

**Module 1: Intro to Peer Support – Participant Handbook**

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# **Module 1 Pre-work**

**This pre-work should be completed before Module 1, our first session together.** It should take approximately 45 minutes.

1. Video #1: “Out of the Box (Celebrating the Voice of Peer Support).”
It is 22 minutes and 29 seconds. (p.2)
2. Video #2: Peer Support Testimonials. It is 7 minutes and 37 seconds. (p.2)
3. Activity: Definition of Peer Support.
Should take approx. 10 minutes. (p. 3)

## **Videos**

1. Watch the video “Out of the Box (Celebrating the Voice of Peer Support).” It is 22 minutes and 29 seconds.
<https://www.youtube.com/watch?v=_BUIn81_Kt8>

**Video Description**: "Out of the Box“(2016) was commissioned by OPDI (www.opdi.org) to celebrate the 25th anniversary of the organization. The documentary highlights the crucial role peer support plays in the continuum of recovery. "Out of the Box" highlights the wisdom and strengths of the 50 Consumer Survivor Initiatives (CSIs) that are members of OPDI across the province. The documentary offers portraits of 3 of those member organizations as examples of the diverse, unique and distinct voices of Consumer/Survivor organizations across Ontario.

While PeerWorks members celebrate the past and present of their community, the organization also addresses urgent issues, which challenge the independence of Consumer Survivor Initiatives. CSIs are crucial to peer support movement and serve as the critical conscience of the mental health care system. "Out of the Box" is a tribute to the strength and wisdom of past, present and future OPDI and CSI peer support programs.

1. Watch the video of Peer Support testimonials. It is 7 minutes and 37 seconds. <https://vimeo.com/485308880>

**NOTES ON THE VIDEOS (optional)**:

## **Activity: Definition of peer support**

1. Take time to craft a definition of peer support. How would you define Peer Support? What does it mean to you? This should take no more than 10 minutes.

Everyone will be coming to this exercise with different backgrounds and experiences. You may not be very familiar with Peer Support (yet) and that’s okay! You don’t have to do any research in order to write this definition. Just use the knowledge and ideas you already have, and those that you have gained from watching the “Out of the Box” video. **Make sure to have your definition prepared for the beginning of the synchronous session, as we will be discussing them.**

**You will have time to revise your definition during the session, and you will be asked to submit this revised definition before Module 2.**

**SPACE TO CRAFT PEER SUPPORT DEFINITION:**

# **Module 1 Resources**

* Sign up for PeerWorks’ NewsToGo newsletter. <https://opdi.us8.list-manage.com/subscribe?u=8f832ee75cf3305556ea0f0ce&id=cb2e85f8fc>
* How to Find and Write a Land Acknowledgement in Ontario, Canada

**Step 1: Identify the Traditional Territory**

* + Use online resources like Native-Land.ca to determine whose ancestral and unceded territories you are on. For example, Toronto is the traditional territory of the Mississaugas of the Credit, the Anishinaabeg, the Chippewa, the Haudenosaunee, and the Wendat peoples, and falls under Treaty 13 and the Williams Treaties.

**Step 2: Research Indigenous Nations and Treaties**

* + Once you've identified the likely nations, verify with local documents—municipality, school, university, or workplace—for the exact phrasing. Ontario has 46 treaties, and for example, the Toronto area is covered by Treaty 13 and involves multiple Indigenous groups.

 **Step 3: Draft a Meaningful Acknowledgement**

* + Include: 1. A statement recognizing the Indigenous nations. 2. A mention of treaty names, if applicable. 3. A note of continuity—“is now home to many diverse First Nations, Inuit, and Métis peoples.” 4. A brief statement of why acknowledgment matters or your commitment to reconciliation.

**Step 4: Refine It Mindfully**

* + Learn correct pronunciation.
	+ Show personal reflection—your relationship to the land and commitment to reconciliation.
	+ If using it at an event, start with the land acknowledgement, then briefly explain its importance.

**Example Template**

* + “Hello, I’m [Name], and I work with [Organization]. I acknowledge that we are gathered on the traditional territories of the [Nation(s)]—[list nations]—which are covered by [Treaty(s)]. This land is and has always been a place of gathering, teaching, and contribution for Indigenous peoples, including First Nations, Inuit, and Métis. I honour with gratitude their past, present, and continual stewardship. We commit to engaging in truth, learning, and meaningful action toward reconciliation.”

