CONSUMERS WITH MENTAL ILLNESS SEEKING VOCATIONAL REHABILITATION SERVICES: A PLANNING DOCUMENT

A Project

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Counseling
(Vocational Rehabilitation)

by

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2015
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Graduate and Professional Studies in Education
Abstract

of

CONSUMERS WITH MENTAL ILLNESS SEEKING VOCATIONAL REHABILITATION SERVICES: A PLANNING DOCUMENT

by

Jessie M. Wright

Statement of the Problem

Social inclusion comes when people with mental illness go to work which decreases the negative effects of stigmas associated with mental illness. Stigma, defined by Erving Goffman (1986) is “an attribute that is deeply discrediting, leaving one who is stigmatized reduced in society's mind from a whole and usual person to a tainted, discounted one” (p. 15). Research evidence confirms that competitive employment in today's market helps to reduce social isolation resulting from stigma. The lack of a viable tool developed with information addressing specific avenues to diminish the effects of stigma, led to the development of this planning document. This project focuses on proven techniques that help to reduce stigma.

Sources of Data

The primary research sources for this project included peer-review journals and articles, Masters’ Projects from graduates of the Vocational Rehabilitation program, education websites, books, one workbook, one booklet, and personal interviews with
Senior Vocational Rehabilitation Counselor-Qualified Rehabilitation Professional (SVRC-QRP), and staff in the mental illness field.

Conclusions Reached

The resulting planning document lays the foundational groundwork to produce a DVD in order to improve the efforts of consumers with mental illness seeking vocational rehabilitation services in Sacramento, CA.

__________________________, Committee Chair
Guy Deaner, Ph.D.

___________________________
Date
DEDICATION

This Project is dedicated to the memory of those who completed their earthly mission: my grandmothers Mrs. Amie Randle-Randall and Mrs. Mattie Mae Henderson-Gwinn, my grandfathers Mr. Adam Randall and Mr. Mack Wright, Jr., my brothers Rufus and Douglas, my father Willie P. Wright, my Godfathers Deacon Alvin W. Bryant, Sr. and Superintendent James Thompson, my spiritual fathers Pastor John S. Doyle and Pastor Rickey A. Tates, Sr., my spiritual Godmothers Evangelist Willie B. Henderson, Evangelist Lola Fields, and Mother Ila Jean Hall, my aunts: Elmira “Tea,” Virginia, Cal Ruther, and Rosie Mae, my uncles: Solomon, A.D., Cal Luther, Arthur, Robert Louis, Henry Lt., Mack C., Mac Kelly, and Ephraim, my "sista-friends" Novice Massingale and Arlesha price, my spiritual brother/friend/mentor/counselor Michael Syas, my spiritual brother Elder KimDarryle A. Gordon, and all of my family, friends, and loved ones who have crossed over...

This Project is also dedicated to my mother, Mrs. Jessie Mae Marshall, my children, “Coach” Jessie C., Andre’, and Victoria, my grandsons, Derrick and Andre’ II, my brother, Michael, my aunts: Earnestine, Mac, Doris, Dorothy, Magdalene, Willie B., Louise, Jean, Annie B., Clara Retha, Willie B., Estella, Aggie, Lorean, Erma, Monzell, and Cassandra, my uncles: Alphonso “Poney,” Frank, Jack “Noonie,” Tommie Lee, James, Lee Henry, Charles, Willie D., and Alex and all of my biological, spiritual, extended, and recovery family. Thank you for being active participants in assisting me to
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I love you all with the love of Jesus Christ; the Author and Finisher of my faith!
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Chapter 1

INTRODUCTION

Background of Problem

Numerous studies have shown that negative viewpoints concerning mental illnesses (MI) are prevalent in the general public (Angermeyer & Dietrich, 2006). Stigma, described as one of the most challenging aspects related to MI, causes societal and environmental barriers in the lives of individuals with disabilities and impedes their employment opportunities. “Continued stigma is likely to cause severe direct disability and indirect economic implications” (Shrivastava, Johnston, & Bureau, 2012, para. 6). Stigma of MI impedes opportunities for societal participation and inclusion for individuals with disabilities and can frustrate their efforts toward recovery (Gaebel, Baumann, Witte, & Zaske, 2002; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). Collectively, MI are the number one disability burden in developed countries according to the World Health Organization (WHO) (as cited in Reeves, Lin, & Naters, 2013). It accounts for over 15% of the disease burden and besides being a public health problem, it is associated with other chronic diseases (Cyhlaroval, McCulloch, McGuffin, & Wylkes, 2010). Approximately 43.7 million people in the U.S. have a MI, representing 18.6% of the population. An estimated 61.5 million individuals experience MI each year, while 46% of the population are at risk of developing a MI during their lifetime (National Alliance on Mental Illness [NAMI], 2014b; Reeves et al., 2013). The overall financial burden for individuals diagnosed with mental illnesses is approximately $4 billion
annually, which includes health-care expenditures, disability benefits, and lost earnings and wages (Cyhlaroval et al., 2010; NAMI, 2014b).

Studies examining the association of stigma indicate that MI affects people psychologically, harms self-esteem, leads to self-deception, and can cause or aggravate psychiatric morbidity (Link & Phelan, 2001; Wright, Gronfein, & Owens, 2000). Van Brakel (2006) recommends assessing stigma from all points of view that could possibly have an impact on individuals with mental illnesses. The assessment would include auditing the media, health service providers, and all other entities that propagate unpleasant images of MI (Van Brakel, 2006). Current stigma reduction efforts have not alleviated the negative effects, which can affect the thoughts, feelings, and behavior of MI consumers (Major & O’Brien, 2005). Thornicroft (2006) provides a convincing case of how discrimination pervades the lives and experiences of people who acquire a psychiatric diagnosis and supports the views of many service users that stigma is one of the major barriers to living well. Stigmas are deeply discrediting and isolating and exasperate feelings of guilt, shame, inferiority, and a wish for concealment (Goffman, 1963). Individuals with MI are often viewed with scrutiny and face additional stigmas due to their invisible disability and outer appearance of exhibiting optimal health (Madaus, 2008). However, they have the highest rate of unemployment at 27.2% in California and 24.2% for the nation, in comparison to the general population unemployment rate of 7.4% for California and 6.1% for the nation (California Employment Development Department [EDD], 2012).
Purpose of the Project

The purpose of the project was to develop a planning document for the creation of a DVD. This planning document, which will lead to the development of a DVD at a later date, is organized for individuals diagnosed with mental illnesses (MI). It explains MI and how stigma barriers can be reduced simply by following specific avenues to diminish the effects. Addressing the stigmas of MI through education, research, awareness, and advocacy are just a few of the avenues consumers can pursue with the assistance offered through vocational rehabilitation (VR) services. A created DVD will provide information from consumers who have been successful in their unwavering perseverance to acquire a level of recovery. In seeking recovery, they enhance their opportunities for obtaining and maintaining competitive employment.

This planning document, in conjunction with the future DVD, will provide consumers with basic information and an understanding of how employment can be the vehicle of positive change in their lives (Corrigan & Kosyluk, 2005). Research evidence confirms competitive employment in today's labor market helps reduce social isolation resulting from stigma. Negative effects of unemployment are barriers to individuals with MI, which leads to the loss of purpose, structure, status, role, and a sense of identity in their lives (Waghorn & Lloyd, 2005). The ability to triumph over these negative effects promotes recovery and financial freedom and encourages emotional and personal stability in the lives of consumers with MI. These are just some of the many benefits consumers
can look forward to by being actively employed and responsible for their well-being (Dunn, Wewiorski, & Rogers, 2008).

The foundation for the production of the DVD is implemented in the planning document. The goal of the DVD is to present information that benefits consumers with MI by offering plain and simple detailed steps of individuals who sought and achieved balance and recovery in their lives. Balance and recovery directly impact the progression and successful outcome goals through VR services (Wright State University, 2015). The informed consumers will be able to incorporate and understand that their mental illness does not define who they are nor what they can accomplish and that “they have a mental illness, the mental illness does not have them” (D. Wood, personal communication, May 3, 2014).

A written outline of questions each participant will be requested to answer is also included in the planning document. Using these questions as a guide, each consumer will tell their own stories of how important VR services were in assisting them to become productive members of their community and society as a whole. Most consumers with MI who have used VR services realize their lives can be all they choose it to be within their range of possibilities. By using VR services, consumers can overcome the labels, the stereotypes, and the myths associated with their MI while becoming productive, employed members of their communities.
Definition of Terms

*Barrier to Employment*

Characteristic that hinder an individual’s ability to succeed in the labor force. They vary by location, labor market, personality, and system. Examples of individuals who may face barriers to employment include youth, displaced workers, public assistance recipients, and ethnic minorities. There are also the personal and systemic characteristics that may prevent an individual from participating in or accessing employment or services that may lead to employment. These include disability, health, family, circumstances, interpersonal relationships, and job skills. This also refers to mental and emotional barriers such as deficits in interpersonal functioning, lack of engagement (isolation), cognitive impairment, and psychiatric symptoms. Other barriers can be the lack of rapport that causes one to avoid contact, the fear of losing government benefits, and a lack of limited incentives to obtain employment (Larson, Barr, Kuwabara, Boyle, & Glenn, 2007).

*California Department of Rehabilitation (DOR)*

DOR is an organization that provides assistance and support to individuals with disabilities to get and maintain employment while at the same time maximizing their ability to live independently within their communities. The DOR addresses all such needs of the individuals who may have every kind and category of disability. All eligible individuals receive vocational rehabilitation services.
formulated so individuals with disabilities can be prepared for employment. Once people with disabilities become prepared for employment, they move to the next level where they indulge in training, education and transportation, and placement of a job (California Department of Rehabilitation, 2014).

**Competitive Employment**

Competitive employment is work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting and for which the individual is compensated at or above minimum wage, but not at less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled. Competitive employment means that the job seekers are competing with each other for the job and positions are not reserved for specific individuals in advance (California Health & Human Services Agency, 2014; Waghorn & Loyd, 2005).

**Disability**

Disability is defined broadly in the U.S. Census and includes long-lasting conditions that limit sight, hearing, or basic physical activity, as well as physical, emotional, or mental conditions lasting six months or more that limit cognitive abilities, caring for oneself at home, or going outside the home. The American with Disabilities Act (ADA) of 1990 – defines a “person with a disability” as someone who: “(a) has a physical or mental impairment that substantially limits one or more major life activities; (b) has a record of such an impairment; or (c) is
regarded as having such an impairment” (California Department of Fair Employment & Housing, 2009, p. 9). However, under California law, disability is defined as an impairment that makes performance of a major life activity “difficult.” Thus, under California law, persons with a wide variety of diseases, disorders or conditions would be deemed to have a disability who, under the definitions set forth in the ADA and the United States Supreme Court’s narrow interpretations of that statute, might not be considered “disabled” and therefore are denied protection (California Department of Fair Employment & Housing, 2009).

**Inter-Agency Communication**

Inter-agency communication is a process and a highly essential element to a mutual understanding between agencies and the Department of Rehabilitation. It is the gathering, sharing, and dissemination of information as well as the educational perspective of all involved agencies. Vocational rehabilitation counseling is a key component of guiding, directing, processing, and educating all key players involved in the realignment process (Oseguera, 2015).

**Individualized Plan for Employment [IPE]**

The individual Plan for Employment [IPE] is a client’s individualized written plan that lists his or her job objective. The IPE guides a client through a set of particular steps to reach his or her career goal and list the services the client will receive in order to find and maintain employment. The IPE is developed with the
guidance and assistance of the VR counselor, providing the client meaningful choices along with results of assessment of the client’s vocational interests, academic aptitudes, transferable skills, personal strengths and values, and work history, which defines a vocational or employment goal. The VR counselor and the client discuss the client’s unique strengths, resources, priorities, concern, abilities, capabilities, interests, and informed choice as the plan develops. The IPE will detail a description of the employment goal, a timeline to achieve the employment goal, description of the services and service providers the client will need, a time to begin services, description of methods to get services, criteria used to evaluate a client’s progress, responsibilities of the counselor, the clients and others involved in the IPE, outline of client participation in paying for part of the plan, and identification of comparable benefits (California Department of Rehabilitation, 2008).

*Integrated Setting (purposes of a job placement)*

A setting typically found in the community, in which the individual with a disability interacts with non-disabled individuals, other than service providers, to the same extent that non-disabled workers do in comparable placements (U.S. Department of Health & Human Services, n.d.).

*Mental Disability*

Mental Disability — is having any mental or psychological disorder or condition, such as mental retardation, organic brain syndrome, emotional or mental illness,
or specific learning disabilities that limits a major life activity, or having any other mental or psychological disorder or condition that requires special education or related services. An employee who has a record or history of a mental or psychological disorder or condition which is known to the employer, or who is regarded or treated by the employer as having a mental disorder or condition, that is also protected (California Department of Fair Employment & Housing, 2009).

*Mental health*

Mental health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO definition of health: A state of complete physical, mental and social well-being, and not merely the absence of mental disorder/disease. Mental health is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders. (World Health Organization, 2015, para. 1)

It is a state of successful performance of mental function. It results in productive activities, working productively and fruitfully with others, coping with the normal stresses of life, having fulfilling relationships with other people, and the ability to adapt to change and cope with adversity, from early childhood until late life. Mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem, and is able to make a contribution to her or his community.
Mental Illness

Mental illness refers collectively to all diagnosable mental disorders. Mental disorders are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer’s disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alterations in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (over activity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom. Individuals are divided into three categories based on their diagnosis: cognitive impairments, psychosocial impairment, and other mental impairments (American Psychiatric Association, 1994). According to the Surgeon General’s report (U.S. Department of Health and Human Services, 1999), there are no definitive physical markers or tests that can identify mental illness. It represents a crisis for those affected (American Psychiatric Association, 1994; Centers for Disease Control and Prevention, 2011).
Senior Vocational Rehabilitation Counselor-Qualified Rehabilitation Professional

(SVRC-QRP)

SVRC-QRP under general supervision, determine vocational eligibility and level of severity of disability; plan and arrange for the supervision of vocational rehabilitation of individuals with physical and mental disabilities, which are substantial impediments to gainful employment; serve as a liaison and resource to employers and community organizations regarding opportunities and considerations related to hiring individuals with disabilities; provide vocational counseling, rehabilitation assessment, and placement of individuals with disabilities; and perform other related work (California Department of Rehabilitation, n.d.).

Social Distance

Social distance is the desire to avoid contact with a specific set of people. Its origin is rooted in stigma. Social distance is defined by Goffman (1963) as a mark of shame, causing the individual to feel disgraced, rejected, discriminated against, and excluded from participating in various areas of society. Characteristics of individuals who desire social distance include being more distance from people with mental disabilities than from normal people. It declines in adolescence, stays moderately the same in younger adults, but is notably higher in older adults. There is also has a weak association between social distance and low education, but there are relatively no differences between
genders. Less social distance is typically required when one has more personal experiences with and knowledge of individuals who have had personal experiences with mental illness. Unfortunately, the perception that mental disorders are due to character weakness is associated with greater social distance (Goffman, 1963; Jorm & Oh, 2009).

**Stigma**

Stigma is a mark of shame and deeply discrediting, causing one to feel inferior and have a wish for concealment. It also causes the individual to feel disgraced as a result of being rejected, discriminated against, and excluded from participating in a number of different areas of society. It involves being viewed in a negative way because one has a distinguishing characteristic or personal trait that is thought to be, or actually is, a disadvantage (a negative stereotype). Unfortunately, negative attitudes and beliefs toward people who have a mental health condition are common. Stigma erodes confidence that mental disorders are valid, treatable health conditions. It can lead people to avoid socializing, employing, or working with or renting to or living near persons who have a mental disorder, especially a severe disorder like schizophrenia. Stigma deters the public from wanting to pay for care and, thus, reduces consumers’ access to resources and opportunities for treatment and social services. A consequent inability or failure to obtain treatment reinforces destructive patterns of low self-esteem, isolation, and hopelessness. Stigma tragically deprives people of their
dignity and interferes with their full participation in society. It must be overcome. Stigma erodes confidence that mental disorders are valid, treatable health conditions (Coulter & Maida, 2005; Goffman, 1963; Hinshaw, 2006; U.S. Department of Health and Human Services, 1999).

