American Psychological Association

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

2. The Recovery Movement: Role of Psychologists and Health Care Reform

August 2014
# Contents

Overview .......................................................................................................................... 3  
Learning Objectives ......................................................................................................... 3  
Resources .......................................................................................................................... 3  
Required Readings ............................................................................................................ 3  
Activities .......................................................................................................................... 4  
Lecture Notes .................................................................................................................... 5  
  Introduction .................................................................................................................... 5  
Schizophrenia Recovery Research ...................................................................................... 6  
Psychologists’ Roles in a Recovery Oriented System versus a Traditional Mental Health  
System: Similarities and Differences ................................................................................. 6  
  Psychologists as Clinicians ............................................................................................ 7  
  Psychologists as Researchers ......................................................................................... 7  
  Psychologists as Program Managers .............................................................................. 8  
  Psychologists as Administrators and Policy Makers ....................................................... 9  
Health Care Reform: What’s in it for People with Serious Mental Illness and How  
Psychology Can Help ...................................................................................................... 10  
  Anticipated Benefits for People with Serious Mental Illnesses ..................................... 10  
  How Psychologists can Help by Using the Research and Demonstration Provisions of  
  the Act .......................................................................................................................... 12  
  Challenges ..................................................................................................................... 14  
  Summary ....................................................................................................................... 14  
Sample Learning Activity ................................................................................................. 16  
Sample Evaluation Questions ............................................................................................ 17  
Lecture Notes Citations ................................................................................................. 18  
Additional Resources ........................................................................................................ 19  
Citing the Curriculum ...................................................................................................... 22
Overview

In this module of the course we will discuss the history of the recovery movement and consider the roles of psychologists and the potential impact of U.S. health care reform.

Learning Objectives

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

- Discuss at least two contributions made by psychologists to the evolution of the recovery movement in mental health
- Identify four roles of psychologists and describe the difference within each between traditional functions and functions of psychologists in a recovery oriented framework or system
- List at least two benefits that are expected to accrue to people with serious mental illness as a result of the Patient Protection and Affordable Care Act of 2010
- List and describe at least two opportunities for psychologists as a result of the Patient Protection and Affordable Care Act of 2010

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

Psychologists have been at the forefront of the recovery movement since its beginnings in the mid 1970s when psychologist Dr. Bill Anthony started the Boston University Center for Psychiatric Rehabilitation and others such as Dr. Larry Davidson began writing about the concept of recovery from serious mental illness. At about the same time, individuals with serious mental illnesses began writing about their experiences and documenting their personal histories of recovery. Some of these individuals are also psychologists who have published extensively on the topic and include Dr. Ron Bassman, Dr. Patricia Deegan, Dr. Fred Frese, and Dr. Kay Redfield Jamison, to name but a few. Following from this, psychologists (and other mental health practitioners) initiated research on the outcomes associated with various interventions. Their resulting publications showed that indeed, people with serious mental illnesses were recovering and living satisfying lives. Concurrently, researchers in several countries began publishing long term outcome data showing that people with serious mental illnesses all over the world had similar recovery rates. Then, in the mid 1980s, psychologist Dr. Courtenay Harding published a study of people in Vermont with serious mental illness, which documented their recovery, and successes in the community. Finally, in the mid 1990s, Harding published a landmark compendium of studies which pulled together the evidence from several countries, all of which documented similar rates of recovery from serious mental illnesses (Harding & Zahniser, 1994). A synthesis of these and more recent studies is provided in the table below:
## Schizophrenia Recovery Research

