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THE WORLD OF BEING ONE IN RECOVERY PROGRAMS.
Lourdes Ladrido-Ignacio MD,
Professor Emeritus in Psychiatry University of the Philippines &
President World Association for Psychosocial Rehabilitation

“One World: the Quest for Integration” as depicted in The Tree of Life and the theme of the recently concluded World Congress for Psychosocial Rehabilitation expresses the truth of our shared world view that we and our patients join all people across the globe in achieving homeostasis and peace within ourselves and with society in general.

We are taking the position that psychosocial rehabilitation will be the strategy to achieve this sense of balance and equilibrium among our patients so that they not only improve from their symptoms but lead a meaningful life. This strategy is not only evidenced based but value based.

We should be ONE in this concept because this recognizes the importance of the individual’s capacity to determine his choice of role function as well as his perception that such a chosen role is valued by the society where he lives. This value based practice of PSR for individuals with serious mental illnesses emphasizes on their recovery or the state of gaining/regaining a life that is meaningful to them. There therefore has been a clearer articulation of the fundamental values of PSR strategies which include having the capacity to choose, hope, form meaningful relationships through a continuing focus on individual strengths and interests and realistic appraisal of weaknesses and limitations. This view does not put as much importance in the acquisition of skills as a result of a specified rehabilitation strategy, but rather on how this would contribute to the desired primary outcome of enhanced functioning in a valued role.

We look back and review the “consensus statement” held for PSR programs and realize that this can only be a logical development. So far, the highlights and trends following the articulation of this statement jointly articulated by the WHO and WAPR has recognized that a) the advances in the neurosciences in support of biological psychiatry has led to a significant development in symptom reduction and relief, b) the resulting deinstitutionalization and attempts to develop and strengthen community services has led to the return of the patients to their homes and a more humanistic management, recognizing their rights to be treated with dignity as another human being. For most of them this means regaining a feeling of being part of their families, c) long term epidemiological studies have shown that mental illness need not be a deteriorating process and that people with psychotic episodes can recover and those with a chronic course may still be helped to
recover and be able to live productively in their communities.

These however continue to be met by the fact that in many countries as in developed countries, deinstitutionalization has resulted in an increase of untreated mental patients and homelessness and, in developing countries where at least 80% of the world’s population lives, there has not been substantial changes in the delivery of mental health resources. Basic treatment and services are still not available for all those patients and their families that need mental health care.

At present our desired shared goal of “recovery” has shifted the perspective for PSR from this rather pessimistic expectation regarding outcomes for our patients and their families. The question for the patient and his family might simply be: “Can the person feel good and satisfied with himself enough to find meaning in his daily life if he/she succeeds to be a mother/father, wife/husband, boss/worker, etc. etc as a result of the PSR he has been involved in?

Recovery has been defined as a state which results from a very personal process of coping with the illness, its symptoms and disadvantages, and of changing values and experiences so that one finds meaning in life beyond illness and disability. (Farkas, 2007). Most often it is described in experiences through testimonies from patients and their families.

I cite here a case I have encountered in the community mental health project in western Philippines, but I am quite sure this is not unique to me because I have encountered similar case stories in several countries in the Western Pacific Region, the most populous of the WHO Regions where I have served as WHO Consultant. An issue of Time Magazine in 2003 has featured these “lost lives” among those with chronic mental illness in Asia. This story did not fail to call attention to the fact that it will not be surprising to find similar cases in other regions, especially in the developing world.

Consider the case of Merlina a 35 year old woman in a remote town in western Philippines. She had the 1st onset of her illness 10 years ago when she was 25 years old and was diagnosed as suffering from schizophrenia. She was confined in a mental hospital for a year and was discharged free of her psychotic symptoms with advise to continue with her medications. Compliance to these medications however was erratic although she remained symptom free enough to have worked at home, but essentially dependent on her mother. As is practiced in their barrio, she was eventually married to a neighbor’s son because her parents thought that marriage would help her overcome her illness. They lived with his family. Although remaining free of her psychiatric symptoms, her behavior was marginal. She was generally non-reactive and without much social skills. Soon, her husband found her unfit and he started to make plans to leave her, which he eventually did by returning her to her parent’s household with her 4 year old daughter. She became acutely psychotic but rather than bring her back to the mental hospital some 300 km away, the family decided to build a cell within their house and kept her there. Herbal medicines known to the barrio as sedating would be given to her when she could not sleep and in times of agitation.

As mentioned earlier, many such cases still prevail in developing countries where 80% of the world’s population lives. Despite what has also been the current situation of severe shortage and tremendous treatment gaps for these patients, PSR practitioners have documented programs that address the pessimism prevailing in the care of these patients in their communities. The dehumanized care even at home prevails but there are increasing trends to address this by adapting the recovery perspective in PSR care.

Our project in western Philippines for example has taken on the many cases of which Merlina is an example. I am sure we are one with other colleagues around the globe that share the view that our patients, have the same aspirations as any other ordinary person. They want to be respected as individuals and lead a life as normally as anyone. Messages like: “We are people like you” are common in anti-stigma campaigns around the world. Guided by this value, we proceeded to start with planning with her family on how she can be taken out of her cell, be helped to recover from her symptoms and eventually take care of her child and participate in housework. With medications, she not only became manageable but functional at home. With regular contacts with a community nurse, her neighbor, she soon took the task of bringing and fetching her child from school and it was a surprise to most that she joined the parent-teacher meetings. At this time Merlina, earns enough to support her daughter by running a food stall selling snacks for children in her daughter’s school.

Merlina has indeed recovered and has been a testimony in her community of the positive effects of
educating her family regarding her treatment, giving them the experience of allowing their daughter afflicted with mental illness the chance to recover and gain a meaningful life.

Although considered as soft data they provide powerful insights nonetheless on how services can now be directed to consider as a significant determinant, the views of “consumers” of these services. These are contained in the UN Declaration of Rights of Patients with Mental Disorders which although articulated as early as 1991 defining practices that aim at helping the consumer choose their targets so that they can attain their human rights to live lives with respect and dignity, is still to be given a more forceful voice in the implementation of mental health programs worldwide, especially in developing countries.

We should BE ONE in giving this voice for our patients, the voice, that they definitely can recover if we change our own paradigms and allow them to choose and be capable to function in the role they choose to function so that their lives can find meaning to them. Our experiences have shown us that this is possible.

However, we find barriers to this value-based PSR strategy. These barriers include: a) prevailing stigma for mental illness, b) the professionals themselves who continue to hold the belief that evidence based psychosocial rehabilitation programs which they have designed are what should be the main determinant to appropriate services, depriving the consumers of such services to have a voice; c) the unavailability and inaccessibility of such mental health services which remain consistent.

Many anti-stigma campaigns are in place, The World Psychiatric Association, in a global program on “Reducing the Stigma of Mental Illness” (Sartorius, 2005) has developed 200 interventions to a wide range of target groups in 20 countries. These are expected to determine more effective ways to reduce stigma forward. Rossler in his “overview of psychosocial rehabilitation today” (World Psychiatry 2006) takes note of the training needs for psychiatrists to experience the patients in their “real world” outside of institutional settings so that they not only open their eyes and ears to what their patients are actually saying and not only to what has traditionally been predetermined.

Our project in the Philippines has shown us that the long held pessimism in providing greater accessibility and availability of mental health services and psychosocial rehabilitation programs, will benefit greatly by taking advantage of current telecommunications technology. Although telehealth programs and more specifically its applicability to psychiatry and mental health programs has already been advocated in the latter part of the 20th century, there has so far not been much development in this field.
It is highly possible to develop community mental health services in remote areas where there are no mental health professionals through training of community health and social workers in mental health and providing them professional support for a referral system through the strategy of telementoring them and therefore effectively help them through teleconferencing.

In the last half of the 20th century, the WHO has articulated the goal of “Health for All” and the strategy for this articulated as the utilization of a primary health care approach. The strategy for extending mental health care at this level of health care was further pursued in a 7 nation collaborative study. That study showed the feasibility of mental health care at the primary health care level through the training of existing health workers in the detection and management of area based identified mental health problems. In providing mental health care at the primary level of care it was expected that the reach of mental health care would be wider and therefore address the long prevailing problem of its inaccessibility. Somehow though this has not caught wide application because of the continuing shortage of mental health manpower who, also remained within the context of institutional mental health care.

Current experiences in the use of telecommunications through wireless telephones and teleconferencing provide the optimism in reaching those unreached by mental health services. More importantly this has the potential not only for mental health professionals to be in closer communication with trained community health workers, but there is greater ease and accessibility among professionals themselves within their respective countries and intercountry worldwide to be in touch and share their creative innovative programs that have a shared view –i.e., the pursuit of all strategies for their patients and their families to recover from mental and psychosocial problems.

While there is acknowledged the need to consider cultural diversity among people around the world, there is universal agreement that there can only be ONE view in the fact that our patients like anyone aspire to lead good meaningful lives. If one adopts the recovery perspective, one recognizes that this strategy must be directed at helping patients choose how they want to be helped, how they will conduct their own recovery and how they will lead their lives with dignity. These have implications for the design of the PSR services and professional attitudes, necessitating the need to recognize that the task for carrying this out is a shared task among the many sectors in society. Yet we are truly aware that because of its position of low priority in society, mental health and psychosocial care finds itself generally, losing out. However, the confluence of recent developments has rendered this much more manageable at present. As mentioned earlier, the entry of the telecommunications technology and our being “wired” as ONE when we pursue our programs offer a real optimistic perspective. Our experiences in our clinics and community psychosocial rehabilitation programs attest to this.

There is indeed a saying: “in change we do not need new landscapes, we only need new eyes”
The Political Economy of Deinstitutionalization.

Madianos Michael MD, MPH, DrMed FAEP

Professor of General and Social Psychiatry School of Health Sciences
University of Athens
Past President, World Association for Psychosocial Rehabilitation

SUMMARY

Deinstitutionalization of chronically mentally ill persons in many western countries was initiated in the late sixties and early seventies of the last century, of course after the massive introduction of neuroleptics. However in many countries the discharges of the inmates were made before community and local support network had organized satisfactory number of alternatives to host the discharged patients resulting to the negative phenomena of revolving door and homelessness.

