

PEOPLE FIRST

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Please See Table of Contents on Page 2

PEOPLE FIRST

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IN THIS ISSUE:

Supportive Housing Options Expand Across Pennsylvania 3

– By Elisa Ludwig

In response to a variety of factors that put af-
fordable housing out of reach of many indi-
viduals with serious mental illnesses, OMHSAS
has stepped up to the plate with a broad array
of housing assistance opportunities.

Self-Directed Care Pilot Puts Consumers in the Driver's Seat 7

– By Elisa Ludwig

A new service gives individuals with mental
health conditions the power to decide which
goods and services will help them achieve
their goals.

Choosing Hope 10

– By Gary Andricks

After losing everything, the author learns that
recovery means turning his back on the past,
living in the present, and choosing hope on a
daily basis.

COVER PHOTO: (Lauren Rieser Shawl)

PHFA Housing Voucher recipients relax in the library of
their Philadelphia apartment building while discussing
their new living arrangements with their case managers
and Department of Behavioral Health staff.

p.4 - Melanie S. moves with the help of friends; later,
settled into her new apartment, she cooks in her new
kitchen.

p.5 - Brian S. (right) happily receives the keys to his new
apartment from a DBH/IDS program analyst.

p.6 - Mark C. (upper right) and Dana B. (lower left) feel
completely at home in their apartments in Philadelphia.

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Supportive Housing Options Expand Across Pennsylvania

By Elisa Ludwig

After living in congregate settings for years, Maria Daniel finally moved into her own apartment in the spring of 2009 – and the new living situation has made all the difference. The 39-year-old, who has been diagnosed with bipolar disorder, said she’s reveling in her newfound freedom and independence. “For the last 10 years I have participated in Dual Recovery Anonymous, where I am now the secretary and treasurer. I also do volunteer work with the Beaver County Blind Association. I am currently employed, which supports my goal of maintaining independent living,” she said. “Doing all of these things and having my own place has helped restore my confidence and dignity, which I haven’t had since before I was diagnosed.”

Daniel’s new home was made possible by Beaver County Behavioral Health as part of Pennsylvania’s recent development of permanent supportive housing options throughout the state.

Supportive housing is intended for a person or family whose “head of household” has mental illness. Rent is limited to the U.S. Department of Housing and Urban Development (HUD) standard of 30 percent to 50 percent of household income. The housing is linked to flexible, supportive services that are voluntary, such as case management.

Work Group Recommendations

Pennsylvania’s supportive housing initiative dates back to late 2006, when the Office of Mental Health and Substance Abuse Services (OMHSAS) created a Housing Work Group in

response to factors such as poverty, older and inadequate housing stock, and a lack of federal support that had made affordable housing all too scarce for individuals with serious mental illnesses. As a result of the group’s efforts, in 2006 OMHSAS issued *A Plan for Promoting Housing and Recovery-Oriented Services*, which built on its 2005 landmark report *A Call for Change: Toward a Recovery-Oriented*

gration Projects Program (CHIPPP) or county base funds (state funds allocated to the counties to provide mental health services) for any housing activity must prepare a plan utilizing the OMHSAS template. (See box on page 7.)

Each of the counties has identified a target group of “priority” consumers – for example, residents of a state hospital, Community Residential Reha-

“While options and resources for people have more often been drying up, having this new partnership between the housing finance system and the behavioral health system is making a real difference in people’s lives.”

Mental Health Service System for Adults. The new plan – drafted with support from consumers, providers, county mental health/mental retardation (MH/MR) programs and other stakeholders – provides guidance for the counties’ planning, resource allocation and development of effective supportive housing models. Subsequently, OMHSAS increased technical assistance to the counties in housing plan development, including guidance on allocating HealthChoices Reinvestment funds for supportive housing.

With these endeavors under way, OMHSAS required that any county seeking to use HealthChoices Reinvestment, Community Hospital Inte-

gration (CRR) service or personal care boarding home – and developed plans to enable these consumers to transition into independent living while continuing to receive services. The counties’ funding arrangements, consumer base and program structure differ but the goal is the same.

The work group also recommended that OMHSAS, in conjunction with the Pennsylvania Housing Finance Agency (PHFA) and the Pennsylvania Department of Community and Economic Development (DCED), team up with counties to develop permanent supportive housing.