**Stigmatization**

Stigmatization is social rejection; those stigmatized are rejected by people because of the label they carry or because their behaviors clearly indicate they belong to a certain labeled group. Stigmatization of the mentally ill is caused by the public’s belief in myths about the danger of the mentally ill, and exposing those myths can reduce stigmatization. It appears that people respond to the mentally ill with feelings of fear and rejection. Individuals who have experiences of being stereotyped experience separation, status loss, and discrimination when stigma interferes with an individual’s ability to participate fully in the social and economic life of his/her community. Thus, stigmatization of individuals with disabilities is a complex process that involves individual biological differences, the negative evaluation of those differences by others, adverse reactions of others, and negative social and emotional outcomes for individuals with disabilities (Dickens, Langé, & Picchioni, 2011; Green, Davis, Karshmer, Marsh, Straight, 2005).
**Vocational Rehabilitation Client**

An individual who has applied for and is receiving vocational rehabilitation (VR) services in the form of counseling and guidance, vocational training, and/or job development or supported employment. As a requirement to receive VR services, a consumer must attend and fully participate in training programs and classes and fully participate in his or her job search and job placement activities. Clients who request rehabilitation services for themselves are typically eager to be employed and display a motivated, positive attitude that is conducive to involvement in vocational assessment (DOR, 2008).

**Statement of the Problem**

The Vocational Rehabilitation Counseling (VRC) Master’s program course of study at California State University, Sacramento (CSUS) and personal observations impressed upon this author the need to address stigma reduction for individuals with mental illness. These experiences exposed how stigmas impact their lives and how it is a barrier to their acquiring stable income through employment. Social inclusion comes when people with MI go to work, which decreases the negative effects of stigma for MI consumers.

While attending classes at CSUS in the VRC Master’s program, this author became fascinated by discussions of topics related to MI. The author had the opportunity to interact with consumers diagnosed with MI during her internship experience at Laguna Creek’s Department of Rehabilitation (DOR) during fall 2011. The author acquired
compassion for this particular group of consumers, noting that their challenges of entering the labor market were further confounded by the stigma surrounding MI. The author requested, and was given, permission by the site supervisor Mark Frayser to attend an educational seminar with the mental health specialist Alina Sala. The accredited seminars provided agencies with knowledge specifically aimed at working with individuals with MI. This and similar experiences provided additional motivation for this author to advocate for consumers with MI.

Numerous studies have shown that negative viewpoints concerning the stigma of MI are prevalent in the general public (Angermeyer & Dietrich, 2006). Unfortunately, similar attitudes occur among families, friends, and employers. Stereotypes are commonplace when the mentally ill come into contact with mental health professionals and other persons in the helping professions (Schulze, 2007). According to Angermeyer and Dietrich (2006), work helps individuals with MI cope with their disabilities, as it encourages them to have a sense of self-worth and stability. Some individuals use work as a distraction from MI while others use work to overcome troubling symptoms of MI. In any case, to become fully integrated into the American dream and to instill hope and empowerment, individuals with MI would benefit from obtaining and maintaining competitive employment (Dunn et al., 2008). According to O’Day, Killeen, and Goldberg (2005), “evidence suggests that a high percentage of people with a psychiatric disability can recover, find meaningful work, develop positive relationship, and participate fully in their communities” (Abstract).
Stigma is a barrier to employment for consumers with MI pursuing VR services. Several barriers of stigma’s negative affect on consumers with MI are: reduced chances for employment, hostile labor market interactions, lack of appropriate VR services, labor market discrimination, lack of work incentives, poverty-level jobs, and programs with no work incentives (Cook, 2006).

People with MI are entitled to have employment based upon their knowledge, skills, and abilities to accomplish the job’s specifications. Meaningful jobs help alleviate symptoms that can occur and that are specifically related to individuals living with MI (O’Day et al., 2005). Work helps consumers cope with their MI, promotes social inclusion, and gives the consumer a source of pride and empowerment. Work can decrease the negative effects of stigma and unemployment as well as the underemployment for motivated consumers seeking VR services (Dooley, 2003).

There is a lack of pertinent information regarding stigma and the tremendous effect it has on consumers with MI in the greater Sacramento area. This author searched through CSUS’s ScholarWorks, Internet sites, peer-reviewed journals, and articles, but was unable to find a planning document or a videotaped testimony in combination with stigma reduction for individuals with MI seeking VR services at the local level. However, the Walk Manager of Sacramento’s National Alliance of Mental Illness (NAMI) Donna Wood informed this author of NAMI’s videotaped copy of the May 2014 walk, highlighting Assemblyman Darrell Steinberg as the guest speaker along with one consumer’s personal experiences with stigma. She was willing to allow this author to
watch the video tape and said she was fascinated about a future videotaping of consumers with MI. She stated, “a videotaped production of individuals with MI discussing their personal challenges with stigma and how they have been able to overcome them, and become a success in spite of them, would be great” (D. Wood, personal communication, May 3, 2014). Therefore, this author will be compiling a planning document for the production of a DVD in the Sacramento, California area at a later date. The DVD will address stigma reduction strategies and interventions used by consumers with MI who no longer allow stigma to deprive them of their self-worth or hinder their full participation in society.

**Limitations of the Project**

The primary audience for this project is consumers with mental illnesses (MI) who utilize Vocational Rehabilitation (VR) services of the greater Sacramento area. The development of the curriculum was based on the author’s perception and ideas regarding a planning document process to create a viable DVD at a later date. The material is directly related to the author’s bias and does not reflect any other individual’s perspective. The author believes that consumers of DOR have a better chance of success than others who do not utilize the services of DOR. Information for the planning document was gathered September 2011 through February 2015.

**Organization of the Project**

An introduction to the background of the problem, purpose of the project, definitions of terms, statement of the problem and limitations of the problem comprise
Chapter 1. A review of the literature related to the history of stigma and how stigma affects consumers seeking training and employment through VR services is in Chapter 2. Chapter 3 is Methodology and includes the method used and a review of sources. Chapter 4 contains the summary and recommendations followed by the Appendix, which is the planning document.
Chapter 2
LITERATURE REVIEW

Introduction

The review of literature is divided into four sections. The first section discusses the stigma of mental illness (MI). The second section highlights individuals’ awareness and acceptance of their MI. This section is followed by treatment strategies for individuals with MI. Finally, the fourth section recommends strategies to reduce the stigma of MI.

Stigma of Mental Illness

According to Goffman’s (1963) classic work, stigma is defined as an attribute that is deeply discrediting, leaving one who is stigmatized reduced in our minds from a whole and usual person to a tainted, discounted one (as cited in Coulter & Maida, 2005). Moreover, he stated that stigma’s relationship is between both an attribute and a stereotype because there are important discredited attributes everywhere in our society. In essence, it is rooted in the fact that all and any human differences are potentially stigmatizable. “Stigmas stem from differences” (Coulter & Maida, 2005, p. 217).

Furthermore, labeling an individual with MI is a form of stigmatization that has negative effects, since a diagnosis of MI impacts public attitudes toward those affected (Angermeyer & Matschinger, 2003). Whether it is from a clinical point of view or a personal experience, the labeling affects those inflicted and their relatives (Anthony, 2008). According to the Mental Health Commission (MHC; 2010), three out of four
mentally ill people have experiences with stigma as they are categorized into a particular group, inundated with involuntary treatment, and they experience a restriction of human rights. These restrictions differentiate between the undiagnosed or “sane” and the diagnosed or “insane.” In other words, by grouping mental illnesses, society believes it minimizes the fear and anxiety that it is possible for anyone to become stricken with a MI (Scheyett, 2005). Additionally, such aversive points of view create prejudice. This kind of prejudice generally incites even more negative actions and discriminatory behaviors and practices from the “sane.” In essence, the prejudice is understood culturally because individuals with MI are categorized into their own grouping, a perpetual cycle that increases the stigmatization of their MI status.

It has been suggested that once it has been established an individual has a MI, they are grouped into a cultural category. This means that due to the nature of those diagnosed with MI, grouping them has enabled observance of particular behavioral patterns within that “culture” (Keller & Loewenstein, 2010). This categorization further stigmatizes and classifies associated individuals as “a mentally ill person,” thereby causing more harm to their genuine, social, and emotional well-being. What appears to be missing is the acknowledgement that this classification causes more harm to their overall wellness (Link as cited in Kroska & Harkness, 2008; Markowitz as cited in Kroska & Harkness, 2008). According to Kroska and Harkness (2008), once an individual has been diagnosed with a MI, their cultural perceptions and ideas about the illness become overriding factors.
Many individuals, in their efforts to avoid prejudice and discriminatory taunting associated with being labeled MI, choose not to pursue the assistance of mental health (MH) practitioners. The research identified several drawbacks associated with being labeled MI. Drawbacks include a negative attitude toward taking medications, distress, unfavorable taunting, and limited life opportunities (Centers for Disease Control and Prevention [CDC], 2012). Labeling individuals with MI is not always based on any particular type of behavior. Without them exhibiting any form of abnormal, incompetent, or dangerous behavior, stigma exists toward individuals with MI (Kroska & Harkness 2008). However, due to being stigmatized by society, it is not uncommon for those diagnosed with a MI to try and solve their own mental challenges (Corrigan, 2007).

Unfortunately, the shame and embarrassment associated with seeking MH services is a barrier to those needing treatment. This is further complicated when comparing individuals treated for MI to individuals who were not treated but who present with similar behavioral complications (Kroska & Harkness, 2006). The concepts of being diagnosed or not diagnosed “lack a consistent operational definition that covers all situations” (Stein et al., 2010, p. 1). Individuals with MI should be encouraged to seek MH services, but due to labeling, they often seek ways and means by which to cope with MI on their own. Their outlook and feelings generally predict this form of behavior due to the bargaining that occurs in their day-to-day existence (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012).
It is important for those with MI and their loved ones to be aware of the possible ramifications of going untreated. In essence, when MI is untreated, there could be severe emotional, behavioral, and physical health problems that can occur (CDC, 2012). Although the exact cause of the various disorders have not been identified (American Psychiatric Association, 2005), due to the regular updating of the *Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV-TR)*, these disorders are much more common than society realizes. Yet, mental disorders have been diagnosed more frequently than other form of disorders (Pasman, 2011). There are 200 classified forms of MI described in the *DSM-IV* and *DSM 5*. With these classified forms come numerous symptoms that one may experience. These symptoms include a change in personality, personal habits, or mood and/or social withdrawal. According to Mental Health America (MHA; 2014), symptoms could be related to environmental stress, emotional events, chemical imbalances, genetic factors, or a combination of these. With these symptoms in mind, research suggests that if a familiar individual appears to be withdrawn or quiet, exhibits outbursts of anger, is disoriented, experiences extreme highs and lows, or has any other uncommon behaviors, it is in their best interest to seek the assistance of a health care provider (Mental Health America [MHA], 2014; Wang et al., 2005).

**Awareness and Acceptance Leads to Treatment**

Perception, consciousness, and cognition are all involved in the state of being aware. To recognize when something is out of order, one must first have awareness to know what is usual and what is unusual. Impaired insight is a fundamental attribute of an
illness. People with a mental illness (MI) commonly lack the necessary insight of their illness and the possible consequences associated with avoiding it (Buckley et al., 2007). One of the most devastating consequences of being unaware of a mental illness is the failure to seek and persist in treatment (Buckley et al., 2007). Clinicians generally expect their patients to gain insight into their mental illness and accept the reality of their illness and the limitations it imposes upon them (Andertor, Elfert, & Lai as cited in Scheid, 2005). One of the most important consequences associated with the lack of awareness is the failure to recognize the need for treatment. Without being aware of a need for treatment, there is non-compliance (Buckley et al., 2007).

Awareness is multidimensional in that individuals with MI must be aware of the illness, recognize symptoms, be capable of attributing consequences, and understand the need for treatment (MHA, 2014). Moreover, knowledge of the illness can vary over a course of time or various episodes. The challenge of being aware is the possibility that the impairment can change and disrupt their lives (Buckley et al., 2007). In other words, symptoms experienced in one moment may be drastically different at another time (Buckley et al., 2007). Additional studies suggest that a psychological process of denial to cope with the illnesses’ negative consequences is also due to a lack of awareness or insight (Tait, Birchwood, & Trower, 2003). Amador (2007) suggested that denial of one’s MI can truly damage their ability to participate in treatment.

Likewise, another study found that patients unaware of their MI symptoms had a smaller brain size than patients who had intact insight (Reite et al., 2010). Without
awareness, individuals with MI do not know that treatment is essential, thereby causing treatment non-adherence. Non-adherent patients have more relapses, become more symptomatic, get involved with substance abuse, and have poorer insight into their illness (Novick, Haro, Suarez, Perez, & Dittman, 2010). Indeed, awareness is imperative because although the relationship between awareness and other clinical variables are complex, there is enough evidence to show that awareness can be considered an important outcome domain (Buckley et al., 2007).

Another key to the treatment of mental illness is acceptance. Acceptance is a crucial stage in the process of recovery from a MI. It is also quite challenging (Keyes, 2005). Acceptance is challenging because it may mean something different to each person ranging from functional changes to the previously noted awareness of one’s MI (Keyes, 2005). An additional challenge relates to the fact that there is no model to follow, no traditional diagnostic label to promote one's recovery process, and no sufficient resources to deal with the personal losses and challenges that occur (Westerhof & Keyes, 2010). Theoretically, people socially maintain negative attitudes toward individuals diagnosed with MI (Alexander & Link, 2003). Therefore, most individuals with MI withdraw into isolation. For them, isolation is easier than being subjected to differential treatment by others as they attempt to cope with the loss of status associated with the diagnosis of MI (Dunn et al., 2008). Basically, societal rejection and avoidance by individuals with MI directly leads to social network instability and indirectly affects
interaction based on the individual with MI’s anticipation of negative reactions from others (Dunn et al., 2008).

Acceptance is a process that involves emotions, cognition, and behaviors that cultivate hope and personal empowerment (Baer & Krietemeyer, 2006). For some, with acceptance comes self-education, eliminating pessimism, continuously working on past denial, and constantly seeking recovery aides. The opportunities to live a more balanced life and gain personal strengths occur when individuals with MI accept their diagnosis and begin the active engagement in sustaining their overall well-being (Hinshaw, 2006). Acceptance leads to seeking counseling versus non-acceptance, which leads individuals to hide their illness, have poor psychosocial adjustment, be less motivated to seek services, and ultimately decrease their quality of life (Groomes, Kampfe, & Mapuranga, 2011). Since the concept of acceptance improves the course of treatment, which also correlates to changes in patient's symptoms, a greater confidence in resisting the negative aspects of MI occurs as well (Gaudiano, Nowlan, Brown, Epstein-Lubow, & Miller, 2013). In other words, without accepting that a MI exists, the likelihood of successful treatment will obviously diminish.

Based upon the diagnosis, self-acceptance, and acknowledgment, acceptance of the MI and seeking assistance begin with tremendous challenges (Dunn et al., 2008). Without acceptance, the likelihood of successful treatment will obviously diminish. Therefore, the earlier individuals accept their MI, the sooner they will seek treatment services of a MH professional (MHA, 2015). At the same time, individuals with MI are
able to incorporate intervention strategies into their lives, which can save their lives and redirect a negative trajectory. The individuals with MI have a greater opportunity to obtain the correct diagnosis and get proper treatment within a reasonable amount of time because MI is treatable (MHA, 2015). By seeking a mental health professional, the individual has a better chance to adjust to the possibility of a different life. Similarly, their support and assistance encourages the individual with MI to recognize that they are not alone and that help is available (MHA, 2014).

Generally speaking, the support, compassionate, and non-judgmental attitude of people familiar with MI in a nurturing environment helps individuals become familiar with their disability. In this type of setting, education and contact are intervention strategies as well as motivating factors that encourage individuals with MI to come to terms and accept help (Lively & Smith as cited in Perry, 2014). With a positive foundation of encouragement, awareness, acceptance, and treatment, the likelihood of avoidances that hinders the individual with MI’s progress are greatly reduced (Anthony, 2008). With proper and continuous support, as well as empathy and acceptance of individuals with MI, they become more willing to do what is necessary to move forward in their lives (Markowitz, Angell, & Greenberg, 2011). In short, awareness, and acceptance become indicators that increase the probability of individuals with MI pursuing treatment in order to live as successfully as possible.
Treatment Strategies

In the most persistent cases of MI, hospitalization is an option that will provide a safe and comfortable place for the individual to psychologically heal while removing themselves from the stressors of their normal environment (National Alliance of Mental Illness [NAMI], 2015h). This also allows an opportunity for them to receive testing and an accurate diagnosis while affording them the ability to find an effective prescription treatment under the watchful supervision and guidance of professionals. The initial phases of introduction to a new medication and its side effects is crucial to achieving a balance in the individual’s life (NAMI, 2015b). However, for some individuals, the possibility of admission to inpatient care is an intimidating prospect. Due to this fear, in these cases, today’s mental health community offers a number of outpatient options.

