Mental Health Awareness Training
Presented by: Mary Schepler & a person in recovery

Slide 1 (announcer)
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Slide 2
Hello and thank you all so much for joining us today for our presentation on Mental Health Awareness: Experiences of Wellness and Recovery.

Slide 3
My name is Mary Schepler and I am currently an IPS Trainer for the Illinois Department of Human Services Division of Mental Health. This slide also has my contact email mary.schepler@illinois.gov in case anyone would like to contact me after this presentation. IPS stands for Individual Placement and Support which is the only evidence based model for supported employment services. The IPS model helps people that have been diagnosed with a severe mental illness find and maintain meaningful competitive employment in the community and in a position of their choosing. For the past two years, I have been incredibly lucky to be a part of an amazing team that works throughout the state of Illinois to expand access and education to this life changing program. Before this position, I was actually an IPS employment specialist and IPS team lead for 5 years so yes, this work is very near and dear to my heart. I love to talk about mental health awareness. I look forward to sharing with you all some of what we have learned and certainly would appreciate the opportunity to learn from you all as well about your experiences in the field.

Slide 4
So yes, I greatly appreciate that you all are here, so let's go ahead and get into it, let's stand up to stigma and talk about mental health awareness. That is what we are here for: we want to open up this topic and conversation, open up this dialogue which takes a lot of courage and self-evaluation, and I want to acknowledge everyone for being a part of that. This slide has a quote from John Lennon that hopefully puts us into an orientation state of mind. "How can I go forward when I don't know which way I'm facing?"

Slide 5
Part of this training and what we have done in the past when we go out to community partners and business we want to talk about this. Starting a candid conversation around what are words or phrases that you have heard associated with mental health conditions. Some things you have heard either through the media or your community. Maybe even have thought or know someone else who may have or currently still do think. Some of the things that have come up often are phrases you may have experienced as well. Some include going postal, crazy, and association with danger or people that are dangerous. So the question is where do we get these messages? Where did they come from and what are they there for and how do we begin to change them?

Slide 6
So let's get into some definitions, discussions about stigma, and conversation around common misconceptions. The dictionary defines stigma as a mark of disgrace or dishonor that is associated with a particular circumstance, quality, or person. So, that's heavy right? Certainly talking about a mark of disgrace or dishonor, when really what we are talking about is an illness that people are impacted by and that people are working towards recovery from. Also an illness that can impact anyone regardless of race, sex, age, culture, or economic status. This slide breaks down some different types of stigma and stigmatization that we will be talking about today.

When we're talking about public stigma, we're talking about discrimination when the general public endorses negative stereotypes, and can lead to loss of services and rights. It can create rejection and create social distance.

Also there is self-stigma. This is when a person internalizes public attitudes and negative stereotypes, when they agree with them and apply them to themselves, which can lead to a "Why Try?" mentality. This also can lead to loss of self-esteem and self-efficacy.

And finally there's structural stigma. This is discriminatory laws, policies, and community attitudes towards a particular group, especially minorities.

As we continue through this presentation, I would like you to think about these different types of stigma, and examples that you may have seen, or even experienced, in your work.

Slide 7
Let's unpack some common myths about mental illness and mental health conditions.
"People that have been diagnosed with a severe mental illness are often dangerous and violent."
"Medications are the only way to treat a serious mental illness and people who have been diagnosed with one need to be on meds for the rest of their lives." "Mental health conditions always run in families." And, "You can tell if someone has a mental health condition."

Slide 8
Some more common myths include: "People with mental illnesses are lazy and lack motivation." "People don't ever recover from a serious mental health condition." "Mental illnesses and intellectual disabilities are the same thing." "People with a mental health condition should never drink or use drugs." "Mental health conditions are relatively uncommon."

Slide 9
I think this quote is really quite dynamic, and needs to be considered when evaluating some of the misconceptions that we just discussed. "People (that have been diagnosed) with (a) mental illness frighten and embarrass us, and so we marginalize people who most need our acceptance…"

Slide 10
When what mental health needs is more sunlight, more candor, and more unashamed conversation. This is a quote from actor and mental health activist, Glenn Close, and again, I really feel that this slide hits home to a lot of the things that we are talking about today. I'm also

going to talk a little bit more further on about Glenn Close and the conversations around, not only our own preconceived notions, but also where they come from, what role media plays in this, the representation of mental health conditions in our society, and what role we can play in regards to reducing stigma including combating discrimination with compassionate language.

Slide 11
So, again, to go back to definitions, what is a mental illness? A mental illness can be defined as a wide range of diagnosable psychiatric illnesses that impair a person's ability to think, feel, and behave in a manner that allows for optimum functioning in day-to-day life.