Nearly four years later, Pennsylvania counties have moved closer to

... continued on page 4

... continued from page 3

their collective goal of creating 5,000 homes for individuals with serious mental illnesses and co-occurring disorders by 2012. To fund new opportunities outside of those described above, the counties draw on such resources as Federal Low-Income Housing Tax Credits, PHFA's PennHOMES, HUD Section 811, County Housing Trust Funds, HUD's HOME (Home Investments Partnerships Program) dollars, local capital and HUD McKinney-Vento grants. Meanwhile, OMHSAS has continued to offer technical assistance to county mental health programs to create customized solutions for their individual needs.

"This [program] has been a tremendous resource for people, particularly at this time of financial crisis, which has left the state, county, providers and participants struggling to make ends meet," said Gerard C. Devine, program manager of the Philadelphia Department of Behavioral Health Community Support Network. "While options and resources for people have more often been drying up, having this new partnership between the housing finance system and the behavioral health system is making a real difference in people's lives. It also speaks to a new model of service delivery, which is more integral, opening the door for greater independence, freedom and autonomy. People are not as dependent on the mental health system to be their housing provider," said Devine, who manages Philadelphia



LAUREN RIESER SHAWL

County's central intake unit for Adult Mental Health Residential and Housing Services.

Following is a snapshot of how several counties are responding to Pennsylvania's supportive housing initiative.

Philadelphia

Philadelphia's "PHFA Initiative," which has been recently added to a slate of existing permanent supportive housing programs, offers housing subsidies to four priority consumer groups: referred individuals who are either aging and/or medically compromised,

returning to the community from extended incarceration or hospitalization, "aging-out" youth, or homeless.

Under Philadelphia's PHFA Initiative, PHFA holds 15-year contracts with developers who provide units that are paid for, in part, by subsidies funded by the Philadelphia Department of Behavioral Health and

Intellectual disAbility Services (DBH/IDS). Using this approach, the county can sign up existing landlords and buildings and thereby quickly offer people a wide array of housing options.

A Note About PBOA

Project-Based Operating Assistance (see box on page 7) has so far been implemented in Chester, Delaware, Lehigh, Montgomery, Philadelphia and York/Adams counties, and this OMHSAS/PHFA partnership is called PBOA in every county but Philadelphia. PHFA is managing this specialized program to support targeted units for OMHSAS priority consumers. A county mental health/mental retardation (MH/MR) office contributes a specified amount of funding in exchange for a specific number of targeted units located in the county, and PHFA and the county MH/MR office collaborate on identifying and selecting multi-family rental projects to receive project-based operating subsidies. However, although Philadelphia's program is set up under the PBOA component through a partnership with PHFA, the program provides tenant-based subsidies and Philadelphia County calls it the PHFA Initiative.

... continued on page 5



LAUREN RIESER SHAWL

... continued from page 4

“Tenants are given the choice of renting any unit available within the contracted landlords’ inventory,” said Emily Camp-Landis, coordinator of DBH/IDS housing planning and development. “In Philadelphia, we saw this as a more appropriate choice. For the property owner, our commitment to services and to paying the subsidy helps them to engage more readily in the project; and we take advantage of

community treatment teams to make sure it all runs smoothly. “So far, almost everyone is doing well,” he said.

“Number one is it makes a huge difference to have a choice of where you can live. Everyone is thrilled with that.”

Villarini describes a 35-year-old man from South Philadelphia who had yearned for his own place for 10 years before being accepted into the program. “Now he’s living independently

project has been an amazing and rare opportunity for our folks who are completing substance abuse treatment and recovery house programs,” said Timothy Sheahan of the Philadelphia Department of Behavioral Health Office of Addiction Services. “For years, the Office of Addiction Services has had little to no permanent subsidized housing options for our graduates; but now, through PHFA, we have recently

“Without the availability of these new subsidies, these are folks who may have otherwise cycled through our shelter, recovery house, and transitional programs, unable to afford independent living.”

existing, decent housing stock that was previously unaffordable to this population. It also helps us to know that the housing will be there when we need access to units 15 years from now.”

Qualified applicants interview with DBH/IDS and are screened before being accepted. “Needs for supports are assessed and, if the tenant needs additional services beyond what they already have, then the program helps match them with what they need even before they move in,” Camp-Landis said.

“It’s very flexible and it runs the gamut,” said Marcella Maguire, project manager at DBH/IDS. “It might be anything from targeted case managers to aftercare from prior housing, peer support or day programs.”