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Size</th>
<th>Average Length Years</th>
<th>Percent Recovered or Significantly Improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleuler 1972 to 1978 Switzerland</td>
<td>208</td>
<td>23</td>
<td>53-68</td>
</tr>
<tr>
<td>Hinterhuber 1973 Austria</td>
<td>157</td>
<td>30 apprx</td>
<td>75</td>
</tr>
<tr>
<td>Huber et al 1975 Germany</td>
<td>512</td>
<td>22</td>
<td>57</td>
</tr>
<tr>
<td>Chiompi &amp; Muller 1976 Switzerland</td>
<td>289</td>
<td>37</td>
<td>53</td>
</tr>
<tr>
<td>Kreditor 1977 Lithuania</td>
<td>115</td>
<td>20+</td>
<td>84</td>
</tr>
<tr>
<td>Tsuang et al 1977 USA</td>
<td>200</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>Marinow 1986 Bulgaria</td>
<td>280</td>
<td>20</td>
<td>75</td>
</tr>
<tr>
<td>Harding et al 1987b 1987c USA</td>
<td>269</td>
<td>32</td>
<td>62, 68</td>
</tr>
<tr>
<td>Ogawa et al 1987 Japan</td>
<td>140</td>
<td>22.5</td>
<td>56</td>
</tr>
<tr>
<td>Desisto et al 1995a 1995b USA</td>
<td>269</td>
<td>35</td>
<td>49</td>
</tr>
<tr>
<td>Marneros et al 1992</td>
<td>148</td>
<td>25</td>
<td>58</td>
</tr>
<tr>
<td>Harrison et al 2001 worldwide</td>
<td>1005</td>
<td>15 and 25</td>
<td>43 - 61</td>
</tr>
<tr>
<td>Hopper et al Sz Only Incidence</td>
<td>502</td>
<td>13 to 17</td>
<td>67</td>
</tr>
<tr>
<td>Hopper et al Sz Only Prevalence</td>
<td>142</td>
<td>26</td>
<td>63</td>
</tr>
</tbody>
</table>

Additionally, despite long held beliefs that serious mental illnesses are chronic deteriorating illnesses, several meta analyses and summaries of recently conducted studies have appeared 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 most have the potential to achieve long-term remission and functional recovery (Zipursky, Reilly, & Murray, 2012).

Since then, and continuing to the present, psychologists, together with consumers, have led efforts to conduct research on recovery outcomes, and have developed and tested instruments designed to assess functional skills. Psychologists have also developed and tested psychosocial rehabilitation (PSR) interventions to assist with the recovery process, conducted clinical trials to identify evidence based PSR interventions, and psychologists and consumers have worked with state and federal government agencies to promote practices that are designed to facilitate the recovery process for people with serious mental illnesses.

### Psychologists’ Roles in a Recovery Oriented System versus a Traditional Mental Health System: Similarities and Differences

Psychologists generally work within certain roles such as clinician, researcher, manager/administrator, teacher, or policy maker, to name the most common. These roles were recently described in detail for psychologists working in medical centers (Robiner, Dixon, Miner & Hong, 2014) and are similar to psychologists’ roles in other settings. Working from a recovery framework however, means approaching these traditional roles from a different perspective. No matter what role psychologists undertake, successful
transformation of the mental health system to a recovery orientation requires a commitment to helping people recover to the greatest extent possible, and doing so on their terms, not our terms or those of other professionals or the service delivery system. Some examples of roles and the opportunities offered by each one are discussed below.

**Psychologists as Clinicians**

Although psychologists are trained to establish a strong therapeutic alliance, psychologists working in a recovery oriented framework must approach people very differently. In a traditional therapeutic setting, psychologists often become the leader, the doctor, or the professional who is seen as having most of the answers and who knows what is best for the client. In a recovery oriented setting, psychologists must be partners with the person they are working with and must demonstrate this partnership by conveying true respect for the person and for his or her wishes and goals.

Another difference within the clinical setting has to do with assessments that psychologists conduct. Most traditional psychological assessments are designed to determine symptomatology, mental state, or diagnosis. Recovery oriented psychologists work with people to determine their strengths, functional skill capabilities and deficits, assess resources needed to increase functional skills and overcome deficits, and assist with goal setting based on skills and resources needed and available to achieve those goals.

