Your Recovery Journey

meaning
management &
medication

Guide for Facilitators

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Your Recovery Journey: Meaning, Management, and Medication

The Schizophrenia Society of Canada is interested in hearing from you. If you find this resource helpful, or if you have any suggestions or questions, please let us know.

E-mail **info@schizophrenia.ca** or phone **1-800-263-5545**

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Chief Executive Officer, member of the advisory committee

Catherine Willinsky, MHSc.
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"Your Recovery Journey" is a valuable resource for those affected by mental illness who are looking for hopeful tools to assist them in their recovery. Recovery is a practical concept. It works in real life, with real people. I know this from first-hand experience.

A member of my family suffered from severe depression. Following an attempted suicide, with professional and spiritual help and medication, my sister was able to recover sufficiently to graduate from university and enjoy a meaningful and productive life for many years.

The national mental health strategy, which the Mental Health Commission of Canada is developing, will have as its cornerstone the principle of recovery.

(Michael Kirby, Chair, Mental Health Commission of Canada)

"We all have something to recover from, whether it is mental illness, addiction, physical disability, loss of loved ones, victimization or loneliness... Recovery creates a community that all can take part in as it erases the distinctions of position, age, skin colour, religion, language and education, and joins us in our common humanity."

(Sowers, W. 2007)

Foreword

"Don't tell me recovery is not evidence based! I am the evidence."

(Woman with a mental illness)

I love this quote! While there is no one definition that all agree on, recovery is all about hope, the hope that people can live lives of quality and dignity in spite of the limitations that come with mental illness.

For years it was thought that mental illnesses like schizophrenia were kiss-of-death diagnoses. Life was over. All hope evaporated. But we now have numerous long-term studies that indicate that up to two-thirds of people with mental illness can and do recover.

Recovery can have many different meanings. Some people will have one episode of psychosis or schizophrenia. Their recovery is much like that of a person recovering from a heart attack; though they are vulnerable, they may never have another episode again.

For others, the recovery or recovering process is much longer, perhaps even life-long. There may be intermittent relapses with mental illnesses like schizophrenia and bipolar disorder. Like people who live with asthma, people with schizophrenia can live a life of quality and purpose, but must pay special attention to self-care and to managing their illness.

Some people who have experienced unremitting mental illness seem to be beyond recovery. I understand this: one of my brothers lives with schizophrenia and another with bipolar disorder. Illness can be unremitting when people can't access recovery-oriented mental health services and systems. But we must still hope they can experience recovery.

Dr. Larry Davidson, professor of psychiatry at Yale University, says that recovery means learning how to live outside the mental illness rather than inside it. To live inside the mental illness is to be lost in its downward spiral. Living outside schizophrenia is about reclaiming your life. It is about self-determination, choice, hope, and empowerment.

Many who experience prolonged mental illness are not only recovering from the mental illness, but are also recovering from the losses associated with mental illness, and from its stigma and discrimination: loss of friends, income, safe and affordable housing, vocational and recreational opportunities, health, and hope of recovery.

We need to address the social injustices and lack of full citizenship opportunities experienced by people who live with mental illnesses.

Experts who work with young people experiencing early psychosis have said that recovery can be seen from three dimensions: personal, social, and illness-related. (Windell, D., et al., 2008)

- Personal recovery is about acceptance and regaining purpose and meaning in life as you come to terms with mental illness
- Social recovery is about living a safe, full, and dignified life in the community with appropriate supports and services
- Illness recovery is self-management and using your own *"personal medicine"* (Deegan, P. 2005), for example stress management, support groups, meditation, or yoga, as well as pharmaceutical medication

In *Your Recovery Journey*, we look at and discuss five topics.

- What is recovery?
- Quality of life
- Self-management
- Medication as a tool for recovery
- Moving forward: personal action planning

One of the best remembered television series from the 1950s was a show called *This Is Your Life*, broadcast from 1952 to 1961. The program was based on a simple principle: each guest was surprised with a presentation of his or her life.

Well, this is your life. You didn't ask for a mental illness. But a recovery journey is part of your life, too. It's a journey of meaning, management, and medication. We hope this resource helps you live life outside mental illness.

People who have experienced mental illness tell us recovery is possible. They say life can be lived beyond the illness.

The motto of Home Depot is *"You can do it. We can help."* The job of mental health service providers, family, and friends is to create environments in which recovery can take place. Only you can do the work of recovery. But we can help.

May this resource, *Your Recovery Journey*, inspire you; may your recovery be as much a reality as your mental illness.

I want to acknowledge the support of Janssen-Ortho Inc. and our advisory board – consumers, family members, and service providers who assisted in the creation of this series. Our project coordinator, Catherine Willinsky, is to be congratulated and complimented on her leadership. She has kept us focused and on track with the project.

Finally, be assured we have endeavoured to be faithful to the literature written about recovery in the past twenty-five years.

I know as a Board Member of the Mental Health Commission of Canada that the Commission is committed to the development of a recovery-oriented mental health system in Canada. I trust that this program will contribute to the much-needed discussion in Canada about the recovery model.

Well, this is your life. Your journey of recovery!

Chris Summerville, D. Min., CPRP
Chief Executive Officer, member of the advisory committee

Schizophrenia Society of Canada

Introduction

Introduction

Rationale for the program

Your Recovery Journey *is based on the premise that there is hope, that people with mental illness can get well and stay well for long periods of time, doing the things they want to do with their lives.*

The program is important for several reasons. It builds on the now well-established literature and evidence base for recovery from mental illness, and contributes to the growing number of programs that focus on empowering people to manage their own treatment and recovery journey.

This program aims to provide participants with the tools to take responsibility for their own wellness and stability; to manage and reduce their symptoms using a variety of self-help techniques; and to effectively reach out for and use the support of a network of family members, friends, and health care professionals.

"There has been a transformation in how people conceptualize schizophrenia, from therapeutic pessimism to hope of recovery… Many things – response to medications, relationships, choices, strengths, capacities, miracles – can happen in a person's life." (Manschreck, T.C., et. al., 2008)

Who is the program for?

Although some of the examples in this manual relate to schizophrenia, *Your Recovery Journey* is intended to serve the needs of a broad range of individuals who have had experience with mental illness, regardless of their diagnosis and the stage of their illness. While there are significant differences in the symptoms, course, and treatment of different mental illnesses, there are also many similarities in people's experiences in working towards recovery. These include identifying and reaching personal goals; working to find meaning and fulfillment in the face of a new reality; dealing with the impact of stigma; and establishing a positive sense of self and of belonging.

Throughout this manual and other program materials, we will use the term *"participants"* to refer to the individuals who are taking part in the program.

Objectives of the program

The overall goal of the program is to increase participants' ability to meet their personal recovery goals by enhancing their self-determination and quality of life. We hope to accomplish this by

- providing an opportunity for participants to explore the many aspects of recovery
- exploring the role of personal goals in the recovery journey
- giving participants the knowledge and tools they need to be active participants in managing their illness and recovery
- modelling hope and recovery by using a peer-support approach
- providing an opportunity for participants to reflect on and plan for their recovery journey

Importance of peer support

We have chosen to use a peer-support model, not only because peer support is an example of the kind of self-determination that occurs in recovery, but also because peer support can transform lives. The group is designed to be led by people who have experienced mental illness and recovery.

> "New in the recovery movement is the peer mentor, individuals living with schizophrenia and serving as teachers and educators. People who engage in that work benefit from that experience as they help other people through recovery... They're leaders and an inspiration to patients who might not be as far along in recovery."
>
> (Manschreck, T.C., et. al, 2008)

Who can facilitate the program?

To reflect a peer-support model, the ideal facilitator is a person who has lived with mental illness and who understands recovery. A recovery-oriented service provider or family member could work alongside the facilitator to help organize and deliver the program.

It is essential that all facilitators understand and support a common set of values and ethics.

Facilitators must:

- lead the program in a spirit of self-help and peer support by encouraging interaction and supporting the active participation of all group members
- honour and model the values of recovery: hope, self-determination, choice, and empowerment
- support the concept that each participant is the expert on his or her experience
- accept participants as they are, as unique individuals
- remind participants that there are no limits to anyone's recovery

You will find more information on facilitation skills later in this introduction and in the appendix.

The program materials

This manual contains the core materials for facilitating the presentations: outlines and notes, PowerPoint slides, the Participant Workbook, and video presentations that accompany each session. (All program materials can be viewed or downloaded from the SSC website at **www.schizophrenia.ca**)

The program materials are designed to be easily adapted to differing groups and formats. Facilitators can use this guide and the accompanying resources as a template, modifying content and length to meet the needs of a range of participants, whether they are early on in their recovery journey or have years of experience to share.

The program is presented as five sessions, each designed to take an hour or an hour and a half. Facilitators can vary the order in which sessions are presented. Session length can be adapted to the desires of the group.

The sessions include presentation information, group activities, and discussion questions related to the topic.

Outline of the Program

Session 1: What is recovery?

Session 2: Quality of life

Session 3: Self-management

Session 4: Using medication as a tool for recovery

Session 5: Moving forward: personal action planning

"Instead of looking at recovery as relapse prevention, I see it as an active process of setting goals and working towards them."

(Gottlieb, D. 1991)

Facilitation outline

This manual contains facilitation outlines to accompany Sessions 1 to 5 of the program. It provides a framework facilitators may use, and includes elaborations on the PowerPoint slides.

PowerPoint slides

Facilitators can use the slides to guide the discussion.

Participant Workbook

The workbook includes five topic areas and contains information and practical tools to help participants when they're not in the sessions. Facilitators can distribute copies of the workbook at the start of the first session and link the content of the group session to the corresponding content and tools in the workbook.

Copies of program materials, including the Participant Workbook, can be ordered free-of-charge from:

The Schizophrenia Society of Canada
100–4 Fort Street, Winnipeg, MB R3C 1C4
Tel: (204) 786-1616
Toll Free: 1-800-263-5545
Fax: (204) 783-4898
E-mail: info@schizophrenia.ca

Please allow 2-3 weeks for delivery of materials.

If you require more copies of the Workbook than you have on hand, or to make additional copies, you will find the content of the workbook, as well as this manual, contained on Disk #1.

For instructions on how to use the Disk, please see the next page.

Videos

Each session has a brief accompanying video presentation. In the videos, people living with mental illness, family members, and service providers address different issues discussed in the sessions. Facilitators can watch the videos in advance, then plan how to use them during the session. For example, a video might be used as a way to initiate discussion or to end a session. Facilitators can also choose not to use all the video presentations.

The Disks

The two disks in this package contain everything a facilitator will need to deliver the program.

DISK #1 contains

- A PDF copy of this manual for reprinting
- Appendices. Registration information and forms, promotional materials, information on facilitation skills, confidentiality agreements, participant feedback questionnaire, certificates of completion, glossary, and recommended resources
- PowerPoint presentations to accompany each session
- A PDF copy of the Participant Workbook for reprinting.

DISK #2 contains

- DVD presentations to accompany each session.

How to use the enclosed Disks

We recognize that in different regions of the country, program facilitators will have different levels of access to funding and technology.

- Some facilitators may not have access to an LCD projector and laptop to display the PowerPoint slides. If you do not have an LCD projector, you can print the PowerPoint slides and make transparencies for an overhead projector.
- To view the video presentation, insert Disk #2 into a DVD machine and select an option from the menu.

To print the material from Disk 1

STEP 1: Place disk 1 into the appropriate drive. Your computer should automatically read the disk and display the table of contents. If this does not happen, double-click the My Computer icon on your desktop, then double-click the CD drive icon.

Please note: you'll need Adobe Acrobat Reader to view and print the documents on the CD. We've included a link on the CD, so you can download free software from Adobe.

STEP 2: In the table of contents, click on the section you wish to view. The pages will appear on your screen.

To print and assemble the Participant Workbook

You will need:

- Disk #1
- a computer with Adobe Acrobat Reader software
- a printer
- a photocopier
- photocopy paper
- 3-hole punch
- 2-inch binder with a clear window on the front for each participant
- binder tabs, five per binder

STEP 1: Print the chapters of the workbook from Disk #1.

STEP 2: Photocopy all the pages; make enough copies for every participant.

STEP 3: Hole-punch the pages.

STEP 4: Organize the pages from page 1 to the end, with a binder tab at the beginning of each section.

STEP 5: Fill the binders.

Organizing the program in your community

Promoting the program

Word of mouth is often the most effective promotion tool. So it's a good idea to develop relationships with your local mental health centre, early-intervention clinics, psychiatrists, and other front-line staff; these people can help you promote the program and recruit participants. You may want to give a presentation about the program to local mental health teams. We've included an information flyer on disk #1. You can customize the flyer to suit your community.

