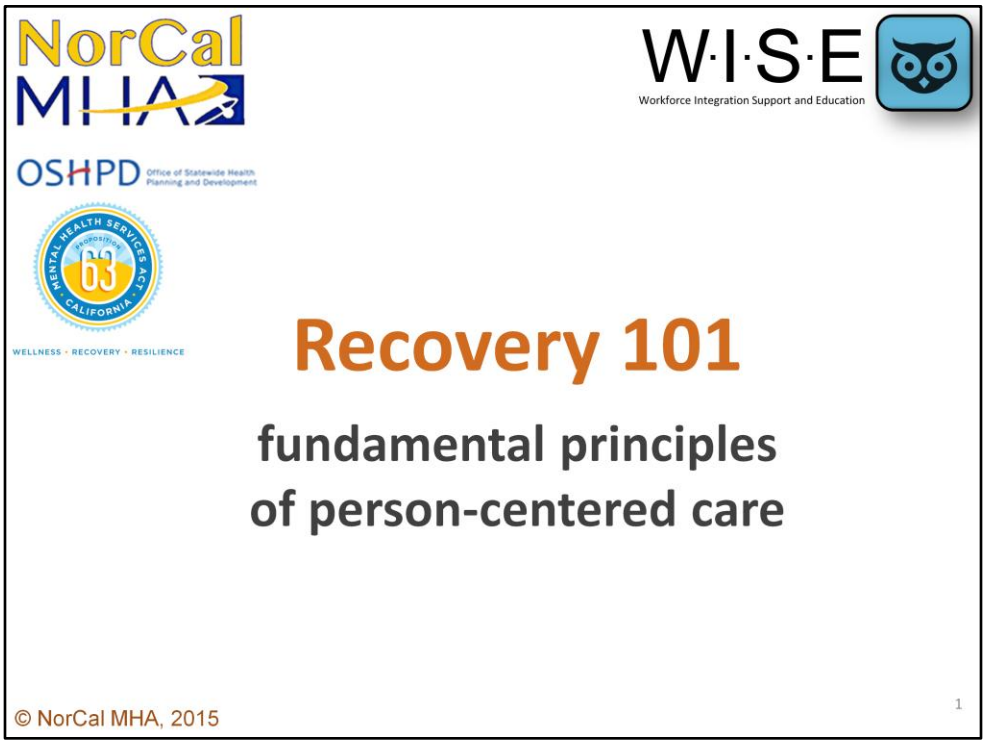
NorCal MHA
OSHPD Office of Statewide Health Planning and Development
MENTAL HEALTH SERVICES ACT
Proposition 63
CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE
W·I·S·E
Workforce Integration Support and Education
Recovery 101
fundamental principles
of person-centered care
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1

Trainer Info

W·I·S·E
Workforce Integration Support and Education

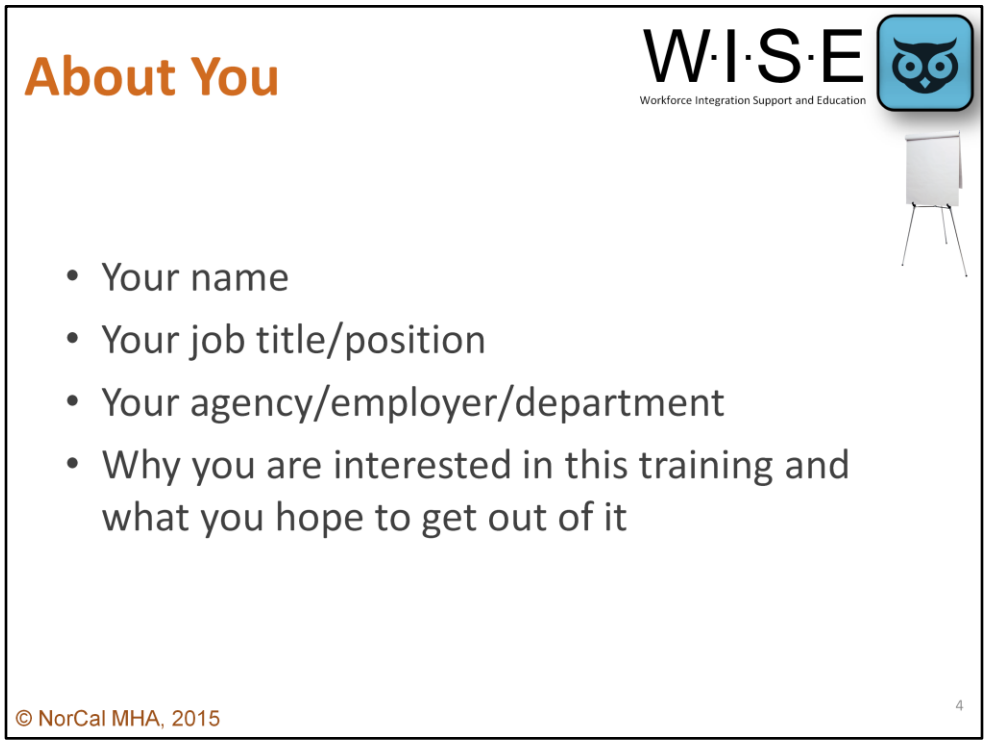
- My name
- My role in WISE
- My agency and position
- How long I've been employed at my agency
- Why I work in the mental health field

THIS SLIDE CAN BE CUSTOMIZED

About Recovery 101

W·I·S·E
Workforce Integration Support and Education

- Recovery 101 was created by peers at NorCal MHA and is a core training in the **W·I·S·E** program
- **W·I·S·E** stands for Workforce Integration Support and Education
- **W·I·S·E** is a program of NorCal MHA, administered by the Office of Statewide Health Planning and Development (OSHPD), and funded by the California Mental Health Services Act (MHSA/Prop 63), as a component of OSHPD's statewide WET plan



ASK: Why are you interested in this training and what do you hope to get out of it?

RECORD responses to last question on flipchart (what each audience member hopes to get out of the training)

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Recovery 101

fundamental principles of person-centered care

Today we'll learn about:

W·I·S·E
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1. The meaning of recovery
2. Key components of recovery, including person-centered and client-driven care
3. Barriers to recovery
4. Recovery's role in California's public mental health system
5. Ways to establish and strengthen a recovery-oriented workplace

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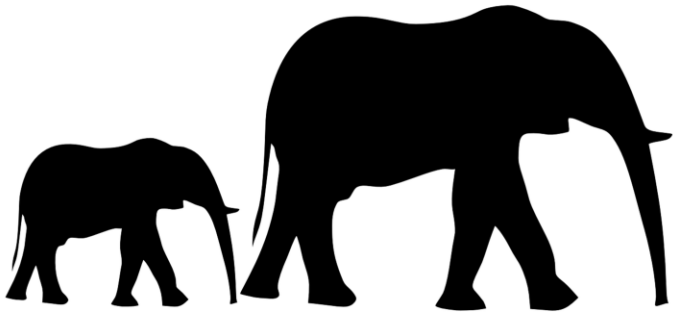
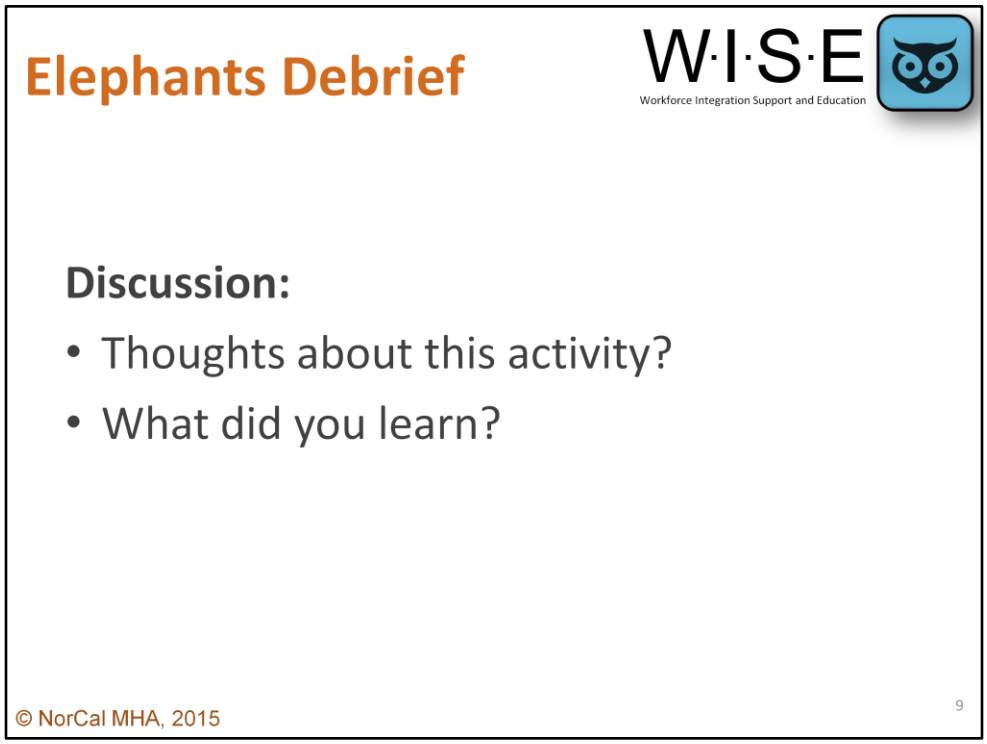
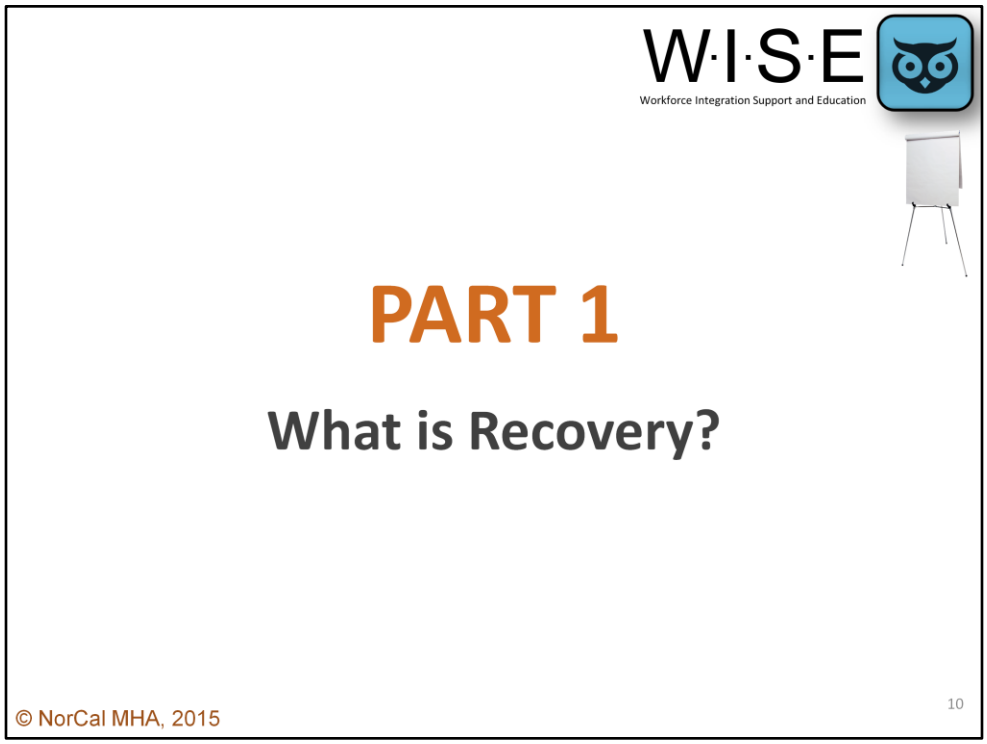
ELEPHANTS IN THE ROOM



REFER attendees to activity handout in their R101 folder

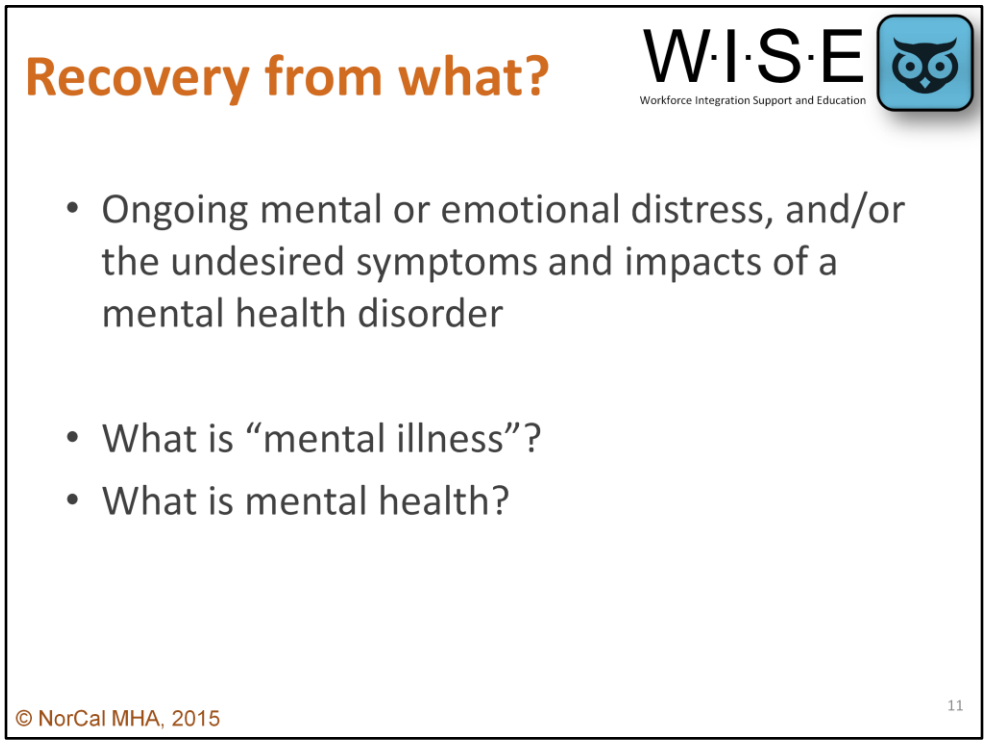


Allow time for participants to discuss their responses to the activity



ASK: What does recovery mean to you?

RECORD responses on a flip chart



SAY: I know a lot of people don't like the term "mental illness" and neither do we. But we need to use it in this narrow context with a limited meaning. Here, we use the term "mental illness" to refer to a current state or condition of unwellness. We are not referring to a specific mental health diagnosis.

ASK: Can anyone provide a definition of "mental illness"? (wait for responses before moving on)

SAY: Mental illness is a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities. Mental disorders result from biological, developmental and/or psychosocial factors and can be managed using approaches comparable to those applied to physical disease (i.e., prevention, diagnosis, treatment and rehabilitation).[2] *Health & Welfare Canada* (1988)

SAY: SAMHSA defines Mental as a serious functional impairment that substantially interferes with or limits one or more major life activities, such as basic daily living skills; instrumental living skills; and functioning in social, family, and vocational/educational contexts.

http://www.samhsa.gov/disorders

ASK: Can anyone define mental health? (wait for responses before moving on)

SAY: The World Health Organization says that: "Mental health is not just the absence of a mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." (WHO, 2010)

SAY: Mental Health is defined as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.

ASK, RHETORICALLY: So, what do we notice about these definitions?

SAY: These definitions involve many more factors than just the individual and suggest that interventions and treatments for mental illness should also look beyond the medical setting and consider the interplay of the individual with his/her environment, his/her community, and with society.

Recovery is Real

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- Longitudinal studies demonstrate most people who have struggled with a mental health challenge – a even severe mental illness – can and do get better
- For some people, symptoms diminish or disappear completely, even without medication

http://psychrights.org/research/Digest/Chronicity/vermont1.pdf

http://psychrights.org/research/digest/Chronicity/myths.pdf

Recovery is Complex

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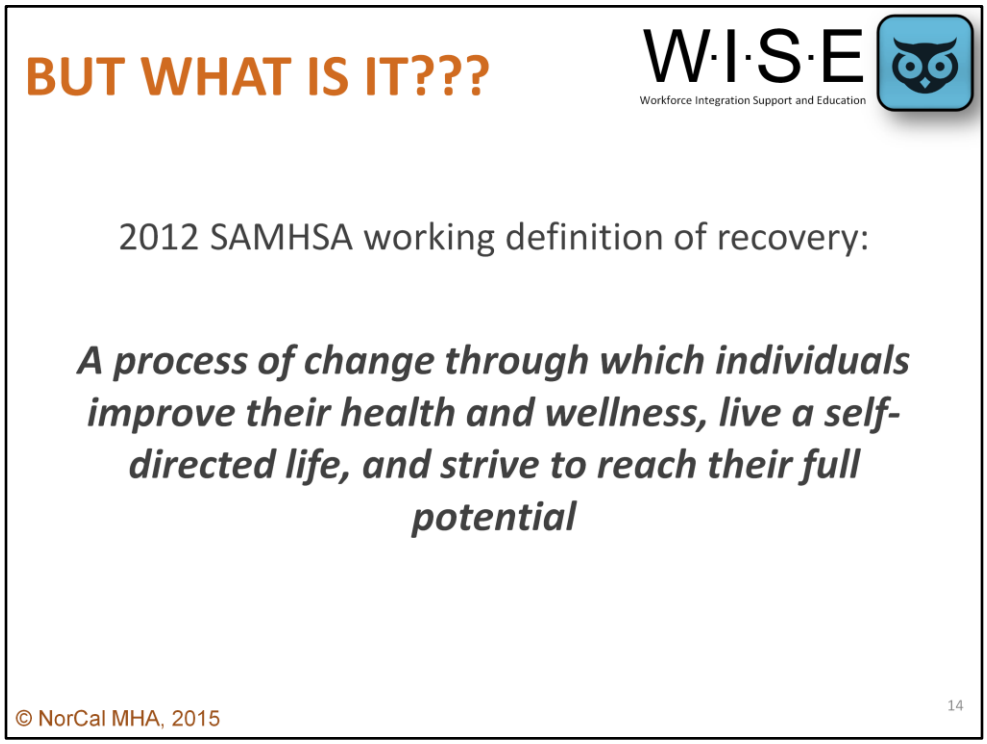
- Means different things for different people
- Can be viewed as both a **process** and an **outcome**
- Recovery is more than just an absence of the symptoms of a mental health disorder



SAY: The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Congress established the SAMHSA in 1992 to make substance use and mental disorder information, services, and research more accessible. It is SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities.

Let's break this down a bit.

