

IN OUR OWN VOICES:  
SPEAKING ABOUT MENTAL HEALTH RECOVERY

A Thesis

Presented to the faculty of the Division of Social Work  
California State University, Sacramento

Submitted in partial satisfaction of  
the requirements for the degree of

MASTER OF SOCIAL WORK

by

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SPRING  
2016

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Division of Social Work

Abstract  
of  
IN OUR OWN VOICES:  
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This study examined how involvement with a mental health speakers bureau impacts the speakers' personal recovery journey. Participants (N=38) were from the Stop Stigma Sacramento Speakers Bureau, and considered themselves to be living in recovery from mental health conditions. Quantitative and qualitative data collected by the author demonstrates that speakers bureaus have the potential to have a pivotal effect on the lives of people living with mental health conditions, their recovery, and their relationships to others living with mental health conditions in their community. The outcomes of this study also demonstrate the importance of having these programs available for people living with mental health conditions. The demonstrated importance comes from the perspectives that matter the most in regards to this topic: people who are living in recovery from mental health conditions themselves.

Francis Yuen, DSW *Committee Chair*

04/20/2016  
Date

## ACKNOWLEDGEMENTS

First and foremost, the author would like to personally thank her mom and dad for their undying support, love, patience, and willingness to listen to her throughout this process (and always).

The author would also like to acknowledge and thank the Sacramento State Division of Social Work, especially Dr. Francis Yuen for his support, guidance, wisdom, and late night responses to her frantic, often catastrophized emails. The author is also very thankful to Dr. Andrew Bein for his mentorship, support and generosity in being willing to be the second reader of this thesis.

In addition, the author would like to thank Crystal Rowland and Julie Leung from Sacramento County DHHS for all of their time and for the support that they offered throughout duration of this process.

Lastly, but also most important, the author is indebted to the members of the Stop Stigma Sacramento Speakers Bureau who participated in the creation of this research and who were willing to lend their voices, feedback, and experience to the research. The author would like to dedicate this thesis to them, as well as to others like her who are living and who have lived with mental health conditions. Here is to life, here is to hope, and here is to recovery.

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## **Chapter 1**

### **INTRODUCTION**

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) estimates that one in five Americans experience mental health conditions in a given year. Despite the fact that 20% of the population experiences a mental health condition, these conditions remain highly stigmatized. Stigma is not a new ordeal. It has affected people living with mental health conditions for many years, and is deeply engrained into society's views about people living with mental health conditions. Much of the stigmatization that affects people living with mental health conditions is the result of myths that are being perpetuated by the media. Rosenberg (2014) points out that often times these stereotypes are fueled by tragic events such as mass shootings. As a result, Holland (2012) notes that the media has consistently portrayed people living with mental health conditions as criminal, violent, and out of control. Unfortunately, these stereotypes lead to the continued stigmatization of people living with mental health conditions (Holland, 2012; Wolf & Rosen, 2015). Thus, although mental health has increasingly become a hot topic, it is not necessarily in a positive way.

#### **Statement of the Problem**

The stigma that people living with mental health conditions face often leads them to experience a great degree of self-stigma as well (Sickel, Seacat & Nabors, 2014). One of the ways in which public stigma and, for the purpose of this research, self-stigma, can be reduced is through programs that are led by people living with mental health conditions themselves. Often called "consumer-led," or peer-led services, programs such

as mental health speakers bureaus have been shown to have a positive impact on both public stigma and self-stigma. Mental health speakers bureaus consist of a group of people living with mental health conditions who speak publicly about their lived experience, put on events for communities to learn about mental health conditions, and seek to break down the stigma that exists towards people living with mental health conditions. Although there is limited information and research that exists about speakers bureaus as it is, there is even less research about how participation in these programs impacts the actual participants who are living in recovery from mental health conditions. Thus, the purpose of this research is to examine how being a member of a mental health speakers bureau impacts recovery. Though there is limited research in the body of literature that is available in regards to this topic, there are studies which examine similar programs, just different aspects of them. These studies will be reviewed in the following Chapter Two. It will seek to better understand the influence of the Affordable Care Act; understanding personal recovery; identity, stages, self-disclosure and “coming out;” indications from existing programs; therapeutic aspects of group membership; speakers bureaus in California; and existing peer-based program challenges.

This study is being conducted in an effort to study the correlation between participation in a speakers bureau and perceived positive recovery. Additionally, this study is being conducted in an effort to bring awareness to the real experience of people living with mental health conditions. Another secondary gain from this study will be bringing attention and awareness regarding speakers bureaus (and other consumer-led programs) to the field of social work and specifically, mental health.

### **Background of the Problem**

Stigma against people living with mental health conditions has long been an issue in the United States, dating as far back as the nineteenth century in the age of institutionalization. Garcia (2010) states that the rise of the asylums during the time of institutionalization came from a fear of difference, the unknown, and an unstable social order. Similar to the experiences of the people who lived in the distant past and were institutionalized, people living with mental health conditions today often face public mental health stigma, or PMHS (Sickel, Seacat, & Nabors, 2014; Holland, 2012). Sickel, Seacat, and Nabors (2014) define public mental health stigma as a social process in which the public perceives someone to be living with a mental health condition based on their behavior, which in turn activates the public's stereotypes about mental health conditions. Stigma has been identified as one of the main barriers preventing people to seek treatment for mental health issues (Sickel, Seacat & Nabors, 2014). The National Alliance on Mental Illness (NAMI), states that without treatment, the consequences of mental health conditions for both the individual and society are detrimental (2015). Some examples of these consequences include: disability, unemployment, inappropriate and unnecessary incarceration, homelessness, and suicide (NAMI, 2015). Additionally, the NIMH estimates that the total costs associated with serious mental health conditions exceed \$300 billion per year in the United States (2002).

The research demonstrates that people do indeed stigmatize others. Vogel et al. (2013) asserted that people who are known to have received counseling services are rated less favorably and treated more negatively than those who had not received counseling

services. They also noted that people who were known to be seeking help for depression were rated as being more emotionally unstable, less interesting, and less confident than those that were seeking help for physical conditions such as back pain. Additionally, in general, the public associates receiving psychological services with not being in control of emotions.

Although PMHS definitely influences one's mental health, Sickel, Seacat and Nabors (2014) stated that PMHS serves as a barrier that also influence other basic human needs such as self-esteem, employment, housing, relationships, and physical health. They found that this barrier influences the individual living with a mental health condition in a significant way. Specifically, when he or she is unable to meet the aforementioned basic needs, it affects the individual's ability to seek out mental health treatment (Sickel, Seacat & Nabors, 2014). Similar to the experience of having multiple stigmas (i.e. being African American, identifying as LGBTQ, and being homeless), the researchers found that PMHS can negatively influence an individual's desire to want to get treatment due to the fact that the individual is often aware that they may be stigmatized for it.

Different from public mental health stigma, understanding the concept of self-stigma and its impact on mental health is equally as important for the proposed research. Self-stigma can have many effects on one's mental health and can ultimately influence whether or not someone is able to recover. Corrigan, Kosyluk and Rusch (2013) have collected data about self-stigma and mental health and have conducted their own studies about self-stigma. The researchers found that people living with mental health conditions who struggle with self-stigma also experience lower self-esteem and self-efficacy which

ultimately may interfere with their mental health condition, achievement of personal goals, and participation in treatment. This can be attributed to identity threat, which the researchers defined as the harm that occurs when an individual's sense of self is challenged as a result of being associated with a stigmatized group. The researchers found that self-stigma may cause some people living with mental health conditions to detach from their pursuit of goals related to independent living, such as obtaining employment in their community. Corrigan, Kosyluk, and Rusch (2013) attributed this to the "why try" effect which can influence people living with mental health conditions to think pessimistically about reaching their goals. One of the examples given by the researchers was "Why try to seek out a job? I am not worthy of it." The researchers mentioned that the "why try" effect is related to modified labeling theory. According to this theory, when people perceive being devaluated, they tend to avoid situations where public discrimination and/or disrespect are anticipated.

In terms of reducing stigma, research has demonstrated that the public is less likely to hold prejudicial attitudes and discriminating behaviors when they have made contact with people who are living with mental health conditions (Corrigan & Matthews, 2003). In other words, exposing the general public to people telling their stories and coming out about their mental health conditions helps to reduce public mental health stigma. One of the ways in which the public can be exposed to people telling their stories is through mental health speakers bureaus. According to Carpenter (2002), programs such as mental health speakers bureaus promote recovery for the individuals involved with

them, and have consistently demonstrated positive outcomes in terms of reducing public mental health stigma.

### **Statement of the Research Problem**

Despite the impact of consumer-led service such as mental health speakers bureaus on stigma, there is little existing research available regarding how involvement with a speakers bureau affects the members of the speakers bureau themselves and their own personal recovery. Without enough research attention, there is little awareness about speakers bureaus and the positive impacts they can have on people living with mental health conditions, and their recovery process. This can affect opportunities for possible funding, as well as opportunities for people living with mental health conditions to get involved with a program such as a speakers bureau. Thus, this thesis focuses on how the experience of being a member of a mental health speakers bureau affects participants' recovery. This research question is examined from the perspectives of the individuals living with mental health conditions who are involved with a mental health speakers' bureau. The research will provide insight as to how speakers bureaus affect the recovery of its participants. Specifically, it will examine how these programs can empower participants; how the experience of being part of a cohesive group like a speakers' bureau can promote empowerment in itself; and how being a member of speakers bureau may be able to fill in some of the existing gaps that remain from purely clinically-based interventions.

### **Study Purpose**

This study aims to explore the benefits of being a member of a mental health speakers bureau and how the experience of being a member affects participants' recovery. This will be demonstrated by responses from participants from the Stop Stigma Sacramento Speakers Bureau using a SurveyMonkey questionnaire. A secondary purpose of this study is to increase awareness for social workers and other clinicians about consumer-led programs such as speakers bureaus. Additionally, one of the goals of this study is to inspire social workers to familiarize themselves with consumer-led programs so that they can learn about the needs and concerns of the populations that they are serving from the individuals that identify as part of those populations themselves

### **Theoretical Framework**

#### **Empowerment Theory**

Theoretical assumptions: Empowerment theory, which has roots in feminist theory, is a social justice theory which acknowledges that oppression exists in society (Zimmerman, 2000). Empowerment theory is based on the concept of empowerment, which is defined by Perkins and Zimmerman (1995) as the process by which individuals, organizations, and communities seek to gain control over issues involving them. Perkins and Zimmerman (1995) state that community empowerment specifically refers to individuals working together in an organized way in order to improve their lives and to improve the connections they have to community organizations and agencies which also have the goal of improving their quality of life.

Application of Empowerment Theory: The previously mentioned concept of oppression can be applied to the concepts of stigma, self-stigma, and how it affects recovery. This theory will provide a possible explanation as to why involvement with a speakers' bureau is empowering and helps to decrease self-stigma. For the purpose of this project, empowerment theory serves as a strong foundation for explaining what motivates individuals with lived experience to step out of their immediate social circle and/or comfort zone to become involved with a speakers' bureau. It guides the author's research question of how involvement with a speakers' bureau impacts recovery in the way that it is assumed that the involvement is empowering for the individual involved. According to Perkins and Zimmerman (1995), empowerment theory links individual health and wellness with more macro-level agents of change in society such as the individual's surrounding community, and politics. In other words, a person's health and wellness plays a factor into why he or she decides to connect with his or her surrounding community, social and political environment.

