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Now happily married and in a profession that brings him joy, the author recalls his battles with mania and severe dyslexia and his years cycling in and out of hospitals.
Cheryl Toland describes her professional transformation as “cathartic.”

After four years as a case manager with the Lenape Valley Foundation Assertive Community Treatment (ACT) team, Toland switched roles to become the team’s certified peer specialist (CPS).

It was a big step. Disclosing to her colleagues that she had a history of mental illness, she enrolled in a peer specialist certification course, graduated, and assumed her new role on the team. Toland said she immediately found herself relating to clients – and colleagues – from a dramatically new perspective. “I think it empowered me, and it moved me to the next level. Now I value my own life experience in my work.”

JoAnne Davis, director of the Lenape Valley Foundation ACT team, agreed, adding that Toland’s transition – personal and professional – made her even more of an asset to the team and the people it serves.

Working from the peer perspective, “Cheryl has an innate sense of where the client is, and I appreciate and respect that,” Davis said. “Cheryl instills hope, because she is a living and breathing example of what recovery can mean.”

Toland, who publicly acknowledges a history of disabling depression, noted: “I have been in that place with no hope or sense of purpose, and I know that there can be that ray of light – and the sense of purpose can be part of recovery also.”

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Rapid Response, Intimate Approach: ACT Teams’ Success Prompts OMHSAS Initiative

By Joseph C. Yaskin, MSS, LSW

Cheryl Toland, a certified peer specialist with the Lenape Valley ACT (Assertive Community Treatment) team, knows that small details of daily life can have transformative effects for individuals struggling toward recovery.

Take, for example, the haircut. “A man I work with who was having a really hard time with his symptoms, he was discouraged,” Toland recalled. “I visited him at his apartment one day, and he was pretty disheveled. It was clear that one thing he needed was a boost. So I gave him a haircut, right over the sink. He said, ‘Do you like it?’ I said, ‘Yeah.’ And people started reacting to him differently, and that gave him a sense that he might be worthwhile, and he started taking care of himself.”

Intimate and Intensive

The success of ACT – an intensive model of community mental health treatment and support services rapidly spreading across the nation – is usually attributed to intensive treatment brought to an individual’s home by a multidisciplinary team, available 24 hours a day, seven days a week.

But the story of Cheryl’s haircut intervention suggests another factor that accounts for ACT’s replicable success in supporting people with histories of repeated crises and multiple psychiatric hospitalizations: ACT teams’ interactions with those they serve are as intimate as they are intensive. Team members – whose backgrounds and training include social work, rehabilitation, counseling, nursing and psychiatry – notice and address subtle but important problems and needs. Then they share this information with ACT teammates at a daily meeting that is an important component of this demanding model of community care. Among the services ACT teams are required to provide are service coordination by an assigned service coordinator/case manager; 24-hour crisis assessment and intervention; symptom assessment and management; medication prescription, administration, monitoring, and documentation; dual diagnosis substance abuse services; employment services; activities of daily living; social/interpersonal relationship and leisure-time skill training; peer support and other support services; and education, support, and consultation to families.

JoAnne Davis, director of the Lenape Valley Foundation ACT team, said that this intensive model addresses the service fragmentation that allows the most vulnerable individuals to fall through the cracks of even the best community mental health systems. “One of the significant recovery-oriented aspects of an ACT team is that the consumer has a relationship with everyone on the team,” Davis said. “If I go on vacation, other members of the team support the person from a knowledge base that we share.”

“The continuity and follow-through that result are among the most significant things consumers cite as a reason why ACT works.”

The ACT model is controversial in many states because the teams can be assigned to ensure that individuals in the community who are subject to a judge’s outpatient commitment order adhere to its requirements. However, Pennsylvania’s outpatient commitment statute is inconsistently invoked across Pennsylvania’s counties; Pennsylvanians supported by ACT teams participate voluntarily.

Past Efforts, Future Expansion

ACT’s core approach is not new in Pennsylvania. The Community Treatment Team (CTT) model of intensive community care was intended to be similar to ACT, although implementation varied, which compromised results.