**Step 5: Go Beyond Words**

* + Land acknowledgements are just a starting point. Best practices include:
		- Ongoing relationships with local Indigenous communities
		- Supporting Indigenous-led programs, advocacy, or calls to action
		- Embedding acknowledgement in communications—signatures, documents, event templates
* Native Land is an interactive map that helps you learn about the native land we live on. <https://native-land.ca/>
* Indigenous Organizations often offer the most respectful and accurate content:
	+ Ontario Federation of Indigenous Friendship Centres (OFIFC): <https://ofifc.org>
	+ Indigenous Tourism Ontario: <https://indigenoustourismontario.ca>
	+ Anishinabek Nation, Nishnawbe Aski Nation, and Métis Nation of Ontario
* Many institutions provide official land acknowledgements that are deeply researched and are often regionally specific and vetted by Indigenous advisors:
	+ University of Toronto: [https://indigenous.utoronto.ca](https://indigenous.utoronto.ca/)
	+ York University: [https://indigenous.info.yorku.ca](https://indigenous.info.yorku.ca/)
	+ University of Waterloo: <https://uwaterloo.ca/indigenous>
	+ OCAD University, Ryerson (TMU), McMaster, and others also have detailed acknowledgements
* Local municipalities in Ontario often publish official acknowledgements on their websites:
	+ City of Toronto: <https://www.toronto.ca>
	+ Ottawa, Hamilton, Mississauga, London, Sudbury, etc. all have their own
	+ Some are posted on pages about reconciliation, diversity, or council meetings

# **Information from Module 1 Slides**

**PeerWorks Definition of Peer Support**

“Peer Support is a naturally occurring, mutually beneficial support process, where people who share a common experience meet as equals, sharing skills, strengths and hope; learning from each other how to cope, thrive and flourish.

Formalized Peer Support begins when persons with lived experience who have received specialized training, assume unique, designated roles within the mental health system, to support an individual’s expressed wishes.

Specialized Peer Support training is Peer developed, delivered and endorsed by Consumer/Survivor Initiatives, Peer Support Organizations and Patient Councils, and is rooted in principles of recovery, hope and individual empowerment.

Consumer Survivor Initiatives and Peer Support Organizations are community-based, self-help organizations run by and for consumer/survivors.”

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# **Homework to complete before Module 2**

**This homework should be completed before Module 2.**  It should take approximately 30 minutes.

1. Activity: Add/alter Expectations
Should take approx. 5 min. (p.2)
2. Activity: Submit revised Definitions (p.2)
3. Reading 1: ‘Person Centered vs. Illness Centered” by Mark Ragins, MD
Should take approx. 12-15 minutes to read. (p. 3-8)
4. Reading 2: Christian’s Story
Should take approx. 6-8 minutes to read. (p.9-11)
5. Reading 3: Tanya’s Story
Should take approx. 4-6 minutes to read. (p.12-13)

## **Activity 1: Add/Alter Expectations**

Here are our current Expectations:

* Arrive on time.
* Help us create a confidential and non-judgement space.
* Please keep your phones on silent.
* Avoid cross-talk and side-talk.
* Learn from each person's perspective.
* Language – please bring new language to us; we recognize that language is ever-changing.
* **Have fun!**

Is there anything that you would want to add or alter? We will discuss these expectations at the beginning of every session, and we want them to be collaborative guidelines agreed upon by the entire group.

## **Activity 2: Submit Revised Definition of Peer Support**

Please e-mail your revised definition of peer support to **[NAME] at [name@peerworks.ca]** with the subject line “Your Name Peer Support Definition.” e.g. “Allyson Peer Support Definition.”