A third difference that exists within the clinical setting has to do with psychotherapy and PSR interventions. While some persons with serious mental illness may desire traditional psychotherapeutic approaches, others may not, instead choosing to focus on interventions that can help with practical problems such as overcoming cognitive deficits, developing the ability to deal with symptoms better by challenging unwanted thoughts, learning appropriate work behaviors, learning how to manage medications and symptom flare-ups, etc. These more practical interventions are some of those that make up the armamentarium of PSR that psychologists helped develop and test. These are the interventions that people with serious mental illness often want because of their direct link to living successfully in the community and psychologists need to be adequately trained to provide them.

**Psychologists as Researchers**

The research skills that psychologists learn in traditional training programs are the same ones that are used in recovery oriented research. What may differ are the topics and hypotheses generated as these may (although not always) be more person centered and or qualitative than traditional psychological research. A significant difference is the involvement of people with serious mental illness in the design and implementation of recovery oriented research studies.

For example, psychologists studying the recovery process may want to learn about the most efficacious means to assist people determine the goals they have for themselves. Or a recovery oriented psychologist researcher may want to help people understand their own
internal processes that influence their everyday decisions. These kinds of research inquiries are not unique but the approach taken to design the study and to involve individuals with serious mental illnesses in the research process is likely to be very different.

Notwithstanding the above, much of the empirical work that has informed the knowledge base of evidence based practices for people with serious mental illnesses has been, and continues to be carried out by psychologists. Many of these studies have been randomized clinical trials that have been led by psychologists. This research has followed very traditional trajectories – only the topics and study population differ. Recovery oriented research may benefit from studies that are more qualitative in nature and design, including those that employ participatory action research methods.

Due to the difficulty of conducting complex community research with multiple variables that are difficult to control, and the need to obtain both quantitative and qualitative data, suggestions have emerged about how to move forward (Creswell, Klassen, Plano Clark & Smith, 2011; Tashakkori & Teddlie, 2003; Teddlie & Tashakkori, 2009) and involve the use of mixed methods designs. These suggestions seem particularly appropriate for our efforts to learn which interventions work best for people with serious mental illnesses. In mixed methods research, quantitative and qualitative data collection and analysis are combined in the same study, not in sequential processes, but as part of one overall design. The central premise of mixed methods research is that using quantitative and qualitative approaches at the same time provides a stronger design and a better way to view the research question and the study results than either approach alone. Combining quantitative and qualitative designs may be the approach of choice for studying the variables of interest in the recovery paradigm and PSR interventions. For additional information about mixed methods research, consult the Scientific Foundations module of this curriculum. Information can also be found in a publication from the NIH Office of Behavioral and Social Sciences Research which developed a guidance document aimed at helping potential grantees understand and use mixed methods research (Creswell, Klassen, Plano Clark & Smith, 2011).

**Psychologists as Program Managers**

Psychologists often serve as team directors or team strategists where they lead implementation efforts and supervise staff who are delivering services. A recovery orientation involves a change in attitudes, values and beliefs, not only about the potential of people with serious mental illness, but also about the roles, responsibilities, and services offered by psychologists and other practitioners. The move to a recovery oriented system requires a paradigm shift and as with any paradigm shift, resistance is frequently encountered from staff who may be fearful of new ways of carrying out their duties and roles, and of what these changes mean for them. Psychologists who work in mental health systems that are changing to a recovery orientation must be prepared to assist staff, including other psychologists, confront the resistance they experience and work through
that constructively. Due to psychologists’ training in group facilitation, psychologists are well suited to help staff understand the reasons that new ways of providing services can be beneficial to people with serious mental illnesses and help staff deal with the anxiety that surrounds change.

