

NEWS AND FEATURES FOR THE CONSUMERS, SUPPORTERS AND PROVIDERS OF PENNSYLVANIA'S BEHAVIORAL HEALTH SYSTEM

PEOPLE FIRST

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PEOPLE FIRST

Volume 19, Number 1

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COVER PHOTO: Colorful trees by Allegheny River in Pennsylvania

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An Innovative Program Brings Integrated Wellness to Pennsylvania

By Elisa Ludwig

In a system where behavioral health and physical health services operate separately, too many people with mental health problems have lacked access to good physical health care and vice versa. “The fact that consumers on average have a shorter lifespan [by] 25 years is a startling statistic – one that we are taking very seriously. We welcome the opportunity to improve the quality of health and life for our members,” said LeeAnn Moyer, deputy administrator of behavioral health for Montgomery County. “Integrated health care has been the missing link in our recovery-oriented system of care, which I believe is the core essence of the HealthChoices Program,” Moyer said. (HealthChoices is Pennsylvania’s mandatory managed care program for Medical Assistance – Medicaid – recipients.)

Two years ago, the Center for Health Care Strategies (CHCS), a non-profit organization that works with Medicaid stakeholders across the country, approached four states, including Pennsylvania, to develop cost-effective strategies to improve the quality of care for high-need, high-cost populations.

Demonstration Projects

The Pennsylvania Department of Public Welfare (DPW) has developed two Rethinking Care demonstration projects: HealthChoices Health Connections is the program in Bucks, Montgomery and Delaware counties; Connected Care is the Allegheny County program. Both demonstration projects work specifically to address a long-held vision in the health care

arena – that physical and behavioral health care should be better coordinated for improved wellness.

“When CHCS came to us about finding a project, we insisted on serious mental illness as the area on which we wanted to focus,” said Ivonne Bucher, chief operating officer and associate clinical director of the Office of the Medical Director at the Office of Mental Health and Substance Abuse Services (OMHSAS) in Harrisburg. “Proportionately, this population uses a consistently high level of behavioral and physical health resources compared to other populations.”

High rates of smoking, poor nutrition, lack of exercise, metabolic syn-

drome (which is associated with an increased risk of cardiovascular disease and Type 2 diabetes), substance dependence, psychotropic drugs, poor access to health care and an overall lack of coordination among mental and physical health care providers contribute to shorter lifespans among people with serious mental illnesses.

Stronger Connections

The Department of Public Welfare (OMHSAS and the Office of Medical Assistance Programs) and the Center for Health Care Strategies saw an opportunity to begin to address

that problem by creating stronger connections in the health care system – among counties, health plans, providers, departments and, most especially, consumers.

“In the area of health care, integration has risen to the top of the priority list for us,” said Allison Hamblin, director of complex populations at the Center for Health Care Strategies in Princeton, N.J. “There’s a great opportunity to improve the quality of care in clinical outcomes for people floating between the two systems. And an absence of coordination has cost implications due to events such as otherwise-avoidable hospitalizations. Improved coordination through better exchange of information between sys-

“Integrated health care has been the missing link in our recovery-oriented system of care.”

tems can help with both quality and cost.”

The Rethinking Care program has zeroed in on a target population of adults 18 and older who are not in the Medicare program and have a diagnosis of serious mental illness (defined as schizophrenia, bipolar disorder, depressive disorders and borderline personality disorder). Participants are assessed on a quadrant with the following risk categories: high physical health/high behavioral health; high physical health/low behavioral health; low physical health/high behavioral health; low physical health/low behavioral health. Assessments can be

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coordinated at either a physical health “home” or behavioral health “home,” depending on the member’s choice. The point is that a “home” for records, decision-making and coordinating care needs to be established.

Structure Varies

The program is designed to accommodate the specific needs of the participating counties, so the exact structure of the program varies by county.

In Montgomery County, for example, a case coordinator for both plans is assigned to coordinate between the health care plans and the providers. An administrative navigator works on the behavioral health side to coordinate between the provider, the plan and the county.

Finally, a navigator works to establish a relationship and partnership with

“The program is designed with consumer input, for consumer engagement, to drive education and empower consumers to participate.”

the member to develop a wellness plan. Development of this plan includes the member’s health care providers, family and friends and any other person(s) identified by the member. In this plan, the members identify their wellness goals.