Many individuals can benefit from individual therapy in which they can discuss their concerns and experiences in a safe and nonjudgmental environment, which is completely confidential (NAMI, 2015g). As such, there are many varieties of therapeutic options, which allows individuals with MI to find a therapist who is ideal for them. This includes therapists who engage in talk therapy, cognitive behavior therapy to diminish negative internal discussion or unwanted behaviors, family and relationship therapy to improve challenging relationships, and substance abuse treatment for individuals who may have an issue with substances in conjunction with a MI diagnosis (NAMI, 2015g). In many cases, individuals who suffer from a dual diagnosis can often benefit from an outpatient support group. In an outpatient setting, the individual can experience the
advantages of social support that comes from peers experiencing similar situations and who have learned to cope with their situations (NAMI, 2015f).

In the meantime, the advances in pharmaceuticals (drugs) for dealing with MI challenges have resulted in countless medications that help balance many of the symptoms associated with MI (NAMI, 2015b). In some cases, adding the treatment of MI medication can directly target the neurotransmitter deficiency or other underlying chemical causation of MI. As a result, therapeutic medications are used for a number of MI and are often prescribed even when another method of intervention is implemented (NAMI, 2015b).

Although there are many effective therapeutic interventions for MH disorders, some are more effective than others for some diagnoses. In fact, NAMI (2015c) suggests that the most beneficial method is often a variety of treatment interventions. For example, a combination of medication for dealing with the biological aspects of a disorder will help improve the individual with a level of functioning consistent with having MI. Medication is frequently the primary treatment process. Even though there are often side effects from the medication, they will subside and counseling will help the individual with MI to cope with their feelings. However, NAMI (2015a) noted that the feelings of individuals with MI concerning their diagnosis is something they eventually will be able to cope with, especially if they are committed and stay in compliance with their individual treatment plan. Having a consistent routine of maintaining one’s well-being promotes the health of the individual’s mind and body. All of these treatment
modalities, including the right clinical professional help to ensure continued wellness by providing assistance during times of challenges, stressors, help MI clients avoid relapses into negative behavior.

**Techniques to Reduce Stigma**

To reduce stigma, there must be effective treatment programs to decrease isolation and coercion. Garfield and Mackler (2009) propose that isolation, or even segregation, is related to distancing the mentally ill (MI) from their families, friends, and the community. On the other hand, coercion is the practice of forcibly persuading someone to do something they may not have otherwise attempted. Corrigan and Kosyluk (2014) have provided a substantial amount of evidence, to change the public’s view of MI stigma. Their evidence includes strategies to help reduce stigma. These strategies consist of education, protest, interpersonal contact, affirmative action, empathizing, and media-based approaches.

Education must be specific. According to Clement et al. (2013), educational strategies provide the most informative approach to stigma reduction, replacing inaccurate stereotypes with factual information. By increasing the public’s general knowledge about specific illnesses, assumptions that typically lead to stigmatization can be countered. Precise educational interventions can include presentations, books, movies, videos, simulations, and other audio visual aids. Corrigan and Gelb (2006) suggested that education usually reduces the negative behaviors portrayed with the false assumptions on
which most stigmas are based. In addition, most information given is about treatment, transmission, and causes of the condition.

Protests highlight injustices brought on by offenders and aim to suppress stigmatizing attitudes toward MI. For example, NAMI “has an email alert system called StigmaBusters that notifies members about stigmatizing media representations and instructions on how to contact both the organization and the sponsors” (Fertman, Delgado, & Terasevich, 2013, p. 261). According to Watson, Corrigan, and Angell (2005), protest strategies significantly change the behaviors of offenders by convincing the media to stop playing programs and advertisements that convey negative and destructive stereotypes and beliefs about MI.

Another strategy to reduce stigma is interpersonal contact with members of the stigmatized group. There are promising findings, found in several studies, focusing on the effects of contact and the stigma of MI. Corrigan and Gelb (2006) found that contact with an individual with MI often produced greater improvements in attitudes than protest and education. Improvements are more evident when the person-to-person contact involves a person with MI who moderately disconfirms prevailing stereotypes (Reinke, Corrigan, Leonard, Lundin, & Kubiak, 2004). As a matter of fact, person-to-person contact usually changes the self-perception held by employers, peers, and neighbors regarding individuals with MI (Corrigan, 2004).

Affirmative action occurs when positive expectations and beliefs to purposely and proactively increase opportunities for individuals with MI are implemented. This is
accomplished through government-approved activities that help decrease historical disparities (Corrigan & Kosyluk, 2014). Structural discrimination allows the individual with MI to access specific limited opportunities. Some of the precise legislation includes the Americans with Disabilities Act (ADA) of 1990 that requires employers to make reasonable accommodations so individuals with MI are able to be equally employed (Corrigan & Kosyluk, 2014). It also includes efforts by legislators and other government officials to seek funding for empowerment, recovery, and programs to dismiss structural discrimination against people with MI.

Empathy is when one has the ability to understand the feelings of another. According to NAMI (2015e), contacts must be credible in that they share similarities such as gender, ethnicity, religious practices, and even socioeconomic status. When a person who does not have a MI experiences the daily tribulations of individuals with MI, they will be more likely to recognize that individuals with MI are actually not much different from themselves. There is a MI present, but the individual with MI is a person first and foremost. Sympathy is not the intended goal of individuals with MI since it involves feeling pity. Most individuals with MI are seeking to live productive lives; they are not looking for sympathy or pity (Corrigan & Kosyluk, 2014). As a matter of fact, NAMI (2013) provides evidence that many individuals with MI desire to be treated as equals and given the chance to succeed with necessary modifications. This empathetic approach may diminish the mindset that the MI are less than human or different from the norm because they repeatedly walk in their shoes.
Media-based approaches, also referred to as Public Service Announcements (PSAs), embedded in social marketing have a tendency to be the best example of the effects of stigma reduction (Corrigan & Kosyluk, 2014). PSAs are collections of principles and practices meant to move an agenda reflecting social justice and health promotion, also known as social marketing (Kotler, Roberto, & Lee as cited in Sullivan, Hamilton, & Allen, 2005). According to Corrigan and Kosyluk (2014), social marketing often includes paper and online resources that integrate contact strategies and education to introduce and maintain the effects of learning about MI and treatment. Most of these programs activate and familiarize viewers via public service campaign materials that spread to social networking sites such as Facebook and LinkedIn. In addition, the increased usage of blogs, tweets, and Instagram provide another tool for brand-new PSAs.

Summary

In Chapter 2, the author begins by addressing the stigma of mental illness (MI). The second section introduces the importance of perception required to achieve awareness and acceptance, which generally leads to treatment, followed by treatment strategies. The last section discusses techniques to reduce stigma by including the importance of education, protesting, interpersonal contact, affirmative action, empathy, and media-based approaches as intervention strategies that help to decreasing stigma in relation to MI.
Chapter 3

METHODOLOGY

Review of Sources

Supporting evidence for the literature review section of this project was obtained through several sources. The author read and studied the *Consumer Information Handbook (2011)*, a manual provided by the Department of Rehabilitation (2008). The manual covers the mission, purpose, who should apply, how to apply, assessment process, basic eligibility guidelines, receiving services and order selection, development of the Individualized Plan for Employment (IPE), definitions, and basic information for providing services to consumers.

Services, The Social Psychology of Stigma, and The Lancet. The author also reviewed masters projects by graduates of the Vocational Rehabilitation (VR) program.

In addition to the articles, the author read three books and one workbook: The Mark of Shame: Stigma of Mental Illness and an Agenda for Change (Hinshaw, 2007), Stigma: Notes on the Management of Spoiled Identity (Goffman, 1963), and The Stigma of Disease and Disability: Understanding Causes and Overcoming Injustices (Corrigan, 2013). The workbook, entitled Action Planning for Prevention and Recovery (Community Care Behavioral Health Organization, 2010), is a training and reinforcement tool to assist consumers with MI.

Meanwhile, the author selected five agencies that provide services to consumers with mental illness (MI) in the Sacramento area to visit and interview personnel as part of her research relating to individuals with MI being able to achieve a level of wholeness in their lives. The five agencies were Laguna Creek’s Department of Rehabilitation (DOR), Wellness for Recovery (WRC), the National Alliance on Mental Illness (NAMI), Transitional Community Opportunities Recovery & Engagement (TCORE), and Women’s Empowerment.

Lastly, the author interviewed several Senior Vocational Rehabilitation Counselors-Qualified Rehabilitation Professionals (SVRC-QRP) inquiring about collaborative services that would be self-motivating for this population to successfully transition into the world of work. The work for this project began during the author’s internship at the Laguna Creek’s DOR in September 2011 and concluded in May 2015.
Method

The process for completing this project began by attending a Culminating Experience Workshop hosted by Dr. Guy Deaner and Patricia Ortman in spring 2011. Dr. Guy Deaner is the advisor and committee chair for the Vocational Rehabilitation program. Patricia Ortman and Dr. Guy Deaner are the authors of *Vocational Rehabilitation Counseling Master’s Project Handbook* (2009). The handbook is specifically designed to be used for completing the culminating project for the Vocational Rehabilitation Counseling Master’s Program. The information contained in the handbook was utilized as a guide throughout the complete construction of this project.

The idea for this project was considered by the author during fall 2011 while interning at Department of Rehabilitation’s (DOR) Laguna Creek’s office. Alina Sala, Senior Vocational Rehabilitation Counselor-Qualified Rehabilitation Professional (SVRC-QRP) and mental health specialist at Laguna Creek’s DOR, brought to the attention of the author that the County of Sacramento Department of Health and Human Services Division of Behavioral Health Services (DHHS-BHS) office regularly presented seminars emphasizing mental illness (MI). Ms. Sala was aware of the author’s interest in information surrounding MI and recommended that she could possibly benefit from attending the seminars. Unfortunately, the seminars were presented during hours which conflicted with the author’s internship hours. However, the author approached Mr. Mark Frayser, Rehabilitation Supervisor at the Laguna Creek’s DOR office, and requested permission to attend the seminars. Mr. Frayser granted her permission to attend one of
the seminars with Ms. Sala. The author chose to attend a seminar entitled *Employment Success and Co-Occurring Disorders*, presented by Dr. Daniel J. Raudenbush and hosted by the Sacramento’s DHHS-BHS office.

One particular portion of the seminar sparked an interest in the author. Dr. Raudenbush spoke concerning the necessity of collaborative partnerships between MH professionals, social services, and related fields to meet the complex needs of individuals with MI. With this in mind, the author began to closely read case management notes of consumers with MI, particularly those who were unsuccessful case closures. Afterwards, inquiries were made of SVRC-QRPs at both the Laguna Creek and Salinas DOR offices regarding their perceptions of the reasoning for unsuccessful case closures of consumers with MI. In addition, the author sought their ideas of ways and means to improve the likelihood of successful case closures for these consumers.

In November 2011, the author asked Ms. Sala her views on what consumers needed to do in order to increase their probability of having successful case closures. Ms. Sala mentioned that having everyone involved, the consumer, the RC, MH provider, a support system and the prospective employer supporting and believing in the individual’s capacity to successfully complete their Individual Plan for Employment (IPE) could greatly improve their success rate. She stated that it is important for the RC to build a network of service providers to emphasize the importance of bridging the gap between unemployment, underemployment, and gainful employment. Also, in November 2011, the author called the Salinas DOR office and spoke with Ms. Irene Lopez, SVRC-QRP
and her former classmate, seeking her observations of how to assist consumers with MI. Ms. Lopez stated, “The consumers had to be really dedicated to what they set out to accomplish, especially the agreed upon guidelines in their IPE” (Personal communication, November 12, 2011).

In December 2011, the author interviewed Mrs. Cheryl Bear, SVRC-QRP at the Laguna Creek DOR, whose caseload included consumers who received Supported Employment (SE). The author asked what, if any, traits she had noted that could hinder a consumer from achieving their IPE goals. In her opinion, Mrs. Bear believed consumers with MI can often achieve the goals of their IPEs. Mrs. Bear replied that she found providing consumers with additional services, which sometimes meant providing accommodations for truly stressful times occurring in their lives, could possibly provide them a greater opportunity to succeed. “It really depends on the consumer a lot of the time, because it is their responsibility to inform their RC if they are experiencing difficulties staying on task” (Personal communication, December 9, 2011).

Equally important was the response provided by Mrs. Carla Ware, SVRC-QRP, located at the Laguna Creek DOR. She is one of two RCs servicing youths in the Transitional Partnership Program (TTP). Of significant importance to the youth was for them to have good, solid, and genuine support. Mrs. Ware stated, “Many of the young people with MI were inclined to really stay to themselves. They really have a difficult time trusting that others will not poke fun and make mockery of them for verbalizing their MI challenges” (Personal communication, December 9, 2011).
Even though there are successful case closures for consumers with MI, information gathered by this author made it clear of the need to develop means by which to increase opportunities for successful case closures with MI. This, combined with numerous campaigns to stop the stigma of MI, encouraged the author to develop a planning document. The planning document is to become a DVD at a later date for consumers with MI seeking DOR services.

On March 12, 2012, the author interviewed Ms. Sala, searching for additional understanding regarding challenges faced by SVRC-QRPs supporting consumers with MI. Ms. Sala mentioned that many times RCs often place their wants and expectations onto the consumers. Ms. Sala further stated that sometimes RC’s past judgment on consumers with MI is based on their own outlook and knowledge, without really having a relationship and workable agreement for services with the consumer. Further, she stated,

With this perception, if the consumer is not really ready to move forward, the RC should know to step back. RC can only take consumers as far as they want and are willing to go in recognizing their abilities and not their disabilities. When a RC catches themselves recognizing they need more of a perspective of the consumer, they should be willing to admit it. They should be willing to admit they are missing the nail (point); maybe not understanding where the consumer is coming from, and the RC should try to step into the consumer’s shoes in order to know how they are feeling… not everybody is ready. (A. Sala, personal communication, March 12, 2012)
Ms. Sala also mentioned the importance of RCs dealing with their own biases because biases can interfere with their ability to be present “in the here and now” with the consumer. She further stated, “I encourage consumers with MI to become proactive in advocating for themselves to know their triggers, to work with their support team, and remain med compliant” (Personal communication, March 12, 2012).

During fall 2012, the author presented the project’s mission to her advisor Dr. Guy Deaner and received approval to proceed with the project. The author was instructed to present new written material to her advisor at each meeting session. However, after the author attended three (3) sessions unprepared, disorganized, and unable to fully comprehend the important instructions provided by her advisor, she realized apprehension within herself and needed to discontinue her educational pursuit. It became obvious to the author’s advisor that she was currently unable to effectively continue in the VR graduate program. For that reason, Dr. Deaner recommended she pursue taking a medical leave of absence to resolve her situations and possibly retain her status as a continuing graduate student. The author requested and was granted a California State University, Sacramento’s (CSUS) medical leave from January 1, 2013 through December 31, 2013, to resolve her situation. After obtaining medical clearance in December 2013, the author contacted Dr. Deaner requesting permission to continue her studies starting in spring 2014. Although Dr. Deaner granted the author permission to continue her studies, the final approval for the author’s medical release was needed from
the Office of Graduate Studies. Their ultimate decision was predicated upon Dr. Deaner’s approval.

Upon re-entry into the program, the author continued to diligently work on her project. She had regularly scheduled meetings with Dr. Deaner who provided guidance, encouragement, and continuous support throughout the author’s endeavors. However, in November 2014, time constraints and the author’s lack of progress prompted Dr. Deaner to present the feasibility of creating a planning document, instead of a DVD, as the author’s project. As a result, the author’s project was revised as recommended and continued without further interruptions as the author followed the advice of her advisor to pursue a research topic that would incite the author’s passion. The author also realized the importance of following the suggestions stated by Ms. Sala regarding what consumers with MI need to possess in order to increase their probability of achieving their goals. The author was reminded of her “nuggets of wisdom” regarding the importance of recognizing triggers, utilizing a support team, and remaining med compliant.

On several occasions between May 15, 2014 and March 9, 2015, the author met Ms. Donna Wood. Ms. Wood is the Walk Manager for the 2014 and 2015 NAMI Sacramento chapter. They discussed the author’s views on how important it is for individuals with MI to be employed in jobs that provide them with a sense of dignity and pride. When the author questioned Ms. Wood concerning her involvement with NAMI, she stated that she took on the task because she saw and felt there was a need for consumers with MI to have a strong advocate. As a consumer’s family member of
NAMI, her goal is “to see the impact of my efforts...I want to be involved in the education of MI. NAMI exist to help one get through a crisis moment.” On her position as the Walk Manager, she stated, “it is not a job that has a large salary attached to it, but I get a lot of gratification from the positive changes in the lives of individuals with MI.”

