagnosed by our GP.

With medication, Larry is easier to live with. He has consistently taken his antidepressants; if he forgets, I know right away because he becomes critical of me again.

I suspect that the antidepressant doesn't work as effectively as it should because of Larry's alcohol intake. He still has a negative outlook about most things. Summers are usually easier, but winters find him in bed sleeping a lot. We try to plan a sunny getaway every winter, as Larry perks up in the sun.

In the spring of 2011, my husband was so sick with his alcoholism that the family did an intervention. Larry seemed to be on the road to death—drinking, vomiting and going back to bed, day and night. He didn't want to go to rehab, but he was in no shape to resist for long. We delivered him to the facility, where he stayed for six weeks.

Larry remained alcohol-free for nine months, but he didn't change his lifestyle, so predictably began drinking again. Although he did attend Alcoholics Anonymous (AA) meetings, a big stumbling block for him in the 12 step-based AA program is that he cannot find a higher power. He didn't do the daily readings, didn't exercise, and is now back to drinking from morning until night, so no longer attends the AA meetings. Some days he is up and about, and others he is in bed all day; "good days" and "bad days" I call them.

Although Larry says he would like to be sober, he continues to handle stress by drinking. Some might say I am enabling my husband to drink by staying with him in the circumstances. When I do leave for breaks of a few days, he tells me how much he missed me and that he doesn't do very well without me. I know he needs me to keep his spirits up. The professionals would probably say I should have left a long time ago, and then Larry would



be forced to cope and make changes. Maybe they are right.

Today a lifetime of smoking (he's now 68) and 17 years of heavy drinking have taken their toll on his body and he is contending with multiple serious medical problems.

My 'recovery' in the face of ongoing relapse

Back when I first realized my husband had become dependent on drink, I learned some valuable lessons from Alanon. I bought *Courage to Change*, the book of daily short readings, and did the readings daily. And I was able to "Let go and let God," as they say in Alanon, meaning that I accepted the fact I had no control over my husband's alcoholism and I just had to entrust him to God's care.

I learned to get on with my own life within my marriage, often without my husband. I created an independent life with my own friends—without them, I would be sunk! I have lunch and coffee dates, a regular walking partner and

confidante, and I keep in touch with many friends daily through Facebook.

Larry and I do family activities together, such as visiting the grandchildren, having lunches out with our son, and spending time with extended family. We also love to go boating and have had some wonderful trips, just relaxing and exploring our tie-up locales.

When we retired about 10 years ago, Larry's drinking became much more 'in my face.' It has been very difficult watching him waste his life, passed out on the couch much of the time. It's certainly not the retirement of boating and travelling we had envisioned. We've taken some trips, but travelling with a smoker (Larry has smoked since he was 16) and alcoholic is difficult. Much of our travelling time is spent looking after his addictions to keep him a contented travelling companion.

Without Larry maintaining sobriety, I cannot 'recover' our former, happier marriage. But I still start every day with

“Life isn’t about how to survive the storm; it’s about how to dance in the rain.”
– *unknown*

my readings, prayer and journaling, which has helped me deal with my situation. And I’ve begun going on trips with other friends and family members. I have only one life to live and I want to enjoy it.

Larry encourages me to plan my life without him. He doesn’t want me to suffer because of him, and perhaps it eases his guilt. He is generous, always making sure I have money to spend. He knows he has let me down and tries to make up for it by supporting me to enjoy myself.

As a part of Larry’s residential treatment, I went to a therapy group for five days, where I discovered that I “stuffed,” or ignored, my emotions. This is a common coping mechanism. For years I haven’t been able to say what I want to say and have been ‘maintaining the peace.’ Now, with the help of Alanon, I’m working at getting in touch with my feelings. With Larry continuing to drink, though, it’s not possible to share intimately with

him. I don’t want to upset him, as it leads to senseless arguments. This loss of intimacy is sad, but given the circumstances, unavoidable.

But there has been plenty of glue to keep us together these 45 years. Larry has always had a wonderful sense of humour. He’s a hard worker—he built our home over 40 years ago, doing most of it himself. His risk-taking nature has paid off financially. He has always been an involved and supportive father. He’s very honest and has good morals. Our best times are when we’re working together, clearing the land, building the house, renovating, cutting firewood—we are still involved in that work together! We have a lot to be thankful for: two grandchildren, a lovely home and financial security.