On the other hand, Deinstitutionalization is directly linked with the welfare state and the adequate financial support of the programme. In several countries the shift from the welfare state to the market economy caused dramatic negative impact in the organization of the delivery of adequate mental health care for the vulnerable low socioeconomical class mentally ill individuals. Deinstitutionalization was proven to be successful, when there where strong ideological or humanitarian motives and when psychiatric reform was a priority and was completed with a comprehensive system of community based alternatives and sufficient welfare support.

1. Introduction

To speak about deinstitutionalization of chronically mentally ill persons, the first thing that comes in mind is the genesis of the large psychiatric institutions, the Asylums, in the 18th century. The discovery of Asylum was a result of the archetypal fear against the inexplicable, strange or ritualistic behavior, the unexpected episodes of violence and other inappropriate manners of some people, phenomena which have long been linked with the evil possession, according to JudaeoChristian tradition (Rothman 1971).

The treatment of inmates in these Asylums was far beyond to be characterized as humane. The common features of “treatment” were restrictive measures such as chains, straw, filthy solitude in small cells, malnutrition provision of some empirical remedies such ipecacuana, tartarised antimony, syrup of buckthorn, valeriana, and other herbal “filters”. Corporal punishment including flogging was commonly exercised. This was the state of...
“psychiatry” with the exception of some enlighten cases of humane care centers called by the historians as “moral treatment” places such as the York Retreat in England, the Bonifacio Hospital in Florence of Italy, the Hospitals of Bicetre and Salpetriere in Paris, the Bloomingdales Asylum in New York. The situation in the large psychiatric asylums was remained unchangeable, although the majority of them were transformed around the middle of the 19th century into Mental Hospitals in many western countries (Mora 1975).

It took more than hundred years with several social, economic and political dramatic events and changes, including two catastrophic world wars, for the theoretical and practical negation of the asylum. It should be noted that in the 40’s several inspired mental health professionals have applied an open door policy in their hospitals and have introduced innovative methods for the rehabilitation of the institutionalized patients including the concept of therapeutic community (Rothman 1971). The era of Social and Community Psychiatry was developed in the 60’s and 70’s in many western countries (Ralph 1983). It was of course the introduction of chlorpromazine and the other neuroleptics, which facilitated the opening of their gates (Mechanic 2007).

In USA the rates if mental hospitalizations per 100,000 of population declined from 400 per 100,000 in 1935 to 200 in 1970. The alternatives for the institutionalized life in the mental hospitals are now based in the community with a variety of types of services such as Day Care Centers, Community Mental Health Centers, Vocational Rehabilitation Centers, Cooperatives and Social Firms, Supported Employment, Halfway houses, Social Clubs, Nursing Homes and Hostels (Mechanic 2007).

In the 70’s the deinstitutionalization movement was grown in United States and in some European countries such as Italy, Great Britain, Sweden, France, Spain and others (Bachrach 1976, Madianos 2002). However, in many countries the massive discharges of chronically mentally ill individuals, were made before community and local support network had organized satisfactory number of alternatives to host the discharged patients (Mechanic & Rochefort 1990). The side effects of deinstitutionalization were the neglect of people with serious mental illness and phenomena of massive homelessness. The story behind was, the inadequate budgeting mainly in USA and in some other industrialized countries (Saraceno & Barbui 1997, Wave & Goldfingers 1997).

So it is the economy linked with the appropriate social welfare policy of the state, playing the major role in the effective deinstitutionalization and rehabilitation of the chronically mentally ill in the community (Thornicroft & Bebbington 1989).

2. Economy and mental illness

It has long shown that social and economic conditions are influencing psychiatric treatments and outcome. Harvey Brenner’s work has shown that Mental Hospital admissions in New York state especially for schizophrenia increased during the economic recession periods, although the annual expenditure of state Mental Hospitals did not decrease considerably (Brenner 1973).

It seemed that the lack of economic resources of families and the related support systems and the existing unemployment had influenced the course of illness, preventing recovery and causing relapses and readmissions. In the 30’s Faris and Dunham in their ecological study in Chicago, reported that the highest treated prevalence rates for “Dementia Praecox” were concentrated in the slum areas of Chicago greater area (7 cases per 1000 adults in the slum areas to 2.5 per 1000 in the upper class areas). This study was replicated in several other cities of USA with the same findings (Faris and Dunham 1939).

In the 50’s the classic study of Hollingshead and Redlich in New Haven, showed that lower income and social class patients had longer admissions to State Mental Hospitals and were more likely to be readmitted (Hollingshead and Redlich 1958). A decade later J. Myers and L. Bean found in New Haven again that lower class patients had longer length of stay in the hospitals and frequent readmissions and when they were discharged had poor work record and their living conditions were characterized by isolation and marginalization due to stigma (Myers & Bean 1968).

In another study by Astrachan et al (1974) lower social class patients had more psychotic symptoms in a 2-3 years follow-up period after discharge from the Mental Hospital. Additionally, the prevalence of stressful life events are more frequent in the lower class populations and consequently the stress diathesis risk for a schizophrenic episode is increasing (Yanos et al 2001).

Some other studies pointed out the harmful effect on mental health from other phenomena related to
3. Deinstitutionalization, Psychosocial Rehabilitation and the globalization of the economy

The relationship between the economy and the effective psychosocial rehabilitation needed for the deinstitutionalized patients, has already been proven. For example, work is a basic rehabilitation goal, and obtaining a job (full or part time) is always a desirable ambition. The question is how to get a job when the economy is in recession and unemployment rates are high. In most Western states, economic recession is a chronic phenomenon. This could cause difficulties even to supported employment programs (Drew et al. 2001). Moreover, the economic recession is always linked with psychosocial rehabilitation programs budget cuts. Globalization of economy has brought serious economic changes (market economy), increasing unemployment rates (investments are moving to cheap labour countries), privatization of social institutions (less social welfare state), high social mobility, transformations in the family structure, and marginalization of socially disadvantaged groups (e.g., unskilled workers, minority groups and disabled persons) (Morrow 2004, Madianos 2006). The marginalization-alienation of the less economically advantaged social groups, including the mentally disabled, in the metropolitan areas of western countries increases the risk for developing a chronic mental disorder of worsening the existing one (Williams et al. 1973). The growing economic insecurity causes a considerable emotional and economic burden especially to families with a member suffering from serious mental illness. These families are often facing profound economic hardship (Madianos et al. 2004, Schene et al 1998). Poverty has a significant negative impact on psychological well-being, self-esteem, health (physical and mental) and the quality of life in general. Particularly low levels of quality of life in its various domains (social relations, leisure activities, nutrition, housing) are experienced by individuals suffering from serious mental illness and their family members (Wilton 2004).

4. Poverty and the development of mental health care and rehabilitation services in the world.

In the new millennium, the majority of the countries of the world, belong in the category of lower or lower-middle level of economic development. These social and economic conditions are reflected in the existing of mental health care and psychosocial rehabilitation services in these countries. On the other hand, the increasing incidence of mental disorders are imposing a great global burden (Murray & Lopez 1996). From the WHO Mental Health Atlas we could observe dramatic discrepancies in the existence of community based mental health services and the specialized services for chronically mentally ill (psychosocial rehabilitation services) (WHO 2000, 2001 a, b, 2005). Only half of the lower economically developed countries, provide community based psychiatric services, disability benefits and rehabilitation services contrasting with the 97.4% to 100% of the higher level of economically developed countries, providing the previously described services and benefits. The median cost of maintenance treatment of psychiatric disorders with 400 mg of Chlorpromazine, is positively correlated with the economic level of the countries. Finally, the economic level of the county is definitively related to the development of specialized services (rehabilitation etc.) for children and the elderly. In the category of lower economic level countries, only 34.5% and 17.9% of the countries provide these services for children and elderly respectively, compared to that of 86.8% and 89.5% of the rich countries, which provide these services respectively. There are also other significant findings such as the percentage of the total health budget spent on mental health to be 0.5 to 1.2% in low-income countries, 2.8% in middle-income countries and 6.9% in high-income countries. The shortage of mental health personnel (psychiatrists, psychologists, social workers, psychiatric nurses etc.) is profound among the low income countries (Saraceno and Barbiu 1997). However, in many of the low income countries family and community network systems still exist supporting the suffering from mental illnesses members (Jablensky et al 1992, Mc Kenzie et al 2004).
The other side of the relationship of economy and mental illness in the era of globalization is the social correlates of the psychiatric deinstitutionalization movement in the developed countries (Williams et al 1973, Scull 1985, Thornicroft & Bebbington 1989).

Moreover, the ongoing process of deinstitutionalization of long-stay inpatients in many western countries are more involving the family and the community. When the family and the local community are economically disadvantaged are unable to accept the deinstitutionalized patients. These chronic mentally disabled patients are likely to become homeless, or trans-institutionalized. Transinstitutionalization is the new phenomenon when large number of chronic mentally ill are incarcerated. In these cases psychosocial rehabilitation sounds ironic.

5. Political economy of psychiatric deinstitutionalization

Deinstitutionalization apart from the theoretical negation of the asylums incorporates the cost-benefit factor for discharging chronic inmates into the community, given the fact that the majority of them belong to lower middle or lower socioeconomic class (Bachrach 1976). In the middle of the 70’s when N.I.M.H. in USA initiated the nation-wide program of closing down the State Mental Hospitals, the first President’s (Jimmy Carter’s presidency) Commission on Mental Health focused on the development of specialized programs for the discharged patients. However, when Ronald Reagan took over the Office in 1981, the mental health policy was not a federal priority, with serious budget cuts, and blocking of series of grants. In this period in USA Medicaid, Supplemental Security Income and Section 8 housing, covered poorly the unmet needs of chronically mentally ill. In the same time period, consumers in USA were organized under the frame of the National Alliance for the Mentally Ill fighting for the protection of their rights (Mechanic 1990, Madianos 2002).

Schizophrenia on the other hand, a diagnosis of which the vast majority of deinstitutionalized patients are suffering, is in many cases debilitating illness, resulting significant economic burden. In the United States the overall 2002 cost of Schizophrenia was estimated to be $62.7 billion with $ 22.7 billion direct health care, cost ($ 7.0 billion for outpatient, $ 5.0 billion for drugs, $ 2.8 billion for inpatient treatment and $ 8.0 billion for long-term care) (Wu et al 2005). The total direct non-health care excess costs, including living cost, were estimated to be $ 7.6 billion and the total indirect costs were estimated about $ 32.4 billion.