Ms. Wood stated the importance of family support and how powerful that support can be to the individual with a MI. Her enthusiasm is matched by her sister, who participates as a photographer for various events to show the tremendous changes brought about in the lives of those who have support. This is exemplified during the numerous activities that occur throughout the year, as the yearly NAMI Walk is the largest fundraiser for the association. The author explained that she was working on a master’s project focusing on individuals with MI. Ms. Wood stated how vital it is for others to know how, “It is important for everyone to be treated equally, but especially those with MI, who are often misjudged and mistreated, often by family because family may not understand.” Ms. Wood whole-heartedly supported this author’s project and recommended the author contact Douglas Smith, Director of NAMI’s In Our Own Voices (IOOV) segment, during their May 2014 meeting (Personal communication, January 8, 2015). The author promised to follow up on her recommendation.

In June 2014, the author met and spoke with Mr. Doug Smith, the Director of NAMI’s Sacramento chapter of In Our Own Voice (IOOV). “The IOOV presentation demonstrates how individuals with severe mental illness experience recovery. Each program presenter has been through training to translate the story of his or her own
struggles and successes” (Personal communication, January 8, 2015). During this meeting, they were able to discuss the author’s goal of interviewing consumers with MI as they answered questions explaining their journey with MI in the same way as demonstrated by the explanation of IOOV. He shared his knowledge and expertise learned since working with NAMI’s IOOV, as they discussed stigmas surrounding MI. Mr. Smith excitedly started mentioning individuals with whom he was familiar who would be potential candidates. He loved the idea of sharing how they had come to a level of acceptance with their MI.

The author, realizing that the ultimate goal of her planning document was to have consumer with MI become competitively employed, asked Mr. Smith about consumers who were back in the workforce. Again, Mr. Smith was positive in his response of knowing individuals who had been able to not only obtain employment, but were able to inform their employers of their diagnosis of MI. The author shared and asked for input from Mr. Smith regarding questions he felt could be helpful without being too intrusive. Mr. Smith informed the author that IOOV was basically a presentation that shared in detail about one’s MI. His suggestion to the author was to be perceptive about the depth of questioning, in case the consumers was not prepared to share openly. The author thanked him for his advice and requested permission to call on him for future conversations as she progressed in her project. He graciously gave the author permission to call whenever he could be of further assistance.
In early September 2014, the author met and interviewed Lisa Culp, the Executive Director of Women’s Empowerment. The author expressed her interest in Women’s Empowerment as a possible site on which to interview consumers with MI for her project. Ms. Culp mentioned that although the women in their program had come from a variety of experiences, she was not aware of particularities. She mentioned that the ordeals endured by one being homeless could be quite challenging, but she could not speak to any particular mental health issues. The author was given liberty to talk to the women, but not during the time they scheduled for various classes and group activities. For the interview process, the author had to schedule time on her own, as Women’s Empowerment has a daily structure for the women to progress in a timely fashion. Ms. Culp encouraged the author to pursue her goal and produce a DVD encouraging consumers with MI to become employable.

In mid-September 2014, the author interviewed Daniel Bejarano, the Employment Education Specialist at Transitional Community Opportunities for Recovery and Employment (TCORE). Mr. Bejarano believed in and encouraged consumers to get back on track with living their lives. One of his favorite sayings was for them to “to see their abilities and not focus on their disability.” He shared that he encourages consumers to seek and obtain services that are available to them, including DOR services, if they qualify for them. He felt that producing a DVD for consumers with MI would be a great way to let other consumers know they are not alone in their struggle to become employed.
I know what it is like to not have anyone believe in or support you, but you also need to believe in yourself and that God is with you…My employers know about my disability…when guys come in who seem hopeless, I am asked to share my experiences with them. (Personal communication, October 14, 2014)

In early October 2014, the author selected and reserved the location for the pilot interviewing to take place. The author used a recorder and conducted a pilot interview at the designated site. The author was able to time the pilot interviews while recognizing that the actual interviews would be between 25 and 30 minutes in length. As the author realized that no two sessions would be exactly the same, questions were provided to each consumer. Providing the questions to each consumer would be the final correspondence until the actual videotaping. These steps allowed the author to complete the outlines needed to refine the process to write and provide a completed copy of the planning document for presentation to be turned into a DVD.

In mid-October 2014, the author interviewed three professional videographers in her search to have a quality production. Using the Internet as a locator, the author found two sites through which she felt comfortable enough to set up appointments with the videographers. However, as she had previously mentioned her goal to others, her pastor Dr. Darnell Thomas referred her to a reputable videographer who recorded the church’s services. This referral made him the third videographer. A selection and quote was agreed upon for the session and December 12 and 13, 2014 were set as tentative dates for the recording sessions.
In November 2014, the author contacted Mr. Smith again with regard to discussing the pilot rehearsals and her personal experiences with doing them. Mr. Smith repeated his caution to the author and they proceeded to work on questions and interview techniques. During this meeting, the questions were revised and reduced from nineteen (19) to nine (9) questions. The author felt confident with the revisions. She again thanked Mr. Smith for his time, knowledge, and patience with her. The meeting ended with Mr. Smith informing the author that he would be supporting her by sending good thoughts and prayers her way.

In conclusion, this author’s personal experiences, along with the support, advice, and motivation from professionals who work closely with consumers with MI, provided this author with perseverance, resilience, and passion. Experienced academic guidance further inspired the determination of the author to research and develop this planning document, to become a DVD at a later date, for consumers with MI. This DVD will be used for VR services by DOR (see Appendix).
Chapter 4

SUMMARY AND RECOMMENDATIONS

Summary

According to the World Health Organization (as cited in Reeves et al., 2013), mental illnesses (MI) collectively are the number one disability in developed countries. Research has established the significant number of individuals with MI in the United States (U.S.) to be approximately 43.8 million people, or 18.5% (NAMI, n.d.) of the population with an unemployment rate of 27.2% in California (NAMI, 2015d). Equally important is the association of stigma and its psychological impact on individuals with MI costing society nearly $4 billion annually (Cylaroval et al., 2010; NAMI, 2014b).

This author reviewed literature addressing techniques to reduce stigma of MI through protest, interpersonal contact, and education. These are some techniques that help replace inaccurate stereotypes with factual information and provide consumers a basis for personal growth and satisfaction. Consumers are able to reduce their sensitivity to stigmas of MI by incorporating lessons from these techniques into their lives. Unfortunately, research also revealed how deeply discrediting and isolating experiences of stigma contribute to low self-esteem; feelings of guilt, shame, inferiority; and a wish for concealment, all of which are counter-productive behaviors for consumers seeking DOR services.

This current planning document sets out a plan to develop a DVD to be used by DOR for consumers with MI. This planning document includes the methodology of the
author’s own research, including the steps taken toward the design of the end product (DVD). The expected outcome for the DVD is for it to inspire future consumers with MI to adopt and practice proven techniques for reducing and coping with stigmas of MI, prior to receiving training and/or employment services from the DOR.

**Recommendations**

The author recommends that the information provided in this planning document be utilized in a collaborative partnership between the California Department of Rehabilitation, Transitional Community Opportunities for Recovery & Engagement, National Alliance of Mental Illness, Wellness for Recovery South, Stop Stigma Sacramento, Women’s Empowerment, and other agencies who provide services to consumers with MI. The inter-agency approach is a critical component of educating, guiding, and assisting all agencies working with MI, providing them an opportunity to develop a more conducive, comprehensive, and collaborative relationship with all consumers and especially those consumers seeking VR services. The inter-agency collaboration creates a team effort approach that assists consumers with MI in maintaining psychological balance. The author further recommends that this planning document be developed into a visual resource, preferably a DVD, to promote proven techniques for reducing the stigmas of MI. Additionally, the author proposes that the planning document’s end product (DVD) become a viable tool to be utilized by numerous agencies determined to improve the quality of life for consumers with MI.
The author recommends that the DVD producer, hereafter referred to as the Project Manager (PM), be a graduate student of California State University, Sacramento and a consumer with a MI who is receiving services from DOR.

The author recommends that the DVD’s production follow the planning document’s steps from the developed script to demonstrate the dissemination of information as well as the educational and in-depth perspective of individuals with MI. By utilizing the DVD, services providers should gain a better understanding of how to tactfully listen to the challenges experienced by consumers with MI, and discreetly express beneficial resources to improve their quality of life.

Finally, the author recommends the produced DVD be used during the intake, or beginning, stages of DOR’s services to consumers with MI. As a means of follow-up, the author recommends that a feedback survey sheet be provided for both the SVRC-QRPs and the consumers with updates provided as needed.
APPENDIX
APPENDIX A

Consumers with Mental Illness Seeking Vocational Rehabilitation Services: A Planning Document
CONSUMERS WITH MENTAL ILLNESS SEEKING VOCATIONAL REHABILITATION SERVICES: A PLANNING DOCUMENT

PHASE I

Introduction

The United States has one of the most distinct populations in the world; mental illness is quite common. California is one of the most diverse states in this country. With that being the case, the Department of Rehabilitation (DOR) and Vocational Rehabilitation (VR) Services along with its consumer population receiving services also has a remarkable diversity with regard to individuals with a mental illness (MI). People with MI seeking rehabilitation services face many obstacles in maintaining or resuming competitive employment. The DOR and VR services and its counselors was created to assist consumers with MI with supportive services because the United States, as a whole, oftentimes fails to provide basic services. It is a separate but unequal system of being accepted versus being ashamed.

There are millions of Americans suffering with some form, or forms, of mental illness. As of 2014, it had been noted that stigma surrounded MI had been codified for more than 50 years. In essence, the mentally ill are penalized for not having a brain that works in the capacity that most expect. The stigma and shaming does not take into consideration that the MI typically did not bring the suffering upon themselves.
This planning document will provide the Project Manager (PM), with resources to acquire a more in-depth understanding of the processes that individuals with MI experience as they seek vocational rehabilitation services. It provides information on how their diagnoses affect them and those closest to them and how the counselors providing assistance need to be more empathetic in their listening and communication skills. By having empathy, the SVRC-QRPs are able to serve the individual and cultural needs of consumers with MI who seek to benefit from available services.

This project has two phases. Phase I provides the PM with resources to acquire a more in-depth understanding of the processes individuals with MI experience as they seek rehabilitation services. Additionally, Phase I details how the author procured information to achieve her goal. The actions include attending seminars; reading cases notes, books, a booklet, Master’s Projects from other graduates students of the VR program, peer-reviewed articles and journals; viewing websites and flyers; visiting several agencies in the Sacramento area that provide mental health services to consumers with MI; and numerous interviews with SVRC-QRPs, other VR counselors, professionals, and a magnificent group of past and current consumers with MI using DOR services. In Phase I, you will also read about the author’s desire to have a DVD created to be used by counselors and consumers to gain a better understanding of a primarily invisible disease known as MI.

For Phase II, you will read about the author's suggestion for a future project to produce a DVD based on the author’s Phase I research. For Phase II, the PM will review
the recommendations the author states in order to create an educational DVD. To successfully complete this task, the PM must become familiar with a variety of mental illnesses, gender and age differences of those with MI, and the stigmas associated with being employed in the Sacramento area. The PM will also need to be very cognizant of how to approach and question consumers of DOR so the consumers comprehend what is being asked in order to promote responses that are direct and concise. Completed properly, the PM has the opportunity to strengthen the communication and empathetic difference in desires and fulfillments between DOR other VR service providers, personnel, and potential consumers seeking assistance within these programs.
PHASE I

1. Action Taken – attended seminars

The author attended the following seminars to obtain information and an in-depth understanding of mental illness and its effects on consumers with MI.

a. Employment Success and Co-Occurring Disorders, October 2011
   i. Facilitator discussed their volunteer in-house program of individuals with mental illness and substance abuse
   ii. Only facility located and situated in southern California
   iii. Open-door policy; individuals seeking to be drug free and vocationally rehabilitated
   iv. 74% success rate; consumers want to make positive changes in their lifestyle
   v. Peer mentors with structured classes/sessions
   vi. Allow participants to have responsible and salaried on-site jobs

b. Investment in Mental Health Wellness Act (SB82), June 2013
   i. The importance of a mobile crisis response team and crisis residential services
   ii. Discussed the importance of having a Community Support Team to provide education, resources, and connections for support
iii. An individual shared a wonderful experience their family had with the support team

iv. Community services and supports could possibly reach $37 million per year

c. Virtual Care in Mental Health (University of California, Davis), October 2014

i. 86% technology is enabling more people to get mental health care

ii. Having the ability to do counseling in the privacy of the home

iii. Virtual online therapy, a pilot program that could be the wave of the future with access at one’s fingertips

iv. A pilot program begun for those with autism has grown to include depression, anxiety, obsessive-compulsive disorder (OCD), and substance abuse

v. It is estimated that 30% of psychiatrists probably use email with patients, and some may even use electronic medical records

The seminars were instrumental in developing questions surrounding intervention, which was an important aspect of this planning document. The seminars presented opportunities for the author to become acquainted with professionals from other agencies who were instrumental in discussing their mode of interventions for consumers seeking to be vocationally rehabilitated. The author learned the needs of individuals with mental illness involve services directed to teaching them about making positive changes,
provided guidance in those changes, and directing them toward being vocationally rehabilitated.

2. Action Taken – read books, peer-reviewed articles, and a booklet

The author read several books, peer-reviewed journals, and a booklet. The author chose these readings as the most relevant to her planning document in relation to the stigma of mental illness and how it impacts the lives of consumers with mental illness.

a. Books

i. *Stigma* by Erving Goffman. The author learned stigma’s definition as penned by Goffman is still valid in today’s society. Goffman alludes to the stigmatized person's acceptance of oneself even though society as a whole has not been accepting of them.

ii. *The Stigma of Disease and Disability: Understanding Causes and Overcoming Injustices* by Patrick W. Corrigan. The author noticed how pain and grief are associated with stigma. Together, they rob individuals of their identity causing them to be labeled and putting them into a group that is devalued, victimized, and often mistreated in ways that are dehumanizing.

iii. *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change* by Stephen P. Hinshaw. The author recognized how prevalently this author discussed the major viewpoints of her project. Mr. Hinshaw discussed the importance of personal narratives being an
essential tool for change because they help to humanize mental illnesses. The author noted his practical strategies for overcoming stigma were directly related to education, the media, and other forms and means of encouraging social policies that are favorable to the reduction of stigma.

b. Peer-reviewed articles

i. “Unemployment, Underemployment, and Mental Health: Conceptualizing Employment Status as a Continuum” by D. Dooley (2003), from the *American Journal of Community Psychology*. The main objective noted by the author was the inadequate employment negatively affects the employment of individuals with mental illness.

ii. “Access and Outcomes for Persons with Psychotic and Affective Disorders Receiving Vocational Rehabilitation Services” by M.S. Salzar, R.C. Baron, E. Brusilovskiy, L.J. Lawer, and D.S. Mandell (2011) from *Psychiatric Services*. The evidence shows how consumers with mental illness are less likely to get the full benefits of vocational rehabilitation services, leading to an even greater probability of unsuccessful case closures. The readings also gave voice to them having jobs that did not measure up to competitive employment.

iii. “Public Beliefs about and Attitudes Towards People with Mental Illness: A Review of Population Studies” by M.C. Angermeyer & S.
Dietrich (2006), from the International Journal of Social Psychiatry. This article gave voice to how the attitude toward people with mental illness continues to be the same. The one thing that made a difference when stigma did not have such a major impact on individuals’ lives was due to whether others were more familiar with the characteristics and behaviors related to individuals who have a mental illness, be it friends or family members.

c. Booklet

i. Action Planning for Prevention and Recovery by U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA). This booklet was on how important it is to implement safeguards against situations that would lead one who has come out of denial to relapse into negative behaviors. The importance of having a regular time of prayer, meditation, and even exercise were noted in the readings. This regular routine helped to set a pattern of healthy habits and assists in breaking bad habits. This booklet told of early warning signs, such as triggers that are often internal and external. One particular word was noted, HALT. It is important for individuals to never allow themselves to become too Hungry, Angry, Lonely, or Tired. The booklet made reference to the danger of having one of these symptoms, but having two or more meant
the individual was in a dangerously, self-destructive personal space.

Finally, the author read about the need to have “Crisis Planning.” This is a personal list of step-by-step instructions to follow if an individual finds themselves in a crisis stage, e.g., relapse mode.

After reading the books, peer-reviewed articles, and booklet, the author realized the role stigma continues to play in the lives of consumers with mental illness and its impact on their lives.