To date, Philadelphia has 35 people housed, with another 28 subsidies in hand; Maguire said they are working on these placements now. As program analyst for DBH/IDS, Carl Villarini oversees 17 of the individuals who are currently living in supportive housing and monitors their progress, including everything from rent payments and landlord disputes to acclimation to a new neighborhood and medication checks. Villarini also coordinates the case management of the new tenants, connecting case managers with other services such as com-

in Center City and doing really well, working on his recovery and really moving forward,” Villarini said.

When asked how things were going, another tenant, Pat, replied, “I have never been happier. I have joined numerous organizations now that I live in Center City.”

Among those the program serves are individuals with substance use disorders who may or may not have co-occurring mental illness. “The PHFA

housed seven individuals, with several more looking to move into units shortly. Without the availability of these new subsidies, these are folks who may have otherwise cycled through our shelter, recovery house, and transitional programs, unable to afford independent living.”

One of the principles behind the program is that independent living in the community can foster confidence and a sense of normalization. “When you’re a consumer and you’re living in a hospital, your primary identity is as a consumer in the mental health system,” Maguire said. “One of the pillars of mental health and drug and alcohol addiction recovery is consumer choice, and this program is setting up an example and giving people hope that they can move forward in their recovery,” she said.



LAUREN RIESER SHAWL

York/Adams Counties

In York/Adams counties, a similar model exists for project-based operating assistance for 20 housing units. “We have been reaching out to area property management companies and independent landlords and working with them to sign contracts that would allow available units to be allotted to individuals who have been approved for the program,” said Amy Hampson, housing specialist for York/Adams HealthChoices Management.

... continued on page 6

“We’ve been talking about improving housing for years, but we’ve been able to go so much further recently with this support.”

The counties have also committed money to capital funding projects (i.e., construction of new housing units), and operate a variation on a master leasing program in which the county advocates with landlords to help consumers with blemished rental or credit histories obtain housing. (In a traditional master leasing program, the county/provider might hold the lease and sublet to consumers.)

In addition, as in Philadelphia, the counties maintain a contingency fund for approved applicants’ needs, such as security deposits, furniture and utilities. “We had several years’ of reinvestment funds and once we got OMHSAS’s recommendations it made sense to try different approaches to providing housing and make sure we were integrating it throughout the community,” Hampson said.

So far, York/Adams counties have found supported housing for a total of

40 individuals since the counties’ MH/MR office began taking referrals in 2008. “I definitely see more movement, more individuals ready to leave group homes and ready to move into independent living. People in our program tend to have lower numbers of inpatient admissions so we are seeing a cost savings as well,” Hampson said.

Beaver County

In Beaver County, the housing plan’s components include capital development funds (to supplement other funding), bridge subsidy funding for vouchers that can later be converted into HUD vouchers, and a housing specialist who helps eligible applicants find safe, affordable housing and matches them with flexible supports. Beaver County has focused its supportive housing efforts on three priority populations: people transitioning out of or being diverted



LAUREN RIESER SHAWL

from Mayview State Hospital, people living in CRRs, and people living in long-term structured residences (LTSRs). At this writing, some 60 percent of applicants have secured housing, and officials are seeing attitudes adapt along with the new approach to supportive housing.

“Change is a process,” said Herta Madder, HealthChoices specialist of Beaver County. “People are slowly coming on board with this new way of doing things. What we are ultimately looking at is a community-wide effort to support people in their recovery process.”

Montgomery County

Montgomery County’s plan is a multi-pronged approach, including tenant-based rental assistance funded by community/hospital integration dollars, HUD McKinney programs, HealthChoices reinvestment dollars and future collaboration with PHFA to obtain new units. Over the past three years, the county has developed 104 new permanent housing opportunities.

While the county certainly considers this a success, one of the goals going forward is not just to

... continued on page 7



LAUREN RIESER SHAWL

... continued from page 6

create housing options and place people who want to move, but to also help sustain the housing and tenant relationships into the future. “The challenge is to really think about this in a preventative fashion,” said Pam Howard, director of adult mental health services for Montgomery County. “There’s no one-size-fits-all solution, but we need to keep thinking of creative strategies to keep people housed.”