Alanon has taught me that it is possible to have a satisfactory life with an alcoholic if that is the choice I wish to make. It’s all about appreciating the life I do have.

Love will prevail, as it always has in our marriage. I won’t desert Larry just because the going is rough. I made a sacred vow to love him in sickness and in health, till death do us part. I intend to keep that vow and am proud that our love has weathered the many challenges put before us. We will finish the journey as always, together. ▼



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Art—An Antidote for Depression

Suzan Milburn

It is August 2003 and the nurses at Willowview mental health treatment centre in Vernon, BC, are scurrying around taking pictures off the walls. And they are pinning up photocopies of paintings I had done over the five weeks I'd been a resident there. I watched them as I sat in their office chair, with tears streaming down my face. I couldn't believe how much value they were putting on my art.



©Suzan Milburn

Suzan lives in Vancouver. She has a private counselling practice and volunteers for the Canadian Mental Health Association. Her video and ebook, Responding to the Call: The Sequel, can be seen at cmha.bc.ca/suzanmilburn. Suzan's art is featured on the cover of this issue of Visions

A self-portrait from Suzan's free ebook, Responding to the Call: The Sequel.

The pictures had emerged out of the hours I had passed on my bed over those five weeks. Hours of exhaustion. What the nurses there referred to among themselves as "riding the bed." There were no planned activities at Willowview. The only thing we had to do was come to the table for lunch and dinner. For those of you who have a mental illness you will know this, but for those of you who don't: mental illness is physically exhausting and you can become 'bone tired.' I felt like gravity had increased a hundred fold. A walk around the block was out of the question. And so, our beds became our world.

Up until that point, I had expressed my inner world through poetry. But

depression took my words away. I used to love dancing in my living room but there was no energy for that. I used to play the flute. But couldn't remember where to put my fingers. So, with no previous experience, I started drawing—copying things and colouring them with some old pencil crayons that I found at the facility. Then I would pin the finished drawing on the wall and marvel that it had such colour and life.

A year earlier, my mother had attempted suicide. My sister and I found her lying on her bedroom floor. The daily visits over the following three weeks to see her in the psychiatric unit was one more demand on my already hectic life. With full-time work

as a counsellor in private practice, three teenagers and an emotionally abusive relationship, I was stretching myself as thin as I could. I just couldn't make myself do one more thing. I was exhausted and depressed. But it was "smiling depression." No one knew because I wore the "I'm fine and I take care of others" mask. That's where I found my value.

Until that August, when I woke up one day and knew I needed help, because I could barely move, let alone smile.

Within days I was admitted to Willowview, thinking I would use my two weeks holidays to recover. After all, I thought, "I'm a counsellor and understand how to recover from mental breakdown. I'm not really like the other residents—they actually have a problem." I really didn't think recovery would take me long at all.

What I didn't understand then, but am quite clear about now, is that our intellectual understanding can be quite separate from our emotional understanding. So, intellectually I knew about self-care—before my breakdown I was going to the gym, getting massages and taking holidays: all external self-care.

Internally, I was in emotional pain and denied I felt anything. Refusing to feel, of course, affected my thinking. My thoughts were and still can be quite self-critical. The phrase "Depression is anger turned inward" is true for me. Once I left Willowview, and started to have enough energy to begin counselling, I became aware of my thoughts that were screaming abuse at me. It was hard to accept such malicious thoughts but there they were. Seeing them led to shock and anxiousness. Therapies

The paintings reassure me that I do exist. In my recovery, my pictures are life buoys that keep my nose just above the sea of dark, abusive thoughts.

like acupuncture, meditation, cranial sacral therapy, and yoga have helped to soothe my anxiousness somewhat.

I realize now that my drawings have been essential in my recovery because they contradict the darkness of my thoughts. They do this when I am actually putting the colour on the page, but also once they are finished and I look at them and feel reassured that I am not all dark crags and hidden pain. The paintings reassure me that I, as a spirit and soulful person, do exist. That my thoughts are not all of who I am. In my recovery, my pictures are life buoys that keep my nose just above the sea of dark, abusive thoughts. And slowly, I am feeling safer to feel.