Keeping costs minimal

We encourage you to find volunteer facilitators and free meeting space. You'll need to find funding for refreshments, which should include coffee and tea (maybe you can borrow an urn); water; and a healthy snack.

Picking a date

Consult community calendars and social-service organizations to find out what other group programs are being offered in your community. Try to choose a time slot that is not already filled.

Finding space

It's best to have a quiet, private room where people will feel comfortable about sharing very private information. Hospitals and mental health centres often have rooms large enough to accommodate fifteen to twenty people; churches and schools may also be willing to provide rooms. Some organizations provide rooms free of charge to groups offering educational programs.

Meeting prospective participants

Arrange a meeting with your participants before the program begins, so you can provide information and make sure they understand the content and approach of the program. It's a chance to find out their expectations, their interest in participating, and whether the program will meet their needs. You may want to ask:

- What interests you in participating in the program?
- We ask that you do your best to attend all the sessions. How do you feel about this?
- Outside the sessions, who can you talk to when you need support?

If you both decide that the program is appropriate, ask participants to fill out the registration form (in the appendix, on CD #1). Provide prospective participants with a copy of the confidentiality agreement (in the appendix, on CD #1) and discuss the need for all group members to maintain confidentiality within the program. Participants will sign the agreement during the first group session.

Let participants know you'll be in touch with a formal invitation as soon as arrangements are finalized.

"Participants and peer facilitators build powerful connections; people form relationships in which hope is borrowed and shared. The importance of these connections is highlighted in the peer-support literature, which shows that peer support reduces symptoms, enlarges social networks, and enhances quality of life."

(Groopman, J. 2004)

Information for facilitators

Welcoming the group

It is essential for group facilitators to set up a safe, positive, and predictable environment from the very first group meeting. This will involve starting and finishing the group on time, and ensuring that people adhere to time limits during the session.

Some of the things to consider before each session:

- Are there enough chairs for each participant, facilitator, and guest speaker?
- Can group leaders see one another?
- Can all group members see one another when they're sitting down?
- Do any group members have special needs, such as mobility, hearing, or visual difficulties?
- Is the room too warm or too cool? Facilitators may want to ask how group members feel at the beginning of the session
- Are supplies readily at hand? Check for markers, chalkboards, flip-chart paper, computer, and projector

Ensuring confidentiality

Because stigma and discrimination are sometimes attached to mental illness, some family members may come to the group concerned that what they say in the group could become public. Facilitators need to stress the seriousness of the confidentiality agreement every participant has signed. It's also a good idea to suggest ways to prevent a violation of the agreement, and to discuss what will happen if a group member violates the agreement.

Beginning and ending each session

Check-in

- Each session begins with a check-in. The most common question used as a check-in is, "What is one thing you did to take care of yourself this week?" A question like this conveys the message that self-care is important. A check-in question also provides the opportunity for group members and facilitators to give their focus and attention to the group

Check-out

- At the end of each session, summarize the central topics the group discussed, and the work and activities everyone completed. It's also a good time to acknowledge the group's commitment and the willingness of members to dedicate their time to the group
- You may close the meeting by asking one question as a way to focus on ideas from the session that can be helpful to participants. Check-out questions can also address self-care and recovery. If you ask a question and group members are not eager to offer a response, a facilitator should respond, so the group will hear an appropriate way to answer the question

Evaluating the program

Educational programs require continual monitoring, so facilitators can make sure they meet the needs of their participants. We developed a monitoring tool, the participant feedback questionnaire, for the group's last session. The questionnaire is designed to gather information about the effectiveness of the program and asks participants about the program's strengths and areas for improvement. The feedback will help facilitators when they're organizing the next program.

During sessions, facilitators should encourage group members to speak to them outside of group time if something is not working for them personally or if the group is not meeting their needs or expectations.

Facilitation basics

What is facilitation?

Whether you're in a meeting (large or small) or a training session, someone has to shape and guide the process of working together so you meet your goals and accomplish what you've set out to do. The agenda and goals may be set by the group, but groups need one person to ensure that the group will move through that agenda and meet those goals effectively. This is the person we call the facilitator.

Facilitation has three basic principles.

1. A facilitator is a guide who helps people move through a process together. The facilitator isn't there to give opinions, but to draw out opinions and ideas from group members
2. Facilitation focuses on how people participate in the process of learning or planning. Facilitation does not focus on what is achieved
3. A facilitator never takes sides

Effective facilitators are able to balance several tasks at once. They ensure that agenda items are covered, that important issues are discussed, decisions made, and actions taken, and at the same time they focus on how the meeting is structured, and they make sure everyone has the chance to participate.

Why do group leaders need facilitation skills?

If you want to plan effectively, keep members involved, and provide positive leadership for the program, you need facilitation skills. The more you know about how to shape and run a session, the more your participants will feel empowered to contribute, participate, take on responsibility, and stay in the group.

These skills will come in handy in many places: for planning, for encouraging new leaders, for resolving conflicts, and for maintaining good communication among participants.

Facilitating is both a skill and an art. It is a skill in that people can learn certain techniques and can improve their ability with practice. It is an art in that some people just have more of a knack for it than others.

Facilitating means:

- understanding the goals of the meeting and the organization
- keeping the group focused on the agenda and moving forward
- including everyone in the meeting, drawing out the quieter participants, and controlling the domineering ones
- making sure decisions are made democratically

How do you plan a good facilitation process?

A good facilitator is concerned with the outcome of the meeting or planning session; with how the people in the meeting participate and interact; and with the overall process – all at the same time. Achieving goals and outcomes is, of course, important, but a facilitator also wants to make sure the process is sound, that everyone is engaged, and that the experience is the best it can be for each and every participant.

To plan a meeting, a good facilitator addresses three areas: climate and environment, logistics and room arrangements, and group guidelines.

Climate and environment

Many factors affect how safe and comfortable people feel about interacting with each other and about participating. The environment and general feeling – the "climate" of a meeting – set the tone for participation.

Facilitators need to ask:

- Is the location a familiar place, where people will feel comfortable?
- Is the meeting site accessible to everyone?
- Is the space the right size for the number of people in the group?

Logistics and room arrangements

Factors such as the way people are seated, whether they are hungry, and if they can hear easily may make or break your meeting.

Some things to consider:

- **Seating.** Arranging chairs in a circle or around a table encourages discussion, equality, and familiarity
- **Flip charts or chalkboards.** You'll need a space to display the results of brainstorming sessions and other important material
- **Refreshments.** If people are hungry, they are much less likely to participate fully. Make arrangements for refreshments well before the meeting begins
- **Microphones and audiovisual equipment.** Will you need any equipment? Arrange for it early, and make sure it works

Group guidelines

One of the roles of a facilitator is to create a secure environment for the group. The first step is to develop guidelines, which are designed to help people feel more comfortable with each other and be committed to the outcomes of the sessions. Group guidelines also promote trust and encourage predictable ways of relating to each other.

When you establish guidelines as a group, everyone in the group feels invested in and responsible for the group's process and goals. Group guidelines can improve communication, promote good attendance and participation, and minimize competition and conflict.

Some examples of group guidelines:

- be non-judgmental
- respect differences of opinion and experience
- use "I" statements
- avoid the word "should"
- don't interrupt
- make sure there are no private conversations during meetings
- honour confidentiality and privacy
- arrive on time
- attend every meeting

Facilitators can ask participants for situations when the guidelines may be difficult to enforce. As the group progresses, participants will see how the guidelines work. When problems arise, facilitators can encourage participants to refer to or revise the guidelines.

Session 1: What is recovery?

Session 1: What is recovery?

Summary of key points

- Recovery is a process built on hope, choice, self-determination, and empowerment
- People with mental illness are resilient and know their own experience of recovery
- Recovery is possible for all people who live with mental illness
- Recovery is more than reducing symptoms. Recovery happens when people with mental illness set and achieve their life goals and ambitions
- The goals and the journey belong to the individual. Individuals must be encouraged and given the tools to direct their own recovery
- Taking responsibility for yourself and your own actions is part of recovery. So is seeking support from others
- Recovery is a process that may involve many stages, and will include inevitable setbacks and uncertainty

Session outline

Activity	Suggested time	Materials
Introduction to the program	10 minutes	Slides 1–3
Icebreaker	15 minutes	Slide 4
Confidentiality agreement & group guidelines	20 minutes	Group guidelines, confidentiality agreement
Recovery brainstorm	10 minutes	Flip chart
Exploring recovery	30 minutes	Slides 5–18
Discussion/Video	10 minutes	Video Part 1/Slide 19
Wrap-up/Check-out	10 minutes	

Introduction to the program | 10 minutes | Slides 1–3

- Welcome participants
- Briefly explain why or how you became involved in the program as facilitators
- Describe what participants can expect from the program: peer support, a chance to share stories, ideas, successes and challenges, information, and tools that will help them in their recovery journey
- Distribute copies of the Participant Workbook and explain to participants that the workbooks accompany the program and are theirs to keep. Explain that the content of the workbook follows the group sessions and provides an opportunity for participants to reflect on their learning and make their own notes and plans.

Icebreaker | 15 minutes | Slide 4

Activity steps: icebreaker

- Use Slide #4, or write the three topics on a flip chart
- Who I am: What I would like the group to know about me
- What I want to give: What I can offer the group, my strengths and knowledge
- What I want to get: What I hope to gain by participating in the group
- Ask the participants to form into pairs and give each pair a piece of flip chart paper and a marker. Give the pairs ten minutes to ask each other the questions and record the answers; ask each participant to come up with two answers for each question
- After ten minutes, ask for a volunteer to introduce his or her partner. After each pair has finished, tape their flip charts to the wall

"To me recovery means freedom, hope."
(Maritza)

Using an icebreaker is an effective way to start the program for several reasons. First, it sets a friendly and open mood for the program and helps put participants at ease. Participants may be reluctant to speak in a group setting; an icebreaker gets people talking right from the start, so everyone will be ready to join in the session.

The icebreaker also gives facilitators and participants a chance to get to know each other and learn what strengths and capacities people can offer the group. People may also articulate their expectations of the program, and their goals.

To illustrate the icebreaker, facilitators can ask each other the questions and record their answers on a flip chart, then introduce each other to the group.

You will have met with participants during the registration process and have introduced the idea of a confidentiality agreement. In this activity you can explain what the agreement means within the context of the group and have the participants sign the agreement.

As a group you can create group guidelines, a set of house rules participants and facilitators will follow during your time together.

Confidentiality agreement & group guidelines | 20 minutes

Activity steps: confidentiality agreement

- Lead a brief discussion about the importance of confidentiality within the program
- Distribute copies of the confidentiality agreement (from the appendix on CD #1)
- Ask each participant to sign an agreement and to witness each other's agreements

Activity steps: group guidelines

- Ask group members to suggest guidelines they would like the group to use during the program
- Record the ideas on a flip chart so everyone can see them
- For a list of common group guidelines, please see page 23

"You're so much more than just this illness. Yes, it may have a profound impact on you at the moment, but you're a lot more than someone with schizophrenia."

(Dr. Pamela Forsythe)

In this session we will discuss recovery: what people with mental illness have said, what the research says, and what is important to you. Let's start with a brainstorm.

Recovery brainstorm | 10 minutes | Flip chart

Brainstorm question: If you could dream of the perfect recovery, what would it look like to you?

Exploring recovery | 30 minutes | Slides 5–18

Slide 5: Defining recovery

Let's look at some definitions of recovery that have been offered by researchers and people with mental illness.

"Recovery is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." (Anthony, W.A. 1993)

- During a brainstorm, facilitators record people's answers on a flip chart, but do not correct or comment on the ideas.
- All responses get written down.
- Post the flip chart on the wall, and refer to it during the session.

Ask participants – especially those who were reluctant to offer ideas during the brainstorm – to add to the discussion.

Acknowledge the points made in the brainstorm and the discussion, and any others suggested by participants.

Slide 6: Defining recovery

"Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again… The need is to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution." (Deegan, P.E. 1988)

Slide 7: Defining recovery

"Recovery is a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members."
(Pennsylvania Office of Substance Abuse Mental Health Services 2005)

Slide 8: Defining recovery

"Recovery is an uncharted, unpredictable and personal journey." (Sheehan, A. 2002)

Discussion question: Do you notice any the common themes in these definitions? What are the themes? What else do you think is important in defining recovery?

Slide 9: Summary

To summarize our discussion, here are some key points about recovery.

