American Psychological Association

Recovery to Practice Initiative Curriculum: Reframing Psychology for the Emerging Health Care Environment

1. Introduction to Recovery Based Psychological Practice

August 2014
## Contents

Overview .......................................................................................................................... 3  
Learning Objectives ....................................................................................................... 3  
Resources ......................................................................................................................... 3  
Required Readings ......................................................................................................... 3  
Activities ......................................................................................................................... 4  
Lecture Notes .................................................................................................................. 5  
  Introduction ................................................................................................................... 5  
  Evolution of the Recovery Movement .......................................................................... 5  
  Guiding Principles of Recovery from Serious Mental Illness ................................... 8  
  Challenges .................................................................................................................... 11  
  Summary ...................................................................................................................... 13  
Sample Learning Activity ............................................................................................... 18  
Sample Evaluation Questions ....................................................................................... 19  
Lecture Notes Citations ................................................................................................. 20  
Additional Resources .................................................................................................... 20  
Citing the Curriculum .................................................................................................... 22
Overview

In this module, we will discuss the concept of recovery for people with severe mental illness and learn about the principles on which the recovery model is based.

Learning Objectives

At the end of this module you will be able to:

- Describe four points related to the concept of recovery from serious mental illness
- Discuss two points related to the historical context from which the recovery movement arose and describe the evolution of the movement
- State three reasons for mental health practitioners’ reluctance to accept the validity of recovery from serious mental illness
- List and describe the ten guiding principles elucidated by SAMHSA in 2006
- Identify at least two challenges faced by people with serious mental illness as they work to recover
- Discuss at least three actions mental health practitioners need to take to help overcome these challenges

Resources

- Lecture Notes
- Required Readings
- Lecture Notes Citations
- Sample Learning Activity
- Sample Evaluation Questions
- Additional Resources

Required Readings


**Activities**

Complete the following activities:

- Read the lecture notes
- Read the required readings
- Engage in a learning activity related to this module
- Evaluate students’ understanding of this module.
Lecture Notes

People with lived experience of serious mental illness are strongly encouraged to be part of the delivery of the curriculum including being active participants in the delivery of the lecture. Refer to the curriculum Instruction module for additional information.

Introduction

The concept of recovery from mental illness, especially severe mental illnesses such as schizophrenia, schizo-affective disorders, bi-polar disorder, and other illnesses severe enough to include psychotic episodes in their symptomatology, was foreign to most mental health practitioners until the mid 1970s.

Until this time, psychologists and other practitioners generally believed that individuals with serious mental illness would be chronically ill and would not be able to function in society.

As a result, this pessimism was communicated to people with the disorders and they too felt hopeless, useless, and generally considered themselves doomed to a life of institutionalization or at best, repeated hospitalizations.

However, this began to change in the mid-1970s when long term studies from several countries began to show that people from all over the world who had these disorders and who had been hospitalized for long periods of time, were able to live in the community and lead satisfying lives. At about the same time, people with the illnesses also began to notice that, given the opportunity and appropriate supports where needed, they could live successfully in the community and did not need continuous hospitalization. Many individuals began to work in regular jobs, and many others were able to live without assistance in homes of their choice.

These two factors - long term studies showing that people can and do make substantial progress on their recovery journey, and individuals themselves realizing that there is the real possibility of recovering and living successfully in the community - led to the development of the recovery movement in several countries around the world.

Evolution of the Recovery Movement

The recovery movement evolved from the work of disability rights advocates who argued for inclusion of individuals and their families in the planning and service delivery process and argued that people with disabilities should be considered full members of their community and the larger society. These efforts also paralleled those of the civil rights movement that was working for inclusion and full citizenship for people from all races and cultures. These efforts culminated in the push for better research and for trauma informed service delivery systems that are respectful and that include consumers as decision makers, ultimately leading to what is known today as the recovery movement.
The concept of recovery has not been an easy sell for most mental health practitioners, including psychologists. Until about the mid 1990s, the movement was principally advanced by people with the illnesses themselves.