Slide 12
Prevalence of psychiatric disorders: So the reason that we are talking about this is to discuss exactly what the prevalence is. How common are mental health conditions? This information comes from NAMI which is the National Alliance on Mental Illness. Research shows that 1 in 5 people in the United States will be diagnosed with a major mental illness at some point in their life. 1 in 4 Americans have a first-degree relative with a major mental illness. Schizophrenia has a .5% prevalence worldwide. Bipolar disorder has a 2-3% prevalence worldwide. Major depression falls between 10 and 25%. Anxiety disorders fall in about 5-8% prevalence. Substance abuse disorders comes in at about 10% prevalence. These numbers are of worldwide prevalence. In the United States 1 in 100 (or 2.4 million) adults are living with schizophrenia, 2.6% (or 6.1 million) adults are living with bipolar disorder, 6.9% (or 16 million) adults live with major depression, and 18.1 (or 42 million) of American adults are currently living with an anxiety disorder. And, again these data and statistics all come from the National Alliance on Mental Illness.

Slide 13
Now I'm going move into a bit more about diagnosis and creating a shared language. Talking a little more about different mental illness diagnosis, signs, and symptoms.

Slide 14
In order to talk about this, we cannot not talk about the DSM. DSM stands for The Diagnostic and Statistical Manual of Mental Disorders. It attempts to codify and categorize psychiatric illnesses into distinct groups with specific sets and definable features. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association (the APA) and offers a common language and standard criteria for the classification of mental disorders. It is used, or relied upon, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, the legal system, policymakers, and of course, mental health practitioners.

The DSM is now in its fifth edition, the DSM-5, published on May 18, 2013. The first edition was published 1952, and since then, revisions have incrementally added to the total number of mental disorders, although also removing those that are no longer considered to be a mental disorder. As I mentioned before, for this conversation, we're going to use the DSM as more of a dictionary providing a common language for understanding psychopathology.

Slide 15
Using the DSM as a guide, we're going to cover with some very broad brushes to begin to define some of the more common mental health disorders that we work with in the Division of Mental Health, and at our local community mental health care providers.

Starting with the schizophrenia spectrum and other psychotic disorders, which are related to a disturbance in thinking. This can also be described as either experiencing symptoms that others do not, and/or alternately, not experiencing the world as it is experienced by others around you, which can be described through positive symptoms and negative symptoms which we will talk a little bit more about in the next slide.

Also a quick note regarding signs versus symptoms: Signs are what a health care professional, or someone from the outside, sees whereas a symptom is what an individual experiences. So, while the sign may be the physical manifestation or behavior of injury, illness, or disease, the symptom can be described as what the patient experiences about injury, illness or diseases. Ideally, signs are objectively observed by others whereas symptoms are subjective and can only be observed by the individual experiencing them.

When we talk about bipolar and related disorders, we are talking about a disturbance in mood constancy. Bipolar I is a disorder that involves periods of severe mood episodes from mania to depression. Bipolar II also is a milder form of mood elevation, which involves milder episodes of hypomania alternating with periods of severe depression. Cyclothymic (cycho-thigh-mia) disorder describes brief periods of hypo-maniac symptoms alternating with brief periods of depressive symptoms that are not as extensive or as long-lasting as seen in some other diagnoses. Depressive disorders relate to disturbances in mood. Under this area falls major depressive disorder, dysthymia (dis-thigh-mia) which is now known as persistent depressive disorder (PDD). It is a mood disorder consisting of the same cognitive and physical problems as depression, with less severe but longer-lasting symptoms. And also premenstrual dysphoric disorder is listed under this area as well. Just to note some of the changes that occur with new editions of the DSM, we now see a change between bipolar and depressive disorders that were once all listed as mood disorders and now have been separated into mood and mood consistency disorders. We have now learned these two disorders are no more similar than for instance bipolar disorder is related to schizophrenia, hence the change.

Slide 16
Schizophrenia is often described in terms of positive and negative symptoms, which do not refer to good or bad but to the type of experience. Positive symptoms are those that individuals do not normally experience, but that are present in people who've been diagnosed with schizophrenia. This can include delusions, disordered thoughts or speech, tactile, auditory, visual hallucinations, typically regarded as manifestations of psychosis.

Negative symptoms, on the other hand, are deficits of normal emotional response or of other thought processes. This might include a flat expression or little emotion, poverty of speech, an inability to experience pleasure, a lack of desire to form relationships, or generally a lack of motivation.

On this slide, we have listed just some of the possible positive and negative symptoms someone might experience including hallucinations, delusions, disordered thinking, disorganized speech, psychomotor agitation, bizarre dress or appearance (which could actually fall more into a sign rather than a symptom, depending on who is defining the bizarre dress or appearance), and paranoia would all fall under positive symptoms. Whereas negative symptoms could include a blunt or a flat affect, impoverishment of speech, experience of withdrawal and isolation, anhedonia (ann-he-donia), which is defined as the inability to experience pleasure from activities usually found enjoyable – for example, exercise, hobbies, music, or social interaction – and alogia (al-o-ga) which is a type of poverty of speech. It is a general lack of additional or unprompted content than is normally seen in speech patterns. Slowed cognition and thought processes also fall into this category, as well as catatonia (cat-a-tonia), which is a state of apparent unresponsiveness to external stimuli in a person who is apparently awake.

