Mentalism

Twelve Wikipedia Articles

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Mentalism (discrimination)

Mentalism is a form of discrimination and oppression against people based on intelligence, mental type (ex. ADHD, bipolar or schizophrenia) mental action (ex. stuttering or Tourette syndrome) or neurology (ex. neurotypical or autism spectrum disorder) especially against those who have a mental disorder or a mental illness.

Like other "isms" such as sexism and racism, it is characterized by complex social inequalities in power. It can result in blatant mistreatment or multiple, small insults and indignities. The negative attitudes and terms may be internalized. Terms with a similar meaning that are sometimes used are "psychophobia" and "sanism".[1]

Origin

The term developed in the 1970s out of the psychiatric consumer/survivor/ex-patient movement,[2] mentioned specifically by Judi Chamberlin in a well-known book of the period "On Our Own", published in the United States in 1978.[3] People began to recognize a pattern in how they were treated, a set of assumptions which most people seemed to hold about mental (ex)patients - that they were incompetent, unable to do things for themselves, constantly in need of supervision and assistance, unpredictable, likely to be violent or irrational etc. It was realized that not only did the general public express mentalist ideas, so did ex-patients, a form of internalized oppression.[2]

As of 1998 the term had been adopted by some consumers/survivors in the UK and the USA, but had not gained general currency. This left a conceptual gap filled in part by the concept of "stigma", which could be focused on experiences and perceptions (a "mark of shame") rather than on the actual material discrimination (unfair treatment). Nevertheless, a body of literature demonstrated widespread discrimination across many spheres of life, including employment, parental rights, housing, immigration, insurance, health care and access to justice.[4]

Divisions

Mentalism, at an extreme, splits people into an empowered group assumed to be normal, healthy, reliable, and capable, and a powerless group assumed to be sick, disabled, crazy, unpredictable, and violent. This divide can justify inconsiderate treatment of the latter group and expectations of poorer standards of living for them, for which they may be expected to express gratitude. Further discrimination may involve labeling some as "high functioning" and some as "low-functioning". In either case, their behaviors are recast in pathological terms.[5]

The discrimination can be so fundamental and unquestioned that it can stop people truly empathizing (although they may think they are) or genuinely seeing the other point of view with respect. Mentalism may lead a person to erroneously believe they understand the other's situation and needs better than they do themselves.[5]

Clinical terminology

Mentalism is often enshrined in clinical terminology in subtle ways, including in the basic diagnostic categories employed. It is argued that they can stigmatize or communicate contempt or inferiority, rather than help with the understanding of specific experiences. Mental health professionals may argue that the terms are needed, which has been compared to the way a person may justify the use of ethnic slurs because they intend no harm, but it is argued that most could easily be expressed in a more accurate, less offensive manner.[5]

Some terms may be used far beyond their usual meanings, in a way that obscures the reality of the experience of the person concerned - for example, having a bad time may be relabelled as decompensation; incarceration or solitary confinement may be described as "treatment"; regular activities like listening to music, engaging in simple activities or even just being in a certain environment, become "therapies"; all sorts of behaviors are recast as "symptoms"; core adverse effects of drugs are termed "side" effects.[5]

Blame

Interpretations of behaviors, and applications of treatments, may be done in an arrogant unjustified way because of an underlying mentalism. If the recipient disagrees or does not change, they may be labeled as "non-compliant" "uncooperative" or "treatment-resistant". This is despite the fact that it may be due to inadequate understanding of the person or his/her problems, medication adverse effects, a poor match between the treatment and the person's lifestyle, stigma associated with the treatment, difficulty with access, cultural unacceptability or many other issues.[5]

Mentalism may lead people to assume that a person isn't aware of what they're doing and that there is no point trying to communicate with them, despite the fact that they may well have a level of awareness and desire to connect even if they are acting in a seemingly irrational or self-harming way. In addition, mental health clinicians tend to equate subduing a person with treatment; a quiet client who causes no community disturbance is deemed "improved" no matter how miserable or incapacitated that person may feel as a result.[5]

Clinicians may blame clients for not being sufficiently motivated to work on treatment goals, or as "acting out" when their own goals are not supported. It is argued, however, that in the majority of cases this is actually due to the client having been treated in a disrespectful, judgmental, or dismissive manner. Such mentalist behavior may again be justified by blaming the person as having been demanding, angry or "needing limits", but it is argued that power-sharing can nevertheless be cultivated and that when respectful communication breaks down, the first thing that needs to be asked is whether mentalist prejudices have been expressed.[5]

Neglect

Mentalism has been linked to negligence in monitoring for possible adverse effects, or viewing such effects as more acceptable than they would be for others. This has been compared to instances of maltreatment based on racism. Mentalism has also been linked to neglect in failing to check for or respect people's past experiences of abuse or trauma. Treatments that do not support choice and self-determination may cause people to re-experience the helplessness, pain, despair, and rage that accompanied the trauma, and yet attempts to cope with this may be labeled as "acting out", "manipulating" or "attention-seeking".[5]

Mentalism can lead to "poor" or "guarded" predictions of the future for the person; a pessimistic view skewed by a narrow clinical experience, that can be impervious to contrary evidence because those who succeed can be discounted as having been misdiagnosed or didn't have the "real" disorder. The result can be self-fulfilling, as individuals are told they have no real hope.[5]

Institutional discrimination

Offensive and injurious practices may be integrated into clinical procedures, a form of institutional mentalism to the point where professionals no longer recognize them as discrimination. Mentalism may be apparent in physical separation, including separate use of facilities or accommodation, or lower standards. Mental health professionals can be drawn into systems based on bureaucratic or financial imperatives and social control, resulting in alienation from their original values and disappointment in "the system", and adoption of the cynical, mentalist beliefs that pervade such organizations. However, just as employees can be dismissed for disparaging sexual or ethnic remarks, it is argued that staff who are entrenched in negative stereotypes, attitudes, and beliefs about those labeled with mental disorders need to be removed from service organizations.[5]

At a society-wide level, mentalism has been perceived as linked to people being kept in poverty as second class citizens, to employment discrimination keeping people living on handouts; to interpersonal discrimination hindering relationships, to stereotypes promoted through the media spreading fears of unpredictability and dangerousness, and to people fearing to disclose or talk about their experiences.[6]

A 2001 publication by psychiatric nurses on stigma in healthcare that included the view of a leading figure in the Consumer/Survivor/Ex-Patient Movement, Pete Shaughnessey, concluded that the National Health Service in

England is "institutionally mentalist and has a lot of soul searching to do in the new Millenium" including addressing the prejudice of its office staff. He suggested that when prejudice is applied by the very professionals who aspire to eradicate it, it raises the question of whether it will ever be eradicated.[7] Shaughnessey committed suicide in 2002.[8]

It has been argued from a feminist perspective that mentalism in psychiatry "acts as a threat to all women" and to women's families and children.[9]

A psychiatric survivor and professional said that "Mentalism parallels sexism and racism in creating an oppressed underclass, in this case of people who have received psychiatric diagnosis and treatment" She reported that the most frequent complaint of service users is that nobody listens, or only selectively in the course of trying to make a diagnosis.[10]

Multiple discriminations

A spiral of oppression experienced by oppressed groups in society has been identified. Firstly, oppressions in society on the grounds of difference (for which terms may exist, such as racism, sexism, classism, ageism, homophobia etc.) can have a negative physical, social, economic and psychological effects on individuals, which may cause emotional distress and sometimes "mental health" problems. Society's response to such distress is to treat it within a system of medical and social care rather than understanding and challenging the oppressions that gave rise to it, thus reinforcing them with further oppressive attitudes and practices, which can lead to more distress, and so on in a vicious cycle. In addition, due to coming into contact with mental health services, people become subject to the oppression of mentalism, since society (and mental health services themselves) have such negative attitudes towards people with a psychiatric diagnosis, thus further perpetuating oppression and discrimination.[11]

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External links

- Solving the Problems of Mentalism (http://home.att.net/~parisser/Mentalism10_06.doc) Presentation at the National Association of Case Management NACM 2006 Conference
- Psychophobia in Art (http://talentdevelop.com/articles/Page28.html)
- Fight Psychophobia (http://www.indymedia.org.uk/en/2005/02/305230.html)
- Challenging ideas in mental health (http://openlearn.open.ac.uk/mod/resource/view.php?id=288089)
- Loose-talking psychophobes show nothing but contempt (http://www.guardian.co.uk/society/2007/dec/05/guardiansocietysupplement.mentalhealth)

Neurodiversity

Autism rights movement
Philosophy
Neurodiversity · Neurotypical · Sociological and cultural aspects
Organizations
Autism National Committee · Autism Network International · Autistic Self Advocacy Network · National Autistic Society
Events
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Neurodiversity is an idea which asserts that atypical (neurodivergent) neurological development is a normal human difference that is to be recognized and respected as any other human variation.[1] Differences may arise in ways of processing information, including language, sound, images, light, texture, taste, or movement. The concept of neurodiversity is embraced by some autistic individuals and people with related conditions. Some groups apply the concept of neurodiversity to conditions potentially unrelated (or non-concomitant) to autism such as bipolar disorder, ADHD,[2] schizophrenia,[3] circadian rhythm disorders, developmental speech disorders, Parkinson's disease, dyslexia, and dyspraxia.[2]

Origin of the term

According to an article in *New York Magazine*, the term was put forward by Judy Singer and first published by Harvey Blume.[4] The earliest published use of the term appears in a *New York Times* article by Harvey Blume on September 30, 1998:[5]

> Neurodiversity may be every bit as crucial for the human race as biodiversity is for life in general. Who can say what form of wiring will prove best at any given moment? Cybernetics and computer culture, for example, may favor a somewhat autistic cast of mind.

Previous to this, although Blume did not make explicit use of the term *neurodiversity*, he wrote in a *New York Times* piece on June 30, 1997:[6]

> Yet anyone who explores the subject on the Internet quickly discovers an altogether different side of autism. In cyberspace, many of the nation's autistics are doing the very thing the syndrome supposedly deters them from doing -- communicating.
>
> Yet, in trying to come to terms with an NT-dominated world, autistics are neither willing nor able to give up their own customs. Instead, they are proposing a new social compact, one emphasizing neurological pluralism.
>
> The consensus emerging from the Internet forums and Web sites where autistics congregate (...) is that NT is only one of many neurological configurations -- the dominant one certainly, but not necessarily the best.

Blume is also notable for his early public advocacy and prediction of the role the internet would play in fostering neurodiversity.[7]

> There is a political dimension to this bond with the Internet. A project called CyberSpace 2000 is devoted to getting as many people as possible in the autistic spectrum hooked up by the year 2000, reason being that "the Internet is an essential means for autistic people to improve their lives, because it is often the only way they can communicate effectively."
>
> [...] the community of autistics, which may not have matured and come to self-awareness without the Internet, presents the rest of us with a challenge.
>
> The challenge we will all be increasingly confronted with, on-line and off, is, to look at ourselves differently than we have before, that is, to accept neurological diversity.