Thanks to the research training that psychologists receive, psychologists are also well suited to translate the research literature so that it is understandable and to highlight the relevance of scientific findings for the population being served. One way to accomplish this is to use the research behind evidence based practices and other empirically supported practices to inform staff about the improved outcomes demonstrated following their use and a recovery oriented philosophy of care. This can help staff to more easily see the benefit of new and different kinds of services. Psychologists are also trained to conduct program evaluations of new services and when these assessments indicate positive results, staff are more likely to see the benefits of the changes. Such evaluations serve another valuable purpose – when the evaluation results are not positive, programs and services can be revised to ensure that they are truly meeting the needs of the people they are intended to serve. Likewise, designing and implementing a performance monitoring system to track results and monitor progress is an essential component of this aspect of the change process. Developing monitoring systems is another skill most psychologists have and is one that system managers can use to facilitate systems change.

**Psychologists as Administrators and Policy Makers**

Psychologists who serve in administrative and policy making roles have unique opportunities to effect system change. Increasingly, psychologists are serving as senior executives in governmental agencies and behavioral health organizations, and are being elected to political office at local, state, and federal levels. This presents unprecedented opportunities to lead the mental health service delivery system to a recovery oriented system that values and respects users of services. For those psychologists who have access to resources, an obvious place to start is by allocating funds and other resources needed to accomplish change and ensure successful implementation.

One challenge faced by psychologists in administrative and policy making positions is that these are relatively new roles that have not been traditionally occupied by psychologists. Psychologists have not traditionally embraced the worlds of politics and advocacy, preferring instead to work directly with people in need of clinical assistance. Thus, despite being in administrative leadership positions, many psychologists may not feel comfortable with, nor have the skills needed, to undertake system transform, especially when that transformation is likely to evoke resistance from others within and outside the system. Changing systems of care and attendant practices requires knowledge of the practices to be implemented, leadership capability, political savvy, and, in some cases, great tenacity.
Health Care Reform: What’s in it for People with Serious Mental Illness and How Psychology Can Help

The Patient Protection and Affordable Care Act of 2010 (U.S. Public Law 111-148, 2010) and the subsequent amendments to it, the Health Care and Education Reconciliation Act of 2010 (U.S. Public Law 111-152, 2010) ushered in a new era for the provision of health care in the United States. In addition to the mental health parity legislation that was passed in 2008 (the Mental Health Parity and Addiction Equity Act of 2008), (Federal Register, 2013), the health care reform legislation of 2010 has many provisions that can ultimately benefit people with serious mental illness and that are of interest to psychologists. Many parts of the new law remain to be clarified and there will no doubt be challenges and changes. However, there are some immediately apparent benefits for people with serious mental illness and also for psychologists that can be identified. These are discussed below.

Changing mental health service delivery systems and changing the behavior of those who work in these systems will not be easy. In recent years, several attempts at changing systems have been made. While there have been some successes, change has proven difficult and many times, changes that were accomplished have been rolled back when new leadership and/or new clinicians entered the system. However, according to a recent report commissioned by the U.S. Agency for Healthcare Research and Quality:

> The opportunities associated with health care reform are many, and business as usual, with its incremental efforts to improve outcomes, is no longer possible. Researchers, administrators, policy makers, and clinicians are at a crossroads. It is time to take on the challenge of producing learning systems that can provide real patient-centered and patient-directed care to individuals with serious mental illnesses (Green, Estroff, Yarborough, Spofford, Solloway, Kitson & Perrin, 2014, p xi).

**Anticipated Benefits for People with Serious Mental Illnesses**

For people with serious mental illnesses, the new law, now referred to as the Affordable Care Act (ACA) or simply health care reform legislation, will significantly broaden the opportunities they have to obtain health insurance (Beronio, Po, Skopec & Glied, 2013). This is nothing short of monumental for individuals with serious mental illness who have traditionally been among the nation’s poorest and most vulnerable groups. Currently, for people who are not insured through Medicaid or by an employer with 50 or more employees, it is very difficult to access affordable mental health services due to limitations in the Mental Health Parity and Addiction Equity Act and the failure of many states to adopt their own mental health parity laws. Under health care reform, these individuals will be able to obtain subsidies to purchase insurance if they cannot afford it, and it will not be possible to deny coverage due to a person’s illness(es), even where those illnesses were pre-existing prior to enactment of the legislation. However, since the Act is new and states are able to “opt out” of the provision for receipt of subsidy funding, it may be that individuals
in states that choose to opt out will continue to lack access to coverage. This will need to be watched carefully (Garfield, Lave & Donohue, 2010).