The campaign of the Office of Mental Health and Substance Abuse Services (OMHSAS) on behalf of ACT implementation across the state is rooted in an internal review of community mental health models three years ago. This review resulted in a white paper, Strategies for Promoting Recovery and Resilience and Implementing Evidence Based Practices, released by OMHSAS in October 2006.

Recognizing the potential for ACT to successfully support recovery and community integration for people... continued on page 4
who were failing under existing community programming, OMHSAS initiated a technical assistance and quality management program. While OMHSAS’ broader goal is to make fidelity-based ACT programs available universally in the state, the immediate focus of the technical assistance initiative is on ensuring that current CTT/ACT programs meet the standards of fidelity, said Carol Ward-Colasante, OMHSAS division chief for planning and program development. (By late 2009, according to Ward-Colasante, ACT was widely but not universally available in Pennsylvania: there are currently some 43 ACT teams serving about a third of its 67 counties.)

The first phase of statewide program implementation was to contract with a consultant to train Pennsylvania ACT programs. The Program of Assertive Community Treatment (PACT) in Madison, Wisc., created ACT as a research program in the early 1970s and continues to research and provide effective services for persons with severe and persistent mental illnesses. Rutkowski worked at PACT in the late 1970s, developed and ran an ACT team, and was the lead clinical consultant and trainer for the Wisconsin Office of Mental Health.

PACT has helped communities in 48 U.S. states and many other nations establish ACT services that adhere to the national standards for the PACT model. In 1998, The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-up, which included the national ACT standards, was published, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The manual was authored by Deborah J. Allness, MSSW, and William H. Knoedler, MD, who were among the creators of the model.

Leadership Is Key

Effective team leadership is one of the most important factors in the success of an ACT program, Rutkowski explained.

The organizational structure of the program is consumer-centered, as all staff schedules are directed by consumers’ individual plans. The daily team meeting is the central vehicle for staff communication and team supervision. All staff members attend, and review each consumer’s status along with other team members.

Peer Specialists...

In retrospect, Toland said she felt stifled by self-imposed constraints and the limitations of her previous job. “Now, I am more open with clients about my experience, and I try to use my experience to motivate or encourage them. It helps build confidence. The client benefits and I benefit – I have grown tremendously as a person.”

Some ACT programs in Pennsylvania have included consumers in paid positions for almost a decade, said Kim Patterson, director of program development and management for Allegheny HealthChoices Inc. The professionalization of peer support with the CPS model is likely to accelerate the inclusion of consumers on ACT teams across the state, she said. “The teams I visit around the state vary in how they use peers, but I think [certification of peer specialists] will help standardize roles but hopefully not limit the creative use of individual peer skills.

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with the previous day’s activities. “Our team goes through 144 clients every
day,” Rutkowski said. “The Team
Leader monitors service provision, and
provides an opportunity for team
members to share their immediate
clinical assessment. During the meeting,
we continuously monitor how people are doing and, if they are ex-
periencing difficulty, we make immedi-
ate changes to the plan, based on that
daily feedback.”

Rutkowski noted that effective
leadership ensures strong team inte-
gration and fidelity to the ACT model,
two characteristics common to pro-
grams with the highest rates of suc-
cessful outcomes. Another role of the
team leader that ensures fidelity is as-
serting the team’s needs with the pro-
der and the region’s community
mental health system.

**Overcoming Structural Barriers**

Community mental health systems
implementing ACT teams face a vari-
ety of challenges in creating and main-
taining a service that achieves the out-
comes associated with adherence to
the original model. The statewide
technical assistance effort was de-
signed to address both implementation
and fidelity issues.

Mary Fleming, CEO of Allegheny
HealthChoices Inc. (AHCI), a non-
profit that provides consultation and
training to mental health providers in
Allegheny and surrounding counties,
explained some of the challenges in-
herent to ACT implementation.

“The ACT team does not auto-
matically fit within the policies and
procedures for agencies,” Fleming
said. One challenge is that compensa-
tion must reflect the demands of re-
sponding at night and on weekends;
but a provider’s job titles and salary
guidelines can be barriers to this.
Procurement policies are another struc-
tural issue. Fleming said that a late-
night response to a crisis – say, a fight
with a roommate – may require an
immediate cash outlay for a night in a
motel room. There is no time for the
agency to approve a purchase order,
she explained.