In Allegheny County, the “navigator” role is played by a “wellness advocate” who works with the treatment team to make sure everyone is on the same page. This role can be filled by whomever the consumer designates; it could be a family member,

friend, provider or another representative.

Across counties, however, the program’s stated goals and desired outcomes are the same. A significant pillar of the

program is active consumer involvement, in keeping with the recovery model. “The program is designed for consumer engagement, to drive education and empower consumers to participate,” Bucher said.

Data Coordination

Another pillar of the program is data coordination – a major challenge in the current health care model. For the purposes of the program, DPW established

codified guidelines for sharing information within the framework of existing regulations and laws. Thus counties have a model that integrates and maintains data between physical health and behavioral health care providers.

With member consent, physical and behavioral health plans have created a single member profile that is updated regularly and allows the navigator and provider to review both sides of the consumer’s care at a glance.

The program is also focusing heavily on making sure consumers’ medical doctors are kept abreast of the medications they are taking or discontinuing to avoid mistakes, interactions and side effects. Discharge coordination is another of the program’s areas of oversight and increased communication.

First-Year Goal

The goal for the program’s first year was to develop an integrated care plan or member profile for 2,000 members across the participating counties by June 30, 2010. The second-



“People tend to be intimidated when confronted with the health care system, and we’re helping them find their way through it.”

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year goal is to produce specific outcomes, including reduced hospitalizations and inappropriate emergency room use.

One of the biggest challenges in the program's first year has been the consent process. "This program is part of the recovery-oriented model and we want the consumer to be informed throughout the process," Bucher said. "By the very nature of the project we need to coordinate and share data, so consent is critical."

So far, while counties have varying numbers of enrollees, administrators report positively on the program's progress. "We have not had enough

system, and we're helping them find their way through it."

Administrators are also finding that the pilot has been a great way to learn more about the specific barriers mental health consumers face in accessing physical health care, and vice versa. "We've found out that there are many people presenting with physical health problems that have not been able to address their physical concerns due to underlying behavioral health issues," said James Schuster, chief medical officer of Community Care Behavioral Health Organization (CCBHO) in Allegheny County. "By pulling both treatment systems to-

bipolar disorder and a co-occurring history of dependence on alcohol and cocaine. In the year before she started with the program, she had a 16-day inpatient stay for mental health treatment, two crisis interventions, and 15 emergency room visits, most of which Keystone Mercy Health Plan would consider "inappropriate emergency department utilization." She had seen 14 specialists for conditions including diabetes, heart failure and esophageal reflux. She enrolled in July 2009. Since then, she has not been admitted to the hospital, nor has she had any inappropriate emergency room visits.

The program was able to implement true integration of the physical and behavioral health systems last fall. Jennifer had gone to her primary care

"There's a lot of enthusiasm about seeing this program succeed."

experience yet to know for sure whether we have significantly reduced inappropriate use of hospital and ER [emergency room], but we have some very promising information and are encouraged by what we've been beginning to see in the data patterns," Bucher said.

Going Forward

Jonna DiStefano, administrator of the Office of Behavioral Health in Delaware County, said her office is moving toward permanently integrated health care, regardless of whether the pilot succeeds. So far, the county has 244 consents and DiStefano is thrilled. "It has been a learning experience and very eye-opening. We now want to take it to the next level," she said. "This is the way we should be doing business for everyone in our county."

On the front lines, navigators are already engaging with consumers. "I really believe we are helping empower people to take care of themselves," said Joe Schatz, a nurse who works part time as a navigator in Montgomery County. "People tend to be intimidated when confronted with the health care

together, we can develop strategies to better engage the person in their care. The ideal outcome is that people have access to care, can work towards wellness as part of their recovery – and that providers, in the meantime, have a better awareness about the whole spectrum of care."

Providers, too, have expressed interest in the project's outcomes. "One thing we have heard from our outreach to physical health providers is that there's a lot of enthusiasm about seeing this program succeed," said Regina Janov, mental health programs specialist supervisor for the Allegheny County Office of Behavioral Health. "Providers on both sides feel this program is a good way to break down the disconnect." Janov said she believes the program will also increase consumer awareness about wellness to better inform advocacy efforts.