### **Recovery Paradigm**

Theoretical Assumptions: The recovery paradigm can be viewed as an alternative to the medical model of disease (Gehart, 2012). According to Barton (1998), the recovery paradigm holds the idea that people living with mental health conditions assume responsibility for their lives by making choices and learning from that process, and part of that process involves professionals affirming the person's choice. The recovery "philosophy" holds four main values. The first value is wholeness, or integrated services for people living with mental health conditions. The second value is client-centered

services, which should be individualized based on the person's needs. The third value is hope, which acknowledges that people living with mental health conditions can live a good and fulfilling life. The final value is partnership, which refers to professionals working collaboratively with people who live with mental health conditions, their families, and other health care professionals (Barton, 1998).

Application of the Recovery Paradigm: Unlike the medical model of disease, which places an emphasis on symptom management and learning functional skill development, the recovery paradigm places an emphasis on aspects such as hope, optimism, and self-determination. It is important that people living with mental health conditions are viewed through a lens which recognizes that recovery from mental health conditions is possible and that recovery is a journey, rather than a destination. In the context of a speaker's bureau, the recovery paradigm can be applied in order to understand the process of recovery, and how it is possible for members of a speaker's bureau to come to a point in their recovery to where they are comfortable with and are willing to share their story with the community.

### **Social Contact Theory**

Theoretical Assumptions: Corrigan and Matthews (2003) noted that there are three ways of changing public mental health stigma. The first of these is protest. According to Corrigan and Matthews (2003), protest strategies highlight how stigma is unjust and ultimately can lead to a moral decision for people to stop thinking in that way. The second way to change public stigma is through education. The researchers mentioned that education strategies have mainly focused on changing the conversation about mental

health conditions. Specifically, they focus on replacing myths (i.e. people living with mental health conditions are violent) with facts (i.e. people living with mental health conditions are twice as likely to be the victim of a violent crime than they are to be the perpetrator). The third of way of changing public mental health stigma is through contact. People who interact with a person living with a mental health condition who is part of and is leading an anti-stigma program show significant changes in their attitudes towards those living with mental health conditions (Corrigan et al., 2001). Contact has been shown to yield the best results in challenging stereotypes, prejudice, discrimination and ultimately, public mental health stigma.

Social contact theory states that the public is less likely to hold prejudicial attitudes and participate in discriminating behaviors against people living with mental health conditions (both forms of public mental health stigma) when they have made contact with people who are living with them (Corrigan & Matthews, 2003). Corrigan and Matthews (2003) note that contact is most easily understood in terms of familiarity. Research shows that people who are familiar with individuals living with mental health conditions are less likely to hold prejudicial attitudes. Additionally, contact has been shown to yield the best results in challenging stereotypes, prejudice, discrimination and ultimately, public mental health stigma.

Application of Contact Theory: As previously mentioned, the level of public mental health stigma that an individual living with a mental health condition experiences affects his or her levels of self-stigma. If public mental health stigma is reduced by members of speakers bureaus making contact with the public, it provides an opportunity

for more awareness of what mental health conditions really look like to be noticed which in turn creates change. Additionally, this can have an impact on a member of a speaker's bureau when he or she realizes that they are part of the change that is happening.

### **Definitions of Terms**

**Mental Health Condition:** Mental health conditions are more frequently known to the public as mental illnesses, or mental disorders. According to the National Alliance on Mental Illness (NAMI, 2015), a mental health condition is a condition that affects a person's thinking, feeling, or mood which in turn may affect his or her ability to have relationships and/or function on a daily basis. For the purpose of this research, the term mental health condition will be used instead of mental illness or mental disorder in order to alleviate some of the stigma associated with having one of these health conditions.

**Mental Health Parity:** SAMSHA (2016) defines mental health parity as having the same health insurance coverage for mental health and/or substance abuse conditions that someone with a physical condition such as heart disease would have.

**Recovery:** According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) *Working Definition of Recovery: 10 Guiding Principles of Recovery* (2012), recovery can be defined as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (p. 3). It is important to mention that the definition of recovery varies widely and may be different from one individual to another.

Stigma: The President's New Freedom Commission on Mental Health (2003) defines stigma as "A cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses" (2003). Stigma can be direct or indirect, and it often results in the stereotyping and shaming of people living with mental health conditions.

Self-stigma: Self-stigma (also known as internalized stigma) is defined by Boyd, Otilingam, and DeForge (2014) as, "the psychological point of impact" of public mental health stigma on people living with mental health conditions. Quite simply, it is the stigma that people living with mental health conditions have towards themselves. Self-stigma is associated with depression, reduced self-esteem, reduced empowerment, and decreased motivation to pursue personal goals (Corrigan, Kosyluk, & Rusch, 2013; Boyd, Otilingam, & DeForge, 2014).

## Chapter 2

### REVIEW OF THE LITERATURE

The purpose of the study is to explore how involvement with a speaker's bureau impacts the personal recovery journey of the participants. The study is being conducted in order to gain a better understanding of programs such as speakers bureaus which are thought to promote recovery. With this information, more awareness of recovery, speakers bureaus, and their importance will be available. States, counties, etc. that want to implement these sorts of programs will have a better understanding of the benefits of having them in place.

The review of literature will explore major emerging themes in the current research that is related to mental health, recovery, and being "out" about one's mental health condition. It will also explore the impact that involvement with a speaker's bureau has on recovery. The themes include the influence of the Affordable Care Act; understanding personal recovery; identity, stages, self-disclosure and "coming out;" indications from existing programs; therapeutic aspects of group membership; speakers bureaus in California; and existing peer-based program challenges. Finally, this review on literature will conclude with a description of the current gaps in the literature and will offer an explanation of how the proposed research will fill in those gaps. Before the themes are explored, however, an overview of the changes to mental health policy that have occurred as a result of the Affordable Care Act will provide insight as to what brought about programs such as mental health speakers bureaus.

### **Mental Health Parity and the Affordable Care Act**

It is estimated by the National Institute on Mental Health that one in five people in the United States live with a mental health condition (2014). According to Garcia (2010), 15% of those adults (many of which are uninsured) use mental health services in a given year. For this reason and more, Congress enacted the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act (MHPAEA) which extended health insurance coverage as well as the scope of coverage to include mental health and substance abuse treatments. According to Frank, Beronio, and Glied (2014), prior to the passage and implementation of the MHPAEA, approximately two thirds of people with health coverage had limits on inpatient behavioral health coverage and nearly three quarters also faced limits on outpatient behavioral health coverage. Additionally, approximately one quarter of people with health insurance coverage had a plan that required higher levels of cost sharing for behavioral health services.

The history of mental health parity and treatment in the United States dates all the way back to the nineteenth century. Many Americans are familiar with the history of institutionalization: the creation of state mental asylums to house the mentally ill. According to Garcia (2010), the rise of these asylums is often seen as the result of fear of differences, and of instability in regards to social order. Eventually, after World War II, people began to notice major problems that existed around state asylums. They tended to be overcrowded (37% of discharges from the military at that time were due to mental health conditions or mental deficiency) had poor conditions, and to many people they appeared to serve little purpose aside from being a holding place for people living with

mental health conditions. In other words, they were very different from environments that treated people who were physically ill.

Fast forward to the age of the Affordable Care Act. The Department of Health and Human Services (2013) notes that the Affordable Care Act expanded mental health and substance abuse coverage, making it so employers would be required to cover them at parity with other health conditions. The idea of mental health parity has gotten a lot of attention, as has the idea that people can recover from mental health conditions similar to how someone living with a physical illness can recover. This view validates the biological component of mental health conditions. However, this idea has conflicting views. One of the arguments in opposition to the idea of parity is that unlike many physical illnesses, there is no definitive “cure” for mental health conditions (Wolf & Rosen, 2015). Thus, the closest thing to a “cure” is recovery. However, recovery in the context of mental health conditions is a subjective experience. It is different for every individual that experiences it. For example, Wolf and Rosen (2015) state that in many cases of mental health conditions, in order to experience relief from symptoms, treatment such as prescribed medication, therapy, etc. must continue over the course of an individual’s lifetime. However, some individuals reach a point of recovery without ever taking prescribed medication or attending therapy. On the opposite end of the spectrum, some people take medication, participate in therapy, etc. and may never reach a point of recovery.

### **Understanding Personal Recovery**

Since the late 1980s and early 1990s, recovery has increasingly been of interest to mental health researchers, providers, and policy makers (Kartalova-O'Doherty & Doherty, 2010). Additionally, in recent years, SAMSHA (2012) has identified recovery as being a primary goal for behavioral health. According to Williams et al. (2012), personal recovery (which differs from the definition of clinical recovery) is defined by people living with mental health conditions as a way of living a meaningful life despite any of the limitations caused by their mental health condition. In mental health care, recovery is an individual-centered approach that is framed by principles such as hope, optimism, and self-determination (Hungerford & Fox, 2014). Although recovery is an individual experience, there are some common themes that emerge from the literature. Some of these include hope; taking self-responsibility; empowerment; support from others; having meaningful activities to participate in; and through self-acceptance, being able to establish a positive identity (Williams et al., 2012; Kartalova-O'Doherty & Doherty, 2010).

Kartalova-O'Doherty and Doherty (2010) assert that another aspect of recovery is that it has having phases, dimensions, indicators, as well as. They describe that research has identified three general stages of recovery. These include being overwhelmed by the mental health condition, struggling with the mental health condition, and living life beyond the mental health condition. Additionally, there are three major steps that have been associated with achieving a point of recovery: developing an explanation for

understanding one's mental health condition, gaining control over the mental health condition, and moving into meaningful, productive, and valuable roles in society.

Along those same lines, SAMSHA (2012) identified four major dimensions that support a person who is in recovery from mental health conditions: health, home, purpose, and community. Health refers to overcoming or managing one's symptoms, as well as making informed, healthy choices that support recovery, physical, and emotional wellbeing. Home refers to a stable and safe place to live. Purpose refers to having meaningful daily activities such as a job, school, volunteering, and having the independence, income, and resources to fully participate in society. Community refers to the relationships and social networks in a person's life that provide support to them, friendship, love, and hope (SAMSHA, 2012).

SAMSHA also identified 10 guiding principles of recovery. The first of these guiding principles is hope. Hope allows the individual in recovery to believe that recovery is real, and that it is possible to overcome the challenges, barriers, and obstacles that confront them as a result of living with a mental health condition. Hope is also the true catalyst of the recovery process. Recovery is also person-driven (the second guiding principle). Self-determination and self-direction allow the individual to define his or her own life goals and to design his or her own unique path towards those goals. Additionally, this guiding principle allows individuals to be empowered and make decisions to help regain control over their own lives. SAMSHA (2012) also states that recovery occurs as a result of many pathways (the third guiding principle). Individuals are unique with distinct needs, strengths, cultures, and backgrounds. Thus, an individual's

background which can also include trauma experience, also affects and determines their pathway to recovery. Pathways to recovery are very highly personalized. Whereas for one person, professional clinical treatment or the use of medications may suffice, for another, faith-based approaches may be one of the most important components. It is a highly individual experience. Recovery is non-linear and is marked by continual growth and improved functioning which at times can also include setbacks. However, regardless of set backs it is important to foster resilience in the lives of people living with mental health conditions, and to create a supportive and non-stigmatizing environment (SAMSHA, 2012).