The reasons for practitioners’ reluctance are easy to discern. As disparaging as it may seem, most mental health practitioners did not want to lose their status as “the doctor” or “the professional” who knew what was best for the person being served. Additionally, mental health practitioners, even to this day, are often not trained to accept the concept of recovery or to provide the interventions that are most helpful to people with serious mental illnesses, i.e., those interventions that can help people live successful lives in the community. On the contrary, most practitioners, including psychologists, are trained to see serious mental illnesses as chronic deteriorating illnesses and to provide traditional mental health treatment, i.e., medications, psychotherapy, etc. While these may be of assistance, they are not sufficient to help those with serious mental illness learn to live successfully in the community. In fact, despite the long held and pervasive beliefs about the deteriorating course of serious mental illnesses, several meta analyses and summaries of well conducted studies have been published and all continue to document that individuals with serious mental illnesses can, and do recover from the effects of their illness (Warner, 2010), and indeed that most have the potential to achieve long-term remission and functional recovery (Zipursky, Reilly, & Murray, 2012).

At this point, you might be asking yourself why people with serious mental illness would need help to learn how to live in the community. After all, everyone grows up, finishes school, and seemingly effortlessly moves out into the world to live on his or her own. However, the majority of people with serious mental illness experience their first symptoms in early adolescence and their first psychotic episode between the ages of 16 and 26. Prior to their first episode of psychosis, they are often in considerable distress as they may hear and see strange things, become socially isolated, have difficulty concentrating, and may not be able to learn age appropriate concepts and behaviors. All of this comes at a crucial developmental stage when most young people are completing formal education and acquiring the informal knowledge needed to communicate and interact with peers, educators, family members, friends, co-workers and work supervisors. For the majority of young people who develop serious mental illness, these developmental learnings are not acquired. And even where good early psychosis intervention programs are in place, these young people may spend considerable time in treatment before their illness is stable enough to allow them to resume their education or attain vocational pursuits. In order to help individuals with serious mental illnesses overcome the developmental deficits that frequently occur, mental health practitioners must be trained to offer the specialized interventions that constitute psychosocial rehabilitation.

A major turning point and step forward occurred in 2003, when the U.S. President’s New Freedom Commission on Mental Health published the Final Report of their work, entitled “Achieving the Promise: Transforming Mental Health Care in America” (President’s New
Freedom Commission Report, 2003). The Report has had an enormous impact on mental health systems of care throughout the United States because it gave legitimacy and a “push” to mental health systems that were on the cusp of embracing a more recovery oriented approach to mental health treatment. The Report contains many recommendations, all geared toward encouraging a transformed system of care to one which promotes recovery for people with serious mental illness. A hallmark of the Report, and perhaps its essence, is the recommendation that consumers and family members are to be full partners in the decision making process about which services are provided and about the professionals that will provide those services. Since publication of the President’s New Freedom Commission Report, many changes have occurred throughout the country and many systems have moved closer to the ideals espoused in the Report. This is not true everywhere however, and there remains much work to be done, especially among established practitioners and administrators, many of whom are still resistant to change.

By the end of the first decade of the twenty first century (2010), the concept of recovery from serious mental illness had become fairly well known and was of interest to many mental health practitioners including psychologists. However, knowing how to implement the concept in practice and having the ability to appropriately use the proper interventions are skills that were then, and continue to be foreign to most practitioners (Mueser, 2012).

In an effort to encourage mental health practitioners to learn about the possibilities that exist for recovery from serious mental illness and learn how to provide appropriate rehabilitative interventions, the U.S. federal agency with responsibility for mental health services (Substance Abuse and Mental Health Services Administration, SAMHSA) provided funding to the major mental health professional associations to develop a curriculum specifically focused on recovery oriented practices for their profession. In recognition of the need to train psychologists to appropriately work with people with serious mental illnesses, the American Psychological Association undertook the development of its curriculum using the funding provided by SAMHSA. This module is the introductory chapter for that curriculum. The goals of the APA curriculum are to train psychologists to:

- End discrimination and pessimism in prognosis
- Train psychologists to adequately and appropriately provide services that have been shown to be effective in helping people recover their full potential
- Make self-determination and choice central
- Ensure community and social inclusion
- Adhere to the fundamentals of consumer and family-driven interventions using ecological, multicultural, and trauma informed perspectives
- Use recovery-oriented outcome measures.
**Guiding Principles of Recovery from Serious Mental Illness**

Recovery is based on the “novel” idea that individuals with serious mental illness can and do recover and live productive and meaningful lives in the community – just like anyone with an illness that may flare up from time to time. A recovery oriented framework is one which is driven by the person with the illness and one which operates from a belief, shared by the mental health team, and actively communicated to the person, that recovery can occur and should be expected.