- Recovery emphasizes a person's capacity to have hope and lead a meaningful life
- Severity of illness does not predict long-term outcome. There is hope for recovery for every person with a mental illness
- Just as the course of illness varies greatly from person to person, so each individual's story and recovery are unique
- Recovery is more than symptom management
- Personal recovery can happen even if a person continues to experience symptoms of his or her illness

Slide 10: Phases of recovery

Many people think there are three major phases in recovery. (Young, S.L., et. al., 1999) We'll talk about the three phases now, and throughout the program.

Slide 11: Initial phase: Overcoming stuckness

- Acknowledging and accepting the illness
- Having a desire and motivation to change
- Finding/having a source of hope and inspiration

Slide 12: Middle phase: Regaining what was lost and moving forward

- Actively taking control and responsibility for one's own life
- Gaining insight about oneself and about relationships with others
- Being able to take care of oneself
- Being active and connecting with other people

Slide 13: Later phase: Improving quality of life

- Striving to attain an overall sense of well-being
- Striving to reach new potential
- Feeling fewer symptoms
- Finding meaning and purpose in life

Slide 14: What are we recovering from?

Often one of the first tasks in starting out on our recovery journey is to think about what we're recovering from – not only the effects of illness, but losses, trauma, stigma, the mental health system, and a lack of enriching opportunities.

- Loss can include loss of power, loss of valued roles, loss of meaning and purpose, loss of hope
- Many people have said that stigma, discrimination, and negative attitudes about mental illness can be more difficult to deal with than the illness itself
- Mental health services and systems can devalue and disempower those they are intended to serve

Slide 15: Hope

A researcher at Boston University who has studied recovery in people with schizophrenia observed:

"The power of the human spirit to sustain grief and loss and renew itself with hope and courage defies all description." (Gottlieb, D. 1991)

Slide 16: The process of recovery

Pat Deegan is accepted as an inspirational leader of the international recovery movement because of her personal experiences with schizophrenia and her innovative academic research. She describes her recovery journey as a balance that includes both self-care and self-management along with professional support and treatment.

"My recovery journey is still ongoing. I still struggle with symptoms, grieve the losses I have sustained… I am also involved in self-help and mutual support and still use professional services including medications, psychotherapy and hospitals. However, I do not just take medications or go to the hospital. I have learned to use medications and use the hospital. This is the active stance that is the hallmark of the recovery process." (Deegan, P. 1996)

Slide 17: Personal recovery strategies

- Pat Deegan has created the concept of "personal medicine" to describe the things in peoples lives that help build self-esteem, empowerment and confidence.
- Just like prescribed medication can reduce symptoms, "personal medicine" has also been shown to help symptoms.

Slide 18: Personal recovery strategies

"One of my major findings has been that people who are recovering do not simply swallow pills in a passive way. Instead they get active and they understand that recovery is about changing our lives, not just our biochemistry. I have learned that psychiatric medicine is not the only type of medicine that is important to recovery. Personal medicine, or those things that raise our self esteem and make life worth living are vital to recovery. Fishing, meditating, exercising, having dinner with a friend, being a good mom, all of these things and more can be vital to our recovery. All are forms of what I have come to call personal medicine." (Deegan, P. 2004)

Discussion/Video | 10 minutes | Video Part 1/Slide 19

Slide 19: Discussion questions

- What has helped you in your recovery journey?
- What are the things you do to reduce your symptoms?
- What kind of personal recovery strategies or activities have you found effective?
- Has your recovery changed your perception of mental illness?

You can use the questions in Slide 19 as a discussion guide, if they were not already discussed in the session. If the group has actively participated in discussions throughout the session, view the first segment of the video.

The videos are each less than 5 minutes in length. Showing the videos (which are included on Disk 2 of the Facilitator's package) is a great way of introducing a group discussion.

Wrap-up/Check-out | 10 minutes

- Briefly review Chapter One of the Participant Workbook. Remind participants to work through the materials during the week ahead
- Ask participants to share one thing they found interesting or helpful about the session

Preparing for the next session

- Ask participants to bring with them to the next session an object that symbolizes their recovery, for example, a photo, a book, a CD, a movie. Facilitators could begin the second session by showing and describing their recovery object
- Ask people to complete as much of the workbook as possible before the next session

"Mental illness is just one part of me, like I like music and writing poetry and I have family and friends, and all kinds of other things that make up me."

(Sherri)

"Schizophrenia is not a hopeless disease. Many, many people who are diagnosed go on to live full lives where they have a sense of happiness."

(Dr. Sonia Chehil)

Session 2: Quality of life

Session 2: Quality of life

Summary of key points

- Recovery is more than quality of life, but having a positive quality of life is essential to recovery
- The factors that contribute to quality of life are different for everyone, but commonly include relationships with family and friends, work, neighbourhood, housing, income, community, health, education, and spirituality
- To achieve quality of life, we need a practical understanding of the illness; a positive sense of self; purpose and meaning; a feeling of inclusion and belonging; and a sense of control or personal empowerment
- Identifying the activities, supports, relationships, and roles that promote quality of life can help people reach their recovery goals
- Access to recovery-oriented services contributes to quality of life

Session outline

Activity	Suggested time	Materials
Agenda/Check-in: Recovery objects	15 minutes	Slide 1
What is "quality of life"?	20 minutes	Slides 2–3
Discussion	20 minutes	Flip chart
Key components of quality of life	30 minutes	Slides 4–10
Discussion/Video	10 minutes	Video Part 2/Slide 11
Wrap-up/Check-out	10 minutes	

Agenda/Check-in: Recovery objects | 15 minutes | Slide 1

In the first session we discussed recovery, what it means to us as individuals, and the things that have helped us in our journey of recovery.

In this session we focus on the things that help us achieve our desired quality of life and that give our lives meaning and purpose. We'll also talk about the ways we find support and live a satisfying life.

Before we get started talking about quality of life, let's talk about the objects we brought with us today, things that symbolize or represent an aspect of our recovery.

Activity steps: recovery object

- Ask each participant to spend a minute talking about his or her recovery object. Participants can share why they chose their object, what it means to them, and so on
- Try to limit each participant to one minute so everyone gets a chance to speak
- Thank participants for bringing in and sharing their recovery objects with the group

"Quality of life means that you're in a place where you feel really good – about yourself, about what you're doing, who you are, where you live."

(Corey)

What is "quality of life"? | 20 minutes | Slides 2–3

Slide 2: What is quality of life?

A lot of research has measured quality of life of people with mental illness, but mostly from the service providers' point of view. Increasingly, though, there is an interest in finding out what quality of life means for people with mental illness, and how it is connected to recovery.

Slide 3: Quality of life

Quality of life:

- comes from the opportunities people experience
- is based on both personal and environmental factors
- includes areas such as relationships with family and friends, work, neighbourhood, income, housing, community, health, education, and spirituality
- means knowing that we are valuable to ourselves and others, having a sense of why we are in this world and what we are striving for
- means feeling that we have a clear role and place to belong

Discussion | 20 minutes | Flip chart

Activity steps:

- Ask participants the discussion question.
- Record responses on the flip chart.

Discussion question: What do you think is essential for people to achieve a positive quality of life?

Key components of quality of life | 30 minutes | Slides 4–10

Many people with mental illness have articulated their most basic needs as "a home, a job, and a friend," or, as someone recently put it, "somewhere to live, something to do, and someone to love." People say that a decent quality of life depends on access to these basic things, which are important for everyone. (Martin, N. 2008)

Slide 4: Key components of quality of life

(CMHA National, 2004)

The key components of quality of life include:

- an understanding of personal mental health strengths and challenges
- a positive sense of self
- purpose and meaning
- belonging, being included
- a feeling of control over your own life – personal empowerment

Slide 5: Understanding our mental health strengths and challenges

The process of coming to grips with the illness and the impact it has on our lives and on our mental health is very important and has many aspects, including:

- finding information about the illness
- understanding how the illness affects our feelings and behaviour
- understanding and explaining our experience of the illness
- examining the effect of the illness on our sense of self and identity
- the effect on our social situation and our expectations

The work we do together in this program as well as the work we do on our own will help us develop our understanding of our illnesses.

Slide 6: Having a positive sense of self

A positive sense of self is a basic tool for dealing with mental illness. When we are positive about ourselves, we can:

- separate the illness from our identity
- believe we have value
- give ourselves a chance to grow
- put the illness in its place

Slide 7: Finding purpose and meaning

All people strive and sometimes struggle to make sense of their lives and develop a sense of purpose and meaning. In recovery, we need to develop a new purpose and meaning within and beyond the limitations imposed by the illness. We need to do this as we face losses that resulted from the illness itself as well as losses associated with the effects of stigma.

Different people find purpose and meaning in different ways, which often include:

- spirituality or religion
- a sense of connectedness or purpose beyond our individual life
- connection to our cultural or traditional values
- a feeling of contributing to a collective life as a citizen or a member of a community, for example through our involvement as workers, volunteers, and students

Slide 8: Inclusion and belonging

Mental illness can be a very alienating experience. Social rejection and stigma often combine with an inner sense of isolation and can make the challenges posed by mental illness even more difficult. Many people living with and overcoming mental illness find the effects of stigma more difficult than the illness itself.

A sense of inclusion and belonging can limit the impact of mental illness and its tendency to separate us from participating fully in a social life.

A sense of inclusion and belonging can come from:

- day-to-day interactions with others
- positive relationships with our peers and families
- social identities – worker, family member, spouse, parent, member of religious or spiritual group, community volunteer

"Quality of life? It means living, not just existing"

(Sherri)

Slide 9: Personal empowerment

The things we've just been talking about – understanding our mental health strengths and challenges, purpose, meaning, inclusion, and belonging – all contribute to a sense of personal empowerment.

- Having a sense of controlling our lives in relation to services, activities, and relationships is an important part of mental health for everyone, not just for people with mental illness
- The feeling of being at the mercy of factors beyond our control leads to stress, depression, and poor mental health in general.
- The right tools and resources can help us make choices and take action

Slide 10: Recovery and support services

Access to services and supports that are recovery-oriented, that promote self-determination and choice, is often a key component of achieving a positive quality of life. Such recovery-oriented services and supports:

- recognize that people need to be active participants in directing and managing their own care
- are oriented towards helping people achieve their life goals and ambitions
- reinforce people's personal, cultural, and spiritual ideals
- focus on wellness and resilience and encourage people to participate actively in their care
- include a wide range of rehabilitation services such as psychosocial support, self-help, and peer support

It's never possible to control everything in life! But with the right tools and resources, we can make choices and take action for ourselves. We'll talk more about this in our next session, which will focus on self-management.

"It's really empowering when you can learn all these things, and you say to yourself "I have the power to change, I have the power to get better."

(Corey)

Depending on how much group discussion has taken place throughout the session, you may choose to use questions on slide 11 to guide a discussion, or you can view Part 2 of the video. Ask the group what they would prefer. If there is enough time, you may want to consider doing both.

Discussion/Video | 10 minutes | Video Part 2/Slide 11

Slide 11: Discussion questions

Now that we've learned a bit about how quality of life has been described by others, let's talk about what it means to us.

- What does having a positive quality of life mean to you?
- How have stigma and discrimination affected you? How have you coped?
- What settings or situations help you feel you belong?
- What has helped you develop a positive sense of self?
- What keeps you well and gives your life purpose and meaning?

Wrap-up/Check-out | 10 minutes

- Briefly review the content of Chapter Two of the Participant Workbook. Remind participants to work through the materials during the week ahead
- Ask participants this check-out question: What is one thing you will do to take care of yourself this week?

"Sometimes life is what you make it... I think to improve your quality of life you have to be the person behind that wheel saying 'Yes, this is where I'm going to go, this is what I think is good for me.'"

(Sherri)

Session 3: Self-management

Session 3: Self-management

Summary of key points

- Studies show that self-management – a person's determination to get better, manage the illness, take action, face problems, and make choices – facilitates recovery from mental illness
- The concept of recovery from mental illness is relatively new. But people with mental health difficulties were self-managing and functioning in the community long before the idea of recovery became popular
- Self-management means different things to different people. The term generally includes: self-awareness and monitoring, coping strategies, and personal goal setting, relapse planning, and management
- Effective communication with members of social support networks – family, friends, service providers – can help us manage symptoms, prevent relapse, and maintain recovery

Session outline

Activity	Suggested time	Materials
Agenda/Check-in	5 minutes	Slide 1
Defining self-management	10 minutes	Slides 2–7
Discussion	20 minutes	Slide 8
Self-management and recovery	5 minutes	Slides 9–10
Brainstorm: What's in a self-management plan?	15 minutes	Slides 11–16/Flip chart
Stress management	10 minutes	Slide 17
Discussion/Video	10 minutes	Video Part 3/Slide 18
Wrap-up/Check-out	10 minutes	

Agenda/Check-in | 5 minutes | Slide 1

In this session we're going to focus on the things that we can do to take charge of managing our illness and our recovery.