Slide 17
When discussing anxiety disorders, we’re talking about a dysregulation in psychomotor arousal including panic disorder, generalized anxiety, social anxiety, and experiencing a specific phobia. Agoraphobia, which is a type of anxiety disorder, is one in which you fear and avoid places or situations that might cause you to panic and make you feel trapped. This fear is about an actual or anticipated situation, such as using public transportation, being in open or enclosed spaces, standing in line, or being in a crowd.

Obsessive-compulsive and related disorders also fall under anxiety disorders. Obsessive compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania (trik-uh-til-uh-mey-nee-uh) which is a hair pulling disorder, and excoriation (ick-scurry-ation) which is a skin picking disorder, again all fall into this category.

Slide 18
Personality disorders are characterized as disturbances in personality formation.
These are characterized by deficits in interpersonal relating, affect management, problem-solving, identity, and impulse control. I want to be careful to be very clear that we are not talking about someone being unpleasant or difficult to deal with in this area. What we’re talking about is a long-term, pervasive, maladaptive pattern of relating to others and the world, which can create incredible distress and impairment in major areas of life functioning.

Slide 19
For trauma and stressor-related disorders, reactive attachment disorder falls into this category which is a rare but serious condition in which an infant or young child doesn't establish healthy attachments with parents or caregivers. Post-traumatic stress disorder, which is also an anxiety disorder, that develops following a frightening, stressful, or distressing life event, and is also known as PTSD. PTSD is characterized by intense fear, helplessness, and stress, which can greatly affect functioning of the patient.

Substance and addictive disorders, substance use disorders: Just a note that abuse and dependence are now viewed as a part of a singular disorder with a continuum of severity. Related also is gambling disorder; feeding and eating disorders, and gender dysphoria fall into this category. A note on this one as well: gender dysphoria used to be known as gender identity

disorder. This shift is largely regarded as a very positive change in the right direction considering gender identity disorder does imply that there is something wrong with those that do not conform or identify with their assigned gender.

Slide 20
The diagram here on slide 19 *[sic]* is to demonstrate how psychopathology can, not always, but can coincide with addiction. When someone is experiencing both a psychopathology diagnosis, as well as an addiction, diagnosis this is referred to as a co-occurring disorder. If one diagnosis is primary (which is defined as the condition that requires the most resources and care) then the second would be named and treated as a secondary condition.

Slide 21
Now that we've gone through that, what are some advantages of diagnosis? For some, it can be helpful to have a name for all the myriad of symptoms they have been experiencing. A diagnosis can also change the treatment approach. For example, we may understand/approach helping someone with symptoms related to depression differently than someone struggling with negative symptoms of schizophrenia, even when the behavior (isolation, lack of motivation, limited pleasure in activities) may look similar. A diagnosis is a part of medical necessity, and without it, we have no justification for providing mental health professional care. Diagnosis can aid understanding what is behind certain symptoms and help to increase empathy. Understanding a diagnosis, and related criteria, can also enrich our understanding of a person – not just limit it – so long as we are mindful of the whole person.

Slide 22
But with a diagnosis there are also risks. A diagnosis can be used to label people, which in turn is used to stigmatize and marginalize people. People can be treated as if they are only their illness and not a whole person. And finally a diagnosis is just a small part of understanding a person and the impact of the illness and/or other illnesses.

Here's a quote by Carl Jung that I think really helps define this as well. "Clinical diagnoses are important since they give a doctor a certain orientation, but they do not help the patient. The crucial thing is the story, for it alone shows the human background and the human suffering…"

Slide 23
People who have been diagnosed with a mental illness or illnesses are often impacted by feelings and experiences of powerlessness, hopelessness and despair, feelings of invisibility, and worthlessness, stigma, marginalization, loss of personal control around one's situation, isolation, loneliness, not being listened to, or understood. Often, they're faced with dealing with cumulative effects of poverty, homelessness, trauma, illness, and also, unresponsive systems of care.

Research has also shown us that people with a mental health condition are more likely to encounter law enforcement than get medical help during a psychological crisis. There are currently more people with mental illnesses in jails and prisons than in hospitals. They are regularly blamed for violence, when in fact they are much more likely to be the victims not the

perpetrators of violent crimes and, as already mentioned, experience greatly higher rates of homelessness.

Slide 24
So how do you know when someone has a mental health condition or a substance use problem?

Slide 25
The answer is most of the time you don't, at least not without a lot more information.