You can send your definition in the body of the email or attach your definition as a Word document and name it “Your Name Peer Support Definition.” E.g. “Allyson Peer Support Definition.doc”

## **Reading 1: Person Centered vs. Illness Centered by Mark Ragins, MD**

**Approximately 12-15 minutes to read.**

***Note from trainers:*** *Mark Ragins’ entire Recovery Paper can be found at the following link. Dr. Ragins is a physician and not a Peer Supporter; however, his focus on People rather than Illnesses is one that is embodied in the Peer Support field. This paper provides clear examples that explain the difference between person-centered support and illness-centered support.*

<http://www.ibhpartners.org/wp-content/uploads/2016/04/Recovery-model-paper-Ragins.pdf>

**Content warning**: The article briefly mentions abuse and sexual violence.

I’ve been doing a lot of workshops lately trying to help people really “get” recovery. I’m beginning to think that a crucial step to open up a clear vision of recovery is to move from an illness centered perspective to a person centered perspective.

Let me try to explain with an analogy: Before Copernicus came along we believed that the earth was at the center of the universe and that everything else moved around it. Although this made sense to everyone, it did make it difficult to describe the orbits of the other planets, the sun, and the stars as we observed them moving around the earth in complex, idiosyncratic paths. Copernicus figured out that although the earth is a very important place, it isn’t actually the center of the universe or even our solar system. The earth is one of a number of planets that revolve around the sun. It turned out the orbits were simple ellipses explainable by gravity.

Our mental health system at present is almost entirely illness centered. We act as though we believe that illnesses are at the center of the universe and that everything revolves around them. We need a great deal of complex, idiosyncratic explanations to make sense of people’s lives from this perspective: Housing is in treatment settings, friends are social support networks to reduce the risk of relapse, employment is therapeutic activity, and families are given psychoeducation so they can be extensions of treatment professionals. If we drive someone to a job interview we write a Medical note stating that we did in vivo anxiety reduction and social skills training for a schizophrenic who has barriers of paranoia and interpersonal anxiety in order to get him some employment as a therapeutic activity in order to decrease his symptoms and reduce the risk of hospitalization. That all may be true but it’s a pretty convoluted, pre-Copernican orbit. We can change our perspective. We can figure out that although illnesses are very important, they aren’t actually at the center of life. People are. It turns out that the orbits are relatively simple from this person centered perspective. People live in homes; have friends, jobs, families, and illnesses. When we drive someone to a job interview we’re trying to help them get a job.

Our illness centered perspective pervades everything we do. For example, when someone first comes to us in need of help with their problems the first thing we do is to define their problems as symptoms of an Axis I Major Mental Illness. If we can’t do this, they’re not eligible for services. We can’t get paid. They have to go away even if there’s no other help available. If we can identify their illness, but they can’t, they are lacking insight and we need to assess them for dangerousness, suicidality and grave disability. If they have any of those things we can lock them up. If not, there’s nothing we can do. We rarely shift to a person centered perspective to find other ways to be helpful. If we both agree they have an illness, we can try to help them within our illness centered perspective. We can give them treatment for their illness and if we can relieve all their symptoms, they shouldn’t have any more problems, since their problems were all symptoms in the first place. If, as is far more common, we are unable to relieve their symptoms, even with multiple medications and lengthy therapy, we can get them other social support services as long as we can use their ongoing illness to justify their needs. Labeled with the correct diagnosis, they can get Social Security income, Shelter Plus housing subsidies, vocational rehabilitation, disabled students’ support, etc.

When someone first gets a serious illness it can feel like it swallows them up. It’s hard to hold on to their remaining strengths and keep hope alive. Our illness centered responses, in effect, agree with this alarming feeling. We can clearly see that the illness has indeed swallowed them up. We took a careful history of their illness that documented it. They are now officially a schizophrenic or a manic depressive. But they shouldn’t lose hope just because we don’t see their strengths either. They’ve come to the right place. We’ll be the strong ones for them now. Hope rapidly becomes entirely coupled to our ability to successfully treat their illnesses. They can try to keep hoping we’ll be able to cure them and that then they’ll be fine again. Unfortunately, along the way we may neglect and lose all the other things that used to give them hope before they became patients like family, loved ones, their own strengths, God, perseverance, resilience, pets, understanding, compassion, or love. With illnesses at the center of life instead of people, treatment is the only visible wellspring of hope.