Similarly, in neighboring Canada the direct health care and non care costs for the estimated numbers of persons with Schizophrenia (n: 234.305) were estimated to be 2.02 billion CAN dollars in 2004. This combined with their high unemployment rate and loss of productivity and higher mortality and morbidity rates, resulted an estimate additional cost of 4.83 billion CAN dollars (Morrow 2007).

In Australia the estimate of the annual cost of psychoses is about 2.25 billion Australian dollars (Neil et al 2003).

The above economic figures are showing that Schizophrenia affecting hundred thousand persons, the majority of them been deinstitutionalized, has a high economic burden requiring serious allocation of resources not a simple hospital beds reduction policy and letting these persons in their fate in the community. Some studies have shown a negative correlation between reduction of hospital beds and excessive mortality rates (Saha et al 2007). The medical care neglect of such persons is reflected in their increased mortality and morbidity rates. People with chronic mental illness die on average 20-25 years earlier than the general population (Parks et al 2006).

Several studies document there is a serious public health problem for the people underserved by the mental health care systems (Yanos et al 2001). The majority (60%) of the premature deaths are due to medical conditions (usually preventable), such as
cardiovascular, pulmonary and infections diseases. Another 30-40% of mortality is due to suicide, injuries, and accidents. Among these persons, natural causes of death are cardiovascular disease, complications from diabetes and metabolic syndrome, respiratory disease due to heavy smoking, and infections including HIV/AIDS and tuberculosis. Tuberculosis was found to be frequent among residents in group homes and homeless shelters. Serious health problems are associated with malnutrition, obesity, lack of exercise, excessive smoking and alcohol consumption, and unsafe sexual behavior. The relative risk of cardiovascular disease is 2 times for persons suffering of schizophrenia due to excessive obesity, 2-3 times for smoking, 2 times for diabetes and 5 times for dyslipidemia. An 18-20% of these persons are suffering from hypertension. It is a common finding that persons with serious mental illness often lead a marginal living in the poor areas of the urban centers, in conditions of extreme low quality, having unhealthy habits, high rates of substance use, being often victims of violence and theft, with little access to all forms of health care, because of insurance or absence their lack of motivation, fearfulness and social instability and due to competing demands and stigma by the providers and fragmentation of the health-mental health care system (Wilton 2004).

6. Conclusions
It becomes apparent that deinstitutionalized persons with serious chronic mental illness, in many western countries, are vulnerable to a series of health and social problems, are facing significant difficulties in the accessibility of health care services. In the USA people with serious mental illness, due to their social class condition, are addressed to under-funded publicly supported health-mental health care systems trying to overcome a number of obstacles, such as lack of reimbursement for health education and family support, inadequate and under-shilled case management services, poor coordination between services and lack of integrated treatment for co-occurring psychiatric and substance abuse disorders and medical conditions. Finally, the phenomenon of transinstitutionalization complements the policy of deinstitutionalization. In the USA there are about 200,000 incarcerated persons with serious mental illness in State or County prisons. Last but not least, deinstitutionalization was often linked with community’s reaction and negative attitudes, prejudice, stereotypes, stigma and discrimination against the community placement of persons with serious mental illness (Matschinger and Angermeyer 2004). However, stigma and negative attitudes can be changed if appropriate systematic community mental health intervention efforts are made (Madianos et al 1987, Madianos et al 1999). In sum, ideological, political and social economical motivations were behind the movement of deinstitutionalization in western countries.
• Ideological: the case of Italian reform (Warner 1994).
• Economical: cost savings and the value of Asylum buildings, the case of USA and Great Britain.
• Humanitarian: concerns for the liberation of inmates, the case of France, W. Germany, Spain, Greece and other European states (Madianos 1994).
Particularly in Italy deinstitutionalization became synonymous to the ideology of “Psychiatria Democratica” with echoes from May 1968, and the closure of all public mental hospitals. In Greece, Spain and some other European states the Psychiatric Reform was the first priority before the opening of the gates of large psychiatric hospitals (Madianos 1974, Madianos & Christodoulou 2007). In USA deinstitutionalization was forced in an inadequate milieu of alternatives, putting the inmates in their fate, resulting the phenomenon of revolving door and homelessness in urban centers. There are now about one million homeless chronically mentally ill persons in all the major cities of USA.
Deinstitutionalization was proven to be successful when in these countries psychiatric reform was a priority and was completed with a comprehensive system of community based alternatives and sufficient welfare umbrella. This means that the process of deinstitutionalization is step by step multidimensional and consumer centered. Deinstitutionalization encompasses the individual’s whole life needs, including continuity of treatment (health and mental health care) housing, employment, education, community support system and complementary services (athletics, recreational etc.). If family exists, the state alleviates the burden of care. The final goal is the community autonomous tenure of the suffering individual and his/her integration, in a status of full social and clinical recovery and full citizenship.
Recognition & treatment of mental health problems are at the heart of current priorities in health care systems. The last few decades have seen a tremendous increase in the efforts aiming at improving the current psychiatric services and incorporating a number of new innovations and initiatives in different areas of mental health. Rehabilitation Psychiatry like many other specialities is an emerging sub speciality in mental health services & is gaining a lot of importance in current mental health programmes. The concept of rehabilitation, however, is not new to psychiatry as we have seen its growing application across a number of fields such as severe mental illnesses, personality disorders, drug abuse, learning difficulties, behavioural problems and organic brain syndromes. The recent history of "deinstitutionalisation" has also given more prominence to the concept of rehabilitation & plans for resettlement of mentally ill back to the community have always brought more hopes to the needs and requirements of these patients. The emergence of Therapeutic Community concept for dealing with the challenges of mental illnesses and borderline personalities has also played a remarkable role in strengthening the efforts for improving rehabilitation services during the last century and paved the way for initiating new plans and ideas in this field.

*(This paper has been submitted to a peer reviewed Journal for publication as well)*
impairments, handicaps and social disadvantages to describe the extent of needs for rehabilitation purposes. Recent addition of the term recovery has also extended the concepts of rehabilitation to a more meaningful notion with emphasis on achieving a fulfilling existence despite enduring disability.

It is a pity that despite growing evidence about the needs for rehabilitation services, little improvement has been noted even in countries with a lot of resources. Internationally there are few comprehensive and integrated models of rehabilitation and many countries are simply relabeling their services to fulfil local requirements to meet targets and satisfy their policy makers. Taking the example of UK, there have been concerns about the lack of rehabilitation services in many parts of the country and there appears to have been less emphasis for the needs of people with enduring mental health problems which has been considered as “denial of disability”. In a recent report on the National Services Framework for Mental Health, it has been emphasised that there is still a strong need of reinvestment in rehabilitation models including research & evaluation of the current practices.

Looking at the different models in rehabilitation, one can find a huge variation in these approaches that range from differences in concepts to the application of such principles in the service provision programmes. Each model has strengths and weaknesses. Most if not all services are also in a continuous process of change & development. It is therefore essential to look at some of the emerging trends in rehabilitation so that we can start having more insight for our future needs in this field of mental health.

While looking at the proposed definition of rehabilitation by WHO (as the application of measures aimed at reducing the impact of disabiling and handicapping conditions and enabling disabled people to achieve social integration), it is evident that there are two important concepts in this definition that are needed to be recognised. These include, first, a need to mitigate the constraints of disease, and second, an awareness to make changes in the environment, including the attitudes of non-disabled people towards those who require rehabilitation. There has been a voluminous literature available to look at these areas & it is generally believed that among many of these issues, some are universal and some are local issues that need an urgent attention of the professionals as well as the policy makers. Starting from the definition of the disease to the diagnostic formulations and from staffing levels to the range of services, many such aspects require continuous revisions for the emerging priorities in rehabilitation psychiatry.

Diagnosis in psychiatry is an important tool in the hands of the professionals. However the validity of diagnostic systems has always been challenged despite its relevance and importance to the clinical settings. Diagnosis in rehabilitation does provide information about the long term nature of the illness & prognosis and rather than just being a label, it also serves the purpose of structured assessments for evaluation of future needs, risks and range of services for individual patients. As the diagnostic boundaries may change during the course of the illness, its recognition & reviews do get more significance in rehabilitation settings for any further changes in the needs of the patients. It is interesting to note that despite controversies in the diagnostic systems, due attention is given to the diagnostic boundaries in current rehabilitations research.

Recovery model is an important addition to the concept of rehabilitation. Although there may be difference of opinion in the definition of recovery model, it has emerged as a guiding vision for current developments in the mental health services. Looking at the history, recovery is not a new concept as the application & the introduction of therapeutic milieu and looking at kindness, compassion & hope of recovery had always been acknowledged in the development of rehabilitation psychiatry over the last few centuries. It is true that the long term assumption about the mental illnesses is that people with severe mental illnesses do not recover fully and this belief often leads to low
expectations about the outcome and prognosis in many of our patients. Recovery in its new directions has reconceptualised these assumptions and has introduced its remit as a personal process of learning how to live, and how to live well, with chronic and ongoing symptoms and vulnerabilities. This concept can be rightly phrased by saying that the goal of recovery is not to become normal; but the goal is to embrace the human vocation of becoming more deeply and more fully human. The term recovery has also been variously used to mean an approach, a model, a philosophy, a paradigm, a movement and a vision. The term is again perceived differently by the patients, their families and by the treating professionals. The concept of recovery has thus seen remarkable changes in its understanding and applications and is still under reviews and revisions for its universal application. With an increased interest in the model(s) of recovery and the growing enthusiasm for recovery principles some concerns have been raised about the implication of recovery in service provisions. A great deal is yet to be learnt about different dimensions of recovery & this certainly requires more experience for its application and clarity of different concepts of the processes involved in recovery model. However the conceptual background of recovery model does offer a lot of hope that may be offered to our patients, their carers, treating professional and service providers for bringing change in the lives of those who experience chronic and long term mental health difficulties. Looking at different dimensions of rehabilitation & recovery, it can be argued that, rehabilitation should be conceptualised as a professional and service process & recovery should be seen as the aim and the desired outcome of this process.