The fourth guiding principle is that recovery is a holistic process. It is a process that encompasses an individual's entire life, including his or her mind, body, spirit, and community (SAMSHA, 2012). Thus, multiple areas of living need to be addressed including but not limited to self-care practices, spirituality, primary healthcare, creativity, family, housing, employment, and transportation. Along those same lines, the fifth guiding principle is that recovery is supported by peers and by allies. Mutual support groups often play a huge role in this. In many ways, a speaker's bureau can be categorized as a mutual support or mutual aid group. In a speaker's bureau, peers encourage each other and share experiential knowledge and skills, all of which play a vital role in recovery. Additionally, a speaker's bureau provides an opportunity for speakers to give back to the community which also fosters recovery. Clinicians can also play a role in a person's recovery process by providing treatment and other services that support individuals in their chosen paths to recovery.

The sixth guiding principle states that recovery is supported through relationships and social networks. The presence and the involvement of people who believe in the individual's ability to recover and are able to offer hope and encouragement throughout the process are an invaluable part of the person's recovery (SAMSHA, 2012). SAMSHA states that "Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (i.e. partner, friend) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion and community participation" (2012, p. 6). The seventh guiding principle according to SAMSHA is that recovery is culturally-based and influenced. Values, traditions, and beliefs are all key components in determining a person's journey and pathway to recovery (SAMSHA, 2012). Thus, services should also be culturally grounded, sensitive, and competent, as well as personalized for every individual.

Recovery is also supported by addressing trauma such as physical or sexual abuse, domestic violence, war, disasters, and more (the eighth guiding principle). The aforementioned traumas can often be precursors to or associated with alcohol and drug use and mental health issues. SAMSHA asserts that, "Services and supports should be trauma-informed to foster safety and trust, as well as promote choice, empowerment, and collaboration" (2012, p. 7). The ninth guiding principle is that recovery involves individual, family, and community strengths and responsibility. All of these things serve as a foundation for recovery. Individual responsibility refers to the fact that people living with mental health conditions should always be supported in speaking for themselves. Individuals also have a social responsibility to join with peers to speak collectively about

their strengths, needs, wants, desires, and dreams, and to combat challenges together. Families and loved ones have a responsibility to support their loved ones who are living with mental health conditions. Communities have responsibilities to provide opportunities and resources to address issues such as discrimination and stigma, and to foster resilience and recovery in its community members (SAMSHA 2012). Lastly, the tenth guiding principle is that recovery is based upon respect. The acceptance of people living with mental health conditions and substance use problems at the community, systems, and societal levels (which includes the protection of their rights and eliminating discrimination) are crucial for individuals achieving recovery. Taking steps towards recovery requires great courage, thus, self-acceptance and believing in one's self is extremely important (SAMSHA, 2012).

### **Identity, Stages, Self-Disclosure, and “Coming Out”**

As previously discussed, self-stigma is a barrier to seeking treatment for mental health conditions. Corrigan et al. (2010) pointed out that although there have been efforts in the past decade to attempt to challenge stigma that exists in the public, these efforts are not easily applied to self-stigma. There are several reasons for this, one of which is related to the identity of having a mental health condition. Corrigan, Kosyluk, and Rusch (2013) stated that one of the reasons that people often don't “come out” about their lived experience may be because the prominent medical perspective (focused on eliminating disease), recommends that people distance themselves from the “identity” of having a mental health condition and limit self-disclosure. According to Corrigan et al. (2010), the main reason is that the experiences of living with a mental health condition and receiving

treatment for it is often times hidden by the individual experiencing it. Both Corrigan, Kosyluk, and Rusch (2013) and Corrigan et al. (2010) bridged the connection to the Lesbian, Gay, Bisexual, Transgender and Queer community (LGBTQ) in that the LGBTQ community is not easily recognized unless they choose to come out about it or identify themselves. In other words, people living with mental health conditions are similar because they are not often obvious unless they choose to discuss their mental health status or history (Corrigan et al., 2010). Corrigan et al. (2010) stated that this is often to protect oneself from additional stigma, discrimination, and social isolation.

According to Pachankis (2007), there are benefits to being “out” about one’s mental health status. Sharing one’s lived experience can be empowering and has been shown to enhance self-esteem (Corrigan, Kosyluk, & Rusch, 2013) and are less likely to experience self-stigma (Corrigan et al., 2010). . Corrigan et al.’s (2010) studied eighty-five individuals who identified themselves as having serious mental health conditions. Their findings suggest that people who are out about their mental health conditions experience less self-stigma, better quality of life, report personal empowerment, and are overall more satisfied with life than they were when they were not out about their mental health conditions.

### **Indications from Existing Programs**

Corrigan, Kosyluk, and Rusch (2013) discussed programs that have been developed to reduce the effects of self-stigma towards mental health conditions. Out of these programs, it was found that one of the most common ones was a psychoeducational approach where participants are taught various facts that dispute the typical stereotypes of

people living with mental health conditions. Additionally, the aforementioned researchers assert that the psychoeducational experience is often led by a participant who has experienced stigma related to a mental health condition his or herself. In terms of relevance to the proposed topic, the psychoeducational experience is similar to the experience of a speakers' bureau.

Along those same lines, Corrigan, Vega, Larson, Michaels, McClintock, Krzyzanowski, and Gause (2013) did a study about consumer-based antistigma programs in California. It was a qualitative study that featured interviews from 4 agencies in California. From this study, the researchers found that according to those agencies, the most effective contact-based antistigma programs are provided face-to-face with a trained presenter being matched with the target audience. An example of this is having a member of the LGBTQ community who lives with a mental health condition speak to LGBTQ community members. Additionally, the researchers found that in order to be effective the antistigma programs must be held in the target audience's setting which requires the presenters to travel to that setting. Corrigan et al. (2013) also spoke to the importance of providing take-home information as well as being aware of the audience size (between the numbers of 5 and 50). The importance of having a discussion as part of the presentation was also discussed. This way, it allows audience members and the presenter the opportunity to discuss questions and answers, and for any audience members to disclose their own lived experience, if applicable. The researchers concluded by stating that presenters should be compensated for their work (Corrigan et al., 2013).

One of the major areas of research related to similar existing programs are peer-led, or peer-based programs. A speakers' bureau is considered an example of one of these types of programs. All of the speakers in the bureau either live with a mental health condition and receive or have received mental health services, or are family members of people who do. Although all of the speakers must participate in an initial orientation and training, which offers helpful techniques for telling one's story, it is up to the speakers to come up with their own narrative and to tell their story in their own words.

Peer-led programs have been shown to have positive effects on recipients; less discussed however is the idea that working as a peer can also have positive effects on the peer leaders themselves (Salzer et al., 2013). To demonstrate this, Salzer et al. (2013) conducted a study based on the benefits of working as a Certified Peer Specialists (CPS) in Pennsylvania. Results indicated that the majority of the respondents agreed that the CPS training gave them confidence to continue doing things that would further their recovery (Salzer et al., 2013). Additionally, most of the participants believed that their work that they did as CPS was satisfying, meaningful, and allowed them to give back to their community (Salzer et al, 2013). This sense of purpose and meaning is a common theme amongst members of speakers bureaus.

### **Therapeutic Aspects of Being a Member of a Group**

Irvin D. Yalom considered 11 therapeutic factors to be curative forces that typically occur in groups such as a speaker's bureau, and which are essential for positive change to occur (Alle-Corliss & Alle-Corliss, 2009). The first of these factors is the instillation of hope. According to the researchers, one of the most crucial components of

a group setting is the leader's belief in the value of their work and the power of the group. Group leaders who encourage positive change set a hopeful tone that only grows as members witness growth in themselves and in their peers. This factor can be applied to a mental health speaker's bureau context in the way that many speakers bureaus begin with only a few members. Over time, they continue to grow in terms of numbers of members when other people living with mental health conditions become aware of its existence and want to become involved. When some of the original members participate and encourage involvement among the other newer speakers, it fosters positive growth not only in the context of the individuals involved, but also in the context of the group itself.

The second therapeutic factor is universality. Alle-Corliss and Alle-Corliss (2009) state that as a group progresses and grows, its members become more aware of the universality of their life issues which in turn encourages cohesion, catharsis and therapeutic gains. In a mental health speaker's bureau context, the realization that each speaker is not alone or abnormal in their experience with living with a mental health condition encourages cohesion in the group, and also allows each individual to feel supported by the other group members. As a result, there is a general understanding among the members of the speaker's bureau that they are not alone and that they have others to support them when they are struggling with issues such as loneliness, which other group members may have experienced.

The third therapeutic factor is imparting information. Imparting information refers to when group members directly or indirectly share information with other members that is therapeutic in nature (Alle-Corliss & Alle-Corliss, 2009). In a mental health speaker's

bureau context, sharing information can come in the form of a member living with anxiety talking about a certain method for reducing their anxiety (such as mindfulness techniques) that works for them. As a result, other members are able to learn from the member who has shared his or her experience which in turn may foster the other members' own recovery processes, and allow them to manage their anxiety more effectively.

Altruism is the fourth therapeutic factor. Altruism can be described as the way that "Members gain through giving, not only in receiving help as part of the reciprocal giving-receiving sequences, but also in profiting from something intrinsic to the act of giving (Alle-Corliss & Alle-Corliss, 2009, p. 38). Additionally, according to the researchers, altruism allows the opportunity for people to be active and engaged members in groups, which allows them to realize that they are not only working toward their own positive change, but are also helping other members. In the context of a mental health speaker's bureau, altruism can happen in two different ways. The first example of altruism is between members of a speaker's bureau, and the second can be applied to a community setting when members of the speaker's bureau interact with community members and other stakeholders.

The fifth therapeutic factor is the corrective recapitulation of the primary family group. This factor refers to the fact that being part of a group often resembles a family (Alle-Corliss & Alle-Corliss, 2012). Just like in many families, in groups, there are often times authority and parental figures (or leaders), peer and sibling figures, and there are often deep personal revelations, strong emotions, deep intimacy, and sometimes hostile

feelings or competitiveness. Additionally, members of a group are often able to experience a more positive way of relating to other members which did not originally occur in their own families of origin (Alle-Corliss & Alle-Corliss, 2012). In the context of a mental health speaker's bureau, a family type resemblance can occur between members as a result of relating to each other about the experiences that they may share.

Imitative behavior is the seventh therapeutic factor, and it refers to the fact that group members can learn social skills by imitating the behaviors that are observed in the group environment (Alle-Corliss & Alle-Corliss, 2012). One example of this is that when positive actions of other group members are demonstrated such as assertiveness, other members can perform those same actions. When a positive behavior is learned, it can lead to both individual and group growth (Alle-Corliss & Alle-Corliss, 2012). An example of this in a mental health speaker's bureau setting is that members of speakers bureaus who maybe are not so comfortable with public speaking at first can learn tips from other members.

The eighth therapeutic factor is interpersonal learning. This therapeutic factor refers to the fact that in groups, members transfer interpersonal learning from the group to other interpersonal relationships outside of the group (Alle-Corliss & Alle-Corliss, 2012). Group members are able to learn about their own behaviors through constructive feedback from other members. In a mental health speaker's bureau, this takes the form of members learning things from other members that they can try, or do to promote recovery in their own lives. The insight from other members that is provided by other members can become an important component of an individual's own recovery process.