Howard, like many of the county administrative staff interviewed, expressed gratitude to OMHSAS for encouraging the use of reinvestment funds for housing and providing technical assistance along the way. “We’ve been talking about improving housing for years, but we’ve been able to go so much further recently with this support,” she said. “It’s made a huge difference.”

Camp-Landis agreed: “It’s clear that everyone is eager to help make this project work.”

So far, tenants seem to be equally pleased with the new housing choices in the state. “I have recommended this program to many other people,” said Daniel, now a recovery coordinator for Allegheny HealthChoices. “Coming home to my own place, I feel a sense of peace. For the first time ever, I’m actually bragging about my life.”



Pennsylvania Counties’ Housing Funding Options

Bridge Subsidy: short-term, tenant-based rental subsidies (a “bridge” to more permanent housing).

Master Leasing: leasing units from private owners, subsidizing these units, and subleasing them to consumers.

Capital: using county-based funds as capital financing to create targeted permanent supportive housing units. (The funding goes into “bricks and mortar.”)

Project-Based Operating Assistance (PBOA): a partnership with the Pennsylvania Housing Finance Agency in which the county provides operating or rental assistance to specific units, which are then leased to eligible persons.

Clearinghouse: an agency that coordinates and manages permanent supportive housing opportunities.

Housing Support Services: services temporarily provided by counties to individuals until permanent funding for such services can be identified.

Contingency Funds: funds for one-time and emergency costs, such as security deposits for apartments or utilities, or to pay back rent or utility costs.

Self-Directed Care Pilot Puts Consumers in the Driver’s Seat

By Elisa Ludwig

For the first time in several years, Julie Schnepf is moving into her own apartment. Diagnosed at age 38 with bipolar disorder, Schnepf, now in her 50s, has struggled as a single parent of three children and has lived on the streets. Now, through the Consumer Recovery Investment Funds Self-Directed Care (CRIF SDC) program – a pilot project offered to some individuals with mental health conditions in Delaware County – “I’m getting back to a way of life that I never thought I would get back to,” Schnepf said. “I’m cutting back on services I don’t need and realizing new dreams.”

Self-directed care came out of the physical disability rights movement in the 1970s, when people began to question whether the services that the system chose for them were really what they needed. In self-directed care, individuals meet with peer recovery coaches who help them create and control their own budgets, which they can use to hire and manage staff and purchase goods and services that support their recovery.

“The idea really started to gain traction in the late 1990s after [several] Robert Wood Johnson-funded pilots showed great promise, and the federal government formally

recognized the model in its Medicaid Home and Community-Based Services waiver rules,” said Kristin Ahrens, policy coordinator at Temple University’s Institute on Disabilities, who serves on the Home and Community-Based Services (HCBS) Stakeholder Planning Team – a Pennsylvania Department of Public Welfare (DPW) group comprising individuals with disabilities and advocates – which advises the DPW secretary. HCBS supports replicating or expanding CRIF.

Ahrens explained that when the federal Centers for Medicare and Medicaid Services added structures that allow states to operate self-

... continued on page 8

... continued from page 7

directed care models and obtain federal matching funds, states became more willing to explore such models and on larger scales.

Though research has been limited, the model shows promise. An often cited 2007 *Health Services Research* study found that elderly people, individuals with physical disabilities and children with special needs in a self-directed Cash and Counseling program reported more satisfaction and fewer unmet needs, and experienced equal or better health outcomes, than those receiving traditional services. And a recent report by the Substance Abuse and Mental Health Services Administration on a program piloted in Arkansas, Florida and New Jersey indicated that individuals with mental health conditions who use self-directed care obtain similar results.

A Pennsylvania Program

In 2007, Joseph Rogers, chief advocacy officer of the Mental Health Association of Southeastern Pennsylvania, and Richard Baron, director of knowledge translation of the Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities, submitted a proposal to develop a self-directed care program for individuals with mental health conditions to the state Office of Mental Health and Substance Abuse Services (OMHSAS). Rogers had attended a training on the Florida program and “I thought it would be good to do something similar in Pennsylvania,” he said.

With OMHSAS’s encouragement and some seed money, Rogers approached the Temple University Collaborative, the Office of Behavioral Health in Delaware County, and Magellan Health Services, the behavioral

health managed care organization for the county. The first goal was creating a sustainable, Medicaid-reimbursable program that the Collaborative could study.