Promoting a culture of healing and offering hope is another important factor that is gaining more acceptances in the current rehabilitation strategies. There is a lot of evidence that if people are treated with dignity, hope and optimistic approaches, the outcome of their illnesses is better and it takes a promising course. From a service delivery point of view, positive reinforcement of success rather than fear of punishment for failure provide better perspectives and is advocated as a guiding principle in many programmes. Empowerment is another principle that brings a healthy change in the practice of rehabilitation. The empowerment can be provided by making changes externally in the environments & the structures of the service and equally internally by improving self esteem, self growth and self confidence among the patients and service users.

Understanding the vulnerability-stress-coping-competence model is another useful concept in understanding the genesis of stress and its relevance to mental health. It is vital that rehabilitation programmes should address this model while formulating the plans of future care as this would help in reducing the exposure to stress and optimise the protective factors by developing and reinforcing coping skills.

Looking at the aetiological basis of mental disorders, genetic basis are considered as important causative factor for many psychiatric illnesses but the role of social environment also plays a major role in determining the onset, course and outcome of these disorders. Rehabilitation should therefore address these issues more specifically. The de-institutialisation movement is an example that has provided a greater insight for understanding the importance of social factors. Although many advantages have been observed following these directions, there is still a long way to go & issues like gaining employment, offering equal opportunities, respecting human rights and provision of preferred option of treatments & supportive social networks are still considered vital & fundamental for the success of any rehabilitation programme.

There is no doubt that stigma still poses a major barrier in the recognition of acceptance of mental illnesses and mental health problems. Fears of rejection and isolation continuously keep distances for social integration of mentally ill in the
community and similarly harassment and exploitation are other issues that put a detrimental impact on the recovery process and lead to further relapses and unsuccessful outcomes in many patients.

There is no doubt that while minimising the impairments, efforts should be addressed to find the appropriate treatments for the mentally ill. We have seen major advances in the pharmacological treatment of mental illnesses during the last few decades. The new drugs are effective and give fewer side effects. Similarly the introduction of psychological treatments like CBT, family therapies, skills training, cognitive remediation and many self help tools are valuable additions to the range of therapeutic interventions and have shown evidence based findings in the management of long term care of these patients. Current emphasis on the physical well being of mentally ill has also raised a lot of awareness among the clinicians about the forgotten links between physical & mental health. It is also worth mentioning about the recent changes in the concepts of ‘Therapeutic Community’ that had emerged as a novel practice in the post world war period and played an important role in the historical developments of rehabilitation psychiatry worldwide.

In terms of service provisions, residential care and non hospital residential options are generally debated in terms of financial implications. There may be considerable overlap between traditional community rehabilitation teams and newly established assertive out- reach, crisis intervention & home treatment teams. This certainly needs regular reviews in terms of financial viabilities but more importantly with reference to their effectiveness and successes.

Sensitivity to the special needs and groups is another area that has assumed importance in the current range of services and emphasizes the need to understand cultural attitudes and norms regarding the expression and management of mental health problems across different ethnic and culturally diverse groups. In the context of mental health organisation, it is also worth asking whether separate rehab services are needed, or whether these services should be incorporated in the general health services. There is thus a need that each rehabilitation service should prioritise its directions for meeting the needs and requirements of their patients.

Looking at the advances in the field of rehabilitation, it can be concluded that many new concepts have emerged in this field. Contemporary understandings of rehabilitation continue to recognise the complex dimensions associated with mental health disorders and argue for reviews in its practical applications. The guiding principles are generally based on the notion of self respect & development of a culture of recovery, empowerment & optimism and these ideas have equally been
supported and supplemented by recent research & advances in the pharmacological & non pharmacological treatment of mental illnesses. Current literature strongly supports and approves these principles as appropriate for practice and argues for its wider application in current, ongoing or future rehabilitation services. It is hoped that these principles will be followed in the future practice and further evaluation of these aspects will be an ongoing process in rehabilitation psychiatry research.

**Further Reading:**

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How to Recognize a Recovery-Oriented Practice

Larry Davidson, Ph.D., Janis Tondora, Psy.D., Maria O’Connell, Ph.D.

Yale Program for Recovery and Community Health

Based on our collective efforts to operationalize the notion of “recovery” for psychiatric care, we suggest that service recipients will be able to recognize a recovery-oriented practice by the degree to which it meets the following criteria.

Is the care offered centered on you as an individual person? Is it based on your unique life goals and informed by your personal needs, values, and preferences? Recovery-oriented practice can only be carried out at the level of each individual, unique person within the context of his or her family and life. Your recovery plan should look different from anyone else’s, and be based squarely on your particular goals, needs, values, and preferences. Does the plan provide you with a roadmap for where you are headed and what you are trying to do in your life? Does the plan address a life outside of or beyond formal mental health services, or does it remain within the boundaries of the mental health system? Can you tell from the plan what you will be doing between treatment appointments? Is there more for you to do than simply to receive treatment or attend meetings with providers? Since treatment and rehabilitation are to be tools to be used for you to reclaim a whole and gratifying life, it is essential for any interventions that are offered to you to be useful for these purposes. Do you understand why you need certain treatments, or why providers ask you to attend meetings or groups? Is it clear to you how these activities will help you to get where you want to in life, or do they simply seem to aim to keep you busy? Do providers take an interest in how you spend your time between your appointments with health providers will help you to identity and utilize your strengths, both your own and those within your social environment? Can you tell from the plan what your specific interests are, and how these interests have contributed to the formulation of goals and objectives? Does the plan help you to move toward what interests you, or does it simply try to move you away from problematic behaviors or activities? If substance abuse is identified as a problem to be addressed, for example, does the plan also address what kind of sober activities you may want to participate in instead? Are community activities and resources identified in the plan that would support you in pursing your interests? Are there people identified in the plan with whom you can share these interests?

Do you have a recovery plan that addresses what you will be doing between treatment appointments? Is there more for you to do than simply to receive treatment or attend meetings with providers? Since treatment and rehabilitation are to be tools to be used for you to reclaim a whole and gratifying life, it is essential for any interventions that are offered to you to be useful for these purposes. Do you understand why you need certain treatments, or why providers ask you to attend meetings or groups? Is it clear to you how these activities will help you to get where you want to in life, or do they simply seem to aim to keep you busy? Do providers take an interest in how you spend your time between your appointments with

Collaborations
them? Do they have concrete suggestions for things you might try in the community, or do they expect you only to participate in mental health-related activities?

**Does the recovery plan clearly delineate the tasks and roles to be performed and the parties responsible for each?** Of particular importance is, does the plan clearly identify your own sphere of responsibility and the tasks that you have agreed to take on? Do the mental health providers help you to identify what you can do to promote or progress in your recovery? Do they support you in carry out these responsibilities successfully? Do providers help you to identify the next one or two steps in your recovery and to sketch out, no matter how provisionally, what will be involved in your taking these next few steps? Do they assist you in obtaining the resources needed to take these steps? Are they willing to accompany you on the way, at least initially, or do they expect you to take these steps on your own? Do they suggest strategies for managing symptoms that do not go away in response to medication?

**Does the plan and the care provided change over time with your evolving goals and needs?** Recovery plans do not accept maintenance as a valid goal, as people do not want merely to be “maintained.” It is quite possible for people to want to maintain a level of clinical stability, or to want to remain at a plateau of functioning for an extended period of time. Few people like change for the sake of change, and many people are afraid of taking risks or trying new things out a very legitimate fear that they might suffer a setback (a fear often reinforced by caring practitioners who do not want to see people relapse). But life also does not stand still. Therefore, while containing your illness may be a very real concern and goal for you at times, it is not possible to do so simply by maintaining your life; i.e., by trying to stand still. Recovery plans anticipate that change is inevitable and that you will need to continue to adapt to new situations and new challenges, whether you like to or not. One important contribution recovery-oriented practices can make in such situations is to help you identify those things that you want to keep the same while other things are changing around you.

**Do you find the plan, and the care offered, to be accessible and understandable?** Just as the plan needs to identify your role in promoting or pursuing recovery, the plan and the care offered need to be accessible to and understandable by you as well. Does the plan address those aspects of your own experiences that are of concern to you, and in a language that you will be able to understand and to
use (e.g., voices as opposed to auditory hallucinations, feelings of being unsafe, vulnerable, or unprotected as opposed to paranoia, etc.)? Do you know what care you have agreed to receive or participate in? Has your consent been truly informed, or are things done to you that you have not agreed to? Even in cases in which you are receiving treatment involuntarily, or have had a conservator or guardian assigned to you, have concerted efforts been made to inform you of the available options and to explain what you can expect to happen, including what needs to happen for you to no longer be receiving care involuntarily or no longer need a guardian?

**Does the plan encourage and support you in assuming increasing control over your life, including the power to make your own decisions?** Because of a history of paternalism and maternalism in psychiatry, you may need to be encouraged to take back control of certain parts of your life, the responsibility for which may have been assumed by other people. Do providers encourage you to do so? Do they encourage you to view yourself as capable, and as having intact domains of functioning beyond the reach of the illness? Do they remind you of, or introduce you to, your strengths and gifts? Do they help you to focus on achieving some small successes, or easy wins, in order to rebuild your self-confidence and sense of personal efficacy? Do they encourage and support you in taking risk and trying new things—perhaps even prodding you gently to get unstuck, to be liberated from the inertia of chronic illness?

**Is the care offered in a dignified setting and in a respectful manner?** Does the care offered help you to feel better, or does it make you feel worse? Seeking and receiving health care is intended to help people feel better rather than worse. While being told that you have an illness or disability is sure to be distressing, when offered compassionately, such care should also help you to understand your situation better and to at least be confident that you and everyone else are doing what you can to make things better. Does attending mental health appointments feel humiliating or demeaning? Do you leave the provider’s office feeling better or worse about yourself and your prospects for recovery? Do providers treat you as an equal, and as someone who is trying your best to deal with your circumstances? Or, do they treat you as an anonymous patient who is riddled with deficits and problems? Are the services offered in a safe, clean, and pleasant setting, or does the setting look run down and not cared for? Would you recommend the provider or service to other people?