Group cohesiveness is the ninth therapeutic factor. According to the researchers, group cohesiveness refers to the fact that being part of a group allows group members to join together with other group members to develop a sense of “we-ness” which promotes a sense of connection. Group cohesiveness is achieved when members feel trusting enough to let other members know them in a meaningful way (Alle-Corliss & Alle-Corliss, 2012). In a mental health speaker’s bureau, this therapeutic factor can be achieved when members get to know each other and each other’s experience in a more intimate way. This can be done through methods of social media (such as Facebook or Instagram) or in the form of in-person interactions. Additionally, the more cohesive a group is, the more positive the therapeutic outcome. Thus, in the case of a mental health speaker’s bureau, the more cohesive the members of the bureau are, the more effective it can be on the member’s recovery process, and in general as a community program.

The tenth therapeutic factor is catharsis, or a therapeutic way for members of the group to be able to express their emotions and thoughts freely and outwardly to the other members of the group (Alle-Corliss & Alle-Corliss, 2012). Alle-Corliss & Alle-Corliss (2012) note that catharsis and cohesion often go hand in hand with each other. For example, if a group member feels like the group is cohesive enough, they may feel comfortable sharing their own emotions and thoughts, which builds more cohesiveness and also creates a trusting as well as an open atmosphere.

The eleventh and final therapeutic factor takes the form of existentialism. Existentialism refers to aspects of life such as mortality, freedom and responsibility for each person’s own lives, and the search for meaning (Yalom & Leszcz, 2005). In a group

context such as a speaker's bureau, this takes the form of being able to give back to the community, and a sense of purpose and meaning. It also takes the form of being able to recognize that each member of the group is accountable to him or herself.

### **Speakers Bureaus in California**

California's Proposition 63, also known as the Mental Health Services Act (MHSA), was passed in November 2004. According to SpeakOurMinds.org, Proposition 63 has helped provide some of the funding and the framework that is needed to assist with shifting the community mental health system from a crisis-driven system to a system focused on prevention, wellness, and recovery (2015). Additionally, Proposition 63 allowed for the expansion of mental health services to reach vulnerable populations and California's diverse communities which were previously underserved (Prop63.org, 2015). The MHSA provides funding for community services and supports, prevention and early intervention (PEI), housing, innovation, capital facilities, technology and workforce investment and training.

PEI specifically includes consumer-driven services, including mental health-related speakers bureaus. As previously mentioned, since the implementation of Proposition 63 in 2005, speakers bureaus in California have become increasingly more prominent. One of the projects related to PEI in Sacramento County specifically is project 3 which includes community education, outreach, a multimedia campaign to reduce stigma and discrimination (the "Mental Illness: It's Not Always What You Think" project), and the Stop Stigma Sacramento Speaker's Bureau. The Stop Stigma Sacramento Speaker's Bureau held their first training for potential members in May

2012. According to Stop Stigma Sacramento's website, the goals of this program are to reduce stigma and discrimination, promote mental health and wellness, and to inspire hope for people and families living with mental health conditions. Since 2012, 110 speakers have been trained, and 43 are currently considered active speakers. Each speaker has one or multiple specialty subject areas that they talk about (such as depression, anxiety, psychosis, etc.). There is a wide variety of kinds of events and locations that speakers have spoken at, tabled at, or participated in while representing the speakers bureau. Law enforcement, education, and mental health professionals are some of the more common audiences at speaking events. The Summarized Project Period hand-out demonstrates that the speakers bureau is very well received in Sacramento County. From May 2012 – December 2015, there were 129 speaking events, and 5,613 audience members reached. Surveys from audience members show that many local people are learning about mental health conditions and how stigma impacts people living with them as a result. For example, eighty-five percent (N=671) of audience members agreed that the presentations given by speakers increased their understanding of how stigma affects people living with mental health conditions. Other counties in California have also incorporated similar projects for consumers to tell their stories of hope, wellness, and recovery.

### **Peer-Based Program Challenges**

Although peer-based programs have been shown to have a great deal of value, there have been several challenges, most of which can be classified as being environmental (Alberta, Ploski, & Carlson, 2012). Certain organizations and systems of

care that are built specifically around professionally credentialed staff often embrace a culture that does not welcome, nor see the value and effectiveness of peer-based services. An example of how this can happen is that someone may be hired for a peer based program and be given a role (i.e. driving clients to their appointments) which although may be important, does not utilize the skills and experience that the person may be able to offer. Some other reasons why this may occur might include difficulties with integration (especially when credentials and academic training do not match that of other staff members), ambiguity regarding roles and regulations, and staff weariness about giving up responsibilities as clinicians (Alberta, Ploski, & Carlson, 2012).

Another set of challenges that Alberta, Ploski, & Carlson (2012) identified are of an individual nature. An example of how this could manifest in a peer-based program is that a person hired to provide peer-based services may act more like a clinician than as a peer (Alberta, Ploski, & Carlson, 2012). This can happen if peer support staff hold the belief that since they received mental health services themselves, that they know what it means to work in a behavioral health setting, and that they can replace the role of a clinician in the treatment of an individual (Alberta, Ploski, & Carlson, 2012). As a result, the weariness that some clinicians may already hold regarding having peer-support staff in the organization may increase. Other individual challenges include the need to train and supervise peer-support staff.

In a behavioral health context, it is important to recognize the value of clinicians and peer support staff, and how each one can contribute to the treatment of a person living with a mental health condition. It is possible to combat both environmental and

individual challenges. One way to combat environmental challenges is to encourage the level of cooperation in an agency between licensed clinicians and staff, as well as peer support staff (Alberta, Ploski, & Carlson, 2012). One way to combat individual challenges is to have administration provide trainings for peer support staff around topics such as supervision and boundaries.

### **Summary of the Review of the Literature**

In conclusion, the review of the existing literature indicates that there are distinct benefits for having peer-led programs to promote recovery while there is a need for further research on the topic of mental health speakers bureaus. Although some speakers bureaus have been researched, much of the research is quantitative or is focused on how the audience is impacted, rather than how the speaker is impacted. How involvement in a speakers bureau affects recovery is one area of the research that has not been given proper attention. This study strives to fill in that gap by contributing research to the body of literature that is not only quantitative but also qualitative in nature, and focuses on how involvement with a speakers bureau impacts the speaker's personal recovery journeys.

## **Chapter 3**

### **METHODOLOGY**

This chapter presents the methods used to conduct the study and includes the following sections: Study objectives, study design, study population, study sample, study questions, human subjects protocol, data collection process, instruments, and the data analysis plan.

#### **Study Objectives**

The objective of this study was to analyze participants' responses to questions pertaining to their experience being involved with a speakers' bureau and how it has impacted their personal recovery journey. The researcher utilized a non-probability purposive sample of 38 members of the Stop Stigma Sacramento Speakers Bureau as the source of analysis. It is expected that the findings of this study will not only raise awareness about speakers bureaus and benefits of participation but will also allow for the actual voice of the speakers to be heard.

#### **Study Design**

The design of this study is descriptive in nature with both quantitative and qualitative elements. The rationale for utilizing a descriptive design is that this design is able to describe the nature of the relationship between participation in a speaker's bureau and recovery. This study involved surveying speakers involved with a mental health speakers' bureau. The participants are all people living with mental health conditions.

The survey results from this study were both quantitative and qualitative. The quantitative data results were analyzed using SPSS software, and the qualitative data

were organized and analyzed by themes. Although numeric data is used more frequently, both quantitative (numeric) and qualitative (thematic) data were featured in this study because both kinds of data are important to consider regarding this topic. Additionally, it was the researcher's goal to include qualitative data in this study in order to shed light on the speaker's actual experiences, in their own words and voices. According to Steinberg (2004), qualitative data is characterized by data collected through words and quantitative data is data collected in numerical form.

The study questionnaire included 26 closed-ended questions and 2 open-ended questions which featured topics relevant to recovery and dynamics of being part of a group such as that of a speaker's bureau. Participation in this study was voluntary, and participants were not required to answer every question. The responses presented in this study will for the most part present as statistics or as themes. The results section includes quotes from survey participants, however all identifying features are removed.

### **Study Population**

Participants in this study included speakers from local mental health speakers bureaus. The speakers came from different backgrounds, however there was not as much diversity in the demographics such as gender and ethnicity as the researcher had originally hoped there would be. There was, however, diversity as far as the number of years that participants had been diagnosed, and how many years that the participants had been part of a speaker's bureau. Since the researcher identifies as a speaker herself, access to the speakers was not difficult to achieve. All of the participants were voluntary. Some of the participants were recruited by a Sacramento County Health Educator by

means of electronic mail, and others were recruited through a “secret” Facebook group for speakers. There are 38 participants in the study and information was collected using SurveyMonkey.com in an anonymous and confidential format. Participants were not required to answer each question. The researcher did not experience conflicts of interest in the process of interacting with participants since she does not know who participated in this study and who did not. Additionally, the researcher was not employed with a speaker’s bureau of any kind and was not in a position that could jeopardize the participants opportunity to participate in speaking engagements and speaker bureau-related events in the future.

### **Study Sample**

The researcher collected data from October 2015 – December 2015. Due to time restrictions associated with completing a thesis and a limited number of available participants in the Sacramento area involved in mental health speakers bureaus, the researcher was able to survey 38 participants. This convenience sample consisted of individuals who are personally living with a mental health condition and who are members of a mental health speaker’s bureau. Due to confidentiality requirements in Sacramento County, the participants that were recruited by a Health Educator could not be emailed directly. This presented as a challenge to recruitment since the author was unable to email any of the participants herself and had to rely on secondhand communication. The exception to this was the individuals that the researcher knew already through her own participation in a speaker’s bureau and social media platforms such as Facebook.

### **Data Collection Tool**

The study questionnaire (See Appendix 1) included 26 closed-ended questions and 2 open-ended questions which featured topics relevant to recovery and dynamics of being part of a group such as that of a speaker's bureau. Some of the dynamics that were explored included empowerment, peer support, self-awareness, and motivation to stay in recovery. The survey consisted of 28 total questions. There were twenty-six Likert scale questions and two open-ended questions. Additionally, there were seven questions pertaining to the demographics of the sample including gender, age, ethnicity, level of education, the number of years since they were initially diagnosed, the average number of speaking engagements/events that they participate in per year, and the number of months/years that they've been involved with a speaker's bureau. The questions featured in the study were designed to gain an understanding of the participants' experience being involved with the speakers' bureau; how the speakers' bureau has impacted the participants' lives as people living in recovery from a mental health condition; and how the participants' recovery has been impacted by their involvement.

### **Human Subjects Protocol**

In compliance with the guidelines set by the California State University, Sacramento Committee for the Protection of Human Subjects Protocol, the researcher submitted a Request for Review by the Sacramento State Institutional Review Board (IRB) through the Division of Social Work. The Committee for the Protection of Human Subjects through the Division of Social Work approved this Human Subject Application

on 9/15/14 as “exempt.” Additionally, this study also received approval from the County of Sacramento Institutional Review Board.