Success Stories

Montgomery County already has a few success stories. One concerns "Jennifer" (not her real name), who has

physician for a follow-up visit after being discharged from the emergency department with low sodium levels. Her primary care physician told her to discontinue one of her psychotropic medications because he feared it was responsible for depleting her sodium. Jennifer worried that, without her medication, she would experience increased symptoms. She informed her navigator, Joe Schatz, and together they discussed their concerns with both the primary care physician and the psychiatrist.

Schatz, Jennifer and both doctors worked together to find a different drug for her. Through that encounter, Jennifer developed a great working relationship with Schatz and speaks highly of the program.

Everyone is happy that Pennsylvania may finally be moving toward a more coordinated system for consumer health care. Bucher believes that the program's design has given counties the tools they needed all along. "In some sense, you think this is what people are supposed to be doing already," she said, "but this model actually

Improving Services for Pennsylvania's Deaf/Hard of Hearing Consumers:

By Elisa Ludwig

East meets West as regions share best practices

For individuals who are deaf or hard of hearing (*see box on page 9*), isolation is an all too common experience. Worse still for those seeking mental health treatment is the increased possibility of misdiagnosis or mistreatment. "Any deaf person you meet can probably share some bad experiences with the health care system due to miscommunication," said Louise Montoya, mental health therapist and coordinator of the Family Wellness Program of the Center for Childhood Communication at the Children's Hospital of Philadelphia.

Montoya grew up in a Deaf household with American Sign Language (ASL) as her first language, and she has seen firsthand the challenges of

Abuse Services (OMHSAS) has worked to bring the experts in the two regions together. "We feel some obligation as an agency to try to share what we've learned in these more populous areas," said Robbie Altenor, former special assistant for special populations to the deputy secretary of OMHSAS (recently retired).

A November 2009 teleconference has paved the way for a (virtual) meeting of the minds. The first in what will likely be a series of such meetings brought together ideas and best practices, and inspired participants to be creative about improving access to services.

"What we all deal with in our field is the fact that there are very few resources," said Wendy Heines, vice president

outpatient and case management services.

DSC is unique in that it is operated by deaf persons; its 100-person staff includes at least 80 who are deaf or hard of hearing. "Since everyone is signing at DSC, hearing people who visit often remark that they get a taste of what deaf people experience in their everyday lives, because now they are the ones who can't communicate in this setting," said Heines, who herself is Deaf. "Because we are deaf, we know what deaf people need."

OMHSAS has recently provided DSC with funding to staff and operate a statewide warmline by using video-phones to provide peer support to deaf individuals. This summer DSC will be opening a residential program for deaf adolescents with behavioral health issues.

The Family Wellness Program at Children's Hospital is another example of programming for children and families with deaf or hard of hearing members in Southeastern Pennsylvania: Louise Montoya works with children and their families who are coping with hearing loss.

"Because we are deaf, we know what deaf people need."

mental health treatment for individuals who are deaf. "When my father was hospitalized in his early twenties for a nervous breakdown, he could not read lips," she recalled. "He was lucky that a psychiatrist took extra time with him and communicated with him on paper, and that is what helped him to recover."

The population-dense Southeast and Southwest regions of Pennsylvania have traditionally been leaders in services for consumers who are deaf or hard of hearing across the state. Recently, in the effort to expand access and improve offerings, the Office of Mental Health and Substance

of Deaf Services Center (DSC) in Glenside, Pennsylvania. "You can refer hearing people to any number of behavioral health services, but we need to think long and hard about where we can refer our deaf clients. The teleconferences are helping us look at those gaps."

A Unique Program

Deaf Services Center has addressed the need for housing in the Southeast with a residential program, which was started eight years ago with five individuals and now houses 27. The Center also provides a host of

Southwestern Pennsylvania

In the Southwest, the Behavioral Health Task Force of Allegheny County for Persons Who Are Deaf, Deafblind (sic) and Hard of Hearing was formed in 2004 to address the disparities in behavioral health care for individuals with hearing loss. The Task Force has held numerous focus

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groups and has set out to increase awareness through training, conferences and meetings between the deaf/hard of hearing community and the mental health community. The Task Force also started a Web site, <http://www.healthbridges.info>, which provides information about advocacy and local services and supports for mental health consumers who are deaf, deaf-blind or hard of hearing. The Web site is now going statewide.