The term mostly appears within the online autistic community, but its usage has spread to a more general meaning; for example, the Developmental Adult Neurodiversity Association (DANDA) in the UK encompasses developmental dyspraxia, ADHD, Asperger syndrome and related conditions.[8] Usage of the term has seen a boost with a 2004 *New York Times* article by Amy Harmon, "The Disability Movement Turns to Brains".[1]

Neurodiversity as an ideology

The language surrounding neurodiversity has been a major point of contention. Those proposing the medical model label learning differences as “disorders, deficits, and dysfunctions.” From this point of view, neurodiverse states are viewed as medical conditions that can and should be corrected.[9] Others see neurodiversity as an inclusive term that refers to the equality of all possible mental states. Still others reject the word because it sounds too medical and overshadows the needs of people with learning differences.[9]

The idea that there are "normal" people and "abnormal" people is being challenged by more recent research in psychology. Many psychological disorders are spectrum disorders, including Autism, meaning that people with varying degrees of symptoms will be placed at various spots on a theoretical spectrum, yet be given the same broad diagnosis. One of the common symptoms in individuals with autism is having inordinate interest in a narrow subject, yet taken loosely, nearly everyone could be described this way. How to determine where the spectrum should end, where on one side an individual is termed "normal" and the other "abnormal", is often difficult to say. In contrast to trying to classify humans into discrete categories, the neurodiversity movement views each human as unique and supports the expression thereof.

Neurodiversity as a term does capture the discovery that autism has an organic basis, representing a move away from the “mother-blaming” theories of the 20th century. Before the scientific advances in the 1980s, autism scholars including Bruno Bettelheim popularized the belief that autism came from “extremely abnormal mother-child relations.” Bettelheim, a researcher and author of many books about autism, pioneered the "refrigerator-mother" idea, claiming that cold, distant parenting was a cause of autism. Though Bettelheim later admitted to falsifying his credentials, the stigma remained until recent genetic research debunked this myth.[10]

The post-1980 geneticization of autism, wherein the condition is said to have an organic basis, was a change that prompted the idea of neurodiversity. Since the condition is innate, it is able to be accepted as a natural difference in individuals. It is important to note that the true cause of autism is contested and could result from a variety of factors that are genetic, biological, or environmental in nature. The important shift is that the basis of autism is no longer believed to be entirely social.[10]

There has been a large increase in the number of autism diagnoses in the past few decades. Though the causes of this "autism baby boom" are disputed, ranging from childhood mercury poisoning to increased healthcare to non-uniform standards of diagnosis, there has been an undeniable growth of the diagnosed autistic population.[11] Public attention has grown to match this rise, with articles in *Newsweek* and *Time* showcasing new research, in turn bringing autism, and, to a lesser extent, neurodiversity, more attention from leading elements in politics and contemporary culture.

Goals of the neurodiversity movement

Proponents of neurodiversity are striving to re-conceptualize autism and related conditions in society. Main goals of the movement include:

- acknowledging that neurodiverse people do not need a cure
- changing the language from the current "condition, disease, disorder, or illness"-based nomenclature
- broadening the understanding of healthy or independent living; acknowledging new types of autonomy
- giving neurodiverse individuals more control over their treatment, including the type, timing, and whether there should be treatment at all[12]

Autistic supporters of neurodiversity want their way of life to be considered as a respectable, autonomous, and equal way of living. Since autism is inseparable from daily perceptions and decisions, some believe it ought not be separated from the person and treated as a curable disease. Rather, autism should be recognized as a different but equal way of understanding and approaching the world.

Proponents of neurodiversity are typically not opposed to medical treatments, but they believe that it should be up to the individual and be seen as aiding in the enjoyment of life rather than "fixing" a person.

Legislation and its implications

In 1990, President George H.W. Bush signed the Americans with Disabilities Act into law. This act prohibited discrimination based on disability in schools, the workplace, and other public institutions.

In 1995, the United Kingdom passed the Disability Discrimination Act, making it illegal to deny people employment, goods and services, education, or transportation based on disability.

Both countries were required to anticipate and make "reasonable adjustments" for people with disabilities. Some of these adjustments were outlined under the Disability Equality Duty (a provision under the Americans with Disabilities Act):

- promote equality of opportunity
- eliminate unlawful discrimination
- eliminate harassment of disabled persons that is related to their disabilities
- promote positive attitudes towards disabled persons
- encourage participation by disabled persons in public life
- take steps to take account of disabled persons' disabilities[13]

These changes have brought increasing participation by neurodiverse people in both countries. The numbers of neurodiverse students in higher education have increased tenfold in both the US and the UK since their respective anti-discrimination acts have been passed,[9] though the rate of autism diagnosis has quintupled in the same period of time.

Proponents and opponents

Neurodiversity was prefigured by the work of French historian and theorist Michel Foucault, whose book *Folie et déraison* ("Madness and unreason"; published in an abridged version in English as *Madness and Civilization*, and eventually in full as *The History of Madness*) influenced the anti-psychiatry movement of the 1960s.

Some parents say they value their children's individuality and want to allow their children to develop naturally. For example, Morton Ann Gernsbacher is a parent of an autistic child and a psychology professor, who argues that autistics need acceptance, not a cure, and endorses the theory that autism cannot be separated from the person.[14]

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Mad Pride

Mad Pride is a mass movement of mental health services users and their allies. The first known event specifically organized as a Pride event by people who identify as psychiatric survivors/consumer/ex-patients was in Toronto, Canada when it was called "Psychiatric Survivor Pride Day", held on September 18, 1993. It was first held in response to local community prejudices towards people with a psychiatric history living in boarding homes in the Parkdale area of the city, and has been held every year since then in this city except 1996.[1] By the late 1990s similar events were being organized as Mad Pride in London, England and around the globe from Australia to South Africa and the United States, drawing thousands of participants, according to MindFreedom International, a United States mental health advocacy organization that promotes and tracks events spawned by the movement.[2]

A flyer for a 2003 Mad Pride event.

Mad Pride activists seek to reclaim terms such as 'mad', 'nutter' and 'psycho' from misuse, such as in tabloid newspapers. Through a series of mass media campaigns, Mad Pride activists seek to re-educate the general public on such subjects as the causes of mental disorders, the experiences of those using the mental health system, and the global suicide pandemic. One of Mad Pride's founding activists was Pete Shaughnessy, who later committed suicide.[3] Robert Dellar and 'Freaky Phil' Murphy were among the other founders of the movement. *Mad Pride: A celebration of mad culture* records the early Mad Pride movement.[4]

History

Mad Pride was launched alongside a book of the same name, *Mad Pride: A celebration of mad culture*, published in 2000.[4] On May 11, 2008, Gabrielle Glaser documented Mad Pride in The New York Times.[5] Glaser stated, "Just as gay-rights activists reclaimed the word queer as a badge of honor rather than a slur, these advocates proudly call themselves mad; they say their conditions do not preclude them from productive lives." The Mad Pride (see gay pride for more on gay rights) movement was further mentioned in The Huffington Post.[6]

Mad culture and events

The Mad Pride movement has spawned recurring cultural events in Toronto, London, and other cities around the world. These events often include music, poetry readings, film screenings, and street theatre, such as 'bed push' protests, which aim to raise awareness about the poor levels of choice of treatments and the widespread use of force in psychiatric hospitals.[7] Commentaries on the Mad Pride movement have been made by such literary luminaries as the English Republican Jonathan Freedland[8] and popular novelist Clare Allan.[9] Mad Pride cultural events take a variety of forms, such as the South London collective Creative Routes, the Chipmunka Publishing enterprise, and the many works of Dolly Sen.[10]

Mad Pride parade in Salvador, Brazil, in 2009.

Bed push

Mad Pride Week in Toronto is proclaimed as such by the city itself. Highlighted by the MAD! Pride Bed Push, the festival is now in its fourteenth year. A series of bed push events take place around London each year.[11]

The ABC-TV show Primetime Outsiders ran a segment about Mad Pride on August 25, 2009 that included interviews with actor Joey Pantoliano; musician Madigan Shive; and David W. Oaks, Director, MindFreedom International.[12]

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External links

- Mad Pride Network (http://madpridenetwork.com)

Psychiatric survivors movement

The **Psychiatric survivors movement** is a loose coalition of people who, united by the resentment that they have been harmed or betrayed by psychiatry, advocate in favor of mental health treatment alternatives, or just the right to freedom from the system, for those diagnosed with (or simply accused of being afflicted by) mental illnesses. The wider movement is also known as the Psychiatric consumer/survivor/ex-patient movement.

Human rights

According to members of the Psychiatric Survivors movement, coerced and/or forced psychiatric interventions are a violation of a person's basic human rights; including the right to autonomy, the freedom to make one's own choices, the right to liberty and security of the person, the right to physical and mental integrity, freedom from torture, the right to health care on the basis of free and informed consent, etc. Many people who have experienced forced institutionalization, forced drugging and forced electroshock respond with outrage because they consider there to be a prejudice within society that ignores their human rights and over-rates the judgment of psychiatrists, pharmaceutical companies, the police, and the legal oversight of the mental health system. According to the movement, many also view such interventions made in the name of help to be coercive and inherently violent in nature.

Origins

The psychiatric survivors movement grew out of these experiences, though there are perhaps earlier inspirations for the movement (e.g., anti-psychiatry and the opposition of surrealism to psychiatry).[1] According to the movement, other influences include the civil rights movement.

History of movement

The beginning of a formal movement is often attributed to Dorothy Weiner, a union organizer, Tom Wittick, a political activist/organizer and Howard Geld, or *Howie the Harp*, a homeless advocate,[2] and the formation of the *Insane Liberation Front* in Portland, Oregon, in 1969. Many other local initiatives followed, many of them with Howie's direct participation, and most owing to his articulation of peer alternatives to traditional treatment methods, and demonstrated success in funding and operating peer-operated service centers. A coalition of such programs meets annually at the *Alternatives* conference.

MindFreedom International and the World Network of Users and Survivors of Psychiatry have also played important roles in the psychiatric survivors movement.

Aims

People with mental illnesses often "suffer from widespread systemic discrimination and are consistently denied the rights and services to which they are entitled".[3] One of the goals of the psychiatric survivors movement is to have mental illnesses protected by Anti-discrimination laws, thus affording them the same legal protection as those of varying sex, age, race, religion etc. Additionally, it is well recognised that those with mental disorders have generally higher rates of unemployment, and lower occupational attainment. Proponents of affirmative action believe that, as with other minority groups, there should be equal representation of those with mental illnesses in all occupations, even though mental illnesses can negatively affect job performance.

Legal issues

A January 4, 2007 restraining order issued by U.S. District Court Judge Jack B. Weinstein forbade a large number of activists in the psychiatric survivors movement from posting links on their websites to ostensibly leaked documents which purportedly show that Eli Lilly and Company intentionally withheld information as to the lethal side-effects of Zyprexa. The Electronic Frontier Foundation appealed this as prior restraint on the right to link to and post documents, saying that citizen-journalists should have the same First Amendment rights as major media outlets.[4] It was later held that the judgement was unenforcable, though First Amendment claims were rejected.[5]

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External links

- MHSelfHelp.org (http://www.mhselfhelp.org/) - National Mental Health Consumers' Self-Help Clearinghouse

Psychiatric consumer/survivor/ex-patient movement

The **psychiatric consumer/survivor/ex-patient movement**, also known as the **psychiatric survivor movement**, is a diverse association of individuals (and organizations representing them) who are either currently "consumers" (clients) of mental health services, or who consider themselves survivors of psychiatry or mental health services, or who simply identify as "ex-patients" of mental health services. The movement typically campaigns for more choice and improved services, and/or empowerment and user-led alternatives, and against prejudice in society more generally. Common themes are "talking back to the power of psychiatry", rights protection and advocacy, and self-determination. While activists in this movement may share a collective identity, individuals can be seen as enacting their concerns along a continuum from conservative to radical, according to their position in relation to psychiatric treatment and their relative levels of resistance and patienthood.[1] This can in turn relate to an individual's experiences of the mental health system, particularly if subject to forced detention and/or forced medication, electroshock or other practice.