I was taught in medical school the distinctly illness centered idea that the foundation of a good treatment is a good diagnosis. I no longer agree. It seems to me that the foundation of a good treatment is a good relationship with the person – a distinctly person centered idea. Think about it. If I have a good diagnosis, but no relationship it’s not really very likely that much will happen. On the other hand, if I have a good relationship, but the wrong diagnosis, I’m a pretty smart guy, I’ll figure it out, and, more to the point, they might trust me enough to tell me the truth about their illiteracy, sexual molestation, drug abuse, lack of medication taking, abusive spouse, or whatever it was that they were hiding that confused me in the first place. (Of course if I was firmly illness centered enough, I wouldn’t see any problem as a lack of relationship. Instead I’d see, as a recent analyst of the CATIE drug study did, that “patient-initiated drug discontinuation appears to be a core illness behavior from schizophrenia onset to chronic illness.”)

The reason it’s important to change from an illness centered perspective to a person centered perspective to “get” recovery is because illnesses don’t recover, people do. Illnesses can be cured, put into remission, stabilized, or controlled, but they don’t recover. The person with the illness recovers when they rebuild their lives from the destruction caused by the illness. There’s no need for recovery if there’s no destruction from the illness. Illness centered treatment is sufficient. Unfortunately, most people with serious mental illnesses do have destruction in their lives and need person centered recovery services. The process of recovery is the same whether they’re recovering form an illness or from any other serious destruction, like a rape or the death of a loved one, or the trauma of an abusive childhood, the lack of a family, or going to war. People can recover functions - as in the ability to read, to sleep restfully, to work, to have coherent conversations, to make love, to raise children, to drive a car, etc. People can recover external things – as in an apartment, a job, friends, playing in a band, a spouse, a car, family relationships, stereo, TV, educational programs, etc. And people can recover internal states – as in feeling good about oneself, satisfaction, self confidence, spiritual peace, self-identity other than mentally ill, self-responsibility, etc. But when all is said and done, it still remains that illnesses don’t recover, people do. That’s why we can’t even see recovery from an illness centered perspective. It simply doesn’t exist. We must switch to a person centered perspective for recovery to emerge.

Here’s an example: Imagine a spectacular football player. He runs with amazing grace and abandon. He cuts sharply. He’s fearless. He finds the holes seemingly by instinct. And now imagine that a hard tackle twists his knee and severely injures it. But he gets great medical care. His arthroscopic surgery is a success. He’s very motivated so he does months of strenuous rehabilitation, and as a result his knee is completely healed. Tests show that it’s just as strong and flexible and mobile as ever. But, when he gets back on the field somehow he’s never the same. He doesn’t move the same way. He’s been changed by the injury. Even though he’s no longer injured, he’s still subtly crippled. More treatment simply won’t help, unless we switch to a person centered approach. We have a large number of people with serious mental illnesses who, even if we gave them pills tomorrow that relieved all their symptoms would still be severely “crippled.” As a matter of fact, we have lots of people who we’ve already given them those pills who are still on our caseloads crippled. And we keep giving them more illness centered treatment.

Don’t misunderstand me. I’m not against treating illnesses. It’s much easier to avoid being crippled if there’s effective treatment and rehabilitation. But I am against waiting to begin person centered recovery services until after the illness centered treatments are successful. Recovery should be our principal concern from the beginning. After all, isn’t that football player thinking about how he’s going to return to the field from the moment he’s injured? “Meeting people where they’re at” usually means beginning with recovery. By contrast, the beginnings of public mental health treatment are usually far removed from recovery. I’ve heard that half of all people in the public mental health system enter involuntarily. These people are forcibly restrained by police or ambulance personnel and brought to crowded, frightening psychiatric emergency rooms, and rapidly sedated often with forced injections “losing” their mind still further. Too often, we’re inadvertently adding more trauma and destruction to be coped with later and dramatically reducing their sense of hopefulness, self confidence, collaboration, and self determination – the keys to their recovery. Even if people begin voluntarily in a clinic, they’re likely to have to begin with long waits and extensive intake processing that focuses on system needs and diagnostic based treatment plans that may be experienced as impersonal processing not really responding to their needs. Most don’t return.