**Do providers ask you for your feedback?** Do they ask you if they are being helpful? Do they tell you what you can do if you are dissatisfied with the care you receive? Part of becoming an empowered consumer or user of mental health services is being able to tell providers whether or not they are being helpful to you. Do the providers you work with welcome your feedback about the care they provide? Do these providers ask you for your suggestions or ideas about how the care they provide can be improved? When you give feedback to your providers, do they listen to you and take you seriously? Do they make changes based on your feedback? Do they suggest what you can do if you remain dissatisfied with the care you receive? Do they suggest how you might go about changing providers or services if you are not finding them to be helpful? When you complain or file a grievance, do they treat you respectfully, and do you receive a timely response to your concerns?

While no mental health service provider, and no mental health service, will be perfect, these are some of the characteristics of recovery-oriented practice that you are entitled to expect to receive as systems of care transform to a recovery orientation.
BAPR Staff and Beneficiaries who are the entire palliative, OVC’s and many of the care givers had a very big family experience at the BAPR Center on the first of December, 2009! The day began with a prayer by the Pastor of St. Theresa Catholic Church who has been so supportive and involved in the activities of BAPR. There were +/- 800 people that day. It was a very successful day for all to share the events of the year after the following activities: counseling, workshops, home visits, and support groups for adults, teenagers and the OVC program for the young ones. The Christmas party brought a sense of cohesiveness, belongingness and appreciation of all in the various programs that have motivated the Palliative people to accept their status as HIV+ with or without mental illness and to adhere to the ARV’s. The Care Givers That were present showed their appreciation for the support they have received and for all the liberation from the stigma/discrimination they experienced at home, community and work place because of the programs and services provided by BAPR in the field and at the center by all the staff at BAPR.

The other success at the Christmas party was the visible community involvement and recognition of BAPR’s beneficiaries and programs. This community involvement brought a self esteem that many did not have before becoming part of the BAPR family. BAPR’s Christmas Party/World Aids Day Commemoration was funded with a donation from GlaxoSmithKline (gsk) of P40, 000! GSK has their regional office in Johannesburg, South Africa and a country office in Gaborone, Botswana. The 4 representatives from the Botswana Office were present for the event and participated in the distribution of the Christmas Hampers that were filled with Laundry and bath soap, face clothes, toiletries and sweets for all the adults and children as well. For most of BAPR’s Beneficiaries this will be the only Christmas present they will receive during the Christmas holidays. There were 600 hampers that were put together by the Supermarket Pick and Pay here in Lobatse. Pick and Pay has started a relationship with BAPR since they opened this year in July, 2009 when they donated P5, 000 at the opening of the supermarket to BAPR as a sign of giving back to the community from their profits.
Pick and Pay also provided the buckets and canvas bags that the goods were put in from GSK’s donation. Pick and Pay also provided free transport of the hampers drinks and meals.

The next step was the distribution of the meals and drinks provided once again by the GSK donation. Each child and adult that are BAPR’s beneficiaries were also served a meal. Pick and Pay employees and the owners spent over time preparing for this Christmas party with no extra pay. It was a labor of Love!

There were many other people from the community present who raised the dignity of all the BAPR’s family that day. The Mayor of Lobatse was present which sent a message to all the beneficiaries of how important and recognized they are in the community. She donated P1000 that day for BAPR’s program and services. The executive from the Muslim Women’s Group were present. They also have been involved in various donations of clothes and toys over the past year. They donated 3 gift vouchers worth P150 to buy books for BAPR’s children (OVC) afternoon program as well as some cakes, sweets biscuits and a drink. Nurses, Hospital Matron, Social workers, Traditional Court Presidents were present. A friend of one of the GSK representatives who heard about BAPR from him was moved and donated a P1, 000 cheque to BAPR.

There were donations in kind as well by the Gospel Music Group called ELV A VOH. They organized the whole sound system and provided us with their beautiful music and dance. They even helped to clean up after the Christmas Party was finished that day. The Botswana Defense force donated 5 tents that the use of provided shade for everyone on that extremely hot December summer day. To rent those tents would have cost quite a lot.

The children were amazing with the singing of the Christmas Carols and Dance that they prepared a few weeks before the event. They even led in the singing of the National Anthem.

The guest speaker gave a very inspirational speech on never giving up in times of sickness and adversity. He included the disclosure and adherence with pride and dignity that all should receive as children of God; All created equally and loved equally by God.

This was a successful day of Liberating respect, care, dignity, and appreciation for all as individuals, children, adults, families, members of BAPR and the community.

John Mistelske.
The harmful concept of Schizophrenia

L Marius Romme MD PhD*  Mervyn Morris**

*Visiting Prof. at the Mental Health Policy Centre, University of Central England, Birmingham.  
**Director of the Centre for Community Mental Health at UCE Birmingham, Visiting Prof. at University College Buskerud in Drammen, Norway.

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Introduction.

On 11 October 2006 an initiative called CASL, the ‘Campaign for the Abolition of the schizophrenia Label’ was launched by Paul Hammersley and others from the University of Manchester. The problems of labelling and stigma are already familiar to nurses, but it is the concept of schizophrenia itself as an illness entity that is rightly attacked in the campaign. This campaign is one that mental health nurses should support, because, as we will explain, the concept of schizophrenia is a problem that impacts on us all. Schizophrenia is harmful because it conceptualises experiences in a way that makes it impossible to resolve the problems that lie at the roots of a person becoming ill. In order to explain this and establish a more helpful cause-related alternative, we will discuss the following issues: 1. The scientific validity of the concept is nil, and it does not refer to a brain disease. 2. The diagnostic process neglects the reasons for the experiences. 3. The relationships between the core illness experiences and life experiences are neglected. 4. The inter-relationships between the core experiences are neglected. 5. The core experiences do not represent expressions of psychopathology. 6. Learning to cope with the experiences and with the problems at the heart of the problem are neglected. 7. People who recover from being ill can achieve that outside of psychiatry.

Scientific validity

For many years, authors have criticised the concept of the illness we call schizophrenia, because it lacks both construct and content validity. In other words, putting together the experiences professionals call ‘symptoms’ to form the disease construct ‘schizophrenia’ is erroneous. And this being the case, any causal explanation of schizophrenia is meaningless.

The British researchers Richard Bentall and Mary Boyle, and also Walter Heinrichs, are particularly notable for their thorough literature reviews, in which they demonstrate that validity of the construct is missing. In Reconstructing Schizophrenia in 1990, Richard Bentall outlined his argument about this scientific error, and from his further examination of the literature he later concluded that:
‘It would seem that schizophrenia is an illness that consists of no particular symptoms, that has no particular outcome, and that responds to no particular treatment. No wonder research revealed that it has no particular cause.’ (Bentall, 1998).

Mary Boyle (1990) has examined the historical development of schizophrenia and shown that it has never been validated. Her conclusion is that Kraepelin and Bleuler (who coined the term) merely postulated the existence of a peculiar pattern of ‘symptoms’ that they then attempted – unsuccessfully – to validate. Their studies never provided any justification whatsoever for the so-called peculiarity of the cluster of ‘symptoms’ they described. As Boyle states:

‘None of them (including Schneider [who devised ‘first rank’ ‘symptoms’] as well) presented evidence of having observed a set of irregularities which would justify a new hypothetical construct. Certainly, none of them identified a syndrome.’ (Boyle, 2002 p.80).

Mary Boyle also studied the development of the DSM series (American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders) (APA, 1994) and concludes:

‘The development of DSM III, IIIR and IV is based on question begging. Like Kraepelin, Bleuler and Schneider, the devisers of the DSM did not appear to doubt the validity of “schizophrenia”: It might be complex, but it is a diagnosable disorder which clinicians recognise when they see (it). This cognitive starting point is crucial also in making failure seem like a temporary aberration’. (Boyle, 2002, p.151)

British-based Canadian researcher Walter Heinrichs (2001) carried out a Medline search of publications appearing between 1980 and 1999, reporting on objective disease markers in schizophrenia. His work constitutes a review of the results from neuroscience research. As we know, many claims have been made pertaining to the presence of specific disease markers in Schizophrenia. Heinrichs calculated the effect size of each of these studies. He states: ‘In summary, this extensive appraisal across many areas of neuroscience reveals no common abnormality in all cases of schizophrenic illness. The strongest, most consistent evidence suggests that 50-70% of schizophrenics are deficient in cognitive brain function. In comparison, most of the neurobiological abnormalities in the illness, probably occur in a minority of patients. Moreover, close to 40% of the biological findings are so weak and variable that they may represent minor, unimportant, or chance abnormalities with no intrinsic link to schizophrenia.’ (Heinrichs 2001, p. 84)

From the work of Heinrichs, we may therefore, on the balance of evidence, cautiously conclude that contemporary neuroscience research likewise fails to provide persuasive means of validation for the schizophrenia concept. Indeed, it seems strange to us that it has become necessary to disprove schizophrenia, when actually the emphasis should always have been, and continues to be, on everyone who uses this concept to prove its validity.

The implications do not simply challenge our beliefs, but our practice. Every mental health nurse and doctor is used to the diagnosis of schizophrenia. The vast majority of doctors and nurses will tell you that in meeting patients they recognise the illness. As members of these professions we agree that you meet patients with the ‘symptoms’ that are categorised in the DSM (APA, 1994) as schizophrenia. People talk about hearing voices, have peculiar explanations for them, and show all kinds of behaviour that is socially and emotionally peculiar and can be easily interpreted as negative ‘symptoms’. In other words, people appear to present with experiences interpreted as ‘symptoms’ categorised in the DSM (ibid) as schizophrenia, but in fact there is no actual substantive scientific evidence that these experiences are an illness caused by a disease. Logically, there is one plausible and important conclusion: The people with the illness experiences exist, but the illness-causing disease ‘schizophrenia’ does not exist.

So this leaves the question: what can be taken from this discrepancy between the experience and the science? We accept that suffering and serious complaints are sensibly seen as an illness experience, but that does not conclusively mean there is a disease entity like the concept of schizophrenia. As these ‘symptom’ experiences do not result from an underlying disease, the word ‘symptom’ is not appropriate at all. These experiences require another explanation, one that like the rest of medicine points to a cause.