An additional feature that will benefit individuals with serious mental illnesses and their families is that children will be able to be included in their parents’ insurance plans until age 27. Since schizophrenia and other psychoses often strike young people in their teens and early twenties, the developmental trajectory of these young people is often altered resulting in an inability to complete educational plans and obtain sustained employment. Being maintained on their parent’s health insurance while they work to recover will be a major boost to many of these young people.

For those people with serious mental illness that are working, their condition will no longer pose an impediment for their employer to provide coverage. In fact, employers will be required to provide coverage to everyone equally, as everyone will be entitled to, and in fact required to have, health insurance. All qualified health plans are now required to comply with the federal parity law, the Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343. This means that mental health and substance use benefits must be provided at parity with medical/surgical benefits in these plans (Federal Register, November 13, 2013).

A fundamental component of the legislation is that patient-centered, integrated primary health care should be available to all Americans. In addition to expanded access to health care, people with serious mental illness should realize other benefits as well, principally in the physical health domain. The legislation encourages accountable care organizations (ACO) and smaller-scale patient-centered medical homes (PCMH) as two models for comprehensive, integrated patient care led by primary care providers. ACOs contract with payers to provide a broad range of services to a designated population, with the goal of reducing costs while ensuring quality care. The PCMH model of care involves an interprofessional team of providers led by a personal physician delivering continuous and coordinated care to patients. Under these models, service delivery focuses on “whole person” care that recognizes the mind-body connection and the importance of integrating physical health services with mental and behavioral health services (American Psychological Association, 2012). People with serious mental illness often have substantial physical health problems and increased morbidity and mortality from those conditions. Since everyone will have access to general medical care, it is hoped that a good portion of these disparities will be reduced. Expanded benefits will apply to long-term care for supportive services and from improved coverage of preventive services in expanded health insurance plans.

One of the guiding principles of the new legislation is that all health care should be integrated and delivered by interdisciplinary teams and that consumers of that care should be seen as part of the team. This emphasis on integration of mental health care is to be achieved in the broader context of promotion of patient-centered treatment models. One model supported in the Act is the “medical home”, which is a valuable means for
enhancing mental health treatment. Locating specialists – such as psychologists and other mental health professionals – in a primary care setting is seen as a potentially effective way to identify and manage multiple treatment needs and coordinate care. At the heart of this move is the concept of patient centered care. While not identical to the concept of recovery from serious mental illness, patient centered care is a step toward the recovery concept because it emphasizes the need to put consumers of care at the center and requires coordination with consumers and respect for their wishes. The leap from patient centered care to recovery oriented care in mental health is not difficult to make.

Examples of discrepancies that exist for people with mental health disorders can be seen from the following data. It is hoped the ACA will substantially reduce or eliminate these discrepancies:

- One in four uninsured adult Americans has a mental disorder, substance use disorder, or both (National Alliance on Mental Illness and National Council for Community Behavioral Healthcare, 2008);
- Mental illness is the leading cause of disability in the United States and Canada for people between the ages of 15 and 44 (World Health Organization, 2008);
- The Global Burden of Disease study indicates that the burden of disease from mental disorders for countries like the United States exceeds those from any other health condition (World Health Organization, 2001);
- Adults with serious mental illness die, on average, 25 years sooner than those who do not have a mental illness (National Association of State Mental Health Program Directors Medical Directors Council, 2006);
- In 2002, mental illness and substance use disorders led to $193 billion in lost productivity – more than the gross revenue of 499 of the Fortune 500 companies – and by 2013, this figure is estimated to rise to more than $300 billion (Kessler, 2008);
- Almost one in four stays in U.S. community hospitals involved depression, bipolar disorder, schizophrenia, and other mental health and substance use disorders (Agency for Healthcare Research and Quality, 2007).