For many people with mental illness, learning about and practising self-management are key components of recovery. Let's talk a bit about what self-management means.

Defining self-management | 10 minutes | Slides 2–7

Slide 2: Self-management

Self-management is something we all do to cope with life's challenges.

Slide 3: Self-management

Applied specifically to people with mental illness, it includes the ways we cope with, manage, or minimize the ways the condition limits our lives, as well as what we do to thrive, to feel happy and fulfilled, to make the most of our lives despite the condition.

Slide 4: Self-management

Self-management

- is about taking control of your life and being active in your own recovery
- a decision to self-manage can be a key factor contributing to recovery
- allows and encourages people to make choices and participate in setting their goals and determining the types of interventions that are likely to be helpful. Service providers can help develop plans and act as guides as people put their plans into action (**www.rethink.org**)

Slide 5: Self-management

Self-management

- supports a variety of goals. This is important because different individuals have their own unique set of goals that are meaningful to them
- can mean different things to different people, but generally means that people are actively engaged in dealing with their disorder and in determining their care

Spend 5–10 minutes facilitating a discussion about the things that participants do to manage their illness. Once everyone has had the chance to offer their ideas, you can move on to the next question. You can refer to some of the ideas offered here to summarize after participants have responded.

Slide 6: Self-management

For some people, self-management describes what they do to cope with difficulties and make the most of what they have. For others, it means preventing or minimizing mental health crises through recognizing and acting on danger signals.

Slide 7: Self-management

In self-management, people learn about:

- the benefits associated with different treatments
- the costs, such as the financial costs of treatment
- the effort and skill that may be required to achieve those benefits
- strategies for improving their mental and physical health and preventing and dealing with relapse

"You need other things in your life to have that healthy balance, to make you feel good about yourself inside-out."

(Sherri)

"I have to always be aware of my triggers and my stressors, and I have to be aware of when I might be slipping... Educate your friends and family members, or your main supports – they need to know what's going on as well."

(Corey)

Discussion | 20 minutes | Slide 8

Slide 8: Discussion questions

1) **What kind of things do you do to take an active role to manage your illness, mental health care, and recovery?**

- tracking symptoms, triggers, early warning signs, etc
- finding social and emotional support
- taking good care of yourself and maintaining a healthy lifestyle
- pursuing self-advocacy to obtain services

2) **What do you see as the potential benefits of self-management?**

- improving ability to manage illness and reach recovery goals
- preventing relapses and hospitalizations, thus providing greater control over your life
- more time for pursuing personal goals
- less distress from symptoms, and thus better quality of life (Mueser, K.T. et. al. 2002)

Self-management and recovery | 5 minutes | Slides 9–10

Slide 9: Self-management and recovery

A person's ability to self-manage is an important factor in moving towards recovery. The quotes on the next two slides, both by people with mental illness, show the link between self-management and recovery.

"Self-management entails a positive mental attitude and positive actions that help you get on with living your life the way you want to. It includes knowing when to recognize the illness limitations and adjusting your way of life to accommodate them…and living your life to the full… The more you live your life and achieve goals, no matter how big or small, that is active self-management." (**www.rethink.org**)

Slide 10: Self-management and recovery

"We are all different and what works for one person may be useless for another. Therefore, one has to discover one's own ways of improving. Also, it may take many years to become really good at it. But just starting is important: changing the attitude of 'passing the buck' and taking the decision to take as full a role as possible in one's own treatment. Set yourself a different course with renewed hope."
(Jenner A. *National Voices Forum Report*, 1998)

Brainstorm: What's in a self-management plan?
15 minutes | Slides 11–16/Flip chart

Brainstorm Activity steps:

- Ask participants to brainstorm for five minutes about what areas they think might be included in a self-management plan
- Record their ideas on a flip chart
- You can use the information below to summarize and categorize the ideas generated in the brainstorm

Brainstorm question: What needs to be included in a self-management plan?

Slide 11: Summary of brainstorming

A self-management plan can include:

- setting and pursuing personal goals
- wellness planning
- self-assessment and monitoring
- coping strategies, stress-reduction techniques
- relapse management and crisis planning

Let's look at each of these in a bit more detail.

Slide 12: Setting and pursuing personal goals

- having a sense that you can write your own future and get on with your life the way you would like to
- setting both long-term and short-term realistic, manageable goals
- being organized and planning small steps towards larger goals, challenging yourself, and taking personal responsibility

Slide 13: Wellness planning

- creating a toolbox of ideas and activities you enjoy or that help you feel better
- these tools can be things you've used in the past or would like to use in the future
- wellness tools often include things such as eating well, exercising, spending time with friends and family, pursuing hobbies, spiritual or religious practices, artistic or creative pursuits, and pets

Slide 14: Self-assessment and monitoring

- keeping track of the things that help and can act as obstacles to recovery
- identifying triggers, strengths, and weaknesses
- monitoring the impact of side effects and early warning signs
- using journal writing and other kinds of recording

Slide 15: Coping strategies, stress reduction techniques

- finding ways to cope with and manage stress
- self-help manuals, tapes, and videos produced by people in recovery on topics such as coping with voices and a description of what helped others heal
- exercise, diet, activities for everyday well-being, such as meditation, stress reduction, visualization

"You really have to be proactive and take charge of your own health."

(Corey)

Slide 16: Relapse management and crisis planning

- creating a plan for support and treatment in the event of relapse, so that your wishes will be respected
- making a Wellness Recovery Action Plan and Psychiatric Advance Directives

We'll talk more about creating our own self-management and wellness plans in the final session of the program.

Stress management | 10 minutes | Slide 17

There's a difference between the "healthy" stress we feel when we are challenged and engaged, and the kinds of stress that can threaten our recovery. Recovery does not happen by avoiding all of life's stresses. Professionals advise us to "avoid stress" – but for many of us, that advice is unhelpful.

Understanding your stress level is important. If you are suffering from extreme stress or long-term stress, you may experience physical and mental health problems that may make your symptoms worse. But short-term or positive stress can give you the extra energy or motivation to perform well.

Slide 17: Stress management – things to consider

- avoiding healthy stress and realistic challenges can lead to apathy and boredom, which can work against recovery
- achieving valued roles such as student, parent, and worker may be stressful, but also may provide purpose and meaning and may help keep people well
- there are many effective ways of coping with and managing stress
- we can avoid situations that we know will cause us unhealthy stress, such as abusive relationships and substance use

Discussion/Video | 10 minutes | Video Part 3/Slide 18

Slide 18: Discussion question

Can you think of a situation where you challenged yourself to do or try something that felt risky at first, but ended up helping with your recovery?

Wrap-up/Check-out | 10 minutes

- Thank participants for their contributions to the session
- Briefly review the content of Chapter Three of the Participant Workbook
  Remind participants to work through the materials during the week ahead

"You're always checking yourself and making sure that every day is a little better than the last."

(Ian)

Depending on how much group discussion has taken place throughout the session, you may choose to use the discussion question to guide further discussion, or you can view Part 3 of the video.

Ask the group what they would prefer. If there is enough time, you may want to consider doing both.

Session 4: Medication as a tool for recovery

Session 4: Medication as a tool for recovery

Summary of key points

- For most people with mental illness, medication is a necessary part of treatment
- Although most people with mental illnesses usually find that medication is necessary, it should not be considered the sole treatment. Medication should be used in addition to other therapies and service and support options
- Sticking to a medication plan is a key factor in self-management and recovery
- To be effective, an individual's treatment plan must support his or her ability to reach personal goals
- There are effective ways of dealing with the issues and problems – for example, side effects – associated with medication

Session outline

Activity	Suggested time	Materials
Agenda/Check-in	10 minutes	Slide 1
Medication and recovery	10 minutes	Slides 2–3
Discussion: Your relationship with medication	10 minutes	Slide 4
Perspectives on medication adherence	20 minutes	Slides 5–9
Medication brainstorm and discussion	20 minutes	Slides 10–13/Flip chart
Discussion/Summary: Using medication effectively	10 minutes	Slides 14–19
Video	10 minutes	Video Part 4
Wrap-up/Check-out	10 minutes	

Agenda/Check-in | 10 minutes | Slide 1

In this session we're going to focus on the issues involved in using medication as a recovery tool. We'll start by looking at our own relationship with medication.

Medication and recovery | 10 minutes | Slides 2–3

Slide 2: Medication and recovery

We have learned a great deal in recent years about the different factors that influence the effectiveness of medication for people with mental illness. Much of the learning has come about because people with mental illness and researchers have worked together to investigate the issue.

Some of their most important findings include the following:

- using medication is an active process that involves complex decision-making and a chance to work through problems and issues. People are faced with many choices in deciding the role of medications in their recovery process
- for medication to support recovery, it needs to enable people to more effectively pursue activities that provide meaning and purpose, for example employment, education, relationships, and spirituality
- when medications interfere with the ability to pursue activities that are essential to recovery – because of side effects or other issues – a person may have problems sticking to a treatment plan

Slide 3: Medication and recovery

- People's choices are influenced by legitimate concerns about the effect of medication on their lives
- Medication helps create an environment in which recovery can take place Medication can open the door so people can access other supports
- People with mental illness and service providers can act in partnership to share information and collaborate to find the best treatment plan

Participants may have strong feelings about their relationship with prescribed medication. It is important to give them an opportunity to discuss their experiences at the outset of the session so that the group can move on to discuss other topics relating to medication as a recovery tool. Use the discussion question to open up a discussion about participants' experiences.

Discussion: Your relationship with medication | 10 minutes
Slide 4

Slide 4: Your relationship with medication

A quote from a recent article in the newspaper describes one person's relationship with medication.

"I have no shame in saying that I take medication to cope with everyday life, but I am not a walking prescription. I'm not just 300 milligrams of whatever." (Batson Feuer, S. 2008)

Discussion question: How do you feel about taking your medications?

Perspectives on medication adherence | 20 minutes
Slides 5–9

Slide 5: Different perspectives on medication

Sometimes there can be a clash of perspectives between the service provider's and the client's point of view about the effectiveness of medication, and about reasons for taking or not taking medication.

- A service provider might think a medication is helping a client be more in control of the illness, but the client might feel controlled by the medication
- A service provider might see a successful reduction in symptoms, but a client might feel disabled by the medication. Perhaps the price of reducing symptoms seems high because side effects prevent a client from pursuing activities that support their recovery

Slide 6: Compliance and adherence

- To understand and overcome differences in perspective, we need to look at the concepts of "compliance" and "adherence." The term "compliance" was often used in the past to describe the process of following the doctor's orders about taking medication and making lifestyle changes
- Many people have found the focus on compliance paternalistic and disempowering, because it emphasized obedience to medical authority, and non-compliance has often been viewed as irrational or willful behaviour
- The term "adherence" is now more commonly used, because it describes a more collaborative approach to medication management, and envisions the clients in an active role in managing the illness (McGregor, F. 2007)

Slide 7: Therapeutic alliance

- The emphasis now is shifting to the development of a therapeutic alliance or shared decision-making model between service providers and their clients. In this model, medication use is framed within the context of the client's life, goals, and history (Deegan, P., Drake, R. 2006)
- Both research evidence and lived experiences demonstrate that helping people use medications effectively is a complex undertaking, and that an exclusive focus on compliance is not the best approach. Service providers and people with mental illness need to form a "therapeutic alliance" in which both are key partners in decision-making

Slide 8: Practitioner's role

"The practitioner's role is not to ensure compliance but rather to help the client use medications and other coping strategies optimally in the process of learning to manage his or her own illness." (Deegan, P., Drake, R. 2006)

Slide 9: Issues in medication adherence

- To put the problem in perspective, adherence to treatment is an issue in all forms of medical treatment, not just in the mental health field
- Research articles have focused on the difficulty of getting patients to adhere to treatment for diabetes, heart disease, and many other ailments
- Studies show that in the case of mental illness, non-adherence to treatment is a major contributing factor to relapse
- Medication adherence is a more complex problem than it might seem, and is not just about the patient being at odds with the doctor's orders. For example, the patient may not be aware that they are non-adherent, and the doctor may not know that the patient is non-adherent (McGregor, F. 2007)

Medication brainstorm and discussion | 20 minutes

Slides 10–13/Flip chart

Activity steps:

- Ask participants the brainstorm question below
- Encourage participants to offer as many answers as they can think of

Brainstorm question: If medication is effective and reduces symptoms, why is there often such a problem with taking it?

"Sometimes you get a little leery because they have all the side effects listed, which makes you not want to take them. But you need to know how to weigh the pros and the cons."