3. Action Taken – read case notes

During the author’s internship (fall 2011), the author read numerous case management notes at DOR regarding consumers with mental illness.

a. Successful case closures

i. Several consumers’ notes showed evidence of being on task, then straying. The notes documented the SVRC-QRP’s repeated efforts to veer them back on task in order to help them accomplish their Individual Plan of Employment (IPE) goals. Notes by numerous SVRC-QRPs showed periods of no contact by the consumers, but once contact was re-established, some consumers’ IPEs needed to be amended. The consumer’s deviations from their goals were documented. They returned to complete their goals of obtaining competitive employment. The author was grateful to see notes by
SVRC-QRPs that outside support was considered an important asset for these consumers. Some of the cases had been re-opened for those who lost jobs. The time spent to gain another job was generally a shorter time period, evidence that the consumer had a “better follow through attitude” about themselves, which the author noted was documented in their files.

b. Unsuccessful case closures

i. One of the things noticed immediately while reading the notes was the lack of detailed information about the consumer. Several of the SVRC-QRPs had remarks that implied consumers were not forthcoming in answering questions; they did not state their MI as a disability, they often did not want a psychiatric evaluation, would become annoyed, and they were hesitant in signing their paperwork. Many of the cases reflected the consumers did not return after the initial intake. Even with documentation of several attempts to contact the consumer, the SVRC-QRPs had to close the cases by regulation. Some of the consumers would start off with vigor and eagerness. There records would reflect them doing great, keeping in touch with their SVRC-QRPs, and then the notes reflect a total lack of responses from the consumer. The SVRC-QRP had documented attempts to reach them by telephone with no call-back from the consumer. It seems that a significant number of
consumers did not have a “follow through” attitude about themselves.

The author read notes regarding unopened and returned ten-day notices that were in several of the files.

The case notes showed evidence of SVRC-QRPs following the rules and regulations of contacting consumers and providing them ample response time. However, the lack of consumers returning and/or answering telephone calls showed a lack of responsibility on the part of the consumers. The letters that were stamped “Return to Sender” as undeliverable could have been due to an incorrect address or they had moved without a forwarding address, as the letter was addressed according to the paperwork. Having good support is advised and needed for consumers. Several cases in both groups had evidence of support systems. The unsuccessful cases often had notes of consumers appearing to be guarded in their manner of talking about their diagnosis and even getting a little annoyed at the SVRC-QRP’s suggestion of a psychological evaluation. The orientation process discusses the importance of being found eligible based on the Level of Significance of Disability (LSOD), and surprisingly a number of the unsuccessful cases were approved for services after the initial intake. The author noted that several of the consumers in the unsuccessful cases were approved, contacted, and did not follow through to get services. This could be due to the consumer’s lack of trusting the process and the researcher noted the concern many consumers had about losing their financial support once they became employable. The author found it rather strange that so many of the unsuccessful case consumers would start out doing so well, but fell off and did not complete their IPEs.
These cases were instrumental to the author’s planning document in regard to gaining a better understanding of how some consumers are able to be successful in reaching the goal of their IPE. However, the most prevalent cases were the unsuccessful cases, indicating the need to find other ways to keep consumers from falling through the cracks. This thought influenced the development of the author’s planning.

4. Action Taken – searched websites and reviewed flyers

The author searched various websites to obtain information on mental health facilities and services in the Sacramento area. The author decided to use the websites that she felt were most relevant and prevalent in relation to the consumers interviewed for the planning document. The websites selected were helpful in formulating questions to ask the participants, as the sites alluded to a wide variety of mental illnesses that impact the lives of consumers seeking to be vocationally rehabilitated (see Attachment 4).

a. [www.dor.ca.gov](http://www.dor.ca.gov)

   Department of Rehabilitation Mission Statement: The California Department of Rehabilitation works in partnership with consumers and other stakeholders to provide services and advocacy resulting in employment, independent living, and equality for individuals with disabilities.
1. To assist the Californians with disabilities in obtaining and retaining employment and maximizing their ability to live independently in their communities

2. Vision Statement: Employment, independence and equality for all Californians with disabilities


   The nation’s largest nonprofit, grassroots mental health organization dedicated to providing free services to improve the lives of individuals with mental illness, their families and friends. NAMI has a total of 12 different segments involved with its organization in the Sacramento area.

c. http://www.stopstigmasacramento.org/

   This particular site provides numerous individuals who give their personal testimonies concerning their individual battles of how they have overcome the stigma of mental illness. Personal stories of various individuals can be observed on their website, helping others to specifically see what mental illness actually looks like because it is an invisible disability. When shame is removed from the equation, people with mental illness will more readily seek treatment, achieve recovery, and engage in meaningful activities.
d. [http://www.tlcssac.org/service](http://www.tlcssac.org/service)

Transitional Community Opportunity for Recovery and Engagement (TCORE) is a collaboration program between Human Resources Consultants, Inc. (HRC) and TLCS, Inc. to provide intensive services to those adults living in Sacramento County who have a mental health diagnosis and are currently unlinked to any outpatient services.

TCORE provides recovery-based services to all participants with intensive short-term services to ensure their needs are met while in the process of connecting to ongoing outpatient mental health services that meet the individual and cultural needs of the participant. The length of services in the TCORE program may vary based on individual needs.

e. [http://www.consumersselfhelp.org/Home/south-center](http://www.consumersselfhelp.org/Home/south-center)

To develop and implement consumer-driven programs and services based on the self-help philosophy. To provide culturally appropriate and integrated co-occurring mental health and substance abuse services and supports that assist participants in their strength-based process of wellness and recovery and that foster self-responsibility and empowerment.

1. Providing self-help, value-driven and evidence-based approaches to mental health services, activities, and groups.

Medication support services are referred by Sacramento Adult
Access. The center is a supportive place that honors diversity and encourages individuals to reach their highest potential.

2. Members are expected to interact with dignity and respect. Attendance is voluntary and free of charge to participate in groups. The Center’s Membership is open to all Sacramento residents who have an interest in mental health support, wellness, and/or recovery services that are innovative.

3. It is the membership support and optimistic contributions that promote the ongoing effectiveness of the Wellness & Recovery Center’s programs.


Women’s Empowerment educates and empowers women who are homeless with the skills and confidence necessary to secure a job, create a healthy lifestyle, and regain a home for themselves and their children.

1. Located in Sacramento, CA, their mission was created by homeless women expressing their needs and a community coming together with a desire to end homelessness, for good.

2. Some of the women clients have MI.

The selected websites provided information that clearly identified the importance of personal testimonies of individuals who are openly talking about their mental illnesses.
More importantly, the websites provide information that will assist individuals with mental illnesses in locating the agencies, the requirements for services, and an overview of the various services offered, with each agency seeking to help the consumer acquire a better quality of life. Although most of the agencies offer many needed services, the Department of Rehabilitation is the agency that focuses more on helping the consumer obtain and maintain employment. These sites were particularly helpful, as based on the participants’ testimonies, the author was able to formulate questions to explore with the consumers the author interviewed.

5. Action Taken – interviewed DOR counselors

The author interviewed four SVRC-QRPs between November 2011 and March 2012: Alina Sala, Cheryl Bear, and Carla Ware from Laguna Creek DOR and Irene Lopez from Salinas DOR. These particular SVRC-QRPs were selected because their caseloads appeared to be predominately composed of consumers with MI. The author questioned them for insight regarding their experiences of working with consumers with mental illness. The author sought to learn if the SVRC-QRPs could give any particular characteristics that occurred with consumers with MI.

a. Consumers prefer to classify themselves by another form of disability, not MI
   i. A significant number of consumers exhibit agitation to being referred for psychological evaluation
ii. Prefer not to fill out applications; they leave most questions unanswered on forms

iii. When questioned by SVRC-QRPs, one of their favorite questions is “Why?”

iv. Leery about signing their name, “Why I need to sign that form?”

b. Particularly significant was a response regarding youth and their experiences with mental illness

i. Being labeled among peers was a deterrence to their acknowledgment

ii. Lack of having someone trustworthy to confide in

c. The importance of consumers being proactive and advocating for themselves

i. Consumers should be forthcoming in informing their SVRC-QRP if their signed Individual Plan for Employment (IPE) does not provide for unforeseen accommodations. However, the only foreseeable accommodations are written in the original IPE

ii. Consumers being willing to seek assistance for other possible sources that are available, e.g., financial aid for education

The information presented to the author by the SVRC-QRPs was truly vital in creating questions to ask of DOR consumers in the pilot rehearsal. Especially important was how consumers could become their own advocate for what was needed to make their transition from training and/or education more successful. Ms. Sala and Ms. Lopez both encouraged the author to produce the DVD, mentioning it would be an asset to have for
future consumers with mental illness. The SVRC-QRPs provided the author with information that greatly assisted in formulating questions for the pilot rehearsal.

6. Action Taken – sought approval of project

The author recognized her growing desire to proceed with her studies of consumers with mental illness. It was at this time that the author met with her advisor Dr. Guy Deaner and received approval to proceed with the author’s project.

   a. The author compiled new material to present to the advisor during their meeting sessions

   b. The author progressed at a snail’s pace, but exhibited determination to complete the task

   c. The author was relentless in her struggles to overcome the challenge of repeating coursework

The author recognized the importance of choosing a topic that ignited a passion in her and encouraging persistence during times of self-doubt. The author learned it is quite lonesome to be on a journey of such writing without the comradery of peers. The author learned she would not like to pursue such a project without the support of a good advisor and friends.
7. Action Taken – interviewed agency contacts

The author interviewed personnel from agencies that serve consumers with mental illness. The author made a conscious decision to choose agencies most helpful in assisting her to identify prospective consumers for her planning document.

a. The author interviewed Donna Wood, Walk Manager (2014/2015) for the National Alliance of Mental Illness (NAMI)

Ms. Wood and the author first spoke of the possibility of a DVD recording of consumers in May 2014. Ms. Wood was excited at the possibility of bringing more awareness to the public regarding consumers with mental illness. She invited the author to call her office and make a future appointment to discuss the idea further. She informed the author that there could possibly be resources to assist with the DVD’s production. She encouraged the author to attend general NAMI meetings where she might find potential consumers for the project. She recommended the author contact Doug Smith, President of NAMI’s In Our Own Voice program and provided the author with additional samples of testimonial of consumers to help with the development of possible formats.
b. The author interviewed Doug Smith, President of In Our Own Voices (IOOV)

IOOV is a unique informational outreach program developed by NAMI that offers insight into the recovery now possible for people with severe mental illness. Started by a grant from Eli Lilly and Company, the goal of IOOV is to meet the need for consumer-run initiatives, to set a standard for quality education about mental illness from those who have been there, to offer genuine work opportunities, to encourage self-confidence and self-esteem in presenters, and to focus on recovery and the message of hope. The program was implemented in 1996 as a consumer education program for people living with schizophrenia.

1. Mr. Smith and the author initially met for a brief lunch to become acquainted with the project and goal in June 2014

a. He was excited about the prospect of doing a DVD regarding consumers with mental illness

b. He informed the author he had been with NAMI’s IOOV since 2011

c. He discussed the process of how IOOV presenters make their presentations

d. He advised the author that he would consult with several of his colleagues who could be potential candidates
e. The author requested and was approved for a follow-up appointment to further discuss ideas of the DVD

2. The author met with Mr. Smith and one of his colleagues at NAMI’s November 2014 general meeting
   a. The colleague was enthusiastic about being videoed for the DVD
   b. The author was informed about another individual who was a potential candidate

3. The author and Mr. Smith met in December 2014, at which time the author informed him that the project’s goal had changed from a DVD to a planning document
   a. Mr. Smith asked if there was any way possible for the author to still do the DVD
   b. He continued to assist the author with formulating questions related to IOOV’s format

4. The author continued to keep in touch with Mr. Smith by telephone and scheduled a mock interview with him
   a. During the mock interview, questions were revised and narrowed to simplify the interview process
      i. The author attended a session where Mr. Smith was one of the presenters of IOOV
b. The author informed him of the selection process, which required consumers with mental illness having used DOR or VR services.

c. He informed the author that being a consumer of the services was not the case for his colleagues nor himself.

d. He continued to work with the author to fine tune interview questions for her planning document.

c. The author interviewed Daniel Bejarano, Employment Educations Specialist (EEC) at Transitional Community Opportunities for Recovery and Engagement (TCORE). Mr. Bajarano spoke candidly to the author about the services he provides to clients who are members of this agency.

   i. Informed the author that clients had to be mentally ill to receive services at TCORE.

   ii. His position allows him to assist consumers in getting services from various vocational rehabilitation services.

   iii. Consumers are often referred to DOR to be supplied with additional training or to further their education.

d. The author interviewed William (Bill) Waters, Director of Wellness and Recovery Center (South). Mr. Smith is responsible for the overall day-to-day running of the agency.

   i. DOR's SVRC-QRPs come in to tell consumers about potential services.
ii. DOR’s SVRC-QRPs encourage consumers to seek DOR services as they seek employment

iii. Consumers sign over their Ticket to Work to DOR

e. The author interviewed Lisa Culp, the Executive Director of Women’s Empowerment. Ms. Culp said she was the excited about being the founder and director. It was through some of her own struggles and observing the various plights of challenges encumbering women that she keeps her constant drive to empower women. This is the goal of Women’s Empowerment.

i. Ms. Culp saw a need and made a decision to make a difference in the lives of women

ii. She told the author that many of the women who come to the facility have a mental illness, some diagnosed and some undiagnosed

iii. She informed the author that it is important for the women to have all-around health, which definitely means providing them resources for shelter

1. She stated that in order for change to occur, changes have to involve empowering women who are caretakers

2. Mentioned the importance of assisting with locating housing

Interviews with these agencies helped identify consumers with mental illness to be interviewed for the pilot rehearsals. The numerous endeavors taken by the author as well
as the meeting with Mr. Doug Smith assisted the author in formulating questions for her research.

8. Action taken – developed questions for pilot rehearsal

The author initially began to formulate questions as she sat in a seminar during her internship at Laguna Creek DOR, fall 2011. The author’s interest was sparked as she listened to the presenter Dr. Daniel Raudenbush discuss the importance of collaborative partnerships in meeting the complex needs of consumers with MI. The statement caused the author to ponder the idea of collaborative partnerships being a key factor in determining successful case closures of DOR’s consumers with MI. It is important for all consumers to obtain the stated goals of their Individual Plan of Employment (IPE), but for consumers with MI it truly is a noteworthy accomplishment given that consumers with MI are classified as the most unemployed individuals with disabilities. At the same time, DOR’s records reflected a number of consumers with MI described in their case notes as being full of vigor and zeal but failing to follow through after their initial interviews determined their Level of Severe Disability (LSOD). The author began to study consumers with MI case notes, seeking attributes that influenced the outcome of successful and unsuccessful case closures.

a. The author solicited the agencies she visited for potential consumers with MI.

