Is Recovery Attainable in Schizophrenia?
(From A Personalized Historical Perspective)

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(Educated consumers views of recovery)

Recovery from Schizophrenia: With Views of Psychiatrists, Psychologists, and Others Diagnosed With This Disorder

By Frederick Frese, Ed Knight, Elyn Saks
1. Trace the approaches to treatment of schizophrenia from the days of no hope of recovery to today’s “recovery models”. An admittedly “revisionist” history from consumer perspective.

2. Ten examples of mental health professionals who are “in recovery” from schizophrenia, many of whom have contributed to the development of recovery models.
Emil Kraepelin
late 1800’s

Schizophrenia (Dementia Praecox)

“Incurable”, “deteriorating”, “no recovery”
GREAT AND DESPERATE CURES

Figure 2.3. Julius Wagner von Jauregg (1857–1940). Wagner-Jauregg won the 1927 Nobel Prize in Medicine and Physiology for his introduction of malarial treatment for general paresis. (Courtesy of the National Library of Medicine.)
Antonio Moniz
Nobel Prize –
Frontal lobotomy
1949
Adolf Meyer
1866 - 1950

Figure 2.4. Adolf Meyer (1866–1950). (Reproduced with permission from the Archives of Neurology 64 [1950]:880. Copyright © 1950 American Medical Association.)
Adolf Meyer, M.D.
1928 President American Psychiatric Association

- Coined the term “Psychobiology” – pre-dating G. Engel’s 1977 introducing the ‘Biopsychosocial Model’.
- Co-founded the National Mental Health Association with the “recovered” Clifford Beers
Harry Stack Sullivan, M.D.

Stressed Interpersonal Relationships

First hand experience of psychosis (Had a “schizophrenic break” around age 17)

Hired “recovering patients” as staff
The Magnitude of Deinstitutionalization: Number of Patients in Public Mental Hospitals, 1950–2005
Community Mental Health Act of 1963

- Establishes community mental health center “catchment areas” (for population areas from 82,000 to 240,000) – Divides up state and larger counties throughout the U.S.
1966

Bethesda Naval Hospital
The Asylum for the Chronic Insane campus at one time housed 6,000 patients.

PEOPLE IN MILWAUKEE COUNTY:
■ With mental disability
■ On disability for a psychiatric

FILE PHOTO

Milwaukee County Hospital

1967
Committed as insane
1968

Columbus State Hospital
Asylum Scenes
KU Professor Contends

Mental Health Dangerous Concept

By JANE CRAIG
Eagle Staff Writer

Mental illness is a potentially dangerous concept used to enforce social conformity, a University of Kansas psychologist believes. Mental health is defined by the dominant society on the basis of cultural values, explained Dr. Louis Frydman, KU School of Social Welfare faculty member. Persons who do not accept the dominant value system and deviate from prescribed behavior are labeled “sick.”

“The labeling process is used as a means of social control to keep those who upset society in line,” he said. Frydman was in Wichita Tuesday and Wednesday conducting an institute on “Changing Perceptions of Mental Disturbances” for health and social welfare professionals.

To illustrate, Frydman said a white girl who ran away with a black youngster to join a hippie culture would be called mentally ill by the dominant society.

“However,” he said, “if the hippie or black community had that (labeling), power chances are they would consider the psychiatrists the abnormal ones.”

“We tend to think the drug addict, the homosexual, the hippie, are such because they are “sick” and we look within the individual for an explanation of his behavior,” he said. “We prejudge the individual to be sick and take it for granted that the context in which the individual acts and exists is normal, benign, sane, good.”

However, this is not necessarily true, he said, pointing out that the juvenile delinquent in a slum neighborhood might be coping very appropriately for survival within his environment.

One approach to deviant behavior which stresses individual motivation, accepts the notion the problem is contained within the individual and, accordingly, chooses the individual as the object for labeling and the target for change, he said.

“However, in order to understand the behavior more fully we have to consider that the individual may be abnormal, the context may be abnormal or the interaction between the individual and the context may be abnormal.”