To ensure confidentiality and anonymity, a county employee sent a recruitment email to the potential participants, including an electronic invitation to participate form and a link to the SurveyMonkey survey. The informed consent was obtained through an electronic invitation to participate. The form was attached to the email to potential study participants along with the SurveyMonkey link. The researcher and the research advisor’s electronic mail addresses were also provided in the consent form in the invitation to participate form in the case that participants had any questions or concerns related to the study. Participation in this study was voluntary, and participants were able to skip any questions they did not want to answer. Participants were also able to discontinue participation at any time.

Neither identifying characteristics nor information about the participants of the study were available to the researcher nor to the research advisor. All of the collected information was maintained with the highest level of confidentiality and was secured through SurveyMonkey which utilizes https encryption. Additionally, access to the anonymous results of the questionnaire through SurveyMonkey was only available to the researcher, and was also shared with the research Advisor. Although the researcher made efforts to protect the data as much as possible, given the nature of online research, there are no absolute guarantees for the confidentiality of electronic data.

### **Data Collection Process**

After receiving Human Subjects approval from both the Division of Social Work at California State University, Sacramento and the County of Sacramento Department of Health and Human Services, the researcher coordinated with a county employee who distributed the invitation to participate form and the study questionnaire link to individuals who were involved with the county's mental health speaker's bureau. The survey itself was administrated via SurveyMonkey.com as this website is used often, is easily accessible, and is also user-friendly. SurveyMonkey provides secure data collection through encrypted https links and allows participants to stay anonymous. The data was only accessible to the researcher, and was then shared with the research advisor. The researcher's goal was to reach members of the Sacramento County mental health speaker's bureau (also referred to as the Stop Stigma Sacramento speaker's bureau) who were living in recovery from mental health conditions. Given the nature of the study and the fact that it was online, however, there was no way to tell if all of the participants were indeed members of the Sacramento County mental health speaker's bureau.

The first page of the SurveyMonkey survey was the informed consent (see Appendix A). There were 38 consented responses to this survey. Participants were required to choose to consent or to not consent by either participating in the survey or not participating in the survey, but participants who gave their consent were not required to answer all of the questions that were in the survey. Participants had the option to provide their email addresses at the end of the survey if they wanted to participate in a focus group at a later date. However, given the time constraints associated with completing a

thesis on time and the author's available amount of time, the researcher decided not to do focus groups. The participants who included their email addresses were notified of this decision, and were also notified that they would be able to read the finished thesis.

### **Data Analysis Plan**

The data collected from the SurveyMonkey website was organized by the researcher into quantitative and qualitative categories. Once the data was organized, the quantitative data was analyzed using SPSS (Statistical Package for Social Sciences) software and the qualitative data was organized by themes. Data were interpreted through various relevant statistical analyses. The findings that emerged from this study and from the data analysis are presented in the next chapter.

## **Chapter 4**

### **STUDY FINDINGS AND DISCUSSION**

This study collected both quantitative and qualitative data through a questionnaire that was administered via SurveyMonkey. There were 38 participants total, all of which were involved with the Stop Stigma Sacramento Speakers Bureau, and all of which who are living in recovery from a mental health condition. However, since questions could be skipped, there were questions that were not answered by every participant. This chapter will present the demographics of the participants, as well as the major themes and findings that emerged from the study.

#### **Profile of Study Subjects and Demographics**

This section presents the demographics of the study population. The profile of a typical respondent who participated in this study was a college-educated, Caucasian female who was between the ages of 46-55. Although the author had hoped to display more diversity in demonstrating the demographics, it does not take away from the fact that individual experiences, regardless of demographics, are important. Given the nature of this study, experiences as a whole hold more meaning than what kind of person's experiences that they are.

Some of the demographics that were unique to this study include the number of years since the participants had been diagnosed, the average number of speaking engagements they participate in per year, and how long they have been with the speakers bureau. These demographics are identified in Table 1.

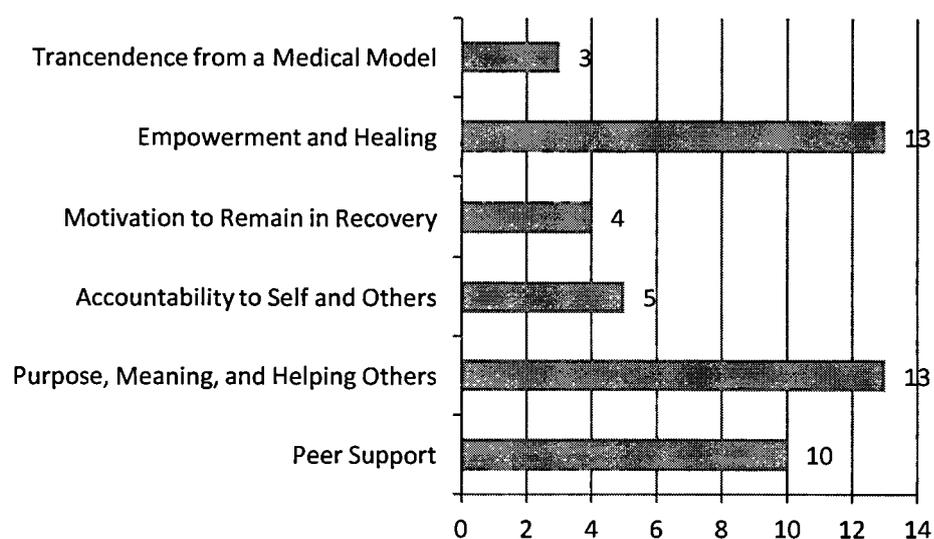
Table 1

*Years Diagnosed, Years with Speakers Bureau, and Engagements*

	Years Diagnosed	Years with Speakers Bureau	Engagements Per year
N	34	36	36
Mean	14.63	2.51	7.88
Median	14.00	2.00	3.50

**Emerging Themes and Findings**

The results of the study indicated that there were multiple common emerging themes among participants related to the most rewarding parts of being involved with a speakers bureau, and how involvement with a speakers bureau has impacted the participants' recovery journeys. These themes included peer support; having a sense of purpose, meaning, and helping others; accountability to self and others; motivation to stay in recovery; empowerment and healing; and transcendence from a purely medical model. Figure 1 below highlight these themes.



*Figure 1.* Emerging themes

***Trascendence from a Medical Model.*** One of the themes that was of high interest to the researcher (based on her own experience as a speaker) was the idea that being part of the speaker’s bureau is therapeutic to the extent that for some speakers, it could supplement, or even take the place of formal psychotherapy and/or psychotropic medication. The medical model, also known as the model of disease, holds the belief that the answer to curing disease (or in this case, mental health “disorders”) is coming up with new ways to treat symptoms. However, this model often views people living with mental health conditions as “cases” that need to be solved and treated, rather than people who can and should recover, and who have the potential to live meaningful lives regardless of the presence of a mental health condition. There were several participants that alluded to this concept. One participant stated,

This project has helped more than therapy ever could. Don't get me wrong I benefit from therapy, but this has helped me learn to accept myself because all the

other speakers are accepting themselves. Before I got involved, I was on a dark road. I still struggle with depression, but it no longer feels as heavy. Knowing that other people (other speakers) are getting up every day and dealing with their mental health issues gives me the courage to do the same. (Participant 20)

Another participant mentioned success with therapy and success as a result of involvement with a speakers bureau:

My goal when I joined four years ago was to be able to share my experiences as openly as possible with any type of audience. I saw that as the next step after completing ten years of successful therapy. I'd say the speaker's bureau has played an essential part in helping me reach a new level of recovery. That process continues with each speaking assignment, and I am more confident than ever that I made the right choice.

Another participant spoke to the fact that involvement with a speakers bureau takes healing, empowerment, and recovery to a new level:

Speakers bureaus [are] NOTHING like group therapy! In group therapy I met others who were struggling but that is where I learned to self abuse, and "take control" in negative ways. The speakers bureau helps me see I am not alone and recovery is possible since others are there with me recovering.

These responses indicate that there is something very special about being involved with a speakers bureau, and that it has a unique impact on recovery that traditional therapy and/or other forms of treatment do not.

Along the lines of treatment, something that is also worth mentioning is the idea that involvement with a speakers bureau may play a role in motivating speakers to continue to maintain their recovery, including receiving and staying in treatment.

***Empowerment and Healing.*** One of the two most commonly mentioned themes among participants was empowerment and healing. There were several questions on the survey that had an overwhelmingly uniform set of responses amongst participants. One of these questions was empowerment. One hundred percent (100%, n=34) of participants agreed with the statement that they feel empowered as a result of their involvement with a mental health speakers bureau. There were also many responses to the open-ended part of the questionnaire that indicated empowerment is one of the major benefits of being involved with a speakers bureau. One participant said,

I like being empowered and connecting with people who hear us speak. I like starting the conversation about mental health without the shame. I think the speaker's bureau helps promote that. We are not just sick; we are strong people who have value in our struggle. We can teach others, not just those suffering with mental illness. (Participant 37)

Empowerment, which can also be labeled as self-determination, is one of SAMSHA's ten components of personal recovery. According to SAMSHA, recovery is person-driven and should allow for individuals to create their own paths toward recovery (2012).

Additionally, recovery means optimizing one's independence, and allows them to make decisions about their own recovery. Along those same lines, involvement with a speakers bureau allows people living with mental health conditions to decide when they are ready

to tell their story, how they are going to tell their story, what kind of details they will include, and to whom (or which audience) they would prefer to do so. It has been the author's experience that one of the major milestones for many of the "newer" speakers is to tell their story to the public for the first time. It has also been the researcher's experience that once a speaker does so for the first time, it allows for a unique experience of relief. Speaking to the empowerment aspect as well as the sense of relief that was previous described, another participant said,

I signed up with the intention of changing people's perceptions about mental illness. It never occurred to me that I would be impacted as well. During [my] many years of living with mental illness, I have never felt such a well rounded feeling of wellness. For lack of a better word, I finally feel "normal." I know that having my face up there for all to see played a huge role on this feeling of wellness. I think it was akin to "coming out of the closet." I know I'll live with mental illness for my entire life, but having left the shame burden locked in that closet took a huge burden off my back. (Participant 3)

The comparison of "coming out" about mental health conditions with the experience of "coming out of the closet" for people who identify as LGBTQ is a growing area of research, some of which was discussed in the literature review. Shame and self-stigma are two aspects of living with a mental health condition that can often prevent people from coming out about it to their loved ones, and often serves as a barrier towards seeking treatment. Many participants alluded to the fact that self-stigma served as a major barrier for them, but is something that was combatted as a result of their involvement

with the speakers bureau. The empowering feeling of coming out about something so stigmatized was emphasized by many participants. For example, one participant stated,

When I was first diagnosed many years ago, I believed that my forehead was branded, "mental patient". I hid in shame and it made my depression worse. Now most people in my life know that I am in long-term recovery from bipolar disorder and addiction. I can live my life in victory and live an ordinary (or actually, an extraordinary) life. I feel so grateful that I have overcome so many challenges. I want to give back by showing others that they can do it too. That is so fulfilling and it does wonders for my own mental health! (Participant 6)

***Motivation to stay in recovery.*** Another theme of interest to the researcher (due to her own personal experience as a speaker) was how involvement with a speakers bureau motivates individuals to stay in recovery, or to continue to maintain their recovery. Several speakers alluded to this fact, and how their involvement with a speakers bureau motivates them to set a healthy example for others who are experiencing mental health conditions. One participant affirmed,

It has impacted my recovery because it has been motivational for me to stay in recovery. In speaking about my recovery, I want to show others that it is possible to recover. My mental illness is anorexia, and it is very important for me to be healthy in order to help others and to spread awareness about the disorder.  
(Participant 32)

In other words, the motivation to stay in recovery also has some ties to wanting to give back to the community. Ninety-three point seventy-five percent (93.75%, N=32) of

participants agreed with the statement that as a result of their involvement with the speakers bureau, they feel more motivated to stay in recovery. Another participant described their belief that the “family” environment of a speakers bureau also encourages motivation to stay in recovery,

The feeling of being part of this particular family has helped me to be more proactive in seeking and maintaining my own treatment. Because everyone is doing their best to stay in recovery, it is infectious. The more I get involved, the more their positive influences rubs off on me. (Participant 4)

*Accountability to self and others.* As previously mentioned, one powerful aspect of being involved with a speakers bureau is the fact that since many of the speakers have made their story so public, there is a sense of wanting to stay in recovery. Along those same lines, another aspect of involvement with a speakers bureau for the speakers is desiring to be accountable to themselves, their own recovery journey, and to others that are looking up to them. For example, one speaker said,

Before speaking and getting involved with other speakers, I lived day to day. Now I feel a commitment to be in a recovery journey since I want to spread the word to others who struggle that they are not alone, and having a mental illness is not something to be ashamed of. Don't get me wrong, there are still days of struggle but the will to overcome and cope with those struggles is much more prevalent. (Participant 5)

In other words, the feeling of accountability to themselves, other speakers, and their community is motivating in itself.