Kim Patterson, who coordinates
ACT implementation and fidelity
improvement for Allegheny County,
commented: “When you give an ACT
team the challenge of keeping people
out of the hospital while engaging
them in their recovery, service and
funding gaps are quickly identified
that, in turn, push the funder and
provider system to change to meet
people’s needs and wants.

“Everyone understands that en-
gagement is a crucial part of ACT,
[which] means that staff must be
given the flexibility needed to meet
people where they are,” Patterson
continued. “Evening and weekend
coverage, flexible and immediate
funds, and quick access to housing,
respite, and crisis services must be
immediately available. Engagement
works because the team can be very
helpful very quickly.”

Patterson, director of program
development and management for Al-
legheny HealthChoices, continued:
“Teams work with individuals to de-
velop short- and long-term life goals
but assess in 24-hour timeframes what
people need. Sometimes it might be a
bag of food, or a night in a hotel for
somebody who is homeless, or job
coaching for someone who works third
shift and weekends, or to go out for a
coffee at 3 in the morning with the
therapist or the peer specialist for a
person in crisis.” “All this is very ex-
pensive,” noted Mary Fleming, adding
that she does not expect ACT to be
available in all regions of the state. “A
lot of systems [in rural counties with
sparse populations] will simply say
they can’t afford it.” However, rural
regions can adopt a team approach
that incorporates the philosophy of
ACT and most of its methods, she said.

There is disagreement about the
feasibility of ACT in sparsely populated
areas, said Rutkowski, the national ACT
rural area, people are used to creating
their own resources, and that is what
ACT is all about.”

Rutkowski said that outcomes are
compromised when ACT teams oper-
ate in systems that fail to create the
flexibility required. For example, she
said, there is “windshield time”: Team
members in rural areas spend signifi-
cant time driving to clients spread
across a wide geographic region, so the
provider has to accommodate employ-
ees who spend less time in the office.

**Fidelity to National Standards**

OMHSAS is working to improve
fidelity to national standards, with
efforts to find out what counties and
providers need. “We are asking all
counties to do a fidelity action plan,”

…”Pennsylvania is doing this right.”

**JoAnne Davis, LSW, ACSW**

Director
Lenape Valley Foundation ACT Team

consultant: “There is less adaptation
[necessary] than you would think, and
the standards permit minor modific-
tations. Having run an ACT team in a
rural area, I think the model can be
more easily implemented [compared to
urban regions],” “That is because, in a

…” continued on page 6
said Benny Varghese, OMHSAS planning section chief. “The fidelity action plans will tell us what they need and what is available.”

Patterson of AHCI said she has seen fidelity problems firsthand. The problems start small, she said: “A team can start out following the model; but, within six to 18 months, deviating from the model can cause the team to completely derail movement toward fidelity to the standards.”

Data from the county fidelity action plans will frame future phases of OMHSAS’ technical assistance efforts. “In partnership with the counties, we will decide on the content of the technical assistance,” said Ward-Colasante. “We will identify four teams [as pilot projects]. They will receive extensive training and possibly funding, and the work with them will involve the national consultant [Rutkowski] and the in-state consultant.”

“ACT develops individualized services around and with the person.”

As statewide implementation of ACT approaches, OMHSAS will require counties and managed care organizations to audit ACT teams annually for fidelity to national standards.

Pennsylvania’s approach contrasts with how ACT is often implemented elsewhere, Rutkowski noted. “People attempt systems change all the time; but they don’t collect the data, they don’t put together the action plans and training that each program needs to implement ACT,” she said. “A lot of states just say, ‘Let’s implement ACT,’ and they move forward without looking at the outcome data, without providing the technical assistance to support fidelity. So they don’t get the outcomes they expect. But Pennsylvania is doing this right.”

**Assertive Community Treatment Fills Gaps When Intensive Supports Are Needed**

What differentiates Assertive Community Treatment from previous practices intended to help individuals with mental illnesses and complex needs live successfully in the community?