The consumers needed to be informed that they would be interviewed regarding their experiences with MI and DOR.
i. Formulated 10 brief questions for consumers to access them during introductory meeting (see Attachment 1)

ii. A total of eight consumers volunteered and permitted their contact information to be given to the author as potential candidates to be interviewed for the planning document to eventually become a DVD

iii. The consumers consisted of 3 males and 5 females

iv. The author called the consumers, seeking their availability for a preliminary screening

v. Sessions were 30 minutes in length on three separate days

vi. Appointments were spaced, giving the author time to make notes

vii. Initial meetings took place between August 23 and August 25, 2014

viii. Weekday hours were between 3:00 p.m. and 8:00 p.m.

ix. Saturday and Sunday hours were between 12:00 p.m. and 8:00 p.m.

x. Day and time were scheduled based on the availability of consumers

xi. The location chosen for the screening was Starbucks, 6200 Valley Hi Drive (drinks furnished by the author)

b. After an exchange of pleasantries, the author offered to purchase the consumer a beverage

i. The author gave a synopsis of the planning document’s ultimate goal

ii. Next, the author asked and was granted permission to verbally record 6 of the 8 sessions
iii. One of the most pertinent questions posed dealt with consumers’ comfort level sharing in-depth details about their MI

iv. It was equally important to know if the consumes had acquired acceptance surrounding their diagnosis of MI

v. The consumers provided feedback on services provided to them by DOR

vi. After the author completed her inquiries, she asked the consumers if they had any additional comments or questions to ask

vii. Thank you cards were presented to the consumers for their cooperation

viii. The author promised to call consumers whether they were chosen or not

c. The author studied her notes and listened to the recorded conversations

i. Consumers for the pilot rehearsal were chosen at the author’s discretion

ii. All potential candidates were called and informed of the author’s decision

iii. 2 males and 3 females were chosen based on their overall presentation and disposition

d. Questions for the pre-interview were formulated based on seminars, books, peer-reviewed articles, a booklet, case studies, websites, SVRC-QRPs, personnel from various agencies, and master’s projects by graduates of the Vocational Rehabilitation (VR) program. The questions were formulated in a manner that allowed the consumers to detail their journey as they became aware of their MI to where they are in their lives today
i. Formulated nineteen (19) questions for a pilot rehearsal (see Attachment 2)

ii. Called selected individuals to make appointments for pilot rehearsal
   i. Scheduled rehearsal date and time for participant/consumer convenience
   ii. Scheduled 1-hour appointments between October 3 and October 7, 2014
   iii. All appointments scheduled in blocks of ninety (90) minutes
   iv. Possible interview sites
       1. California State University, Sacramento (CSUS)
          Library or Academic Information Resource Center (AIRC). Each building has rooms to allow for privacy
       2. Sacramento City College (SCC)
          a. Available empty classroom in Rodda North or Rodda South
          b. Library in one of the study rooms
       3. No private homes (safety and precaution for all parties)
          a. Starbucks suggested; no privacy provided
          b. No location suggested by consumers
v. Met consumers at location centrally located for their convenience
   1. Provided consumers with copy of official interview questions
   2. Each session was tape recorded

vi. Informed consumers of Informed Consent forms to be signed at official recording
   1. Provided consumers with copy of Informed Consent forms to read at their leisure
   2. Informed consumers of actual video recording date to be scheduled as soon as possible with videographer
   3. Strived to accommodate consumers’ work schedules

vii. What was unfortunate about the nineteen (19) interview questions
   1. There were too many questions
   2. Longer than anticipated
   3. Allowed consumers to talk until they needed to stop
   4. Too many open-ended questions
   5. Consumer continuously losing focus of questions
   6. Answers not always related to questions
   7. Three consumers shared detailed accounts of their experiences with MI
   8. Two of the females excused themselves after sharing
9. Two of the three females excused themselves during the interview as they shared details of their experiences with MI
   a. Two female interviewees cried as they were talking
   b. The interviewer was caught off guard by emotional outpouring (stated by consumer)

10. Answers were too long
    a. Difficult to condense interviews to 3-minute DVD presentation
    b. Previewed recorded videos by consumers of DOR averaging 2.5 to 4 minutes in length

viii. What was good about the nineteen (19) interview questions

1. Consumers’ acknowledgement of DOR’s importance:
   a. Having competitive employment
   b. Providing guidance in achieving their IPE goals
   c. Regular check-ins with SVRC-QRP
   d. Encouraged to have balance in their life
   e. Make sure to play as hard as they work

2. Consumers expressed how they cope with and overcome stigma
   a. Being able to talk about their experiences of MI
b. Not having a job requiring knowledge of diagnosed MI

3. Importance of ongoing positive support
   a. Not receiving judgmental attitudes
   b. Being around like-minded people
   c. Knowing when to dissociate from so-called friends

4. The habit of keeping a daily journal and making regular inscriptions

5. Knowing they have “crisis intervention” for themselves

6. Getting to know the consumers in greater detail

e. The author had maintained her regular contact with Mr. Smith, Director of the National Alliance for Mental Illness (NAMI) In Our Own Voices (IOOV) for suggestions with the revision of questions to ask consumers. The author determined that the questions should allow for sharing pertinent information about their employment and significant conclusions that highlight their accomplishments with DOR’s assistance.

   i. The nineteen (19) questions were revised to 9 questions. They were formulated using the guidelines of IOOV, with the focus on DOR’s wellness and recovery (see Attachment 3)

   i. These question were not used in the pilot rehearsal
ii. The author did a personal video with her telephone while being interviewed by a family member three different times.

iii. The goal was to produce a 3-minute DVD illustrating DOR’s assistance in becoming competitively employed, along with establishing coping techniques.

ii. What was unfortunate about the 9 questions

i. The questions caused the interview process to be more than 8 minutes in length.

ii. Providing brief and one-word answers did not provide the message the author wanted to convey to future DOR consumers with MI.

iii. Talking in a rapid mode of speech got within range of the 3 minutes, but the pronunciation of words sounded like a 33 1/3 RPM at the speed of a 45 RPM album, rushing to put a lot into a tiny space.

iv. The initial consumers were never given an opportunity to rehearse new interview questions.

iii. What was good about the 9 revised questions

i. They totally reduced the time required to perform interviews.

ii. The questions were not as open-ended as the previous 19 questions.

iii. The revised questions allowed for answers that were more direct and to the point.
iv. Questions could elicit pertinent details from former DOR consumers who are currently maintaining competitive employment acquired as a direct result of following the IPEs and the advice of their SVRC-QRP

The author felt that her initial 19 questions should have been more focused on DOR’s training and/or education process, competitive employment, and the progress of consumers with MI. Providing information related to accomplishing the goal of the IPE is paramount to consumers’ successful case closures. DOR’s IPE is written for the benefit of guiding consumers in their efforts to acquire more than just a job. It helps to build perseverance and confidence with each milestone the consumer achieves. The efforts of consumers do not go unnoticed by SVRC-QRPs. They genuinely support efforts made by consumers in staying on course to complete their overall goal of obtaining a job. The author recognized that her enthusiasm in formulating questions for the planning document resulted in too many questions. The numerous open-ended questions added over 9 hours of interviews and spanned three days. Some additional time involved two sessions in which the interviewees became emotionally distraught, requiring time to compose themselves. The author asked each interviewee if there was a particular question that triggered their expression of tears. The responses provided by one interviewee was that she touched on some points that were never disclosed before. The other interviewee said that talking about what triggered her MI caused her to feel an uncontrollable wave of sadness. The women apologized for taking longer than expected
for each of their interviews. However, as a student in the counseling field, the author realizes that these times will occur in numerous individual's lives when they need an empathetic ear to listen, allowing them to share their troubles. The overall process of formulating questions from the author's research was truly an experience that has provided new, different, and stimulating knowledge regarding the importance of consumers with MI. Consumers must take responsibility to seek and utilize services available to them through other agencies or service programs they are qualified to receive. The ability to move forward sometimes requires the consumers to step back, make a true assessment of determination to persevere, and know that with the right frame of mind success will come.

The CSUS human research committee suggested requesting each consumer involved with the videotaping of the future DVD to sign an Informed Consent form and for the author to keep them locked away for at least three years, in the event of a recorded DVD.

9. Action taken – interviewed and selected videographer

As a final step in preparing Phase I, the author interviewed three videographers: two were randomly selected from a website and one was recommended by Dr. Darnell Thomas, the author's pastor. The author was not aware of any videographers and decided to use the Google search engine to acquire a reputable videographer. The author located two on a website and was provided the telephone number of the third videographer. The author realized she had interviewed all other participants involved with the project and
proceeded to formulate questions based on what she would have required if she were doing the DVD.

a. Arranged interview sessions with each videographers
b. Scheduled appointment for 30 minutes
c. Appointments were scheduled October 17 through October 18, 2014
d. Time was set between 3:00 p.m. and 8:00 p.m.
e. Meet at Starbucks in the Valley Mack Plaza
f. Videographer referred by Dr. Thomas asked to meet at his studio
g. Requested videographer to bring sample of their work
h. The author decided to formulate 6 questions to ask each videographer
i. The author questioned the videographers in regard to their qualifications
   - How long have you been doing videotaping?
   - Are you experienced in the full spectrum form videoing to the final DVD production
   - Do you have any references I may call regarding your previous work?
   - Have you ever done confidential production work?
   - Do you have a 3 to 5 minute recording of your previous work? May I see it?
   - What is your total cost for the recording, editing, and production of the master copy of the DVD?
a. The author selected a videographer to recommend to the Program Manager based on their experiences and total projected cost for a complete package of services


i. The author negotiated the total cost to $600 (included venue, video, editing and production of master copy)

ii. Informed the videographer of the Consent Form to be signed prior to the start of filming

1. Provided a copy of Consent Form to videographer

The author accepted the videographer who provided her the best price for a total package deal to produce the actual DVD.
Attachment 1

Questions Used in Selection of Potential Consumers

1. Do you have a medically diagnosed mental illness?
2. Can you tell me what interested you in participating in this project?
3. When were you diagnosed?
4. Was there a particular incident that led to your being diagnosed?
5. Have you shared openly about your mental illness before?
6. How did others respond to your sharing?
7. How did you feel in response to their listening to you come out about your mental illness?
8. What has been one of your most satisfying accomplishments in your life?
9. I know what I hope to accomplish from this recording, but what or do you have any expected outcome? (No monetary compensation involved)
10. Do you have any questions for me?
Attachment 2

Original Questions Used for the Pilot Rehearsal

The questions were written and asked in a manner that allowed the consumers to detail their journey from where their lives are today to a point of acceptance in their lives today with mental illness.

1. Can you provide us with a 60 second me about yourself?

2. Would you tell us a little about your current employment?

3. Do you believe that the Department of Rehabilitation (DOR) was instrumental in you getting your current job?

4. What gave you the strength to strive for a training and/or educational goal with DOR?

5. What were your expectations when you applied for services with DOR?

6. Considering the knowledge that there is a process of applying for services with DOR, what was your experience like from the Orientation at DOR to your first day of competitive employment?

7. Did you have any major challenges or crisis during the process from training and/or education to achieving the goal of your Individual Plan of Employment (IPE)?

8. What do you feel was most helpful to you in achieving your IPE goal of becoming successfully employed?

9. Did you need to have changes to your IPE along the process? If so how did you deal with the needed changes?
10. Would you say that your overall experiences with DOR were favorable?

11. Does your employer know that you have a mental illness? Why or Why not?

12. If not, do you have a plan in place to help yourself in the event you experience a crisis moment?

13. If so, how was that process for you to provide your employer with the knowledge that you have a mental illness?

14. How or did stigma play a part in your being able to talk about your mental illness to your employer?

15. Do you mind sharing your diagnosis with a few details of what that was like for you?

16. How old were you when you received your diagnosis and was it through an intervention process?

17. What helped you to come to terms with acceptance around your diagnosis?

18. What type of assistance/service/therapy do you use for helping you to maintain and keep your condition under control, allowing you to be competitively employed?

19. Can you share what it has been like for you having the strength and determination in not allowing your mental illness to keep you bound?

Any parting words of encouragement for future consumers receiving services in their efforts to achieve competitive employment?
Attachment 3

Revised Question for Interview

1. Can you tell me about yourself in 60 seconds which includes the following-
   - employment
   - strengths
   - goals
   - accomplishments

2. What gave you the strength to strive for a training and/or educational goal with the Department of Rehabilitation?

3. What do you feel was most helpful in assisting you to navigate through the stages of your Individual Plan for Employment? Explain

4. What is your overall impression of the services that you were given by DOR assisting you to go from being unemployed to becoming competitively employed?

5. Does your current employer have knowledge of your mental illness? Why or why not?

6. How or does stigma play a part in your being able to conceal or reveal your mental illness to your employer?

7. What has been most helpful in your coming to terms with your mental illness?

8. How does acceptance affect coping with your day to day tasks on the job?

9. What type of coping system do you utilize in order to maintain your symptoms and your job?

Parting words…
PHASE II

RECOMMENDATIONS FOR THE PRODUCTION OF DVD

Phase I of the Planning Document gave an accounting of what the author achieved toward the project, the production of a DVD. Phase II provides the author’s recommendation on how to achieve a purposeful product that speaks to future Department of Rehabilitation (DOR) consumers with mental illnesses seeking to be vocationally rehabilitated. The future Project Manager (PM), a graduate student and consumer of DOR, should investigate the author’s Phase I to gain an understanding of the subject matter. They will need to study the detailed information to produce the actual goal of a DVD production for future Consumers with Mental Illness Seeking Vocational Rehabilitation Services.

The following are the author’s recommendations to the PM in charge of producing the DVD. The PM should read the author’s work from cover to cover, so they will have an understanding of and grasp on the material and the projected goal. The PM should read the requirements for Human Subject Review for Student Research at California State University Sacramento and submit the necessary paperwork for human subject’s research.

1. Action to be taken – Reading

The author took advantage of various materials to assist her in becoming knowledgeable about consumers with mental illness. This was accomplished over an
extended period of time. It is suggested the PM make full use of Phase I in conjunction with the material provided below.

Familiarize yourself with the topics of mental illnesses and stigma.

a. Read books and/or booklets. Read those noted by the author in Phase I. Avail yourself of new and updated material that speaks to the subject of consumers with mental illness.

   i. *Breaking the Silence: Mental Health Professionals Disclose Their Personal and Family Experiences of Mental Illness* by Stephen P. Hinshaw. This is a book that would provide the PM with information on personal narratives and accounts of serious impairments that accrue for consumers with MI. It sheds light on why many of those who have family members with MI decide to enter the mental health field.

   ii. *Living with Voices: 50 Stories of Recovery* by Marius Romme (2009). This author alludes to the fact that everyone hears voices in their brain. It allows those who have been labeled as “psychotic” to be heard and valued.

b. ScholarWorks

   i. Masters’ projects from graduates of the Vocational Rehabilitation Program (California State University Sacramento)

   ii. Zachary Nathan; Two Model Case Studies of California Department of Rehabilitation Consumers
iii. Search for additional titles in Vocational Rehabilitation section

c. Peer-reviewed journals and articles listed by the author in Phase I. Take full advantage of new and relevant peer-reviewed articles on the subject matter.

Recommended reading material published within the previous five years of production date (suggestions only)

i. “Stigma, Agency and Recovery Amongst People with Severe Mental Illness” by Whitley, R., & Campbell, R. D. (2014), from *Social Science & Medicine*


2. Action to be taken – attend seminars and visit websites

Phase I also contains numerous websites and agencies the author found relevant. Use the websites and agencies, as well as search for additional ones, to seek current information on the support and services for consumers with mental illness in the Sacramento area. The information below is a collection of sites to check for upcoming seminars and agencies that work with consumers with MI (see also Attachment 4).
Familiarize yourself with various websites and agencies

  &online=0#A23
  County of Sacramento Department of Health and Human
  Services: Behavioral Health Services (7001 East Parkway,
  Sacramento, CA 95823)

e.  conferences@cibhs.org
  California Institute for Behavioral Health Solutions (Leaders in
  Policy (916) 379-5333)

f.  http://www.cde.ca.gov/re/ca/cc/
  California Department of Education (1430 N Street,
  Sacramento, CA 95814)

  Cross Country Education Seminars (1 800 943-1935)

  1. Borderline Personality Disorder: Treatment and
     Management that Works (December 2015)

  2. Therapy for the Mind, Body and Spirit (December
     2015)
NorCal Mental Health America is the oldest consumer advocacy agency in Northern California. Established in 1946, NorCal MHA has actively supported consumers’ rights and championed consumer-and-family inclusive mental health policy for nearly seven decades.

1. Our Mission – dedicated to improving the lives of residents in the diverse communities of Northern California through advocacy, education, research, and culturally relevant services. In all of its programs, NorCal MHA works with individuals and families with mental health challenges to promote wellness and recovery and prevention and improve access to services and support.

2. NorCal MHA staff strive to provide peer services that foster recovery, reduce stigma and discrimination, and improve cultural competency through self-help, education, and culturally relevant research. (916) 366-4600
El Hogar Community Services, Inc. has been in existence since 1977. Originally created under the auspices of the Sacramento Concilio to provide mental health services to the Latino community. It is from these beginnings the agency took its name, which translates to “The Home” in Spanish. Over the years, El Hogar has expanded its services beyond its original client base and has evolved to address the needs of our diverse cultural and ethnic community.

1. Our Mission: to provide services that contribute to the mental health and emotional well-being of individuals and families in the community. Our Vision – we envision a community in which behavioral health challenges are recognized as public health issues that are both preventable and treatable.

Vision Unlimited, Inc. is a Sacramento County funded Regional Support Team which contracts to provide outpatient mental health services to children and adults with serious mental health challenges.
mental health issues. Visions is located on 6833 Stockton Boulevard, Ste. 485, Sacramento, CA 95823

1. Clients are referred and authorized for services by the Sacramento County Adult or Child and Family ACCESS team. Vision’s multiethnic, multicultural, multilingual staff of clinicians, counselors, mental health workers, psychiatrists, and support staff are trained to help individuals and their families work through mental health problems that interfere with daily living.

2. Our services are provided at the clinic, in the schools, in the home, and in Board and Care homes. Vision’s staff offers their clients the tools to strengthen their lives and to function effectively in the community.