Slide 26
With that being said, there is a lot known about the course of mental health conditions, and they include as many as 2/3 of people diagnosed with a serious mental illness get much better over the long term. One's current level of illness severity does not predict long-term outcomes. No one can predict who gets better and who does not. Access to rehabilitation services improves long-term outcomes. And a trusting relationship with at least one helper can have significant impact on outcomes. So now I would like to invite our guest speaker, who is going to share a piece of her recovery story on the next slide.

Slide 27
It's really good to be here today. I have worked in Individual Placement and Support [IPS] Supported Employment for those in mental health recovery in Chicago for 12 years. One of the many reasons that I like my job so much is I believe that work is a very important piece of recovery for persons with mental illness. Maya Angelou is quoted as saying "Nothing will work unless you do."

I would like to share with you a little bit about myself. Before working in IPS Supported Employment, I mostly worked in outside sales, inside sales and product training positions. Except for a brief 6 month period, I have been working full time since college graduation. I believe that working was a very important piece of my recovery, and it still is. I attended college and graduated with honors. I went to graduate school and received a Master's degree in broadcast journalism. During graduate school, I did a documentary on homelessness. I spoke with a homeless man who had a mental illness. I was 24 then. I never dreamed that I would soon face a mental illness, too.

I first started experiencing mental health symptoms when I was 30 years old. I have been hospitalized 5 times for mental health reasons. The final time was in in the summer of 2000. In July of 2018, I will celebrate the 18th year of my being well, out of the hospital, and back to work. I can truly say that there is great treatment for people with a mental illness. As NAMI (the National Alliance on Mental Illness) says, "treatment works."

My current psychiatrist has diagnosed me with schizoaffective disorder in remission. With a previous psychiatrist, I was diagnosed with schizophrenia. To treat my illness, I take an antipsychotic medication, along with an additional medication to treat the side effects of the antipsychotic medication. I also take an antidepressant. Outside of work, I volunteered for NAMI as a speaker for 12 years. As a speaker on the NAMI speaker's bureau, I helped to educate

different audiences that people with a mental illness can recover and live bright, productive, and meaningful lives.

In addition, I am very close to my family. My brothers and their wives, my parents, my cousin and my husband, they have all been very supportive. When I have been sick, they have been there to get me help.

When I have been sick in the past, I have had 5 major symptoms going on: symptoms including paranoia. I was fearful that people were following me and monitoring me. I believed there were hidden cameras in TVs and mirrors, that the phone was tapped and the room was bugged. If you remember the movie, The Firm, where someone is living in a home, where they are totally under surveillance, that's what it was like for me. I also experienced delusions. A delusion is a false fixed belief. Where I believed something to be very true, but, it was really false and a symptom of my illness. The delusion that I got pulled into was, in the area where I grew up, there was a lot of conversation about the mafia. So, when I started thinking about who could be monitoring me and victimizing me – guess what popped into my head – the mafia. And psychosis, a lost touch with reality. I am sure you can appreciate, if I thought I was being monitored and victimized by the mafia, that was a total loss of touch with reality. It was not true at all, but rather a symptom of my illness. I also have a little tendency toward depression and anxiety that I have to keep an eye on.

I remember the dark days. In fact, I keep reminders of them. Now, my memories of the dark days serve as a reminder that I have mental illness, and I need to take my medication every day to correct the chemical imbalance that causes my thinking to be confused.

As I mentioned, when I became sick and before I agreed to accept medication, I had delusional thoughts about the mafia. Trust me, I love my family. But one delusion, when I was not taking medication was, I truly thought that my parents were in the mafia. I was over at their house one evening and I perceived them to be a threat to my safety and my 4 year old niece. I left their house and went into their neighbor's backyard and dialed 911. The police came and, after questioning my parents, the police wanted to take me to the hospital. In fact, I thought the mafia had installed hidden cameras and bugs in my home and my car and I thought that they were monitoring me. In my delusional thinking, I thought I was working with the undercover police officers, the CIA and the FBI to shut down the United States mafia. I came up with a plan to write letters to some very important people and mail them to The White House. In the letter, I explained that I was being victimized by the mafia and I was asking for their help. After a few months of mailing about 4,000 letters to The White House, in many cities throughout 12 states, I got a visit at my home from a Secret Service agent. He showed me his badge. I invited him in and we sat at my dining room table. He asked me "Are you mailing letters to The White House?" I proudly answered, "Yes." My name and address were on all the letters and envelopes. I even put my phone number on the letters. He then asked my "Why are you doing this?" I asked him if I addressed, stamped, and mailed a letter to President Bill Clinton in a United States Post Office, and if someone broke into the post office, and intercepted and read the letter, what would the penalty be? He answered, "5 years in jail." I replied that I thought I was putting a lot of people in jail for 5 years. He said, "Just please stop mailing the letters." And I did not mail any more letters.