***Purpose, Meaning, and Helping Others.*** When an individual is experiencing symptoms of a mental health condition, it can often lead to feelings of purposelessness.

Additionally, the human desire to find meaning in things is often times overshadowed by feelings of despair, loneliness, isolation, and worthlessness. The presence of suicidal ideation can make purpose and meaning seem even further away. More often than not, purpose and meaning in the face of mental health conditions become secondary goals, with primary goals being to just make it through an hour, day, or week without experiencing symptoms, or for some, without wanting to die. That being said, Slade and Longden indicated that a major part of recovery is, “The development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (2015, p. 3). Additionally, one of the major recovery processes identified by Williams et al. (2012) was meaning and purpose. All (n=34) of participants agreed with the statement that their involvement with a speaker’s bureau has given them an opportunity to give back to others. One participant affirmed,

The most rewarding part to me [about being involved with a speaker’s bureau] is that helping others gives meaning to my suffering. If I can simply help one person not go through what I had to go through, it is all worth it in the end. (Participant 9)

Additionally, another participant powerfully stated,

I love having the opportunity to share hope and make an impact in other people's recovery. We discover that when we bless others, we are blessed. We go from feeling damaged and useless to having a true purpose. Our society [is] fed so

much misinformation about mental illness; they want to hear the real deal from someone who has dealt with mental illness. I think people have wanted to talk about this stuff for a long time, and we give them the opportunity to open up by being vulnerable ourselves and we give them hope. (Participant 6)

Similar to the idea of giving back to others, 100% of participants (n=34) agreed with the statement that being involved with a speaker's bureau allows them to have a positive impact on their communities. One participant spoke to the fact that telling their story has been not only rewarding, but also freeing in terms of shame,

I have only been able to speak once so far, but I found the act of simply telling the truth about my experience to be very freeing. Being a part of the bureau has taken away what shame still lingered about my illness. Also, the opportunity to let others know they are not alone is very powerful. When I spoke I could see a lot of nodding heads, a few tears, and a woman approached me after the event. I could tell it was making a difference for those people. That is very rewarding.

(Participant 37)

**Peer Support.** Another one of the ten components of personal recovery according to SAMSHA (2012) is peer support. In substance abuse, peer support is a major component of recovery, and mental health is similar in that aspect. The feeling that one is not alone in what they are going through, and that there are other members of the speaker's bureau who also understand their struggle is a crucial part of the normalization of one's mental health condition. According to Ostrow and Adams (2012), peer support can be defined as bringing mutual support and shared responsibility for recovery to the relationships that

exist between individuals living in recovery from mental health conditions and their peers.

From the literature that exists on peer support in a mental health setting, peer support and peer-led services have been identified as a growing influence on the recovery movement in the United States (Ostrow & Adams, 2012). It is important for people living with mental health conditions to be aware of the fact that they are not alone in what they are experiencing and that there are others out there who can understand and support them. Ninety-one percent (91%, n=38) of participants in this study reported experiencing some kind of improvement, whether small or significant, in feeling less alone regarding their own mental health experiences. One participant said in regards to how being involved with a speaker's bureau has affected their recovery,

I am not sure if words can describe the positive impact the bureau has had in my life. Although I had already started speaking about my condition, I felt so alone, so very alone. Then I joined the bureau and for the first time in my life, I met people that [I] could actually relate to. (Participant 38)

In addition, eighty-eight (88%, n=38) of participants reported improvement in experiencing a sense of similarity; in other words, their belief that they are connected to people who have been through similar experiences as they have. This sense of similarity may also contribute to making groups such as a speaker's bureau feel like a "family."

One participant stated,

The absolute best part [of being involved with a speaker's bureau] is my speaker's bureau family members. The other people in the bureau inspire to do my best with

whatever situation life throws at me. All of our stories are so different, yet they all have a common theme. I hear the hard things the other speakers have lived through and I can't help but count my blessings and be grateful for my own trials. I feel stronger, like I can handle and overcome my ongoing struggles, because I see how they've been strong in their own lives. (Participant 4)

That same participant explains how the feeling of being part of a family that accepts them has had a positive influence on their recovery:

One of the best parts about being in [a speaker's bureau] is that I experience unique feelings relating to being part of a family where I am understood, but more importantly, accepted, regardless of how I may be feeling or acting. I am very close with my biological family, but they just don't understand like members of the bureau do. Everyone "gets it" and I don't have to explain myself.

### **Additional Findings**

In addition to the findings above, when data were analyzed using SPSS software, there were several findings of interest. For example, as previously mentioned, there was a great deal of uniformity amongst certain responses from participants, something that is very unique in data collection. However, this finding occurred after data variables had been recoded (i.e., from "Disagree" and "Strongly Disagree" to just "Disagree"). Although the majority of responses leaned toward "Agree" and "Strongly Agree", prior to data being recoded, it was noted that there was a significant split between "Agree" and "Strongly Agree" for certain variables, and an insignificant split between other variables. Tables 2, 3, 4, and 5 as well as figures 1, 2, 3, and 4 below demonstrate this difference.

Table 2

*Confidence in Ability to be in Recovery*

	<u>Frequency</u>	<u>Percent</u>
Disagree	1	3.1
Agree	20	62.5
Strongly Agree	11	34.4
Total	32	100.0

Table 2 demonstrates a 62.5% vs. 34.4% split between individuals who say that they agree or strongly agree that their involvement with the speakers bureau has allowed them to become more confident in their ability to stay in recovery. This example demonstrates a moderately-sized split.

Table 3

*Confidence in self*

	<u>Frequency</u>	<u>Percent</u>
Agree	16	48.5
Strongly Agree	17	51.5
Total	33	100.0

Table 3 demonstrates a 48.5% vs. 51.5% split between individuals who say they agree or strongly agree that their involvement with the speakers bureau has encouraged them to become more confident in themselves.

Table 4:

*Motivation to Stay in Recovery*

	Frequency	Percent
Disagree	2	6.5
Agree	14	45.2
Strongly Agree	15	48.4
Total	31	100.0

Table 4 demonstrates a similar example to Table 3, with a 45.2% vs. 48.4% split between participants who say they agree and strongly agree that their involvement with the speakers bureau makes them feel more motivated to stay in recovery. In other words, participants who agree that their involvement with the speakers bureau makes them more confident in themselves also agree that their involvement motivates them to stay in recovery. Similarly, those that strongly agree that their involvement with the speakers bureau makes them more confident in themselves also strongly agree that their involvement motivates them to stay in recovery.

Table 5:

*Confidence Telling Story*

	Frequency	Percent
Agree	6	18.2
Strongly Agree	27	81.8
Total	33	100.0

Unlike the previous two tables, Table 5 demonstrates an 18.2% vs. 81.8% split between participants who agree or strongly agree that their involvement with the speakers bureau promotes confidence in telling their story. This is a much wider split than the previous tables and the variables they represent. The figures below demonstrate a visual view of these splits.