You see, though I was expressing inner angst, pain and suffering, the paintings would come out quite hopeful. I never sat down telling myself, "I'm going to paint a hopeful painting to make myself feel better." It was more, "I'll paint anything to distract myself: a candle, a tree, a turtle, a flower—just to lighten my mental stress." And then, I was surprised to see how they turned out—the colour so vibrant or the content so uplifting. I found solace in my own images.

Dear reader, I am not unique. We all are creative. But, because of negative childhood messages, many of us do not have a sense of our own creativity. In fact, many people believe they have no

creativity at all. And this can lead to a deep sense of loss—the kind of loss you can't quite put your finger on. But, it is there nonetheless.

Whether or not you believe you are creative, you can engage in creative acts: restoring an old car, setting the table, growing a garden. Whether we admit it or not, "human creativity is the driving force inherent in the human organism from birth."¹

Like the emergency lighting that comes on when all the lights go out, our creative energy can offer us solace during depression. It may be the one bridge that remains standing when all the other roads have washed out.

And now, it's not the Willowview nurses putting my paintings on display, but the warm-hearted people at the Canadian Mental Health Association, who have taken my paintings and put them on the Internet!

The therapeutic nature of my art has thrown me a lifeline—first to myself, and then to others who relate to my images. Art has been a welcome and surprising antidote for my depression. ▽

WRAP® Gave Me Freedom From Depression's Control

Margo Robinson

Depression used to have a powerful hold on my life. I was a slave to it, barely able to function at times. I have bipolar disorder, but only experience mania occasionally.



Margo has taken first year English and psychology at Vancouver Community College. She is a certified WRAP Facilitator and previously facilitated a Mood Disorders Association of BC (MDABC) support group for four years. Margo now does public speaking for MDABC and co-facilitates a faith-based support group called the Living Room

In 2006 I experienced a debilitating depression. I hardly ever dressed or got out of bed. I'd been an avid reader and enjoyed time on the computer. Those loves were taken from me because I lost my concentration. My days consisted of lying in bed with the TV on but not really watching it. The days were endless, dragging, the clock seemed to move so slowly.

After six months of this, I remembered a Mood Disorders Association of BC (MDABC) group I had attended for a few months in 2001. My partner had told me he couldn't go on with me this way, so I finally started attending the MDABC peer-led support group. My depression began to lift as I began to relate to my peers.

Through my MDABC support group, I heard about some courses to help me in my recovery. One of them was the WRAP (Wellness Recovery Action Plan) course. I asked what that was and was told it was a course that would help me learn how to stay well. I said, "I want that! How do I get to take this course?" I was given a name and phone number to contact.

Taking WRAP was the best thing I ever did for myself—other than my MDA support group—to help me stay well and live in recovery.

WRAP—What's it all about?

The Wellness Recovery Action Plan®, or WRAP®, is an evidence-based system used world-wide by people who are dealing with mental health

and other kinds of health challenges. It was developed by a group of people with lived experience of mental health difficulties. WRAP is listed in the National Registry of Evidence-based Programs and Practices, a database of the US Substance Abuse and Mental Health Services Administration.

The key concepts of WRAP are: hope, responsibility, self-advocacy, education and support. And there are seven components to building a WRAP plan:

1. Wellness toolbox
2. Daily maintenance plan
3. Identifying triggers and an action plan
4. Identifying early warning signs and an action plan
5. Signs that things are breaking down and an action plan
6. Crisis planning
7. Post-crisis planning

The WRAP course is eight weeks long, and the weekly sessions are two and a half hours long. The course is led by trained peers.

Why I love WRAP

It was a great bonding experience with other people living with mental illness. But it was much more than that—taking the course taught me how to

recognize my triggers, identify things I could do to deal with these feelings, and develop positive coping skills.

I learned to recognize my early warning signs and take appropriate action. What is appropriate action for depression? Well, for me, it's getting out in the world. This can be going to the support group, or for a walk or coffee with a friend. Since taking WRAP, I've not spent a single day in bed when I get depressed. At the first signs of mania, I contact my doctor. Although it's tempting to stay with the good mood, I know where mania can lead, so the earlier it's treated the better. Since taking WRAP, I've never had to be hospitalized or even had the mania get out of control.