Here’s my view of person centered recovery based services from beginning to end: The first priority is to establish a relationship. If people don’t return, even the best assessment and treatment plan is a waste of time and paper. We should have a variety of outreach and engagement offerings to welcome people, whether they come voluntarily or involuntarily, that precede assessment. These offerings should be based on helping to meet the person’s goals directly. For example we might help by actually listening tomake someone feel better. We might help them straighten things out with their family or boyfriend. We might give them instructions how to get a two week hotel voucher from the welfare office, or advocate for them to get their SSI check restarted. We might call family to get money sent for a ticket home. We might give them a cigarette and a quiet place to think. We might give them a lunch or a day labor job to make $20. Or we might even give them an explanation for what is wrong with them so they’re less confused and more hopeful. After we’ve been helpful, perhaps a number of times, the person may be engaged enough with us to form a collaborative service relationship.

The goal of our service is not to treat illnesses, but to help people with serious mental illnesses have better lives. For example, when we give someone medication it’s not to reduce voices; it’s to help them get a girlfriend or keep their job. We focus not on illness based outcomes, like symptom relief, but on quality of life outcomes, like improved housing, employment, education, finances, health care, social life, and families, while avoiding legal problems, drug abuse problems, hospitalization, and homelessness. The goals are socially valued, but individually determined, based on each person’s choices. Services, including, but not limited to, treatment and rehabilitation, are goal driven, not symptom driven.

Throughout, a focus on the relationship is primary. SAMHSA’s new recovery consensus statement includes following the person’s self direction, being empowering, strengths based, respectful, responsibility building, and hopeful. These are all characteristics of service relationships that build recovery. Sometimes we’ll give up ground on the illness treatment or rehabilitation if it means gaining ground on the person moving towards a recovery relationship with us.

The goal throughout is to help the person attain recovery. We guide them through the process of building hope, empowerment, self-responsibility and attaining meaningful roles in life. We don’t leave recovery to chance, hoping that it will result from our treatment and rehabilitation efforts. We intentionally use treatment and rehabilitation as tools to promote recovery. We chose techniques that emphasize growth, building skills and natural supports, learning from successes and failures, and internalizing recovery gains to enhance resilience and wellness, rather than emphasizing stability, caretaking, risk reduction, and treatment compliance. Recovery is inside of them, not us. All recovery based services are transitional, though usually not time limited. The person moves on as they grow and change, not as their illness responds to treatment. They graduate and leave the system, when they are able to manage their lives, including their illness if it’s still there, not when they are cured.

When all is said and done, the recovery process and what we need to do to promote it is much clearer from a person centered perspective than from an illness centered perspective.

## **Reading 2: Christian’s Story**

**Approximately 6-8 minutes to read.**

I have struggled with mental health issues since I was a teen, as far back as I can recall. Only now am I able to pinpoint the moment my life changed.  I was sixteen and my best friend was diagnosed with cancer. After a quick and painful battle, he succumbed to the illness, and my life was shattered.

I wrestled with depression throughout the rest of my teens, and into my twenties, finding solace on a skateboard, with girls, and at the bottom of too many bottles to count. The physical pain of an injury, the momentary embrace of a stranger or the anesthetic effect of booze worked for a while to dull my senses and to numb my mind from my reality. Self-doubt, worthlessness, pity, sorrow, anger, fear. These were my baseline.

At thirty, a chance encounter on an online dating website introduced me to the woman who would impact my life in a more meaningful way than I ever thought I deserved. A few years of dating led to the most beautiful outdoor Autumn wedding surrounded by our loved ones. Months later we welcomed our son. My tribe was complete. I was happy.

Life was good, until it was not. I had a fine paying job, a couple of cars, and a home. I had a wife that loved me with her soul and a boy that thought I was Superman. Even my dog made me feel I embodied all things virtuous every time I came through the door. I had the audacity to take all this for granted.

That is the thing with depression. It comes for you when it is ready, not when you are. It is unapologetic. It is relentless.

The darkness followed me everywhere I went: work, social gatherings, even at home. I was safe nowhere. As is true with most stories of depression, I thought if I could stay one step ahead of it, I was going to be fine. Quietly and secretly. On my terms. I lied to myself, telling my brain that I was in charge. No one was to know my weakness, particularly not my wife who loved me and my son who looked up at me with those big blue eyes. And those who did not count are the ones I hid my illness from the most.