(Sherri)

Summary

You can use the list provided on Slides 10–13 to summarize the discussion or to make sure you cover a range of issues. The list is not exhaustive, and participants may have other ideas to offer.

Slide 10: Things that can get in the way of taking medication

- Not understanding why and how the medication should be taken. For example, that it needs to be taken consistently, not only when symptoms are present, or that it needs to be taken even when the person is feeling better
- Social, recreational, and lifestyle choices. An example is substance use. People may decide to go off their medication if they plan on using drugs or alcohol because they know they aren't supposed to "mix"
- Misunderstandings. For example, not wanting to become addicted to the medication
- Not seeing medication as necessary or helpful
- Stigma. People may not want others to know they're taking medicine for a mental illness. They may fear their friends or relatives will have negative opinions about mental illness and treatment
- Financial issues. Some people can't afford the medications
- Inconvenience. Complex prescriptions may have to be taken with food, or without food, or two hours after eating, or multiple times per day

Slide 11: Things that can get in the way of taking medication

Illness-related reasons

- Forgetting. Some mental illnesses, for example schizophrenia, can affect concentration and motivation
- The effect of positive symptoms – for example hallucinations and thought disorder – can interfere with a medication routine
- Symptoms of the illness can affect thinking, insight, or judgment, so that a person may not be aware of a mental illness. A person may also experience denial or have certain beliefs about the cause of the illness. Some people do not believe using medication leads to improvement in symptoms

Participants will have many ideas about what helps them use their medication as an effective tool in their recovery.

There is no one reliable method for increasing medication adherence and effectiveness.

Slide 12: Things that can get in the way of taking medication

Side effects:

- Sometimes people believe the effects of the treatment are worse than the disorder; some people find that side effects keep them from doing the things that make life worth living
- Some people become frustrated because they experience side effects before they feel any of the benefits of the medication
- It can be difficult to distinguish between symptoms of an illness and side effects of a medication. Pharmaceutical literature doesn't always help clarify the issue

Slide 13: Things that can get in the way of taking medication

This quotation from Pat Deegan sums up problems of side effects.

"Getting rid of symptoms at the cost of losing the things that make life worth living is unacceptable" (Deegan, P. 2003)

Discussion/Summary: Using medication effectively

10 minutes | Slide 14–19

Activity Steps:

- Show discussion questions on Slide 14

Slide 14: Discussion questions

- What have you learned about using medication to support your recovery?
- How do you deal with issues that come up, such as side effects?
- What strategies have you found useful in helping you stick with a medication plan?

"If you're on the wrong medication, you won't want to take it, and if you don't take it, you get sick again."

(Corey)

Summary

You can use the information on slides 15–19 to ensure that a range of areas is addressed and to summarize the discussion.

Slide 15: Accurate information about medications

Factors that clarify information about medications can help people use their medication most effectively. **These include:**

- Having a clear understanding of why the medication is required, how long the medication is required, and what the benefits and side effects are
- An individualized approach. The same person may have different needs at different times, depending on what he or she are experiencing and the stage of the illness. Service providers need to be sensitive to where people are at in their treatment and recovery, so they can tailor the information they provide accordingly

Slide 16: Developing a partnership with service providers

- When services and supports are provided in ways that respect and value people and their responsibility to choose, those services can play a major part in providing people with the foundation they need to achieve recovery
- Recovery-oriented mental health professionals work with their clients to find ways to frame treatment goals within the context of the client's life so treatment supports the clients' "personal medicine" (for example, yoga or meditation)
- Service providers and clients need to establish agreement about what the problem is, what the treatment goals are, and how they will know when the goals have been met
- In shared decision-making, practitioners and clients combine their expertise and work together to find the medications and dosages that help the clients reach recovery goals (Deegan, P., Drake, R. 2006)

Slide 17: Finding the right medication and delivery method

- All medications have their strengths and weaknesses, and different medications work for different people.
- Medication and doses are different for every individual. The rule of thumb is to find the lowest possible dose of medication that effectively reduces symptoms and prevents relapse.
- There are many more choices in medication available now than in the past. There are oral, injectable and long acting injectable medications available for various conditions. Each medication has its own benefits. It is important to understand the side effects and clinical significance of any medication you are taking. The majority of people with mental illness will be able to find a medication that will help.
- For many people, fewer doses during the day are more convenient and easier to remember.

Slide 18: Understanding what works for you

Some factors people say have helped them deal with their medications

- being aware of how your illness is affecting you at any given time, and the effect the medication has on your behaviour and functioning
- experiencing the positive role medication can play in helping you reach your recovery goals
- having access to a range of services and supports beyond medication and treatment, such as social support, help with employment and housing, and peer support
- getting practice. People tend to find it easier to stick with a medication plan if they become comfortable with a particular routine
- reminders. Some people find that reminders (by phone or from friends and family) help them remember to take medication. Special packaging, such as blister packs and dosettes, can also simplify a medication routine
- talking about it. Participating in education and peer support groups; sharing ideas and concerns with other who have had similar experiences

Slide 19: Making medication work for you

This quote shows the potential of medication as a tool for recovery.

"The turning point was when my medications became not only stabilizing but energizing, and I suddenly had more ability to face everyday tasks."
(Manschreck, T.C., et. al. 2008)

Video | 10 minutes | Video Part 4

Activity Steps:

- View Part 4 of the video.
- Ask the group what they thought of the perspectives expressed in the video.

Wrap-up/Check-out | 10 minutes

Activity Steps:

- Ask participants to name one new strategy or idea from the session that they found helpful
- Thank participants for their contributions to the session
- Briefly review the content of Chapter Four of the Participant Workbook. Remind participants to work through the materials during the week ahead

"It's better to deal with the side effects than to be ill."

(Mia)

Session 5: Moving forward: personal action planning

Session 5: Moving forward: personal action planning

Summary of key concepts

- People can take an active role in staying well by creating and using personal wellness recovery and action plans
- A strong community and social support system is important to maintaining recovery
- Even with careful self-management, relapses can happen. By preparing for relapses, people can get back to their recovery journey more quickly
- There are tools to help people maintain autonomy and facilitate recovery after a relapse

Session outline

Activity	Suggested time	Materials
Agenda/Check-in	5 minutes	Slide 1
Discussion	20 minutes	Slide 2
Dealing with relapse	10 minutes	Slides 3–4
Brainstorm: Wellness Toolbox	10 minutes	Flip chart
Wellness planning	30 minutes	Slides 5–16
Discussion/Video	10 minutes	Video Part 5
Program evaluation	10 minutes	Participant feedback questionnaire
Certificates of Completion	5 minutes	Certificates
Closing comments	10 minutes	

Agenda/Check-in | 5 minutes | Slide 1

Throughout the program we've been talking about the fact that there's a lot more to recovery than managing symptoms. People with mental illness have consistently said that being connected to, and being an active participant in, the broader community is a key aspect of recovery.

Many resources can enrich people's lives – the informal support of family, friends, and community, access to income, housing, jobs, and education, and involvement in peer support and self-help groups.

We're going to start today's session by looking at our relationships and connections to the broader community, and how these relationships contribute to our recovery.

We've already discussed the importance of self-management in dealing with symptoms and in taking an active role in our recovery. In this section we'll bring together information about connecting to the broader community, preventing relapse, dealing with relapse when it happens, and planning for your recovery and wellness.

Discussion | 20 minutes | Slide 2

Action steps:

- Ask participants to find a partner
- Ask each pair to spend ten minutes discussing the three questions on Slide #2, and recording their answers
- After ten minutes, bring the group back together. Ask each person to share their partner's responses with the group

Slide 2: Discussion questions

- What/who are your key sources of support?
- How do you connect with the broader community, for example, work, study, faith groups, volunteering, hobbies, leisure?
- How does your involvement in the community support your recovery?
- Can you remember a time you took a risk in your recovery journey – that is, stepped out of your comfort zone, pushed yourself to try something new (a new job, a social situation) and experienced success?

Many people who have travelled the road to recovery have said that being in recovery is an ongoing process that can involve many stages, with inevitable setbacks and uncertainty.

Dealing with relapse | 10 minutes | Slides 3–4

Slide 3: Dealing with relapse

- Experiencing relapse is often an expected part of the recovery process for people with mental illness, and should not be seen as a failure, but instead as an opportunity to learn and improve

Slide 4: Dealing with relapse

- Even though relapses can't always be avoided, managing or preventing them is a key part of self-management
- Preventing relapse means that we spend less time and energy dealing with illness and symptoms, so we have more time and energy to pursue goals and develop the aspects of our lives that keep us well
- Often there are warning signs before a relapse. By keeping track of symptoms and following a wellness plan, people can identify early warning signs and take action to prevent a relapse

"I've gotten to a point where I'm in a pretty good place with my mental illness, but I still have symptoms. I've learned how to recognize them, I've learned to identify them, I've learned what my stressors are, and I've learned how to deal with the symptoms."

(Corey)

Brainstorm: Wellness Toolbox | 10 minutes | Flip chart

Brainstorm question: What are some of things you might want to include in your wellness toolbox?

- Let's start with the things you need to do every day.
- What about every week or so?
- Every month?
- Some examples: take a nap, exercise, play with pets, spend time with kids, talk to friends/family members, write in a journal, make your bed, clean the house, do something nice for someone else, watch a video, listen to music, see a counselor or physician, ask for a medication check, do something creative.

Wellness planning | 30 minutes | Slides 5–16

Slide 5: Wellness Recovery Action Plan

Let's look at some of the ways we can plan and take action to stay well.

- The Wellness Recovery Action Plan – or WRAP (Copeland, M.E. 1997) – is a peer-based program aimed at helping people develop a personalized plan for managing their wellness and getting their needs met, both individually and through support from significant others and the mental health system
- WRAP is a self-designed plan for staying well and for helping you feel better when you are not feeling well, to increase your personal responsibility and control over your own life, and to help you make your life the way you want it to be
- Creating your own WRAP will help you monitor and relieve uncomfortable and distressing feelings and behaviours and identify your best course of action

Slide 6: The Wellness Toolbox

- The first step in creating a wellness plan is to develop a wellness toolbox, which we mentioned briefly in Session 3
- Your wellness toolbox contains the things you can do to help yourself stay well and feel better when you are starting to feel down
- Wellness tools usually include positive activities and lifestyle choices that increase a sense of balance, physical health, and stress management

Ask participants to brainstorm as many ideas as possible.

You can use the ideas provided as prompts if it helps.

Try to cover daily activities as well as tools that are needed less frequently but play an important role.

Record participants' answers on the flip chart, using different headings for daily, weekly, and monthly ideas.

Slide 7: Steps in a WRAP

Once you've identified your wellness tools, you're ready to move on to creating your own WRAP. There are six sections to a WRAP, and we'll talk a bit about each one.

- Daily maintenance plan
- Identifying triggers
- Identifying early warning signs
- When things are breaking down
- Crisis plan
- Post-crisis plan

Slide 8: Daily maintenance plan

- a description of yourself when you are well
- the wellness tools you know you must use every day to maintain your wellness
- a list of things you might need on any particular day to feel well

Slide 9: Identifying triggers

- Recognizing the events or triggers that might make you feel bad. Examples of potential triggers: having an argument with a friend, financial worries
- Looking at how you can use your wellness tools to make sure you stay well if these things happen

Slide 10: Early warning signs

- Many people with mental illnesses such as schizophrenia have said that, over time, they learn to recognize when they are becoming unwell; they can then find ways to avoid a psychotic episode
- People become attuned to early signs, and many manage to reason their way through complex, distressing, and delusional ideas. It's important to identify the subtle signs that let you know you are beginning to feel worse. Such signs include being irritable, anxious, and unable to sleep
- You can use your wellness tools to respond to these signs and to get back to feeling good again

Slide 11: When things are breaking down

- You can make a list of the signs that let you know you're feeling much worse – for example, feeling very sad all the time, or hearing voices
- Think about which wellness tools you can use to feel better quickly and prevent things from getting worse

Slide 12: Crisis plan

- We know that choice and self-determination are important aspects of recovery, no matter what stage people are in. During times of psychiatric crisis people may experience a frightening loss of choice and self-determination. Such a loss can be damaging and traumatic
- Increasingly, people are recognizing a person's right to be in charge of his or her own care even while struggling with severe symptoms. In a crisis plan, you identify signs that tell others to take over responsibility for your care and decision-making. The crisis plan lists who you want to take over for you and support you through this time; it includes health-care information; and it lists things you would like others to do or not do
- Crisis planning helps you keep control even when things seem to be out of control

A crisis plan can include:

- a list of your supporters, their roles in your life, and their phone numbers
- a list of all medications you are using and information about those medications
- a list of the signs that indicate your supporters need to make decisions for you and take over responsibility for your care
- instructions for your supporters, so they know what you want them to do

Slide 13: Post-crisis plan

- You may want to make a list of things to do after a crisis
- Some people make notes as they recover from the crisis, when they have a clearer picture of what they need to do for themselves so they can to get well

Slide 14: Psychiatric Advance Directives

- The Psychiatric Advance Directive (PAD), a legal tool, is a statement of rights and preferences. You use it to tell people what you want if you lose your capacity to speak for yourself
- The exact form and use of PADs will vary from one province to another depending on the provincial Mental Health Act, but there are a number of basic elements covered in a PAD
- With the PAD, you to plan for, consent to, or refuse hospital admission, administration of medication, and specific treatments, for example electroconvulsive treatment (ECT)

Slide 15: Psychiatric Advance Directives

A PAD generally includes a Mental Health Power of Attorney (MHPA), which states who you appoint to take over responsibility for your care and decision-making.