When things are breaking down, I take the right action, which may involve going to the hospital, or may just be seeing my doctor and calling one of my support people. For example, when I recognize that I'm starting to become manic—not sleeping, more energy and excessive cleaning and sorting—I see my doctor right away. He prescribes the appropriate medication and some behaviour modification—often, to stay away from stores and wherever there's lots of activity.

What is appropriate action for depression? Getting out in the world. This can be going to the support group, or for a walk or coffee with a friend.

WRAP®

To find out more about WRAP® and its founder Mary Ellen Copeland, visit www.mentalhealthrecovery.com

WRAP is offered in various communities across BC at various times. To find a WRAP course near you, contact your local mental health team, clubhouse, or local branch of the Canadian Mental Health Association, BC Schizophrenia Society or Mood Disorders Association. In Metro Vancouver, contact Vancouver Coastal Health at 604-708-5274.

With WRAP, I learned the value of having and identifying my support system. Thanks to my MDA support group, I have a whole network of peers I can call. I've made some very close friends in the group, and we are each other's support system.

Learning how to change negative thoughts to positive ones was very helpful. A key exercise for this is writing positive rebuttals to challenge the negative thoughts. For example: in response to thoughts like "This will never end" and "I will never feel well again," I'd write "I have felt this way before and it always gets better."

I also learned that I was responsible for my own recovery. Taking responsibility for myself, rather than relying on other

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Clubhouses

A VITAL PIECE IN THE WELLNESS PUZZLE

Mike JR

When I moved to Langley in April 2011, my mental health situation improved dramatically. The services I had been receiving in Vancouver's West End, though adequate, paled in comparison to what I found in Langley.



Mike, now in his 40s, enjoys writing, editing and being a life-long learner. After doing some travelling overseas, he returned home to the Lower Mainland to enjoy life with family and friends. Mike has been a member of the Stepping Stone clubhouse for the past two years

Downtown Vancouver mental health teams have very large case loads of people with much more complex and severe issues. I don't have chemical dependency issues and my schizoid affective disorder was kept in check through medication. Thus, in Vancouver I wasn't a high priority and didn't require extensive attention.

When I first stepped into Fraser Health's Langley Mental Health office, I encountered a competent, well-oiled machine. As in Vancouver, a psychiatrist and a social worker dealt with my psychological needs, but in Langley I also had a community support worker who dealt with my psychosocial needs.

One of the psychosocial supports I was introduced to is what clients like to call "The Clubhouse" or "The Stone." The clubhouse program is one of several psychosocial rehabilitation programs

offered by Stepping Stone Community Services. Stepping Stone is a non-profit agency that aims to improve quality of life for people in Langley who face mental health challenges, as well as homelessness and poverty. Other programs include housing services and community living support.

A "clubhouse," in a mental health context, is a centre that provides community for people who have mental illness. Clubhouses provide hope and opportunities for members to rejoin the worlds of friendships, family, employment and education. They also help members to access the services and support they need to continue their recovery. The clubhouse movement began in New York in 1948. Stepping Stone's Langley clubhouse opened in the mid 1990s.

"Membership" is a key concept, as it creates a sense of belonging. The

members are involved in planning, implementing and evaluating the programs offered. Membership at the Stepping Stone clubhouse is 100% voluntary. There is a gentle expectation that you participate in activities and that you come to the clubhouse to keep your membership current; however, there are no mandatory requirements for attendance.

My direct experience at Stepping Stone over the past two years has been overwhelmingly positive and constructive. Let's start at the beginning. I was referred to the clubhouse by my social worker. The first time I walked into the clubhouse, people—members as well as the staff—smiled, said “hello” and chatted; they really helped take the edge off my arrival there. It was a new experience to be greeted so warmly and genuinely. And very quickly people took an interest in my welfare, and I was encouraged to get involved in the programming at the clubhouse.

One of the clubhouse staff suggested I come down to the craft group room and check it out. The women in the group welcomed me and started to suggest projects I could become involved in. With my clumsy guy fingers, I was learning to bead and knit. At first, I was a bit put off by the tasks, but then I began to gain skills, which encouraged me on. Making things with

my hands was something I'd never had an opportunity to do before. Through these activities, I began to rebuild my stamina, which I'd lost due to illness, and to acquire a newfound discipline to complete tasks.