For a long time we too did not understand these experiences very well at all because the concept of schizophrenia had led us to believe we didn’t need to, identifying ‘symptoms’ only required attention to the form rather than analysing the content. But we have come to understand a great deal more about these experiences, in particular by finding (often
metaphorical) meaning in the life history of the person. Part of the harm of the schizophrenia explanation is that mental health professionals have never sought such an alternative explanation for these experiences. There are many arguments to underpin this conclusion. These arguments come from the other issues we will now explain.

The diagnostic process

Looking at the diagnostic procedure in clinical psychiatry, assessment means that a psychiatrist talks about the complaints of the patient, trying to find out how he can interpret the behaviour in terms of ‘symptom’ categories. Based on theories the psychiatrist has studied, there are quite a number of interpretations of behaviours and experiences. For example, when a person tells he hears voices, the psychiatrist asks for the characteristics of an auditory hallucination: are these voices representing your own thoughts or are they coming from someone else? If the person says that the voices are not his own, but from somebody else, then the psychiatrist might easily conclude that the patient suffers from an auditory hallucination. The psychiatrist will then ask what explanation the voice hearer has for those voices and will probably be told a story that is strange. Following this, the psychiatrist might easily conclude that the patient suffers from hallucinations and delusions. According to the generally used diagnostic system, the DSM (APA, 1994), schizophrenia is the diagnosis category available to the psychiatrist.

So in the clinical psychiatric diagnostic procedure, the complaints, behaviour and experiences are interpreted into a reduced number of ‘symptom’ categories. It has not been necessary to explore what the voices say or thoughts are about. It has not been necessary to find connections and meaning in these experiences. With these ‘symptom’ categories the psychiatrist constructs a diagnosis within the rules laid down in the DSM. But of course this is in principle not even a diagnosis but a category, because it is only based on the behaviour and experiences; there are no causes for the experiences and behaviour taken into account.

This is what makes a diagnosis harmful, because there is no inherent interest in either the problems of the person that have led to the different complaints, or for the psychological suffering of them. How will it ever be possible to help a person with his problems when in the diagnostic procedure there is not the slightest interest in these questions?

There are naturally (and fortunately) psychiatrists who not only construct a diagnosis, but who are also interested in the problems of their clients. But with psychosis, it is both our and many patients’ experience that mainstream clinical psychiatry is hardly interested. This is especially a problem with psychosis, because slowly over the last 30 years the idea has formed that the social and emotional background is not essential to the development of psychosis; the general view is they may play a role as triggers, but not so much as a cause.

What is also misleading about the diagnostic procedure is that it is presented as a medical model. This is simply not the way of working in general medicine, where the clinician looks for the cause for the complaint and this cause is essential for the diagnosis. For example, in diabetes the diagnosis is based on the disturbance of insulin as the cause of the complaints. In other words diabetes, unlike schizophrenia, has a clearly specified cause; this is what makes it a diagnosis.

In clinical psychiatry, a diagnosis in the area of psychosis generally is constructed on the basis of a person’s behaviour and experiences only. The great problem is that as a consequence treatment is given without analysing the causes for this behaviour, and therefore only the ‘symptoms’ are treated, not the patient’s underlying problems. From our perspective this looks like a juridical system that reacts to behaviour and is not much interested in the reasons for that behaviour. It is therefore no surprise to us that many patients in psychiatry are not very content with these procedures – and they are quite right.

The background of the core ‘symptoms’.

It is harmful to make a diagnosis without analysing the reasons for the behaviour and experiences. Not only do we know there are no particular causes for schizophrenia, we now know that that there are causes for the different core ‘symptoms’ of schizophrenia when we look at each person individually. The diagnosis of schizophrenia instead mystifies the cause of the various behaviours and experiences of the individual. It is our understanding that experience and behaviour needs to be de-mystified and this analysis can be the successful focus of therapy. And there are various studies that point us toward a cause in individuals.

In our research concerning people who hear voices (Romme 1996; Romme and Escher 2006, Honig et all 1998), we found that in 77% of the people diagnosed with schizophrenia, the hearing of voices was related to traumatic experiences. These traumatic experiences included being sexually abused, physically abused, being extremely belittled over a long period from a young age, being neglected during long periods as a youngster, being very aggressively treated in marriage, not being able
to accept one's sexual identity. These results were also found in research by nurses Mike Smith (1999) in Birmingham, and separately by Babs Johnston (2002) in Dingleton. Besides these studies, there are quite a number of other studies showing a high percentage of trauma experienced in the population of people diagnosed with schizophrenia (Mueser et al, 1998; Morrison et al, 2003; Read et al, 2003).

Recently, an overview of 180 studies has been published (Read et al 2004) where the authors came to the conclusion: ‘Symptoms considered indicative of psychosis and schizophrenia, particularly hallucinations, are at least as strongly related to childhood abuse and neglect as many other mental health problems. Recent large-scale general population studies indicate the relationship is a causal one, with a dose-effect’.

Although there are to our knowledge fewer epidemiological studies about the relationship between traumatic experiences and the development of delusions, we know of some studies and reports from individuals (Nieland, 1959; Mirowsky and Ross, 1983; May, 2003; Bullimore, 2005). The same holds for negative ‘symptoms’ (Strauss et al, 1989; Deegan, 1995).

These studies should open our eyes to the importance of analysing the background of the separate experiences within the concept of schizophrenia. This brings the discussion to the question of how does the full picture of schizophrenia ‘symptomatology’ develop, because the relationship between one of the core ‘symptoms’ and the experienced trauma does not explain the development of the other ‘symptoms’. In our view it is necessary to recognise the inter-relationship between the different core experiences and other secondary reactions.

The importance of the interaction between what are regarded as the core ‘symptoms’ and secondary reactions of ‘schizophrenia’ was made clear by Ron Coleman, a well-known mental health activist. He retrospectively analysed the different experiences of his psychotic illness and came to the conclusion that he started to hear voices, and only afterwards developed the other experiences as a reaction to his hearing voices, because he couldn’t cope with them at that time. He now uses this interaction in a simple experiment in which he tries to make it clear for non-voice hearers what it is like to hear voices.

In this experiment he asks an audience to split up into threesomes and then two of the three have a discussion and the third plays a voice in the ear of one of the discussants. This gives a feeling of how a voice can be very disturbing and influence one’s functioning. The participants afterwards tell how they reacted to this disturbing influence. People come to realise that a lot of the experiences we find in schizophrenia can be secondary reactions to this disturbing influence. This can be easily verified with voice hearers by asking them about their reaction to their voices, like the strange explanations, which are often in psychiatry called delusions. Other problems include difficulty with concentration, the inability to work or the tendency to isolate oneself.

One of the clearest inter-relationships, rigorously researched by Maher (1974), is the explanation for the voices. Because the voices are for the voice hearer a strange and unknown experience, the explanation they think of is also mostly strange to us, and therefore easily identified as a delusion. The conclusion here is that auditory hallucinations and delusions are actually interrelated experiences, and not separate ‘symptoms’. This holds for many ‘symptoms’ being secondary reactions to a primary experience like hearing voices; experiences that scare the person and with which he/she is unable to cope.

When the concept of schizophrenia is examined in this way, the ‘symptoms’ are not the results of a disease entity, rather the illness picture is composed of primary experiences – possibly a reaction to traumatic experiences, and with secondary reactions because of the inability to cope with the primary experiences. This is not such a strange conception, because as we have already stated: the core experiences are in themselves not a sign of psychopathology.

There are now a significant number of epidemiological studies that show us that hearing voices and also ‘delusions’ are experienced by many individuals without any psychiatric diagnosis (Tien, 1991; Eaton 1991; Bijl et al 1998; Os et al, 2001). There are even more people hearing voices or experiencing delusions without illness than people with these experiences that become psychiatric patients.

This is mostly very difficult for mental health professionals to accept, because they do not meet these people, the reason being these people do not need any care. Many people are even content with their voices and their ideas, because they are helped by them in daily life.

The reality that there are many people in the general population who hear voices, or have peculiar personal convictions that we call delusions without being ill, forces us to realise that these experiences are, in themselves, not a sign of mental illness.
This is an important fact in understanding psychiatric patients with these experiences, because it opens our eyes to the reasons why the person became ill. A person hearing voices becomes ill, not because he hears voices, but because he cannot cope with these voices or find a way that they can be understood. Those who can’t cope with their voices are also unable to do so because they cannot cope with the problems that led up to the experience of hearing voices. This double inability makes it important not to focus on an unknown illness, but to teach the person to cope with his voices and or delusions and with the problems that lead to them.

In this way it becomes clear that to focus on experiences as being caused by the non-existent disease 'schizophrenia' does not solve a persons problems that lie at the roots of becoming ill. The essential difference between becoming ill and having a 'diagnosed illness' We have to realise that there is an essential difference in ‘psychotic’ experience between becoming ill and being seen as suffering from a disease like schizophrenia. If we focus on the illness as a disease concept and try to treat the diagnostic construct, then we will never be able to help the patient to solve his problems. In order to help the patient we will first have to help him to cope with his experiences of hearing voices and personal convictions, and it is entirely possible to reduce the anxiety for these experiences with cognitive interventions alone. But after that, we also have to help the person to learn to cope with the original problems that lead to the experiences. This mostly concerns a change in attitude towards these problems and those people involved with them. Not simple, but rewarding.

People who recover do this outside psychiatry. We often meet people who recover from these mental health problems and diagnosis, who have achieved this outside of psychiatry. They invariably started in psychiatric care, either in or outside psychiatric hospitals, but became dissatisfied and angry with the care they received because: 1. There was no interest in the distress they suffered from their psychotic experiences. The focus was on the interpretation of their complaints as a ‘symptom’ category, not on the suffering from it. 2. The diagnostic procedure did not help them in any way to solve their problems; it more or less denied their human need to make sense of what happened to them. 3. There was no interest, and they where never asked, as to what had happened to them in daily life in connection with the experience. 4. Demoralising statements were made about the consequences of their diagnosis: ‘you have to take medicine all your life’ and ‘you will have to adapt to your illness and expect less in life’. 5. The medication did not help with their complaints, but the doctors stuck to the idea that the person needed them nevertheless.

This anger seems to have motivated many patients to try to take back control of their life, or go looking elsewhere to be helped more successfully (Coleman, 1999; Deegan, 1995; Boevink, 2002; Dillon, 2006; May, 2003; Bullimore, 2005). But in mental health care this reaction is often seen as part of the illness; although anger is not a ‘symptom’ of schizophrenia, it can be interpreted as demonstrating a lack of insight into their illness, an interpretation that makes people all the more powerless.