A broader, more useful approach, Frydman suggested, is to consider an individual’s behavior in a larger frame of reference composed of the individual, those reacting to the behavior, those in power to label and treat the individual and the socio-cultural value system used to define the act.

“This will allow us to understand what we can consider social or organizational pathology, and not just limit ourselves to individual pathology.”

“For instance,” he said, “we tend to explain the poor person as poor because he is culturally deprived, stimulus deprived, comes from a broken home, or is emotionally sick.” However, his poverty might be more relevantly understood as caused by economic conditions including employment.

Another example Frydman cited involved the use of marijuana. “The reason the marijuana user is ‘sick’ is because the laws are ‘sick’” he contended. There is no rationale for cigarette smoking and drinking not being illegal while marijuana is.” Yet the drug users’ behavior is defined in terms of “their illness” rather than “our oppression,” he said.

“Concern is growing in this country that mental health is assuming priority over humanism and civil rights,” Frydman remarked.

Adjustment to one’s culture is a basis of mental health, but it is dangerous to make adjustment or conformity to a value over human attributes or moral obligations, he said.

Take the case of a white mother asking a behavior modificationist to treat her child because he befriends black children when interracial friendship is not accepted in that community, he said.

“If the principle of adjustment is employed, it is appropriate to help the mother in her objective, he said. “However, as professionals concerned with the human quality of these children, we should realize it is destructive to turn people against others because of skin color.”
Psychiatric Inmates’ Liberation Movement
Judi Chamberlain

“On Our Own”

1978

Alternatives Conference 1985 - Present
1985 – The Schism

- Consumers (NMHCA)
- Survivors (NAPS)
- Ex-Patients

- C/S/X – inclusive term
- ”service users” in Europe
1979

Families
My Triumph Over Schizophrenia

In celebration of Mental Health Awareness Week, Summa Health System is proud to present nationally respected psychiatrist, Dr. Carol North. Dr. North is a former mental patient diagnosed as schizophrenic.

Following her recovery with an experimental treatment in 1978, she completed medical school and residency training in psychiatry. A harrowing description of her experiences is detailed in her book “Welcome Silence.” Join us as Dr. North shares her unique perspective on and triumph over schizophrenia.

CALL 375-3232 TO REGISTER FOR THIS FREE PROGRAM.

Raymond C. Firestone Auditorium, Professional Center South, Akron City Hospital

Dr. Carol North

1987
CAROL NORTH, M.D.

THE AMAZING TRUE STORY OF A HEROIC YOUNG WOMAN WHO NEARLY LOST HER LIFE FIGHTING HER DISEASE AND WHO IS NOW A PSYCHIATRIST TREATING OTHER SCHIZOPHRENICS

WELCOME, SILENCE

MY TRIUMPH OVER SCHIZOPHRENIA
“For me …it’s now pretty much a closed chapter in the book of my life, since it (schizophrenia) left me over 30 years ago.”

“the only thing that opens that chapter again these days is stigma…because of the label I can never remove”
(From e-mail - 3/7/’11)

“There are a number of people who recover from schizophrenia, and although they are rare, they do exist.”
30% of patients diagnosed with schizophrenia “fully recovered” - full recovery defined as being:
- symptom free,
- holding a job,
- having a social life,
- and taking no medication)

“Treat everyone as if they have the capability to recover”
In Psychiatric (Psychosocial) Rehabilitation - Focus is on teaching persons disabled with serious mental illness to improve their functioning in society despite the having the "signs and/or symptoms" of serious mental illness.