ASK: (give time for 1-2 responses to each question before moving on)

1. A process of change – what does that mean to you?
2. Improve health and wellness – what does that have to do with mental illness? (Hint – it's about more than mental illness or wellness)
3. Self-directed life – people diagnosed with mental illness are capable of taking care of themselves and taking control of their lives
4. Strive and REACH their full potential – people with mental illness get better and move on. They aren't always sick and they won't always experience a relapse. They don't stay fragile forever. Do you agree or disagree with this?

http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF

Two Views of Recovery

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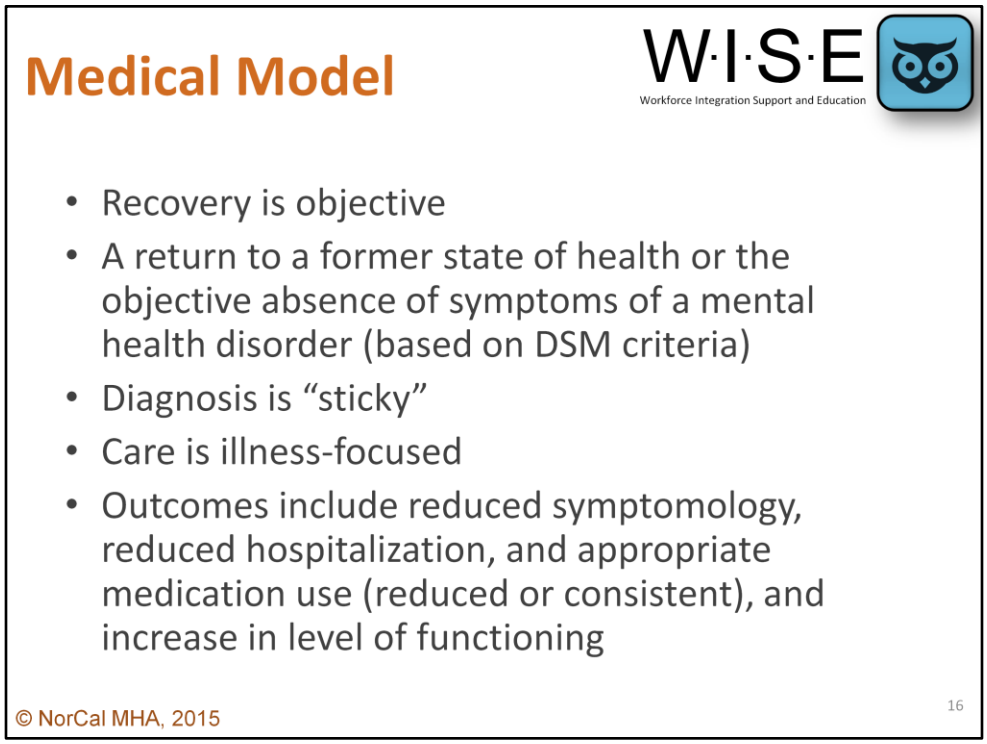
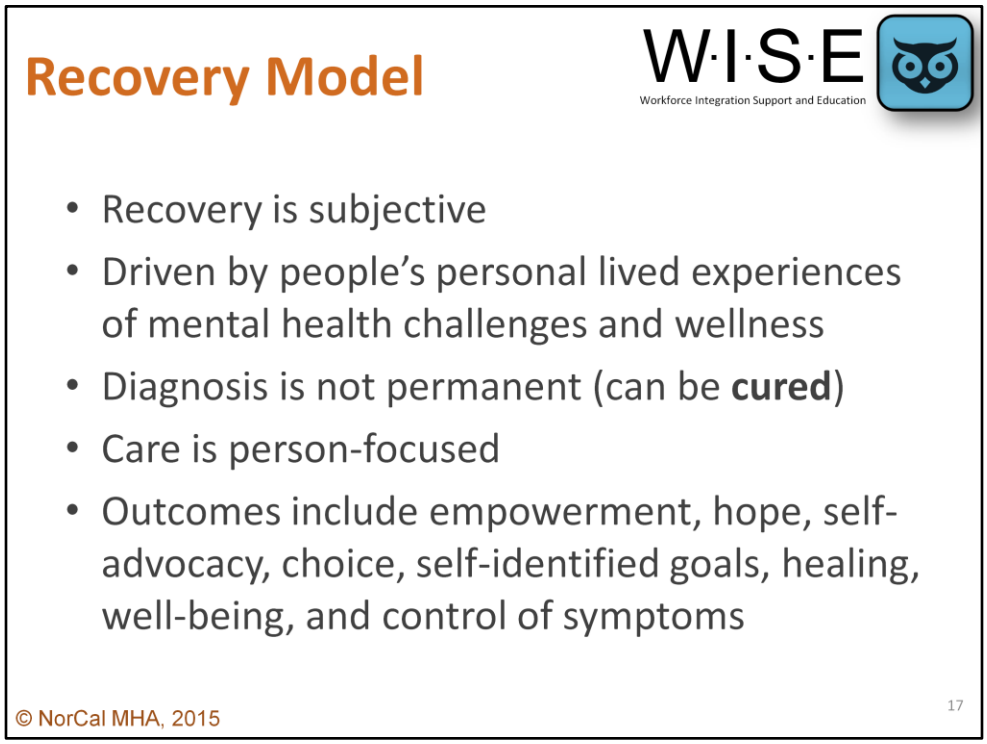
- **Medical Model / Clinical View**
- **Recovery Model / Consumer View**

these views coexist



SAY: One criticism of the Medical Model:
In recent years, consumer advocacy groups have expressed concerns related to how clients are classified. Many take exception to terminology that seems to put them in a "box" with a label that follows them through life, that does not capture the fullness of their identities. A person with COD also may be a mother, a plumber, a pianist, a student, or a person with diabetes, to cite just a few examples. Referring to an individual as a person who has a specific disorder—a person with depression rather than "a depressive," a person with schizophrenia rather than "a schizophrenic," or a person who uses heroin rather than "an addict"—is more acceptable to many clients because it implies that they have many characteristics besides a stigmatized illness, and therefore that they are not defined by this illness.

http://www.ncbi.nlm.nih.gov/books/NBK64184/#A74170



INSTRUCTOR NOTE: You do not need to read this word for word

Symptoms of a mental health disorder may not always result in an impairment in functioning. For instance, someone who is diagnosed with ADHD may not experience any significant impairment if they work at a job that involves physical activity, varied tasks, and mental stimulation.

ASK: Think of the uptick in diagnosis of children with ADHD in recent decades – what has changed in the school environment that is correlated with this increase? (give time for responses before moving on)
Some examples to offer:

- Reduction or elimination of PE, art, music, recess, or after school programs that may provide outlets to release pent-up physical and creative energy
- Increased use of technology and reduction of physical activity
- Increased reliance on cars, buses, and other transportation that require minimal physical activity

SAY: So we may be labeling kids as the problem when their environment has changed and kids' physiology has not adapted. The same child who has trouble functioning in a strict environment where the classes are overcrowded and the school is underfunded may do just fine in a school that provides more creative outlets and a free-flowing learning environment.

Adults are similar in this regard – the environment and social context may have a big impact on the ability to cope with one's symptoms. And people can choose to treat their symptoms in various ways that are subjectively right for them. They can exercise more. They can change their diet. They can take medications. They can change their social environment. They can engage in activities and relationships that they find personally meaningful. Of these, only one is a medical intervention.

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PART 2

Key Recovery Concepts

Back to SAMHSA

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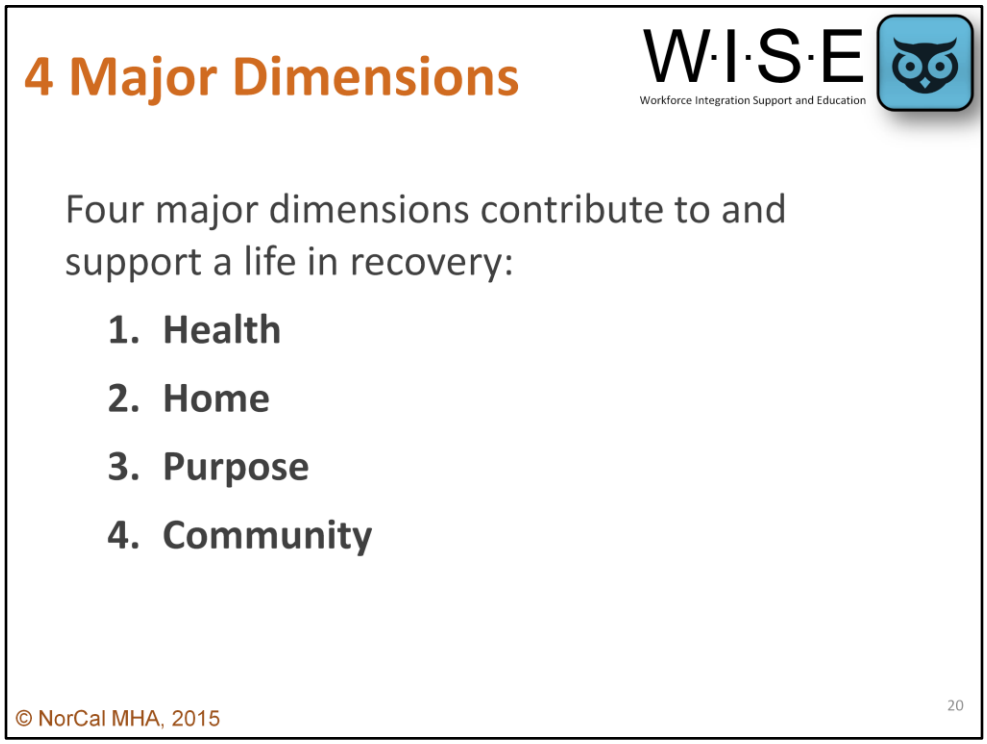
A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential

- SAMHSA's definition of recovery includes:
  - 4 Major Dimensions
  - 10 Guiding Principles

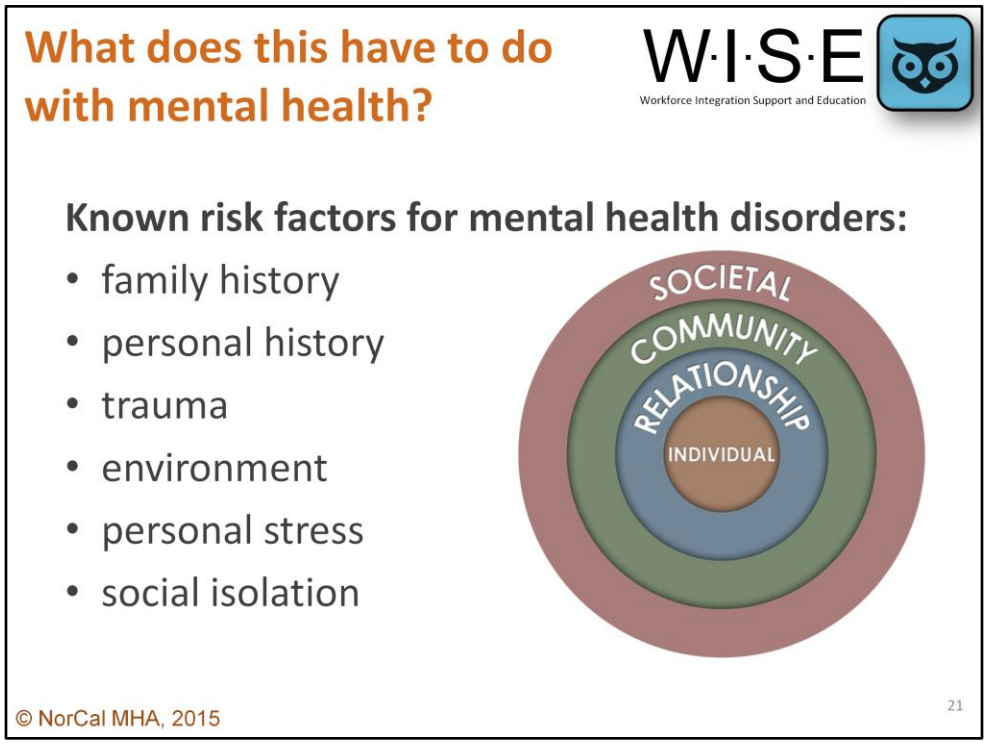


ASK: Before we get into the definitions of each of these components, what do you notice about this list? (give time for responses)

SAY: Health is just one component of recovery – it is the first one listed and perhaps even the most important one, but it still only 25% of the picture. Also notice, it does not say MENTAL health …

ASK: what does that tell you? (give time for 1-2 responses)

SAY: This definition includes psychosocial factors that contribute to personal wellbeing. Other people have a significant role to play in a person's recovery from mental illness (home, community)



SAY: We do know what makes people more vulnerable, and these are called risk factors. Each of these is an independent risk factor, and the more you have the greater your risk.

EXPLAIN:

FAMILY HISTORY - biological connection have been diagnosed with a mental illness or have experienced mental health problems, addiction, suicide or suicide attempts. This refers also to an individual's previous history.

PERSONAL HISTORY - If someone has had a previous episode of mental illness, they are more at risk of having another episode than someone who has never had one.

TRAUMA - This refers to chronic trauma, like living through a war, or child abuse or domestic abuse. It can involve being the victim of a crime or witnessing violence. It can also refer to physical trauma, like being in a car accident or having a significant illness or injury. It can refer to a critical traumatic incident like being in a fire or a bank robbery.

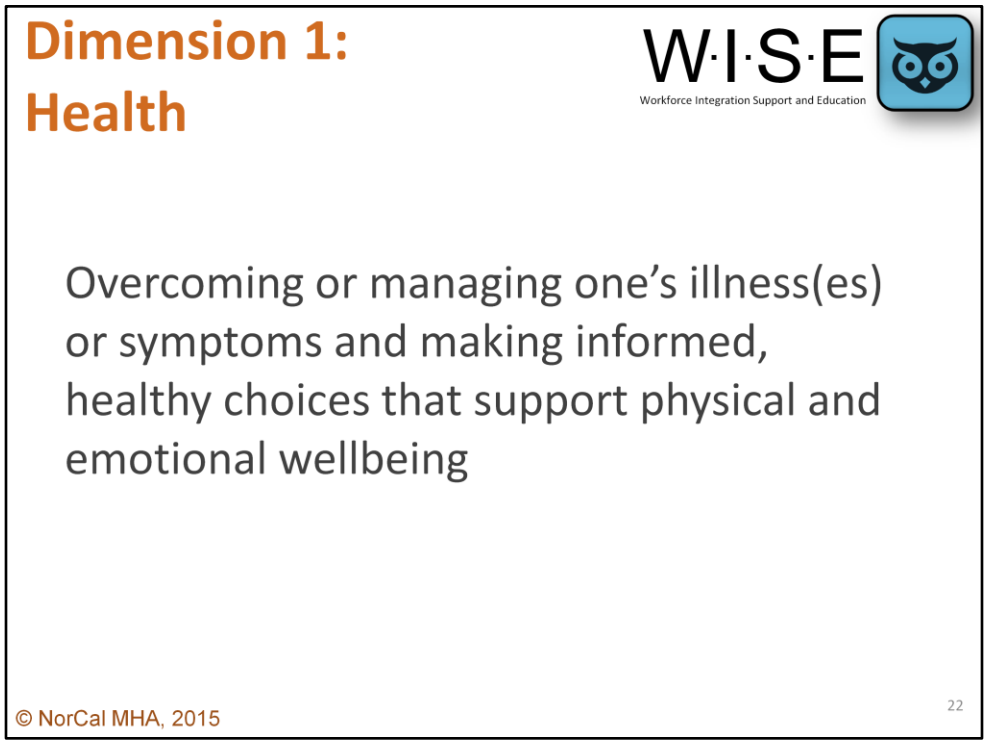
ENVIRONMENT - the psychosocial conditions in which someone lives – might create substantial risks, such as exposure to ongoing violence, neighborhood poverty, or institutional stigma and discrimination (e.g., racism, heterosexism). It could also include the environment in which someone was raised (e.g., inadequate parental involvement/supervision, parents with substance abuse histories, lack of health care

and other resources, childhood maltreatment or neglect, peer rejection, association with delinquent peer group), even if they no longer live in this environment.

PERSONAL STRESS - involves significant financial problems, relationship problems, housing problems, problems with children or our parents or other family members, housing problems. This can also include **workplace stress**. This involves work overload, chaotic environment, changing priorities, high demand with low control, lack of resources, lack of training to do the job well, and a very significant stressor: lack of social support at work.

SOCIAL ISOLATION - Research into social prejudice and stigma seems to be finding a link between **social isolation** and increased risk for developing a mental illness. Also, research into disability rates is finding a possible link between social isolation and increased risk for depression**. This is seen when employees go off work for a physical issue and then develop clinical depression** which keeps them off work even after they have recovered from the physical issue.

Remember that even one of these means that you are more vulnerable. If you have even one, you may want to take a look at how you take care of your mental health to minimize the impact of the risk factor.



ASK: What do you think of this definition? (give time for responses before moving on)

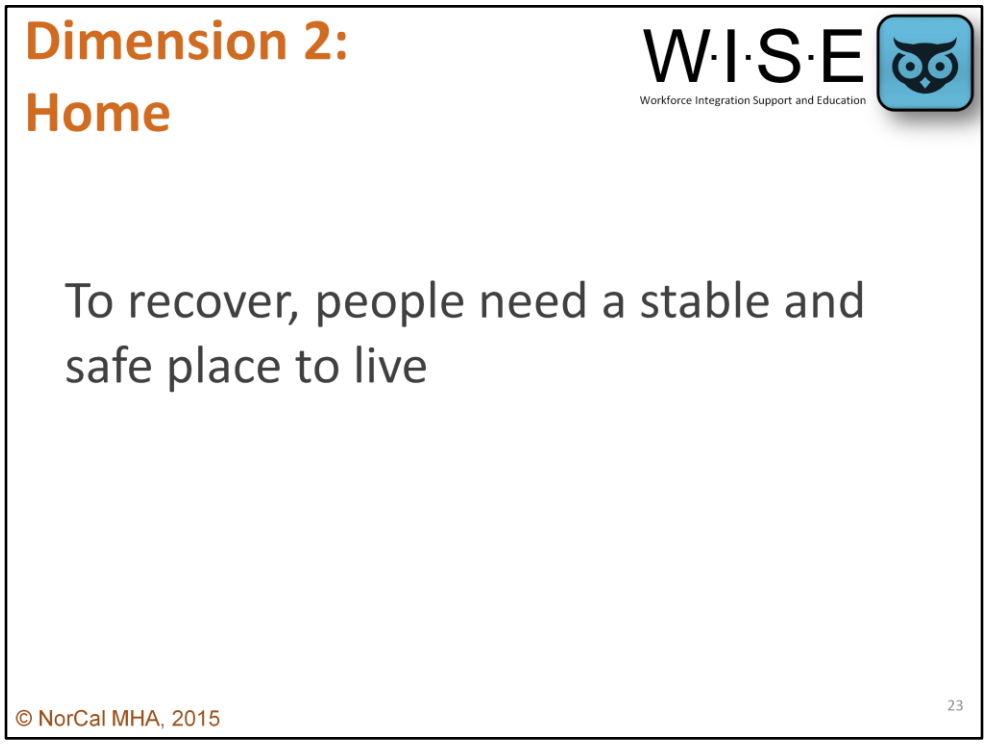
ASK: Do you think the authors of this section view recovery as objective or subjective? (allow 1-2 responses before moving on)

ASK: If recovery involves making informed, healthy choices, what does that tell you about individuals living with mental illness? (allow 1-2 responses before moving on)

ASK: Why do you think physical wellbeing is relevant to maintaining mental wellness? (allow 1-2 responses before moving on)

- comorbidity, physical illness can lead to mental illness or relapse

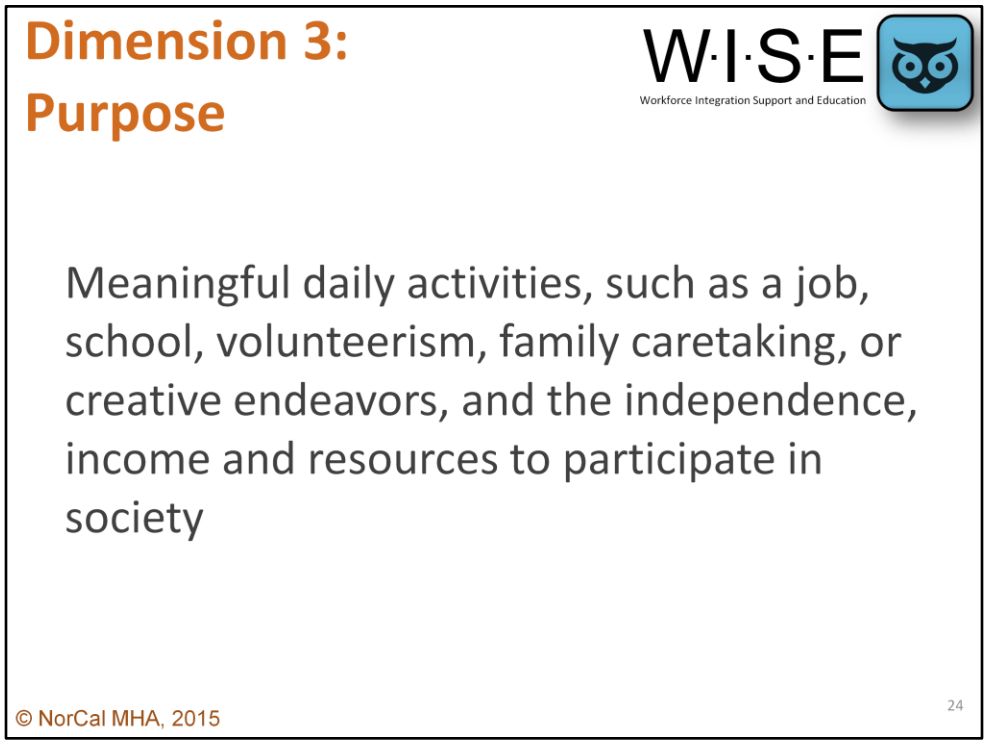
SAY: We know that people with a serious mental health diagnosis tend to die much earlier than those without – as much as 20 years sooner! Individuals who have serious behavioral health conditions and lack financial resources are often unable to access quality care, either for their behavioral health conditions or for other health problems. Properly addressing behavioral health conditions is necessary because untreated mental and substance use disorders not only negatively impact a person's behavioral health but also lead to worse outcomes for co-occurring physical health problems. Good behavioral health is associated with better physical health outcomes, improved educational attainment, increased economic participation, and meaningful social relationships



ASK: Why would a stable and safe place to live support mental wellness and recovery from mental illness? (allow 1-2 responses before moving on)

SAY: Permanent supportive housing has emerged as a model in which individuals who have mental and substance use disorders can secure stable housing and receive the range of supports they need to manage mental illnesses or other disabilities.