Slide 16: Benefits of PAD

Research has shown that creating a PAD/MHPA can support the recovery process.

The documents:

- help people maintain autonomy during periods of psychiatric crisis
- provide people with a way to clearly express their wishes about treatment, and to say what they know is most effective during a crisis
- make others aware of a person's treatment needs
- identify preventive actions, coping skills, and self-management techniques
- recognize a person's expertise in his or her own treatment
- empower the person who is experiencing a psychiatric crisis
- facilitate stronger patient-provider relationships by creating an informed and open dialogue (Kim, M.M. et. al. 2007)

You'll find more information about the Psychiatric Advance Directive in your participant workbook.

Discussion/Video | 10 minutes | Video Part 5

Play Part 5 of the video before wrapping up and handing out program evaluation forms.

Program evaluation | 10 minutes | Participant feedback questionnaire

Activity steps:

- Distribute the participant feedback questionnaire
- Give participants 10 minutes to complete the forms, then collect them

Explain that the feedback participants provide will evaluate the usefulness of the program and help you make improvements for future participants.

Certificates of Completion | 5 minutes | Certificates

The last item on today's agenda is to hand out certificates for successfully completing the program. We are pleased that you were able to participate in the program and we hope the time we've spent as a group and the individual work you've done will be helpful as you continue on your recovery journey.

We encourage you to stay connected to your support groups and organizations so you can continue your learning and share your knowledge and experience with those who are just starting out on their road to recovery.

Closing comments | 10 minutes

Thank you all for participating in the program, and for sharing your insights and ideas with us. It has been quite a commitment of time and energy to be part of the group. We hope you continue to benefit from having participated in this recovery journey with us.

Before we wrap up, would anyone like to share their thoughts on the end of the group and their plans for finding support in the community?

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All program materials can also be accessed for viewing and downloading on the SSC website at **www.schizophrenia.ca**

Notes:

Appendix

Table of contents:

Facilitation tip sheets

Program flyer

Registration form

Participant feedback questionnaire

Certificate of completion

Glossary

Confidentiality agreement

Order form

Facilitator Report

Additional Resources

All of the materials you will find in the Appendix are available for download and printing from the enclosed Disk #1.

Facilitation tip sheet # 1: Facilitation checklist

Things to keep in mind while you are facilitating each week:

- ○ Greet the participants warmly at each session, making an effort to greet them by name
- ○ Ensure your voice is clear and understandable
- ○ Encourage the participants to ask questions, and listen to their questions
- ○ Ensure the equitable participation of all present
- ○ Treat all participants with respect and patience
- ○ Manage group time effectively, being mindful of start, break, and finish times
- ○ Slow down when discussing complex and difficult topics; use questions to verify comprehension
- ○ Be well-prepared and organized for each session, and familiar with the activities, handouts, and discussion topics
- ○ Be aware of what material has been covered in previous sessions
- ○ Take time to clarify difficult topics
- ○ Help families learn from one another by encouraging them to come up with solutions to shared problems
- ○ Clearly stress the main points at the end of each session
- ○ Share your stories and experiences wisely, always maintaining the focus on your role as a facilitator and not a participant
- ○ Create a safe environment by ensuring that everyone has an understanding and agreement on the importance of confidentiality
- ○ Make sure to provide refreshments – coffee/tea, juices, water, and a healthy snack

Facilitation tip sheet # 2: Facilitating discussions

Suggestions to assist you in facilitating group discussions:

Getting more information

- Does anybody else have an idea?
- What did you wish would happen?
- Let's get other people's ideas on that…

Interpretation

- How do people feel about that?
- How was that good/bad?
- How is that significant?

Generalizing

- What led you to expect that?
- Have you considered other alternatives?
- What does that say to you about_____, in general?

Summarizing /Checking out

- I think we had some excellent comments today (list a few).
- Let's go around the room and state what we gained from or will take away from this session.

Facilitation tip sheet # 3: Intervention techniques

Behaviour	Motivation	What to do
Overly talkative/interrupting	May be a show-off or "eager beaver." May be well-informed	Interrupt by acknowledging his/her point, then turn it over to the group
Argumentative or hostile	May have a gruff personality, May be naturally good-natured but upset by a particular problem	Keep your cool. Find merit in one of his/her points and move on. Talk to the person privately during a break to find out what is really bothering him/her. Turn discussion back to group, Does anyone else have some thoughts on this?
Overly helpful	Really trying to help. Keeps others out of the conversation	Thank the person. Use his/her points to summarize discussions
Rambling	Talks about everything except topic at hand. Uses unusual analogies and gets lost	When the person stops, refocus on the relevant points and move forward. Indicate that while his/her point is interesting, it is a bit off track
Personality clashes within the group	Two or more participants clash. Can divide the group into factions	Emphasize points of agreement and minimize points of disagreement. Ask that people set aside personal differences
Won't participate	Bored, indifferent, timid, shy, or feels superior	Arouse interest by asking for the person's opinion. Ask all participants one by one to comment
Negativity/complainer	Everything is wrong or bad	Ask if person can find anything positive in the situation and how to cope with issue

Your Recovery Journey

Mental illness and recovery—is it possible? Many wonder if it is indeed possible for a person living with mental illness to accomplish goals, reconnect with self and others, and recapture meaning and purpose in life.

Your Recovery Journey is based on the experiences of people who have a mental illness and who know there is hope, who are well and doing the things they want with their lives.

The program offers five free interactive weekly sessions, each ninety minutes long, and all facilitated by people in recovery who can give you valuable information that will help you on your recovery journey. You'll also learn how to find peer support and build new life skills.

Session topics:

- ○ What is recovery?
- ○ Quality of life
- ○ Self-management
- ○ Medication as tool for recovery
- ○ Moving forward: Personal action planning

Come learn more about recovery and how you can live beyond mental illness!

is hosting the next group

Sessions start

Register today.

Phone

Your Recovery Journey

Registration Form

Personal information

Last name: First name:

Address:

Phone: W: H: Cell:

Can we leave a message?: ○ Yes ○ No

E-mail:

➜ Please tell us a bit about what interests you in taking part in the program?

➜ Are there specific topics that you would like to see addressed during the program?

➜ The program is designed to offer an opportunity for growth and support for any individual who experiences mental illness, regardless of their diagnosis. In order to ensure that we have relevant information and resources available, it would help us to know if you have been given a specific diagnosis or diagnoses.

How did you hear about the program? (check all that apply)

○ Newsletter
○ Website – Which organization?
○ Poster
○ Someone I know (e.g. friend, family member)
○ Other (specify):
○ Referral by a family doctor
○ Referral by psychiatrist
○ Referral by hospital
○ Referral by other service provider
○ Media (newspaper, radio, TV)

Your Recovery Journey

Participant Feedback Questionnaire

Your responses to the following questions will provide useful feedback to help facilitators and organizers improve the program for future participants.

Section I:

For each statement below, please circle the number that best fits your experience.

	Very low	Moderate			Very high
Question 1					
Before this program, my knowledge and understanding of recovery was:	1	2	3	4	5
As a result of this program, my knowledge and understanding of recovery is now:	1	2	3	4	5
Question 2					
Before this program, my understanding of the role of personal goals in achieving recovery was:	1	2	3	4	5
As a result of this program, my understanding of the role of personal goals in recovery is now:	1	2	3	4	5

	Very low	Moderate			Very high
Question 3					
Before this program, my confidence in speaking to service providers about my personal goals was:	1	2	3	4	5
As a result of this program, my confidence in speaking to service providers about my personal goals is now:	1	2	3	4	5
Question 4					
Before this program, my ability to use medication as a tool in my recovery journey was:	1	2	3	4	5
As a result of this program, my ability to use medication as a tool in my recovery journey is now:	1	2	3	4	5
Question 5					
Before this program, my ability to plan for my personal wellness and recovery was:	1	2	3	4	5
As a result of this program, my ability to plan for my personal wellness and recovery is now:	1	2	3	4	5

Section II:

Please rate your assessment of each session by circling the statement that best fits your experience.

Question 6			
Chapter 1: What is recovery?			
Relevance	Not relevant	Somewhat relevant	Very relevant
Quantity of information	Too little	Just right	Too much
Understandability	Too simplistic	Just right	Too difficult
I would suggest the following changes:			
Chapter 2: Quality of life			
Relevance	Not relevant	Somewhat relevant	Very relevant
Quantity of information	Too little	Just right	Too much
Understandability	Too simplistic	Just right	Too difficult
I would suggest the following changes:			

Chapter 3: Self-management

Relevance	Not relevant	Somewhat relevant	Very relevant
Quantity of information	Too little	Just right	Too much
Understandability	Too simplistic	Just right	Too difficult

I would suggest the following changes:

Chapter 4: Medication as a tool for recovery

Relevance	Not relevant	Somewhat relevant	Very relevant
Quantity of information	Too little	Just right	Too much
Understandability	Too simplistic	Just right	Too difficult

I would suggest the following changes:

Chapter 5: Moving forward: Personal action planning

Relevance	Not relevant	Somewhat relevant	Very relevant
Quantity of information	Too little	Just right	Too much
Understandability	Too simplistic	Just right	Too difficult

I would suggest the following changes:

Section III:

Question 7

On a scale of 1 to 10, what is your overall rating of this program? (Please circle one)

1 2 3 4 5 6 7 8 9 10

Question 8

Would you recommend this program to other people who have mental illness? ○ Y ○ N

Why or why not?

Question 9

Would you be interested in any follow-up activities to this program? ○ Y ○ N

Why or why not?

What activities would you be interested in (e.g. support group, further education programs)?

Question 10

Do you have any suggestions about how the facilitation can be improved?

Question 11

Can you suggest additional topics or changes to make future sessions more effective?

Question 12

Any additional comments:

Thank You!

awards this

Certificate of Completion

to

for participating in the program **Your Recovery Journey**

Group Facilitator | Date | Group Facilitator

Glossary

You may find that medical professionals and other people use words you are not familiar with. This is a short glossary of some commonly used terms.

acute schizophrenia: The shortest and most intense period of schizophrenia, when the most serious symptoms are found.

affective disorder or mood disorder: A mental illness characterized by greatly exaggerated emotional reactions and mood swings from high elation to deep depression. Commonly used terms are manic depression (or bipolar disorder) and depression – although some people experience only mania and others only depression. These extreme mood changes are unrelated to changes in the person's environment.

affective flattening: Limited range and intensity of emotional expression. A negative symptom of schizophrenia. Also referred to as emotional blunting.

agranulocytosis: A serious condition in which white blood cells decrease in number or disappear altogether. This can be a side effect of an antipsychotic medication called clozapine (brand name Clozaril).

akathisia: The medical word for extreme restlessness. This may include rocking from foot to foot or back and forth, walking in place, pacing, or an inability to sit still. An extremely confused mental state generally accompanies akathisia.

akinesia: A state of reduced movement; lack of muscle movement.

alogia: The loss of ability to speak or understand spoken or written language due to disease or injury of the brain. A negative symptom of schizophrenia.

amenorrhea: Absence of menstrual periods. This can be a side effect of antipsychotic medications.

anhedonia: A lack of pleasure or interest in activities an individual previously enjoyed.

anosognosia: A symptom of several brain disorders. Anosognosia is a very severe lack of awareness. It is not simply denial of illness, but a lack of awareness of the illness. The individual cannot understand that he/she is ill.

anticholinergic: Blocking the action of acetylcholine, one of the chemicals the body makes to help nerve cells communicate with each other. This describes a group of the most common side effects of psychotropic medications, including dry mouth, blurry vision, palpitations, and constipation.

antidepressant: Medication used to treat depression. *See* medications.