After a few months, I joined the creative writing group, which offers members the opportunity to express themselves through the printed word. Here I found a real avenue toward wellness. The writing allowed me to express emotions I hadn't previously expressed, and to articulate my problems. The format of the group supported us to make ourselves vulnerable, without any negativity or backlash.

The group was run by a Stepping Stone employee, then by a student, and now I'm running the group as my way of contributing to the community. Usually we write in response to a prompt provided by the group facilitator. The creative writing group has a strong core membership, and we also have people who come and go. All are welcome.

Last October, the clubhouse issued a newsletter called *The Grapevine*. In addition to writing, we publish cartoons, paintings, recipes, sports write-ups and more. As one of the main editors, I take great joy in seeing the contributions of our members shape into a wonderful publication.

The clubhouse offers many other programs and events. They include personal development and wellness programs such as a Wellness Recovery Action Plan group, Toastmasters (public speaking and leadership skills), smoking cessation and harvest box distribution; and employment support such as job search assistance and supported work programs. Social and recreational opportunities include piano lessons, painting class, birthday celebrations, weekend outings and more.

Members experience some participatory democracy at the weekly membership meetings. We are encouraged to take part in the meetings, ask questions and comment on programming. We also share responsibility for the ongoing upkeep of the clubhouse facility.

Through membership at the clubhouse, I have gone from being unemployed, isolated and disenfranchised to functioning at an extremely high level. I have a part-time job in the private sector. I've made tons of friends; polishing my social interactions at the clubhouse has assisted me to make contacts and friends both in and outside the clubhouse community. My symptoms have reduced and my well-being has improved many-fold.

With combined services from Langley Mental Health (psychiatric treatment, group therapy, social worker services and referrals to other services), The Clubhouse (I still drop in a couple of times a week), and my new friends in the Langley community, I have become a happy, contributing member of society. Stepping Stone has had, and continues to have, a huge hand in my recovery. It has been not only necessary, but truly essential to my well-being. ▾

related resources

International Center for Clubhouse Development (ICCD), also known as Clubhouse International: www.iccd.org

Stepping Stone Community Services: www.sscss.org

Note: There are mental health clubhouses all across BC. Talk to your local mental health service provider to find one near you.

Peering Along the Path Toward Recovery...

Jude Swanson

I live with severe and persistent mental illness. I also live with a seizure disorder. And, I've been employed as a peer support worker (PSW) for almost 10 years.

When I meet another person who lives with a seizure disorder, there is immediately some connection due to our mutual understanding of what each other is going through. Our actual diagnosis and experiences about seizures are always different, but there are many commonalities that only other people living with seizures can understand.

Interacting with peers helps you realize you are not the only one with challenges and that you can help one another by sharing your life experiences. I often use my life experience with seizures to explain aspects of mental illness and peer support, since both seizures and mental illness have had stigma attached.

Peer support helps individuals share commonalities that can exist for people living with mental illness. And peer support can be a part of recovery from mental illness. When I say "recovery," I'm talking about a life process an individual engages in, leading toward personal life satisfaction.

I have progressed a ways down my path of recovery, and now have tools to help me live with my mental illness. It is this life experience with recovery (along with the six-month training program) that qualifies me to work as a peer supporter.

As a PSW, I work one to one with people on a variety of goals. Some

goals include reducing isolation, making friends, attending groups, taking transit and adjusting to a new neighbourhood. My peer and I meet for a two-hour weekly session and usually try to complete the goal in six months. Sometimes, the goal takes longer, or my peer may end up motivated to attempt another goal based on the success of the first one. All our meetings take place out in the community except for periodic review sessions where the peer and I meet with rehab/clinical staff to discuss how things are going.

Peers are referred to me either by their case manager and/or my supervisor, who is the occupational therapist at the community mental health team.

As a PSW, when I share my personal experience of living with mental illness with a peer, I am selective in what I share. I only share aspects of my experience if it will be of value for the peer. I don't share parts of my past that will not help my peer on their path toward recovery. For example: I live in the Downtown Eastside neighbourhood, but whether I'd share that fact depends on my peer. It helps some peers recognize I have

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Peer support can be a part of recovery from mental illness. "Recovery" is a life process an individual engages in, leading toward personal life satisfaction.

experience around the addictions issues the neighbourhood is well known for. Other peers, who have shared that they don't trust people who live in that area because they're all drug addicts, wouldn't be able to trust me.