Wellness and Recovery Center North. Location: 9719 Lincoln Village Drive, Sacramento, CA 95827. To develop and implement consumer-driven programs and services based on the self-help philosophy. To provide culturally appropriate, and integrated co-occurring mental health and substance services and supports that assist participants in their strength-
based process of wellness and recovery and also fosters self-responsibility, and empowerment

1. To provide self-help, value-driven and evidence-based approaches to mental health services, activities, and groups. Medication support services are referred by Sacramento Adult Access. The center is a supportive place that honors diversity and encourages individuals to reach their highest potential.

2. Members are expected to interact with dignity and respect. Attendance is voluntary and free of charge to participate in groups. The Center Membership is open to all Sacramento residents who have an interest in mental health support, as well as wellness and/or recovery services that are innovative.

3. It is the membership’s support and optimistic contributions that promote the ongoing effectiveness of the Wellness & Recovery Center North

It is recommended the author contact the DOR offices located in the Northern Sierra District to see if an appointment can be scheduled to meet with a SVRC-QRP. The PM should maintain good records from all contact with agencies and exchange business cards with the contacts. It would be to the advantage of the PM to prepare questions to ask if
the information provided from Phase I, and the other material, has not presented them enough clarity to complete the DVD.

3. Action to be taken – selection of videographer and consumers

The action to be taken next is preparing for the DVD production. The PM has visited all the agencies and acquired a network of agency contacts they can use to build the consumer population for the DVD. The PM should have explained the criteria for consumer selection because the agency needs to know this information in order to relay it to the consumers. The PM now needs to select a videographer. The author recommends the PM use the questions contained in Phase I (10b) to select the videographer. The PM may use other means by which to obtain a videographer (see section 10 of Phase I to follow steps of the author in making a selection). If it is acceptable, the author recommends using a videographer previously interviewed to cut down on the time between the pre-interview and the actual time of the recording session. The videographer is skilled in editing and assured the author he has enough skills to assist with developing a quality DVD, provided the consumers responded clearly. It may not be possible to schedule the session, but the PM will have the videographer information as they move through the final stages.

Next, the PM can prepare for the consumer interviews by first reviewing the original interview questions located in Attachments 1 and 3. The PM has read Phase I; therefore, they should be familiar with the process of selecting consumers with MI for Phase II. The author observed the consumers being overwhelmed during the interview and she did
not know how to console them. Thus, it is recommended that the PM find friends, family, and peers of his or her own who are willing to be interviewed in a pilot rehearsal first. A pilot rehearsal will allow the interviewer to adjust the questions to minimize emotional responses. This pilot rehearsal should look just like what the actual consumer interviews would look like except with regard to the videographer. There is no need for the videographer to be present at the pilot rehearsal. The following steps should still be undertaken for the pilot rehearsal:

- Use the questions in Attachment 1 to ask each potential pilot candidate their story
- Determine commonalities between the pilot candidates and select candidates based on such commonalities
- Schedule an appropriate amount of time for each interview
- Interview pilot participants using interview questions (see Attachment 3)
- Record each interview
- Review transcripts with pilot participants

The author recommends reducing the number of questions so the total recording time for each consumer would be 3-4 minutes; the author noted several people with mental illness she interviewed mentioned their limited attention spans. Challenges, along with time constraints, did not enable the author to accomplish that goal. The author recommends the PM set the video session within two weeks of the pilot rehearsals. After the PM does the pilot study, he or she can proceed to searching for actual candidates for the DVD
utilizing the pre-questions in Attachment 1. The pre-questions allow the PM to determine whether the consumers fit the criteria to be interviewed.

Once the PM has acquired the specified number of potential candidates/consumers the next steps should include:

a. Contact each potential candidate and arrange for an initial meeting
b. Suggest a meeting location that is neutral for all parties
c. It is suggested that each candidate be allotted sufficient time that does not require taking off time from work
d. The interviews should be spaced in a manner that provides each consumer privacy. The author allowed herself to have approximately 30 minutes between interviews. It is suggested that if the PM feels more time is necessary for interviews, that is at their discretion.
e. The author offered and purchased drinks for each of the candidates (this will be at the discretion of the PM)
f. The PM should get the consent of the candidate if the sessions will be recorded
g. The PM should be courteous, approachable, and considerate to the candidates
h. Inform the candidates/consumers about the selection process for the project
i. Choose candidates that are representative of the Sacramento area

j. Gender and age diversity that is representative of the overall population served by DOR is advised

The next stage of the process deals with the PM scheduling the pre-interviews for the selected consumers. The PM has the responsibility of ensuring to the best of their ability that consumers with MI are not placed in environments or situations that will cause them unnecessary harm or danger. It is suggested that the PM provides enough copies of the questions (Attachment 3) for the recorded interview and that a copy be given to each consumer at the end of the interview. It is recommended the consumers not be familiar with each other and time is allotted so they do not cross each other’s path as they leave and arrive at the pre-interview location. The author is suggesting this as a precaution for the possibility of each consumer’s emotional state of mind following the session.

4. Action to be taken – Recording session

1. The PM and videographers make arrangements for the recording session (previously worked out)

   a. Call and inform consumers of location

   b. Provide consumers with dates and times

   c. Schedule consumers

   d. Provide details related to attire, fragrances, etc.

   e. Follow up with consumer at least 24 hours prior to session
2. Recording day arrives
   
a. (I am no longer privileged to know the stages from this point)

Good Luck!

The author suggests that the DVD production be funded by the stipulations set forth in the IPE signed by the PM as a requirement for completing the Vocational Rehabilitation Program at California State University Sacramento.

The author recommends that the information provided in this planning document be utilized in a collaborative partnership between DOR, SVRC-QRPs, the National Alliance of Mental Illness (NAMI), TCORE, and other providers of Vocational Rehabilitation (VR) services to consumers with MI.

Additionally, the author proposes that the planning document’s end product (DVD) become a viable tool to be utilized by DOR during their initial orientation process of consumers with MI. The author recommends the produced DVD be utilized during the intake, or beginning, stages of DOR’s services to future consumers with mental illness.
Attachment 4

Agencies and Resources
California Department of Rehabilitation

The California Department of Rehabilitation (DOR) is an employment and independent living resource for people with disabilities.

About the Department of Rehabilitation

The California Department of Rehabilitation (DOR) administers the largest vocational rehabilitation program in the country.

We have a three-pronged mission to provide services and advocacy that assist people with disabilities to live independently, become employed and have equality in the communities in which they live and work.

DOR provides consultation, counseling and vocational rehabilitation, and works with community partners to assist the consumers we serve.
DEPARTMENT VISION AND MISSION STATEMENTS

VISION STATEMENT:

Employment, independence and equality for all Californians with disabilities.

MISSION STATEMENT:

The California Department of Rehabilitation works in partnership with consumers and other stakeholders to provide services and advocacy resulting in employment, independent living and equality for individuals with disabilities.

OUR CORE VALUES

The values under which we operate all of our programs and services.

- **Quality**
  Strive to meet stakeholders’ needs through continuous improvement, competence, creativity, and teamwork.

- **Respect**
  Be sensitive to the diverse needs of others, both internal and external stakeholders, by being courteous, compassionate, responsive, and professional.

- **Integrity**
  In all endeavors, act in an ethical, honest, and professional manner.

- **Openness**
  Be willing to listen to and share information with others. Be flexible, inclusive, trusting, and receptive to new ideas.

- **Accountability**
  Take ownership and responsibility for actions and their results.

OUR GUIDING PRINCIPLES

The principles that guide us in our daily work.

1. Delivering effective vocational rehabilitation services, and other programs and services in an efficient, caring, professional, and prompt manner.

2. Attracting, developing, and retaining a competent, creative, and highly motivated workforce.
3. Maintaining public trust by being fiscally responsible and ensuring quality programs and services.
4. Sustaining our role as a respected leader in the disability community; inspiring hope in those we serve.

Vocational Rehabilitation

- **What does DOR do?** - How does DOR help? Descriptions and links to specific service information.
- **Are You Eligible for Vocational Rehabilitation Services?** - Basic eligibility and application information.
- **Consumer Information Handbook** - The Roles and Responsibilities of the Department of Rehabilitation and You
- **Vocational Rehabilitation Services Application** - Ready to apply, or need to return to DOR? Submit a new application. Try the Online version.
- **What Happens Next: Details on Service Eligibility** - Information on the assessment process, severity of disability and the status of waiting lists.
- **Resolving Disputes** - Do you need help with your current DOR case?

Programs and Other Information

- **DOR Office Locations** - Find the DOR office nearest you.
- **Disability Access and Rights in California** - Information on disability access in California for both citizens and businesses.
- **Disability and Rehabilitation Resources** - Disability and Rehabilitation Information.
- **Employment Resources** - Resources to assist you in getting employment.
- **Mental Health Cooperative Programs (RTF)** - These programs assist County Mental Health consumers to find, get, and keep meaningful community employment.
- **Independent Living Information** - The Independent Living Section of the Department of Rehabilitation (DOR) is one part of California's Independent Living Network. The network is dedicated to the idea that communities become fully accessible and integrated so that all persons with disabilities can live, work, shop and play where they choose, without barriers. DOR administers the program
in California and provides technical assistance and financial support for the independent living centers.

- **Limited Examination and Appointment Program** - an alternate examination and appointment process designed to facilitate the recruitment and hiring of persons with disabilities for State Jobs.
- **Publications and Forms** - Several DOR forms and publications are available via the internet. DOR English forms and publications are also available in alternative formats. Information on ordering these and other items not available online is included.
- **Schedule A Fact Sheet (RTF)**
- **Specialized Services** - Including Blind Field Services, the Business Enterprises Program, California Vendors Policy Committee, Deaf and Hard of Hearing Services, the Older Individuals who are Blind Program, and the Orientation Center for the Blind.
- **Supported Employment Program and Vocational Rehabilitation/Work Activity Program** - The Supported Employment Program provides activities and services, including ongoing support services, needed to support and maintain an individual with a most significant disability in an integrated employment setting for the term of employment.
- **Social Security Work Incentives and the Ticket to Work Program** – Social Security Administration (SSA) has several work incentives programs available to support beneficiaries of Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) in their work efforts.
- **Transition Partnership Program (RTF)** - The Transition Partnership Program builds partnerships between local education agencies and the Department of Rehabilitation (DOR) for the purposes of successfully transitioning high school students with disabilities into meaningful employment and/or post-secondary education.

**How Do I Apply for Services?**

There are three requirements that comprise the application process.

1. Request services. You can do this through several methods:
   a. Complete and sign a DR 222 - Vocational Rehabilitation Services Application in person, [online](#) or [by mail](#); or
   b. Visit a One-Stop Center and complete an intake application form requesting vocational rehabilitation services; or
   c. Otherwise requesting services from the DOR.
2. Provide the DOR with information necessary to begin an assessment to determine your eligibility and priority for services.
3. Be available to complete the assessment process. This includes activities such as attending the initial interview, watching an orientation video, participating in the evaluation of your skills and capabilities, and completing your part of any actions you and your counselor agree upon.

**Department of Rehabilitation Responsibilities**

It is your VR counselor's and VRSD team’s responsibility to:

- Assist you in exercising informed choice.
- Provide counseling and guidance.
- Keep information confidential, except where the law requires the VR counselor to share information.
- Inform you of available resources and referrals, as appropriate.
- Advise you of your rights and remedies, including review of the DOR decisions.
- Explain how to request Mediation, Fair Hearing, or file a discrimination complaint.
- Inform you about the Client Assistance Program.
- Assist in coordinating services for your plan.
- Monitor your progress periodically and complete an Annual Plan Review to continue timely service delivery.
- Reach an agreement with you and provide a written amendment for your signature if there are major changes in your IPE.
- Keep you fully informed throughout your plan, including a full consultation before closing your record of services (case file).
- Communicate and interact with courtesy, consideration, and respect.
Together We Can Make Great Things Happen!
Case Closure

Your record of services (case file) may be closed for various reasons.

The best reason is you have been employed successfully for 90 days. At that time, your record of services can be successfully closed.

Other reasons for closing your record of services include:

• You are determined to be ineligible for services.

• You are not available to complete a needed assessment to determine your eligibility or priority for services.

• You cease contact with the DOR, and you cannot be located or contacted.

• You decline to accept, participate in, or use the DOR services.

• You fail to cooperate in assessments or your I P E.

• You engage in any criminal activity, including fraud, when applying for or receiving VR services.

You may appeal any of the DOR’s actions or decisions, including actions to close your record of services.
Northern Sierra District

Northern Sierra District Office (130-00)
(916) 558-5300 (Voice)
(916) 558-5302 (TTY)
721 Capitol Mall
Sacramento, CA 95814

Auburn Branch (130-05)
(530) 823-4040 (Voice)
(530) 823-4040 (TTY)
11641 Blocker Drive , Suite 125
Auburn, CA 95603-4672

Capitol Mall Branch (130-16)
(916) 558-5300 (Voice)
(916) 558-5302 (TTY)
721 Capitol Mall
Sacramento, CA 95814

Chico Branch (130-23)
(530) 895-5507 (Voice)
(530) 345-3897 (TTY)
470 Rio Lindo Avenue , Suite 4
Chico, CA 95926-1899

Grass Valley Branch (130-21)
(530) 477-2600 (Voice)
(530) 477-7049 (TTY)
380 Sierra College Drive , Suite 220
Grass Valley, CA 95945-5081

Laguna Creek Branch (130-03)
(916) 691-1555 (Voice)
(916) 691-1555 (TTY)
8701 Center Parkway , Suite 100
Sacramento, CA 95823-7919
Modoc Branch (130-22)
(530) 260-1749 Voice/Text (Voice)
802 North East Street, Suite 106
Alturas, CA 96101

Northeast Sacramento Branch (130-02)
(916) 537-2640 (Voice)
(916) 537-2659 (TTY)
(916) 537-2660 (TTY)
7840 Madison Avenue, Suite 160
Fair Oaks, CA 95628-3589

Placerville Branch (130-06)
(530) 626-0900 (Voice)
(530) 626-0900 (TTY)
1166 Broadway Suite S
Placerville, CA 95667-5745

Roseville Branch (130-13) (916) 774-4400 (Voice)
(916) 774-4416 (TTY)
151 N. Sunrise Ave., Suite 601
Roseville, CA 95661-2900

South Lake Tahoe Branch (130-01)
(530) 541-3226 (Voice)
(530) 541-3226 (TTY)
P.O. Box 10380
2489 Lake Tahoe Blvd., Suite 4
South Lake Tahoe, CA 96150-7732

Susanville Branch (130-20)
(530) 257-6073 (Voice)
(530) 257-6073 (TTY)
170 B Russell Avenue
Susanville, CA 96130-4216
Woodland Branch (130-18)
(530) 668-6824 (Voice)
(530) 668-6829 (TTY)
1100 Main Street, Suite 340
Woodland, CA 95695-3513

Yuba City Branch (130-19)
(530) 822-4591 (Voice)
(530) 822-4594 (TTY)
1237-B Live Oak Boulevard
Yuba City, CA 95991-2998
NAMI California Mission

Mission

NAMI California is a grass roots organization of families and individuals whose lives have been affected by serious mental illness. We advocate for lives of quality and respect, without discrimination and stigma, for all our constituents. We provide leadership in advocacy, legislation, policy development, education and support throughout California.

Vision

NAMI California is the leading organization of individuals working with mutual respect to provide help, hope and health for those affected by serious mental illness.
Purpose

NAMI California is dedicated to the strengthening of local grassroots organizations. We provide updated information and support to local affiliates and are here to help organize new affiliates. NAMI California has 71 local affiliates and represents 19,000 people to the California Legislature and Governor on mental illness issues. NAMI California educates families, professionals, and the public about the recent explosion of scientific evidence that shows serious mental illnesses are neurobiological brain disorders. NAMI California works to provide a strong, coherent system that offers a continuum of care for the persistent, long-term needs of people with mental illness. NAMI California advocates for increased research to uncover causes and new, effective treatments. NAMI California strives to eradicate stigma.

What is NAMI In Our Own Voice?

NAMI In Our Own Voice is a unique presentation in which two trained speakers share their compelling personal stories of living with mental health challenges and achieving recovery. Audiences range from individuals with mental health challenges, students of all ages, law enforcement officials and faith community members to veterans and service providers. While audiences benefit from the inspirational stories of the speakers, presenters increase their confidence and develop leadership skills while helping to inspire and motivate others.