antipsychotic: A group of medications used to treat psychosis. There are two types of antipsychotic medications: neuroleptics (also called "standard" or "typical" antipsychotics) and atypicals. Neuroleptics are older, first-generation medications used to treat serious mental illness. Neuroleptics have a tendency to cause neurological side effects (see extrapyramidal symptoms) such as akinesia (slowed movement), akathisia (restless limbs), and tardive dyskinesia (permanent, irreversible movement disorders). *See* medications, neuroleptics.

anxiolytics: Medications used to reduce serious anxiety, tension, and agitation. They used to be known as minor tranquilizers.

apathy: A lack of interest.

atypical antipsychotics: The atypical antipsychotics (also known as second generation antipsychotics) are a group of antipsychotic drugs used to treat psychiatric conditions. Some atypical antipsychotics are approved for use in the treatment of schizophrenia. Some carry indications for acute mania, bipolar mania, psychotic agitation, bipolar maintenance, and other indications. Atypicals are a group of unrelated drugs united by the fact that they work differently from typical antipsychotics. Most share a common attribute of working on serotonin receptors as well as dopamine receptors.

avolition: The individual lacks energy, spontaneity, and initiative. There is a loss of drive and interest. It's very difficult to begin a new task or to finish any assignment. A negative symptom of schizophrenia.

bipolar disorder: A serious affective disorder characterized by extreme changes in mood ranging from high elation to deep depression. An individual with bipolar disorder may feel extremely excited with boundless energy, and then suddenly feel very sad and depressed. Previously called manic depression.

blunted affect: Also called blunted emotions. An apparent lack of emotion. An individual's voice may become monotonous, and his or her facial expression may not change. This does not mean the individual cannot feel emotions, but that he/she appears emotionless.

catatonic behaviour: An extreme lack of reactivity to the surrounding environment. Symptoms include stupor, muscular rigidity, or excitement. A positive symptom of schizophrenia.

catatonic schizophrenia: Categorized by a marked disturbance in physical activity. The disturbance might be a long period of staying very still in a strange position, muteness, or uncontrolled excitement. This is one of the schizophrenia subtypes.

central nervous system (CNS): The brain and spinal cord. The CNS is responsible for coordinating the activities of all parts of the brain and spinal cord.

cognitive impairment: Cognitive abilities (also called "executive skills") include knowing, thinking, learning, and judging. Cognitive impairment means the individual is experiencing difficulty with memory, concentration, and decision-making.

compliance: "The extent to which the patient's behaviour (in terms of taking medications, following diets, or making other lifestyle changes) coincides with medical recommendations" – in other words, doing what health professionals want a person to do. People who don't follow the recommendations are called non-compliant. The definition is from F. McGregor in *Visions Journal* (vol. 4, no. 2, 2007).

concurrent diagnosis: Also called "dual diagnosis" or "co-occurring disorders." A concurrent diagnosis is made when an individual shows symptoms of both a mental illness and substance or alcohol abuse. The term is also used when a person is diagnosed with two or more mental disorders.

CT scanning, computerized tomography: A technique using X-rays or ultrasound waves to produce an image of interior parts of the body. These images can help with diagnosis.

delusion: A symptom of many mental illnesses, a delusion is a fixed belief that has no basis in reality. This belief is strongly held even in the face of evidence that it is false. Individuals suffering from this

type of thought disorder are often convinced they are famous people, are being persecuted, or are capable of extraordinary accomplishments.

depersonalization: Also known as "derealization." A feeling that a person is becoming unreal, or that a person's mind is being separated from his/her body.

depression: Feelings of sadness, hopelessness, helplessness, and worthlessness. In many cases the affected individual has a lack of energy and motivation. Sometimes there are physical symptoms, such as slow movement and speech.

diagnosis: Classification of a disease by studying its signs and symptoms. Schizophrenia is one of many possible diagnostic categories used in psychiatry.

disordered speech: Also known as "disorganized speech." Disorganized patterns of speech in which an individual shifts erratically from topic to topic. A positive symptom of schizophrenia.

disorganized type schizophrenia: Categorized by disorganized speech, disorganized behaviour, and flat or inappropriate affect. Severely disrupts the ability of the individual to perform simple tasks of daily living. This is one of the schizophrenia subtypes.

dopamine: A neurotransmitter found in high concentrations in the limbic system in the brain. Involved in the regulation of movement, thought, and behaviour.

dual diagnosis: Also called "concurrent diagnosis" or "co-occurring disorders." A dual diagnosis is made when an individual shows symptoms of both a mental illness and substance or alcohol abuse. The term is also used when a person is diagnosed with two or more mental disorders.

dyskinesia: Involuntary movements, usually of the head, face, neck, or limbs.

dyspnea: Shortness of breath or difficulty breathing.

dystonia: An extrapyramidal symptom (EPS) caused by some antipsychotic medicines. The main features are sticking out the tongue, abnormal head position, grimacing, neck spasms, and eyes rolling up. *See also* torticollis.

edema: The buildup of watery fluid in parts of the body.

electroconvulsive therapy (ECT): A treatment occasionally used for serious depression, catatonic schizophrenia, and mania. The individual is given a general anesthesia; then an electric current is passed through his or her brain, causing a convulsion. ECT is used primarily for patients suffering from extreme depression for long periods, who are suicidal, or who do not respond to medication or to changes in circumstances.

electroencephalogram (EEG): A recording of the electrical activity from various parts of the brain. An EEG is used to study the brain's electrical activity; the results may help make a diagnosis.

extrapyramidal symptoms (EPS): The medical term for neurological side effects, which include a disturbance of facial or body movements. These symptoms can be caused by antipsychotic medications. Common symptoms include muscle stiffness, tremors, and lack of arm movement when walking.

flight of ideas: Refers to a period where the individual's thoughts become very accelerated.

florid symptoms: Symptoms that are obviously worsening.

galactorrhea: An excessive flow of breast milk in men or women. This is sometimes a side effect of antipsychotic medications.

gradual-onset schizophrenia: Symptoms develop so slowly that it takes a long time for anyone to notice the illness.

grossly disorganized behaviour: Unusual behaviour, such as being silly and childlike or angry and aggressive. A positive symptom of schizophrenia.

hallucination: A false perception of something that is not really there. Hallucinations may be seen, heard, touched, tasted, or smelled by an ill individual.

hyperdopaminergia: A neurochemical condition of excess dopamine neurotransmission. This is thought to partly underlie the pathophysiology of schizophrenia.

hypertonicity: Excessive tension of muscles.

ideas of reference: The unfounded belief that objects, events, or people are of personal significance. For example, a person may think that a television program is all about him/her.

inappropriate affect: Reacting in an inappropriate manner, such as laughing when hearing bad news.

involuntary admission: The process of entering a hospital is called admission. Voluntary admission means the patient requests treatment, and is free to leave the hospital whenever he/she wishes. People who are very ill may be admitted to a mental health facility against their will, or involuntarily:

- under a medical admission certificate or renewal certificate;
- under special court order when they have been charged or convicted with a criminal offence. Under the court order, people may be held in a forensic facility.

Before someone can be admitted involuntarily, a physician must certify that the person is:

- suffering from a mental disorder and requiring care, protection, and medical treatment in hospital;
- likely to cause harm to self or others or to suffer substantial mental or physical deterioration if not hospitalized.

Involuntary admission varies from province to province. Contact your provincial health authorities or local mental health organization for specific details.

labile mood: An individual in a labile mood has alternating euphoria and irritability.

limbic system: Group of brain structures composed of the hippocampus and amygdala. The limbic system is associated with memory storage, the coordination of autonomic functions, and the control of mood and emotion.

major depression: A severe mental illness characterized by feelings of hopelessness, helplessness, and worthlessness; often accompanied by a loss of energy or motivation. Some individuals also experience suicidal thoughts.

mania: An emotional disorder characterized by euphoria or irritability, rapid speech, fleeting thoughts, insomnia, poor attention span, grandiosity, and poor judgment; usually a symptom of bipolar disorder. Positive symptoms of psychosis may also be present.

medications: In psychiatry, medication is usually prescribed in either pill or injectable form. Several different types of medications may be used, depending on the diagnosis. Ask your doctor or pharmacist to explain the names, dosages, and functions of all medications, and to separate generic names from brand names to reduce confusion.

- antidepressants: these are normally slow-acting drugs, but if no improvement is experienced after

six weeks, they may not be effective at all. Some side effects may occur, such as dry mouth, drowsiness, or headaches.

- antipsychotics: these reduce agitation, diminish hallucinations and destructive behaviour, and may bring about some correction of other thought disorders. Side effects include changes in the central nervous system, which can affect speech and movement, and reactions affecting the blood, skin, liver, and eyes. Periodic monitoring of blood and liver functions is advisable.
- mood stabilizers: one example is lithium carbonate, which is used in manic and manic-depressive states to help stabilize the wide mood swings that are part of the condition. Regular blood checks are necessary to ensure proper medication levels. There may be some side effects, such as thirst and burning sensations. Also called "mood normalizers."
- tranquilizers: generally referred to as benzodiazapines. These medications can help calm agitation and anxiety. Examples include Valium, Librium, Ativan, Xanax, Rivotril.

mental disorder: Also called "mental illness." Describes a variety of psychiatric (emotional, thinking, and behavioural) problems that vary in intensity and duration, and may recur from time to time. Major mental illnesses include anxiety, mood, eating, and psychotic disorders. Mental illnesses are diagnosable conditions that require medical treatment as well as other supports.

mental health: Describes a balance between the individual, his/her social group, and the larger environment. These three components combine to promote psychological and social harmony, a sense of well-being, self-actualization, and mastery.

Mental Health Act: Provincial legislation for the medical care and protection of people who have a mental illness. The Mental Health Act also ensures the rights of patients who are involuntarily admitted to hospital, and describes advocacy and review procedures.

motor neuron: A nerve cell in the spinal chord that causes action in a muscle.

multifactorial: Multiple factors. Doctors use the term to describe the causes of some illnesses.

multiple personality disorder: A disorder categorized by the appearance of two or more distinct and separate personalities in one person. Many people confuse multiple personality disorder and schizophrenia.

negative symptoms: Symptoms that should be present in an individual but are not present. May include blunted affect (blunted emotions), apathy, a lack of energy or motivation, and emotional or social withdrawal.

neuroleptics: A group of medications used in the treatment of schizophrenia and other serious mental illnesses. *See* antipsychotics, medications.

neurotransmitters: Molecules that carry chemical messages between nerve cells.

non-compliant: Used to describe an ill individual who is not taking his/her medication or following the treatment plan. There are various reasons for non-compliance, including inability to remember to take medication, unpleasant side effects, or a lack of awareness about being ill.

obsessive compulsive disorder: An anxiety disorder in which individuals become trapped in repetitive patterns of thoughts (obsessions) and behaviours (compulsions). These patterns are potentially disabling, senseless, and extremely hard to overcome.

outpatient: An individual who goes to a hospital for medical or surgical care but does not have to stay after the treatment.

paranoia: A mental state that includes unreasonable suspicions of people and situations. A person who is paranoid may be suspicious, hostile, feel very important, or may become extremely sensitive to rejection by others. Paranoia falls within the category of delusional thinking.

paranoid type schizophrenia: Categorized by the presence of prominent delusions and auditory hallucinations in an individual whose cognitive functioning is otherwise well organized. This is one of the schizophrenia subtypes.

Parkinsonism: A group of symptoms including loss of movement, a lack of facial expression, stiff gait when walking, tremor, or stooped posture. These symptoms are sometimes side effects of older antipsychotic medications, for example, neuroleptics.