My paranoia caused me to consider taking my life, when I thought that the mafia would torture me to a cruel death if they thought that I was working with the police to try to send them to jail. I also came close to being harmed after I confronted and said some pretty harsh words to a man that I thought was in the mafia following me in a shopping mall. After I finished telling this man off, he threw me into a glass window of a coffee shop. Luckily, the glass window did not break and my neck did not break. I realize that it's very dangerous for me to be sick. I can get hurt.

Now, I am doing great. I have a great job. I am very close to my family. I married 13 years ago to a wonderful man that I love very much. I shared with him while we were dating that I had mental illness. I am looking forward to a celebration in July when I will celebrate 18 years of being well, out of the hospital, and back to work.

I would like to cover 3 of the steps that I have found to be critical in my recovery from mental illness. First, I believe the foundation of hope for recovery begins with building an excellent support system. My support system consists of my doctor, my therapist, and my family. I see my psychiatrist once a month, and I also see my therapist once a month. I have learned that it's important for me to be open and honest and share my thoughts with my doctors.

Second, I believe a second step to recovery is that the person with the mental illness must understand that they have a mental illness and they must accept that they have mental illness. A big turning point is when someone can understand and accept they have mental illness and get with the program. It took me 6 years of struggling before I came to understand and accept that I have mental illness and get with the program.

So, as I mentioned, mental illness did not hit me until I was about 30 years old. As I mentioned, I really struggled for the first 6 years. I did not understand and accept that this was a condition that I would have to manage for the rest of my life. It was not until the summer of 2000 that I came to understand and accept that I need to take my medication every day and see my psychiatrist on a regular basis. And things never really got better on a permanent basis until I got with the program. I think that people with mental illness have to accept that they have mental illness. And in my case, I have to accept that I have to take medication for the rest of my life. That this is not something I'm going to get well from like the flu or a cold. And that taking medicine for the rest of my life is okay. A lot of people with physical illnesses have to take medicine for the rest of their life. True, there are side effects, but you can work with your doctor on reducing side effects. I believe that you have to accept that, and this will play an important part in your recovery.

So, what does acceptance mean to me? It means that I have to be responsible and make decisions on a daily basis to continue my wellness. Acceptance can mean giving up or doing things that one really may not want to do. For example, I made the decision to no longer drink alcohol because my psychiatrist explained to me that even though I was only having one or two glasses of red wine a week that we would have to increase my medication, and pretty soon, the alcohol would cause my medication to no longer work. And, when I think about decisions like whether or not I am going to drink alcohol or take my medicine, I have to make a decision like, what's more important, a glass of red wine or my ability to pay my bills, keep my condo, keep my marriage, keep my job, take care of my family, and keep my happy little life? The answer is clear

to me. I have to take my medicine, and I cannot drink alcohol. I have to take responsibility for myself and make decisions to continue my wellness.

I think it is not easy at first but after I got out of the hospital and started getting stable, I had to get up and get out of the house and reconnect back into society. It's not easy. You have a bit of a shattered image and you have to rebuild your confidence. To really recover, you need to reconnect. A person with mental illness has to connect back to their family, connect back to social outlets, and connect back to work. It is by understanding and acceptance that I have been able to stay well year after year.

I believe a third step to recovery is to find employment. It's important to be realistic regarding the level in which you reenter back into the workforce. You may be able to start back where you were, but you may also have to work your way back up. What's important is to get back to work.

As a Supported Employment Specialist, I helped people in mental health recovery find employment. I know from experience how important work is in one's recovery. One of my psychiatrists explained to me once that work is very stabilizing for everybody! Work can provide structure, routine, social interaction, a chance to contribute to the community, a sense of accomplishment, self-confidence, self-esteem, a paycheck, and insurance.
Let me break each one of them down because they are all very important in a person's recovery from mental illness.

Structure: When you are at work you have a plan for the entire day. A reason to get up, shower, get some breakfast, and off you go to work! Once you are at work you have a plan for the morning, then lunch and a plan for the afternoon. Then, home to dinner and bed. And, it all starts again the next day. This structure is wonderful for people with mental illness. They have a reason to get up and get out of the house.

Routine: It's important to have a routine, a schedule that you can count on. To know what the day will look like.

Social Interaction: Research shows that one of the side effects of unemployment in the general population is alienation and being isolated from others. One of the great benefits about work is that it integrates one back into the community and work takes us out of the house so that we can be around others.

An opportunity to contribute to the community: I agree with a poem by the author Rumi. The poem says, "Everybody has been made for some particular work, and the desire for that work has been put in every heart." I think that almost everyone deep down really wants to contribute to the community.