• NAMI In Our Own Voice is a free presentation designed to shatter negative stereotypes against people with mental illness
• The presentations last 60-90 minutes
• NAMI In Our Own Voice follows a structured format. Two presenters who have experienced mental health challenges share their personal stories, from the dark days of a mental health crisis to the successes, hopes and dreams they are now experiencing in recovery
• The presentation also features a DVD with eight other individuals from diverse backgrounds sharing the impact of and recovery from mental health challenges
• Personal experiences with major depression, obsessive-compulsive disorder, schizophrenia and borderline personality disorder and other brain disorders are discussed
• NAMI In Our Own Voice demonstrates that recovery is possible
• Audience members are encouraged to ask questions and share their own experiences. This exchange helps combat the stigma and misinformation which surrounds these illnesses
• Presenters have often been viewed as role models for audience members who are also learning to live with mental health challenges

What are the goals of the NAMI In Our Own Voice presentations
• To allow audience members to connect on a personal level with the presenters via question and answer sessions
• To provide an opportunity for audience members to gain insight into the lived experience of life with mental illness

NAMI California Peer Programs Coordinator
Erik Villalobos
erik@namica.org
916-567-0163
NAMI’S Programs and Services

NAMI Sacramento offers an array of free programs for individuals living with mental illness conditions and their family members and friends. NAMI Family-to-Family Course is a free, 12-session course for families of individuals with serious mental illness taught by trained NAMI family caregivers of individuals living with mental illness. Course participants learn about diagnoses, symptoms, treatments, coping skills and communication techniques.

NAMI Parents and Teachers As Allies Presentation is a free, one-hour in-service program that helps school professionals and parents better understand the early warning signs of mental illnesses in children and adolescents so that youth with mental illness treatment needs can get linked with services.

NAMI Family Support Group is a free, 90-minute peer-led support group for families, partners and friends of individuals with mental illness. Family support group participants can talk frankly about their challenges and help one another through their learned wisdom.

NAMI Basic Course is a free, six-session, peer-directed education program developed specifically for parents and caregivers of young children and adolescents with mental illness. The course covers the fundamentals of mental illness, including symptoms, treatments, services and self-care.

NAMI Peer-to-Peer Course is a free, 10-session, peer-led, recovery education course open to any person with a mental health condition. NAMI Peer-to-Peer emphasizes recovery from mental illness as a feasible, supportable goal and challenges the stigma often wrongly associated with mental illness.

NAMI Connection Consumer Recovery Support Group is a free, weekly, 90-minute recovery support group for individuals living with mental illness where people learn from one another’s experiences, share coping strategies and offer mutual encouragement and understanding. The groups provide an ongoing opportunity to discuss the challenges of living with mental illness that includes the sharing of their personal experiences with mental health recovery. These presentations are available in English and Spanish.

NAMI Ending the Silence Presentation is a 50-minute presentation designed for middle and high school students. The transformational program gives
students an opportunity to learn about mental illness through an informative PowerPoint, short videos and personal testimony. Students learn symptoms of mental illness and are given ideas about how to help themselves, friends or family members who may need support.

NAMI Crisis Intervention Training Presentations are presentations given to law enforcement officers by individuals living with mental illness and family members. These presentations help officers learn how to de-escalate a situation when interacting with an individual experiencing a mental health crisis.

NAMI FaithNet Presentations are customized presentations provided to religious groups to promote faith communities where awareness, inclusion, support and spiritual care for individuals and families facing mental illness is provided.

Northern California NAMIWalk is a 15K walk and resources fair for the entire community held in Sacramento every spring. This event raises awareness of mental illness, reduces stigma and raises funds for NAMI services provided in seen northern California counties. For more info: www.namiwalks.org/NorthernCalifornia

NAMI Sacramento Hotline provides education, information and referrals to build callers’ ability to obtain proper services and cope with life situations. Phone: (916) 364-1642  Email: offic@namisacramento.org

NAMI Sacramento
3440 Viking Drive, Suite 104a
Sacramento, CA 95827-2844
Phone: (916) 364-1642
Fax: (916) 364-5051
Stop Stigma Sacramento: Mental Illness is Not What you Always Think

Stopping Stigma in our community will take the voices of many. If you are living with a mental illness, have a friend or loved one living with a mental illness, or want to support our efforts, join the Stop Stigma Sacramento Speakers Bureau and:

- Share your personal story about living with mental illness
- Promote positive attitudes about living with mental illness
- Share messages of wellness, hope and recovery

Public speaking experience is not necessary. An orientation and training will be provided for all new Speakers Bureau participants.

Click here for the Speakers Bureau application form and follow the submission directions on the bottom of the application. New speaker orientation and training sessions are held 2-3 times yearly. A member of the Stop Stigma Sacramento team will contact you with more information after your application is received.

1. Make a pledge

Refuse to perpetuate or tolerate stigma and commit to changing your language and attitude about people living with mental illness. Using words like "crazy" or "insane" to describe someone living with mental illness is hurtful. Commit to removing this type of language and other labels from your life.

Mental illness does not discriminate. But sometimes people do.

Stigma and discrimination against those living with mental illness is widespread and reaches into schools and institutions of learning, employment, housing, health care and media. It causes shame, prejudice and hopelessness and inhibits over half of those living with mental illness from seeking treatment. This creates serious personal and societal consequences. When shame is removed from the equation, people with mental illness will more readily seek treatment, achieve recovery and engage in meaningful activities.
Stigma is the largest obstacle to recovery, treatment and societal acceptance for people living with mental illness. Stigma and discrimination was a major theme during Sacramento County's Mental Health Services Act (MHSA) community planning process from 2005-2011. Continuing the efforts of the MHSA initiative, the Sacramento County Division of Behavioral Health Services (DBHS) initiated a multimedia, mental health promotion and stigma and discrimination reduction project. The goal is to fundamentally change negative attitudes and perceptions about mental illness and demonstrate that people living with mental illness are everyday people leading meaningful lives.

The anti-stigma and discrimination project ultimately seeks to eliminate the barriers to achieving full inclusion in society and increase access to mental health resources to support individuals and families. All of us can make a difference by making a commitment to end stigma and discrimination.

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**Mental Illness:**
It’s not always what you think.

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Mental illness affects every ethnic, racial, economic, religious and age group. Roughly one in every four adults will experience a diagnosable mental disorder during their lifetime. Nearly one out of every five children will experience emotional or behavioral difficulty. In Sacramento County, it is estimated that nearly 355,000 residents are living with a mental illness.
Mental illness is treatable, and recovery is possible when education, family, peer and community supports are available and used. However, many never seek help or treatment because of the stigma, discrimination or shame they experience. The result is unnecessary pain and sadness for the person with the mental illness, their family, friends and the community as a whole.

The *Mental Illness: It's not always what you think* project was initiated by Sacramento County Department of Health and Human Services/Division of Behavioral Health Services (DHHS/DBHS) to:

- Reduce stigma and discrimination
- Promote mental health and wellness
- Inspire hope for people and families living with mental illness

We want to change minds, attitudes and outcomes. As you read on, you may find that mental illness is not always what you think.
TCORE

The Transitional Community Opportunities for Recovery & Engagement (TCORE) is a collaboration program between Human Resources Consultants, Inc. (HRC) and TLCS, Inc. to provide intensive services to those adults living in Sacramento County who have a mental health diagnosis and are currently unlinked to any outpatient services. TCORE provides recovery based services to all participants with intensive short-term services to ensure that their needs are met while in the process of connecting to ongoing outpatient mental health services that meet the individual and cultural needs of the participant. The length of services in the TCORE program may vary based on individual needs. Each participant will complete an individualized goal plan that will assist in determining length of stay, however the length of service should not exceed 180 days and most participants will be linked to outpatient services within 120 days.

TCORE staff includes a Program Director, Clinical Director, Psychiatrist, and a Registered Nurse. New participants are assigned to a Rehabilitation Team which includes a Team Leader, 4 Personal Service Coordinators, and a Consumer/Family Advocate. TCORE also has a Benefits/Resource Specialist available to all participants.

Additional support and services provided by TCORE include:

- Quick access to medication services
- Assistance managing persistent mental health symptoms
- Services provided in preferred language
- Linkage to community resources
- General medical care
- Substance abuse assistance
- Individual counseling
- Housing assistance
- Family support services
- Advocacy
• Skill building groups
• Employment support
• School enrollment support
• Transportation assistance
• Assistance in applying for benefits (SSI/SSDI, SDI, Medi-Cal, GA, TANF, etc.)
“We believe that the potential for life change is not only possible but at times, miraculous.” Karen Brockopp, LCSW

Services

TLCS offers several mental health recovery programs that provide supportive services to individuals with a psychiatric disability to achieve the goals they have set for themselves to increase their quality of life. The following are brief descriptions of these programs:

TLCS Mental Health Crisis Respite Center (CRC)

Staffed 24/7 and serves “any individual” in Sacramento County who is at least 18 years of age experiencing a mental health crisis but is not in immediate danger to self or others. There is no medical staff at the Crisis Respite Center and participation is completely voluntary. All individuals utilizing the Crisis Respite Center may be eligible to stay for up to 23 hours and expect service based in compassion, understanding and knowledge. While at the Crisis Respite Center, the primary goal is to offer a stable and supportive environment so that the “guest” is better positioned to explore their crisis with a solution oriented mindset. Every guest will leave with an individualized resource plan. If transportation to the CRC is an issue, the CRC staff may be able to help.

Please call 916 RESpite (916-737-7483)
New Direction Program

A Full Service Partnership, funded by the Sacramento County Division of Behavioral Health Services and HUD (Housing and Urban Development), New Direction provides individually tailored services for the achievement and maintenance of a stable and satisfying life in the community. The staff provide the assistance one-to-one and in group settings to support and encourage life management and coping skills to achieve greater self-reliance.

The Services offered by The New Direction Team include:

- Case Management
- Psychiatry, nursing and psychotherapy
- Medication Assessment and Monitoring
- Advocacy and Referral
- Crisis Response Benefits acquisition
- Employment Support and Assistance Housing referral, support and subsidies
- Substance Abuse Recovery and Support
- Assistance with Medical Care
- Skills Building Activities

Peer Warm Line available to all New Direction Clients and Co-op Residents 24/7.
SRO Service Center

The SRO Service Center provides a wide variety of services to residents of the downtown single room occupancy hotels. Services include mental and physical health, entitlements, substance abuse recovery, and socialization. There is a weekly food pantry onsite and a visiting public health nurse.

The Clubhouse

TLCS presents "THE CLUBHOUSE" opening Thursday November 6, 2014 at 3737 Marconi Ave. Sacramento, CA 95821. The Clubhouse is a drop in place for those receiving services from HRC and TLCS and will function as a centralized location for members to receive support and encouragement on the road to self-sufficiency and recovery. The Clubhouse will have three main functions: A place to build meaningful relationships with peers and come have fun, volunteer team opportunities and resources to increase self-esteem and self-confidence and to begin preparation for future employment opportunities.
Mission Statement

To develop and implement Consumer driven programs and services based on the self help philosophy.

To provide culturally appropriate, and integrated co-occurring mental health and substance services and supports that assist participants in their strength-based process of wellness and recovery and that foster self-responsibility, and empowerment.

Vision & Philosophy

The vision of the program is based on the vision and guiding Principles of the Mental Health Services Act (MHSA) Section 7, 5813.5 (d):

Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.
(3) To reflect the cultural, ethnic and racial diversity of mental health consumers.
(4) To plan for each consumer’s individual needs

Program Description

Sacramento County Wellness & Recovery (WRC) multi-service community center promotes the wellness and recovery of participants by fostering meaningful activities and community involvement of their choice. The center is consumer/family member directed and operated.

With the goal to reduce the adverse consequences of serious mental health problems, the WRC provides inclusive, voluntary consumer driven, holistic approaches, attentive to mental health and drug/alcohol disorders that are culturally responsive to the beliefs, traditions, values and languages of the individuals and families served.

The guiding principles of the WRC are directed by effective services and supports implemented through the development and expansion of values-driven, evidence-based and promising practices, policies, approaches, processes and treatments which are sensitive and responsive to the client’s expressed culture and favorable outcomes.

Services are based on increasing resiliency, improving problem-solving, developing and/or maintaining positive and healthy relationships and creating opportunities to build or maintain a meaningful life in the community.

The Wellness and Recovery Center offer comprehensive services designed to support individuals with mental illness with wellness by providing curriculum and skill building activities, family education, community-based peer support. Services offered include peer-to-peer support, goal setting, crisis planning, and other wellness services. Services may include medication evaluation. The expectation is for participants to have improved overall health and wellness, to set and achieve personal goals independently, within their family and/or community, and to create and maintain meaningful relationships. Adult 18 years and older are welcome to drop in Monday – Friday, 8:00 a.m. – 5:00 p.m.

To Qualify
Adult 18 years and older are welcome to drop in. Diagnostic criteria for medication evaluation must be determined and authorized by the Adult Mental Health Access Team.
Cost
There is not cost for Wellness Center activities. Costs for other services are based on program specifications. MediCal coverage or other public insurance/resources, and the individual’s ability to pay. The Adult Mental Health Access Team will assist in determine the individual’s share of cost as applicable.

Contact Information
Adult Mental Health Access Team
Business Hours: Monday – Friday, 8:00 a.m. – 5:00 p.m.
Telephone: (916) 875-1055

The center offers daytime group activities, outreach, self-help, peer counseling and peer advocacy. The center is an active place and on any given day, the premises are busy with consumers socializing, participating in groups, and exercising their right to be a part of a community which values their presence and individuality.

Attendance is voluntary and free of charge. Program participants are referred to as members and this concept of membership is extended to all aspects of the running of the program. Members help plan Center activities and groups as well as serve on hiring committees and serve on the Board of Directors. It is the membership which contributes to the ongoing effectiveness of the program.

Along with daily activities, the program offers a point of daily contact for those individuals who are often isolated. Continued attendance and involvement allow these sometime vulnerable individuals the opportunity to become part of a viable community, to have a voice and to have a place to belong.

Shower Facilities, Laundry Facilities, Peer Support, Recreational Activities, Social Activities

Patient rights provide advocacy services for mental health clients in Sacramento County. These state law mandated services are provided by Consumers Self Help under contracts with Sacramento County.

The office of Patients’ Rights is responsible for:

- Representing Clients expressed wishes at Certification Review Hearings which are held at psychiatric facilities when a doctor wants to involuntarily detain someone for additional treatment because the doctor believes that as a result of an individual’s psychiatric disorder they are danger to themselves, others or are unable to care for their basic food clothing or shelter needs.
• Investigating complaints/concerns about mental health treatment in an inpatient or outpatient setting.
• Monitoring psychiatric facilities and
• Residential facilities to ensure compliance with federal and state laws and regulations.

Provide training on Patients’ Rights to providers and consumers of mental health services in Sacramento County
Located in Sacramento, CA, our mission was created by homeless women expressing their needs and a community coming together with a desire to end homelessness—for good.

Miracles happen at Women’s Empowerment every day. A homeless child takes her first steps. A homeless woman secures a job. A family, once homeless, moves into their own home. These miracles happen because of YOU! Your support provides life-changing services to women and children who need it most. …
At Women’s Empowerment we pride ourselves on the number of services we are able to provide to our students and graduates. Our mission is to end homelessness through empowerment and employment and it is your help each year that makes it happen. We partner with a number of agencies.

At Women’s Empowerment, we know a job is more than a paycheck. A job provides you with dignity and a sense of pride. Having a job means you have a place in our community. It means respect.

Women’s Empowerment educates and empowers women, who are homeless, with the skills and confidence necessary to secure a job, create a healthy lifestyle, and regain a home for themselves and their children. Each woman who is homeless carries great potential. Women’s Empowerment offers a pathway to a new life for herself and her children. You can help her make it happen.

Miracles happen at Women’s Empowerment every day. A homeless child takes her first steps. A homeless woman secures a job. A family, once homeless, moves into their own home.

These miracles happen because of YOU! Your support provides life-changing services to women and children who need it most.
Take your support even farther by becoming a member of Team Rosie! This group of dedicated, monthly donors makes it all possible. Like Rosie the Riveter (whose image you’ll see all over our office) they know that together, we can do it! Together, with monthly gifts, we’re able to sustain every one of our high-quality programs—without fear of having to close our doors or turn a woman or child away who needs our help.

Become a member of Team Rosie and you’ll join an amazing group of people! It’s an easy way to have a direct impact on the lives of homeless women and children in Sacramento.

To join, simply choose to make a monthly gift that is charged to your credit card automatically (you can cancel your donation at any time). Team Rosie members can also “go green” and choose to receive their thank you letters and appeal letters electronically (saving us the cost of postage and printing—and helping the environment too!). To do so, email Kate (kate@womens-empowerment.org) and she’ll take care of the rest.

Contact Details

Women’s Empowerment
1590 North A Street
Sacramento, CA 95811

Phone: 916.669.2307
Email: support@womens-empowerment.org
REFERENCES