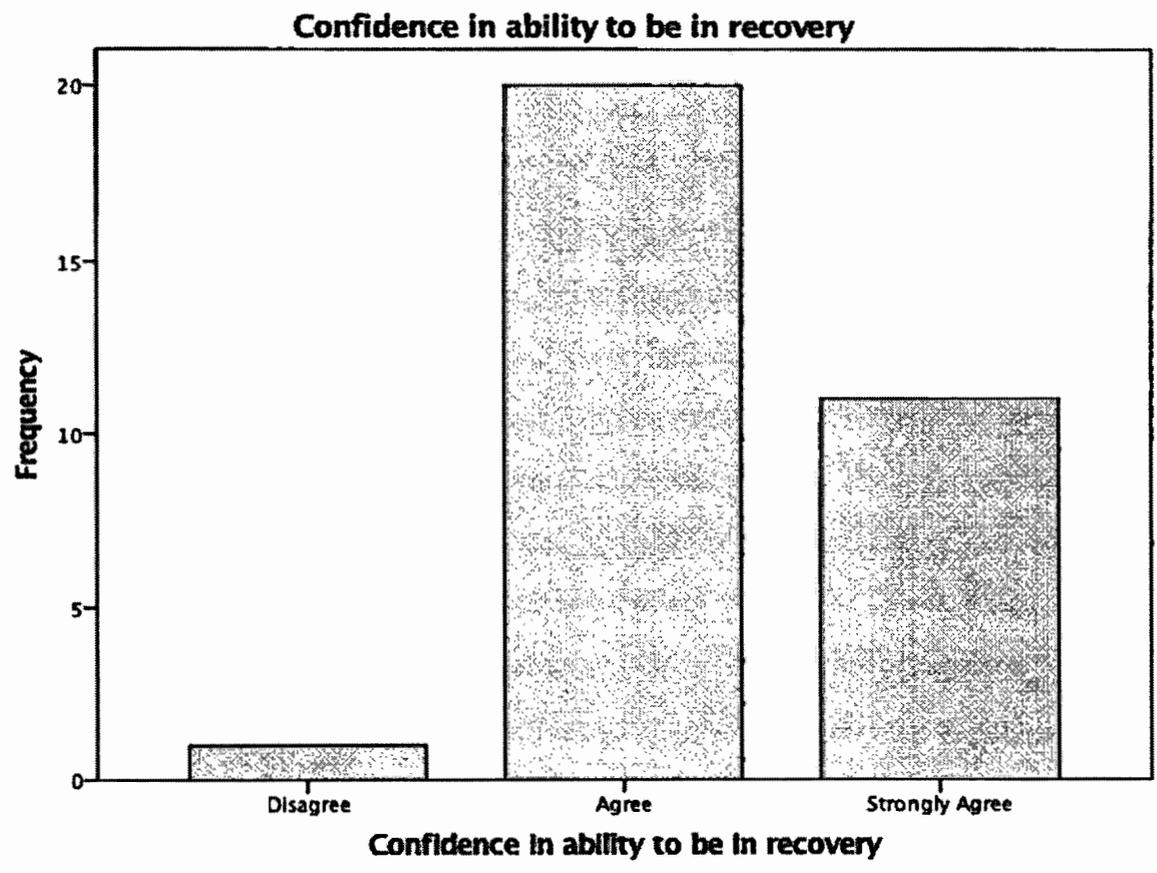


Figure 2. Confidence in ability to be in recovery

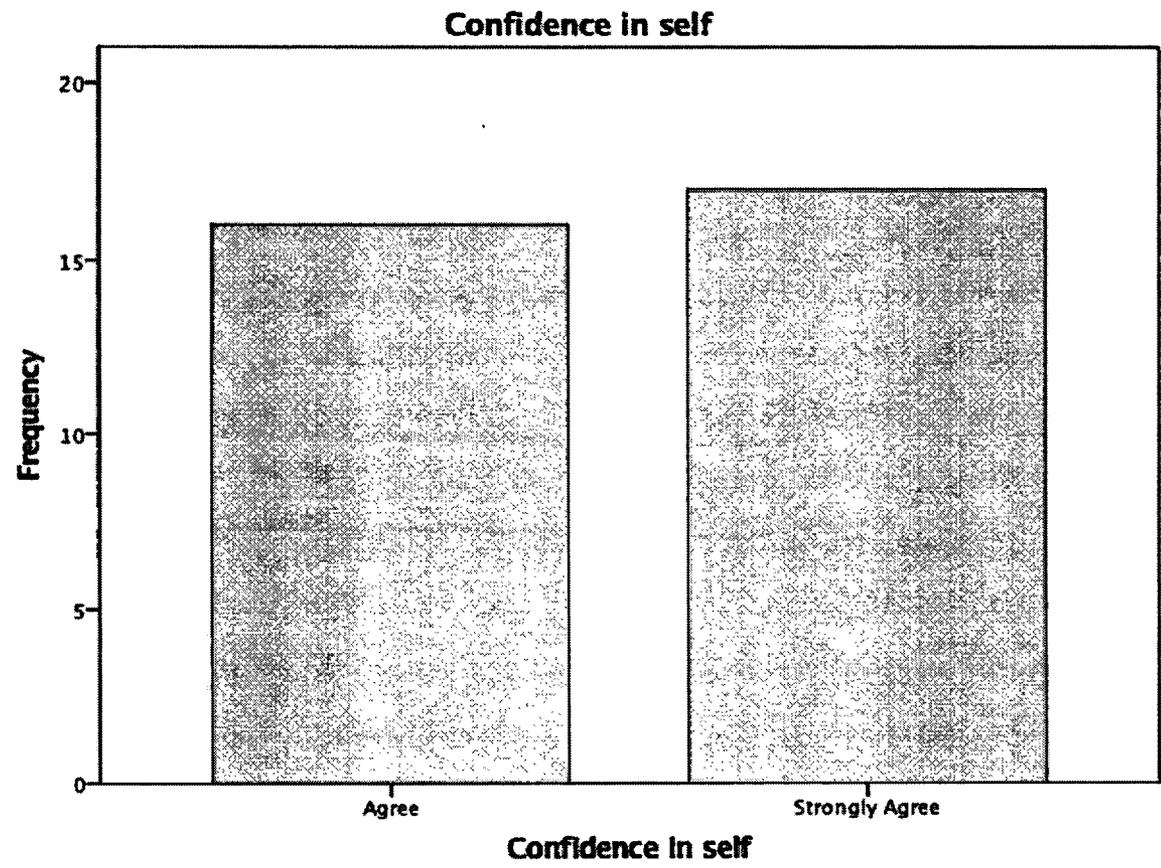


Figure 3. Confidence in self

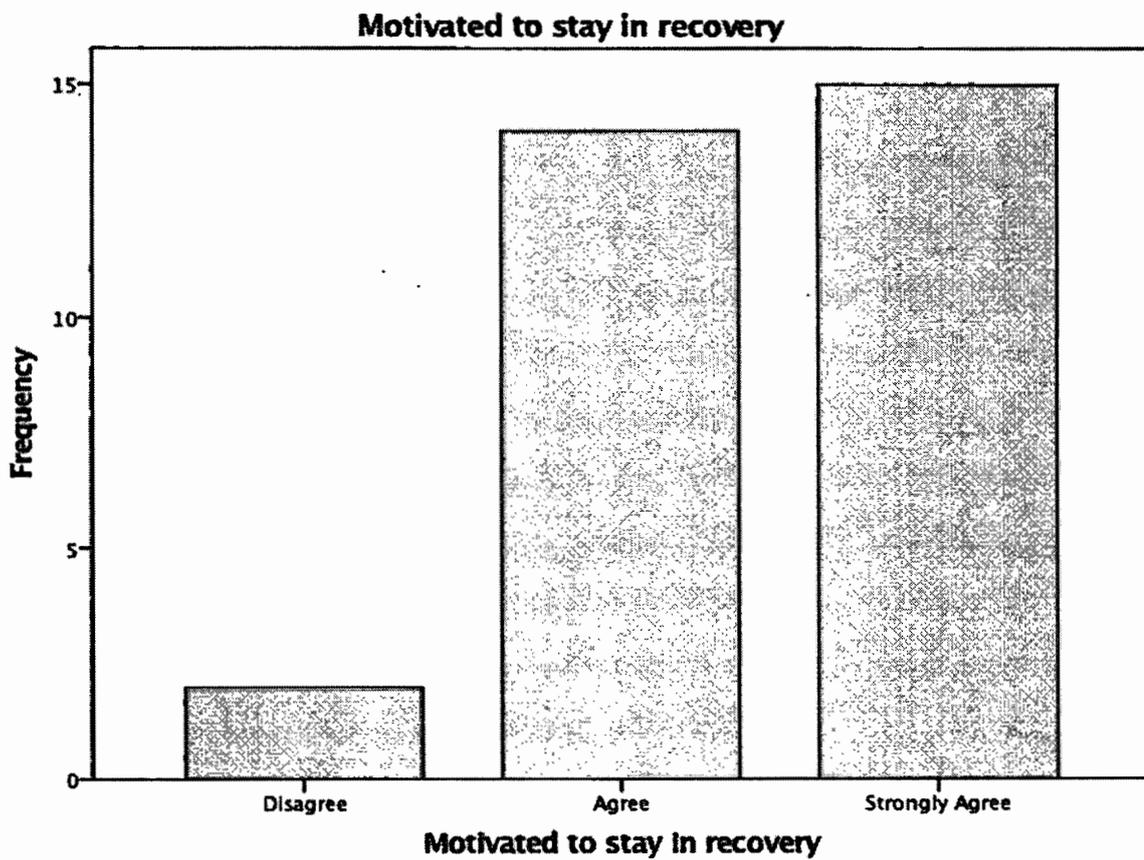
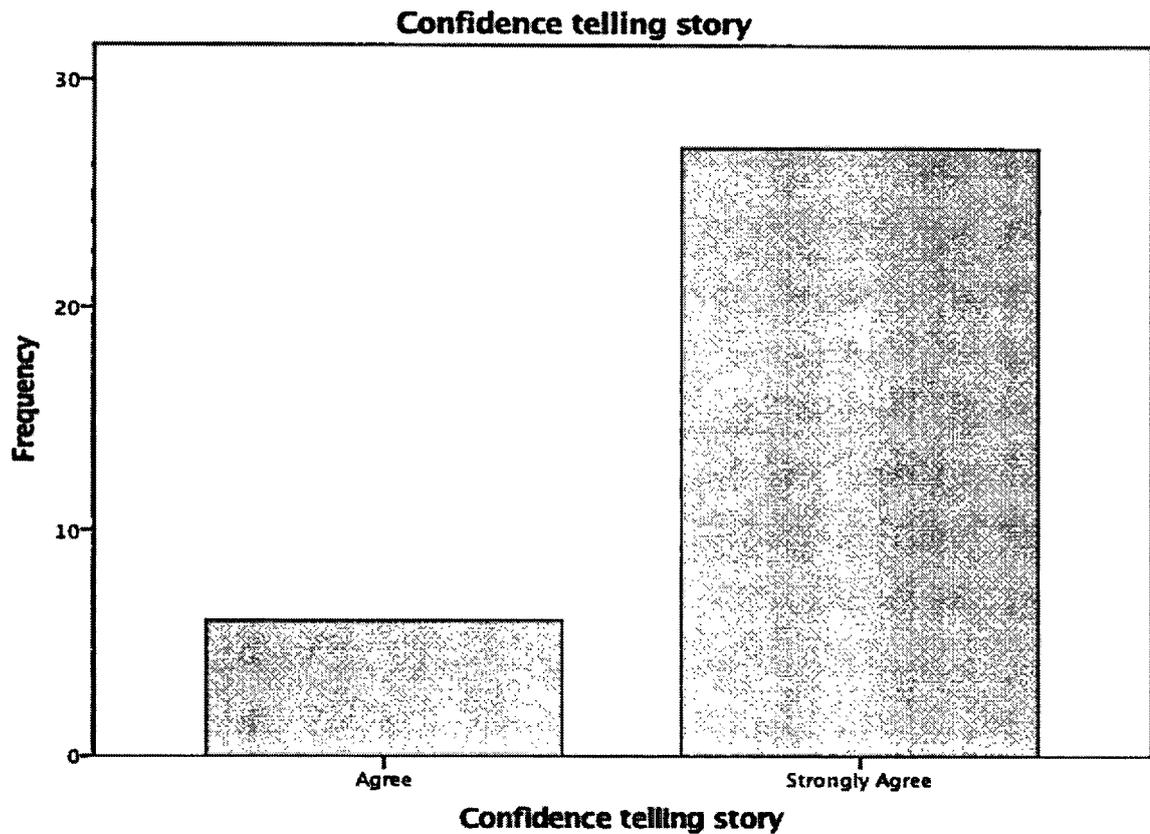


Figure 4: Motivation to stay in recovery



*Figure 5. Confidence in telling story*

Additionally, the author ran a series of correlations between variables. The following correlation matrix (see table 6) displays the correlations between key variables of improvement. In terms of significance, confidence telling one's story and self-acceptance with one's mental health condition had the highest number of significant correlations with the other variables. Specifically, confidence telling one's story was positively correlated with five other variables, including empowerment. Self-acceptance with one's mental health condition was also positively correlated with five other factors, including empowerment.

In terms of data interpretation, there are several findings that have interesting interpretations. For example, the first three variables (confidence in ability to be in recovery, confidence in self, and motivation to stay in recovery) in the matrix had the least amount of significant correlations. They are also, for the most part, individual-based. In other words, they are specific to the individual (i.e. confidence in one's self). Variables four through eight were focused on more psychosocial factors, such as giving back to the community, and feeling empowered. Those variables also had the highest number of significant correlations. These correlations indicate that participation in a speakers bureau provides the psychosocial context and opportunity for participants to accept their mental health conditions, feel empowered, have a positive impact on the community, and be given the opportunity to give back to others.

Overall, these findings support the idea that involvement with a speakers bureau has a positive impact on psychosocial factors in the lives of people living with mental health conditions, and allows them to lead a more fulfilling life, and recovery journey. Although speakers bureaus are not necessarily "therapeutic," they create a supportive environment to supplement treatment.