The process of recovery is aided by the provision of interventions to help people with serious mental illness recover their full potential. These interventions are known as psychosocial rehabilitation (PSR) interventions. The primary focus of PSR services is on improving the capabilities and competencies of persons with serious mental health disorders, similar to the focus of rehabilitation interventions for persons with physical impairments or disorders.

Many professionals and consumers alike have written about the philosophy and process of recovery from serious mental illness. Some notable statements that are often quoted are:

- Recovery is what people with illnesses and disabilities do (Anthony, 1993).
- Treatment, case management, support and rehabilitation are the things that practitioners do to facilitate recovery (Anthony, 1993).
- Recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential (Substance Abuse and Mental Health Services Administration, 2006).
- A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (Substance Abuse and Mental Health Services Administration, 2012).
- Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Despite the severity of the conditions that many people have, people with serious mental illnesses want the same things from life that everyone else wants: meaningful relationships, a safe place to live, satisfying activities, adequate income, job satisfaction, and an enjoyable social life. Yet, for many people with serious mental illness, these everyday pursuits are not easily within reach. This remains true today, despite the years of research that show that recovery and a satisfying life are possible. There are many reasons for this including stigma, social exclusion, and failure of treatment systems to provide needed services, to name but a few. These and other issues are discussed in subsequent modules of this curriculum.
Through its Recovery Support Strategic Initiative, SAMHSA delineated four major dimensions that support a life in recovery (Substance Abuse and Mental Health Services Administration, 2012):

- Health: Overcoming or managing one’s disease(s) as well as living in a physically and emotionally healthy way;
- Home: A stable and safe place to live;
- Purpose: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society;
- Community: Relationships and social networks that provide support, friendship, love, and hope.

There are several principles upon which the concept of recovery is based. These were elucidated at the 2006 SAMHSA National Consensus Conference and updated in 2012 and include:
## Ten Fundamental Components of Mental Health Recovery

<table>
<thead>
<tr>
<th>Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualized and Person-Centered: There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations.</td>
</tr>
<tr>
<td>Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing.</td>
</tr>
<tr>
<td>Holistic: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community.</td>
</tr>
<tr>
<td>Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience.</td>
</tr>
<tr>
<td>Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals.</td>
</tr>
<tr>
<td>Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery.</td>
</tr>
<tr>
<td>Respect: Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery.</td>
</tr>
<tr>
<td>Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery.</td>
</tr>
<tr>
<td>Hope: Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them.</td>
</tr>
</tbody>
</table>

A growing body of research continues to support the principles defined in the table above (Warner, 2010). These principles form the underlying basis for helping people recover from serious mental illness and achieve satisfying lives in the community. They are crucial to success.
Challenges

For someone with a serious mental illness, recovery involves many challenges. Some of these challenges stem from the illness itself, some come from society’s beliefs about people with serious mental illnesses, and some of the challenges come from the mental health system. Public stigma and discrimination can cause individuals to internalize society’s stigma, disavow their potential, and isolate themselves. These challenges are made worse for individuals from already marginalized groups such as those with physical disabilities and those from racial or ethnic minorities who can be further isolated due to lack of access to services, including culturally appropriate services.

These challenges often become circular and self-fulfilling because with each recurrence or episode of illness, the person can lose hope that the illness can be managed, family, friends, and acquaintances can further ostracize and stigmatize the individual, and the treatment system can continue to fail and dehumanize the person. People with serious mental illness, their families, and mental health practitioners often have low expectations of what is achievable and frequently lack knowledge about what symptoms or behaviors are due to illness and what are due to the person’s and society’s reaction to that illness. This often leads to a downward spiral for the affected individual and the effect can be traumatizing. Much of this trauma is iatrogenic and can be avoided if the treatment system has a recovery orientation.

The majority of people with serious mental illness have experienced trauma, much of it severe. A considerable amount of this trauma has likely occurred at the hand of the treatment system itself, which often treats people with dis-respect and in dehumanizing ways.

Trauma that comes from the treatment system may be additive to trauma from societal discrimination that someone with serious mental illness has experienced prior to entering treatment. Many individuals with serious mental illness have experienced severe sexual, physical, and emotional abuse at the hands of family members who either perpetrated the abuse or ignored it, thereby allowing it to continue. Despite the impact of this abuse on the development of serious mental illness, it is often not acknowledged due to fear of reprisal, fear of being blamed, or because of the stigma that is frequently attached to victims of abuse, especially sexual abuse.