A sense of accomplishment: To do the job well is meaningful. To feel good about being a part of a team that is working toward a goal. To contribute and be a part of an organization is meaningful. Work can also help you rebuild your self-confidence and self-esteem. When someone with mental illness gets well and looks back at times when they were sick, they can have a shattered image, sometimes a long with shame and embarrassment. To be able to have a

place to rebuild their self-confidence means a lot and helps to rebuild the person's often shattered image and allows the person to start feeling good about themselves again.

Work can provide a paycheck and, in some cases, insurance. We all know how important it is to be able to pay bills and how good it feels to earn a paycheck for your work. I work full-time, but part-time may be better for others.

It's important for a person with mental illness to get back to work. I believe it is also important to have a diversified workforce including persons with mental illness. According to NAMI National, "1 in 5 adults in America experience a mental illness, and nearly 1 in 25 (10 million) adults in America live with a serious mental illness such as schizophrenia, bipolar disorder, or major depression." It's important for employers to provide a place for individuals with mental illness to reintegrate back into society and back into the workforce. A little support and encouragement can go a long way in making a powerful impact on a person's life.

I believe that you take a negative and turn it into a positive. So, I have grown as a person in my journey with mental illness, and I believe that I am a better and more knowledgeable person because of it. I figure everyone usually gets something: these bodies of ours are not perfect. Whether a person gets heart disease, diabetes, cancer, cerebral palsy, epilepsy, or even neuralgia, and some people develop a brain disorder. Some people have a heart attack, and others have a brain attack. The message is that mental illness can be treated with the right medication to correct the chemical imbalance in the brain, and with the right support of a team so we don't have to face it alone.

So often, through the media, we only hear the negative side of mental illness. But, thanks to organizations such as the IPS Team for the State of Illinois, Community Mental Health Centers, NAMI, and dedicated people like **YOU** who are willing to support these organizations, people with mental illness can get the supports they need to live fulfilling and productive lives and contribute to society. People with a mental illness are people with great potential who with the right treatment team, the right medication, and with understanding of their illness can have hope for a bright future. As I have shared, treatment works for people with a mental illness.

I would like to thank you for understanding that mental illness is just that, an illness. And, it can be treated. And, people with mental illness – just like people with diabetes – can get treatment and recover and live a bright and productive life and contribute to the community. Thank you!

Slide 28
There are many treatments for mental conditions, and we know these treatments will be best implemented when they include client-centered planning, shared decision-making, and when they are strengths-based, and include evidence-based practices. Some common treatments include pharmacological treatments or medications: antipsychotics, antidepressants, mood stabilizers, anxiolytics (ann-ze-o-litic), which is an anti-anxiety drug, and psychostimulants. Other common treatments include counseling and therapy, CBT/DBT (which is cognitive behavioral therapy focused on the development of personal coping strategies and dialectical behavioral therapy designed to help people change patterns of behavior that are not helpful, such as self-harm, suicidal thinking, or unhealthy substance use). Motivational interviewing, which is

a directive, client-centered counselling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Psychodynamic therapy is a form of verbal treatment that helps patients find relief from mental or emotional stress, similar to psychoanalysis. Also case management or group work.

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Some additional treatments may include diet and exercise, yoga and meditation, homeopathic and herbal remedies, self-help and peer support, psychosocial rehabilitation, or PSR, community integration, and, of course, employment.

Slide 30
There are lots of pieces and parts of recovery, and one that far too often gets overlooked is vocational rehabilitation. And, hopefully, that is part of the reason that you here joining us today: to help change that. To shift our thinking to include employment as a standard of care and an essential part of community integration. This quote I think really beautifully sums up the importance of the work that we do to create meaningful pathways to employment opportunities for individuals that have experienced barriers to employment. The quote is by Dr. Robert Drake who is now currently the vice president of the IPS Employment Center at the Rockville Institute, but he made this statement back when he was doing his research around Individual Placement and Support supported employment services, as a researcher at Dartmouth University. “It's totally clear to me at this point that there's nothing about medications or psychotherapies or rehabilitation programs or case management programs or any of the other things that we study that helps people to recover in the same way that supported employment does.”

Slide 31
I have a respected colleague who often talks of how the mental health system has changed over the past 30 years in regards to recovery, and how we are shifting away from systems that keep individuals isolated and segregated from the general public. We have more understanding that people tend to stagnate when they are sheltered from real-life experience, and instead, we are moving towards treatments where individuals can learn, achieve, and grow through both failures and success. We know that people that have been diagnosed with a serious mental illness can and do recover, and can be supported by systems that value empowerment and self-management, commitment to progress, and a whole-person approach.

Slide 32
There are many ways to define recovery and each one will be as unique as the individual experiencing it. But this is a quote that I especially like. “Recovery is a deeply personal, unique process... It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life, as one grows beyond the catastrophic effects of mental illness.” And this quote is by W. Anthony.