We generally see that people who adapt to the psychiatric care system have less opportunity to recover than people who protest against it and make their own path. It is from these experiences that we should learn more in mental health practice.

Conclusion:
Reviewing these arguments it can be concluded that:
• Schizophrenia as an illness entity does not exist.
• The Schizophrenia concept is harmful because: It misses the patient’s social emotional problems, and it makes it impossible to solve the patient’s problems.
• Should a diagnosis be required, then cause-related alternatives should be recognised, such as ‘trauma-induced psychosis’ and other cause-related alternatives, like drug-induced psychosis or identity-problem-induced psychosis.
• Mental Health care should be oriented towards:
  - Learning to cope with, instead of suppression of experiences.
  - Analysing the causes and learning to cope with emotions.
  - Recovery and the development of the person.

Mental health nursing is also harmed by this diagnosis. For many years nurses were actively discouraged in any kind of discourse about psychotic experiences for fear of reinforcing unreality. By extension, this meant any kind of narrative, anything that could help people make some sense or find meaning and perspective was practically impossible. So mental health nursing was largely about safety, ‘reassurance’ and dispensing medication. While cognitive approaches have opened up opportunities, this is still largely adjunctive to pharmacological intervention, and confined to managing the disease schizophrenia. Of course, we do not expect an individual professional in mental health care will be able to change the system, neither do we think that
collectively nurses should necessarily start a protest against the concept of schizophrenia, though supporting the CASL initiative is important. Rather, we are hopeful that because of the time and relationship nurses have with people who have psychotic experiences, you each will play a critical role in letting go of the ideas that keep the schizophrenia concept alive.

Professionals nurses are not powerless in daily practice. When you are with people who are ‘psychotic’, start listening to their experiences and ask them to explain to you what they experience. Then help the person unpick the different kinds of experiences they have, like hearing voices, ideas of reference, delusions, the expressions of their ‘negative symptoms’, taking no initiative or isolating themselves. Then ask what is their difficulty in coping with these experiences, so that you are informed about their anxiety, depressiveness and feelings of powerlessness. It is then possible to explore how these experiences developed over time and possibly interrelate with each other.

Accepting that these experiences are their reality, we would go on to ask what has happened in their life that could possibly relate to these mental health problems, and start with the complaint they started with. If people are confused about that, it is helpful to go over their life story, asking what has happened to them, identifying eventful experiences; illnesses, loss of someone close or a loved one; problems in relationships with others like friends, family, parents, brothers and sisters; problems with work, housing and finances. Also, it is important to explore problems with emotions like aggression, physical abuse, or having been belittled, or having been aggressive themselves, or having had problems with sexuality, sexual identity, or sexual abuse. If a person describes such events, or experiences, a simple question is to ask if it could have anything to do with their voices, paranoia or personal convictions, and discuss this, accepting their thinking and their emotions about it.

We have learnt from our course at UCE in Birmingham over the last seven years that this approach takes time to develop. In the meantime, you may well have relevant skills that for example help reduce people’s anxiety about voices and CBT training, which is widely available, can also be adapted to this way of working. We thoroughly recommend Recovery an alien concept by Ron Coleman (1999), or you can read Making Sense of Voices (Romme and Escher, 2000) and find practical possibilities there.
References


The concept of “Recovery” from severe mental illness is related to the idea that people affected by severe mental illness have of their improvement, specifically the development of personal potentials and the re-establishing of a valid social role even with limitations caused by illness (Anthony, 2007).

Recovery is a process by which people with psychiatric disability rebuild and further develop important personal, social, environmental and spiritual connections, and confront the devastating effects of stigma through personal empowerment. It is a process of adjusting one’s attitudes, feelings, perceptions, beliefs, roles, and goals in life. This is a process of self-discovery, self-renewal, and transformation. Recovery involves creating a new personal vision for oneself. Understanding Recovery as a whole dynamic process is still difficult. This can be understood considered the nature of this construct, which is entirely subjective and still has an incompletely defined meaning.

Recovery can be conceived both as a process and as an outcome. Research on Recovery has shown that it is possible over time and that it represents a multidimensional, highly individualized and non-linear process. It can be described and objectivized. Recovery may be reached with or without professional intervention and it has multiple objective and subjective outcome.
indicators beyond symptom reduction (Farkas, 2007).

International long term follow-up studies of the last two decades on outcomes of severe mentally ill patients have shown recovery rates from 45 to 68%, confirming as a prejudice the Kraepelinian negative view of schizophrenia's outcomes (the unhealable “dementia praecox”).

Increasing efforts have been done in the last years for a definition of “Recovery” from severe mental illness.

Liberman and colleagues (2002) propose some operational criteria for recovery. To be considered recovered from a serious mental disorder, a person should have: a sustained remission of symptoms that constitute the diagnosis at a subclinical level of frequency and severity; full- or part-time engagement in an instrumental role activity, such as work or school, that is constructive, productive, and age-appropriate; a life independent of supervision by family or other caregivers such that the individual is responsible for day-to-day needs in managing money, medication, appointments, shopping, food preparation, and personal possessions; cordial family relations; recreational activities in normal places and settings; satisfying peer relationships characterized by participation in an active friendship, with companions or a social network. The above mentioned criteria should be fulfilled continuously for at least two years.

Scientific research has focussed on qualitative and quantitative aspects of Recovery.

The first ones have been investigated both from the consumer’s and the professional’s perspectives.

Common first-person accounts of factors which foster recovery are: being supported by others, renewing hope and commitment, accepting illness and redefining self, being involved in meaningful activities and expanded social roles, managing symptoms, resuming control and responsibility, overcoming stigma, exercising citizenship.

From the professional’s perspective, key-elements of recovery from schizophrenia are: stability of family or residential factors, absence of substance abuse, shorter duration of untreated psychosis, good initial response to neuroleptics, adherence to treatment, supportive therapy with a collaborative therapeutic alliance, good neurocognitive functioning, absence of the deficit syndrome, good premorbid history, access to comprehensive, coordinated, and continuous treatment (Liberman and Kopelowitz, 2005).

Quantitative research on recovery requests valid instruments of measurement to be identified.

The most often used instrument to measure recovery is the Recovery Assessment Scale (RAS, Giffort et al., 1995). This scale was developed based on the analysis of histories of recovered psychiatric patients, from which some basic concepts were extrapolated to identify if the person perceives him/herself in recovery or not.

The instrument consists of 41 items, which are rated on a 5 point agreement Likert Scale (in which 5 = Strongly agree). The different statements explore five different psychosocial dimensions of Recovery: personal confidence and hope for the future, willingness to ask for help, goal and success orientation, reliance on others, no domination by symptoms. The scale is administered by reading the items to participants in an interview format.

The Recovery Assessment Scale is only available in the original English version and has been found to be to be reliable, valid and coherent (Corrigan et al., 2004).

Qualitative and quantitative research to evaluate recovery processes in people referred to mental health services becomes then fundamental in order to test out the recovery-oriented efficacy of
currently used practices and approaches, and to improve them in this very direction.

In the last years the “Recovery-oriented” approach to the treatment of severe mental illness has started to awake new interests and to take place also in Italy.

Italian professionals and service providers of Psychosocial Rehabilitation feel increasingly the need for the validation of instruments to be used in clinical practice and to collect users’ point of view on key-elements for their recovery process.

Moving over the decades-long deinstitutionalisation process, the new priority becomes identifying factors fostering or hindering recovery, in order to use them in planning recovery-oriented psychiatric services.

The Italian Study on Recovery (S.I.R.) is a multicentric study involving 14 mental health services from various parts of Italy.

Aim of the research is to validate the Italian translation of RAS, to be able to use an instrument which can identify patients in the Recovery phase, in order to understand through them better what really helps and what hinders recoverING.

Specifically, phase 1 of S.I.R., which lasted from May 2008 to April 2009, consisted in the Italian translation of RAS and its administration to a total of 156 subjects.

Inclusion criteria were: a diagnosis of psychosis, age of 18 or more, history of mental illness longer than 5 years, informed consent to the study.

The recruited subjects were differentiated as “recoverING” and “not in recovery” following the operational criteria for recovery proposed by Liberman et al (2002) adapted to S.I.R.: no psychiatric admissions in the previous two years, sheltered work/work in the free market, independent daily living, regular social relationships/a few but true friends; improvements maintained for two years or more.

An initial analysis of phase 1 results has confirmed the validity of the Recovery Assessment Scale in its Italian translation.

By matching the RAS total scores with the two subgroups of “recoverING” and “not in recovery” subjects it was possible to identify a RAS cut-off score which correctly discriminates subjects matching the “recoverING” operational criteria.

The ongoing phase 2 of S.I.R. consists in administering a semi-structured interview to the 23 “recoverING” subjects, to identify the fundamental elements which fostered or hindered their recovery process.

The elaboration of the results of phase 2 will offer the opportunity to understand whether the existing Italian rehabilitative services already match the recovery needs of our clients and will perhaps open new avenues for further research aimed at facilitating the transition to recovery-oriented mental health services.

Bibliography:

Anthony W. Toward a vision of recovery. Center for Psychiatric Rehabilitation, Boston 2007


In Memoriam: Judi Chamberlin.

It is with great sadness that we say goodbye to Judi Chamberlin, a visionary among the mental health community, who passed away Jan 16, 2010 at age 65 after a long illness.

Most of us in our lifetimes never get the chance to meet a true pioneer, a true visionary, someone whose time on earth has had and will continue to have a profound impact on the lives of others. Judi was that person. She never allowed her psychiatric illness to limit her, to control her or to define her.

More than 40 years ago, well before individuals with mental illness were given a say in their treatment, Judi’s own experience in the mental health system sparked the movement that has changed everything.

She was then Judi Ross, 22 years old, and had suffered a miscarriage. After several voluntary hospitalizations, she was involuntarily committed. “There are real indignities and real problems when all facets of life are controlled — when to get up, to eat, to shower — and chemicals are put inside our bodies against our will,” Judi told The New York Times in 1981.