Trauma at the hands of family members or others should always be considered a potential factor in the etiology of serious mental illness and is an important consideration when people with serious mental illness are asked if they wish their family members to be active participants in their treatment decisions. For the reasons mentioned above, this can be quite challenging for the individual, especially if abuse occurred. It is also important to keep in mind that the makeup of the family constellation may have changed. Individuals who were part of the family in years past may no longer be part of the individual’s familial sphere and current family members may be highly supportive. Social connectedness is
important for all of us and for many with serious mental illnesses, family is the prime connection; many times relationships can be positive and nurturing. These are complex and sensitive issues that should be discussed with the individual, keeping in mind that trauma is often hidden and is always very difficult to acknowledge and discuss. Mental health practitioners must be highly sensitive and recognize the person’s fears related to stigma, the possibility of being blamed for trauma and abuse. Ultimately, the individual’s right to privacy must be respected.

As noted above, practitioners more often than not are unaware of the PSR interventions that have been shown to be effective in helping people with serious mental illness re-gain functional capacity to live satisfying lives in the community. Many of these interventions have been rigorously tested and have been shown to be effective, earning the designation of evidence based practices (EBPs). Unfortunately, far too few providers understand how to provide them and far too mental health systems have allocated the resources to implement them. This lack of will to provide these interventions even when knowledge of their effectiveness is present is a major stumbling block in efforts to help people with serious mental illnesses achieve their recovery goals. In the current economic climates faced by governments around the world, there can be a reluctance to apply the resources needed to provide interventions to bring about optimal recovery – this is frequently the case despite the potential economic gain from reduced hospitalizations and potential revenues generated by consumers who have regained the ability to purchase goods and pay taxes. These potential benefits are most often overlooked however as service delivery systems make choices about the services to be offered.

In a nutshell, the challenges that people with serious mental illnesses have include:

- Dealing with diagnoses that are stigmatizing and imply a sense of permanent disability and impairment
- Challenging and overcoming the stigma that they have incorporated into their very being
- Recovering from the iatrogenic effects of treatment settings
- Recovering from the negative effects of unemployment
- Recovering from the effects of crushed dreams
- Fighting for the right to receive effective interventions that will enable them to live satisfying and productive lives.

In order to help people with serious mental illness overcome these challenges, we need to:

- Ensure that mental health practitioners are appropriately and adequately trained
- Change the attitude of existing staff and those being trained in traditional professional training programs in order to eliminate the stigma that many professionals have even today
• Ensure that psychotherapy with a skilled therapist is available to everyone in order to assist with understanding the illness and what it means to each individual person

• Implement education programs and opportunities for contact with persons with serious mental illnesses to overcome stigma and discrimination

• Change the service delivery system from one which delivers only medication and psychotherapy to one which focuses on provision of rehabilitation services and the potential of each person to recover to the greatest extent possible.

Summary

Recognition that people with serious mental illnesses can recover and lead satisfying lives has been building since the mid 1970s when several international studies showed that this was not only possible, but was in fact occurring. At around the same time, consumers themselves began to be empowered to assert their belief that recovery is possible and began to seek greater participation in decisions about their treatment.

Since that time, the empirical literature and first person accounts have continued to document the possibilities for recovery and to elucidate the conditions under which recovery is facilitated.

Despite publications, reports from government commissions, and government funding designed to facilitate change, professionals have been slow to fully embrace the recovery model. For most professionals, the concept remains foreign and is more often than not, viewed with skepticism.

In an effort to change this, the Substance Abuse and Mental Health Services Administration (SAMHSA) provided funding to the major mental health professional organizations to develop and implement a training curriculum for their profession that is designed to enable current and future practitioners to be knowledgeable and competent to provide services that will facilitate recovery.

Many challenges remain. These range from individual lack of knowledge and resistance to systems level issues such as inertia, lack of funding, and resistance – systems are ultimately led by individuals! Frustration on the part of consumers and practitioners alike is another challenge: recovery from serious mental illness is often a complex, time-consuming process – just as it is with any serious illness. There is no quick fix!