After some initial research, including consumer focus groups, Erme Maula was hired in June 2009 to get the CRIF SDC program off the ground. Subsequently, a five-person pilot was conducted to test the model. In January 2010, the project was fully launched, with a goal of enlisting 150 participants, eligible only if they are enrolled in HealthChoices in Delaware County; have been diagnosed with major depression, schizophrenia or bipolar disorder; and have not been hospitalized in the six previous months. “Once they opt in, the study is randomized so some people are entered into a control group, receiving their services as usual, and some are moved into self-directed care,” Maula said.

By the end of 2010, 113 individuals had enrolled in the study: 56 in self-directed care, 57 in “services as usual.” Enrollment continues.

Vision for the Future

Participants start looking at their vision for the future with a team of recovery coaches who are certified peer specialists and WRAP (Wellness Recovery Action Plan) facilitators. “We wanted people with their own personal experience to help others move forward in recovery. Peer sup-

port is very important and it is Medicaid reimbursable,” Maula said.

Then, she said, “we come up with a ‘psychosocial assessment,’ which is really just a life story, putting someone’s experiences into language. We talk about goals and barriers. We do a dream exercise, which we adapted from the self-directed care program in Dallas; it helps people think about where they see themselves down the road. It covers all of the meaningful domains of life: social, physical health, housing, mental wellness, education, work, and meaningful activities,” Maula said. “I tell people to dream big.”

The recovery coaches then help participants break down their goals and dreams into plans for six-, 12- and 24-month periods. They also examine their existing resources and



Erme C. Maula, RN, MSN, CRRN

Program Manager, Consumer Recovery Investment Funds Self-Directed Care (CRIF SDC)

“Sometimes a relatively small amount of money, spent the right way, can make a huge difference to someone’s recovery.”

... continued on page 9

... continued from page 8

services. “From Magellan we can get a full picture of the amount of money the organization has spent on each person in the past 24 months,” Maula said. “We break that down into a spreadsheet where we can view the services by category, and we use that as a budget going forward.”

Reviewing their budgets, participants often see where money is poorly spent: for instance, seeing a case manager two or three times a month just to get a ride to the supermarket. “That might be \$128 each time, when you could call a cab for \$30,” Maula said. “People tend not to look at this as dollars coming out of their own pocket, but they could put that money toward something more useful,” such as going back to school or clothes for a new job.

Participants can choose a mix of “in-plan” (traditional services such as

and she has helped me make changes to improve my life,” he said.

“People are re-evaluating and finding out what’s important to them,” Maula said. “For many, it’s an ‘aha’ moment.”

Self-directed care makes for a more personalized approach. “Right now we have a cookie-cutter system that offers the same things to everyone,” Rogers said. “But sometimes a relatively small amount of money, spent the right way, can make a huge difference to someone’s recovery.”

More Rigorous

The study is scheduled to run for 24 months. “What’s unique about our research is that we’re looking at a larger group of people in the program and it’s a randomized controlled study, which makes it a more rigorous

Florida self-directed care model for individuals with mental health conditions, published in *Psychiatric Services*, which shows program participants using crisis stabilization services less frequently than non-participants. Participants also spent less time in criminal justice and psychiatric inpatient settings and demonstrated improved functioning.

Delaware County is also hoping for positive outcomes. “We want people to make informed decisions to impact their own goals, be more independent and less reliant on traditional services,” said Bill Chambers, mental health program director of the county’s Office of Behavioral Health. “If this works, there’s a possibility we can talk to the state about creating a Medicaid waiver to include self-directed care as a reimbursable ser-

“Because of self-directed care, I’m getting back to a way of life that I never thought I would get back to. I’m cutting back on services I don’t need and realizing new dreams.”

case management) and “out-of-plan” services (which might include college or joining a gym), using the approved CRIF budget, also known as Freedom Fund dollars, to pay for them. Julie Schnepf, for instance, was able to buy new clothes to wear at a conference. She is also rediscovering her love for photography and has used Freedom Funds to purchase a camera; her old one was lost to the streets.

Freedom Funds might also be spent on transportation, job training, health and physical fitness services, appliances and technology, classes or educational supplies. Duane Cooper, a 28-year-old volunteer firefighter from Collingdale, is cutting back on monthly medication visits he doesn’t need and working with his provider to meet less frequently, using the funds for furniture for a new apartment. “Erme has been great to work with

approach than what’s been done,” said Dr. Mark Salzer, director of the Temple University Collaborative. “CRIF is also able to offer participants more substantial budgets than in projects done elsewhere. This means the study will have greater impact. Overall the program is very cutting-edge and it has the potential to get people talking on a national level.”