History

Precursors

The modern self-help and advocacy movement in the field of mental health services developed in the 1970s, but former psychiatric patients have been campaigning for centuries to change laws, treatments, services and public policies. "The most persistent critics of psychiatry have always been former mental hospital patients", although few were able to tell their stories publicly or to openly confront the psychiatric establishment, and those who did so were commonly considered so extreme in their charges that they could seldom gain credibility.[2] In 1620 in England, patients of the notoriously harsh Bethlem Hospital banded together and sent a "Petition of the Poor Distracted People in the House of Bedlam (concerned with conditions for inmates)" to the House of Lords. A number of ex-patients

published pamphlets against the system in the 18th century, such as Samuel Bruckshaw (1774), on the "iniquitous abuse of private madhouses", and William Belcher (1796) with his "Address to humanity, Containing a letter to Dr Munro, a receipt to make a lunatic, and a sketch of a true smiling hyena". Such reformist efforts were generally opposed by madhouse keepers and medics.[3]

In the late 18th century, moral treatment reforms developed which were originally based in part on the approach of French ex-patient turned hospital-superintendent Jean-Baptiste Pussin and his wife Margueritte. From 1848 in England, the Alleged Lunatics' Friend Society campaigned for sweeping reforms to the asylum system and abuses of the moral treatment approach. In the United States, The Opal (1851–1860) was a ten volume Journal produced by patients of Utica State Lunatic Asylum in New York, which has been viewed in part as an early liberation movement. Beginning in 1868, Elizabeth Packard, founder of the Anti-Insane Asylum Society, published a series of books and pamphlets describing her experiences in the Illinois insane asylum to which her husband had had her committed.

Early 20th century

A few decades later, another former psychiatric patient, Clifford W. Beers, founded the National Committee on Mental Hygiene, which eventually became the National Mental Health Association. Beers sought to improve the plight of individuals receiving public psychiatric care, particularly those committed to state institutions. His book, *A Mind that Found Itself* (1908),[4] described his experience with mental illness and the treatment he encountered in mental hospitals. Beers' work stimulated public interest in more responsible care and treatment. However, while Beers initially damned psychiatrists for tolerating mistreatment of patients, and envisioned more ex-patient involvement in the movement, he was influenced by Adolf Meyer and the psychiatric establishment, and toned down his hostility as he needed their support for reforms. His reliance on rich donors and his need for approval from experts led him to hand over to psychiatrists the organization he helped establish.[2] In the UK, the National Society for Lunacy Law Reform was established in 1920 by angry ex-patients sick of their experiences and complaints being patronisingly discounted by the authorities who were using medical "window dressing" for essentially custodial and punitive practices.[5] In 1922, ex-patient Rachel Grant-Smith added to calls for reform of the system of neglect and abuse she had suffered by publishing "The Experiences of an Asylum Patient".[6]

We Are Not Alone (WANA) was founded by a group of patients at Rockland State Hospital in New York in the mid to late 1940s, and continued to meet as an ex-patient group. Their goal was to provide support and advice and help others make the difficult transition from hospital to community. By the early 1950s WANA dissolved after it was taken over by mental health professionals who transformed it into Fountain House, a psychosocial rehabilitation service for people leaving state mental institutions. The founders of WANA found themselves pushed aside by professionals with money and influence, who made them “members” of the new organization . During that period, people who received psychiatric treatment identified themselves as patients, and this term was generally unchallenged as a self-description until the 1970s. A perceived patronizing attitude by health care workers led to resentment among some current and former patients, which eventually found expression in more militant groups beginning in the early 1970s.[7]

Originated by crusaders in periods of liberal social change, and appealing not so much to other sufferers as to elite groups with power, when the early reformer's energy or influence waned, mental patients were again mostly friendless and forgotten.[2]

1950s to 1970s

The 1950s saw the reduction in the use of lobotomy and shock therapy. These used to be associated with grave concerns and much opposition on grounds of basic morality, harmful effects, or misuse. Towards the 1960s, psychiatric medications came in to widespread use and also caused controversy relating to adverse effects and misuse. There were also associated moves away from large psychiatric institutions to community-based services (later to become a full-scale deinstitutionalization), which sometimes empowered service users, although community-based services were often deficient.

Coming to the fore in the 1960s, an anti-psychiatry movement vocally challenged the fundamental claims and practices of mainstream psychiatry. The ex-patient movement of this time contributed to, and derived much from, antipsychiatry ideology, but has also been described as having its own agenda, described as humanistic socialism. For a time, the movement shared aims and practices with "radical therapists", who tended to be Marxist. However, the consumer/survivor/ex-patients gradually felt that the radical therapists did not necessarily share the same goals and were taking over, and they broke away from them in order to maintain independence.

By the 1970s, the women's movement, gay rights movement, and disability rights movements had emerged. It was in this context that former mental patients began to organize groups with the common goals of fighting for patients' rights and against forced treatment, stigma and discrimination, and often to promote peer-run services as an alternative to the traditional mental health system. Unlike professional mental health services, which were usually based on the medical model, peer-run services were based on the principle that individuals who have shared similar experiences can help themselves and each other through self-help and mutual support. Many of the individuals who organized these early groups identified themselves as psychiatric survivors. Their groups had names such as Insane Liberation Front and the Network Against Psychiatric Assault. They saw the mental health system as destructive and disempowering.

With more people out of mental hospitals, there was a larger number of people who could now make links with one another for progressive causes. Dorothy Weiner and about 10 others, including Tom Wittick, established the Insane Liberation Front in the spring of 1970 in Portland, Oregon. Though it only lasted 6 months, it had a notable influence in the history of North American ex-patients groups. News that former inmates of mental institutions were organizing was carried to other parts of North America. Individuals such as Howard Geld, known as Howie the Harp for his harmonica playing, left Portland where he been involved in ILF to return to his native New York to help found the Mental Patients Liberation Project in 1971. During the early 1970s, groups spread to California, New York, and Boston, which were primarily antipsychiatry, opposed to forced treatment including forced drugging, shock treatment and involuntary committal.[7] In 1972, the first organized group in Canada, the Mental Patients Association, started to publish In A Nutshell, while in the US the first edition of the first national publication by ex-mental patients, Madness Network News, was published in Oakland, continuing until 1986.[7] A well-known book of the time by an ex-patient was Judi Chamberlin's 1978 "On Our Own: Patient-Controlled Alternatives to the Mental Health System." Chamberlin publicized the concept of mentalism, a form of stereotyping and oppression of those associated with psychiatric treatment and diagnosis.

The major spokespeople of the movement have been described in generalities as largely white, middle-class and well-educated. It has been suggested that other activists were often more anarchistic and anti-capitalist, felt more cut-off from society and more like a minority with more in common with the poor, ethnic minorities, feminists, prisoners & gay rights than with the white middle classes. The leaders were sometimes considered to be merely reformist and, because of their "stratified position" within society, to be uncomprehending of the problems of the poor. The "radicals" saw no sense in seeking solutions within a capitalist system that creates mental problems. However, they were united in considering society and psychiatric domination to be the problem, rather than people designated mentally ill.[2]

Some activists condemned psychiatry under any conditions, voluntary or involuntary, while others believed in the right of people to undergo psychiatric treatment on a voluntary basis. Voluntary psychotherapy, at the time mainly

psychoanalysis, did not therefore come under the same severe attack as the somatic therapies. The ex-patients emphasized individual support from other patients; they espoused assertiveness, liberation, and equality; and they advocated user-controlled services as part of a totally voluntary continuum. However, although the movement espoused egalitarianism and opposed the concept of leadership, it is said to have developed a cadre of known, articulate, and literate men and women who did the writing, talking, organizing, and contacting. Very much the product of the rebellious, populist, anti-elitist mood of the 1960s, they strived above all for self-determination and self-reliance. In generally, the work of some psychiatrists, as well as the lack of criticism by the psychiatric establishment, was interpreted as an abandonment of a moral commitment to do no harm. There was a deep anger and resentment toward a profession that had the authority to label them as mentally disabled and was perceived as infantilizing them and disregarding their wishes.[2]

1980s and 1990s

By the 1980s, individuals who considered themselves "consumers" of mental health services rather than passive "patients" had begun to organize self-help/advocacy groups and peer-run services. While sharing some of the goals of the earlier movement, consumer groups did not seek to abolish the traditional mental health system, which they believed was necessary. Instead, they wanted to reform it and have more choice. Consumer groups encouraged their members to learn as much as possible about the mental health system so that they could gain access to the best services and treatments available. In 1985, the National Mental Health Consumers' Association was formed in the United States.[7]

A 1986 report on developments in the United States noted that "there are now three national organizations ... The ‘conservatives’ have created the National Mental Health Consumers' Association ... The ‘moderates’ have formed the National Alliance of Mental Patients ... The ‘radical’ group is called the Network to Abolish Psychiatry".[7] Many, however, felt that they had survived the psychiatric system and its "treatments" and resented being called consumers. The National Association of Mental Patients in the United States became the National Association of Psychiatric Survivors. "Phoenix Rising: The Voice of the Psychiatrized" was published by ex-inmates (of psychiatric hospitals) in Toronto from 1980 to 1990, known across Canada for its antipsychiatry stance.[7]

In late 1988, leaders from several of the main national and grassroots psychiatric survivor groups decided an independent coalition was needed, and Support Coalition International (SCI) was formed in 1988, later to become MindFreedom International. In addition, the World Network of Users and Survivors of Psychiatry (WNUSP), was founded in 1991 as the World Federation of Psychiatric Users (WFPU), an international organisation of recipients of mental health services.

An emphasis on voluntary involvement in services is said to have presented problems to the movement since, especially in the wake of deinstitutionalization, community services were fragmented and many individuals in distressed states of mind were being put in prisons or re-institutionalized in community services, or became homeless, often distrusting and resisting any help.[2]

The movement today

In the United States, the number of mental health mutual support groups (MSG), self-help organizations (SHO) (run by and for mental health consumers and/or family members) and consumer-operated services (COS) was recently estimated to be 7,467.[8] The movement may express a preference for the "survivor" label over the "consumer" label, with more than 60 percent of ex-patient groups reported to support anti-psychiatry beliefs and considering themselves to be "psychiatric survivors." [9] There is some variation between the perspective on the consumer/survivor movement coming from psychiatry, anti-psychiatry or consumers/survivors themselves.[10] [11]

The most common terms in Germany are "Psychiatrie-Betroffene" (people afflicted by/confronted with psychiatry) and "Psychiatrie-Erfahrene" (people who have experienced psychiatry). Sometimes the terms are considered as synonymous but sometimes the former emphasizes the violence and negative aspects of psychiatry. The German

national association of (ex-)users and survivors of psychiatry is called the Bundesverband Psychiatrie-Erfahrener (BPE).[12]

There are many grassroots self-help groups of consumers/survivors, local and national, all over the world, which are an important cornerstone of empowerment. A considerable obstacle to realizing more consumer/survivor alternatives is lack of funding.[12] Alternative consumer/survivor groups like the National Empowerment Center[13] in the US which receive public funds but question orthodox psychiatric treatment, have often come under attack for receiving public funding[7] and been subject to funding cuts.