‘Disability Model’ as opposed to a ‘Medical Model’

(But responsibility (authority) remains with the ‘professionals’ in both these models)
About Us

About Patricia E. Deegan Ph.D.
Patricia E. Deegan Ph.D. is a psychiatric survivor, having first been diagnosed with schizophrenia as a teenager. She received her doctorate in clinical psychology from Duquesne University in 1984. She worked as a clinical director of community based programs for the Massachusetts Department of Mental Health from 1983-1987. In August of 1988 Dr. Deegan took a position as a program director with the Northeast Independent Living Program. In this capacity she designed and implemented a model for working with people with psychiatric disabilities in Independent Living/cross disability settings. This program was nominated for a "Community Health Leadership Award" by the Robert Wood Johnson Foundation. Pat is an activist in the ex-patient movement and a co-founder of the National Empowerment Center Inc. which is a federally funded, national technical assistance center run by consumer/survivors. Currently she holds the position of Director of Training at the National Empowerment Center Inc. Pat is also an independent consultant and speaker. She has given keynote addresses, lectures, and workshops across the United States, Canada, Europe, Australia, New Zealand and Israel. Pat specializes in developing trainings and lectures on the concrete application of the concepts of recovery and empowerment. Her papers have been published in many journals and books, and have been translated into Spanish, Hebrew, French, Dutch, Norwegian, Swedish and German.

© 2001 Advocates Inc.
Persons in recovery are not “passive recipients” of services.

Every journey (of recovery) is unique and the task is not to become normal but to become who you are and who you are called to be.

“Shared decision making” & “Common ground”
By James Bule
Monitor staff

NEW ORLEANS

Fred Frese was diagnosed with paranoid schizophrenia at the age of 26. During the next 23 years, despite periodic breakdowns, he earned three graduate degrees and worked steadily as a psychologist and administrator at the Ohio Department of Mental Health.

Frese, who describes himself as a "recovering schizophrenic," offered his colleagues an insider's view of serious mental illness during a symposium at the American Psychological Association convention here in August.

"I am a psychologist who functions reasonably well in spite of the fact my brain episodically functions in a schizophrenic manner that CNPs (chronically normal people) find difficult to understand," Frese said.

As he spoke ironically of "CNPs," there were titters from the audience. But the room quieted in respectful silence as Frese recalled his passage from Marine Corps officer into a state of psychosis, and as he described how "CNPs" can help the seriously mentally ill.

As a young marine, Frese was stationed in Japan for two years in the early 1960's, at a base near Hiroshima, and had observed firsthand the lasting destruction nuclear weapons could cause. When he was assigned responsibility for security of atomic weapons at the Naval Air Station in Jacksonville, Fla., he found the job to be particularly unsettling and stressful.

"About nine months into the assignment, I had a breakdown, was hospitalized and given the diagnosis of paranoid schizophrenia," Frese recalled. "Since that time, I have had numerous hospitalizations and breakdowns and have continued to carry the schizophrenia diagnosis in one form or another constantly during the past 23 years."

At the end of the symposium, about a half-dozen people came up to Frese to thank him for having the courage to talk about his case publicly, and for being a role model for other disabled persons.

"I am personally very proud that I have waged a reasonably successful battle against schizophrenia," he said after the talk. "It was not and is not easy... but if I can do it, so can you!"

In his talk, Frese attributed the lessening stigma and changing attitude about mental illness to the families who have organized and worked in the National Alliance for the Mentally Ill over the last decade. With the families of the mentally ill laying the groundwork, "we have been able to come out in the open and acknowledge that we are members of what has traditionally been a very marginalized group."

Frese has not been hospitalized since 1974, but he still has to have periodic breakdowns, which he says he has learned to handle by taking a few days or sometimes a few weeks vacations at home. During these times off, I confess that I may behave a little strangely, but after a few days of singing, dancing, eating raw corn, and synthesizing the world's major religions—or however else I work out my problems—I return to a fairly normal life.

For the past 12 years, he has directed the psychology department at Ohio's largest state-operated mental health facility.

Psychologists, Frese said, do help the seriously mentally ill "translate from our world to that of the majority population."

"Because of our disability, it is very difficult for us to know what we do that 'normal' do not understand," a trustworthy friend, spouse or psychologist can "teach us what it is about our thoughts that perhaps is best not to openly share with members of the majority population," Frese said. His wife helps him discern when he is saying or doing things that normal people may consider bizarre or offensive.