How Psychologists can Help by Using the Research and Demonstration Provisions of the Act

The healthcare reform legislation seeks to enhance mental health care in the United States by promoting evidence-based treatment of behavioral health conditions. As primary care providers, psychologists are vital in treating and preventing a range of health and mental health concerns in children, teens and adults. Like other healthcare providers, under the new law, mental health professionals will be asked to participate in more efforts to measure outcomes. This will offer psychologists the opportunity to demonstrate the value of the interventions they offer. This will also genuinely reform mental healthcare, as mental health providers are not accustomed to the level of scrutiny required by the new legislation.
The Act places considerable emphasis on provision of “evidence based medicine”. While this is often construed to mean interventions designed to affect physical health conditions, most believe that mental and behavioral health practitioners will be held to a similar standard, i.e., showing that what is provided for people with mental health disorders works and has positive benefits. The PSR interventions that help people recover and live satisfying and productive lives in the community are examples of evidence based medicine in mental health. Psychologists must be prepared to design, deliver, and evaluate them in their work settings. The legislation’s repeated emphasis on quality-of-care measures and on evidence-based treatment will increase the need for use of proven approaches in mental health care. PSR interventions are exactly the kind of proven services that may be required.

Thus, an exciting possibility that may be afforded by the demonstration grant provisions of the law is the opportunity to conduct research on the efficacy of the already identified evidence based and promising practices in less well-resourced environments. Resource limitations have often compromised fidelity to the original evidence based practices and have often been a stumbling block to their implementation. The demonstration grant provisions of the new law may also allow for the possibility of evaluating some practices that have not yet been designated as evidence based, and that may be better suited to provision in a less well structured community setting.

The legislation also affords the opportunity for grants to establish demonstration projects for the provision of coordinated and integrated services to adults with mental illnesses who have co-occurring primary care conditions or chronic medical diseases. These projects will deliver care through the co-location of primary and specialty care services in community-based mental and behavioral health settings. Demonstration grants will afford psychologists the opportunity to refine interdisciplinary models of care and demonstrate the value of incorporating behavioral health specialists in settings previously reserved for medically trained personnel.

The Act also provides funding for training psychologists to work with vulnerable populations, including those with severe mental health disorders. All of these opportunities open the door for psychologists to broaden the traditional scope of training and practice to incorporate people with serious mental illnesses.

In sum, the Act encourages mental health treatment services to be integrated into primary care settings and requires that providers use evidence based practices and demonstrate outcomes. Providers who use practices supported by evidence would be rewarded with greater public reimbursements and where insurance is part of the payment scheme, have more practice opportunities within private plans’ provider networks. All of this speaks to the need for psychologists to be appropriately and adequately trained to approach mental health care from a recovery perspective and to use evidence based PSR practices when these meet the needs and desires of the people they serve.
Challenges

There are many challenges that lie ahead as the United States moves toward a system that provides increased access to health and mental health care for the majority of its citizens. These challenges are magnified by the fact that only the broadest of parameters have been established for the new system. Thus in some ways, the new system is a moving target for both users of the system and for providers. Some of the greatest challenges are discussed below.

For individuals with serious mental illness, the greatest challenge may be learning about and accessing benefits that the new law has to offer. This challenge will be faced by all citizens in the US and people with impairments of any kind need to be especially vigilant to ensure that the new benefits are made available to them. This may require advocacy on the part of individuals and by advocacy organizations.

For psychologists, the challenges may be more self-imposed than system imposed. For example, many psychologists will be reluctant to give up individual private practices to join interdisciplinary teams. Although this will not be required, the legislation encourages multi-disciplinary teams that are patient centered and utilize interventions supported by an evidence base. Improved outcomes for consumers must also be demonstrated. This may be a difficult change for psychologists who are used to practicing autonomously with little oversight or accountability.