SAY: Research and practice reveal that supportive housing decreases symptoms, increases housing stability, and is cost effective.



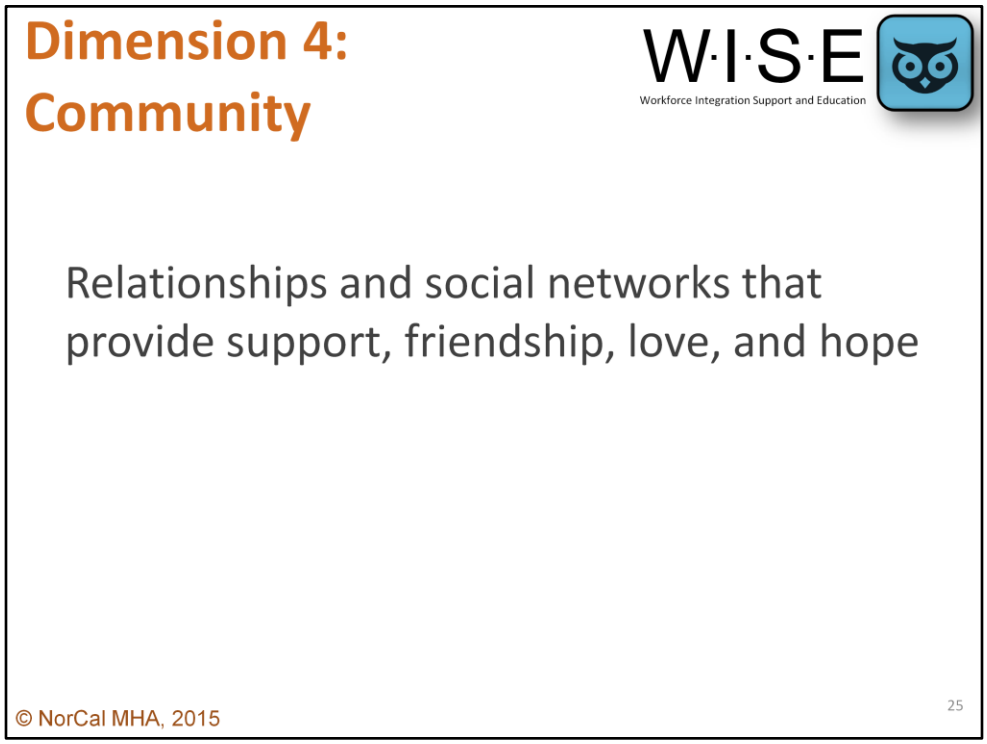
ASK: How does a sense of purpose and meaning contribute to one's recovery? (give time for 1-2 responses before moving on)

SAY: So how does working impact one's personal identity, help develop motivation, and provide hope for the future? When you are unemployed, and someone asks what you do…what do you say? "Nothing." And because so much of our identity is

SAY: So we see how being unemployed can definitely effect how we feel about ourselves. Even unpaid volunteering provides a sense of contribution and meaning. It is also a way to attain important job skills and interact with others to prevent social isolation.

SAY: being unemployed is associated with increased rates of mental disorders, especially among men, and with relapse and substance use.

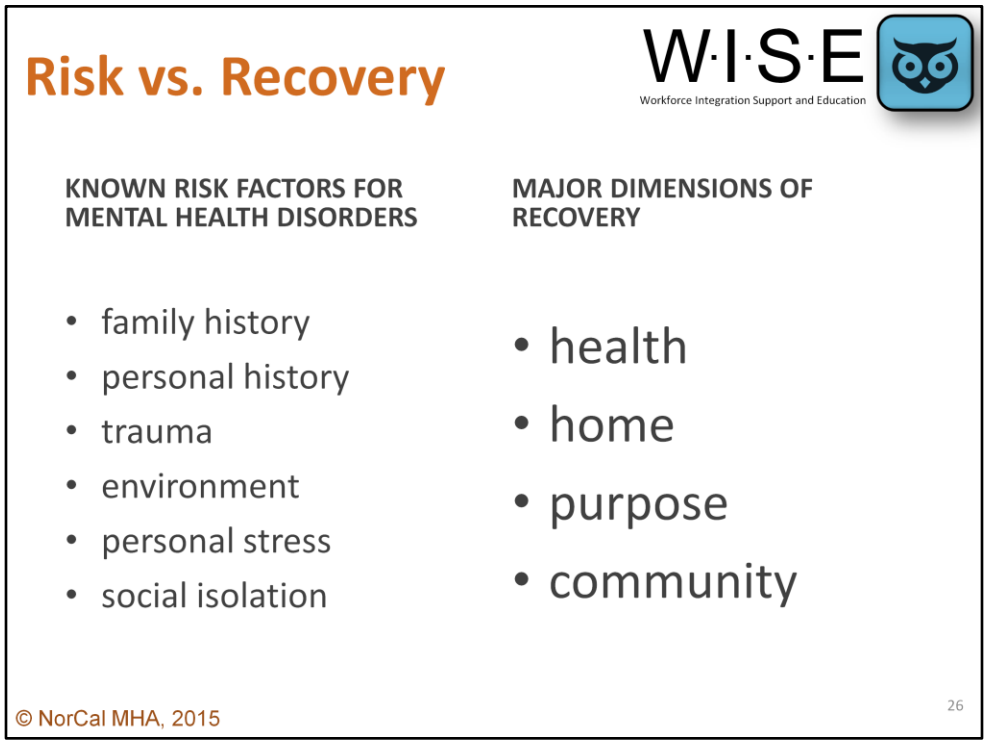
SAY: We know that educational attainment is correlated with higher income and better physical health. Maybe because education helps people understand the benefits of taking care of their physical health or maybe because it gives them access to resources to endure their health needs are met. Unfortunately, mental illnesses often begin when young adults are completing high school and looking at future opportunities and career plans.



SAY: Individuals with behavioral health conditions do not recover in isolation—they recover in families and community.

However, even if they live in neighborhoods alongside people without disabilities, individuals with mental conditions may lack socially valued activity, adequate income, personal relationships, recognition and respect from others, and a political voice. They remain, in a very real sense, socially excluded. The exclusion comes from society's attitudes and fears about persons with mental and substance use disorders as much or more than from any disability associated with these disorders.

Insufficient natural supports exist in the community to involve persons with mental health disorders in shared social activities, either with peers or with members of the community at large. Mutual support groups play a critical role for many, but there is still an unmet need. **A person with a behavioral health condition is as capable of living a full life integrated in a community as anyone else.** Successful recovery from mental disorders is an important societal goal, especially attainment of levels of recovery that enhance economic security and reduce reliance on government-funded disability income support programs. **The goal is for people with behavioral health conditions to flourish, not merely function, in their communities.**



ASK: How do the 4 major components of recovery address these known risk factors? (give time for a few responses)

Ten Guiding Principles

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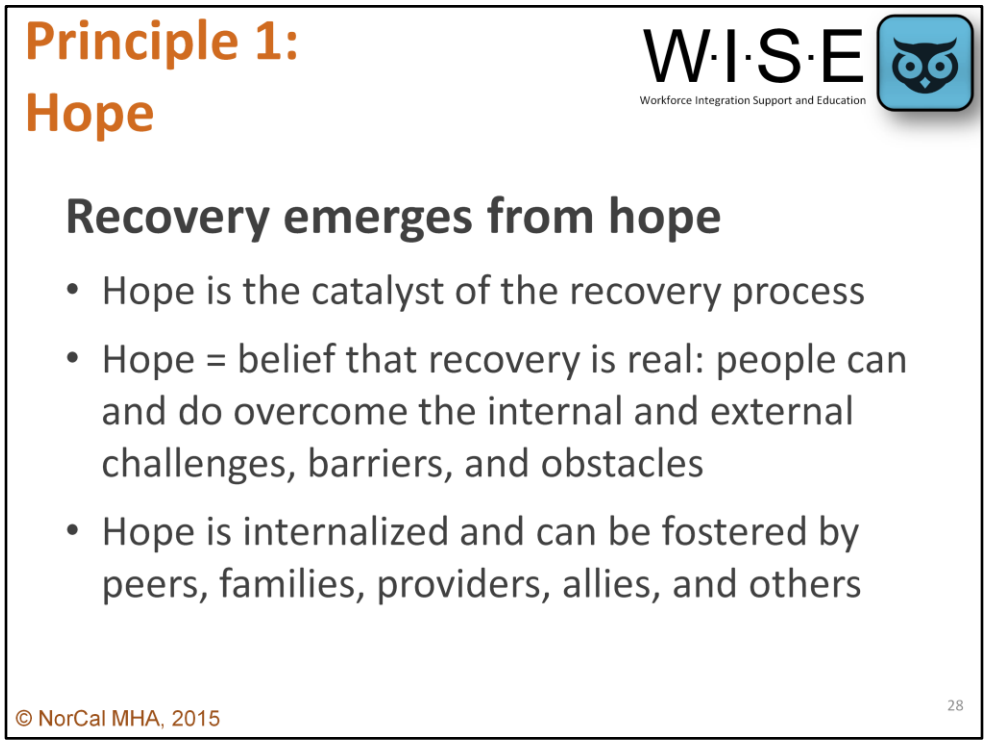
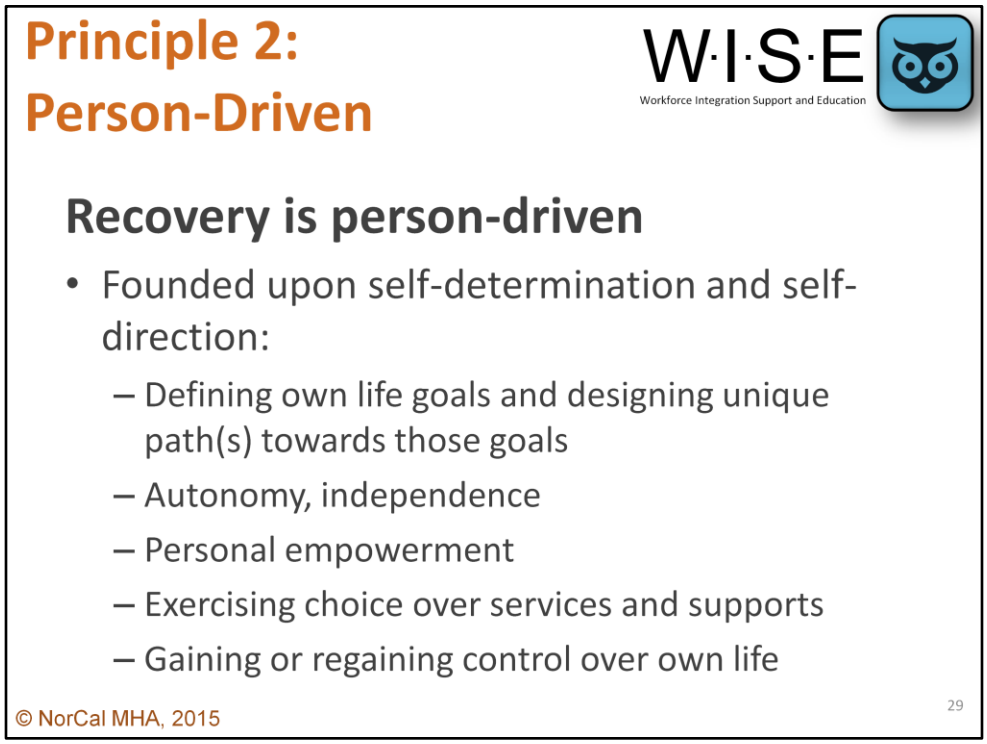
1. Hope
2. Person-driven
3. Many pathways
4. Holistic
5. **Peer Support**
6. Relational
7. Culture
8. Addresses trauma
9. Strengths/Responsibility
10. Respect

Read through quickly, pass through slide



SAY: Hope is internalized and can be fostered by peers, families, providers, allies and others. If you have no hope that things will improve, then you have no reason to take personal action to make things better. Interacting with others who have recovered can inspire hope in those who are experiencing a mental illness.

If comfortable, share how you learned about recovery, and find a way to emphasize the concept of hope.

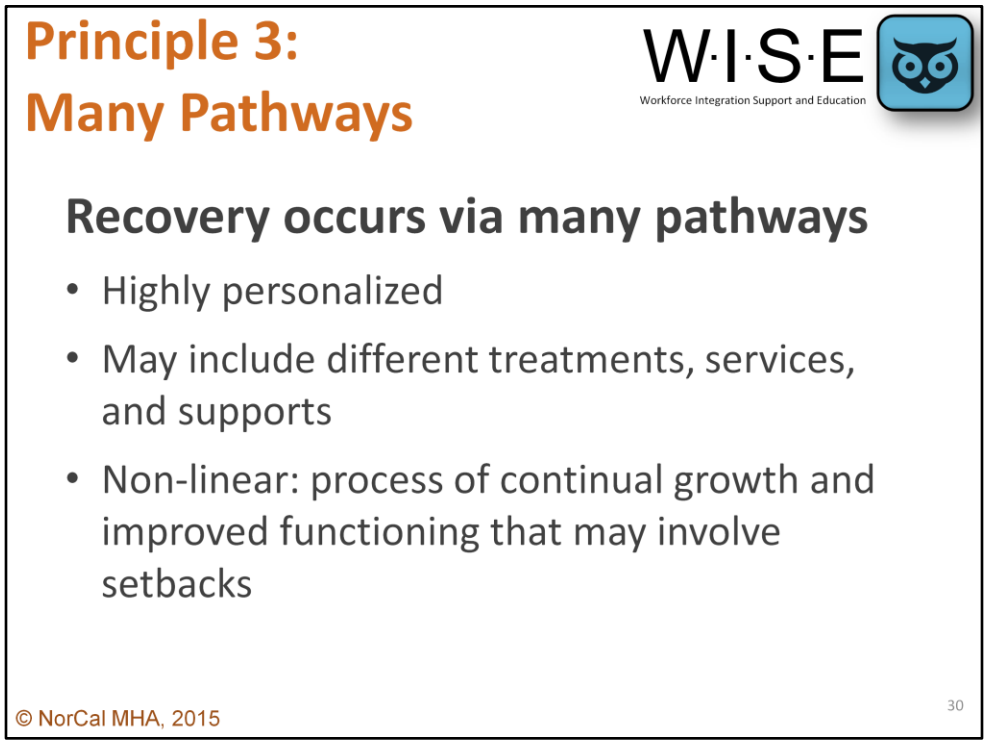


SAY: A major premise of the recovery model is that people with mental illness are FULLY CAPABLE of making good decisions and appropriate choices for themselves when given the information, resources, and support necessary to do so. People with a MH diagnosis are not developmentally delayed, immature, incompetent, child-like, fragile, or forever broken. They can be trusted to think for themselves and make good choices. However, to accomplish this, they must have access to resources to make informed decisions, initiate recovery, build on their strengths, and gain control.

This control can feel uneasy to family members, practitioners, or caretakers who have exercised significant control over the individual's life. These helpers may begin to see themselves differently or question their own personal identities when the roles begin to shift and people in recovery start making decisions for themselves.

SAY: How many of you have teenagers or adult children? How many of you had trouble letting go when they began to grow up and reach important milestones? But you did let go, right?

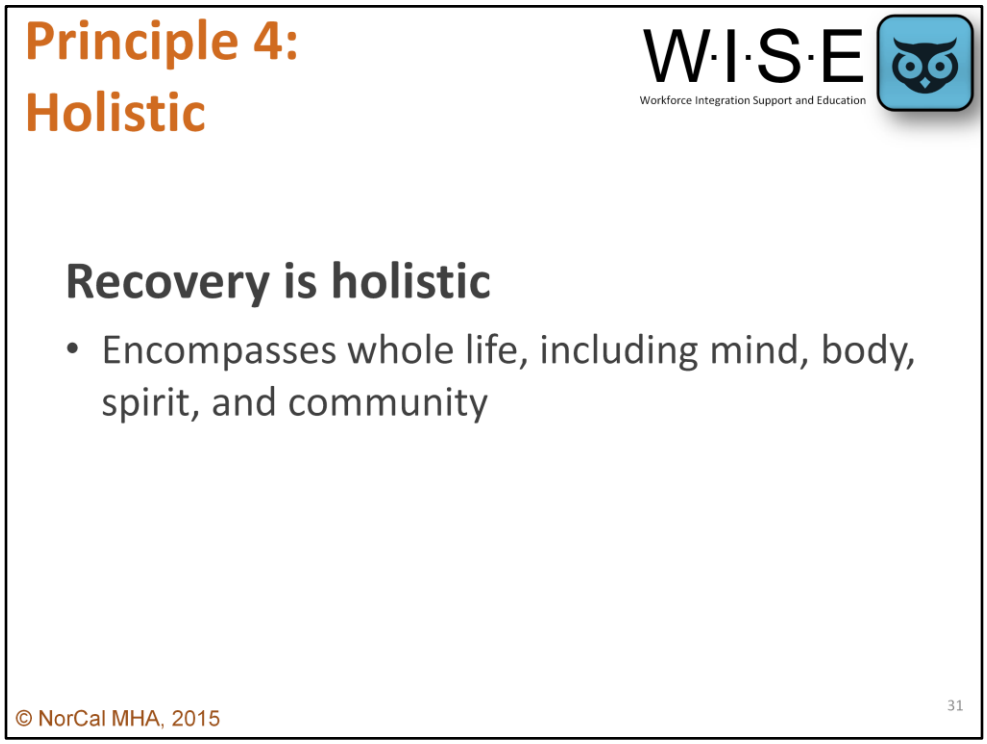
ASK: Why was this the right thing to do? (allow time for 1-2 responses)



SAY: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds— including trauma experience — that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. THERE IS NO ONE RIGHT WAY.

ASK: What does this say about the medical model? Is recovery actually OBJECTIVE or a one-size-fits-all approach? (give time for a few responses

SAY: Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Relapses are not evidence of a defective nature – they are a normal part of recovery and a relapse does not mean someone will never recover.