The difference is connection, say consultants supporting the Office of Mental Health and Substance Abuse Services’ (OMHSAS’) technical assistance initiative to implement ACT across the state.

While previous models, such as Targeted/Intensive Case Management, were intended to bring a wide range of services to the consumer, fragmentation remained. “ACT addresses flaws inherent to that model of community care, [which was] considered a best practice in community mental health in the 1980s,” said Patricia Rutkowski, a consultant to OMHSAS on the PACT model (see story on Page 3). Although community care attempted to integrate all service provision, “fragmentation still occurred,” she said. “Even with a capable case manager, there often was not a fixed point of responsibility coordinating all aspects of service provision.”

The “brokerage” model of community care, usually implemented through targeted/intensive case management programs, only went halfway. “There are people who will not be well served by traditional case management. ACT develops individualized services around and with the person, in the location they need them, such as in their apartments or on the job site. This mobile, intensive, and comprehensive service delivery helps address the tendency of people to get lost in the shuffle, or drop out of services.”

JoAnne Davis, director of the Lenape Valley Foundation ACT team, said that intensive/targeted case management did not prevent many of the most vulnerable people from falling through the cracks between multiple service providers or after discharge from a hospital. “Many people have had experience with prescriptions in their hands and an appointment in two weeks [to see a case manager], and they may not be able to fill the prescriptions or get an immediate response to a crisis,” she said — or they might miss the appointment altogether.

Traditional case management and other services often did not address people’s needs comprehensively or flexibly. For instance, most persons with serious mental illnesses were not offered appropriate, individualized vocational services. “Competitive employment is extremely important for recovery; and, for many folks, the more traditional services did not work,” Rutkowski said.

Kim Patterson, director of program development and management for Allegheny HealthChoices Inc., has tracked outcomes of ACT teams operating in Allegheny and other counties for several years. The data validates the effectiveness of the model compared to targeted/intensive case management. “As we saw the teams develop and operate as all-inclusive services,” Patterson said, “we saw utilization of other, more intensive services decline, like reduced use of corrections, reduced rates of hospitalization admission, and shorter tenure of hospitalizations.”

— Joseph C. Taskin
Workgroup Submits Recommendations to Improve Services to LGBTQI Community

By Melissa DiPento

On July 20, 2009, in Harrisburg, Deputy Secretary for Mental Health and Substance Abuse Services Joan L. Erney was formally presented with recommendations on how to improve behavioral health services for the lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQI) community. The document, Issues of Access to and Inclusion in Behavioral Health Services for Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Consumers, was the product of a workgroup that grew out of activists’ efforts to improve how members of the LGBTQI community are supported in working toward recovery from behavioral health challenges.

Erney, who has been actively involved since the project’s earliest days, urged quick action on taking the recommendations from theory to practice. She said she was pleased with the progress that had been made, and with the number of willing partners who seem ready to step up to the plate. “The role of the state and our group of advisors is to set the stage, respect the individuals and offer them guidance and support,” Erney said. “I think that this administration . . . would really embrace this work, and so we are feeling some urgency to try and really get things started before this administration is over” in January 2011. “We would like to make some significant steps.”

The initiative’s three main goals are “to protect LGBTQI consumers from discrimination and mistreatment,” “to ensure that OMHSAS [Office of Mental Health and Substance Abuse Services] and contracted providers provide culturally affirmative environments of care for LGBTQI consumers,” and “to ensure clinically competent behavioral health care for LGBTQI consumers.” It is widely agreed that current practice falls far short of these goals.

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about traveling from Erie to Pittsburgh just to see a therapist.

“He spent an entire day with the travel and the wait time just to find someone who was trained, clinically competent and understood some of the things he was going through. And that’s just unacceptable,” Cisneros said.

“We really need to have clinically competent providers that are accessible to folks without having to have them travel across the state to get there,” she noted.

Virginia Dikeman, an OMHSAS representative to the workgroup, added that while the large cities are gaining more and more competent providers, some of the less-populated areas in the state are still lacking in policy standards. “When you get into some rural areas,” Dikeman said, “it becomes difficult to find treatment.”