In order to assist those with serious mental illness to recover, psychologists must recognize and embrace the philosophy of recovery and transmit that philosophy to consumers themselves, their families, others in society, and the mental health treatment systems in which they work. Psychologists’ focus on positivism, respect, and individual strengths can be the starting point for additional training in how to help people with serious mental illnesses recover, achieve their life goals and live satisfying and productive lives.
In order to assist people with serious mental illness to recover, psychologists also need to be fully trained in the PSR interventions that have been shown to be effective in helping people achieve a satisfying and productive life in the community of their choice.

The table below depicts the differences in a traditional approach to a person with serious mental illness versus a recovery oriented response to situations that might be encountered. The scenarios presented are instructive as the traditional versus recovery oriented approaches result in vastly different ways of working with people with these conditions.
Moving from a Deficit-Based to a Strengths-Based Approach to Care

The following are examples of how language, thinking, and practice shift in the evolution of a recovery-oriented system of care:

<table>
<thead>
<tr>
<th>Presenting Situation</th>
<th>Deficit-based Perspective</th>
<th>Recovery-oriented, Asset-based Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Perceived Deficit</td>
<td>Perceived Asset</td>
</tr>
<tr>
<td>Person re-experiences symptoms</td>
<td>Decompensation, exacerbation, or relapse</td>
<td>Re-experiencing symptoms as a normal part of the recovery journey; an opportunity to develop, implement, and/or apply coping skills and to draw meaning from managing an adverse event</td>
</tr>
<tr>
<td></td>
<td>Involuntary hospitalization; warning or moralizing about “high risk” behavior (e.g., substance use or “non-compliance”)</td>
<td></td>
</tr>
<tr>
<td>Person demonstrates potential for self-harm</td>
<td>Increased risk of suicide</td>
<td>Indicators of potential for self-harm are important signals to respond differently. The person is likely to have a weakened sense of efficacy and feel demoralized, and thus may require additional support. On the other hand, the person has already survived tragic circumstances and extremely difficult ordeals, and should be praised for his or her prior resilience and perseverance</td>
</tr>
<tr>
<td></td>
<td>Potentially intrusive efforts to “prevent suicide”</td>
<td></td>
</tr>
<tr>
<td>Person takes medication irregularly</td>
<td>Person lacks insight regarding his or her need for meds; is in denial of illness; is non-compliant with treatment; and needs monitoring to take meds as prescribed</td>
<td>Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; has a crisis plan for when meds should be used. Alternatively, behavior may reflect ambivalence regarding medication use which is understandable and normal, as approximately half of people with any chronic health condition (e.g., diabetes, asthma) will not take their medication as prescribed</td>
</tr>
<tr>
<td></td>
<td>Medication may be administered, or at least monitored, by staff; staff may use cigarettes, money, or access to resources as incentives to take meds; person is told to take the meds or else he or she will be at risk of relapse or decompensation, and therefore may need to be hospitalized</td>
<td></td>
</tr>
</tbody>
</table>