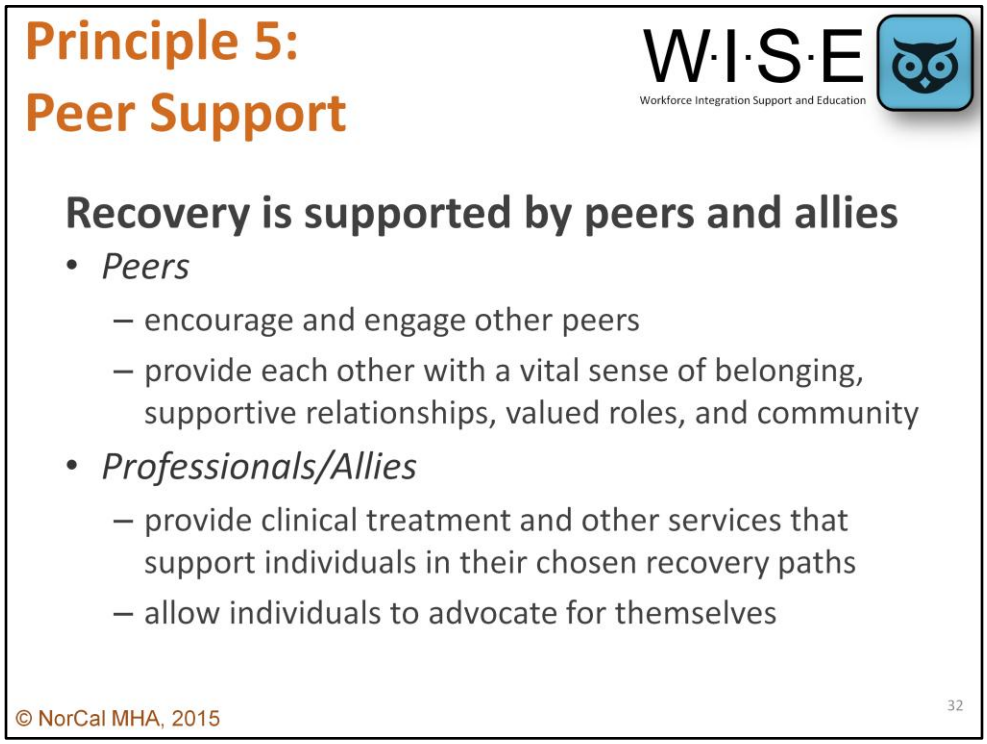


SAY: The array of services and supports available should be integrated and coordinated

READ EXAMPLES:

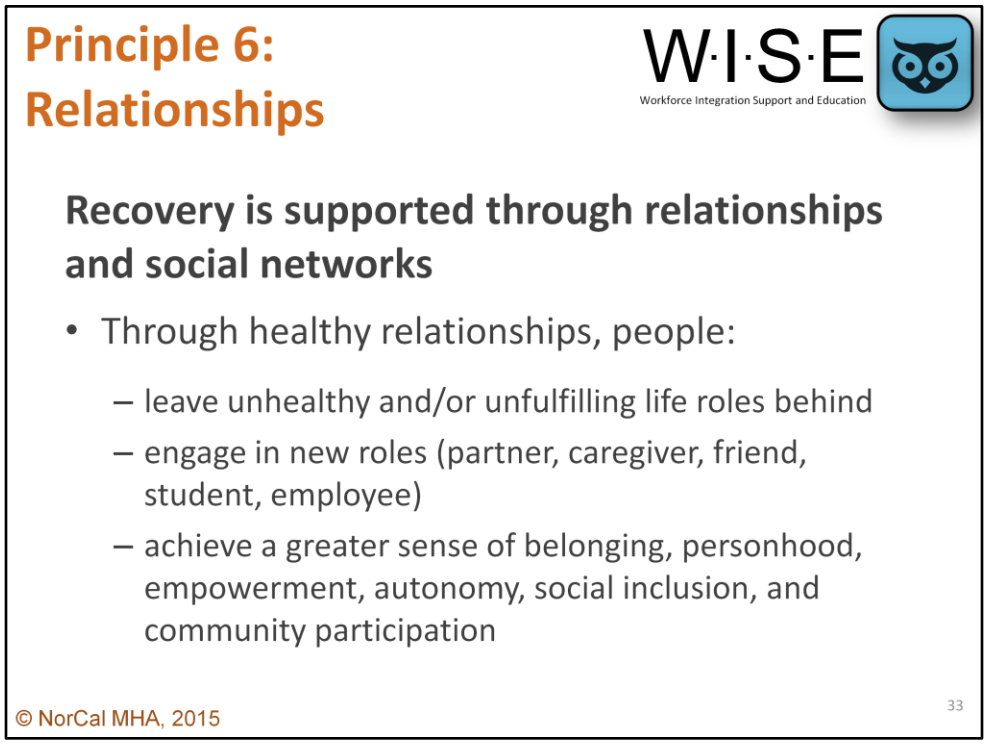
- Self-care
- Family
- Housing
- Employment
- Transportation
- Education
- Community participation
- Clinical treatment
- Services and supports
- Primary healthcare
- Dental care
- Alternative services
- Faith/spirituality
- Social networks

*We will be talking about system barriers to recovery later that makes difficult integrated and coordinated care.

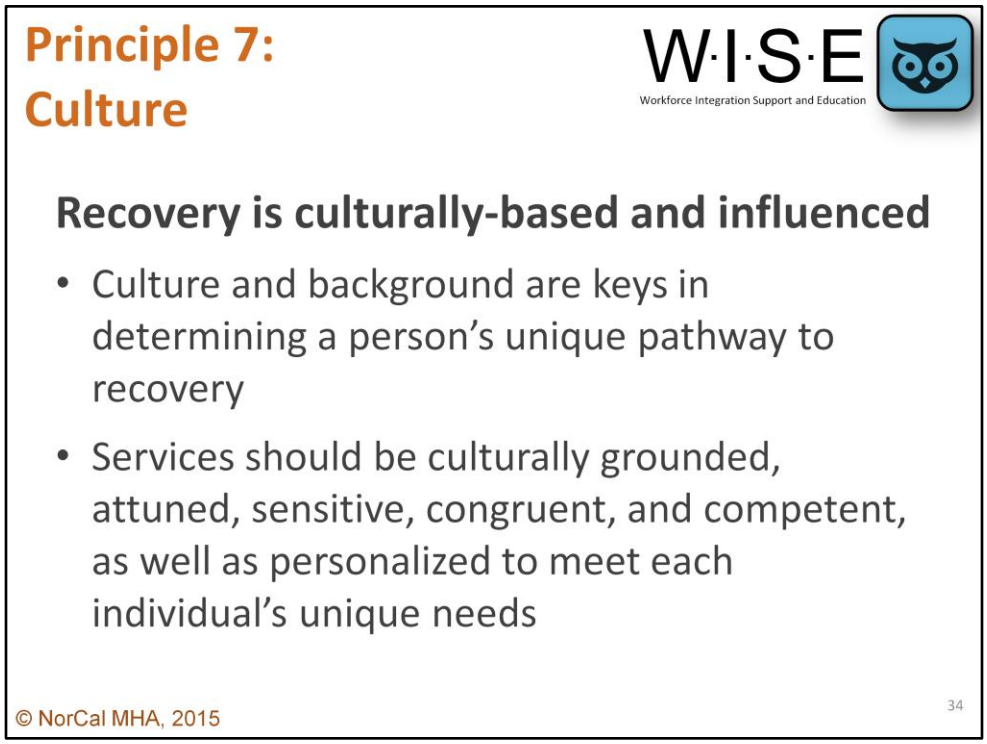


SAY: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Through helping others and giving back to the community, one helps one's self. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

SAY: Will be addressing more about peer support later in the training



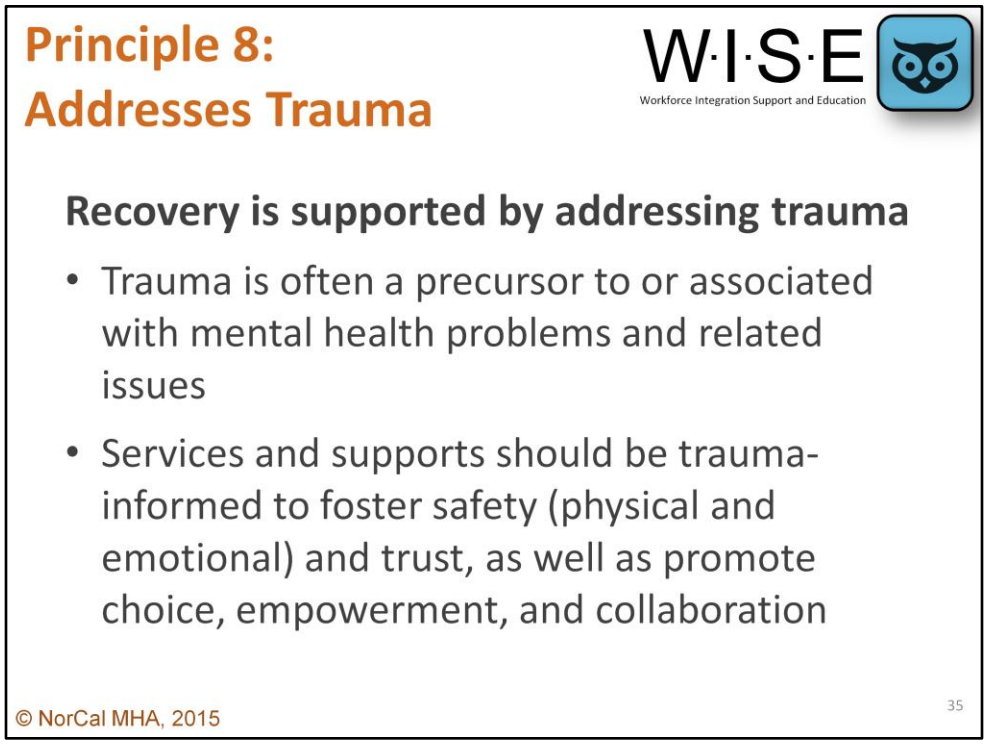
SAY: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks



SAY: Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures. To produce positive change, practitioners must understand the cultural context of the community they serve, and have the willingness and skills to work within this context. This means drawing on community-based values, traditions, and customs, and working with knowledgeable people from the community to plan, implement, and evaluate prevention activities.

SAY: Supporting recovery requires that mental health and addiction services:

- Be responsive and respectful to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups
- Actively address diversity in the delivery of services
- Seek to reduce health disparities in access and outcomes



ASK: What is trauma?

SAY: The term "trauma" refers to experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions.

Practitioners must interact with each client to facilitate that client's recovery and avoid re-traumatization by collaborating with clients to:

• Foster an understanding of integrated treatment for clients with histories of trauma and substance use or concurrent disorders
• Help them acknowledge trauma and heal from it (BUT DON'T FORCE PEOPLE TO REVISIT TRAUMAS THEY HAVE MOVED PAST – THIS IS RE-TRAUMATIZING IN ITSELF)
• Help them develop strategies to minimize the impact of triggers, vulnerabilities or other factors that contribute to re-traumatization
• Support self-efficacy, self-determination, dignity and personal control
• Encourage the choice of treatment options that ensure physical, psychological and emotional safety

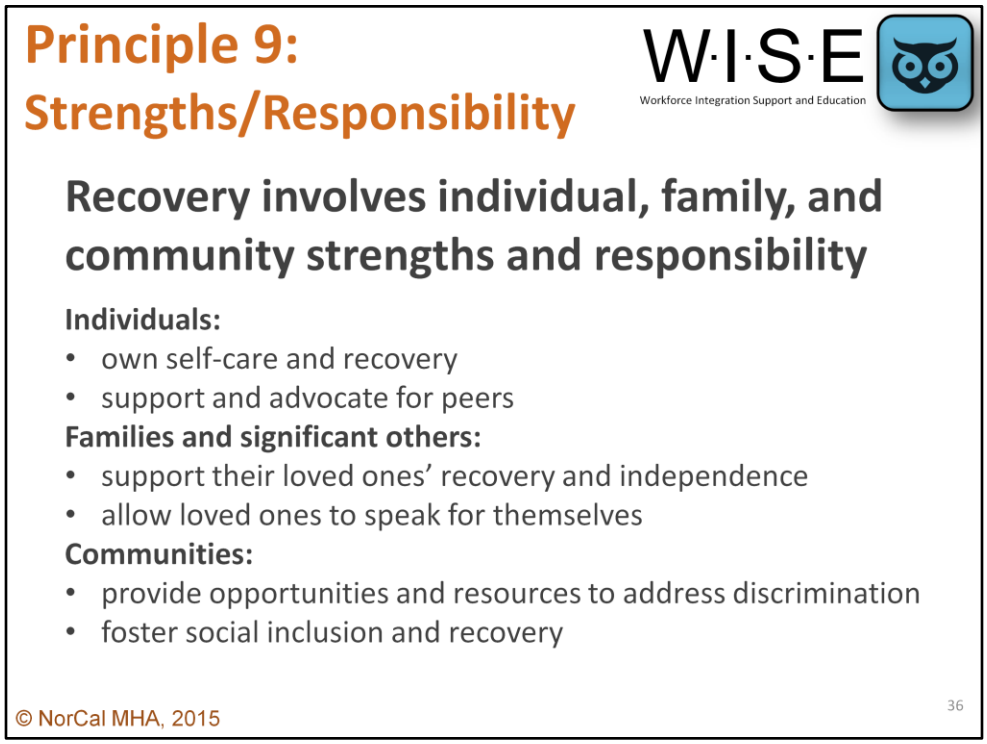
SAY: Secondary trauma is especially relevant to behavioral health providers: "Secondary trauma" is trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all behavioral health settings and among all professionals who provide services to those who have experienced trauma.

DEFINITIONS (only if asked)

Trauma-informed: A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. It involves four key elements of a trauma-informed approach: (1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; (3) responding by putting this knowledge into practice; and (4) resisting retraumatization.

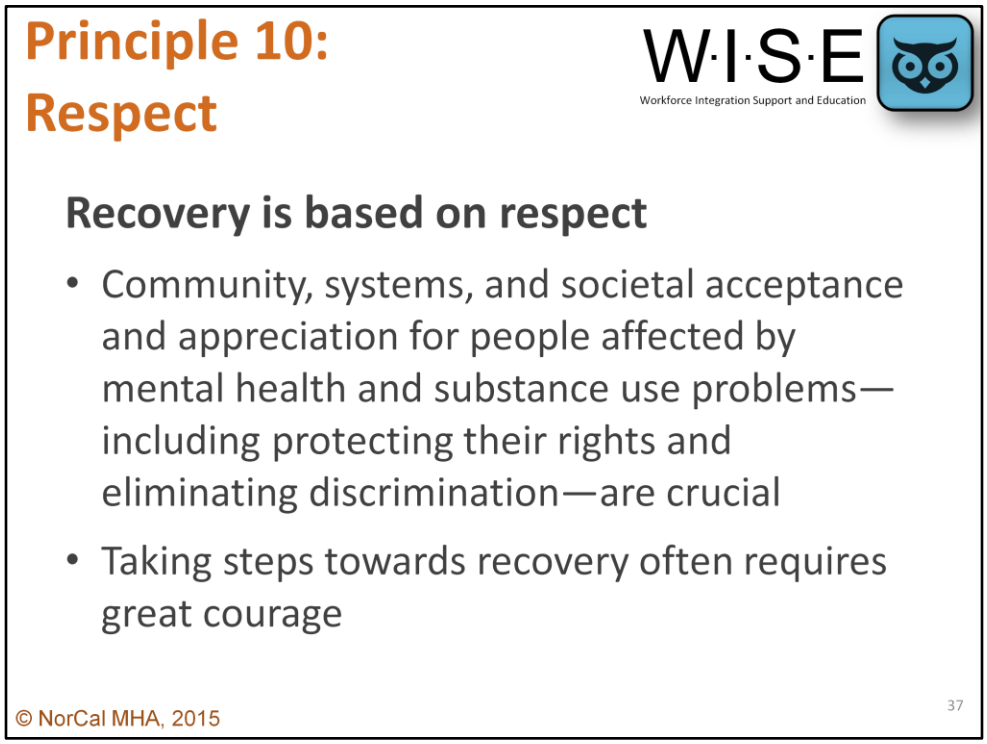
Trauma-informed care: TIC is a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.
Trauma-specific treatment services: These services are evidence-based and promising practices that facilitate recovery from trauma. The term "trauma-specific services" refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.

http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf

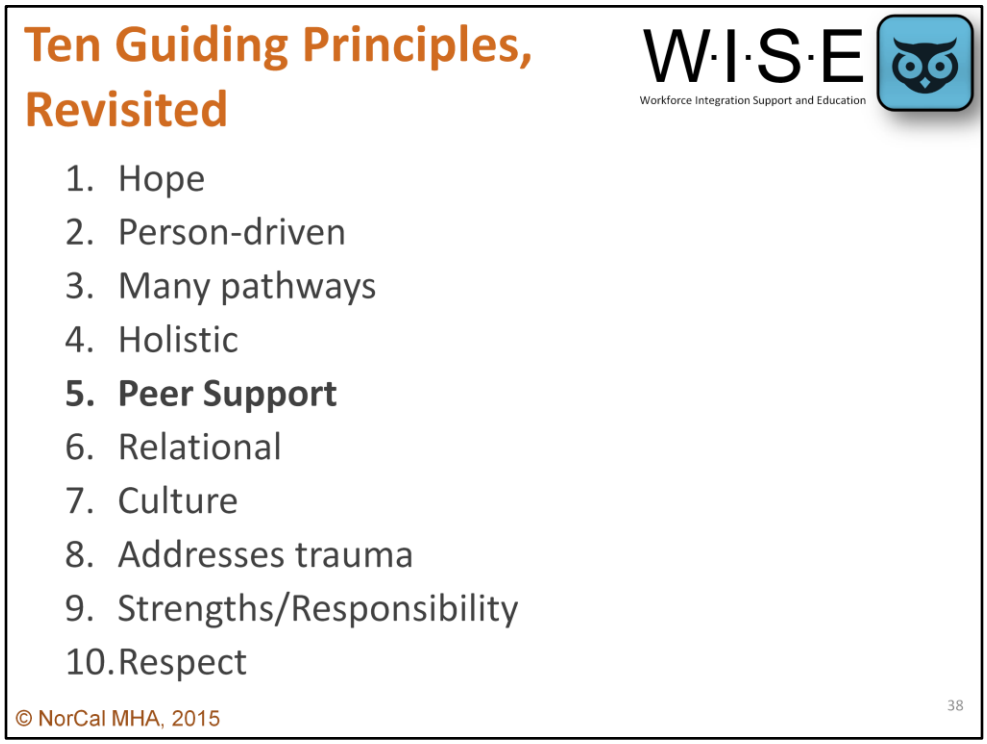


SAY: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. Yes, we ALL have a role to play in supporting (or undermining) recovery. Mental illness doesn't happen overnight – many factors converge and contribute to the development of mental illness. So these same factors play a role in recovery as well.

SAY: Individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.
Individuals should be supported for speaking for themselves. Families have responsibilities to support their loved ones. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery



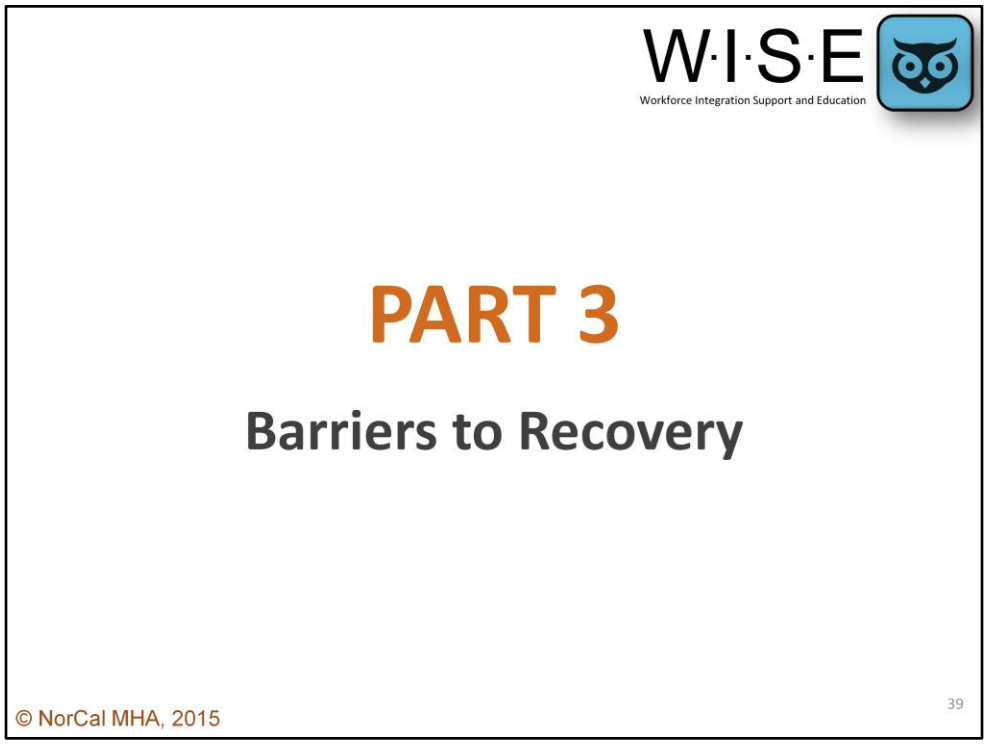
SAY: Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.