Our manners are unique, too, psychologists say. They dream of jobs that will help people with mental illnesses learn to compensate for them.

"Too often, those engaging in research on mental illness do not have sufficient experience being around or working with mentally disabled persons," Frese said.

In the hospital where Frese works, for example, "I generally give new psychologists about three days' exposure to their patients before I expect them to begin to 'catch on' as to how they should function when dealing with mentally ill persons.

"It really takes a long time to study the mentally ill first-hand before they (psychologists) begin to get a feel for how we function," he said.

Frase urged researchers "to get out of their academic laboratories and do serious work in the state hospitals and community support systems. Many of us could be very helpful in guiding you toward what is important to know about us."

Seldom does psychological research end up changing the system of care for the seriously mentally ill, Frese observed. He urged psychologists to be more active in promoting the application of their research findings in the marketplace where they might be of benefit to consumers. Psychologists can also do more to help fight the stigma of mental illness, Frese said. One simple way is to stop using pejorative or derogatory terms to describe the mentally ill, terms such as "bonkers," "wacko," "nutter," "crazy" and "gaga."

"Members of the general public can be excused somewhat because they usually know very little about serious mental illness. But psychologists and other mental health professionals often use these terms without thinking," Frese said.

Psychologists can also try to help employers understand the nature of mental illness, and the fact that some very good employees may have periodic breakdowns and require frequent periods of leave.

"Work for us could be structured so that our disabilities are taken into account. Many of us are relatively educated and/or have useful skills when we are not having episodes," Frese said.

"Why cannot jobs be structured for us where our episodic breakdowns do not automatically terminate us from employment?"

"We want and value your assistance," Frese told the psychologists, "but we are no longer satisfied to pay for it with a loss of our dignity."

"If you want to be of real service to us and our families, then treat us as fellow human beings. We have much to say about our experiences and we expect that what we have to say will be listened to. No longer will we tolerate being treated simply as objects of study and manipulation. Those who want to assist us must be willing to enter into partnership with us. Working together with mutual respect, our lives can be greatly improved.

"We welcome them with a grateful curiosity about the way we function but we are now demanding that we be treated as co-equal, fellow human beings and that substantive steps be taken to weave us into the larger fabric of society.

"There is a new dawn of dignity breaking for persons with schizophrenia and other disorders," Frese concluded. "Please help us and our families get ready for the light that is now just beginning to show on the horizon at the end of a long, long darkness."
“We welcome those with scientific curiosity about the way we function but we are now demanding that we be treated as co-equal fellow human beings and that substantive steps be taken to weave us into the larger fabric of society.” – F. Frese
Dear Dr. Frese:

- “I am a person just like you, except that I know that there is no such thing as schizophrenia, and you don’t.”
- Sincerely,
- Al Siebert, Ph. D. (U. Michigan, 1965)

(I hear essentially the same words later from a well-known psychiatrist who I am debating at the APA in 1993)
A Secret Kept Hidden for Thirty Years

In 1965 Al Siebert, author of *The Survivor Personality*, received his Ph.D. in clinical psychology from the University of Michigan and was awarded a fellowship for post-doctoral training at the Menninger Foundation. The month before his fellowship started he found himself swept up in a life-transforming peak experience rich with insights and synchronicity.

During this time he conducted an experimental interview with a young woman diagnosed as paranoid schizophrenic. His interviewing method led her to immediate recovery. When Dr. Siebert told the psychologists and psychiatrists at the Menninger Foundation about his extraordinary breakthrough, they declared him mentally ill. They cancelled his fellowship. He was locked up in the back ward of a psychiatric hospital.

Signed out “Against Medical Advice” for thirty years, this respected educator, business owner, author, and community leader now tells his fascinating story. In *Peaking Out* he describes a joyous, weeks long, mind-freeing peak experience, exposes undocumented practices and delusions in psychiatry, and reveals how he discovered the survivor personality.