As well as advocacy and reform campaigns, the development of self-help and user/survivor controlled services is a central issue. The Runaway-House in Berlin, Germany, is an example. Run by the Organisation for the Protection from Psychiatric Violence, it is an antipsychiatric crisis centre for homeless survivors of psychiatry where the residents can live for a limited amount of time and where half the staff members are survivors of psychiatry themselves.[12] In Helsingborg, Sweden, the Hotel Magnus Stenbock is run by a user/survivor organization "RSMH" that gives users/survivors a possibility to live in their own apartments. It is financed by the Swedish government and run entirely by users.[12] Voice of Soul is a user/survivor organization in Hungary. Creative Routes is a user/survivor organization in London, England, that among other support and advocacy activities puts on an annual "Bonkersfest".

WNUSP is a consultant organization for the United Nations. After a "long and difficult discussion", ENUSP and WNUSP (European and World Networks of Users and Survivors of Psychiatry) decided to employ the term (ex-)users and survivors of psychiatry in order to include the identities of the different groups and positions represented in these international NGOs.[12] WNUSP contributed to the development of the UN's Convention on the Rights of Persons with Disabilities[14] [15] and produced a manual to help people use it called "Implementing the Disability Rights Treaty, for Users, Survivors of Psychiatry"[16] and ENUSP is consulted by the European Union and World Health Organization.

In 2007 at a Conference held in Dresden on "Coercive Treatment in Psychiatry: A Comprehensive Review", the president and other leaders of the World Psychiatric Association met, following a formal request from the World Health Organization, with four representatives from leading consumer/survivor groups.[17]

The National Coalition for Mental Health Recovery (formerly known as National Coalition for Mental Health Consumer/Survivor Organizations) campaigns in the United States to ensure that consumer/survivors have a major voice in the development and implementation of health care, mental health, and social policies at the state and national levels, empowering people to recover and lead a full life in the community.

The United States Massachusetts-based Freedom Center provides and promotes alternative and holistic approaches and takes a stand for greater choice and options in treatments and care. The center and the New York-based Icarus Project (which does not self-identify as a consumer/survivor organization but has participants that identify as such) have published a Harm Reduction Guide To Coming Off Psychiatric Drugs and were recently a featured charity in Forbes business magazine.[18]

Mad pride events, organized by loosely connected groups in at least seven countries including Australia, South Africa, the United States, Canada, the United Kingdom and Ghana, draw thousands of participants. For some, the objective is to continue the destigmatization of mental illness. Another wing rejects the need to treat mental afflictions with psychotropic drugs and seeks alternatives to the "care" of the medical establishment. Many members of the movement say they are publicly discussing their own struggles to help those with similar conditions and to inform the general public.[19]

Survivor David Oakes, Director of MindFreedom, hosts a monthly radio show [20] and the Freedom Center initiated a weekly FM radio show now syndicated on the Pacifica Network, Madness Radio [21], hosted by Freedom Center co-founder Will Hall.[22]

A new International Coalition of National Consumer/User Organizations was launched in Canada in 2007, called Interrelate.[23]

Impact

There has been some substantial research into consumer/survivor initiatives (CSIs). Many of the studies have been cross-sectional or retrospective and have not used comparison groups, which limits the firm conclusions that can be drawn. However, the findings suggest that CSIs can help with social support, empowerment, mental wellbeing, self-management and reduced service use, identity transformation and enhanced quality of life. However, studies have focused on the support and self-help aspects of CSIs, neglecting that many organizations locate the causes of members' problems in political and social institutions and are involved in activities to address issues of social justice.[24]

A recent series of studies in Canada compared individuals who participated in CSIs with those who did not. The two groups were comparable at baseline on a wide range of demographic variables, self-reported psychiatric diagnosis, service use, and outcome measures. After a year and a half, those who had participated in CSIs showed significant improvement in social support and quality of life (daily activities), less days of psychiatric hospitalization, and more were likely to have stayed in employment (paid or volunteer) and/or education. There was no significant difference on measures of community integration and personal empowerment, however. There were some limitations to the findings; although the active and nonactive groups did not differ significantly at baseline on measures of distress or hospitalization, the active group did have a higher mean score and there may have been a natural pattern of recovery over time for that group (regression to the mean). The authors noted that the apparent positive impacts of consumer-run organizations were achieved at a fraction of the cost of professional community programs.[25]

Further qualitative studies indicated that CSIs can provide: safe environments that are a positive, welcoming place to go; social arenas that provide opportunities to meet and talk with peers; an alternative worldview that provides opportunities for members to participate and contribute; and effective facilitators of community integration that provide opportunities to connect members to the community at large.[26] System-level activism was perceived to result in changes in perceptions by the public and mental health professionals (about mental health or mental illness, the lived experience of consumer/survivors, the legitimacy of their opinions, and the perceived value of CSIs) and in concrete changes in service delivery practice, service planning, public policy, or funding allocations. The authors noted that the evidence indicated that the work benefits other consumers/survivors (present and future), other service providers, the general public, and communities. They also noted that there were various barriers to this, most notably lack of funding, and also that the range of views represented by the CSIs appeared less narrow and more nuanced and complex than previously, and that perhaps the consumer/survivor social movement is at a different place than it was 25 years ago.[27]

There has also been criticism of the movement. Well-positioned forces in the USA, led by figures such as psychiatrists E. Fuller Torrey and Sally Satel, and some leaders of the National Alliance for the Mentally Ill, have lobbied against the funding of consumer/survivor groups that promote antipsychiatry views or promote social and experiential recovery rather than a biomedical model, or who protest against outpatient commitment.[28] [29] Torrey has said the term "psychiatric survivor" used by ex-patients to describe themselves is just political correctness and has blamed them, along with civil rights lawyers, for the deaths of half a million people due to suicides and deaths on the street. Such claims have been controverted by recent publications such as U.S.A. Today which published an article indicating that the medical model and the way persons with mental illness are treated today cause people to die 25 years early on average. More generally, organized psychiatry often views radical consumerist groups as extremist, as having little scientific foundation and no defined leadership, as trying to restrict "the work of psychiatrists and care for the seriously mentally ill", and as promoting disinformation on the use of involuntary commitment, electroconvulsive therapy, stimulants and antidepressants among children, and neuroleptics among adults.[10]

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MindFreedom International

A banner ad for MindFreedom International

MindFreedom International is an international coalition of over one hundred grassroots groups and thousands of individual members from fourteen nations. It was founded in 1990 to advocate against forced medication, medical restraints, and involuntary electroconvulsive therapy. Its stated mission is to protect the rights of people who have been labeled with psychiatric disorders. A majority of MindFreedom members identify themselves as survivors of human rights violations in the mental health system; membership, however, is open to anyone who supports human rights, including mental health professionals, advocates, activists and family members.[1] MindFreedom has been recognized by the United Nations Economic and Social Council as a human rights NGO with Consultative Roster Status.[2]

Origins and purpose

MindFreedom International is rooted in the psychiatric survivors movement, or more widely the consumer/survivor/ex-patient movement,[3] which arose out of the civil rights ferment of the late 1960s and early 1970s and the personal histories of psychiatric abuse experienced by some ex-patients rather than the intradisciplinary discourse of antipsychiatry.[4] The precursors of MFI include ex-patient groups of the 1970s[5] such as the Portland based Insane Liberation Front and the Mental Patients' Liberation Front in New York.[3] The key text in the intellectual development of the survivor movement was Judi Chamberlin's 1978 text, *On Our Own: Patient Controlled Alternatives to the Mental Health System*.[3] [6] Chamberlin was an ex-patient and co-founder of the Mental Patients' Liberation Front.[7] Coalescing around the ex-patient newsletter *Dendron*,[8] in late 1988 leaders from several of the main national and grassroots psychiatric survivor groups felt that an independent, human rights coalition focused on problems in the mental health system was needed. That year the Support Coalition International (SCI) was formed. In 2005 the SCI changed its name to MFI with David W. Oaks as its director.[4] SCI's first public action was to stage a counter-conference and protest in New York City, in May, 1990, at the same time as (and directly outside of) the American Psychiatric Association's annual meeting.[9]

Many of the members of MFI, who feel that their human rights were violated by the mental health system, refer to themselves as 'psychiatric survivors'.[3] MFI is a contemporary and active coalition of grassroots groups which are carrying forward the historical tradition of survivor opposition to coercive psychiatry.[3] It does not define itself as an antipsychiatry organization and its members point to the role which 'compassionate' psychiatrists have played in MFI.[4] Activists within the coalition have been drawn from both left and right wing of politics.[4]

MFI functions as a forum for its thousands of members to express their views and experiences, to form support networks and to organize activist campaigns in support of human rights in psychiatry.[5] [4] The coalition regards the psychiatric practices of 'unscientific labeling, forced drugging, solitary confinement, restraints, involuntary commitment, electroshock' as human rights violations.[4] [10]

Range of campaigns

- In 2003 eight MFI members, led by David W. Oaks, went on hunger strike to publicize a series of "challenges" they had set to the American Psychiatric Association (APA), the US Surgeon General and the National Alliance on Mental Illness (NAMI). Prominent among their challenges was that unambiguous proof that mental illness is brain disorder should be produced. By sustaining the hunger-strike for more than one month MFI forced the APA and NAMI to enter into a debate with them on this and other issues.[3]
- Psychiatric Industry Watch: Criticizes what it sees as pharmaceutical industry financial and political influences upon the direction of 'mental health.' For example, the Watch focuses on the pharmaceutical industry's indirect support and direct lobbying for laws that create civil "outpatient commitment" that enable authorities to

administer psychiatric medication involuntarily in the community, e.g., in a patient's home without involuntary hospitalization. MFI's activities have placed it in direct opposition to the pharmaceutical industry, resulting in legal action against MFI.[11]

- The Right to Remember: Seeks to end involuntary electroconvulsive therapy by publicizing instances of forced electroconvulsive treatment and lobbying decision-makers to stop such practices.
- Oral Histories: Compiles and publicizes psychiatric survivor stories detailing the experiences of those who have been through the mental health system. The stories promulgated aim to document abuse by the mental health system and the success stories of individuals who attained a state of stable remission and were able to regain self-direction, usually by disengaging from traditional mental health treatment,
- Mad Pride: Advocates self-determination among those deemed 'mad'. The coalition has proclaimed July as "Mad Pride Month", and supports events around the world celebrating some of the myriad aspects of 'madness,' i.e., those aspects which are seen as positive.[12]
- International Association for the Advancement of Creative Maladjustment (IAACM): Promotes the right to be nonviolently maladjusted. IAACM is currently chaired by Patch Adams, MD.