**Genesis of the Workgroup**

In mid-2008, LGBTQI activists Mark Davis (the founding president of the Pennsylvania Mental Health Consumers’ Association [PMHCA]) and facilitator of the Pink & Blues, a Philadelphia peer-run support group for LGBTQI individuals in recovery from psychiatric disabilities) and Michael Lewis (the Philadelphia Department of Behavioral Health’s liaison to LGBTQI communities) approached Deputy Secretary Erney, requesting statewide support on improving behavioral health services for LGBTQI individuals. Erney responded quickly, asking Carol Ward-Colasante, OMHSAS division chief for planning and program development, to work with Davis and Lewis. The three decided to pull together a workgroup whose purpose was to assist OMHSAS in developing and implementing a statewide LGBTQI plan of action for the Pennsylvania behavioral health system, including seeking input from regional stakeholder forums. The workgroup was to be composed of individuals who represented LGBTQI issues across the state and would include a minimum of 51 percent consumers and/or family members.

**“Invisible” and Unsafe**

“The motivation for this initiative is based on the exclusion of people from LGBTQI communities in the 2003 report of the President’s New Freedom Commission on Mental Health and the National Strategy for Suicide Prevention,” Davis said. “We were an invisible culture with no consideration for our right to receive quality safe and affirming services. I was never comfortable being an out gay man in mental health services, nor was it safe to be an out mental health consumer in LGBTQI communities.” He added that the initiative will also have an impact on the workplace: “Workers need a safe, affirming environment to work without fear of discrimination.”

The group began meeting in early 2009 to draft the recommendations. Michelle Kline, the director of the Bryson Institute at the Attic Youth Center, Philadelphia’s only LGBTQI youth center, said she was glad to be included. “The most important thing for me is that we are putting forward a plan to equip providers with the structure, knowledge, resources, and support that they need,” Kline said. “Hopefully these factors will assist them in feeling safe at work themselves and also help prepare them to serve whoever comes through their door.”

**Recommended Actions**

The recommendations also include a list of priority actions, such as: “By 2010, adopt a Non-Discrimination Policy that includes sexual orientation, gender identity and expression, and a policy clarifying that OMHSAS does not endorse or pay for so-called conversion therapy.” (Editor’s note: For the other priority actions, see the document at the link at the end of this article.)

Ward-Colasante suggested that some of the recommended actions would be inexpensive and simple to implement. “Some of it is just messaging: It’s telling folks to do things differently or stop doing things that are harmful. One of the recommendations is to issue a policy against conversion therapy, which is thinking you need to change people – and all that takes is saying we really don’t support it or we won’t fund it because we don’t think that’s a good practice. That can be done fairly easily,” Ward-Colasante said.

A steering group – composed of Cisneros, Davis, Lewis, Ward-Colasante, Dikeman and a facilitator – was created to keep OMHSAS updated on the workgroup’s progress and to provide the group with additional support. The facilitator is Rebecca Subar of Rebecca Subar Management Consulting in Philadelphia; she was hired by the UPenn Collaborative on Community Integration, which has partnered with OMHSAS to fund the initiative.

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“It amazes me that it has taken this long to get where we are today, yet I feel blessed that we have emerged from our closets to be out and proud in our recovery.”

Implementation Phase

Subar said the steering group continues to advocate the recommendations and is working on ways to fund the proposed goals. “We’re now beginning the implementation phase under a spanking new name: the Keystone Pride Recovery Initiative (KPRI). We are working to encourage and support OMHSAS in making the policy changes we’ve recommended,” she said. Implementation includes the steering group’s ongoing effort to train providers on the best practices in behavioral health services for the LGBTQI community. Subar also stressed the importance of making sexual orientation and gender identity part of data collection.

The steering group is continuing to solicit grant money from private foundations. And, she added, “We’re delighted that we have gotten some grant money from OMHSAS and the Gill Foundation State Equality Fund.” Through a PMHCA/KPRI partnership, the group is also applying for a statewide organizing grant from the Substance Abuse and Mental Health Services Administration. “We are seeking federal dollars to get the best bang from OMHSAS’s investment,” Davis said. In-kind support, including supplies and equipment, has also been forthcoming, most generously from the Persad Center in Pittsburgh, which calls itself “the nation’s second oldest licensed counseling center specifically created to serve [the] gay, lesbian, bisexual and transgender (GLBT) community.”