It was a Saturday, and I was at a job I hated, a job that demanded I take advantage of people. It kept the lights on and a roof over our heads, but it compromised my ideology and it made me feel dirty. Everyone I knew hated their jobs, so it didn’t occur to me to question my aversion. I was not unique. I took an early lunch to see my son play hockey. This was always one of my favorite things, watching the kids zoom up and down the ice. That day I sat despondently. There was too much noise and too many people. I decided not to go back to work for the rest of the day. That was five and a half years ago.

I gave myself permission to take time. I talked to my wife and looked for help. I was able to find a psychiatrist rather quickly, and was diagnosed with depression, anxiety, and potentially bipolar disorder. Next came the plethora of medications. Some were harder to endure than the illness they were trying to combat. My bed became my new home. I left it only to get my son off to school and to fetch him from the bus in the afternoon. I only had to fake it for a few hours until my wife came home from work, then I could retire back into my darkness.

The meds did not work and I was spiraling downward. My hygiene took a back seat and the last thing I wanted was intimacy. I was still living in the lie that I was staying one step ahead of the worst of it. My weight was climbing, and my physical health was declining. I felt ugly. I felt useless. I did not want to feel.

Following years of ineffective medication, a life that was unravelling and me still believing I was a step ahead of my illness, I was given an opportunity to be in a study at the Centre for Addiction and Mental Health (CAMH). It was a treatment called rTMS (repetitive transcranial magnetic stimulation). Having never heard of it, I did some research. Inquiry and research had always been strengths of mine. I was skeptical but my ever-positive wife encouraged me to try. I conceded. Nothing to lose.

I boarded the GO train every morning only to continue by subway and streetcar every day for four weeks for my treatment. That is eminently intimidating for a guy with crippling depression and anxiety. After the first few treatments, the commute grew a little easier. Then it became a little easier still. Instead of jumping on the train immediately to head home, I would sometimes sit on the steps of one of the buildings downtown Toronto and treat myself to a sausage.

With a newfound light in my life, I began to take interest in pleasures from my old world. I was not perfect, but for the first time I truly was one step ahead of my illness. It was not just a fictional narrative in my head.

Meetings with my doctors finally led to a medication that seemed to be the right fit. I was also armed with the knowledge that it was not completely up to the meds to change my darkness. I had to do the work. I had to prioritize myself. I was finally on the upswing and not ready to stop.

I worked with a terrific therapist that did CBT (cognitive behavioral therapy) with me for ten weeks. She was able to help me reframe my perception. Instead of looking at things negatively, I was to actively find the positives of life. This quip finally had meaning for me. Admittedly, I did not easily abandon my negative default setting. It took time and commitment but with practice, it comes very easily now.

My life seemed to be moving in the right direction for the first time in a long time. I smiled, I laughed, I loved. I had joy again. My life had meaning again. I started to look toward my future instead of wallowing in my past or cursing my present. I had plans to join CMHA (Canadian Mental Health Association) as a peer counselor and had a week worth of studying coming up with OPDI. I was going to be productive and help people instead of being a drain. It was my time to give back!

“We just need 2 weeks to flatten the curve…” The COVID-19 pandemic had arrived.

Everything was put on hold. Peer counselling, the OPDI course, moving forward. Stay in place. Stay home. Save lives. That is easy enough. Save lives while staying home. Deal! Yah... Ok... Deal.

After a few months of realizing that the lockdown was not going to be a quick fix for the pandemic, I needed to take stock in my part. The part that I could control. The part that is going to make me move towards the future instead of retreating to my own personal demons. What the hell was I going to do to help me when the world had stopped?

School! As a multiple college dropout, now was the perfect opportunity to learn and get into a new career, one in which I will be proud to work. Instead of taking advantage of people, I will be their advocate.

That brings us to now. My past, present and future. I am an honour roll student in a CDSW (Community Development and Service Worker) course online and I am loving it. I volunteer in peer support and help people. I look forward to tomorrow, I am proud of today, and I no longer am ashamed of yesterday. Our pasts shape us, but they do not define us. My past does not define me. I define myself.

“There’s a reason the windshield is larger than the rearview mirror.”

I am here to help.

Dedicated to my muse Julie, Avi, April, Abby and Alice.