Slide 33
The diagram on this slide shows the 8 Dimensions of Wellness, which is just an incredible tool created by Dr. Peggy Swarbrick. Some of the ideas around this include the fact that wellness is

incorporated by many interconnecting dimensions that can all affect our overall quality of life, as wellness directly relates to how long we live and how well we live. These dimensions include:

Emotional: coping effectively with life and creating satisfying relationships.
Financial: satisfaction with current and future financial situations.
Social: Developing a sense of connection, belonging, and a well-developed support system.
Spiritual: expanding our sense of purpose and meaning in life.
Occupational: personal satisfaction and enrichment derived from one's work
Physical: recognizing the need for physical activity, diet, sleep, and nutrition.
Intellectual: recognizing creative abilities and finding ways to expand knowledge and skills.
Environmental: good health by occupying pleasant, stimulating environments that support well-being.

When we feel financially stressed (for example, maybe an increasing debt), we experience emotional stress or anxiety, and sometimes that can lead to physical problems, which can lead to illness, less effectiveness at work (occupational), and maybe even questioning our own meaning and purpose in life (which would fall into spiritual). When we are not working (occupational), we lose some of our opportunities to interact with others (social), cannot get the quality foods and medical care we need to stay well (physical), and may need to move to a place that feels less safe and secure (which is environmental). Again, this is going back to focusing on a whole-person approach, and looking at overall wellness in regards to recovery.

Slide 34
What are some ways that we can help to facilitate recovery? We can help individuals to find meaning and purpose in their lives, and help individuals fulfill valued roles and engage in a life in a community of their choosing. Helping individuals see themselves as more than just their illness or illnesses. Accepting that an individual's strong emotions and disagreements with us may be a personal opinion rather than a pathology. And, respecting individuals' personal views of their illness or illnesses.

Slide 35
There are many things we can do that aid recovery, including fostering a shared determination to get better. Also an understanding of one's illness. Taking responsibility and working towards management of the illness. For many, it's identifying the positive aspects of medication and/or helpers. Cultivating friends and family who are accepting and locating supportive health professionals. For some, the acceptance of medication. Optimistic attitudes are not something to be overlooked, and also always finding ways to decrease and dispel stigma in our society. Also spiritual beliefs, whatever they may be, is something that many have found to be integral in their recovery process.

Slide 36
How do you talk to someone with a mental health condition? The same way you would hopefully talk to anyone you come in counter with. With respect, genuine interest, a desire to understand, a listening ear, an appreciation for cultural differences, and a belief that people are doing the best that they can.

Slide 37
This is some information I came across recently on a training around the portrayal of mental health conditions in the media, and yes, thought it was just excellent and very relevant to what we're talking about today. This information was compiled by the Depression and Bipolar Support Alliance (DBSA) and is available on their web site www.dbsalliance.org and gives examples of how to combat discrimination with the use of compassionate language.

They suggest to avoid distancing. Use language that references people or individuals, instead of "them," "those," or "the mentally ill." To choose thoughtfully, to be mindful of the many negative phrases historically associated with mental health conditions that have become part of the common vernacular and that can be incredibly harmful. To portray people and discuss them realistically, and avoid sensationalizing. When we're talking about someone, to avoid showing a person only in an acute episode or in shock-value behavior, and avoid emphasizing the most shocking and tragic aspects of a situation. To separate the person from the condition. To avoid reducing an individual to their condition. Also, to not make assumptions. When referring to individuals as people living with (or experiencing) mental health challenges, we need to allow for personal choice. The DBSA acknowledges that individuals do have the right to the terminology of their choice, but they do encourage a more wellness-focused language when possible. To defy definitions; use of "mental illness" may imply a perpetual state of abnormality, whereas a mental health condition often presents episodic challenges. And, finally, to accept responsibility. Doing our best to choose language that is accurate, respectful, and caring. Understanding that we all make mistakes, and while preferential terms have and will continue to change, it is always helpful to do your best to keep current on accepted vernacular, to try to always be mindful, and accept that we are all in the process of continual learning. Recently I've heard some shifting language from trauma-informed care to healing-centered engagement, and even, challenging language around use of the word "stigma" rather than the term "discrimination." The Illinois Department of Human Services' Division of Alcoholism and Substance Abuse (DASA) has also just changed their name to the Division of Substance Use Prevention and Recovery (SUPR), in order to be in accordance with strengths-based and recovery-oriented language.

Slide 38
On this slide, we're going to talk a little about Mental Health First Aid, which is a national program that teaches skills around how to respond to signs of mental illness and substance use for individuals that are in distress. A quick overview of this program includes assessment for risk of suicide or harm, listening nonjudgmentally, giving reassurance and information, encouraging appropriate professional help, and encouraging self-help and or other support strategies.

Mental Health First Aid is an 8-hour course that gives people the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy, helping the public identify, understand, and respond to signs of mental illness. If you are interested in learning more about Mental Health First Aid, and training opportunities, please visit their web site www.mentalhealthfirstaid.org for information on a training near you. It is trainings like this that shift the conversation from "What's wrong with you?" to "What happened?"