ASK: Which of these principles resonated most with you?

ASK: Which of these principles surprised you or taught you something you didn't already know?

ASK: Which of these principles does your workplace need support in strengthening?



ASK: Has anyone's definition of recovery changed or shifted? (give time for some responses)

SAY Now let's explore some of the most common barriers to recovery …

Recovery is Difficult

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- for the individual, their families, their helpers, communities, and society
- but **NOT** recovering is even tougher

Who has a harder fight than he who is striving to overcome himself?

-Thomas Kempis

SAY: Recovery requires time, dedication, effort, resources, and energy and cannot happen in a vacuum

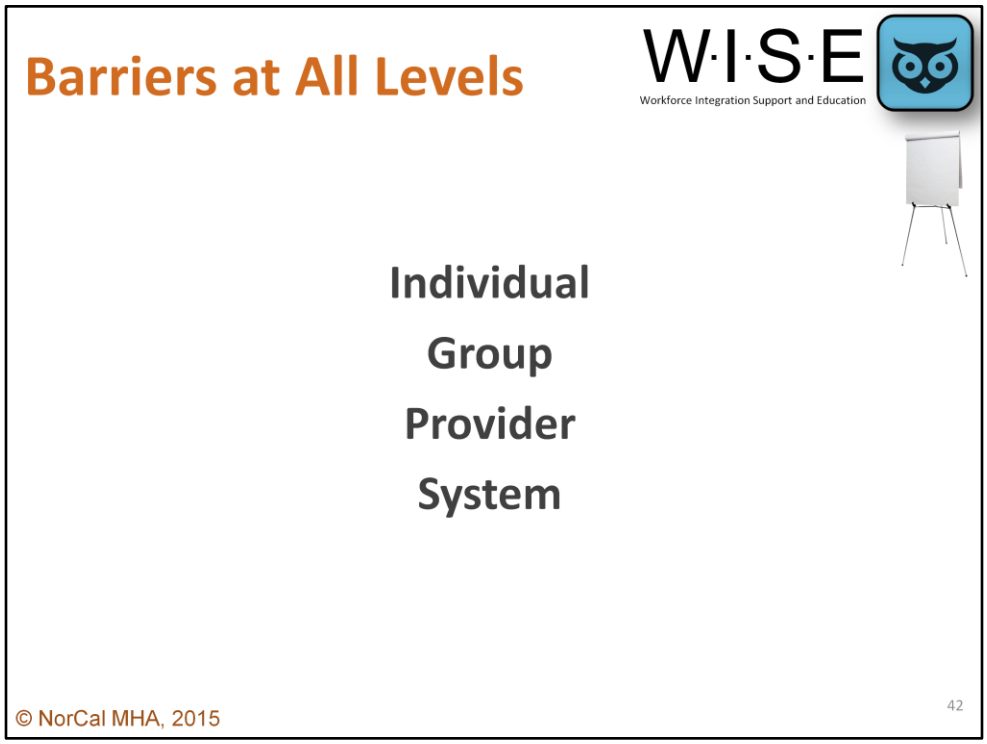
[DO NOT INCLUDE THIS SLIDE IN AUDIENCE SLIDE HANDOUT]

SAY:
•This is sometimes what it feels like when you really have a need to be heard
•This is sometimes what it feels like when you're trying to help some one in their recovery

PLAY the video for attendees.

SAY: Our intent is not to discourage or blame, simply recognizing the challenges we all face. The first step to changing anything is recognizing it. So imagine the woman in the video is a client and the man is someone trying to help her through recovery.

ASK: What are some barriers to recovery from the woman's perspective? (give time for responses)
ASK: What are some barriers to recovery from the man's perspective? (give time for responses)



DIVIDE SHEET OF FLIPCHART PAPER INTO 4 SQUARES/BOXES WITH THE BOXES LABELED:
1. INDIVIDUAL
2. GROUP
3. PROVIDER
4. SYSTEM

INDIVIDUAL BARRIERS
SAY: Many people who are struggling with a mental health challenge may not know they have one. How can one begin to recover if they don't recognize the problem? (I've always been this way; I take after my father/mother; you're the problem, not me; etc.)

ASK: What are some other individual barriers to recovery? (give time for responses)
RECORD responses on flipchart
Examples:
- Income
- Access to health care
- Transportation
- Lack of personal support
- Other illnesses

GROUP BARRIERS

SAY: "Birds of a feather flock together"? How many of you have heard this saying before? The people closest to you may create a barrier to recovery by continuing to enable unhealthy habits and choices or discourage you from improving your situation and moving on. Even well-meaning friends and family members may obstruct someone's recovery because they are thinking more about maintaining their own role in the current dynamic than seeing their loved one get better (or potentially experience relapse or setbacks). And they may lack the tools and resources necessary to support someone in recovery.

ASK: What are some other ways that groups (interpersonal relationships) may prevent someone from recovering? (give time for responses)

RECORD responses on flipchart

Examples:

- mistrust of MH system
- denying there's a problem
- fitting in to certain cultures

PROVIDER BARRIERS

ASK: How might providers create barriers to recovery? (give time for responses)

RECORD responses on flipchart

Examples:

- Long appointment wait times
- Rushed appointments
- Not fully listening to client's needs
- Promoting "shortcut" options without considering the bigger picture
- Unhelpful/insensitive staff
- Provider burnout/cynicism

SYSTEM BARRIERS

SAY: The design of the mental health system itself may undermine recovery.

ASK: How might this be? (give time for responses)

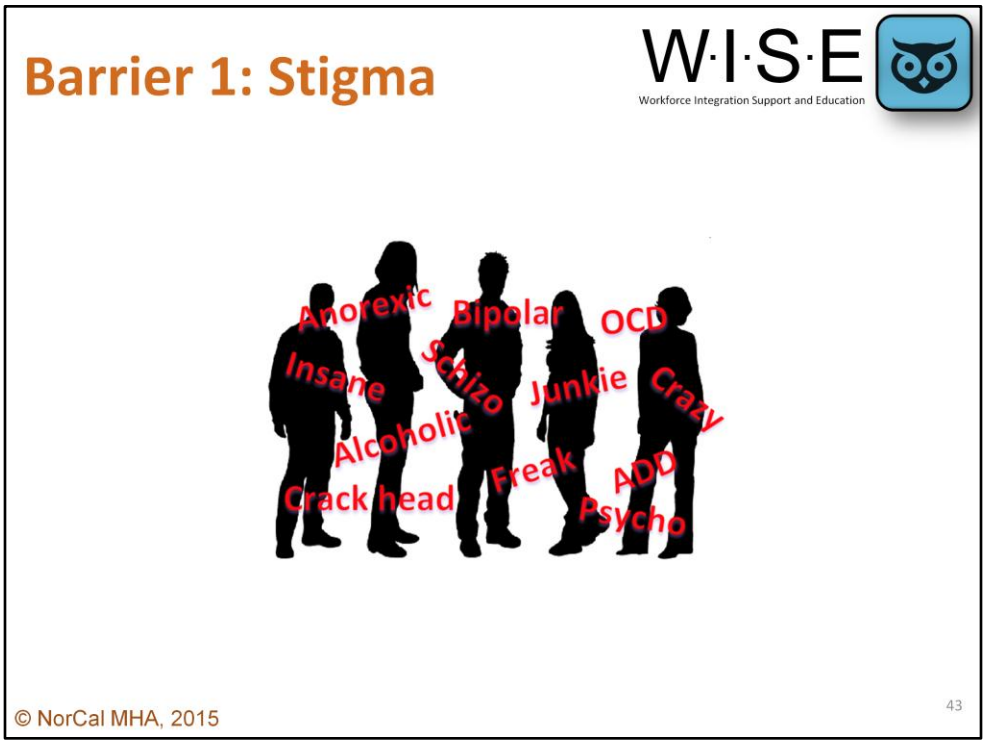
RECORD responses on flipchart

Examples:

- Lack of training in recovery
- Lack of support for people working in system
- Pushing medication as an easy solution
- Expecting people who are struggling to come to them
- No direct access to immediate services

SAY: We're going to look at a few more examples of barriers and how they play out at

the individual, Group, Provider and System levels



SAY: Stigma occurs on many levels and is pervasive throughout society and even in mental health systems.

INDIVIDUAL: Ashamed, embarrassed, afraid, don't know who to tell or what to do. Culture, trauma, and upbringing may contribute to internalized stigma.

GROUP: Other people may say: "Oh yeah, you should go on SSI – you can't work again." Using the words crazy, still use stigmatizing words among ourselves – don't' know how to talk about ourselves in as good way. "Oppression Olympics" – I'm sicker than you; you're more privileged than I am; etc. Infighting amongst peers. Culture may also play a big role in stigmatizing mental illness. Some cultures just don't talk about it or may be less likely to seek outside help. "Suck it up" Other cultures and social groups may have a historic mistrust of the psychiatric profession and therefore avoid seeking medical interventions or may choose not to recognize the existence of mental illness.

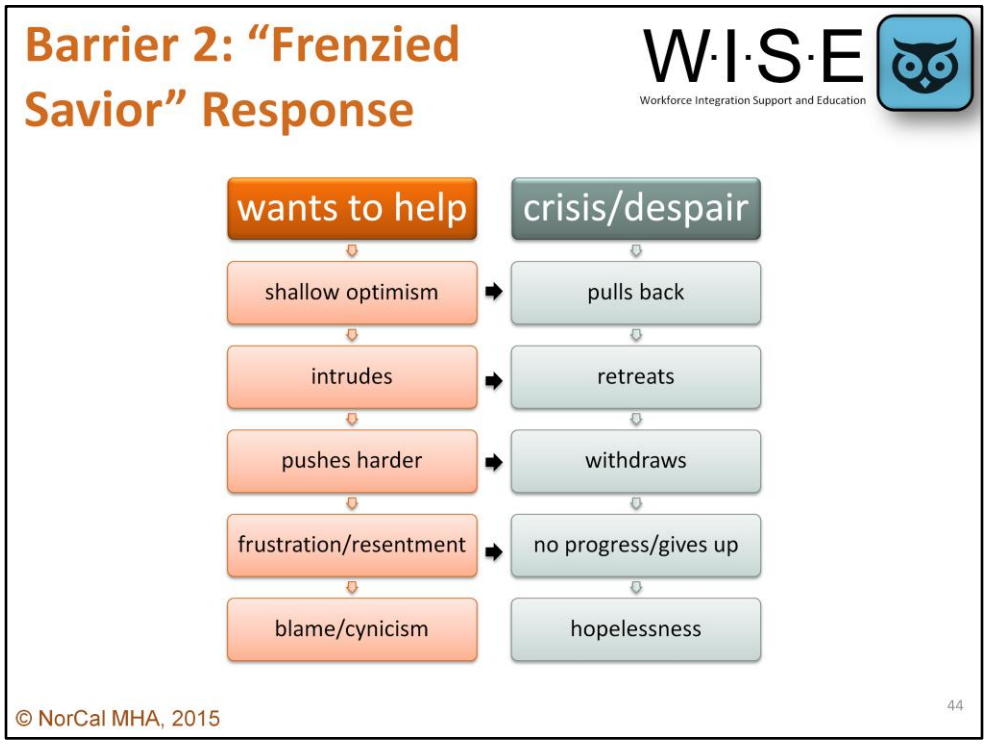
PROVIDER/SYSTEM: Use medical model to the exclusion of the recovery model. Lack of understanding of recovery. Paternalism. "You'll be dealing with this the rest of your life" Labeling someone by their diagnosis, referring to someone as "a schizophrenic" rather than "a person living with schizophrenia" – disease-focused care.

PROVIDERS receive a lot of training and education that paints people as victims or infantilizes people with mental illness – it's hard to rewrite those sorts of things.

- Even if you use Strengths-based language with a Consumer you have to turn around and document they have a disease/condition/problem
- Historically there was a belief people couldn't recover. Some conditions were thought to be especially problematic – and people could never live successfully in society Substance Abuse. . ."

SYSTEMS are more focused on bean counting and streamlining than individualized patient-centered care. It's easier on a systems level to slap a label on someone and group people together than look and each issue in isolation "we have x number of schizophrenics"

ASK: What are some other ways stigma is demonstrated in the mental health field? (wait for responses before moving on)



SAY: People who are struggling often have people in their lives who love them so much they want to do everything so them, including making choices for them. This may come from a sponsor, clinician, peer supporter, caretaker, or family member.

SAY: Because we as the helper think we understand what the other person needs, we want **to do it for them** or direct their recovery step-by-step. We all went into this field because we want to help as much as possible. Maybe we even think we can "save" someone. If our desire to help goes too far, the target of our help feels incapable of doing those things for themselves, babied. Yet, we often find ourselves throwing solutions at the symptoms, not the underlying problems, because the symptoms are easier to address.

EXPLAIN: "When faced with a person lost in anguish and apathy, a frequent response is what I call the 'frenzied savior' response. We have all felt like this at one time or another in our work. The frenzied savior response goes like this: The more listless and apathetic the person gets, the more frenetically active we become. The more they withdraw, the more we intrude. The more will-less they become, the more willful we become. The more they give up, the harder we try. The more despairing they become, the more we indulge in shallow optimism. The more treatment plans they abort, the more plans we make for them. Needless to say we soon find ourselves burnt out and exhausted. Then our anger sets in." – Pat Deegan, The Conspiracy of Hope

ASK, RHETORICALLY: What's another way to describe the "frenzied savior response"? (Codependence. Idiot compassion.)

EXPLAIN

Helper-focused. The helper (without realizing it) focuses on his/her own gratification/satisfying own needs and how the helper views him-/herself. Not about what the person being helped really needs. It's about the helper getting his/her needs met through the appearance of selflessness.

Rescuing is doing something for someone when it has not been asked for but is based on our guess at another's wants or needs. This course of action always includes our continued involvement and importance as rescuer. The main beneficiary of such actions are not those in need but those who come to give rescue.

Enabling. Helping and enabling are often confused with each other. Enabling is doing something that the person could and should be doing for themselves, or assisting them to do something non-beneficial for one's own purposes. Enabling prolongs suffering and leads to co-dependency. Enabling is an insult to another's capabilities and dignity and is only ego gratification for the need-to-be-needed individual.

Controlling. It's more about controlling our own comfort levels than helping. The "giver" of the idiot-compassion becomes the controller of the situation with the ability to withdraw their support at any time. This encourages dependence upon the controlling party. The controlling party then encourages further dependence in order to

maintain that sense of control. It is a typical co-dependent cycle.

Lack of understanding. There is often little time or effort made in understanding a situation before interfering with it. We start supporting other people's real or imagined dramas as a way of bolstering our own little heroic drama, without first determining whether lending such advice or energy is appropriate. It is all about "me". While one is engaged in imagining what is required rather than assessing the real situation any opportunity to act in a genuinely compassionate way is lost.

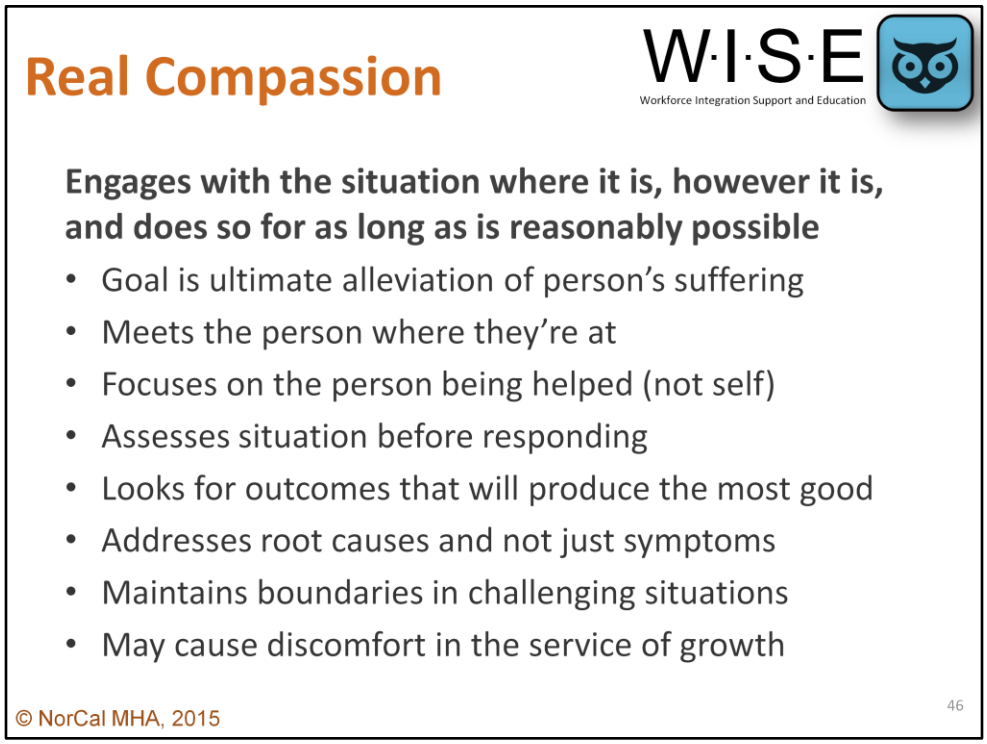
Self-indulgent. Idiot compassion will not often say no to another or to it's own involvement in an activity. There is an assumption that others cannot get along without some intervention. And the intervention is based on self-indulgence. And there is often a subtle aggression to idiot compassion that is not evident in actual compassion.

Disillusionment One of the features of idiot compassion is that it is accompanied by feelings of disillusionment. Whatever we do for someone doesn't seem to "satisfy". We must do more, continue on the same road, push harder, be completely successful at our person-saving or world-saving endeavor, and this generates even greater expectations. And greater disillusionment and discomfort.

Shame. Expectations of gratitude can become shaming behavior when boundaries are too fluid. Phrases like "After all I've done for you." or "They are so ungrateful." are common complaints of the idiotically compassionate.

Anger. Fear of feeling it, fear of expressing it, inability to control it. Helper is angry at self because efforts have been fruitless and may be angry at the target of their "help" for not showing progress or appreciation. The target may also express anger towards the helper because of boundary transgression.

https://enlightenmentward.wordpress.com/2010/04/28/manifestations-of-idiot-compassion/



EXPLAIN

When you set good boundaries, for instance, if someone is engaging in self-destructive activities, it's not the compassionate thing to keep allowing that to happen, allowing someone to keep being able to feed their self-harm. So of course, they're going to freak out and be extremely upset. And it will be quite difficult for you to go through the process of actually confronting the situation. But that's the compassionate thing to do.

Taking the time to confront the situation and its root causes is also the compassionate thing to do for yourself, rather than allow your self to waste time, effort, energy and resources on solving the problem you WISH existed rather than the problem that actually does.