The activists expressed how excited they were to see these recommendations put into action. “Just the prospect of people in the LGBTQI community being treated with dignity and respect and given the treatment they have the right to receive . . . it is incredible,” Cisneros said.

Deputy Secretary Erney – whom Subar calls “a real champion of the cause” – said she is optimistic about the forthcoming changes. “I think that the first change will be that there will be an open discussion and that individuals will feel that they have a voice to be able to insist that they have access to competently trained resources to help support them,” she said. It is important, she added, “to be able to feel that you can raise your voice and it should be heard and listened to and accommodated.

“The second is that we could actually have some resources available – being able to really have a base of support. The third is that we actually can end discrimination. We’ve been working on a lot of fronts for a long time, so we hope to make a difference in this way. I think there are reasons to be optimistic,” Erney said.

Added Davis, “It amazes me that it has taken this long to get where we are today, yet I feel blessed that we have emerged from our closets to be out and proud in our recovery.”
Only Love Can Heal
By Matthew Groff

This is the fifth in a series of first-person accounts of recovery featured in People First. While recognizing that each individual’s pathway to recovery is unique, we hope that these stories might inspire others who are on their own recovery journeys.

In high school, I had a reputation as an “absent-minded professor”: I would bump into lockers or bang my shoulders on the frames of doorways while walking lost in thought. This would send my large stack of books flying, the dog-eared papers in my rat’s nest of a notebook scattering everywhere.

I carried deep dark secrets that I believed no one knew. As far back as the fourth grade, I have memories of feeling as though I just wanted to die. It may seem strange that a fourth grader could have such thoughts. I knew these feelings were irrational; I knew of fellow students whose lives seemed far crueler than my own. In fact, for some reason, these individuals seemed drawn to me, telling me of their traumas. I could not understand why. I had no answers; all I ever did was to listen and ask questions. My challenges and setbacks seemed so minor compared to theirs that I was ashamed to share my dark thoughts and feelings, even when they were sharing theirs with me.

In college, I took a placement test to get into the honors section of freshman chemistry and I had the highest score ever for an incoming freshman. A fellow student who had heard of my score asked for my help. He never went to class; he just read the books and took the tests. He was just not getting the nuclear magnetic resonance thing, which was about interpreting graphs of peaks and valleys into chemical structures. We studied together for six hours before the test and he received the highest score in a class of 300 honors students. I received a D on the very same test. I taught him everything he knew about the subject but, with the clock running and a pencil in my hand, it just did not matter.

Essentially, I could not read. Decades later I was diagnosed with Scotopic Sensitivity Syndrome, a kind of dyslexia: Each sentence would travel across the page like the crest of a wave and I would feel a sense of motion sickness and fatigue. Written assignments were nightmares that would be the source of actual nightmares for years. I stopped going to class; I spent my time helping others study and supporting them as they did their work.

The strange thing is that my friends never seemed to know I was failing all of my classes. They never knew that at times I just wanted to die. They were very willing to share their challenges and traumas, sometimes until 2 o’clock in the morning, but I was not willing to share my own. Mine seemed so insignificant by comparison that I felt ashamed.

I started dating my first girlfriend ever. As we were getting closer, she started asking questions I did not want to answer. After we broke up, I found out that she suspected I was suicidal and felt she needed to place some distance between us for her own protection, just in case.

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My parents called around this time, late in the second semester. They had seen my grades and encouraged me to find work and a place to live. If I was too lazy and undisciplined to succeed at college in spite of all my obvious gifts, I was not going to come home and sponge off them. The world seemed to have nothing for a person with my challenges – not even pity.

I was on the Honors Cabinet at the University of Pittsburgh; I had keys to the Cathedral of Learning (the centerpiece of the Pitt campus); and, even after hours, I had access to “the highest classroom in the Free World”: the Honors Suite on the 34th floor. There, late one night, I stood on a window sill, picked up a phone, and called the closest friend I had ever had. I asked him to give me a reason not to jump. He drove from his home to the campus. Later, I did the math: He must have averaged over 100 miles per hour. I am ashamed that I had anything to do with putting his life, and the lives of others, at risk. Yet, without that phone call, I might not be here today.