At the Center for Hearing and Deaf Services in Pittsburgh

(Allegheny County) and Greensburg (Westmoreland County), therapists are fluent in ASL and offer psychiatric evaluation; therapy for groups, individuals, families and couples; medication therapy and referrals.

Few ASL-speaking Therapists

Unfortunately, organizations like DSC and the Center for Hearing and Deaf Services are still an exception. One of the biggest remaining challenges in Pennsylvania and elsewhere

is finding therapists fluent in ASL. "The methodology by which we treat behavioral health issues is communication; medication is really only an adjunct to that," Heines said. "So if you don't have the communication piece and you have a behavioral health issue, your treatment is effectively cut, if you can have it at all."

Within the hearing behavioral health community there has not traditionally been enough recognition of the value of ASL; and many practitioners, like Montoya's father's doctor,



The Web site subcommittee of the Behavioral Health Task Force of Allegheny County for Persons Who Are Deaf, Deafblind and Hard of Hearing celebrates the launch of their Web site, <http://www.healthbridges.info>, on May 27, 2009.

Front center: Jessica Knoche, interpreter. First row, l-r: Carol Horowitz, Esq., Disability Rights Network of Pennsylvania; Kim Mathos, D.O., M.P.H., Center for Hearing and Deaf Services, Pittsburgh; Beth Nolan, Ph.D., University of Pittsburgh Graduate School of Public Health. Top row, l-r: Dale Gold, Hearing Loss Association; Joan Stone, Western Pennsylvania School for the Deaf; Mary Alice Olson, LCSW, Center for Hearing and Deaf Services; David Fulmer, Web site designer; Michelle Paonessa, recent graduate, University of Pittsburgh School of Social Work; Pam Maciejewski, Center for Community Resources, Butler, Pa.

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“We have to be innovative in the way we begin to think about services development for all persons with hearing loss.”

expect individuals who are deaf to communicate through writing or reading lips. Advocates are hoping to change this attitude.

“ASL is a language just like Spanish. Spanish people often seek providers who share their language and a background about their culture. The same is true of culturally Deaf people. Deaf individuals generally tend to prefer to work with clinicians who are either Deaf themselves or who are fluent in ASL and understand their culture and communication needs,” said Kimberly Mathos, D.O., M.P.H., psychiatrist at the Center for Hearing and Deaf Services, clinical assistant professor of psychiatry at the Pittsburgh Medical Center and a member of the Allegheny Task Force.

Interpreters are helpful but limited: They don’t often pick up behavioral health cues, and their translation from ASL to English often creates misunderstanding. “It’s extremely difficult to conduct therapy or mental health treatment using an interpreter. We’ve been trying to expand the number of ASL-fluent professionals across the state, but it’s still woefully inadequate,” Altenor said. As a representative to the Governor’s Advisory Council for the Deaf and Hard of Hearing, Altenor has participated in outreach efforts to schools and universities to draw new talent into the fold.

At the same time, the Institute for Recovery and Community Integration of the Mental Health Association of Southeastern Pennsylvania (MHASP), which is one of the two agencies that train and certify peer specialists in the state, is planning a training for consumers who are deaf or hard of hear-

ing in spring 2011. To recruit applicants, “we’re reaching out through the Certified Peer Specialist Coalition in Pennsylvania and contacting agencies that directly provide services to the deaf and hard of hearing community,” said Jeanie Whitecraft, MHASP division director of the Institute. She said the training, which will be conducted with the help of interpreters, “will allow for people to provide volunteer or paid services to their own community as a peer and to help others to move forward in their recovery.” This will not be the first time that the Institute has trained individuals from this community, she added: “We trained some folks in the deaf and hard of hearing community in Montgomery County with the help of interpreters” several years ago.

Geographic Challenges

Because of the state’s county system for service delivery, consumers are dependent on what is available to them geographically. “As a hearing person you can pick from a number of agencies to get the services you need. But for deaf people there are probably only four or five case managers in the entire state, and you can’t cross county lines to access them. If you live in Beaver, you may not be able to access culturally or linguistically accessible services, and there’s no easy solution,” said Mathos. “Deaf, deaf-blind and hard of hearing consumers want access to information about mental illness recovery, a peer group, partial hospital programs, housing and drug and alcohol services too. We have to be innovative in the way we begin to

think about services development for all persons with hearing loss.”