And it's the most compassionate thing you can do for them too. They may not thank you for it, and they may not be happy you did it. And they may experience an immediate increase in discomfort or suffering. But if there's any chance for them take control and start to work on their problems, the roots of their suffering must be meaningfully addressed. This allows them to grow and ultimately feel empowered to take personal responsibility for making the changes they need.

https://enlightenmentward.wordpress.com/2010/04/28/manifestations-of-idiot-compassion/

http://www.charlieglickman.com/2009/12/sex-positivity-and-fierce-compassion/

http://old-shambhala.shambhala.org/teachers/pema/qa5.php

ASK: Does anyone know what this picture symbolizes?

SAY: The Gordian Knot is a Greek legend associated with Alexander the Great. It is often used as a metaphor for an unsolvable problem (disentangling an "impossible" knot) that is solved easily by cheating or "thinking outside the box" ("cutting the Gordian knot")

MENTAL ILLNESS IS NOT A GORDIAN KNOT AND MEDICATION IS NOT A SWORD

ASK: Why do we often think this way? (give time for 1-2 responses before moving on)

INDIVIDUAL: Easy fix. You can see it, measure it. Media, culture says take medication to make things go away – without anything else.

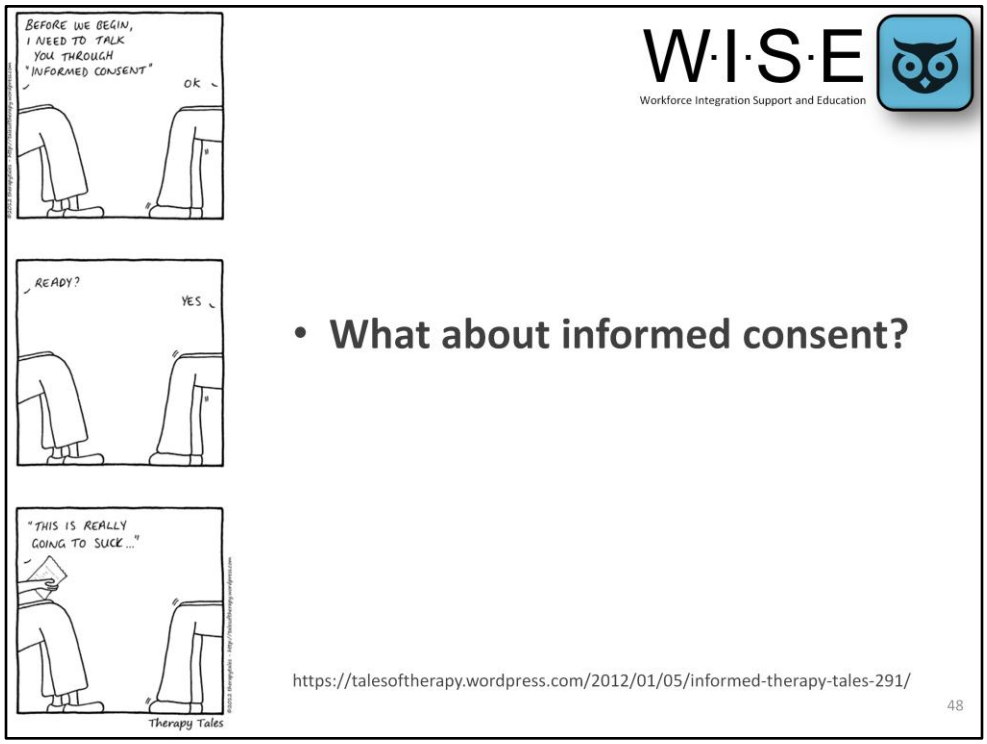
GROUP: I take medication, therefore you should to. In fact, you should take MY medication.

PROVIDER: It's often successful. Easy tool. How often do we say "maybe medication is not right for you" What would happen if we did? The individual probably wouldn't like it.

SYSTEM: Medication is measurable, controllable. "Do you really think that every

person who walks through this door needs medication?" System doesn't allow people to not be on medication and still get care. Labeled "noncompliant" if they don't take meds or prefer a different method of addressing their symptoms.

ASK: How can we say that there are many pathways to recovery if we require everyone in the PMHS to take medication?? (give time for a few responses before moving on)

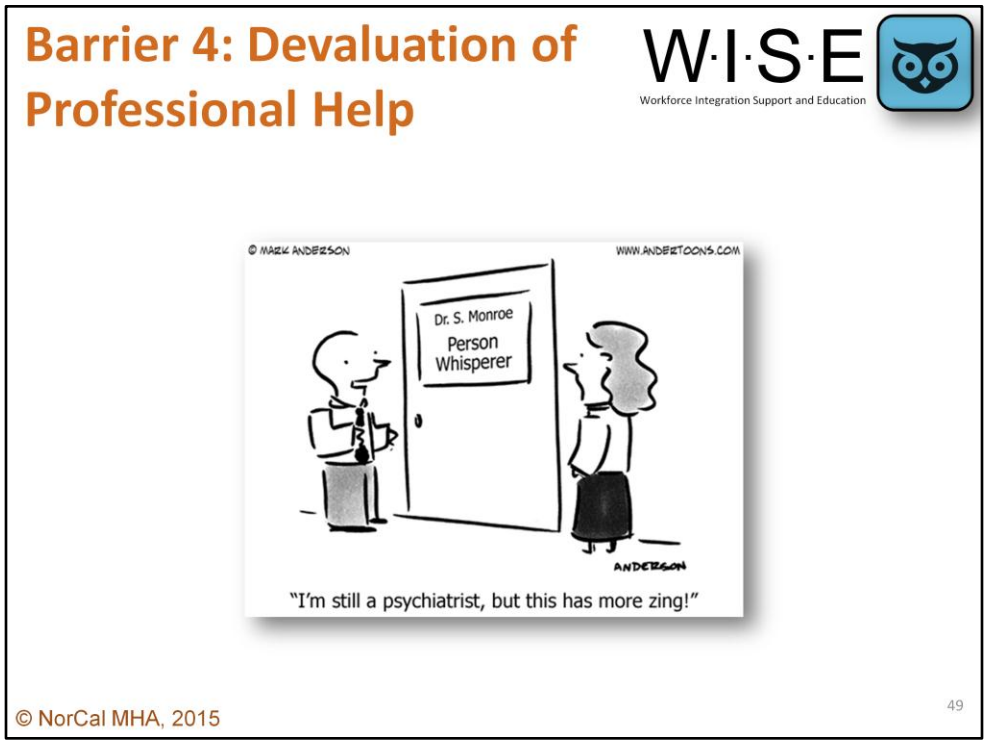


ASK: So what about informed consent? Can anyone provide a definition of this concept?

SAY: Sometimes, side effects can be worse than the symptoms. What about long term side effects of psychotropic drugs? They have major side effects that can significantly shorten one's lifespan. And new evidence is emerging that other treatments and lifestyle changes can be just as effective as medication (but they don't offer a quick fix)

SAY: Why do we think that people with a mental health condition are incapable of giving informed consent? If they have not been declared incompetent or 5150, they are fully capable under the law to make these decisions for themselves and failure to obtain truly informed consent is not good medicine.

ASK: Why does informed consent matter? (allow time for a few responses)



EXPLAIN

INDIVIDUAL/GROUP (PEERS):

- Peer Support is a complement to, not a replacement of Clinical Support.
- If I'm told that I as the consumer/peer have the responsibility for my recovery, I may wonder why I need anyone else and reject professional help. While it is true that not everyone needs professional help, mental health professionals really do have a lot of knowledge.
- Peers often feel we can help each other, so we don't need clinicians or other practitioners: they just don't understand, we'll fix it our own way. Because recovery has many pathways, we shouldn't discount any of the pathways. Professional help is very useful for many people.
- Professionals may also question the value of theirr education and training when consumers have access to other supports. The reality is all specialists have a lot to offer in their scope, and incorporating recovery concepts into practice will enhance the value of Professional Help

INDIVIDUAL/GROUP (PRACTITIONERS/CLINICIANS):

ASK: Mental health professionals often devalue the contributions of social factors and peer support. Why? (give time for some responses)

SAY: Partially, training and education have not traditionally focused on these factors

because they are difficult to OBJECTIVELY MEASURE. But let's think about that for a minute: people respond differently to medication, right? What works for some people doesn't work for others. Yet we see medication as an effective treatment. Why? Because we can measure outcomes. But HOW do we measure these "objective" outcomes? Aren't they largely based on people's subjective experiences of symptoms and funcitoning? Why can't we measure the effectiveness of non-medical interventions in the same way – based on people's subjective experiences?

We've also been taught that medical problems must be treated with a medical intervention – even if many non-medical factors converged to eventually result in the medical problem. We don't see the interplay between risk factors and protective factors in our lives and therefore aren't taught to value protective factors such as social support, physical activity, eating well, stable income, access to transportation for their contributions to our mental health.

Other Barriers?

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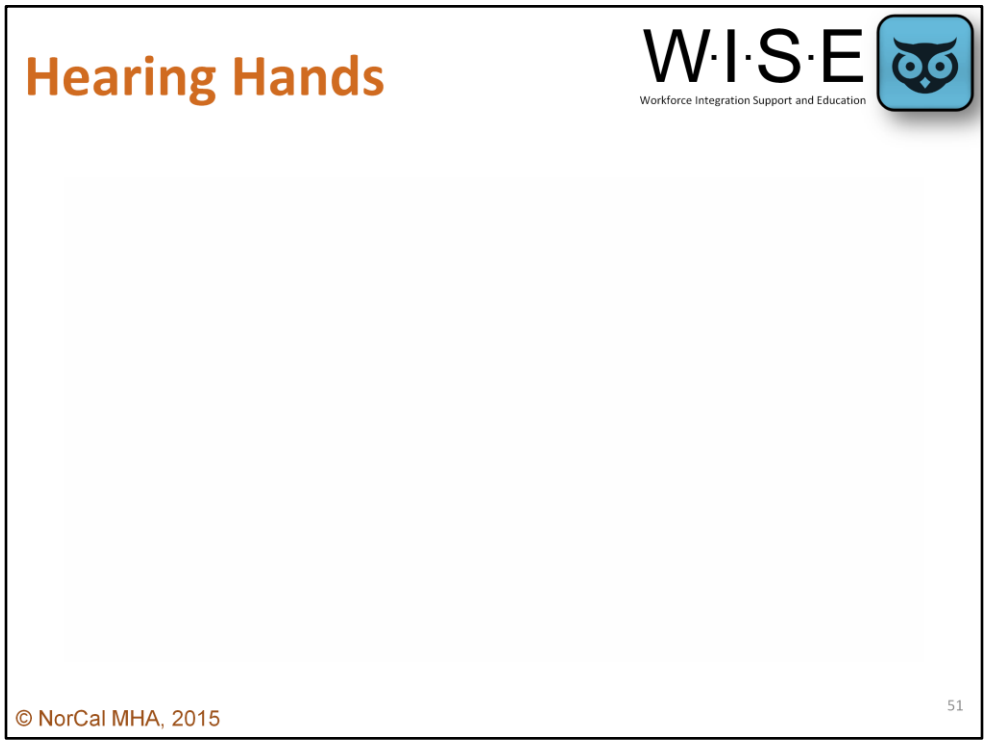
Discussion:

- Can you think of other barriers to recovery that occur on the individual, group, provider, system, or *societal* levels?
- What can be done to overcome these barriers?

ASK: How can the awareness and removal of barriers make a big difference in the effectiveness of mental health services?

ASK: What are some other barriers we can remove so that people in need have better access to care?

RECORD responses to #2 on flipchart



[DO NOT INCLUDE THIS SLIDE IN AUDIENCE SLIDE HANDOUT]

SAY: Watch this video, which provides an excellent example of how we can all do little things to remove barriers for others.

AT THE END, ASK: What do you think of this video as it relates to inclusion and cultural competency? (give time for responses before moving on)

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PART 4

The Role of Recovery in California's Public Mental Health System (PMHS)

The MHSA/Prop 63

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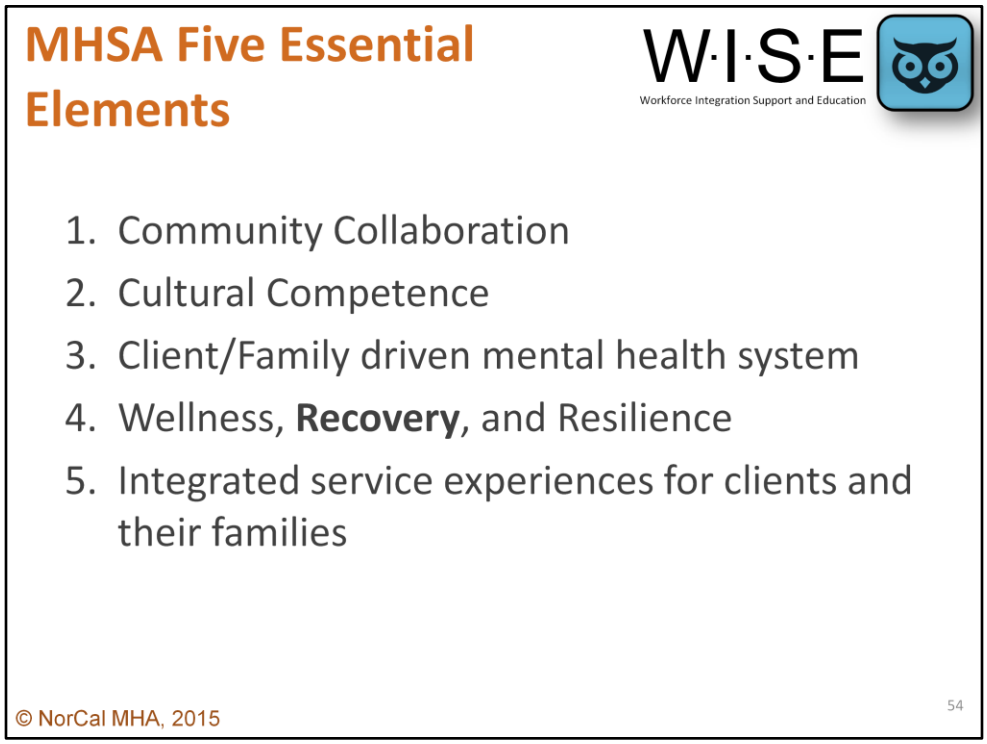
- Passed by voter initiative in November 2004; took effect in January 2005
- Created additional funding and resources for the public mental health system
- Sought to transform the system through:
  - Expansion of services
  - Improved continuum and integration of care

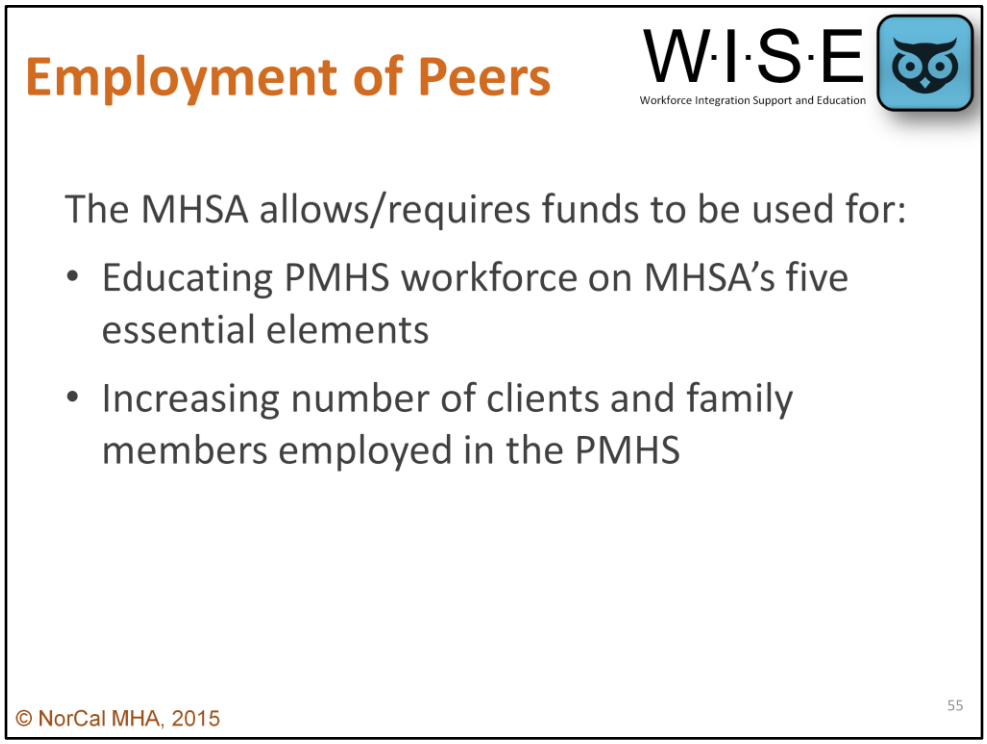


If you have time, **SAY:**

MHSA Calls for:

1. Significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system, including but not limited to
    - Planning
    - Policy development
    - Service delivery
    - Evaluation

2. Increases in consumer-operated services such as
    - Drop-in centers
    - Peer support programs
    - Warm-lines
    - Crisis services
    - Case management programs
    - Self-help groups
    - Family partnerships
    - Parent/family education
    - Consumer-provided training and advocacy services. (CDMH, 2005).