“Peaking Out is a gripping, harrowing story full of implications for the contemporary mental health community and for anyone concerned about her or his own freedom. This is a book to be read.”—LARRY KIRKHART, Ph.D.
Psychiatry Deconstruction Zone

Paradigm Shift Ahead

Proceed at Your Own Risk!

"Our mission is to help psychiatry (for its own good) free itself from the delusions that keep it from being an effective medical speciality and to provide proof that thousands of people are right when they say they are NOT mentally ill"

"...85% of our clients (all diagnosed as severely schizophrenic) at the Diabasis center not only improved, with no medications, but most went on growing after leaving us."

John Weir Perry, *Trials of the Visionary Mind*

- Where are the thousands of former mental patients who got "Weller Than Well?" *(Karl Menninger quote, questions raised.)*
- The "Weller Than Well" Project. Help us contact psychiatric
Recovery from mental illness: the guiding vision of the mental health service system in the 1990’s

“Recovery – a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles.”
The Spirit of Recovery

Without inner peace, nothing else matters; with inner peace, nothing else matters.

Ed Knight's Tale

Waist-high pea green walls divide the large dormitory into six sleeping areas, six metal beds in each, thirty-six patients. A blue-gray cigarette smog clouds the entire room. Shuffling down the hall between the sleeping areas, a figure in State-issue clothing, a shirt crudely sewn from light blue plaid industrial-grade curtain material, beltless gray pants, stiff, too large. Barely able to put one foot before the other, he tugs on his sagging pants every third step. "The thorazine shuffle." The man knows it is not the thorazine. It is emotional pain so deep his skin hurts. As he has done many times before, the man is figuring a way to kill himself. He doesn't want to die. He wants the pain to end, to live without the constant agony. Silently, his lips breath, "Help." He speaks to no image, no divine principle, no inner notion of God. His is just a plea to someone stronger than himself that the pain will go down. He acts on the prayer. He shuffles to bed and curls up tight and falls asleep.

The next morning, awake, I am no longer a stranger, an alien occupying an unknown body. The pain had gone down just enough to allow me to get out of bed. My prayer had been answered. The rest was up to me. Looking around at the hopeless figures that surrounded me in that dismal State hospital ward, I made a decision: if I could help myself, I would find a way to help them as well. This time around schizophrenia would not be hopeless. Instead, it would be an illness with dignity. This time would be different.
Edward L. Knight, Ph.D. (Sociology)

- Vice President, for Recovery, Rehabilitation, & Mutual Support
  Value Options, Colorado Springs, CO

- “Symptom reductions and learning how to ‘fit in’ (are) …. crucial to recovery”

- Feels his ‘social intelligence’ is now better than pre-illness
Psychologists see an opportunity in providing services for people with severe mental illnesses.

By Randall Edwards

Until recently, people with severe mental illnesses were treated only in hospitals or clinics, where psychologists were scarce. But in today's health-care environment, as the system places more emphasis on less expensive outpatient treatment, psychologists have a chance to carve out a stronger role in treating people with severe mental illnesses.

Emerging opportunities include treating children with severe emotional disturbances in outpatient settings; creating and managing programs for the seriously mentally ill; and treating the seriously mentally ill through practice groups that will bid on contracts previously provided by public-sector clinics.

Although they've not been heavily involved in treatment, psychologists have a long tradition of developing diagnostic and innovative programs for treating people with severe mental illness, said Scotty Hargrove, PhD, chairman of the University of Mississippi's psychology department. They can also provide functional assessment, program evaluation and community interventions for people with serious mental disorders, he said.

The profession already has

Filling the void

Psychologists have, for many years, suspected they had little to offer patients suffering from such disorders as schizophrenia or severe depression.

Social workers often have stepped into the void left by psychologists, partly because they demand less salary, but also because they have a different approach in philosophy and training, said Carol Mowbray, PhD, a psychologist who teaches in the graduate program at the University of Michigan's School of Social Work.