Salzer’s hypothesis is that participants will use their resources to more actively engage in the community, whether it’s through a new dress for church or repairing a car. “We’re also hoping to see decreased use of crisis services, like hospitalizations and ER [emergency room] visits. These things are expensive and the CRIF program should, at the very least, be cost-neutral,” he said.

His hypothesis appears to be supported by a 2008 evaluation of the

vice. The county has supported this project and is optimistic about the long-term outcome.”

Many are excited about the program’s potential. “My biggest hope is that, from this study, we will be challenging the system to think about putting as much control as possible into the hands of the recipients of services,” Rogers said. “In the long run, we want to be able to fund recovery goals, which will result in people getting better and the system working more efficiently to support that.”

Meanwhile, Julie Schnepf is looking forward to her future. “Having a mentor and being in control financially of my mental health recovery has made the biggest difference in my life,” she said. “Self-directed care has gotten me back out in the world.”



Choosing Hope

By Gary Andricks

wasn't diagnosed with bipolar disorder until I was 42 years of age. The year was 1997; my wife and I were missionaries in Malawi, Central Africa, where we had served for six years, and we had just returned to the United States.

We were brought back due to my symptoms, which were not only affecting me but the whole family. I had been doing the work of five men and finding myself increasingly irritable and angry. Later, I became depressed to the point of not being able to get out of bed and, eventually, seriously considering suicide. My diagnosis came as somewhat of a relief because it helped me to better understand my present and past life: the ups and downs I experienced as a child, in school, professionally, and as a husband and father.

I remember being a hyperactive, headstrong and an extremely emotional child. I always felt different: more emotional, more "feminine," and not sharing the interests of other boys, such as cars and sports. This made me feel like an outcast. I was very self-conscious about what people might think. I became a "people pleaser" because I wanted others to like me.

I was held back in second grade, supposedly because of my low reading level and because I was enrolled in speech class due to my stuttering. As I look back, I believe the real reason was my lack of focus (a symptom of attention deficit disorder or bipolar disorder). This was humiliating. My self-esteem suffered, and I was often teased by my classmates, at which point I would physically retaliate, even to the point of injuring someone.

In high school I was on an emotional roller coaster, and in 10th grade I found out I had ulcers. I think the ulcers were brought on by the turmoil I felt because of being Christian and gay. As a member of a very conservative Christian church, I could not accept my sexuality. My fundamental religious beliefs and upbringing made me feel like I had to choose one over the other.

I did not lose my faith, but I did draw further away from the Lord because I could not see how I could change who I really was. I finally "came out" when I was 18 years old, but the feelings of conflict did not go away. I wanted to serve God with all my heart, but knew I would not be accepted in the church if people knew that I was gay. Using physical illness as an excuse, I missed many days of school. In reality, I did not like school; I had no friends and felt very out of place most of the time. I could not find the strength to face up to the social pressures that were part of my daily life.

As an adult, I continued trying to figure out where I fit in the world. I have attended eight colleges and many training programs, and have had a variety of jobs. I had many interests, including psychology, music, cosmetology, nursing, emergency medical technology, and missionary work. However, my lack of focus, concentration, and follow-through made it difficult to reach my objectives.

Gary Andricks is a certified peer specialist who works at a hospital in central Pennsylvania.



... continued on page 11

... continued from page 10

Still, I have had a rich life. I have traveled. I have lived in 11 cities and towns in five states, and in three countries besides the United States. I have moved 35 times. I have always been adventurous, wanting to see what opportunities awaited me around the next corner; but at the same time I continued to experience symptoms that I would later understand were associated with bipolar disorder.

Throughout my life, my emotions fluctuated between highs and lows. I could be irritable, angry, and unpredictable. I was a perfectionist: when things weren't perfect, I would become very disappointed, depressed, irritable and/or blow up. On the other hand, I could be a kind and loving person.

I lived as a gay man during my late teens and early twenties. Then, in my late twenties, I met my future wife in the Philippines while I was there attending a Bible School. I told her that I was gay but that I was determined to live a straight life. We shared the same desire to serve as missionaries. After getting married, we moved to the States and completed our three-year diplomas at a Bible School in Chicago. We then had our first child. What followed his birth were some of the best years of our lives. We served as associate pastors and music directors for an inner-city church in Chicago while raising our son, whom we both cherish. He is now 21 years of age and in his last year of college.