DO NOT DISCUSS – RUN THROUGH BRIEFLY

(PMHS = Public Mental Health System)

If asked, Increasing employment through the following activities:

recruitment and retention
promotional opportunities
career pathways
supported employment

9 CCR Secs. 3810(c), (d), 3841(a)(1) 3842(a)(1)

MHSA Also Includes:

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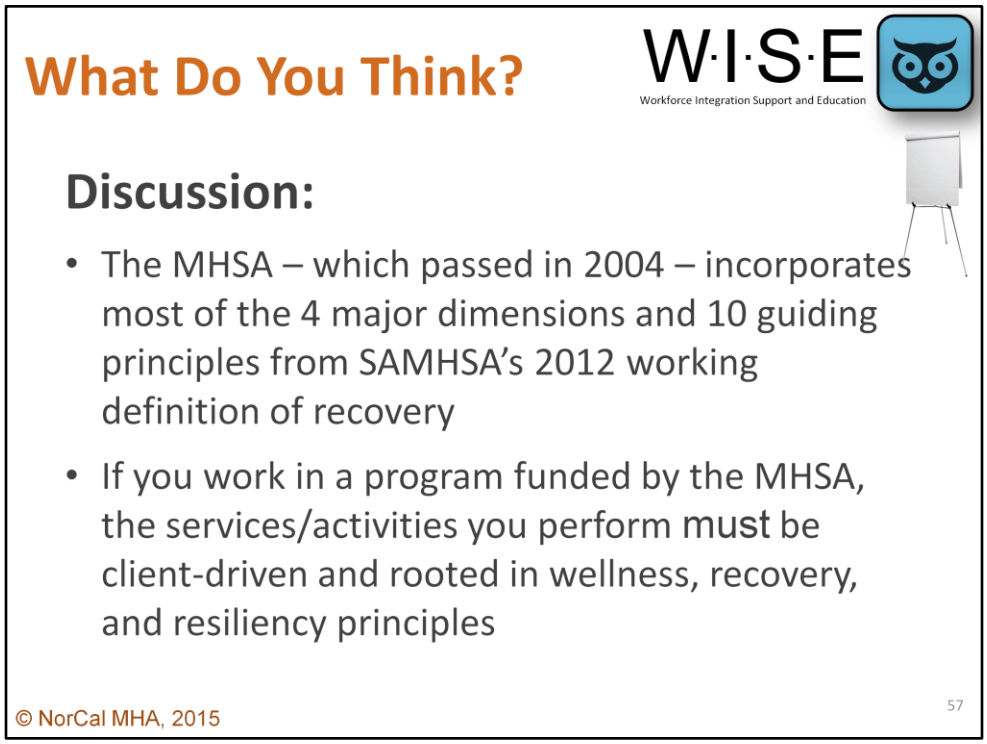
- Housing supports
- Community-based care
- Culturally competent services
- Stakeholder and community collaboration
- Integrated services
- Individualized plans
- Full service partnerships

DO NOT DISCUSS – RUN THROUGH BRIEFLY

9 CCR Secs. 3200.010 – 3200.325



ASK: Why do you think the MHSA is so focused on recovery? (allow 1-2 responses before moving on)

ASK: How can the MHSA's themes and ideals be strengthened in your workplace? **RECORD** responses on flipchart

W·I·S·E
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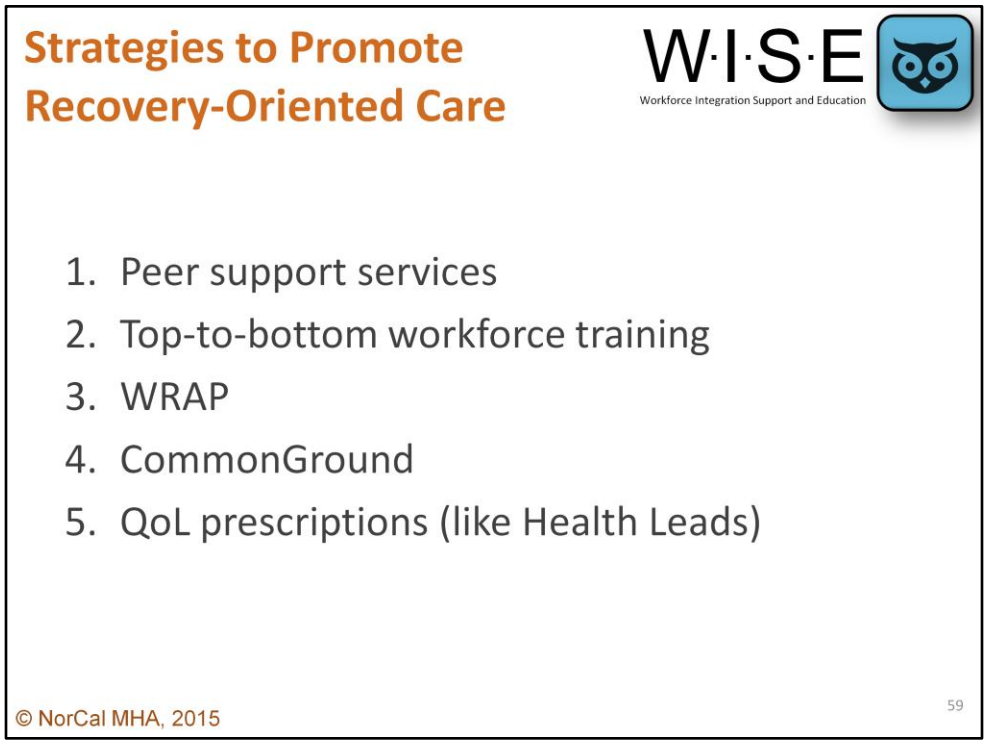
PART 5

Creating and Sustaining a Recovery-Oriented Workplace



DON'T DISCUSS – RUN THROUGH BRIEFLY

QoL = Quality of Life

SAY: In general, a Peer is anyone similar in experience and/or background to you. An equal. People – not just people with a MH diagnosis - often like to talk/work with those who have similar experiences. Just think of who you like to go out to lunch with. People who have like experiences can better relate and can consequently offer more authentic empathy and validation.

No one would tell any of these people NOT to see a medical professional. Peers don't either.

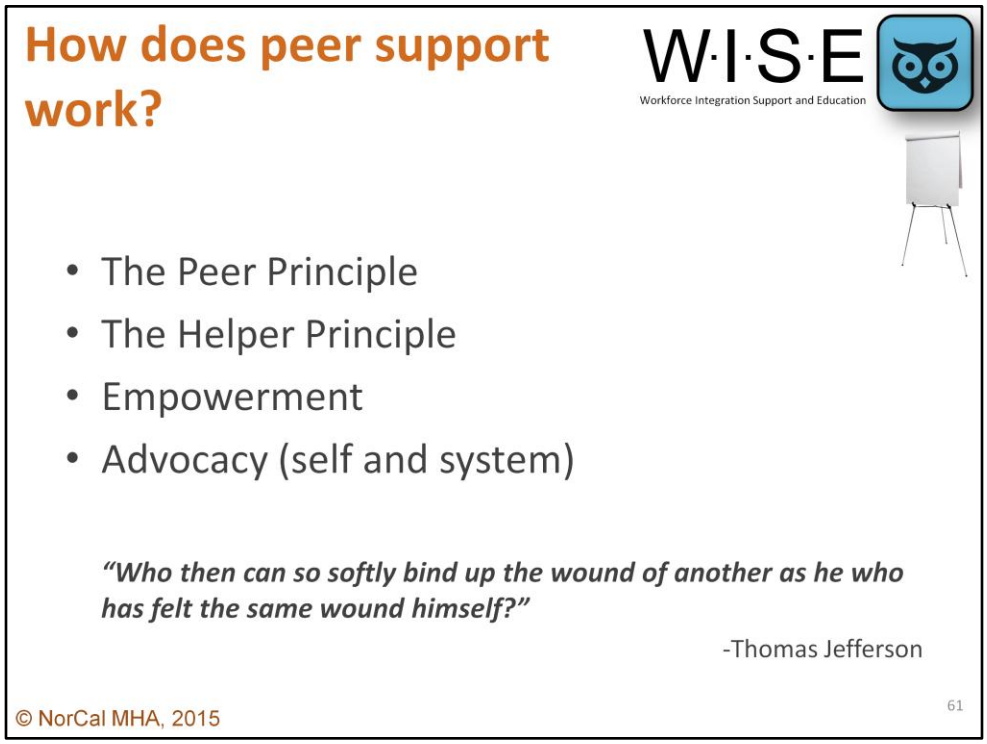
Peer support is not like clinical support, nor is it just about being friends. Unlike clinical help, peer support helps people to understand each other because they've "been there,"
shared similar experiences and can model for each other a willingness to learn and grow.

People come to a peer support program because it feels safe and accepting. By sharing experiences and building trust, peers help each other move beyond their perceived limitations, old patterns and ways of thinking about mental health. This allows members of the peer community to try out new behaviors and move beyond the "illness culture" into a culture of health and ability.
(Copeland and Mead, 2004). From book: "Wellness Recovery Action Plan® & Peer Support"

WARNING: DON'T GET INTO POLITICAL DISCUSSION

Where did it come from? Peer Support in MH grew out of a political frame of reference. Civil/human rights movement in which people affiliated around the experience of negative mental health treatment (e.g. coercion, over-medication, rights violations, as well as an over-medicalized version of their "story").

One study found that case management services plus a peer specialist counselor were associated with enhanced quality of life, fewer major life problems, and greater gains in social support for those receiving such services than for those receiving case management services without a peer (Felton et al., 1995).



EXPLAIN

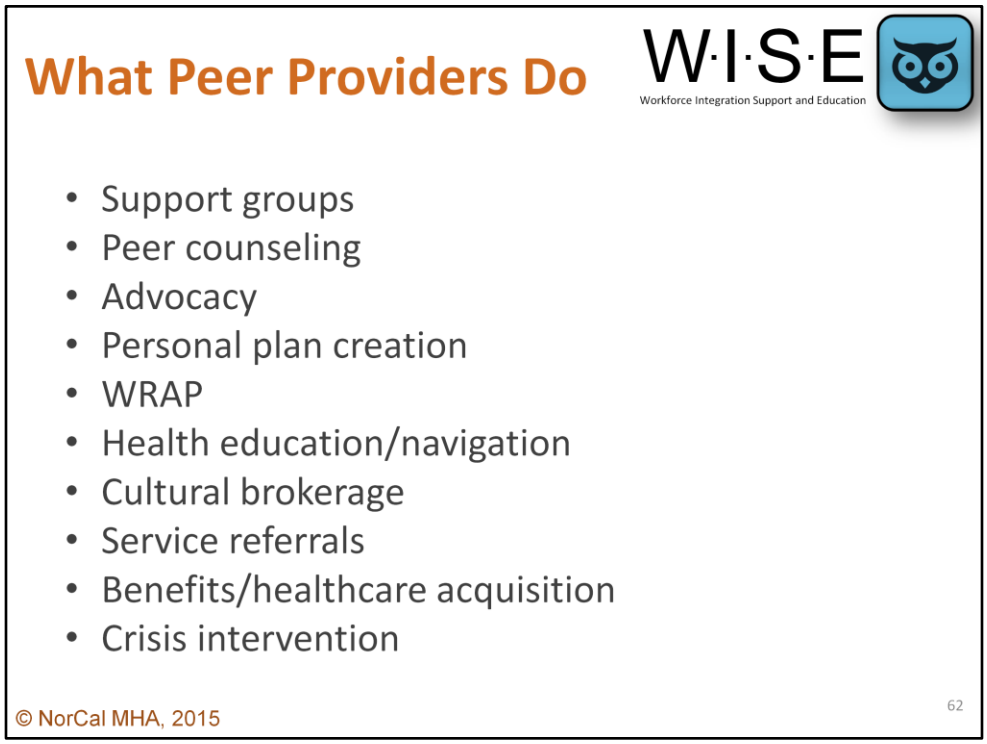
The peer principle (finding affiliation with someone with similar life experience and having an equal relationship)
(Yesterday in group "when I heard you say that you don't bathe when you're not well, I knew you were someone who could understand me – because that's true for me, too")

The helper principle (the notion that being helpful to someone else is also self healing)
- Peers assist others in a healthy manner that is also good for the peer's own healing

Empowerment
-Finding hope and believing that recovery is possible
-Taking personal responsibility for making it happen
-Showing that someone with a diagnosis can contribute meaningfully
-Peer is very motivated to empower others to achieve recovery, too

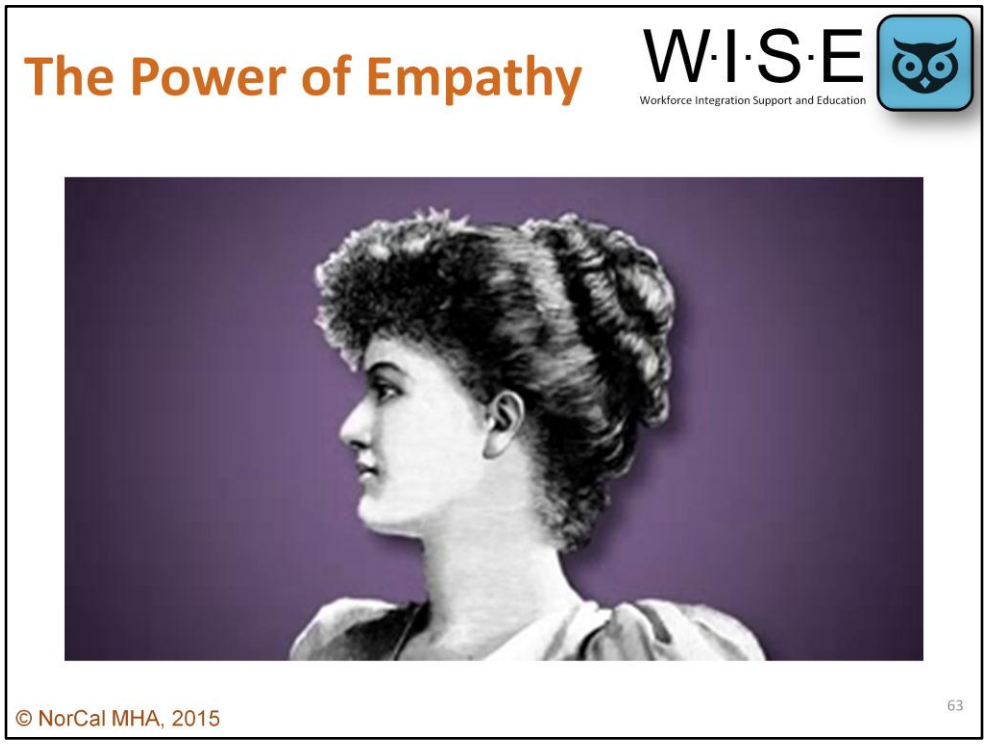
Advocacy (self and system advocacy skills),
- Promote client choice and decision making opportunities, skill development, positive risk taking, reciprocity, support, sense of community, self help, and developing awareness
- Teach clients how to advocate for self, especially by using examples from peer's own experience

ASK: What makes Peer Support different then Clinical support? (give time for responses)
RECORD responses on flipchart



Briefly explain each service.

If delivering to County Staff, SAY:
"Under Benefits/Healthcare Acquisition mention the frustration felt that there are so many Services, and most all Referrals are for this, and we usually refer people out anyway."



[DO NOT INCLUDE THIS SLIDE IN AUDIENCE SLIDE HANDOUT]

SAY: This brief video demonstrates the power of empathy and why effective peer support requires the meeting of equals. Remember, SYMPATHY (feeling sorry for someone) is very different from EMPATHY! EMPATHY brings people closer, while SYMPATHY drives them apart.

ASK: In your own words, how would you describe the difference between sympathy and empathy and why this distinction is important? (allow time for responses before moving on)

PLAY VIDEO

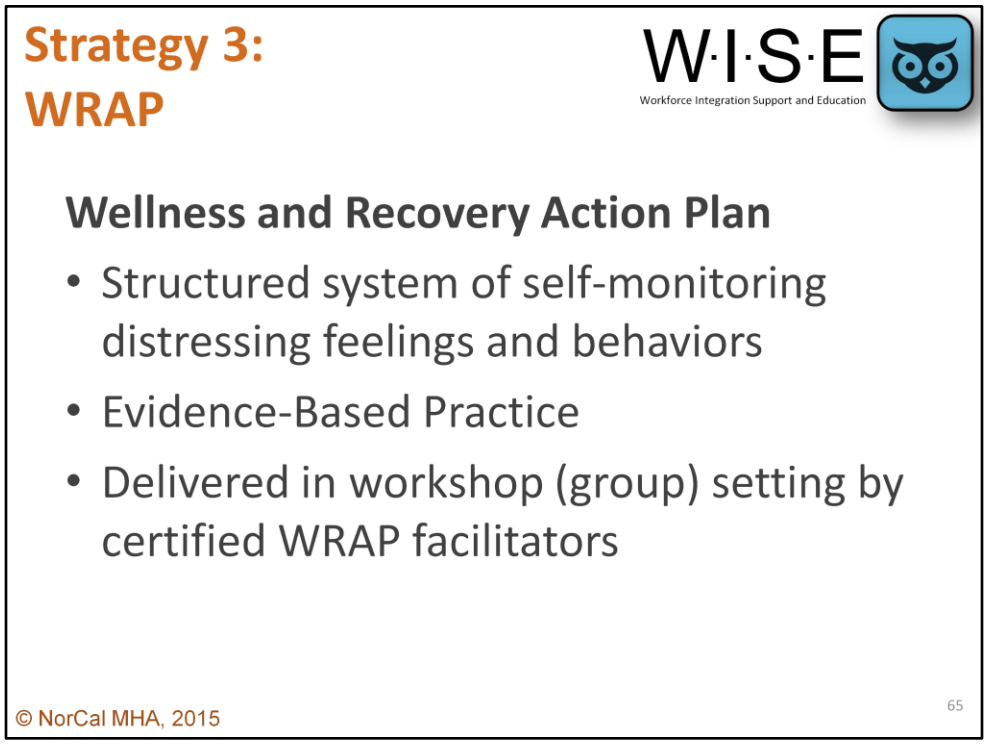
After the Video, ASK: Can you describe a situation you've been in or observed where someone used SYMPATHY as a tool rather than EMPATHY? What happened? What might have happened if the person engaged in EMPATHY instead?

Strategy 2: Comprehensive Training

W·I·S·E
Workforce Integration Support and Education

NorCal MHA's **W·I·S·E** trainings:

- Promote shared vision and values
- Offer a holistic approach:
  - Needs assessment
  - Data collection
  - Individualized reports and plans
  - Broad range of trainings
  - Address all aspects of workplace experience
  - On-call technical assistance & implementation support



ASK: Who here is familiar with WRAP? Can anyone explain what WRAP does? (give time for 1-2 responses)

Discuss workshop format and group size.

Discuss importance of Certified WRAP Facilitators to maintain fidelity to the Copeland Center's model

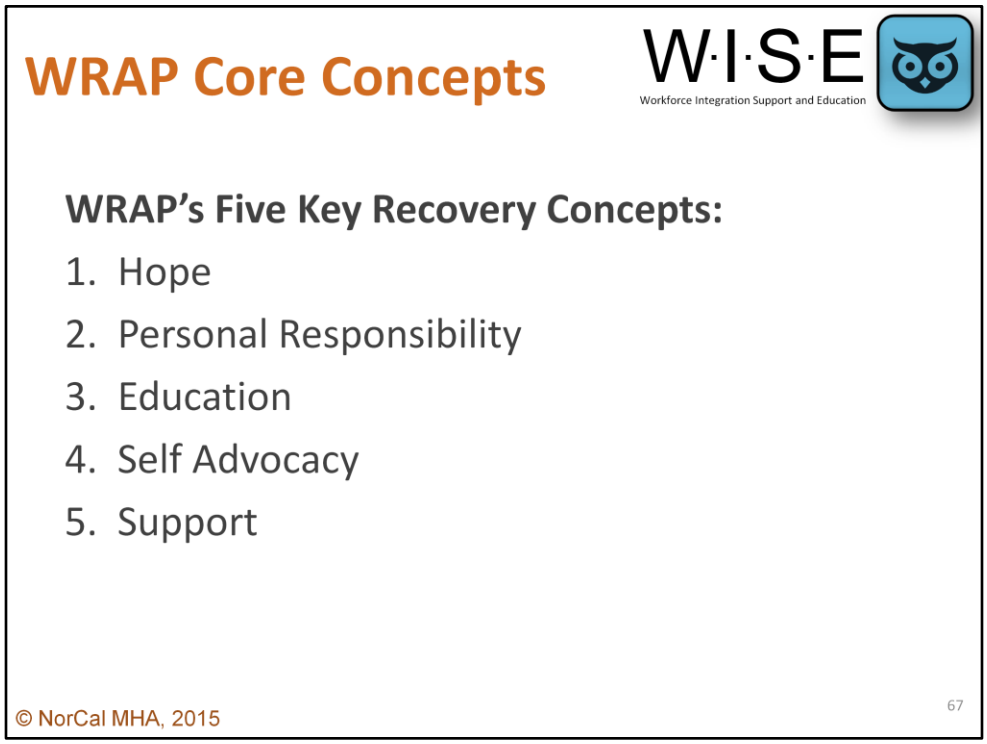
About WRAP

W·I·S·E
Workforce Integration Support and Education

- Developed by Mary Ellen Copeland
- Living in recovery herself
- Studied how people help themselves, get well, and stay well
- Based on lived experience of many, many individuals

Copeland Center
FOR WELLNESS AND RECOVERY

Skip through if audience is already familiar with WRAP



Describe each of these concepts – what they mean

ASK: What do you notice about these concepts as they relate to SAMHSA's working definition of recovery and the 5 essential elements of the MHSA? (give time for 1-2 responses before moving on)

WRAP Includes:

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- Wellness Toolbox
- Daily Maintenance Plan
- Identifying triggers
- Noticing early warning signs
- Recognizing when things are breaking down
- Crisis Plan
  - And creating a personalized action plans for all of these situations!

68

Wellness Toolbox
Things That Make you Feel Better

Daily Maintenance Plan
Things You Do Everyday to Stay Well

Triggers (& Action Plan)
External Events that Could Make you Feel Worse

Early Warning Signs (& Action Plan)
Internal Events that Indicate that You May Be Feeling Worse

When Things Are Breaking Down (& Action Plan)
Signs that Indicate the Situation is Getting Much Worse

Crisis Plan
Identifying your preferences and naming supporters to take over

What People Say

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"Finally, something I can do to help myself."