"Psychologists did not believe many of these people would be able to benefit from psychotherapy," Mowbray said.

"They view [those with severe mental illness] as having low-functioning levels, and no sense of self. That population is not interesting to psychologists. I don't think there is enough understanding of the potential for growth and development."

Also, psychologists rarely treated patients with major mental illnesses because such patients usually receive treatment in hospitals or community mental health clinics, which are more likely to hire social workers than psychologists.

Ron Mather, director of mental health services, said psychologists were often either unable or unwilling to accommodate a patient with a need for a more flexible treatment modality—a situation that needs changing, he said.

A new opportunity

Simon Budman, PhD, a psychologist and director of mental health training for Harvard Pilgrim Health Care, a large HMO in New England, sees treating those with severe mental disorders as an opportunity for psychologists.

"It's much harder these days to make a living as a solo practitioner, hanging out a shingle and waiting for verbal, smart, ambulatory patients with insurance to walk in the door," said Budman, who also serves as president of Innovative Training Systems, a mental health consulting group in Newton, Mass.

In addition to a stronger emphasis on outpatient treatment, health-care providers are recognizing that many patients being treated by medication for serious mental illnesses also need psychotherapy, Budman said.

"Psychologists are learning, by necessity, that many patients with major mental illness also have social..."
Ron Bassman, Ph.D.  
“My ascent from madness to my present state of clarity was and is a journey whose responsibility always resided with me.”

“There can be complete recovery from schizophrenia”

Past President, NARPA
1997

Beth Baxter, M..D.
A doctor who knows the struggle

Psychiatrist has battled her own mental illness

By Dwight Lewis

Dr. Beth Baxter talks to people about breaking down the barriers of mental illness in the South. She believes that residents of the area have been long-term obstacles to the flow of mental health care.

Baxter, 56, has been a psychiatrist for 25 years. In 1994, she was named the first president of the South Carolina Psychiatric Association and is currently a member of the Greenville County Medical Society.

And she's not shy about telling her story — a story that includes being the president of the student body at Mt. Zion College during her senior year in college and making it through the University of Virginia Medical School despite having to take a medical leave for a period of time.

I've spent the past three years traveling around some parts of my country, Baxter tells a visitor sitting in her office at the Mental Health Cooperative in Mockingbird Park.

I think talking about your illness is necessary to help break the stigma of mental illness. When I do my research around the country other people often come up and say, "I have a mental illness, too."

"It takes a tremendous amount of weight off your shoulders to let others know about it."

Baxter says that it's also a very liberating experience.

"If we talk more about mental illness, the average American will feel better about getting treated."

As she continues talking during an interview, Baxter says statistics show that one in 50 Americans will suffer from a major mental illness during their lifetime.

The cost of institutionalization for a person with a mental illness is between $100,000 and $200,000 a year, she says. That's why it's so important to get people with mental illness back into society or back into the workforce.

But Baxter says that people with a mental illness really need to have a good support system to help them get back on track.
Beth Backster, M. D. -1997

“If I can do it they can do it.” (she says to her patients with schizophrenia and similar conditions) – “Turn of the Tide” (2011)

Co-author – BRIDGES: a Peer Education Program - “people can and do recover a new and valued sense of self and purpose”
The notion of recovery reflects renewed optimism about the outcomes of mental illness” (p. 15)

“Overview of Recovery” (p. 97 – 102)
(6 of 487 pages)
Effective Treatment for Posttraumatic Disorders in Severe Mental Illness

Disability Benefits and Return to Work: Are There Disincentives?

Integrating Evidence-Based Practices and the Recovery Model

Therapist Self-Disclosure: When Is It Beneficial, and for Which Patients?
Integrating Evidence-Based Practices and the Recovery Model

Frederick J. Frese III, Ph.D.
Jonathan Stanley, J.D.
Ken Kress, J.D., Ph.D.
Suzanne Vogel-Sechilin, M.D.