Listening is one of the most important parts of peer support—I always listen to what my peer wishes to share. Careful listening helps me get ideas on how to support my peer. Many peers have shared that it was my listening skills that helped them trust me.

Each peer has a unique journey due to their different challenges, goals and strengths. My job is to be peer-centred. This means being an active listener and supporting them to discover for themselves their own path of recovery. It's not for me—or anyone other than my peer—to prescribe their path of recovery. That is not being peer-centred.

Frequently, I help peers adjust either to a new neighbourhood or city. Many newcomers to Vancouver have no idea where things may be and how to get around. I listen to my peers needs and interests. Then I can show my peer resources and transit routes that will help them feel more comfortable in their new neighbourhood. There isn't much point in showing where the coffee shops are if they don't drink coffee.

Another aspect of peer support is providing hope for peers who have little or no hope. I try to build hope via a strengths-based approach. Identifying a peer's strengths—which they may not even realize they have—can be used as the foundation for overcoming challenges or problems. For example, one 'problem' I have is that I'm a shy person. A strength I feel I have is that I like to help others. So, using my strength of wanting to help others, I have overcome my shyness—partly anyways! Helping peers to see themselves in a good light has helped me see myself in a good light.

What's important about using a strengths-based approach is being honest. As a PSW I never make up strengths to make a peer client feel better. And I don't pretend that there aren't challenges that my peer wants to overcome.

A common part of providing hope is that, as a PSW, I model living a life that peers want to emulate—they may want similar outcomes to mine. Peers come to realize they too, are capable of journeying down their own path of recovery, and outcomes similar to mine are possible. It feels amazing when a peer accepts that they have a future and feels hopeful—in part due to seeing themselves in what I have done on my path of recovery.

The best part of my job is reflecting with my peer on where on the peer was when we started and comparing that to where the peer is now. Over the decade I have worked as a PSW, I have witnessed some amazing things. For example, one peer shifted from expressing that he had no interest whatsoever in meeting with me, to agreeing to meet with me for a few sessions, to cheerfully meeting weekly. With limited support from me, my peer accomplished many goals, including moving to a new neighbourhood and getting a volunteer position. He is now able to accomplish much independently—but thankfully, we schedule a yearly review meeting where my peer shares recent progress in his life.

It feels great to get feedback from mental health professionals and family/supporters regarding the support I provided my peer. It is especially great to have my peer express their gratitude. I have been told on many occasions, by different peers expressing their gratitude: "I had given up. You believed in me before I did." But reflecting upon the progress my peer has made (with some support by myself and others) helps me feel that we all made a difference.

And making a difference is an important aspect of my own path of recovery. Through supporting my peers, I often end up being reminded of, or even developing a different perspective of, my own past. Also, I have to put my own struggles aside for two hours so I can focus on supporting my peer. ▼

Being peer-centred means being an active listener and supporting them to discover for themselves their own path of recovery.

Principles of Engagement

SUPPORTING OTHERS TOWARD CHANGE

Mark Goheen, MA

As caring people, we take notice when others in our lives appear to be caught up in doing things that are harmful (like misusing drugs) or avoiding what helps us be well (like exercise). For example, a person challenged with depression is drinking large amounts of alcohol on a daily basis, and this is clearly having harmful effects on their mental health.



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It is natural that this leads to concern, and it makes sense that we would encourage positive change. However, when workers and family raise their concerns about the drinking, this person gets angry at them. He or she argues that "it ain't hurting anything, and it's nobody's business."

This leads to a question: how can we best talk to, and engage with, a person who is caught up in something that is hurting her or him, but who appears not to be open to positive change?

Motivational interviewing provides some helpful directions.

Motivational interviewing

Motivational interviewing refers to the research, ideas and conversation skills

developed by psychologists William R. Miller and Stephen Rollnick. These can be applied in helping relationships where a person is caught up in behaviour that is harming their health, but who appears to be unwilling, unable or not yet ready to make positive changes.