"I used to spend months, even years, in the hospital. Now I have a bad afternoon or a bad day. And it's all because I use WRAP."

"WRAP for me is about personal responsibility. I can just let my 'symptoms' take over my life. Or I can take personal responsibility, use my WRAP, and do what I need to do to take care of myself and feel better."

Strategy 4: CommonGround

W·I·S·E
Workforce Integration Support and Education

- Web-based application that helps clients prepare to meet with psychiatrists or treatment teams and arrive at the best decisions for treatment and recovery
- Focuses on shared decision making to foster a collaborative client-practitioner relationship and identify effective treatments and services
- https://www.patdeegan.com/commonground

Patricia E. Deegan, Ph.D.

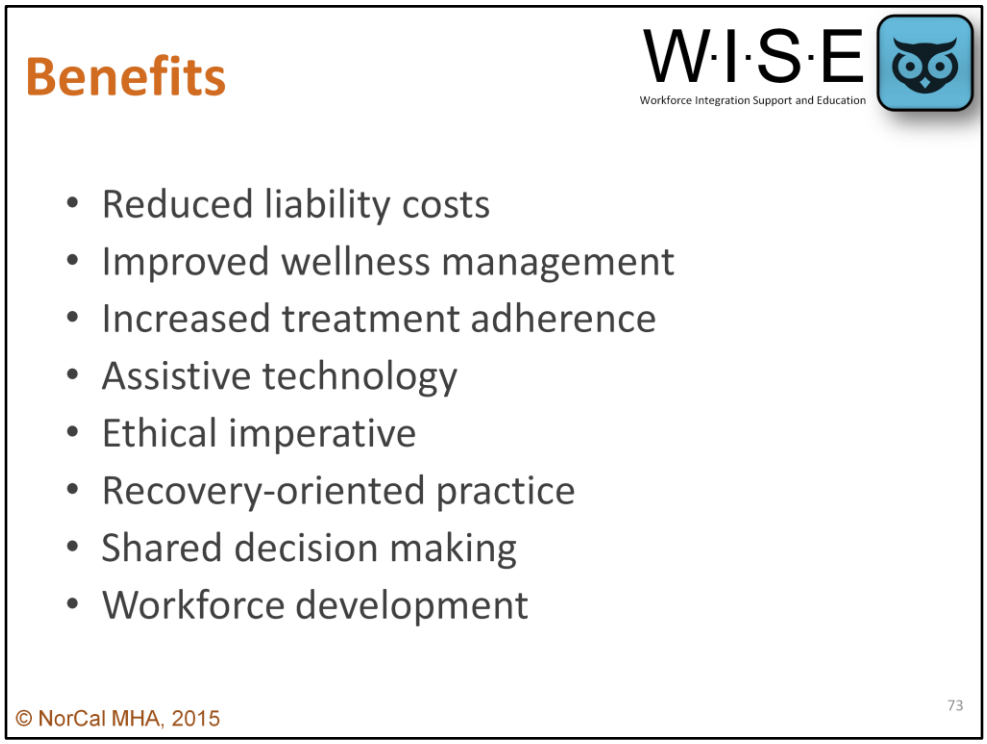
W·I·S·E
Workforce Integration Support and Education

- Creator of CommonGround
- Specializes in the topic of recovery and the empowerment of people with mental illness
- Activist in the disability rights movement
- Adjunct professor at Dartmouth College Medical School and at Boston University, where she works at the Center for Psychiatric Rehabilitation
- Diagnosed with schizophrenia and institutionalized as a teenager

How It Works

W·I·S·E
Workforce Integration Support and Education

- **Before appointment**, client (with or without peer helper) creates 1-page Health Report summarizing current condition, concerns, needs, goals
- **During appointment**, Health Report acts like an amplifier, helping doctor quickly understand client goals, concerns and progress to arrive at shared decision regarding treatment plan and next steps
- **After appointment**, shared decision is printed for client to take as a reminder about what to do for next appointment



If you have time, **SAY:**

Reduced liability costs through joint decision making and adequate disclosures (program screens for pregnancy and other health related conditions that may impact treatment plan)

Improved wellness management - CommonGround introduces people to the concept of Personal Medicine and what they can do, outside of the clinic, to get well and stay well. This is particularly important in light of the fact that many clients get no therapy or case management services. For example, if a person indicates they are having sleep problems, are using recreational drugs or are having distressing voices, CommonGround might automatically provide information on how to improve sleep hygiene, how to reduce harm from recreational drug use and how to manage distressing voices.

Increased treatment adherence - CommonGround may increase treatment adherence because it helps people express and work through concerns about prescribed treatment upstream, before non-adherence becomes a problem. The top 3 reported concerns were side effects, health concerns and concerns that the medicine is unhelpful. CommonGround recommends strategies to resolve decisional uncertainty about using medicine as prescribed. In this way, CommonGround empowers doctors, therapists and case managers with the tools to engage clients about their concerns

upstream before non-adherence becomes a problem.

Assistive technology - CommonGround acts as assistive technology for people with psychiatric disabilities. It helps people organize what they want to say before the medication appointment. In this way, it facilitates communication for people who are anxious, disorganized or non-verbal.

Ethical Imperative - Most medication management decisions in psychiatry involve medications with similar efficacy profiles but complex risk-benefit trade-offs. That's why decisions about psychiatric medications are not just medical decisions. They are also personal decisions that will impact physical health and quality of life

Recovery-oriented practice – An independent survey of 116 CommonGround users found that 4 of 5 reported using Personal Medicine in the past week "a lot" or "somewhat", and said Personal Medicine had helped in the past week. This suggests that CommonGround is a real and effective transformative tool and won't simply end up as "dust-ware."

Shared decision making - CommonGround helps agencies implement shared decision making in a practical way without overburdening the medical staff. Organizations using CommonGround have shared decisions entered, on average, 78% of the time, with some organizations averaging as high as 94%. This suggests that shared decision making can happen in the short 15-20 minute consultation.

Workforce development - CommonGround provides a unique and billable role for peer staff in medication clinics and provides this emerging workforce with defined roles and a ladder for career advancement. CommonGround trains staff in recovery oriented methods in vivo, while at work. For instance, if a client indicates problems with anxiety on the Health Report, a case manager can access proven self-management strategies with one click. Similarly, if a person indicates having trouble with medication co-pay's, a staff person can find prescription assistance information with one click.

What Clients Say

W·I·S·E
Workforce Integration Support and Education

- "I'm empowered … to mention what I want to communicate, I have time to say what I want to communicate. And I feel like I'm being heard."
- "Seeing the improvement ... It makes you really proud of yourself for keeping it going and knowing you can do it. I felt really proud of myself; makes me want to tack it to my wall and say 'see, I did it.'"

74

Comments from CommonGround website

What Clinicians Say

W·I·S·E
Workforce Integration Support and Education

- "The computerized pre-clinic questionnaire [allows] an additional level of assessment that sometimes gave information we didn't obtain in a standard clinic interview." – *Prescriber*
- "I … felt I already incorporated shared decision making into my practice style … Looking back, I would think it would be very difficult for most clinicians to fully understand the difference between practice as usual and a fully developed program of shared decision making without actually experiencing both." - *Psychiatrist*

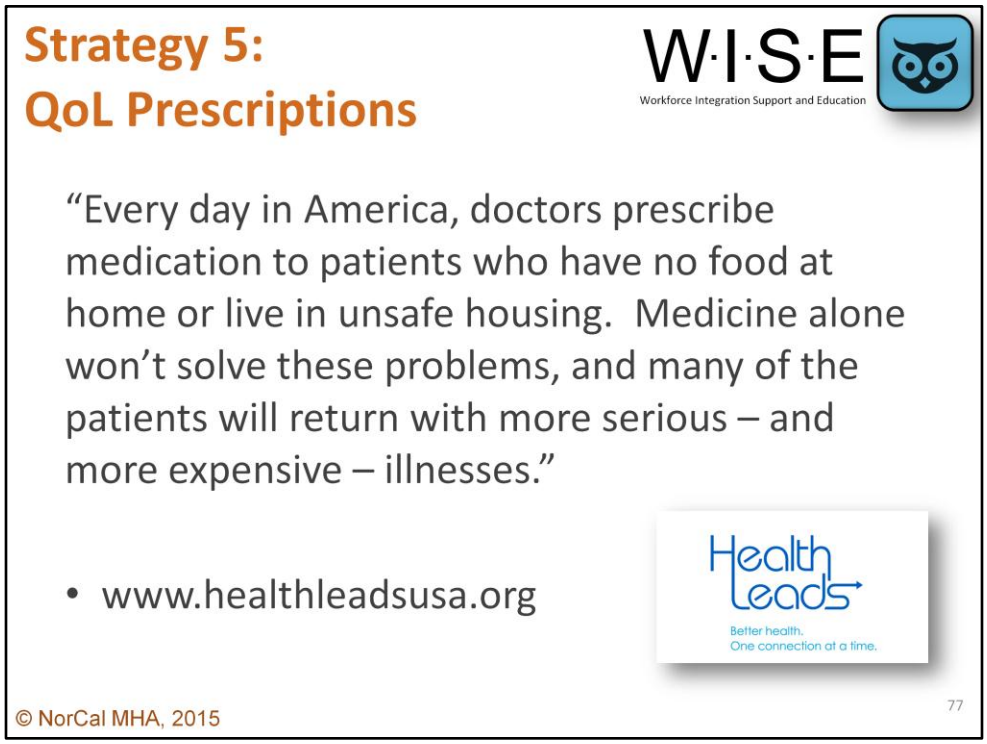
Comments from CommonGround website:

What Clinicians Say

W·I·S·E
Workforce Integration Support and Education

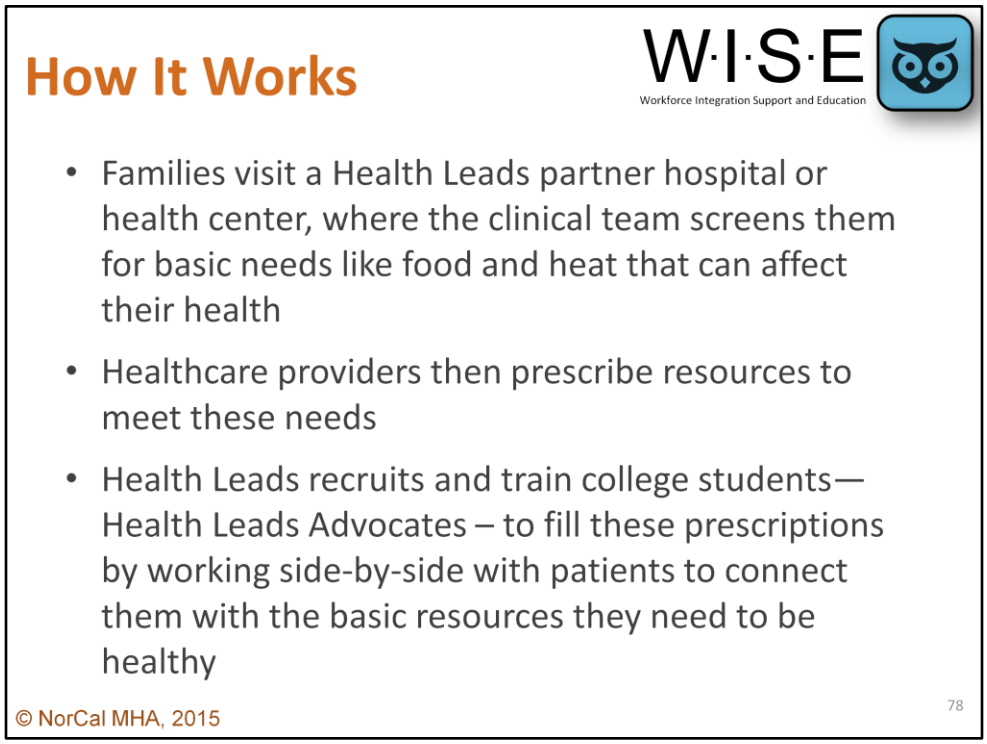
- "What's changed a lot for me [since CommonGround] is that the goal isn't the complete absence of symptoms anymore … If we're just medicating people through the roof to try and get a complete absence of symptoms and then we're turning them into, sort of the smokers on the couch scenario with making them too sedated or drugged up feeling." – *Prescriber*

ASK: What do you think about this clinician's comments and how they relate to the Recovery Model of care? (give time for responses before moving on)



ASK: How many of you have heard of Health Leads?

EXPLAIN: Health Leads is also a very successful model that is working in communities throughout the country, including right here in California in the Bay Area. We can use peer support and model our public mental health services on the Health Leads approach.



Health Leads enables healthcare providers to prescribe basic resources like food and heat just as they do medication and refer patients to our program just as they do any other specialty. We recruit and train college students— Health Leads Advocates – to fill these prescriptions by working side by side with patients to connect them with the basic resources they need to be healthy.

Health Leads Advocates then work side by side with patients and families to navigate the complexity of the resource landscape – including tracking down phone numbers, printing maps, securing transportation, and completing applications. The Advocates follow up with patients regularly by phone, email, or during clinic visits. Relationships may be long-term or short-term based on patients' needs and preferences.

As part of the clinic team, Health Leads Advocates also provide ongoing updates on a patient's progress in securing basic resources to doctors, nurses, social workers, and other healthcare providers.

Prescription Pad

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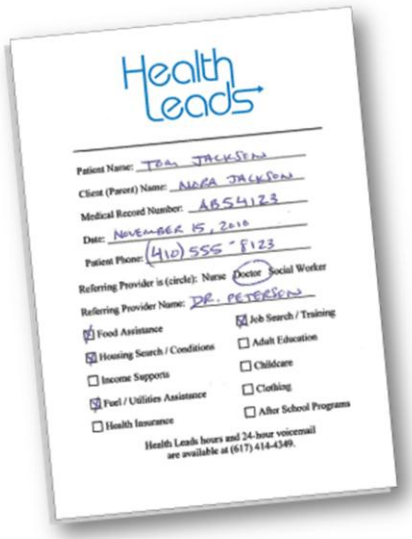


Health Leads PRESCRIBES:

- Food assistance
- Housing search/conditions
- Income supports
- Fuel/utilities assistance
- Health insurance
- Job search/training
- Adult education
- Childcare
- Clothing
- After school programs

79

ASK: If you were adopting this model for a mental health setting, what PRESCRIPTIONS would you add to this list? (give time for responses before moving on)

Have Your Views Changed?

W·I·S·E
Workforce Integration Support and Education

- How would you define recovery now?
- How has this training shaped your definition of recovery?

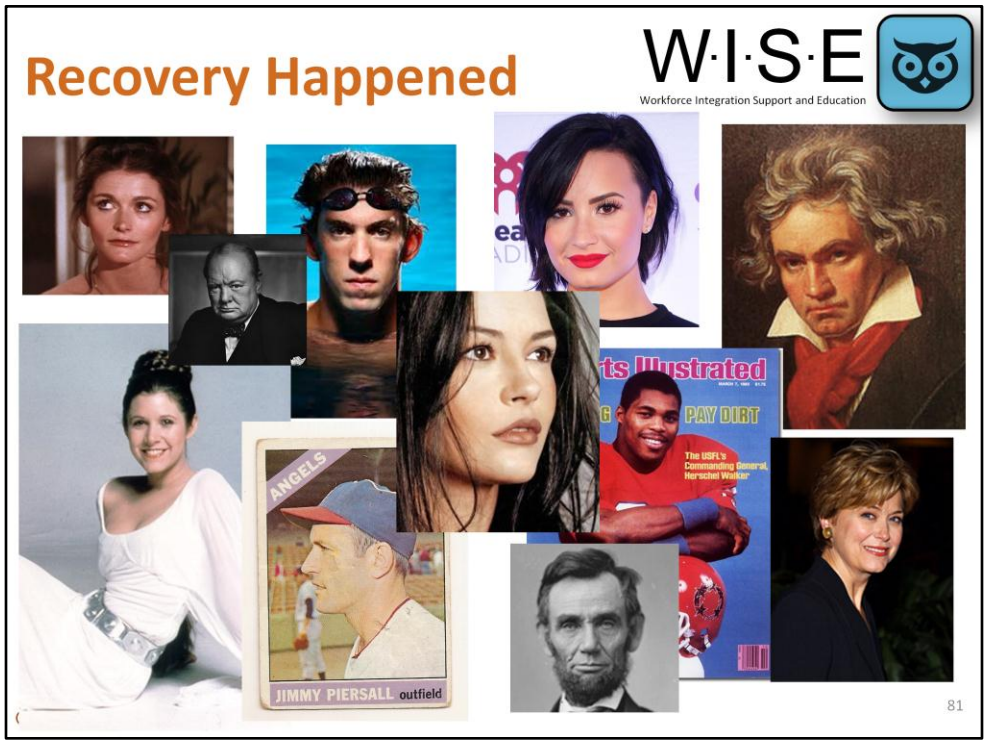
- What are some other ways you can personally help to create and sustain a recovery-oriented workplace?

Review the audience's definitions of recovery from the flipchart from Slide 10

ASK the audience to define recovery again. (give time for responses)

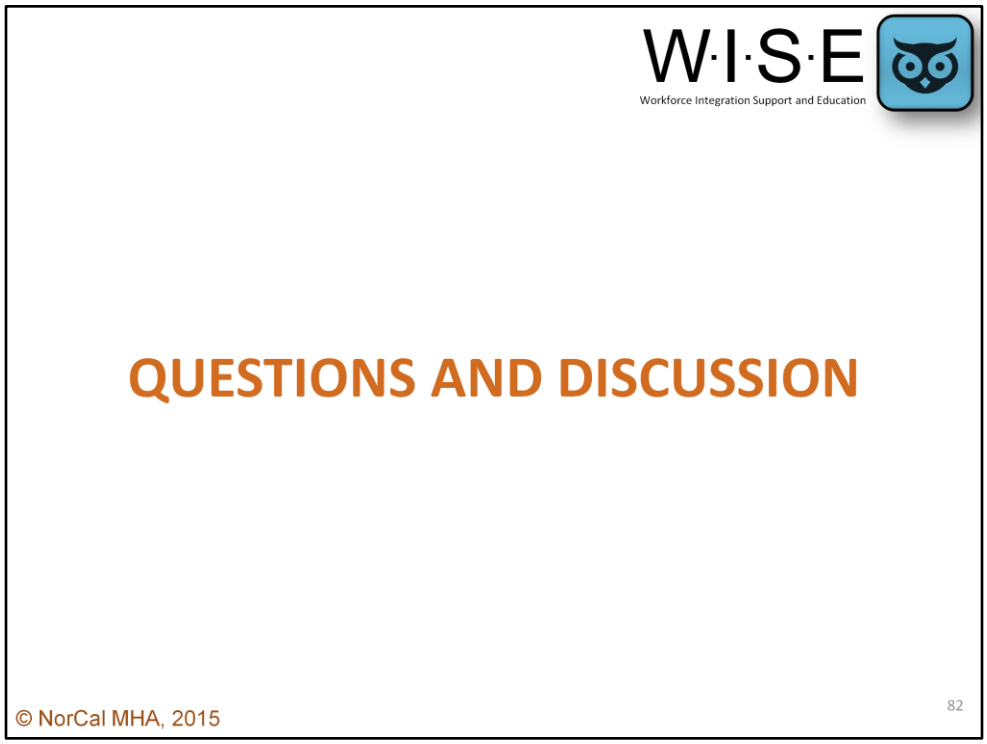
ASK the audience how their definition has changed and why. (give time for responses)

ASK the audience to identify ways that they can personally contribute to recovery at work
RECORD responses to this question on flipchart



[DO NOT INCLUDE THIS SLIDE IN AUDIENCE SLIDE HANDOUT]

Countless successful actors, writers, musicians and artists, politicians, athletes and ordinary people have lived with mental illness and *publicly disclosed*, including all of those pictured here.



REVIEW flipchart responses from Slide 4

ASK audience if this training met the needs they identified when the training began

W·I·S·E Contact Info

W·I·S·E
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