MindFreedom Shield Program

MindFreedom describes their Shield Program as "an all for one and one for all" network of members. When a registered member is receiving (or is being considered for) involuntary psychiatric treatment, an alert is sent to the MindFreedom Solidarity Network on that person's behalf. Members of the network are then expected to participate in organized, constructive, nonviolent actions---e.g., political action, publicity and media alerts, passive resistance, etc.---to stop or prevent the forced treatment.[13]

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National Empowerment Center

The **National Empowerment Center** (NEC) is an advocacy and peer-support organization in the United States that promotes an empowerment-based recovery model of mental disorder. It is run by consumers/survivors/ex-patients in recovery.

NEC is based in Lawrence, Massachusetts. The self-stated mission of NEC is to carry a message of recovery, empowerment, hope and healing to people who have been labeled with mental illness diagnosis. It argues that recovery and empowerment are not the privilege of a few but a process that is possible for everyone to embark on and find help with. Although unconventional to those accustomed only to a narrow medical model, the model is part of a recovery movement that comprises an emerging consensus.[1]

NEC and other groups are working to implement the transformation to a recovery-based system recommended by the New Freedom Commission on Mental Health. It operates a toll-free information and referral line. It organizes and speaks at conferences. Its staff have published in professional journals, scholastic books, popular press and alternative publications. It has been involved in many national boards and committees and in policy consultations at the White House, in Congress, in federal agencies such as HUD, the Social Security Administration, HCFA, the Joint Commission on Hospital Accreditation, and The President's Commission on Disability, and at the regional and local level with organizations such as HMOs and state divisions of mental health programs. It has developed educational, training and self-help resources. NEC staff have been featured on CNN, U.S.A. Today, The Boston Globe, National Public Radio and talk and radio shows in the U.S., Canada, Europe and other countries.[2]

NEC conducted qualitative research with people who were severely mentally ill but have met criteria for recovery, from which 10 major principles of how people recover were extracted:[3]

- Trusting Oneself and Others
- Valuing Self-Determination

- Believing You'll Recover and Having Hope
- Believing in the Person's Full Potential
- Connecting at a Human, Deeply Emotional Level
- Appreciating That People Are Always Making Meaning
- Having a Voice of One's Own
- Validating All Feelings and Thoughts
- Following Meaningful Dreams
- Relating With Dignity and Respect
- Healing From Emotional Distress
- Transformation From Severe Emotional Distress.
- Recovery From Mental Illness.

NEC research also identified characteristics distinguishing those in illness and those in recovery:[3]

- Dependent vs self-determining
- Mental health system support vs Network of friends support
- Identify solely as consumer or mental patient vs identify as worker, parent, student or other role
- Medication essential vs one tool that may be chosen
- Strong emotions treated as symptoms by professionals vs worked through and communicated with peers
- Global Assessment of Functioning (GAF) score of 60 or below and untrained person would describe labeled person as sick vs score of 61 or above and untrained person would describe the recovered person as not sick (normal)
- Weak sense of self defined by authority and little future direction vs strong self defined from within and peers, strong sense of purpose and future

NEC developed an approach termed Personal Assistance in Community Existence (PACE).[4] [5] [6] It is based on the premise that people can potentially recover fully from even the most severe forms of mental illness, and on an Empowerment Model of Recovery and prevention.[7] It is an education program to help shift the culture of mental health from institutional thinking to recovery thinking, designed for people training to become peer coaches, people furthering their recovery, and people learning new skills to help others. It has previously been deliberately contrasted with "PACT" - Program of Assertive Community Treatment - a form of outpatient commitment that was originally designed to enable people to live in the community, rather than in psychiatric hospitals, but according to NEC has become a "coercive, lifelong, and nonclient-directed system with medication compliance as its most important tenet"[1] NEC conducted a national survey of the use of PACE in the mental health system.[8]

Staffing

The co-founder and executive director is Daniel B. Fisher, a board-certified psychiatrist. A graduate of Princeton University, he completed a PhD in biochemistry at the University of Wisconsin, medical training at George Washington University, and a psychiatric residency at Harvard Medical School. While working as a biomedical researcher at the National Institute of Mental Health, Fisher had a psychotic breakdown, including hallucinations and delusions. After three months at Bethesda Naval Hospital, at age 25, which included forced seclusion and antipsychotic medication haloperidol, he was discharged with a diagnosis of schizophrenia. He was involuntarily hospitalized three times. He reports being influenced by those who were able to show they cared about the person inside and gave him hope that he might some day recover. He went on to become a psychiatrist. He was told during psychiatric training that "You can't talk to an illness" but believed that talking to the person inside is a key method for building trust and recovery.[1] He has since worked as a psychiatrist in hospitals and clinics, while also been part of the consumer movement. He said that a very significant part of the reason for becoming a psychiatrist was wanting to bring to the field what he wished had been there when he was going through psychosis[9]

The director is Debbie L. Whittle and other staff are Judene Shelley, Amy K. Long and formerly Judi Chamberlin.[10] Chamberlin was an internationally known psychiatric survivor and advocate of individuals with a mental illness label.[11] She was diagnosed with schizophrenia at the age of 21 but recovered, which she put down in part to having been a "bad" and non-compliant patient. (She died in 2010.) [12]

Laurie Aherne and Patricia Deegan were co-founders and directors for several years.[13][14]

This American Life

Co-founder Patricia Deegan was featured on the award-winning radio show a "This American Life"in "Edge of Sanity," first aired on 1997. Dr. Deegan herself is a psychologist who attended Oxford and Yale despite multiple hospitalizations (when she was diagnosed with schizophrenia as a teenager).[15]

External links

- Personal Assistance in Community Existence: A Recovery Guide [16]
- NEC website [17]
- This American Life featuring Patricia Deegan and the NEC [18]

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World Network of Users and Survivors of Psychiatry

The **World Network of Users and Survivors of Psychiatry** (**WNUSP**) is an international organisation representing, and led by users (consumers) and survivors of psychiatry. As of 2003, over 70 national organizations were members of WNUSP, based in 30 countries.[1] The network seeks to protect and develop the human rights, disability rights, dignity and self-determination of those labeled as 'mentally ill'.

Activities

WNUSP has special consultative status with the United Nations. It contributed to the development of the UN's Convention on the Rights of Persons with Disabilities.[2][1] WNUSP has produced a manual to help people use it called "Implementation Manual for the United Nations Convention on the Rights of Persons with Disabilities." [3]

WNUSP joined with other organizations to create the International Disability Caucus, which jointly represented organizations of people with disabilities and allies during the CRPD negotiations. WNUSP was part of the steering committee of the IDC, which maintained a principle of respecting the leadership of diverse constituencies on issues affecting them, and also maintained that the convention should be of equal value to all persons with disabilities irrespective of the type of disability or geographical location. Tina Minkowitz, WNUSP's representative on the IDC steering committee, coordinated the IDC's work on key articles of the CRPD, including those on legal capacity, liberty, torture and ill-treatment and integrity of the person. Since the adoption and entry into force of the CRPD, WNUSP has worked with other organizations in the International Disability Alliance and its CRPD Forum to guide the interpretation and application of the CRPD on these issues.[4]

In 2007 at a Conference held in Dresden on "Coercive Treatment in Psychiatry: A Comprehensive Review", the president and other leaders of the World Psychiatric Association met, following a formal request from the World Health Organization, with four representatives from the user/survivor movement, including Judi Chamberlin, co-chair of WNUSP, who participated in her personal capacity.[5]

Moosa Salie is the current Chair of WNUSP.

Current International Representative and former co-chair of WNUSP is Tina Minkowitz, an international advocate and lawyer.[6] She represented WNUSP in the Working Group convened by the UN to produce a draft text of the Convention on the Rights of Persons with Disabilities[7] and contributed to a UN seminar on torture and persons with disabilities[8][9] that resulted in an important report on the issue by Special Rapporteur on Torture Manfred Nowak in 2008.[10]

Core values

The core values of WNUSP, in representating a diversity of perspectives within the user/survivor movement or psychiatric survivors movement, guide its activities and assists in determining the focus of the network. These values stress empowerment, equality, self-determination, respect, dignity, independence, hearing voices, mutual support, self-help, advocacy, education, and the right to pursue individual spiritual beliefs.

WNUSP values exposure to information and knowledge as means to enabling empowerment and individual self-direction, understanding that knowledge results in better-informed choices and opportunities to enhance quality of life. The network ascribes to person-centred values where the individual is more important than any diagnostic label or experience in dealing with the mental health system. WNUSP believes the experiences of living with madness or mental health problems can be valuable in exploring human experience, both to individuals and society, and that those suffering distress may offer invaluable insights to necessary changes in mental health diagnosis, treatment and laws.

History

Since the 1970s, the psychiatric survivors movement has grown from a few scattered self-help groups to a world-wide network engaged in protecting civil rights and facilitation of efforts to provide housing, employment, public education, research, socialisation and advocacy programmes. The term 'psychiatric survivor' is used by individuals who identify themselves as having experienced human rights violations in the mental health system. WNUSP was established to further promote this movement and to respond on an international level to the oppression survivors continue to experience.

After initially meeting, in 1991, as the World Federation of Psychiatric Users at the biennial World Federation for Mental Health conference in Mexico, the network's name was changed to WNUSP in 1997. In 2000, the WNUSP Secretariat was established in Odense, Denmark. In 2001, the network held its First General Assembly in Vancouver, British Columbia, with 34 groups from twelve countries represented, and adopted its governing statutes.

In 2004, the network held its Second General Assembly in Vejle, Denmark with 150 participants from 50 countries attending.

In 2007 WNUSP received ECOSOC special consultative status at the United Nations.

In 2009, WNUSP held its third General Assembly in Kampala, Uganda. It adopted the Kampala Declaration stating its positions on the CRPD, which was later expanded into a longer version adopted by consensus of the board and the participants in the Kampala GA.[11]

ENUSP

The European Network of (Ex)Users and Survivors of Psychiatry is the most important European NGO of (ex-)users and survivors. Forty-two representatives from 16 European countries met at a conference to found it in the Netherlands in October 1991. Every 2 years, delegates from the ENUSP members in more than 40 European countries meet at a conference where the policies for the coming period are set out. All delegates are (ex-)users and survivors of psychiatry. ENUSP is officially involved in consultations on mental health plans and policies of the European Union, World Health Organization and other important bodies. Initial funding came from the Dutch government and from the European Commission but has since proved more difficult to secure. ENUSP is involved in commenting and debating declarations, position papers, policy guidelines of the EU, UN, WHO and other important bodies.[12]

External links

- WNUSP [13] - World Network of Users and Survivors of Psychiatry (WNUSP main web site)
- ENUSP [14] - European Network of (ex-)Users and Survivors of Psychiatry (ENUSP)
  - ENUSP.org [15] - 'ENUSP Press Release' (July 20, 2004)
- Inclusion-International.org [16] - International Disability Alliance
- Moosa-Salie.oism.info [17] - 'Launching Conference of the Pan African Network of Users and Survivors of Psychiatry (PANUSP)', Moosa Salie (WNUSP board co-chair)
- CHRUSP [18] - Center for the Human Rights of Users and Survivors of Psychiatry
- UN.org [2] - 'Contribution by World Network of Users and Survivors of Psychiatry', United Nations Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities (January, 2004)

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Icarus Project

The Icarus Project http://theicarusproject.net is a mental health movement characterized by the view that many phenomena commonly labeled as mental illness should actually be regarded as "dangerous gifts". The name is derived from the Icarus mythology and is metaphorically used to convey that these experiences can lead to "potential[ly] flying dangerously close to the sun." [1]

History

In 2002, Sascha Altman DuBrul wrote an article published by the San Francisco Bay Guardian entitled *Bipolar World*, relating to his personal experiences being diagnosed with bipolar disorder. Among the dozens of e-mails and other correspondence that he received after this publication was a letter from Ashley McNamara, an artist and writer who identified strongly with his experiences.[1] The two founders, DuBrul and McNamara, corresponded for a few weeks before finally meeting in person and deciding to start The Icarus Project. The first step, they decided, was creating a website where people who identified with "bipolar and other 'mental illness' [could] find real community and contribute to it."[2]

Mission

The Icarus Project's stated aims are to provide a viable alternative to current methods of approaching and treating mental illnesses. The national Icarus Collective staff is set up to support local groups instead of creating the smaller organizations themselves. The responsibilities of the local group are to gather people locally for support, education, activism, and access to alternatives.[3] The Project advocates self-determination and caution when approaching psychiatric care. It encourages harm reduction, alternatives to the medical model, and self-determination in treatment and diagnosis.