Consumer advocacy has emerged as an important factor in mental health policy during the past few decades. Winning consumer support for evidence-based practices requires recognition that consumers' desires and needs for various types of treatments and services differ significantly. The authors suggest that the degree of support for evidence-based practices by consumer advocates depends largely on the degree of disability of the persons for whom they are advocating. Advocates such as members of the National Alliance for the Mentally Ill, who focus on the needs of the most seriously disabled consumers, are most likely to be highly supportive of research that is grounded in evidence-based practices. On the other hand, advocates who focus more on the needs of consumers who are further along their road to recovery are more likely to be attracted to the recovery model. Gathering the support of the latter group entails ensuring that consumers, as they recover, are given increasing autonomy and greater input about the types of treatments and services they receive. The authors suggest ways to integrate evidence-based practices with the recovery model and then suggest a hybrid theory that maximizes the virtues and minimizes the weaknesses of each model. (Psychiatric Services 52:406-408, 2001)

Shortly after the National Institute of Mental Health was returned to the National Institutes of Health in 1989, President George H. W. Bush declared the "Decade of the Brain." Federal funding for research on the brain was greatly increased during that time, resulting in remarkable scientific progress (1). The 1990s saw advances not only in our understanding of the workings of the human brain but also in our approaches to the treatment of the mental illnesses that are caused by brain abnormalities. During the past decade, confidence in scientific research, with its objective observations and measurements, has increased considerably in the mental health arena.

Evidence-based practices

In recent years, this increased confidence in scientific treatment methods for mental illnesses has given rise to a movement that calls for more widespread adoption of treatment approaches that are scientifically grounded. This movement has been developing under the rubric of "evidence-based practices" (2-7). Under this concept, the call for greater reliance on scientific evidence is being extended to treatment approaches that are supported by psychological and sociological evidence as well as by the findings of biological research.

In an earlier article on evidence-based practices, Drake and associates (3) provided an overview of the topic, outlining the research findings and philosophical underpinnings of the evidence-based practice movement. They spelled out specific reasons for the special focus by Psychiatric Services on evidence-based practice interventions. These reasons include the belief that routine mental health programs do not provide evidence-based practices, that implementation of services resembling evidence-based practices may lack fidelity to evidence-based procedures, and, especially, that in the context of limited resources consumers have a right to interventions that are known to be effective. So described, evidence-based practices appear to be immutable. Who could object to promoting the use of treatments that work rather than those that do not?

Drake and colleagues (5) also delineated a core set of interventions: prescription of medications within specific parameters, training in self-management of illness, assertive community treatment, family psychoeducation, supported employment, and integrative treatment for co-occurring subst...
NMHCA mission statement and agenda

Mission statement
Guided by the principles of choice, empowerment, and self-determination, the National Mental Health Consumers’ Association is a human rights organization that advocates for employment, housing, benefits, service choice, and the end of discrimination and abuse in the lives of persons who use, have used, or have been used by the mental health systems.

National agenda
Employment. We support the full implementation of the Americans With Disabilities Act and the Rehabilitation Services Act. We must be given every opportunity to be gainfully employed in occupations where we, with reasonable accommodation, can contribute. We call upon the mental health system to practice affirmative action in training and employing mental health consumers in professional careers in the mental health system.

Housing. All persons, particularly those identified as being mentally ill, are entitled to adequate, permanent homes of their choice.

Benefits. All psychiatrically disabled persons must be entitled to sufficient income, social supports, and comprehensive health care to enjoy an adequate quality of life.

Mental health systems. Recovery and healing, not social control, must be the goal and outcome of the mental health system; therefore, the mental health system must be client driven.

Self-help. We support the full and sustained funding and development of user-run alternatives and additions to the traditional mental health system, self-determined and governed by and for members, in every community.