It should be emphasized that motivational interviewing was developed to guide helping professionals in being more effective. In many cases, it may not be realistic or even helpful for friends and family members to "take on" this approach. A key reason is that professionals have a duty to develop helping relationships dedicated to the needs of the person served. A professional should not hold any personal

expectations of what needs to be listened to or understood by the person served. In families and friendships, however, there are shared needs. And in many families and close relationships, there is an understanding that the thoughts and feelings of each member deserve to be heard and respected.

With this caution in mind, motivational interviewing does provide some important ideas for anyone to consider when encouraging someone who seems reluctant to make a positive change.

Tips for the lay person

It can be freeing to let go of the idea of interviewing and instead think and act from the place of *dialogue* (two people talking). The notion of interviewing can be intimidating or lead to something more like interrogation: “I ask the questions; you give me the correct answers,” for example.

Further, letting go of the goal of *motivating* someone can help us be more effective. Often, the best way to motivate someone is to *not* try to motivate them.

There is strong research suggesting that, despite our best intentions, confronting or “lecturing” someone who expresses opposition to change, usually makes matters worse. Instead of motivating the person to change, it can lead to anger, fear and shame, and even make challenges, like depression or social isolation, worse.¹ It’s not uncommon for the person to dig in their heels even deeper. For instance, someone with a heavy drinking problem may feel overwhelming emotional discomfort when confronted, and this leads to increased drinking to make it go away.

Instead, Miller and Rollnick encourage helpers to focus more on their own *way of being* as a person, rather than trying to outwit and outplay others with slick motivation techniques and tricks.

Some principles for ‘being with’

Motivational interviewing describes four key principles that are proven to effectively guide our way of being when encouraging people to make positive change. These principles are not magic wands that will snap people into change, but serve as a framework supporting *engagement*—that is, when a person is committed, within a helping relationship, to meaningful exploration, discovery and change. Some signs of engagement include openness to discussing different points of view rather than defending one’s own, following-through on attending appointments, or taking an active interest in developing and working towards agreed goals. In therapeutic relationships, engagement is when both therapist and client are walking together on a shared same path. Helping relationships based on healthy engagement can open a door towards improved well-being.

1. Partnership

The first principle, partnership, emphasizes not taking on the responsibility of getting someone to change. Instead, we need to work *with* the person. We invite developing a way of *walking together*. For example, rather than saying “I need you to quit your drinking,” you might say “I need some help in better understanding what you’ve been dealing with...what life has been like for you lately...how alcohol fits in with what you’ve been feeling...please help me learn what this is about for you...”

2. Acceptance

This principle includes relating in a way that communicates to the person: “I am not here to judge or make you different ... I recognize and appreciate who you are, and I will work at finding a way to be with you as you are.” Of course, this is often easier said than done. It requires patience and letting go of judgments before they become roadblocks to good engagement. But when we don’t maintain acceptance, the person may experience judgment, shame and mistrust, which can lead to things getting worse.

3. Compassion

The third principle, compassion, is about *who we are* in the relationship. It means setting aside some of our needs—to be right, to be the expert, to reduce our own worry about the person’s behaviour, etc.—and giving priority to the needs of the person we are concerned about. Compassion flows from having our heart in the right place as we walk beside the person, dedicated to serving their cause. When we serve from a place of compassion, then trust and engagement can blossom.

4. Evocation

The fourth principle, evocation, focuses on drawing out the wisdom, strengths, ideas and preferences of the person. Rather than making it about *our* voice, we work toward *their* voice. For instance, instead of saying “you need to stop drinking because it’s harming your life,” we might get curious and ask questions like “what parts of your life are working?” and “in what ways does alcohol support what matters most to you?” or “based on your experience, in what ways might alcohol give depression more power over people’s lives?”

This kind of engagement isn't so much about you getting answers; it's more about inviting the person to connect to their own truth and perspectives. It opens doors for the person to connect more fully with their own wisdom, which can lead to genuine lasting change.

Taking care of yourself

No matter what our role, we are all human and maintaining this quality of patience and trust in the process of engagement is hard. For some, such as helpers and family who are closely involved, there rightly can be a lot of emotional energy around the concern (e.g., fear for the person's safety). In

related resource 

The third edition of *Motivational Interviewing*, by William R. Miller and Stephen Rollnick, was released in 2013. It offers a detailed practice framework, case examples and new perspectives from those described in the second (2002) and first (1991) editions.

such cases, it might not be possible to engage fully from the principles of partnership, acceptance, compassion and evocation.