Table 6

## Improvements from Being Involved with a Speakers Bureau

	1	2	3	4	5	6	7	8
1. Confidence in ability to be in recovery	1.0	.353* .048	.547** .001	.105 .569	.240 .187	.333 .063	.039 .833	.242 .182
2. Confidence in self	.353* 0.48	1.0	.437* 014	.486** .007	.459** .007	.039 .833	.159 .378	.266 .134
3. Motivated to stay in recovery	.547** .001	.437* 0.14	1.0	.198 .286	.353 .052	.114 .541	.160 .391	.410* .022
4. Confidence telling story	.105 .569	.486** .004	.198 .286	1.0	.585** .000	.624** .000	.467** .006	.677** .000
5. Self-acceptance with MH condition	.240 .187	.459** .007	.353 .052	.585** .000	1.0	.680** .000	.557** .001	.524** .002
6. Empowered	.333 .063	.527** .002	.114 .541	.624** .000	.680** .000	1.0	.454* *.008	.383* .028
7. Positive impact on community	.039 .833	.159 .378	.160 .391	.467** .006	.557** .001	.454** .008	1.0	.550** .001
8. Opportunity to give back	.242 .182	.266 .134	.410* .022	.677** .000	.524** .002	.383* .028	.550** .001	1.0

n = 33 \*p<.05, \*\*p<.001,

## **Chapter 5**

### **CONCLUSIONS AND RECOMMENDATIONS**

This chapter will present conclusions based on the findings presented in chapter four. In addition, this chapter will present recommendations based on those findings. Implications for the social work profession will also be discussed.

#### **Conclusions**

This study generated quantitative and qualitative findings about how involvement with a mental health speaker's bureau affects the speakers' personal recovery from mental health conditions. This study examined factors related to recovery from mental health conditions, empowerment, and how involvement with a speakers bureau affects speakers' personal recovery journeys. The findings from this study begin to assess how involvement with a speakers bureaus affect the speakers' recovery, in the speakers' own words. The impact of mental health speakers bureaus on its members have not previously been adequately studied, so it is the author's hope that these results will serve as a contribution towards raising awareness about mental health speakers bureaus and their impact.

Both quantitative and qualitative findings were obtained as a result of this study and its design. Many of the quantitative findings obtained from the study were overwhelmingly uniform. There were multiple study questions where one hundred percent of participants answered that they agreed with the statement listed. For example, one hundred percent (100%, n=34) of participants agreed with the statement that they feel empowered because of their involvement with a mental health speakers bureau. Given

that all of the study questions were related to empowerment, opportunities, and other positive aspects of recovery and involvement with a speakers bureau, this uniformity indicates that there is a consensus among speakers that their involvement with a speakers bureau impacts them and their recovery in a positive way. Qualitative findings indicated multiple common themes among speakers. These themes included peer support; having a sense of purpose, meaning, and helping others; accountability to self and others; motivation to stay in recovery; empowerment and healing; and transcendence from a purely medical model.

### **Recommendations**

Based on the findings obtained from this study as well as the information reviewed in the body of literature, it is the author's general recommendation that programs such as speakers bureaus be given a great deal more awareness, funding, and availability. However, the writer has several recommendations that are presented within different levels of social work including micro, mezzo, and macro social work practice.

In terms of micro, or direct practice social work, the author's main recommendations are based on awareness of services. It is important that direct practice social workers familiarize themselves with all different kinds of interventions that could best serve people living with mental health conditions. That includes more than just those that are included in the medical model, or that are considered "evidence-based" as different things may work for different individuals. Additionally, social workers should strive to adhere to the ethical responsibilities that they have to clients living with mental

health conditions, and should promote clients' right to self-determination as it relates to recovery from mental health conditions.

Social workers who practice at the mezzo level should consider the systemic factors that may serve as barriers towards accessing programs such as mental health speakers bureaus. Some of these could include lack of employee knowledge for alternative resources, and agency/organizational culture in regards to peer-led and recovery-based resources. It is of vital importance that social workers at the mezzo level strive to educate employees, volunteers, other stakeholders, etc. about programs such as speakers bureaus which may serve as alternative resources rather than just medical-model based ones. Additionally, it is important that mezzo level social workers recognize and understand agency and organizational culture as it relates to non-medical model based resources, and that they strive to change any possible negative views, culture, and beliefs surrounding them.

Macro level social workers should be primarily concerned with the allocation of resources such as speakers bureaus and funding for them as well. It is important that macro level social workers are aware of policies which can impact the availability and implementation of speakers bureaus. For example, in California, Proposition 63, also known as the Mental Health Services Act (MHSA) is primarily responsible for funding mental health speakers bureaus. Social workers practicing advocacy at this level should also be aware of the benefits of speakers bureaus, and should familiarize themselves with ways to advocate for these programs at the local, state, and federal level. Social workers at the macro level also have the opportunity to monitor funding, and any potential

changes in policy that could affect the funding of speakers bureaus. Macro level social workers should also focus on methods for evaluation and conducting research on how to better improve these programs to meet the needs of people living with mental health conditions.

Overall, many people are still unaware of what mental health speakers bureaus are, and how similar programs can impact people living with mental health conditions and their personal recovery journeys. However, as the findings indicated, mental health speakers bureaus have the potential to provide participants with peer support, empowerment, accountability, and many other aspects of recovery that simple “medical model” treatments and interventions do not. It is the writer’s hope that one day there will be a speakers bureau in every county, including even the most rural ones, to provide people living with mental health conditions the opportunity to tell their story of recovery, hope, and wellness.

### **Implications for Social Work**

Mental health is not a new issue, and it is one that affects many individuals. Approximately one in five people experience symptoms of mental health conditions in any given year. That being said, there are many social workers that are employed in mental health-related fields, and that have the potential to have an impact on the lives of people living with mental health conditions. Although there has been some progress in terms of service-delivery and the diversity of services that are offered, there is still a great deal of room for improvement in this area. Social workers are unique in that they have the opportunity to work in micro, mezzo and macro areas of service-delivery and can

improve services that are provided to people who are living with mental health conditions.

Based on the recommendations that were previously discussed, there are several implications for social work practice. The first of these is that social workers have a responsibility to promote mental health, in the lives of people that are living with mental health conditions. The NASW Code of Ethics states that the mission of social work is to enhance the well-being and lives of vulnerable and oppressed populations in the forms of empowerment and meeting basic human needs. People living with mental health conditions are most definitely considered a vulnerable and oppressed population. Mental health speakers bureaus such as the Stop Stigma Sacramento Speakers Bureau have the potential to not only promote empowerment and personal well-being in the lives of people who live with mental health conditions, but also to reduce the amount of stigma that exists towards them in society.

It is important that social work as a profession recognizes that there are more paths to recovery than just through the medical model of treating symptoms (usually meaning medication). Social workers should display a great deal of cultural understanding and sensitivity for people living with mental health conditions, their wants, needs, and desires as it relates to different forms of treatment. Along those lines, social workers should care about and be receptive to alternative methods not just for treatment, but also for other pathways to recovery including peer-led programs such as mental health speakers bureaus. Participation in mental health speakers bureaus is one way that people living with mental health conditions can empower themselves, access peer

support, and can have the opportunity to give back to others who are struggling with mental health conditions. People living with mental health conditions should be empowered by social workers to find a path to recovery that works for them. As this study demonstrated, speakers bureaus have the potential to further promote empowerment, and to motivate people living with mental health conditions to continue to take control of their own recovery, whatever that may mean for them.

## Appendix A

**SPEAKING ABOUT MENTAL HEALTH RECOVERY**

**Demographic Information** | Please mark the ONE answer that best applies with an "X." Fill in the blanks where indicated.

<b>Gender:</b> [ ] Male [ ] Female	<b>Age:</b> [ ] 18-25 [ ] 26-35 [ ] 36-45 [ ] 46-55 [ ] 56-65 [ ] 65+	<b>Ethnicity:</b> [ ] Caucasian (non-Hispanic) [ ] African American [ ] Asian/Pacific Islander [ ] Native American [ ] Hispanic [ ] Other	<b>Highest Education Level:</b> [ ] K-12 [ ] High school [ ] Some college [ ] College graduate [ ] Vocational / Trade school [ ] Other
<b>Number of years since you've been diagnosed:</b> ____ <i>years</i>	<b>Average number of speaking engagements / events that you participate in per year:</b> ____ <i>per year</i>	<b>Number of years involved with a speakers' bureau:</b> ____ <i>years</i>	

**Questionnaire** | Please mark the ONE answer that best applies with an "X."

SA = Strongly Agree; A = Agree; D = Disagree; and SD = Strongly Disagree				
<b>As a person living with a mental health condition:</b>				
1. I consider myself to be in recovery.	[ ] SA	[ ] A	[ ] D	[ ] SD
2. I would describe recovery as an ongoing journey rather than an end-point.	[ ] SA	[ ] A	[ ] D	[ ] SD
3. I am currently receiving treatment (i.e. therapy, medication, etc.).	[ ] SA	[ ] A	[ ] D	[ ] SD
4. I feel involved in any decisions made that affect my recovery.	[ ] SA	[ ] A	[ ] D	[ ] SD
5. It is important to me that I am involved in any decisions that affect my recovery.	[ ] SA	[ ] A	[ ] D	[ ] SD
<b>As a result of my interactions with other speakers from the speakers' bureau . . .</b>				
6. I feel more hopeful about my own future.	[ ] SA	[ ] A	[ ] D	[ ] SD
7. I feel that I am less alone.	[ ] SA	[ ] A	[ ] D	[ ] SD
8. I feel that I have gained more insight about my own mental health condition and/or recovery.	[ ] SA	[ ] A	[ ] D	[ ] SD
9. I feel that I am able to help my peers feel less	[ ] SA	[ ] A	[ ] D	[ ] SD

alone.				
10. I feel that I am able to encourage my peers.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
11. I feel that my social skills have improved.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
12. I feel that I am part of a “family” of peers.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
13. I feel that I have learned new positive behaviors to practice in my own life.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
14. I feel that I have gained constructive feedback.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
15. I feel connected to people who have been through similar experiences as I have.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
16. I have bonded with my peers.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
17. I feel free to express my emotions outwardly with the other speakers.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
18. I feel a sense of responsibility to make changes in my own life.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
<b>As a result of my involvement with the speakers’ bureau . . .</b>				
19. I have become more confident in my ability to stay in recovery.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
20. I have become more confident in myself.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
21. I feel more motivated to stay in recovery.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
22. I feel more confident about telling my story.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
23. I feel a sense of self-acceptance as it relates to my mental health condition.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
24. I feel a sense of empowerment.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
25. I feel that I am able to have a positive impact on my community.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD
26. I feel that I have been given an opportunity to give back to others.	<input type="checkbox"/> SA	<input type="checkbox"/> A	<input type="checkbox"/> D	<input type="checkbox"/> SD

**Supplemental Questions** | Please answer the following questions as openly and honestly as you can. If you need more room to write, please ask the researcher for an additional sheet of blank paper.

27. How (if at all) has being involved with a speakers’ bureau impacted your personal recovery?
28. What, in your opinion, are the most rewarding parts of being involved with a speakers’ bureau?

**Thank you, once again, for your participation in this study!**

After the survey data analysis has been completed, I would like to share the results with you and further discuss them in a focus group. If you are interested in participating in one of the focus groups, please email me at [kmw337@csus.edu](mailto:kmw337@csus.edu).

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