<p>| American Psychological Association |</p>
<table>
<thead>
<tr>
<th>Presenting Situation</th>
<th>Deficit-based Perspective</th>
<th>Recovery-oriented, Asset-based Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person makes poor decisions</td>
<td>Person’s judgment is impaired by illness or addiction; is non-compliant with directives of staff; is unable to learn from experience</td>
<td>Person has the right and capacity for self-direction (i.e., Deegan’s “dignity of risk” and the “right to fail”), and is capable of learning from his or her own mistakes. Decisions and taking risks are viewed as essential to the recovery process, as is making mistakes and experiencing disappointments and set backs. People are not abandoned to the negative consequences of their own actions, however, as staff stand ready to assist the person in picking up the pieces and trying again. Discuss with the person the pros, cons, and potential consequences of taking risks in the attempt to maximize his or her opportunities for further growth and development. This dialogue respects the fact that all people exercise poor judgment at times, and that making mistakes is a normal part of the process of pursuing a gratifying and meaningful life. Positive risk taking and working through adversity are valued as means of learning and development. Identify discrepancies between person’s goals and decisions. Avoid arguing or coercion, as decisions made for others against their will potentially increase their learned helplessness and dependence on professionals.</td>
</tr>
<tr>
<td>Person stays inside most of the day</td>
<td>Person is withdrawing and becoming isolative; probably a sign of the illness; can only tolerate low social demands and needs help to socialize</td>
<td>Person prefers to stay at home; is very computer savvy; and has developed skills in designing web pages; frequently trades e-mails with a good network of NET friends; plays postal chess or belongs to collectors clubs; is a movie buff or enjoys religious programs on television. Person’s reasons for staying home are seen as valid. Explore benefits and drawbacks of staying home, person’s motivation to change, and his or her degree of confidence. If staying home is discordant with the person’s goals, begin to motivate for change by developing discrepancies. If leaving the house is important but the person lacks confidence, support self-efficacy, provide empathy, offer information/advice, respond to confidence talk, explore hypothetical change, and offer to accompany him or her to initial activities.</td>
</tr>
<tr>
<td>Person denies that he or she has a mental illness and/or addiction</td>
<td>Person is unable to accept illness or lacks insight</td>
<td>Acceptance of a diagnostic label is not necessary and is not always helpful. Reluctance to acknowledge stigmatizing designations is normal. It is more useful to explore the person’s understanding of his or her predicament and recognize and explore areas for potential growth. In addition to exploring person’s own understanding of his or her predicament, explore symptoms and ways of reducing, coping with, or eliminating distress while eliciting ways to live a more productive, satisfying life.</td>
</tr>
<tr>
<td>Presenting Situation</td>
<td>Deficit-based Perspective</td>
<td>Recovery-oriented, Asset-based Perspective</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td><strong>Person sleeps during the day</strong></td>
<td>Perceived Deficit</td>
<td>Intervention</td>
</tr>
<tr>
<td>Person’s sleep cycle is reversed, probably due to illness; needs help to readjust sleep pattern, to get out during the day and sleep at night</td>
<td>Educate the person about the importance of sleep hygiene and the sleep cycle; offer advice, encouragement, and interventions to reverse sleep cycle</td>
<td>Person likes watching late-night TV; is used to sleeping during the day because he or she has always worked the night shift; has friends who work the night shift so prefers to stay awake so she or he can meet them after their shift for breakfast. Person’s reasons for sleeping through the day are viewed as valid</td>
</tr>
<tr>
<td><strong>Person will not engage in treatment</strong></td>
<td>Person is non-compliant, lacks insight, or is in denial</td>
<td>Subtle or overt coercion to make person take his or her medications, attend 12-step or other groups, and participate in other treatments; alternatively, discharge person from care for non-compliance</td>
</tr>
<tr>
<td><strong>Person reports hearing voices</strong></td>
<td>Person needs to take medication to reduce voices; if person takes meds, he or she needs to identify and avoid sources of stress that exacerbate symptoms</td>
<td>Schedule appointment with nurse or psychiatrist for med evaluation; make sure person is taking meds as prescribed; help person identify and avoid stressors</td>
</tr>
</tbody>
</table>

*Source: Tondora & Davidson, 2006*
Sample Learning Activity

Class discussion and consensus activities should be completed with one or more people with lived experience as participants. There are two parts to this exercise.

The first part of the activity is a short video which should be played for the entire class. The video can be accessed via the link:

https://onedrive.live.com/redir?resid=7086A6423672C497!162&authkey=!AL_8-sI4cV1btK4&ithint=video%2c.mp4

The second part of the activity should follow the video and involves class discussion using the following questions:

1. What stood out for you in the clip and why?
2. How did you feel emotionally mid-way through the clip? How did you feel at the end?
3. What did you learn?
4. What if YOU were defined largely by ONE attribute/part of yourself – a part you really struggle with – maybe an illness, maybe a difficult experience in your life. What if that was what others focused on most all the time? What would that be like?
5. How do you get to know people with serious mental illnesses as whole people beyond their diagnoses?
## Sample Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recovery is the reduction or remission of symptoms of mental illness</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2. The pursuit of a satisfying life in the community and valued roles is</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>important for recovery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Recovery from serious mental illness is supported by consumer experience and research evidence</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4. The goal of recovering is to become normal</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5. Providers and family members are the most qualified to determine a person’s care</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Lecture Notes Citations


Additional Resources


Citing the Curriculum

Citation for this Module:

Citation for the full Curriculum:

For additional information, contact:
Recovery to Practice initiative at the American Psychological Association, [www.apa.org/pi/rtp](http://www.apa.org/pi/rtp)
or
Mary A. Jansen, Ph.D., at Bayview Behavioral Consulting, Inc., [mjansen@bayviewbehavioral.org](mailto:mjansen@bayviewbehavioral.org) or [jansenm@shaw.ca](mailto:jansenm@shaw.ca)