Another challenge will be the incorporation of training for work with the most vulnerable populations, including those with serious mental illnesses, into traditional psychology training programs. Although some progress has been made toward this goal, most doctoral training programs currently pay scant attention to the most important aspects of this work, i.e., the recovery paradigm and PSR interventions. Most recently some have begun to argue that such training is needed if we are to adequately prepare psychologists to genuinely be of expert assistance to people with serious mental illnesses (Mueser, Silverstein & Farkas, 2013). Given the long established mentor system that exists in training programs, infusing new clinical and research concepts into training programs may meet considerable resistance and prove to be a major challenge. This curriculum is designed to help meet that challenge.

Summary

Psychologists have worked alongside people with serious mental illnesses since the early days of the recovery movement in the mid 1970s to advocate for clinical and systems change by publishing first person and professional accounts, conducting research, and advocating for change.

Many psychologists have been involved in this effort and continue to work to support the changes needed to ensure that people with serious mental illnesses have hope, are treated with respect, and receive the services they wish to receive.
Psychologists occupy many different roles in academia, clinical settings, and mental health systems. These roles can be substantially different when viewed and carried out from a traditional perspective versus a recovery oriented perspective. The most typical roles that psychologists occupy include functioning as clinicians, researchers, program managers, and administrators and policy makers.

While the specific duties of each role vary widely, the overarching differences are that psychologists who approach their work from a recovery perspective work as a partner with people with serious mental illnesses rather doing to, or doing for, people with these illnesses. While it might not sound like a big difference, this is a huge philosophically different approach.

This means that clinicians conduct assessments that focus on strengths and skills, and only provide interventions that their clients have decided they want; researchers include consumers as equal partners in all phases of studies; program managers help staff understand the value of new, more functionally oriented services and of working with consumers rather than designing programs without their input and agreement; and administrators and policy makers accept the need to take on the risks and challenges that will likely come with system change efforts.

Health care reform legislation enacted over the course of the past few years offers the opportunity for unprecedented gains for consumers of mental health services. The Patient Protection and Affordable Care Act of 2010, its amendments, and the Mental Health Parity and Addiction Equity Act of 2008, hold promise for changing the way that people with serious mental illnesses access and receive services, and for changing the physical and mental health trajectory for individuals.

Health care reform offers the possibility for psychologists to be at the center of the process by conducting research demonstrations on new interventions, alternate venues for service delivery, and outcomes of new service models for people with serious mental illnesses.

In order for consumers and psychologists to truly benefit from the new legislation, psychologists must be adequately trained. This will require a paradigm shift in traditional training programs that have responsibility for imparting new attitudes, values and beliefs to the next generation of psychologists.
Sample Learning Activity

This activity has two parts. The first part consists of watching a short video clip of a person with lived experience who works as a peer support worker. The link to the video is:

http://vimeopro.com/createusmedia/samsha-cps-interviews/video/75881005 and the password is: NAPS2012$SAMSHA

The second part of the activity consists of discussing the following questions:

1. What stood out for you in the clip and why?

2. How did you see some of the goals of “person-centeredness” play out in the clip? (e.g., hope, overcoming stigma/community inclusion, partnership, strengths-based)?

3. What did you learn?
## Sample Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychologists have had little impact on the recovery movement</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2. A person with a serious mental illness has very limited vocational options and should never consider becoming a psychologist or other mental health practitioner</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3. Psychologists who practice from a recovery orientation primarily conduct diagnostic and neurological assessment</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4. Health care reform legislation holds promise of closing the early mortality gap between people with serious mental illness and those who do not have serious mental illness because those with such disorders will have equal access to physical health care</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5. Health care reform opens the door to train psychologists in behavioral health services for the most vulnerable populations</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Lecture Notes Citations


http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_AnnexA.pdf?ua=1


**Additional Resources**


Kreditor, D. Kh. (1977). Late catamnese of recurrent schizophrenia with prolonged remissions (according to an unselected study). *Zh Nevrol Psikhiatr Im S S Korsakova* 77, 110-113.


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)