Structure/Funding

The Icarus Project is currently under the fiscal sponsorship of FJC, a non-profit 501(c)3 umbrella organization arm of an investment firm, based in New York City. The Icarus Project currently gets the bulk of its money from foundation grants, but also has many individual donors.. There has been considerable talk for many years of alternate funding structures, and efforts are currently underway to explore 501c3 and cooperative structures. The Icarus Project maintains a financial transparency page [4] The Icarus Project does not accept funding from pharmaceutical companies.[3]

The Icarus Project network

A full listing of local Icarus affiliated groups can be found on The Icarus Project's website.[5]

Some of the local groups currently meet in

- Anchorage, Alaska
- Asheville, North Carolina
- Chicago, Illinois
- Minneapolis, Minnesota
- Madison, Wisconsin
- New York City, New York
- Northhampton, Massachusetts (Freedom Center)
- Philadelphia, Pennsylvania
- Portland, Oregon
- San Francisco (Bay Area), California
- Columbus, Ohio
- Gainesville, Florida

Publications

Navigating the Space Between Brilliance and Madness; A Reader and Roadmap of Bipolar Worlds, was self-published by the Icarus Project in March 2004. The book is currently in its 6th printing.[6]

In July, 2006, The Icarus Project released the first draft of *Friends Make the Best Medicine: A Guide to Creating Community Mental Health Support Networks*.[7]

In 2008 The Icarus Project released *Through the Labyrinth; A Harm Reduction Guide to Coming Off Psychiatric Drugs*, and in 2009 this publication was translated into Spanish and German and made available for free download on the The Icarus Project website.[8]

Media Mentions

The Icarus Project has been mentioned in the New York Times,[9] by Frontline 20/20, and many local media outlets.[10] [11]

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- MindFreedom Radio - Sascha DuBrul of Icarus Project Next Guest on MF Radio (http://www.mindfreedom.org/campaign/media/mfradio/show/sascha-debrul-guest)

List of psychiatric consumer/survivor/ex-patient related topics

This page aims to list articles related to psychiatric consumer/survivor/ex-patient movement. This list is not necessarily complete or up to date; if you see an article that should be here but is not (or one that should not be here but is), please update the page accordingly.

Recent changes: Psychiatric consumer/survivor/ex-patient topics

General

- Psychiatric consumer/survivor/ex-patient movement
- Disability rights movement
- Human rights
- Insanity
- Mental health consumer
- Mental Patient
- Psychiatric survivors movement
- Self-help groups for mental health

User/survivor/ex-patient/peer support organisations

- **United Kingdom**
  - **England**
    - **19th century**
    - Alleged Lunatics' Friend Society
- **Germany**
  - Socialist Patients' Collective
- **International**
  - GROW
  - MindFreedom International
  - World Network of Users and Survivors of Psychiatry
- **United States of America**
  - Committee for Truth in Psychiatry
  - Hearing Voices Movement
  - Hearing Voices Network
  - Icarus Project
  - Insane Liberation Front
  - Mad Pride
  - Mental Patients Liberation Front
  - MindFreedom International
  - National Empowerment Center
  - Network Against Psychiatric Assault

People

- **18th century**
  - Samuel Bruckshaw
- **Early 20th century**
  - Clifford Whittingham Beers
- **Late 20th century to the present**
  - Linda Andre
  - Ted Chabasinski
  - Judi Chamberlin
  - Lyn Duff
  - Leonard Roy Frank
  - Kate Millett
  - Elizabeth Packard

Concepts and Alternatives

- Democratic Psychiatry
- Independent living
- Kingsley Hall
- Medicalization
- Mentalism (discrimination)
- Open Dialogue
- Peer support specialist
- Philadelphia Association
- Recovery model
- Self-advocacy
- Self-help groups
- Therapeutic community
- Villa 21

Supporters and fellow travellers

- Richard Bentall
- Patch Adams
- Robert Whittaker
- The Radical Therapist

The mental patient

- Mental patient : currently redirects to Mental disorder
- Lunatic
- **Health and mortality**
  - Physical health in schizophrenia
  - Schizophrenia and smoking
- **Coercion**
  - Forced feeding
  - Involuntary treatment
  - Involuntary commitment
  - Outpatient commitment

Services

- Services for mental disorders
- Care programme approach (UK)

Public Bodies

- **United Kingdom**
  - **England and Wales**
    - Commissioners in Lunacy
- **United States of America**
  - **Federal Bodies**

- National Council on Disability
- New Freedom Commission on Mental Health

Legal frameworks

- Diminished responsibility
- Forensic Psychiatry
- Informed consent
- Insanity
- Insanity defence
- Involuntary commitment
- Involuntary treatment
- Irresistible impulse
- M'Naghten Rules
- Macdonald triad
- Mens rea
- Mental health law
- Obligatory Dangerousness Criterion
- Outpatient commitment
- Psychiatric advance directive
- Sanity
- Therapeutic jurisprudence
- Ulysses pact
- Voluntary commitment

Australia

- Justices examination order
- Mental Health Review Tribunal of New South Wales

Ireland

- **1814-1922**
  - Criminal Lunatics (Ireland) Act 1838
- **From 1922-present**
  - Mental Health Act 2001

Italy

- Basaglia Law
- Law 180

U.K.

- Care in the Community
- Criminal Lunatics Act 1800
- Idiots Act 1886
- Fixated Threat Assessment Centre
- Lunacy Act 1845
- Lunacy (Vacating of Seats) Act 1886

- Madhouses Act 1774
- Place of safety

England and Wales

- Approved Mental Health Professional
- Diminished responsibility in English law
- Mental Capacity Act 2005
- Mental Health Act 1983
- Mental Health Act 2007
- Mental Health Review Tribunal (England and Wales)
- Mental Treatment Act 1930
- Nearest relative

Scotland

- Adults with Incapacity (Scotland) Act 2000
- Forensic Network
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Health (Public Safety and Appeals) (Scotland) Act 1999

U.S.A.

- Adjudicative competence
- Civil confinement
- Civil Rights of Institutionalized Persons Act
- Competence (law)
- Duty to protect
- Duty to warn
- Forensic Mental Health Association of California
- List of criminal competencies
- Mental health courts
- PsychRights
- Ultimate issue (law)
  - **Californian mental health law**
    - 5150 (Involuntary psychiatric hold)
  - **Florida mental health law**
    - Florida Mental Health Act: **the Baker Act**

Anti-psychiatry

People

- Franco Basaglia
- David Cooper (psychiatrist)
- Michel Foucault
- R.D. Laing
- Loren Mosher
- Thomas Szasz

Publications

- Against Therapy
- Anti-Oedipus
- Liberation by Oppression: A Comparative Study of Slavery and Psychiatry
- Madness and Civilization

Organisations

- American Association for the Abolition of Involuntary Mental Hospitalization

Pharmaceutical industry

- Allen Jones (whistleblower)
- Pharmaceutical industry
- Anatomy of an Epidemic

Psychiatry

General

- Mental disorder
  - History of mental disorder
- Mental Health
- Psychiatry

Doctor-patient relationship

- Therapeutic relationship

Nosological system

- Diagnostic and statistical manual of mental disorders
- International Statistical Classification of Diseases and Related Health Problems

Individual diagnostic categories

- ADHD
- Bipolar disorder
- Mania
- Schizophrenia
  - History of schizophrenia

- Dementia praecox

Instruments

- Mental status examination

Diagnostic practices

- Rosenhan experiment

Treatment

- Treatment of mental disorders

Chemical treatment

- Antidepressants
- Antipsychotic
- Chemical imbalance theory
- Mood stabilizers
- Psychiatric medication
- List of psychiatric medications
- List of psychiatric medications by condition treated

Physical treatment

Electroconvulsive therapy

- Electroconvulsive therapy
  - History of electroconvulsive therapy in the United Kingdom

Insulin coma therapy

- Insulin shock therapy (defunct)

Psychosurgery

- Psychosurgery
  - Lobotomy (defunct)
  - **Lobotormy instruments**
    - Leucotome
    - Orbitoclast
  - **Lobotomy patients**
    - Howard Dully

Fever therapy

- Pyrotherapy (defunct)

Psychological treatment

- Psychotherapy
- List of psychotherapies

Biomedical model

- Biopsychiatry controversy

Psychiatric Institutions

General

- Asylums (book)
- Psychiatric hospital
  - History of psychiatric institutions
- Deinstitutionalization
- Psychiatric reform in Italy
- Titicut Follies

Australian psychiatric institutions

- List of Australian mental asylums

Psychiatrists

General

- List of psychiatrists

Academic psychiatrists by country

- Ireland
  - Patricia Casey

Eugenics

- Feeble-minded

Involuntary commitment

Involuntary commitment or **civil commitment** is a legal process through which an individual with severe mental illness is provided treatment in a hospital (inpatient) or in the community (outpatient) against his or her will.

Criteria for civil commitment are established by law, which varies between nations and, in the U.S., from state to state. Commitment proceedings often follow a period of emergency hospitalization during which an individual with acute psychiatric symptoms is confined for a relatively short duration (e.g. 72 hours) in a treatment facility for evaluation and stabilization by mental health professionals - who may then determine whether further civil commitment is appropriate or necessary. If civil commitment proceedings follow, the evaluation is presented in a formal court hearing where testimony and other evidence may also be submitted . The subject of the hearing typically is entitled to legal counsel and may challenge a commitment order through habeas corpus rules.

Historically, until the first third of the twentieth century or later in most jurisdictions, all committals to public psychiatric facilities and most committals to private ones were involuntary. Since then, there have been alternating trends towards the abolition or substantial reduction of involuntary commitment[1] , a trend known as "deinstitutionalization."