We were then posted to Malawi, where we had a successful ministry. Even though our personal lives were in turmoil due to my symptoms as well as the stress involved in denying my sexuality and attempting to live as a straight man, there were many good times as well. It was

“Only after I had lost everything did I fully realize that I needed to take responsibility for my recovery and wellness.”

during this time that our daughter (now 16 years old) was born in South Africa – another experience I will never forget.

A few years after returning from Malawi, I continued to experience depression and other symptoms that affected my job and my family life. Taking a break from my work with the church, I bought a Subway franchise and ran the restaurant for three years. But the business failed and my wife asked me to leave. Only after I had lost everything – my marriage, my children, what I thought would be my life's profession as a missionary, my business, the friendships my wife and I shared as a couple, and my home – did I fully realize that I needed to take responsibility for my recovery and wellness.

When I hit bottom, I was living in a personal care home, trying to make sense out of my life. It was during this time that the director of social services asked me to consider attending a certified peer specialist training sponsored by the state of Pennsylvania. I took her advice, and it was the training that changed my life – not all at once,

but gradually. I began to find hope, discovered ways to manage my anger, and learned coping skills, such as deep breathing and meditation, that could help me through the tough times.

I was supported by many people and organizations I will never forget.

One is the Dauphin County Office of Mental Health/Mental Retardation and my case manager there. Another is Keystone Mental Health Services, which supported me in multiple ways: they assigned me to a mental health professional and a rehabilitation specialist. When I began to work for Keystone as a certified peer specialist, I was mentored by other staff. I also continued to benefit from personal one-on-one counseling.

Because of this support, I was able to move out of the personal care home into my own apartment. I started working part time as an integration specialist, and then part time as a certified peer specialist. I received Wellness Recovery Action Plan (WRAP) training; my WRAP was helpful because it gave me specific guidelines on how to stay well. My faith also played an important part: not only knowing Jesus but following Him became a significant part of my recovery. I also found more freedom and acceptance as a gay man, even though I am currently living a celibate life.

I am presently working full time at a local hospital as a certified peer specialist on our acute and extended acute

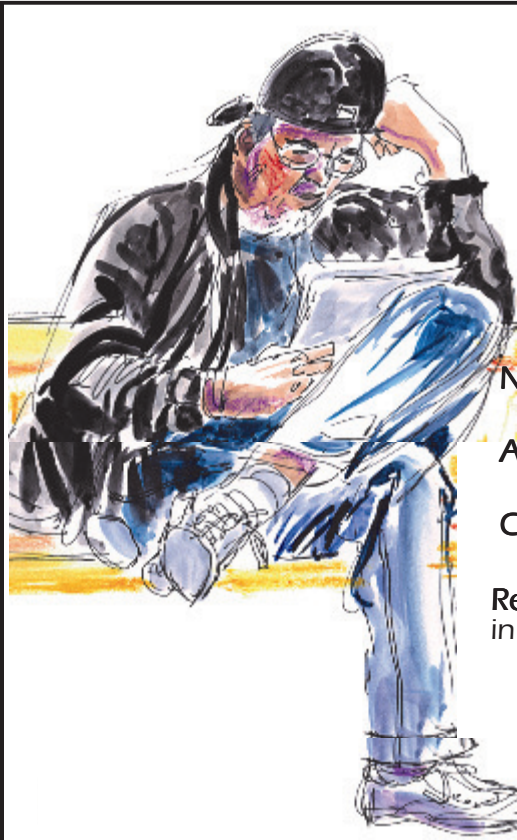
“I found out that I needed to choose hope on a daily basis.”

care units while studying full time, majoring in organizational behavior/applied psychology. This job has helped empower me to continue my own recovery, and to receive the blessings that come from sharing my experience and hope with others.

I was a man of faith, but I did not know how to practice hope. I found out that I needed to choose hope on a daily basis. I also learned to choose to put the past behind me and to live for today. And I choose to ask God for strength to live for Him, and to be a blessing. I have been able to find opportunities in my life to choose to heal my family relationships and begin to live a life of personal accountability. That is my prayer – that I will be a blessing to my family, to those I work with and to everyone around me.

Mental Health Association
of Southeastern Pennsylvania
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