Discrimination. Discrimination, abuse, ostracism, stigmatization, and other forms of social prejudice must be identified and vigorously opposed at every opportunity.
NMHCA Mission Statement (12/12/1992)

- Employment
- Housing
- Benefits
- Mental Health Systems – to be client driven
- Self-help
- Discrimination – must be opposed
NAMI’s TRIAD Standards of Care

Access to Appropriate Medication
Inpatient Care
ACT Programs
General Medical Care
Integrated Services for Dual Diagnosis
Family Psychoeducation and Support
Peer Provided Services and Supports
Supported Employment Services
Affordable Housing and Supports
Jail Diversion Programs
Non-stigmatizing and Non-discriminating Environment
Consumer Quality Review Team (CQRT)

Services seen as needed but not readily available

1. Crisis stabilization
2. Long-term secure residential programs
3. Clubhouse services
4. Housing
5. Job training and placement
6. Consumer-run services

Services needing greatest improvement

1. Access to services
2. Adequate numbers of staff
3. Greater consumer influence
4. More considerate behavior by mental health staff
5. More information needed regarding available services
Figure 3. Relationship between increasing damage to neuronal circuits and clinical phenomenology.

Severity of Psychopathology and Responsiveness to Treatment
“We are encouraging people to become involved in their own rescue.”
Group stirs debate over schizophrenia

Lawrence center says recovery possible, eschews drugs

Laurie Ahern and Daniel Fisher say they contradict the medical orthodoxy on schizophrenics.
President’s New Freedom Commission on Mental Health 2003

Achieving the Promise: Transforming Mental Health Care in America

The Goal of the Transformed System: Recovery
SAMHSA

National Consensus Conference on Mental Health Recovery and Systems Transformation

December 16 – 17, 2004
Mental health recovery is a journey of healing and transformation for a person with a mental health disability to be able to live a meaningful life in communities of his or her choice while striving to achieve full human potential or “personhood”.

Ten Fundamental Elements and Guiding Principles of Recovery

- Self Direction
- Individualized and Person Centered
- Empowerment
- Holistic
- Non-linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope
Mainstream views: (Focus on individual change)

1. Medical (Biological) Model
2. Psychosocial or Disability Model

versus

3. Social Change – Political, Ideological or “Radical” or Civil Rights Model

“Advocacy is the best therapy”
“Nothing about us without us”
“No forced treatment”

Nora Jacobson, Ph.D. 2004
2005

Andreasen NC, Carpenter WT Jr, Kane JM, Lasser RA, Marder S, Weinberger DR.

Robert Miller, Ph. D.
2007 - ICOSR
“Florid psychosis shakes one up for months, even years, before things settle down”

“One has to learn to reinvent themselves in various ways”

“Apart from recovery from the (schizophrenic) traits themselves, there is a lengthy process of learning how to cope with stigma.”

Quotes paraphrased from e-mail - 3/5/’11
Elyn R. Saks, J.D.  
Director  
Saks Institute for Mental Health Law, Policy and Ethics,  
USC School of Law
The Center Cannot Hold

“One of the ten best books of the year 2007”

Time Magazine
2007
Recovery from Schizophrenia
An International Perspective

- Report from the WHO Collaborative Project
- The International Study of Schizophrenia
2007

- Martin Harrow UIC
Five year project
Grants awarded to psychiatrists, psychologists, nurses, social workers, and peer support association ($250k ea.) to become more "recovery oriented"
Larry Davidson, Ph.D. RTP Project Director
Larry Davidson
Jaak Rakfeldt
and John Strauss

THE ROOTS OF THE
RECOVERY MOVEMENT
IN PSYCHIATRY

Lessons Learned

WILEY-BLACKWELL
Summary

Recovery historically has been viewed as:

Remission of symptoms – (medical, disease or biological model)

Increase in functioning despite “deficits” of the disorder (psychosocial or psychiatric rehabilitation model)

Maximum responsibility for recovery is afforded to the person in recovery (recovery model)

Recovery-as-politics, civil rights or ideological model – empowerment, rights, liberation, societal change, fighting discrimination, etc.
IOP Institute of Psychiatry

- Mental Health Research Network (MHRN)
Thank you!