DSC has addressed this issue somewhat by obtaining permission and dedicated funding grants from OMHSAS to open up its services to people in the five Southeastern counties (Bucks, Chester, Delaware, Montgomery and Philadelphia), as well as York, Lehigh and Lancaster counties.

Isolation, particularly in the most rural areas of the state, is still a significant concern for persons who are deaf and have mental illnesses who are not receiving treatment. “It’s scary,” Mathos said. “Many deaf, deaf-blind and hard of hearing people often don’t get an opportunity to learn about their illness or communicate with peers about recovery. A deaf person may not understand what hallucinations are, or what depression is or what alcohol abuse is. They may not know much about what medicines to take or what options they have for treatment. Many times they don’t try to access services at all.”

On a basic level, she continued, the Allegheny County Task Force’s focus groups have shown that many in the state are not aware of their rights granted by the Americans with Disabilities Act of 1990, which stipulates that people with disabilities have equal access to all business and public services and that deaf people have the right to an interpreter, communication device, captioning or other means of communicating.

Montoya said this is a common occurrence in her experience as well. “Because hearing loss runs in my family, I also have an uncle who is Deaf. He is mildly cognitively impaired, barely literate and he has never gotten the help he needs. So while I’m seeing managed care companies, Medicaid and many counties working to improve access to services, we also have plenty of consumers and families who don’t know that there are specialized services out there.”

Many of the existing services target people fluent in ASL, but they still exclude the majority of the deaf and

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hard of hearing population who use oral speech, listening and technology – an oversight Montoya has been hoping to change. But in a financially difficult climate, efforts to expand services can be frustrating. The reality is that services in many areas of the state remain sparse. “What worries me most is that a lot of these people don’t have a line to get in,” Montoya said.

Another challenge is meshing communities in the service of the common good. “In the mental health arena, we are promoting recovery – with the goal of being integrated into the larger community. In the Deaf community in general, people tend to want to be around others who are Deaf, people who speak their language. So there’s a bit of a philosophical struggle in advocating for deaf/hard of hearing mental health programs,” Altenor said.

Encouraging Stories

As with the hearing mental health community, having meaningful connections, having a pleasant residential option, having a treatment team that a consumer can communicate with can make all the difference in recovery. Heines is full of encouraging stories from the DSC. “One consumer had schizophrenia and was literally in and out of hospitals every month. He had good ASL skills but he was living in an environment where no one else understood him. He came here and within a short time his hospitalizations were sharply reduced and he is much farther along in his journey to recovery. You would never know it’s the same person.”

Another consumer at DSC, who communicated through an interpreter and asked that her name be withheld, said she had no options before she came to live there. “I’ve been here nine years. There was nothing for me. I have improved my social skills, become more patient and have learned more independent living skills.

“Therapy and counseling are so important,” she continued. “Before

DSC, I was isolated and lonely. Hearing services with an interpreter is not enough; we must have staff and peers who are Deaf, too.”

Montoya also remains optimistic about the progress she’s seeing from a treatment perspective.

“In the Philadelphia area we have

at least three providers looking to expand care into other types of services, not only to deepen the quality of care but to reach out to other geographic areas,” Montoya said. It’s not a complete system of treatment yet, but we certainly have more of the pieces in place.”

Definition of Terms

“Deaf and hard of hearing people have the right to choose what they wish to be called, either as a group or on an individual basis. Overwhelmingly, deaf and hard of hearing people prefer to be called ‘deaf’ or ‘hard of hearing.’ Nearly all organizations of the deaf use the term ‘deaf and hard of hearing,’ and the [National Association of the Deaf] is no exception. The World Federation of the Deaf (WFD) also voted in 1991 to use ‘deaf and hard of hearing’ as an official designation.”



According to Carol Padden and Tom Humphries, in *Deaf in America: Voices from a Culture* (1988):

“We use the lowercase deaf when referring to the audiological condition of not hearing, and the uppercase Deaf when referring to a particular group of deaf people who share a language – American Sign Language (ASL) – and a culture. The members of this group have inherited their sign language, use it as a primary means of communication among themselves, and hold a set of beliefs about themselves and their connection to the larger society. We distinguish them from, for example, those who find themselves losing their hearing because of illness, trauma or age; although these people share the condition of not hearing, they do not have access to the knowledge, beliefs, and practices that make up the culture of Deaf people.”