He met me in the Honors Suite and took me to his parents’ home, where he lived. During the three days I spent there, I came to realize how much I meant to him and how much what I had considered doing would have hurt him. But, when he revealed that his feelings for me were more than platonic and suggested that we move in together, I had to tell him that I could never return those feelings and that I needed to start a life of my own.

I found a job and a place to live back in Lancaster, Pennsylvania, where I was born. At times, I was riding my bicycle to three different jobs to save money to buy a car. I was abusing every kind of legal stimulant I could find: Speedo bathing suit to celebrate my “six-pack abs” but I never had a chance to wear it in public because I was very heavy during college but, in the nine months after I left Pitt, my waist went from 48 to 32 inches. I bought a Prolixin, Haldol, Stelazine and Mellaril in addition to various antidepressants, anti-anxiety agents, and lithium. Lithium was the only medication that seemed to have any lasting benefit and, although I would try to wean myself off the others as quickly as I could, I took lithium for 24 years.

Between hospitalizations, I dug ditches, cleaned toilets, or did whatever other low-paying job I could find in order to pay my rent and buy groceries. In 1990, in a respite bed of a Community Rehabilitation Residence after my seventh hospitalization, I met Diana, the woman who seemed to have nothing for a person with my challenges – not even pity.”

This gave me the drive and determination I had always felt I was lacking, but I started becoming obsessive about working out and restricting my food intake. I had gotten very heavy during college but, in the nine months after I left Pitt, my waist went from 48 to 32 inches. I bought a Speedo bathing suit to celebrate my “six-pack abs” but I never had a chance to wear it in public because I was beginning to have new problems. I did not want to eat. I could not sleep. I started to believe people could read my mind and I could read theirs. I started to think I had superhuman intellectual powers and that the fate of the human race depended on how I chose to use these powers. The conversations in my head were becoming “loosely associated,” long chains of strange conclusions building upon themselves.

One day, driving to one of my three jobs, I realized that I did not know where I was or how I got there. I pulled over to a pay phone and called a hospital. When they asked my name, I just could not come up with it. They asked if I had a driver’s license and if I could read my name off that, and that worked. I took an ambulance ride to a community hospital, where I met my first psychiatrist of many. He placed an involuntary commitment form in front of me: It said I had lost touch with reality. “Reality? What is reality anyway?” I asked. “That’s my point; sign here” was the reply. Apparently, a psychiatric ward is not the place to wax philosophical.

This was the winter of 1984. During the next seven years, I had seven community hospitalizations for “manic episodes with psychotic features.” I was on Prolixin, Haldol, Stelazine and Mellaril in addition to various antidepressants, anti-anxiety agents, and lithium. Lithium was the only medication that seemed to have any lasting benefit and, although I would try to wean myself off the others as quickly as I could, I took lithium for 24 years.

Between hospitalizations, I dug ditches, cleaned toilets, or did whatever other low-paying job I could find in order to pay my rent and buy groceries. In 1990, in a respite bed of a Community Rehabilitation Residence after my seventh hospitalization, I met Diana, the woman who later became my wife. I have not needed hospitalization or any medication other than lithium since then. Love heals.

After losing my thyroid gland, as many who have taken lithium for decades have, I decided it was time to try to get off this medication. Previous attempts had landed me back in the hospital and I had much more to lose this time. I decided I needed to take it slow; I needed to give my body and mind time to adjust. I needed time to learn life skills to compensate.

I took the Wellness Recovery Action Plan (WRAP) training. I had key supporters who were given warning signs to look for and criteria for deciding when things were breaking down. I had committed to honoring their advice if they told me to restart my medication or sign in to a hospital, even if I did not think it was necessary. It took three long years to decrease my dose from 2,400 milligrams a day to zero, but I have been lithium-free for 20 months while working full time during that whole period. I feel more in control of my life than I ever have. Today I work full time for the Pennsylvania Mental Health Consumers’ Association as a recovery specialist to help others like myself achieve their own dreams.

“I feel more in control of my life than I ever have.”
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