## **Reading 3: Tanya’s Story**

**Approximately 4-6 minutes to read.**

My story involves 17 detox admissions, at least 4 psychiatric admissions, and 4 admissions to residential recovery homes. I clawed my way out of despair and slavery. Thank God I got the help before it was too late.

I had a successful career as a medical professional for over twenty years and two of the most respectable, intelligent, funny, kind, talented sons. But after 17 years of marriage, I could not tolerate feeling empty, alone, and devoid of adult love any longer. Unfortunately, I became severely depressed. I continued to spiral downwards, turning to increased consumption of alcohol. It became a problem, and I was able to refrain for 6 months.

It was then that I became involved with a person that I felt filled my empty void of loneliness. Along with him came serious heavy drug use. I felt addiction sneak into my life and grab control of me. After a year of active addiction, I reported myself to my place of employment. I thought I needed 5 days to detox and then I’d be fine, but it took much longer than that.

Three years later and I am finally fully immersed in recovery and living a healthy lifestyle. I feel rich with the genuine caring support of countless peers. I truly see the value of collaborating with people who can deeply relate to me. I’m proud to say I’ve been sober for 12 months. One thing is for sure, I could not have done it alone. I continue to share, confide, and consult with multiple peers every single day.

When I share with a peer support person, I can be open, honest and complete. When the peer support person has lived experience, I trust that they can relate to my experiences, and I am free from fear of judgment. All people do things when they are in addiction that they normally wouldn’t do. The desperation to stave off the pain of withdrawals led me to live a life I wouldn’t have considered possible. To try and share the shame and guilt of traumas leading up to using in the first place to the horrific events when using, is very difficult.

When a peer support person can listen, look me in the eye and then reciprocate by relating how they experienced something similar or understood because they felt the same, it is key to recovery, letting go, forgiveness, and finding peace.

Due to my involvement with the drug culture, I became victim to a very violent crime. This is where my first real recovery-based relationship started. I’ll skip the gruesome details and say this painful event ended with me surviving and having an unrelenting faith in God.

I’d like to convey the importance of withdrawal management services, which I refer to as detox. I'd like to communicate that throughout my multiple failures, they continued to accept and support me. Especially one counsellor in particular that I still meet with for coffee. I'm no longer utilizing detox services, but the continued peer support I receive from her warms my heart. I have someone who sticks with me through the long haul and continues to celebrate the joys of recovery with me.

Another supportive relationship began after my discharge from a three-week live-in recovery home**.** I received support from my after-care support group facilitator. I did relapse, but I still had an understanding, non-judgmental experienced, knowledgeable and compassionate person to turn to. Especially when I had moments of clarity, moments of awareness of reality. Three years later, I’m so grateful to connect with him in sobriety. He is now a true-blue friend.

I also benefit from the dozens of peer support relationships from the three-month residential recovery home, which was actually eight months for me. I like to say I had a lot of potential still to be met. Because of this group, I now have an army of women behind me. My group currently has three regularly scheduled Zoom peer support meetings a day. Having these opportunities for support when I need it is priceless.

In the past Windsor Essex Community Health Centre (WECHC) also supported me. Though once admitted to my residential recovery home, I haven’t been utilizing their services. A branch of WECHC is harm reduction/street health community outreach; they have a very brave and compassionate team.

I’ve also broadened my support system. In the last three months, I’ve started attending and enjoying! a Caduceussupport group, which is a support group for medical professionals overseen by an addictions physician. I value the slightly different philosophies and I’ve come to appreciate the different perspectives and I’ve made new friends.

I’ve also benefited from Sexual Assault Crisis Centre Counselling, and my We Fight social worker. My very supportive and understanding psychiatrist has also been an incredible support.

Recently, I’ve also utilized Narcotics Anonymous (NA) support groups. I am really looking forward to the ritual of celebrating lengths of sober time with key tags. The key tags symbolize these rites of passage. June 26 will be my proudest moment, as I walk to the front of the group and accept my one-year key tag.

I value all of these relationships.

I feel like this is my medicine for an incurable disease and I need to take it every day. I refuse to deviate from this way of life. I’m surrounded by support. I can’t risk returning to a way of life that felt like trying to breath under six feet of dirt.

I’m so happy to share a part of myself and my journey. I hope that it can in some way help another to freedom and happiness.