“For many people, the words ‘deaf’ and ‘hard of hearing’ are not negative. Instead, the term ‘hearing-impaired’ is viewed as negative. The term focuses on what people can’t do. It establishes the standard as ‘hearing’ and anything different as ‘impaired,’ or substandard, hindered, or damaged. It implies that something is not as it should be and ought to be fixed if possible. To be fair, this is probably not what people intended to convey by the term ‘hearing impaired.’”

Source: <http://www.nad.org/issues/american-sign-language/community-and-culture-faq>

“This Is the Ride”:

My Journey to Recovery

By Ashley Quinn

The only thing certain in life is that nothing is certain. This I have learned over and over again. But I have also learned that, within this framework, we all have choices. We choose to live, to die, to move forward, or to stand still. When I was 14 and in the midst of four solid years of debilitating depression and manic highs, I wanted to choose death. When I was 17 and working with a new psychiatrist, new medication, and new hope, I decided to choose life. When I was 25 and suddenly found myself a widow, I chose to move forward.

Shortly after my 13th birthday, my life as I knew it was put on hold for the first time. My battle with bipolar disorder consumed what is typically the time in a young woman's life when she begins to discover who she is. It took me many long, hard years to see that my life could be anything but painfully unstable. Despite, or arguably because of, a colorful array of medications, I cycled wildly between depressive lows and manic highs for four years. Finally, at the suggestion of a specialist in adolescent psychology at the Children's Hospital of Philadelphia, I agreed to be admitted to the hospital to withdraw from the medication cocktail that was not improving my moods and was also hindering my ability to think.

Recovery came slowly but, after I left the hospital and began to work with a new psychiatrist, we started to rebuild what had been lost over the previous years. Eventually, I gained enough self-awareness that I could manage my disorder on my own, and I have not had a recurrence of symptoms in over 10 years. Through yoga, meditation, exercise, and perspective, I cultivate balance. Despite the difficulty of those years, I consider myself extremely fortunate to have had this experience as an adolescent: as a result, I gained skills and perspective that helped carry me through the death of my husband.

Because when I was 17 I chose life, by the time I was 25 I was well into a joyful and meaningful one. In college I had developed an interest in natural and herbal medicine, and had decided to pursue this interest by becoming a

nurse practitioner and specializing in natural and complementary therapies. I had completed my B.A. and R.N. degrees and had started working in an emergency department to gain experience before going on to graduate school. I had married my high school sweetheart and had settled very comfortably into life.

Then my world suddenly and irretrievably changed for the second time, when my husband and I were hit by a car while bicycling outside of Albuquerque, N.M. He was killed instantly. But because I had already chosen life, the choice to move forward was easy.

For the first year after my husband's death, I did not quite know where to go. I traveled, I thought, I cried, I rode my bike, I waited. Slowly, a new life began to take form in my mind. I believe that when we relax into life,



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into each moment, embracing it fully, feeling it fully, this is when life can flow organically. For me, this natural flow of life brought me two things: hospice and India.

During my year of respite, I thought a lot about what kind of work I wanted to do. I was no longer sure that the path that I had been on was the one I wanted. So when a friend whom I had not heard from in a long time called and told me he had been doing hospice nursing, I listened. I began to think about new directions and this one felt right. I found a job as a hospice nurse and immediately knew that it was the right choice. Life gives us many things, not all of them welcome; but, when we take everything that comes and treat it all as if we chose it, we can move forward with grace. In this way, we find gems even in the deepest wells.

As a hospice nurse, I have learned that one of the most important parts of my job is to bring normalcy to a situation that is very seldom faced directly. In the West, death is still very much in the closet and is too often viewed solely as a time of crisis. But death is a natural part of life, even when it is unexpected, and it is imperative to face it with eyes open. There is peace in acceptance, but peace cannot be found until grief is faced directly. This I know: the road around will only lead you back to where you started. One must go through grief to come out the other side.

Shortly after the second anniversary of my husband's death, I traveled to India for six months. I went with nothing but a sense of openness, seeking nothing but to release the heaviness my heart had been carrying. India took it willingly and gave me so much in return.