Slide 39
Some additional strategies to consider when a person is exhibiting distress are to demonstrate empathy and acceptance, to listen with respect while acknowledging and validating feelings, inquire about personal comfort ("What do you need right now?" or "What can I do to help you?"), checking your tone of voice, volume, and body language. Also pay attention to cues and adjusting your responses accordingly.

Slide 40
When interacting with a person who appears to be experiencing paranoia, it might be best to avoid eye contact. Stand abreast of him or her, as if facing a hostile world together, sends a message of comradery and non-confrontation. When dealing with someone who is angry or agitated, listening respectively conveys understanding. Avoid asking too many questions or re-directing immediately. When responding to someone who seems to be actively hallucinating, we encourage you to speak calmly and gently inquire what might make them feel more safe and more comfortable.

Slide 41
A quick cautionary note: There are potentially many reasons or possible causes of "odd" or unusual behaviors, and automatically assuming that a behavior is the result of a mental illness is stigmatizing and erroneous. The Committee on Economic, Social, and Cultural Rights defines discrimination as something that "occurs when an individual is treated less favorably than another person in a similar situation for a reason related to a prohibited ground." In other words, when a person is mistreated or regarded differently than someone else based on their circumstances.

Slide 42
This is a resource that I recently came across and just loved so much I wanted to share with you all. Each year the Substance Abuse and Mental Health Services Administration grants the SAMHSA'S Voice Awards. The Voice Awards program honors people in recovery and their family members who are improving the lives of people with mental illnesses, substance use disorders, or both in communities across the country to support in raising awareness and understanding of behavioral health issues. These awardees stories of resilience demonstrate that recovery is real and possible through treatment and recovery supports.

This awards program also recognizes television and film productions that educate the public about behavioral health, and showcase that recovery is both real and possible. The writers and producers of these productions give voice to people with mental illnesses, substance use disorders, or both by incorporating dignified, respectful, and accurate portrayals of these individuals into their scripts, programs, and productions. The goal behind these awards is to highlight and educate the public about behavioral health. They have been doing this since 2013 and yes, it is an incredible celebration of accomplishments made by individuals and the media in regard to representation and transparency. If you would like to look at this past award winners please visit www.samhsa.gov/voice-awards. Something else that I think is so important about this is in regards to changing views. I mentioned Glenn Close at the opening of this training, and she is just one of many public figures that has increased her presence as a mental health advocate. Many years after portraying the female lead in the 1987 film, Fatal Attraction, Ms.

Close opened up about her regrets as to how this movie contributed to the misunderstanding of mental illness. In an interview with CBS news she stated, “I think as public figures, as entertainers, that we have a moral responsibility to only portray characters, that if, if they have disruptive behavior or behavior that is negative, it has to be responsibly explained. I really do not believe that we can anymore just say, 'Oh, let's make our person somebody mentally ill.' That's really easy because that plays into the stigma that people with mental illness are violent, and that is not the truth. Most people with mental illness are not violent. And, most people who commit violent crimes do not have a diagnosis of mental illness. That is wrong, and it is proven wrong, and it is immoral to keep that perpetrated.”

It is public statements like this that promote the continual evaluation and evolvement of our expectations around media and appropriate representation.

Slide 43
While I am sure that this is something that is deeply etched into the hearts of helpers everywhere, it is always a good reminder to ourselves and others to always be kinder than necessary because everyone you meet is fighting some kind of battle.

Slide 44
On this slide we have some additional resources for you, your teams, and those that you serve. These are just a few among many, and this is in no way a comprehensive list, but is just a sample of services out there.

National Crisis Hotline (800) 866-9600

CASO (Chicago Area Service Office of Alcoholics Anonymous)
(312) 346-1475

Mental Health Association of Greater Chicago
(312) 368-9070

Depression and Bipolar Support Alliance
(773) 465-3280

National Alliance on Mental Illness (NAMI) of Metro Suburban
(708) 524-2582

National Suicide Prevention Life Line
1-800 273-8255

Slide 45
I want to thank you all again so much for your time and for your work towards ending mental health discrimination. Accepting people for who and what they are, and believing that they can do better, is the key to supporting one’s recovery. I had an individual the privilege of working with an individual years ago, and I loved her personal mantra, “I did the best I could today and I can do better tomorrow.”

Slide 46
So on that beautiful note, I would like to thank you all again for all that you do, for participating in this brave conversation, and for supporting recovery in Illinois. Thank you all for being somebody who makes someone else look forward to tomorrow. Take care and have a lovely day.

Slide 47 (announcer)
Thank you for listening. You can obtain additional recordings or download a transcript by visiting the Illinois supported employment transformation initiative web site.