Purpose

In most jurisdictions, involuntary commitment is specifically applied to individuals found to be suffering from a mental illness that impairs their reasoning ability to such an extent that the laws, state or courts find that decisions must or should be made for them under a legal framework. (In some jurisdictions this is a distinct proceeding from being "found incompetent.")

Involuntary commitment is used to some degree for each of the following headings although different jurisdictions have different criteria. Some jurisdictions limit court-ordered treatment to individuals who meet statutory criteria for presenting a danger "to self or others." Other jurisdictions have criteria that are broader.

First aid

Training is gradually becoming available in mental health first aid to equip community members such as teachers, school administrators, police officers, and medical workers in recognizing and managing situations where evaluations of behavior might be appropriate.[2] The extension of first aid training to cover mental health problems and crises is a quite recent development.[3] [4] A mental health first aid training course was developed in Australia in 2001 with no demonstrated efficacy. This form of training has now spread to a number of other countries (Canada, Finland, Hong Kong, Ireland, Singapore, Scotland, England, Wales, United States).[5] Mental health triage may be used in an emergency room to evaluate the degree of risk and prioritize treatment.

Observation

Observation is sometimes used to determine if a person warrants involuntary commitment. It is not always clear on a relatively brief examination whether a person is psychotic or otherwise warrants commitment. In most cases the issue of commitment under these circumstances has been proven to be unsound.

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The purpose of this examination is often lost and it brings with it a
plethora of legal issues. The use of this program is often a part of
political oppression or fraud in which those individuals are held and
forced to prove their sanity making use of the same services in which
they are enrolled by force. The requirement for this program of forced
extensive screening under detainment is a medical personnel which can
include any untrained or inexperienced person at a very low standard.
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These individuals have no ability nor experience with which to make a
decision of forced detainment and the human rights abuses under this
style of detainment are clear.
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The abuses which are recorded in this are evaluation while medicated and the use of force or threat of force. Access to the funds and assets of the individual and the rights of their children or dependents. The use of these programs creates an opportunity in reverse oness on the individual to allow the Police and or their partners to access the funds of the individual through corrupt partnerships with those who would false accuse. While an innocent person is undergoing torturous interference by use of these programs of abuse the funds and legal rights of that person are accessed and a services fee paid to the offenders or reporters. In fact political actions such as the opening of Alberta Hospital in Edmonton as an action by the Alberta Union of Provincial Employees acting against an identifiable group of patients is a hate crime under our law. That is those elderly patients without family members who were able to prevent their detention. They were moved to Alberta Hospital while medicated often after miner surgeries or procedures in which they normally would not be considered to have any mental health issue. They had often been provided with both pain medications and combinations of psychiatric medications producing symptoms. The abuse of these elders became a matter of The Elders Advocates of Alberta Association.

These individuals were politically silenced as whistle blowers and the abuse of their personal property and of their person was swept under the rug as the matters advanced. This is considered a human rights violations in itself and was accomplished by MLA Heather Forsythe's intervention on their behalf. The Matter was the subject of a study by Nurse administrator and University of Alberta Professor Dr.Nancy Wilson. A nurses committee advocate for the Hospitals Internal Review Committee and employed by Alberta health services for that purpose. Their assets were in some cases taken or were at risk during their forced confinement in a wave of politicized assaults by the workers of the Alberta Union Of Provincial Employees efforts to keep the Hospital from being closed by the Alberta Government. Since that time additional forced evaluations have been accomplished against a series of person who are through these programs removed of their assets or their political voice such as MLA Dr. Raj Sherman who was silenced politically via a accusation of mania by Dr. PJ White formerly of Dublin. Dr White has been employed by the University of Alberta Hospital and was instrumental in this service preventing doctors from accounting for their actions against the interests of their patients as an Alberta Health services employee.

All of their rights to even access their own funding or bank accounts. The laws surrounding habeous corpus do not apply in Alberta. The privacy laws surrounding the issue of medical service often prevent family members from accessing information after a disappearance into the hospital system. The refusal of nurses to identify themselves or wear a numbered badge is also a matter discussed by patients. Patients are held incommunicado during the referral and early process. The RCMP have sought and retained warrants against several elders and have removed them to a facility. They are accompanying the members of their health services teams. This is often done in contravention of the elders right to freedom of association as well. The victims of this abuse of power are under Canadian law unable to proceed. No legal access to services is permitted in countries with a public health care system. No legal service is available until the date of a hearing via the Mental Health Advocates Office or the Legal Aid service. The use of funds for provision of evidence in the reverse ones created by these attacks on citizens is against human rights legislation but the individuals administering the assaults are public employees. Independent assessments cost an average of fifteen thousand dollars.

Federal courts in Alberta can be accessed but only if and when each of the other techniques to stop this abuse are completed. If no hearing is permitted at the earliest date the matter is moot in all but health care records that a detainment has taken place. The use of these assaults as retaliation fro complaints against Police of any member in the Alberta Response Model partnership is done very often. The assaults are generally also leveled against the poor, women, or elders and First nations or in some cases business partners. The detainment time is one week prior to hearing by a committee. In most cases a false detainment is released prior to the hearing date preventing their access to the hearing process. The issue still has created a falsified detainment which must be disproven at a later date by

the victim. The assaults which take place during these exams can include forced medicating in order to create symptoms. The key intentional misuse of medications is drug combinations with the intention of creating agitation. This permits physical abuse.

This violations of civil and property rights is moving forward in each country where the civil liberties are under attack and oppressive civil rights violations are done in order to prevent legitimate protests (demands for Police services/ demands for investigation of a criminal activity/ fraud theft or dishonest provision of a public service human rights complaint or appearance before or at a town hall meeting) Secondly. complaints or legal actions begun by an individual by torturous interference (divorce and custody proceedings/ civil litigation / Police complaints/ appearance before a tribunal/ children's services complaints/ quasi-judicial hearings).

The issue of corruption by the creation of complexity and hate crimes against identifiable groups is often involved in these procedures. Corruption by removal of transparency and accountability of both judicial and early processes is accomplished by this already known to be false type of service. The United Nations has condemned this practice in developing countries but it has been recently installed in these developed countries. Investigations into market manipulation and bribery (Healthpro/GHX) has not yet been completed in Canada but it is a matter of world wide knowledge that several large pharmaceutical companies have already been convicted or have paid fines in specific instances. Many more are under investigation through the Department of Justice and in Europe. The making of a mental health claim against any individual can often be the result of any of these types of issues. The abuse of patients under this act and of their civil rights creates a SOVIET RUSSIA style abuse of the individual which was discredited through the Royal College of Psychiatrists in London in the later 1980s.

Containment of danger

A common reason given for involuntary commitment is to prevent danger to the individual or society. People with suicidal thoughts may act on these thoughts and harm or kill themselves. People with psychoses are occasionally driven by their delusions or hallucinations to harm themselves or others. People with certain types of personality disorders can occasionally present a danger to themselves or others.

This concern has found expression in the standards for involuntary commitment in every U.S. state and in other countries as the "danger to self or others" standard, sometimes supplemented by the requirement that the danger be "imminent." In some jurisdictions, "danger to self or others" standard has been broadened in recent years to include need-for-treatment criteria such as "gravely disabled."

In Arizona, the government can mandate in-patient treatment for anyone determined to be "persistently or acutely disabled." Virtually anyone who suspects that someone has mental problems and needs help could file an application to a state-licensed healthcare agency for a court-ordered evaluation.

In Connecticut, someone can be committed only if he or she has "psychiatric disabilities and is dangerous to himself or herself or others or gravely disabled". "Gravely disabled" has usually been interpreted to mean that the person is unable on his own to obtain adequate food, shelter and clothing.

In Iowa, any "interested person" may begin commitment proceedings by submitting a written statement to the court. If the court finds that the respondent is "seriously mentally impaired," he or she will be placed in a psychiatric hospital for further evaluation and possibly treatment. Further hearings are required at specific intervals for as long as the person is being involuntarily held.

The Michigan Mental Health Code provides that a person "whose judgment is so impaired that he or she is unable to understand his or her need for treatment and whose continued behavior as the result of this mental illness can reasonably be expected, on the basis of competent clinical opinion, to result in significant physical harm to himself or herself or others" may be subjected to involuntary commitment, a provision paralleled in the laws of many other jurisdictions. These types of provisions have been criticized as a sort of "heads I win, tails you lose". Understanding one's "need for treatment" would cause one to agree to voluntary commitment, but the Bazelon Center has said that this "lack of insight" is "often no more than disagreement with the treating professional"[6] and this disagreement

might form part of the evidence to support one's involuntary commitment.

In Nevada, prior to confining someone, the state must demonstrate that the person "is mentally ill and, because of that illness, is likely to harm himself or others if allowed his liberty."

In Oregon, the standard that the allegedly mentally ill person "Peter [h]as been committed and hospitalized twice in the last three years, is showing symptoms or behavior similar to those that preceded and led to a prior hospitalization and, unless treated, will continue, to a reasonable medical probability, to deteriorate to become a danger to self or others or unable to provide for basic needs" may be substituted for the danger to self or others standard.

In Utah, the standard is that "the proposed patient has a mental illness which poses a substantial danger".[7] "Substantial danger" means the person, by his or her behavior, due to mental illness: (a) is at serious risk to: (i) commit suicide, (ii) inflict serious bodily injury on himself or herself; or (iii) because of his or her actions or inaction, suffer serious bodily injury because he or she is incapable of providing the basic necessities of life, such as food, clothing, and shelter; (b) is at serious risk to cause or attempt to cause serious bodily injury; or (c) has inflicted or attempted to inflict serious bodily injury on another.[8]

Deinstitutionalization

Starting in the 1960s, there has been a worldwide trend toward moving psychiatric patients from hospital settings to less restricting settings in the community, a shift known as "deinstitutionalization." Because the shift typically was not accompanied by a commensurate development of community-based services, critics say that deinstitutionalization has led to large numbers of people who would once have been inpatients being incarcerated in jails and prisons or becoming homeless when outpatient services are not available or they choose not adhere to treatment outside the hospital. In some jurisdictions, laws authorizing court-ordered outpatient treatment have been passed in an effort to compel individuals with chronic, untreated severe mental illness to accept treatment while living outside the hospital.

Around the world

United Nations

United Nations General Assembly (resolution 46/119 of 1991), "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" is a non-binding resolution advocating certain broadly-drawn procedures for the carrying out of involuntary commitment. These principles have been used in many countries where local laws have been revised or new ones implemented. The UN runs programs in some countries to assist in this process.

Australia

In Australia, court hearings are not required for involuntary commitment. Mental health law is constitutionally under the state powers. Each state thus has different laws, many of which have been updated in recent years.

Referral for service

The usual requirement is that a police officer or a physician determine that a person requires a psychiatric examination, usually through a psychiatric hospital. If the person is detained in the hospital, they usually must be seen by an authorized psychiatrist within a set period of time. In some states, after a further set period or at the request of the person or their representative, a tribunal hearing is held to determine whether the person should continue to be detained. In states where tribunals are not instituted, there is another form of appeal.