Any attempt to define India in words will inevitably fail, for it defies all common notions of order, reason and explanation. It is a place of extreme contradiction, endless confusion, constant hassle, subtle nuance, radiant magic, boundless love and unbelievable beauty. It is home to 1.2 billion people yet has more "space" than I've ever seen. It invites you to step outside of the narrow framework of what you believe to be possible. It is a place so adept at confusing the mind that one cannot help but find insight in the untangling. It is a place where all the doors of possibility are open to those who are looking. It is a place where the standard greeting is to acknowledge God within each person. Through the magic and openness of India, and a few very special guides, I was able to fully face the parts of my grief that had, until then, remained hidden.

In India, I became certified to teach yoga, and also studied yoga with a teacher of the Scaravelli method: a beautiful, fluid, intuitive practice that opens up space and releases tension in the body, mind and heart. It is a dance that is never static, always intuitive, and deeply satisfying. It throws all notions of "ideal position" right out the win-

dow, and uses the wisdom of the body to move deeply through layers, opening and freeing the body and the mind. The challenge is mental, trying to let go of deep patterns of tension and forced effort and remember that the body knows how to live in lightness. When you're there, it feels like coming home.

Our lives may or may not be destined. For me, it doesn't make a bit of difference. What does make a difference is how I choose to move forward. I may not have chosen to have my adolescence marred by bipolar disorder or to become a widow at the age of 25. But if I move forward "as if I chose it," then I am accepting responsibility for my life; and, from that, beauty is born. I know that everything in life brings you only to this moment and that every moment is created from every preceding moment, thought, and experience. When every moment is faced with the same careful attention, then all doors are open. When we clamp down, resist, or create tension, we create barriers to the flow and flowering of life, and we can easily miss the beauty that is right in front of us.

I believe we all have gurus, and that they come in many forms throughout our lives. The word guru comes from Sanskrit, and means "dispeller of darkness": someone who lifts the veil of ignorance, thus allowing the light of truth to shine in. A guru is said to come into a person's life

"When we take everything that comes and treat it all as if we chose it, we can move forward with grace."

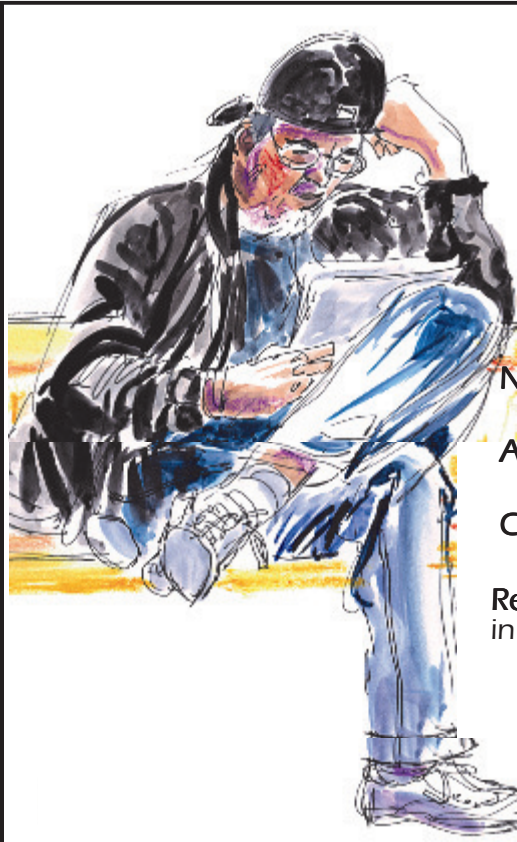
when the person is ready. I have had the extraordinary pleasure to be in the presence of many very wise souls in my lifetime, and the benefit of their grace has been invaluable to my life.

One of the most influential gurus in my life was my husband, and I have many beautiful memories of him. One thing that made me love him right away was his ability to challenge me, to push the boundaries of my life and look at things from a different angle. One of his most poignant teachings came on the morning of the day he died. We had just started off on the bicycle ride that would mark an irrevocable turning point in my life, and would be the end of his – in this incarnation, anyway. The road out of town was busy, with many traffic lights, and had an unrelenting uphill grade. I was bemoaning this fact, saying how I wished we could just skip this part and "get to the ride," meaning the beautiful open road that we both loved. At this, he looked over at me, smiled, and said, "This is the ride." *Om Namah Shivaya*. Thank you, love; you're right: this is the ride.

Ashley Quinn grew up in Bucks County, Pa., and lives in Santa Fe, N.M., where she works as a hospice nurse, teaches yoga and rides her bike as much as possible.

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