There was a lack of activity, of fresh air. There were seclusion rooms and wards for noncompliant patients, even those who were in no way violent. The drugs, which made her lethargic and affected her memory, seemed more intended to control than cure. And she could not sign herself out. She had become, she said, “a prisoner of the system.”

At a time when treatment for a psychiatric illness often meant a life sentence to an asylum or state hospital and to a life of hopelessness and isolation, Judi talked about, promoted and advocated for the concepts of recovery, consumer involvement, consumer-run and directed programs, independence and dignity.

She co-founded the Mental Patients Liberation Front with her peers in Boston in 1971, a group dedicated to achieving equal rights for both in- and outpatients and reducing the stigma attached to psychiatric disorders and wrote about her experiences in a seminal book called “On Our Own,” which was published in 1978 and now translated into many languages. In it she argued that, as she had experienced, just the ability to have some say in your own treatment was critical in making that treatment work. And because of Judi’s courage, dignity and refusal to accept that mental illness would ever limit her or anyone else, the consumer and recovery movement was born.

Dr. Daniel Fisher, executive director of the National Empowerment Center called Judi’s book “the bible of the movement”. The National Empowerment Center is run by people who have experienced mental health issues, and is an American organization that provides support, teaches recovery skills and works to reduce the stigma faced by psychiatric patients and those who have recovered. Dan called Judi’s book “a set of beliefs and principles of which the most fundamental is in the subtitle: ‘Patient-Controlled Alternatives to the Mental Health System.’”

Her direct, audacious challenge to professionals in the field caught the attention of Boston University’s Center for Psychiatric Rehabilitation, which recruited her for its advisory board in 1979. My colleague, Dr. William Anthony, Executive Director of the Center for Psychiatric Rehabilitation said that while Judi always denied it, the reason that he asked her to serve on our advisory board is he heard she destroyed grand rounds at one of our teaching hospitals here! He thought she would certainly bring a different dimension than most of our
helped the convention, adopted by the

on the Rights of Persons With Disabilities she

recommendations in the

of the team that framed the mental health

Advanced of People with Disabilities. As a member

began building coalitions with such organizations.

common cause with cross disability movements and

Board. In the latter half of her life, Judi found

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consumer movements across the world as well as

Board of WAPR and she linked the organization to

of the first survivors/ex patients to serve on the

movements. We shared experiences in countries

systems and foster the growth of consumer

international projects to improve mental health

Frequently, we would end up partnering on

spread the knowledge she gained through her

Consultant, traveling the country and the world to

Facing. "Label jars, not people" was a favorite saying

respect and empowerment in this case, a human

"patient" meant doing cooking class. Judi's stories

living in a halfway house, and being a "good

she had come out of the psychiatric hospital and was

activities were mandated. As a result she had to go
to cooking class each and every time she was
discharged from hospital in order to keep her
housing, since in those days, housing was tied to day
center attendance. The problem was Judi was a
gourmet cook. She could teach cooking. I ate with
her many times and in my estimation-she could have
opened a cooking school. But the day center didn’t
care about individual strengths or specific needs--
she had come out of the psychiatric hospital and was
living in a halfway house, and being a “good
patient” meant doing cooking class. Judi’s stories
always managed to give a principle, like need for
respect and empowerment in this case, a human
face. “Label jars, not people” was a favorite saying
of hers.

Until her death, Judi served our Center as a Senior
Consultant, traveling the country and the world to
spread the knowledge she gained through her
experiences and advance the consumer movement.
Frequently, we would end up partnering on
international projects to improve mental health
systems and foster the growth of consumer
movements. We shared experiences in countries
such as Hungary, Sweden, and France. Judi was one
of the first survivors/ex patients to serve on the
Board of WAPR and she linked the organization to
consumer movements across the world as well as
helped to bring other survivors along to join the
Board. In the latter half of her life, Judi found
common cause with cross disability movements and
began building coalitions with such organizations.
Judi was on the Board of the Association for the
Advanced of People with Disabilities. As a member
of the team that framed the mental health
recommendations in the United Nations Convention
on the Rights of Persons With Disabilities she
helped the convention, adopted by the General
Assembly in 2006, call for mental patients to be treated
with dignity and for a reduction in forced treatment.
We are fortunate to have had Judi Chamberlin touch our lives, change our course and most of all, leave us the legacy and the guidebook that will keep mental illness out of the darkness and consumers and their families in a place of hope and dignity.

She died as she wished: at home, in her favorite chair, surrounded by friends and family. Her passing is a great loss to the mental health community and we extend our deepest sympathy to her family, friends and the many lives she so eloquently and elegantly touched.

In Memoriam:
Yair Carlos Bar-El.
1937-2009

Carlos was born in Buenos Aires, Argentina in 1937. In 1961 he graduated from the Medical School at the University of Buenos Aires, and at the same year he immigrated to Israel. He completed his residence in Psychiatry at Hadassah and Eitanim hospitals. Since then he became one of the central figures in Israeli psychiatry.

In 1976 he was appointed as the Jerusalem District Psychiatrist and in that position he was one of the main leaders of forensic psychiatry in Israel. He was one of the developers of the Israel Mental Health Law, and was successful in balancing between the needs and human rights of the mentally ill on one hand, and the interests of the community and the law, on the other hand. But his main passion was Rehabilitation. He planned and directed community mental health centers in different regions of the country, that emphasized therapy and rehabilitation. When he became Director of Kfar Shaul Hospital in Jerusalem in 1978, he transformed it from an old style institution into a dynamic center for psychiatric rehabilitation for the long term psychiatrically ill. Carlos was devoted to the peace process in the Middle East and was one of the first to promote meetings between Israeli and Palestinian psychiatrists. He became world famous after he described, together with other colleagues, the Jerusalem Syndrome, as an acute psychotic disturbance in tourists, induced by the mystic atmosphere of Jerusalem. From 1997 to 2000, as recognition for his distinguished role in Israeli psychiatry, he functioned as President of the Israel Psychiatric Association. In 1995 he quit his position as Director of Kfar Shaul hospital, and continued his forensic work as District Psychiatrist, till his retirement in 2003, after which he continued to fulfill different tasks for the Mental Health Services of the Ministry of Health.

Carlos was one of the founders of the Israel Association for Psychosocial Rehabilitation, and - for a long time - its National Secretary, representing it in WAPR. He was active in WAPR, and was member of the WAPR Board of Directors for many years. He never missed a congress, and prepared himself enthusiastically for Bangalore, mainly to go on working in organizational tasks, to meet his many friends in WAPR and also to fulfill his dream of visiting India with his wife Lia. At the height of his planning efforts, on September 25, 2009 he died suddenly of a heart condition. He left behind his beloved wife Lia, 5 children, 13 grand children and 6 great-grandchildren. He will be remembered by all of those who had the privilege of knowing him and working with him as a skilled, perceptive and devoted clinician, as well as a warm and lively friend.

Tristan Troudart
The II WAPR Conference “Knocking down Barriers, Opening Ways” will take place in Valladolid, Spain, on June 18th & 19th. The conference is expected to examine the current situation in PSR in the European Region, explore the common challenges, propose ways to face the new reality and build new consensus.

Many countries in Europe are developing Psychosocial Rehabilitation programmes and policies. However, the situation is very unequal: while some countries in the north have a strong tradition in public mental health and social policies, and others have more recently begun to develop them, some other countries and in particular those that have recently joined the EU are facing the need of wide reforms and a lot of new services and investments in this field.

After some decades, PSR has had different paths and experienced in different parts of Europe.

Differences among countries and regions can be described in terms of concept, level of support, array of services and management. We can take advantage on these different experiences to discuss different approaches to the transformations the services will face in the next future.

Now, the economical crisis is leading many people to unemployment, families with weak economies to ruin and many countries to fund restrictions in social areas. It has been shown that this combination of factors hit the weaker states of society, as people with mental illnesses are. We will probably witness an increase of risk of relapse, homelessness, suicide, and other complications, and we have to realize actions will be needed to face these problems.

Recovery has been proposed as a new paradigm to understand how users can overcome their...
situation. However it is a complex concept with different meanings, many European documents are incorporating it. Consensus is needed to clarify as much as possible the concept and its implication for services and for future research. This very brief overview gives a glance of what is the challenge for PSR for the immediate future in Europe. And this is the challenge for professionals defending PSR in the next future, that will be discussed in Valladolid.

Venue:
Palacio de Congresos Conde Ansúrez,

Programme:

JUNE 18th:

Proposed Workshop 1: Research in recovery.

Proposed Workshop 2: Improving access to work market for the mentally ill.
Chair. Martin Gittelmann. WAPR Past President. New York.

JUNE 19th:

Roundtable 1: “European Policies in Psychosocial Rehabilitation”.
Chair: Manuel Gomez-Beneyto. Valencia University.
- Francisco Villegas: “FEARP Observatory”.
- Stakeholder of Mental Health Europe. (To be confirmed)

Roundtable 2: “European Experiences, perspectives and tendencies”.
Chair: Ricardo Guinea. WAPR Secretary General.
- Paola Carozza. “Italian Perspective”. Director of the Unit of Psychiatric Rehabilitation, Mental Health Department of Ravenna (Italy) and member of Executive WAPR Italy.

Closing Conference:
- Lourdes Ladrido-Ignacio. Manila (Filipinas) President WAPR.

Registration:
www.eventoplenos.com/fearp2010/

Registration fee:
WAPR Members: 150€ before april 18th. 180€ after april 19th.
Non WAPR members: 250€ before april 18th. 300 after april 19th.
Deadline for free papers or posters: april 18th.
Updates at www.wapr.info
Images from
X WAPR World Congress.
Bangalore (India) 2010.
“Asociación Alonso Quijano” presented the III AAQ International Poetry Award. It was the third edition of the award, aimed to produce positive events linked to social participation of people with mental illness.

More than 200 poems from 5 different Spanish speaking countries contested. A Juror formed by users, family members and professionals selected the awarded works.

The ceremony of delivery of prices took place in Sala Clamores, a very well-known music hall of Madrid. Musicians, actors and a magician contributed to a very warm and amusing act.

Asociacion Alonso Quijano is an association created in 1998, formed by users, family members and professionals, aimed to “think, help and accompany” in the experience of mental illness, that has participated in many academic and participative activities involved with the promotions of good practices and citizen rights form the mentally ill.