Whatever our role, it's important to work toward engagement with a sense of acceptance and patience with

ourselves. "One step at a time" and "progress not perfection" approaches help support good engagement with someone who is having difficulty getting on the path of positive change. Using these approaches is an act of compassion towards ourselves. ▼

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people to 'fix' me, motivated me to take other programs to help me in my recovery. I looked for ways to improve myself and to cope better with my illness. I know I have to make my own positive choices on a daily basis.

The section on having a crisis plan is very important. I have written out my wishes in case I am hospitalized. I've specified what I would not want done for treatment and have listed medications I've had a bad response to or that wouldn't be an option for me for various reasons. I keep a record of my current medications and supplements up to date. I list the name and phone numbers of my doctors and my support people.

This information is included in my personal WRAP book, which I put together.

If I'm hospitalized, what happens when I come home is very important as well.

What will I need to help me feel better? What will make my feel worse and not be helpful? Who will I want involved in supporting me and helping with chores, meals and support? All this and more is laid out in the crisis plan.

By far the most helpful part of WRAP, for me, is the daily maintenance plan. This is a list of things I will do each day no matter how I feel. In addition to having major depressive periods, I often feel poorly due to dysthymia, a low-grade depression. So, the first item on my plan is that I will get up by 9 every morning. Previously, on days that I felt especially bad, I would roll over and go back to sleep. Then I'd awaken to find it was almost noon and would feel guilty and even worse. For me, this one act of rising at 9 a.m. sets the tone for the day. I may still feel crummy, but I put one foot in front of the other and stick to my plan.

The other things on my daily maintenance list are: take my meds, eat good nutritious food, eat three meals and drink six glasses of water daily, write in my journal, read my devotions and Bible, and pray. And I try and get out of the apartment every day, even briefly.

I feel passionate about WRAP because of the significant change it has made in my life. Because of this passion, I trained as a WRAP facilitator, to share with others the tools that have empowered me.

No, it isn't always easy, but I keep moving and do what I need to do. I suit up and show up. That, for me, is what recovery is all about. ▼

Resources from HeretoHelp

- **Managing a Mental Illness**—A series of info sheets to help you cope with a diagnosis, work your doctor, and prevent relapse. You'll find tips, strategies and activities to help you take control of your health. For more, visit www.heretohelp.bc.ca/factsheet/managing-a-mental-illness
- **Managing Depression**—A series of info sheets specifically for people who are diagnosed with depression. Learn more about coping with a diagnosis of depression, working with your doctor, and preventing relapse. For more, visit www.heretohelp.bc.ca/factsheet/managing-depression
- **Wellness Modules**—A series of eight info sheets that support well-being. Learn why mental health is important and build skills around managing stress, finding social support, solving problems, managing anger, sleeping well, eating well, and thinking well. For more, visit www.heretohelp.bc.ca/wellness-modules

Helping People who Use Substances:

A health promotion perspective

This info sheet from the Centre for Addictions Research of BC offers strategies and tips for people who support someone in changing their substance use. For more, visit www.heretohelp.bc.ca/factsheet/understanding-substance-use-a-health-promotion-perspective.

 This list is not comprehensive and does not imply endorsement of resources.

Psychosocial Rehabilitation Canada

PSR supports inclusion, recovery and well-being through advocacy, education, and knowledge exchange. You can connect with others, find research and other resources, and take part in events. For more, visit www.psrpscanda.ca.

Center for Psychiatric Rehabilitation

A US-based organization that provides research, training and consultation around recovery-orientated strategies and systems. You'll also find a library with articles, fact sheets, online courses, webinars, and other helpful resources. For more, visit www.cpr.bu.edu.

National Empowerment Center

A US-based organization that advocates recovery-orientated approaches to mental health systems. You'll find articles and guidelines, recovery stories, and other helpful resources. For more, visit www.power2u.org.

The Framework for recovery-oriented rehabilitation in mental health care

This framework from South Australia Health supports individual journeys to wellness. You'll find key messages and evidence-based strategies around care and recovery, social determinants of health, partnerships, and safety. For more, visit www.sahealth.sa.gov.au and type 'framework for recovery' in the search box.



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