Parkinson's disease: A disease mostly affecting middle-aged and elderly people, characterized by tremors and rigid, slow movements.

personality disorder: A deeply ingrained and maladjusted pattern of behaviour that persists over many years. It is usually well-established in later adolescence or early adulthood. The abnormality of behaviour is serious enough to cause suffering to the person involved or to other people.

positive symptoms: Symptoms that are added to the individual's behaviour that should not be present. May include delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behaviour.

positron emission tomography (PET): A technique used to evaluate the activity of brain tissues. PET scanning is used as a research tool in schizophrenia and in cerebral palsy and similar types of brain damage.

postural hypotension: Also known as "orthostatic hypotension." Characterized by low blood pressure. Can cause dizziness and fainting when a person stands or sits up quickly. An early side effect when starting some psychotropic medicines.

poverty of speech: The inability to start or take part in a conversation, particularly small talk. This very common symptom in schizophrenia prevents people from taking part in many social activities.

prodromal phase: The first or early stage of an illness.

prolactin: A hormone produced by the pituitary gland. Stimulates lactation and ovarian function. Many older antipsychotic agents stimulate excess release of prolactin, resulting in abnormal menstrual cycles, abnormal breast milk production, gynecomastia (excessive development of the male mammary glands), and sexual dysfunction.

psychiatric advance directives: Legal documents that enable a person to maximize decision making about treatment and care when or if his/her capacity to fully participate in decision making may be compromised – for example during a crisis. Advance directives outline preferences for medication, treatment, and hospitalization. A person can also appoint an alternate decision maker. The creation and application of advance directives can help build an alliance between a person with mental illness and his/her care team.

psychosis: A group of symptoms of several major mental disorders. These symptoms include loss of contact with reality, breakdown of normal social functioning, and extreme personality changes. People affected with this condition usually experience delusions and/or hallucinations.

psychotherapy: Basically, "talk" therapy. Psychotherapy is a form of treatment that involves discussions between a patient and a mental health professional, and is often combined with prescribed medications. The many different types of psychotherapy have different aims and approaches.

psychotropics: Drugs used in the treatment of mental illnesses.

rapid schizophrenia: Also called sudden onset schizophrenia. The symptoms develop quickly, and the individual experiences dramatic behaviour changes within a few days or weeks.

receptor: A protein molecule that resides on the surface or in the nucleus of a cell. Receptors recognize and bind to specific molecules of appropriate size, shape, and charge.

recovery: Recovery is both a process and a goal. It is learning to successfully manage a disorder, control symptoms, and experience quality of life. Recovery is defined differently for each individual, but generally includes hopefulness, renewed meaning and purpose, managing the symptoms of schizophrenia, remission from substance abuse, living independently, having a job, having friends and social support, and experiencing quality of life.

residual schizophrenia: Signs of schizophrenia that may remain in some people after the most serious schizophrenic episode has passed.

schizoaffective disorder: The diagnosis of this illness is made when the clinical picture is not "typical" of either schizophrenia or a mood disorder, but the person shows symptoms of both psychosis and severe mood swings. Treatment usually consists of a combination of antipsychotic medications, antidepressants, and/or mood stabilizers.

schizoid: Sometimes used to describe a person who is unusually shy, aloof, sensitive, and withdrawn.

schizophrenia: A severe and often chronic brain disorder. Common symptoms include personality changes, withdrawal, severe thought and speech disturbances, hallucinations, delusions, and bizarre behaviours.

side effects: Drug reaction that goes beyond or is unrelated to the drug's therapeutic effect. Some side effects are tolerable, but some are so disturbing that the medication must be stopped. Less severe side effects include dry mouth, restlessness, stiffness, and constipation. More severe side effects include blurred vision, excess salivation, body tremors, nervousness, sleeplessness, tardive dyskinesia, and blood disorders. Some side effects can be controlled with drugs. Side effects are sometimes confused with symptoms of the illness. A doctor, pharmacist, or mental health worker can explain the difference between symptoms of the illness and side effects caused by medication.

serotonin: A neurotransmitter that relays impulses between nerve cells (neurons) in the central nervous system. Functions regulated by nerve cells that use serotonin include mood and behaviour, physical coordination, appetite, body temperature, and sleep.

serotonin-dopamine antagonists (SDAs): Also known as "atypical" or "newer" antipsychotics. Unlike their predecessors, these medications treat both the positive and negative symptoms of schizophrenia and other serious mental illnesses, with fewer side effects. Examples include Seroquel (quetiapine fumarate), Clozaril (clozapine), Zyprexa (olanzapine), and Risperdal (risperidone).

split personality: *See* multiple personality disorder.

stereotypical behaviour: Repeated movements that have no obvious cause and are more complex than a tic. The movements, for example, rocking backwards and forwards or rotating the body, may be repeated in a regular sequence.

stupor: A condition that makes a person immobile, mute, and unresponsive, although the person appears to be fully conscious: the eyes are open and follow the movement of external objects.

tardive dyskinesia: An occasional reaction to medication, usually after prolonged usage. Characterized by abnormal, spasmodic, involuntary movements of the tongue, jaw, trunk, or limbs.

thought alienation: Also known as thought withdrawal. A belief that thoughts have been stolen from a person's mind.

thought broadcasting: A belief that a person's thoughts are being made known to others, usually through radio or television.

thought disorder: A symptom of severe mental illnesses. Thoughts may be slow to form, may come extra fast, or may not come at all. The person may jump from topic to topic, seem confused, or have difficulty making simple decisions. Thinking may be coloured by delusion – false beliefs with no logical basis. Some people also feel they are being persecuted or are convinced they are being spied on or plotted against. They may have grandiose delusions: they are all-powerful, capable of anything, and invulnerable to danger. They may also have a strong religious drive, or believe they have a personal mission to right the wrongs of the world.

thought insertion: A person's belief that thoughts are being put into his/her mind.

topectomy: Surgical removal of a small and specific part of the brain in the treatment of mental illness. Surgery is generally limited to cases where medications and other treatment methods have not been effective.

torticollis: A contraction of one or more of the neck muscles on one side, resulting in an abnormal position of the head. Also called wry neck. This sometimes occurs when a person is experiencing dystonia.

tranquilizer: A medicine that produces a calming effect. The "major tranquilizers" are used to treat serious mental disorders; the "minor tranquilizers" are often used to treat anxiety.

treatment: Remedies or therapy designed to cure a disease or relieve symptoms. In psychiatry, treatment is often a combination of medication, counselling (advice), and recommended activities. Together, these make up a person's treatment plan.

typical antipsychotics: Also called standard, or first-generation, antipsychotics. Typical antipsychotics seldom have an effect upon the negative symptoms and often result in greater incidences of neurological side effects – muscle stiffness, tremors, lack of arm movement when walking. Typical antipsychotics include haloperidol and chlorpromazine.

undifferentiated type schizophrenia: Categorized by symptoms of schizophrenia in a person who does not meet criteria for specific schizophrenia types such as paranoid, disorganized, or catatonic. This is a subtype of schizophrenia.

ventricles: Four fluid-filled chambers in the brain, which form a network with the spinal cord.

Your Recovery Journey

Confidentiality agreement

I _____ agree that I will keep confidential the personal information of other group participants taking part in the program *Your Recovery Journey: Meaning, Management, and Medication*, which is to take place from _____. "Personal information" refers to information that may be used to determine the identity of another group member, such as the name of a group member, the name of other family members, home address, or phone number.

I also understand that once the group has been terminated I must continue to abide by this confidentiality agreement.

Confidentiality may be breached by the group facilitators under the following situations:

- If it is disclosed that a minor, which is defined as a child who is 16 years of age or younger, has been or is at risk of being physically, sexually, or emotionally injured by another individual;
- If it is disclosed that one of the group members intends to physically, sexually, or emotionally injure another individual; or
- If it is disclosed that a group member intends to inflict personal injury on himself or herself.

I have read and fully understand the information provided above about the risks of this group. I understand that if I breach this agreement I may be asked to leave the group. By signing this document, I agree to accept the risks listed in this form.

_____

Signature of Group Member Date

_____

Signature of Group Facilitator Date

_____

Signature of Witness Date

Your Recovery Journey

Order Form

Please complete this form and fax back to: 204-783-4898

Schizophrenia Society of Canada
100–4 Fort Street, Winnipeg, MB R3C 1C4
Tel: (204) 786-1616
Toll Free: 1-800-263-5545
Fax: (204) 783-4898
E-mail: info@schizophrenia.ca

Today's date: _____

Your name: _____

Name of sponsoring organization: _____

Telephone: _____ Fax number: _____

E-mail: _____

Mailing address: _____

_____

Planned start date for program: _____

Planned number of participants: _____

Please allow 2-3 weeks for delivery of materials.

Your Recovery Journey

Facilitator Report

We value your comments and feedback about the program and the materials. Please complete this form and return to:

Schizophrenia Society of Canada
100–4 Fort Street, Winnipeg, MB R3C 1C4
Tel: (204) 786-1616
Toll Free: 1-800-263-5545
Fax: (204) 783-4898
E-mail: info@schizophrenia.ca

Name of facilitator(s): _____

Affiliation / Sponsoring organization: _____

Contact information for facilitator: _____

Mailing address: _____

_____

_____

Telephone: _____ Fax number: _____

E-mail address: _____

List of attendees:

Name	Gender	Age	Diagnosis
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Comments:

Program Promotion

How did you promote this program in your community?

- Flyer
- Information Brochure/leaflet
- Community announcements
- Newspaper advertisement
- Other:

If a flyer or information brochure/leaflet was used, where was it distributed?

- Doctor's office (family doctor or psychiatrist)
- Community mental health organization
- Hospital
- Community centre
- Other(s):

Program start date: End date:

Location of program sessions:

Facilitator Comments:

Was the group engaged by the content and approach of the program?

As the facilitator, did you find the materials clear and user-friendly?

My suggestions for improvements or changes for future programs are:

Additional Resources

Web sites

Recovery Innovations. **http://www.recoveryinnovations.org/**

Pennsylvania Recovery and Resiliency. **http://www.mhrecovery.org**

Mental Health Recovery. **http://www.mhrecovery.com**

Rethink. **http://www.rethink.org/**

Recovery Opportunity. **http://www.recoveryopportunity.com/**

Canadian Mental Health Association. **http://www.cmha.ca**

Journals

Psychiatric Rehabilitation Journal **http://www.bu.edu/cpr/prj/**

Videos

"Voices of Resiliency." Manitoba Schizophrenia Society. Order at **www.mss.mb.ca**

"Psychosis, Early Intervention and Recovery." British Columbia Schizophrenia Society, Victoria Chapter. Order at **www.bcssvictoria.ca**

Mental Illness Education Project has numerous excellent videos on recovery. Order at **http://www.miepvideos.org/shop/**

Books

Recovery in Mental Illness by Ruth O. Ralph and Patrick W. Corrigan. Washington, D.C: American Psychological Association, 2005.

The Complete Family Guide to Schizophrenia by Kim T. Mueser and Susan Gingerich. Guilford, 2006.

Living Outside Mental Illness: Qualitative Studies of Recovery in Schizophrenia by Larry Davidson. New York: New York University, 2005.

Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice edited by L.Davidson, C. Harding, and L. Spaniol. Boston: Boston University. Vol I, 2005; vol II, 2006.

Articles & Chapters

"Scientific and Consumer Models of Recovery" by A. Bellack. *Schizophrenia Bulletin*, 32(3) 2006, pp. 432–442.

"What happened to civil rights?" by L. Davidson. *Psychiatric Rehabilitation Journal,* 30(1), 2006, pp. 11–14.

"Recovery in serious mental illness: A new wine or just a new bottle?" by L. Davidson, M. O'Connell, J. Tondora, M.R. Staeheli, and A.C. Evans. *Professional Psychology: Research and Practice*, 36(5), 2005, pp. 480–487.

"The top ten concerns about recovery encountered in mental health system transformation," by L. Davidson, M.J. O'Connell, J. Tondora, T. Styron, and K. Kangas. *Psychiatric Services*, 57(5) 2006, pp. 640–645.

"'Simply to be let in': Inclusion as a basis for recovery from mental illness," by L. Davidson, D.A. Stayner, C. Nickou, T.H. Stryon, M. Rowe, and M.J. Chinman. *Psychiatric Rehabilitation Journal*, 2006, 24: 375–388.

"Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities," by L. Davidson, J. Tondora, M. Staeheli, M. O'Connell, J. Frey, and M.J. Chinman. In *Community Based Clinical Practice*, ed. A. Lightburn and P. Sessions (New York: Oxford University Press, 2005), pp. 476–501.

"Implementing recovery oriented evidence based programs: identifying the critical dimensions," by M. Farkas, C. Gagne, W. Anthony, and J. Chamberlin. *Community Mental Health Journal*, 41(2), 2006, pp. 141–158.

"Integrating Evidence-Based Practices and the Recovery Model," by F.J. Frese, J. Stanley, K. Kress, and S. Vogel-Scibilia. *Psychiatric Services*, 52, Nov. 2001, pp. 1462–1468.

"The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia," by C.M. Harding, G.W. Brooks, T. Ashikaga, J.S. Strauss, and A. Breier. *American Journal of Psychiatry*, 144, 1987, pp. 727–735.

"What is recovery? A conceptual model and explication," by N. Jacobson and D. Greenly. *Psychiatric Services*, 52, 2001, pp. 482–485.

"The process of recovery from schizophrenia," by L. Spaniol, N.J. Wewiorski, C. Gagne, and W.A. Anthony. *International Review of Psychiatry*, 14, 2002, pp. 327–336.

The Schizophrenia Society of Canada exists to improve the quality of life for those affected by schizophrenia and psychosis through education, support programs, public policy, and research.

www.schizophrenia.ca info@schizophrenia.ca

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