Some Australian states require that the person is a danger to the society or themselves; other states only require that the person be suffering from a mental illness that requires treatment. The Victorian Mental Health Act (1986)

specifies in part that:

> "(1) A person may be admitted to and detained in an approved mental health service as an involuntary patient in accordance with the procedures specified in this Act only if—
>
> (a) the person appears to be mentally ill; and
>
> (b) the person's mental illness requires immediate treatment and that treatment can be obtained by admission to and detention in an approved mental health service; and
>
> (c) because of the person's mental illness, the person should be admitted and detained for treatment as an involuntary patient for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
>
> (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
>
> (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action.

There are additional qualifications and restrictions but the effect of these provisions is that people who are assessed by doctors as being in need of treatment may be admitted involuntarily without the need of demonstrating a risk of danger. This then overcomes the pressure described above to exaggerate issues of violence to obtain an admission.

Treatment

In general, once the person is under involuntary commitment, treatment may be instituted without further requirements. Some treatments such as electroconvulsive therapy (ECT) often require further procedures to comply with the law before they may be administered involuntarily.

Community treatment orders can be used in the first instance or after a period of admission to hospital as a voluntary or involuntary patient. With the trend towards deinstitutionalization this is becoming increasingly frequent and hospital admission is restricted to people with severe mental illnesses.

Europe

Germany

In Germany there is a growing tendency to use the law on legal guardianship, instead of mental health law, to justify involuntary commitment or treatment. The ward's legal guardian decides that he/she must go into mental hospital for treatment, and the police will act on this decision. This is simpler for the government and family members than the formal process for commitment under mental health laws.

In German criminal law a person that was convicted of certain crimes can also be sentenced to be kept in preventive detention; see article on preventive detention.

Netherlands

In Dutch criminal law a convict can be sentenced to involuntary psychiatric treatment in a special institute called a TBS-clinic. TBS is an abbreviation for "Ter Beschikkingstelling," literally meaning "being placed at disposal." Legally, such a sentence is not regarded as punishment like a prison sentence, but as a special measure. In the Netherlands, it is common practice to sentence criminals to a combination of a normal prison term and TBS. The convict will then be placed in a TBS-clinic after serving time in prison (usually two-thirds of the original prison sentence, although this practice is under discussion).

According to Dutch law, meeting three conditions is required for a convict to be sentenced to TBS. These conditions are:

- the crime committed must have been directly related to a psychiatric disorder,
- recidivism must be likely, and

- the convict can not, or only partially, be held accountable for the crime.

To determine if these conditions are met, the suspect is observed in a forensic psychiatric detention center, the Pieter Baan Centre.[9] Neither the prosecution or the defense can effectively challenge the Pieter Baan Centre's report, since it is the only institution that can conduct such investigations. Fatal mistakes have occurred, for instance, when a child molester regarded by the Pieter Baan Center as "not dangerous" killed a child upon release. The conclusions in the centre's report are not binding, the judge can decide to ignore, or only partially accept them.

Every convict detained in a TBS-clinic may get temporary leave, after serving a certain time or after some progress in treatment. This is regarded as an essential part of treatment, as the convict will be gradually re-entering society this way. At first the convict will be escorted by a therapist, and will be allowed outside the clinic for only a few hours. After evaluation, time and freedom of movement will be expanded until the convict can move freely outside the clinic without escort (usually for one day at a time). At that time, the convict will find work or follow an education. Generally, the convict is released after being in this situation for one or two years without incident.

The time to be served in TBS can be indefinite, and it may be used as a form of preventive detention. Evaluation by the court will occur every one or two years. During these evaluations the court determines if any progress is made in treatment of the convict, and if it will be safe to release the convict into society. In general, the court will follow conclusions made by the TBS-clinic.

Average time served in a TBS-clinic by a convict is slightly over eight years.

Dutch TBS-clinics

In the Netherlands there are currently 12 institutions regarded as TBS-clinics:

- AMC de Meren/Arkin, Amsterdam
- Dr. Henri van der Hoevenstichting, Utrecht
- Dr. S. van Mesdagkliniek, Groningen
- Hoeve Boschoord, Boschoord
- FPC Veldzicht, Balkbrug
- Pompestichting, Nijmegen
- Oostvaarderskliniek, Almere
- De Kijvelanden/FPC Tweelanden, Poortugaal
- FPC Oldenkotte, Rekken
- FPC De Rooyse Wissel, Venray
- GGz Drenthe, Assen
- GGz Eindhoven/De Woenselse Poort, Eindhoven

These institutions combined currently are holding about 1840 convicts.

By the end of the 20th century, it was concluded that some convicts could not be treated and therefore could not be safely released into society. For these convicts, TBS-clinics formed special wards, called "long-stay wards". Transfer to such a ward means that the convict will no longer be actively treated, but merely detained. This is regarded as more cost-effective. In general, the convicts in these wards will be incarcerated for the rest of their lives, although their detention is eligible for regular review by the court.

Controversy

Since the latter half of the 1990s considerable controversy has grown among Dutch society, about the TBS-system. This controversy has two main reasons. The first reason is the media increasingly reported cases of convicts committing crimes while still in, or after, treatment in a TBS-clinic.

Some examples of these cases are:

- During 1992, a truck driver was convicted for raping and murdering three young children. Eight years earlier he was released from a TBS-clinic after being treated for child molestation.
- A convict, about to be released from a TBS-clinic, murdered the owner of a garage in 1996 while under the influence of drugs.
- An ex-convict, treated in a TBS-clinic, murdered two women in 1994 and 1997.
- A convict, still treated by a TBS-clinic, randomly killed a man in the city of Groningen in 1999.
- Between 2000 and 2004, an ex-convict tortured several animals and killed a homeless man. He had been treated in a TBS-clinic.
- In 2002 an ex-convict was sentenced for triple murder. He also was released earlier.
- In 2005 a convict escaped his escort during leave. He was arrested several days later after killing a man.

Political and social commotion increased, and debate started about the effectiveness of the TBS-system and if convicts should be granted leave from TBS-clinics. Especially right-wing politicians pleaded the TBS-system should be discarded altogether. Numerous articles in newspapers, magazines, television and radio programs and a revealing book written by an ex-convict (which for the first time openly questioned the effectiveness of the TBS-system) boosted discussion. Prior to that, any problems had been mostly denied by TBS-clinics themselves.

The center of attention became a highly renowned TBS-clinic, Dr. S. Van Mesdagkliniek in the city of Groningen. Events that took place there, by the end of the 1990s and the first years of the 21st century, initiated the second reason for controversy. Concern rose about signs of unprofessional behavior by staff working in TBS-clinics, and the Dr. S. Van Mesdagkliniek proved to be among the most infamous for these problems. This TBS-clinic has been plagued with unprofessional and even criminal acts by its staff since 1999. During that year, the Dr. S. Van Mesdagkliniek came under investigation by Dutch police after rumors about female staffmembers committing sexual offenses against convicts.[10] Five such cases were discovered during the investigation, and also numerous cases of drug-abuse, smuggling and trading of contraband such as: alcohol, mobile phones, pornographic material and hard drugs.[11] It became apparent that staff members did not have the required education, had not been informed about rules and regulations, disregarded legal procedures, gave false testimonies, tampered with evidence, uttered false accusations against convicts, and intimidated colleagues.[10] At least one psychiatrist, employed as such by the Dr. S. Van Mesdagkliniek, proved to be not qualified,[12] and treatment of convicts was in many cases simply non-existent.[13] These problems had been known for long by the management, but were always kept hidden. After public outcry about this situation, management was replaced[14] and all of the nine (at the time) TBS-clinics in the Netherlands were subjected to investigation. Six of them proved to be below the required legal standards.[15] However, problems for the expensive Dutch TBS-system did not end there. In spite of many measures taken by the government, convicts still were released without proper treatment. As a consequence, numerous crimes were committed by convicts that were regarded as treated by TBS-clinics. Also, sexual offenses against convicts by staff members and smuggling of contraband did not cease in several TBS-clinics.[16] In 2006, the Dutch government formed a committee to investigate the TBS-system. Some, however not the worst, problems were recognized and measures were proclaimed. One of the known actual results is that fewer convicts escape during temporary release.

Controversy regarding the, often praised, Dutch TBS-system does not cease to exist. In 2005, a staff member working in the Dr. S. Van Mesdagkliniek was caught while smuggling liquor to convicts suffering from alcohol-related problems.[17] In 2007, a female staff member committed sexual offenses against a convict, and had smuggled contraband.[18] She was sentenced to three months in prison in 2009. That same year, investigation proved convicts still had ample access to illicit drugs[19] and four inmates from the Dr. S. Van Mesdagkliniek were arrested

for possession of child pornography.[20] Many crimes committed by released convicts treated in TBS-clinics, escape statistics because they occurred in other countries, or because they differ from the crime the convict was originally convicted for (many convicts released from TBS-clinics find their way in illegal drug trade and related crimes). Because there seems to be no acceptable alternative available, political support for the much plagued TBS-system remains, in spite of controversy.

United Kingdom

In the United Kingdom, the process known in the United States as involuntary commitment is informally known as "sectioning," after the various sections of the Mental Health Act 1983 (covering England and Wales), the Mental Health (Northern Ireland) Order 1986 and the Mental Health (Care and Treatment) (Scotland) Act 2003 that provide its legal basis.

In England and Wales, Approved Mental Health Professionals have a lead role in coordinating Mental Health Act assessments, which they conduct in cooperation with usually two medical practitioners. Under the Mental Health Act, detention is determined by utility and purpose. Ward-based patients can be detained for periods of up to 3 days while further assessments are arranged. In the community, mentally ill individuals may be detained under Section 2 for a period of assessment lasting up to 28 days or Section 3 for a period of treatment lasting up to 6 months. Separate sections deal with mentally ill offenders. In all cases detention needs to be justified on the basis that the person is mentally ill and constitutes a risk of deterioration and/or of risk to themselves or others.

Under the amended Mental Health Act 2007, which came into force in November 2008, to be detained under Section 3 for treatment, treatment that is appropriate must be available in place of detention. Supervised Community Treatment means people can continue to be detained and discharged on extended conditional leave to the community in accordance with a Community Treatment Order.

United States

Involuntary commitment is governed by state law and procedures vary from state to state. In some jurisdictions, laws regarding the commitment of juveniles may vary, with what is the *de facto* involuntary commitment of a juvenile perhaps *de jure* defined as "voluntary" if his parents agree, though he may still have a right to protest and attempt to get released. However, there is a body of case law governing the civil commitment of individuals under the Fourteenth Amendment through U.S. Supreme Court rulings beginning with *Addington v. Texas* in 1979 which set the bar for involuntary commitment for treatment by raising the burden of proof required to commit persons from the usual civil burden of proof of "preponderance of the evidence" to the higher standard of "clear and convincing" evidence.[21]

In 1975, the U.S. Supreme Court ruled that involuntary hospitalization and/or treatment violates an individual's civil rights in *O'Connor v. Donaldson*. This ruling forced individual states to change their statutes. For example, the individual must be exhibiting behavior that is a danger to himself or others in order to be held, the hold must be for evaluation only and a court order must be received for more than very short term treatment or hospitalization (typically no longer than 72 hours). This ruling has severely limited involuntary treatment and hospitalization in the U.S.[22] In the U.S. the specifics of the relevant statutes vary from state to state.[23]

This was the case in a famous United States Supreme Court decision in 1975, *O'Connor v. Donaldson*, when Kenneth Donaldson, a patient committed to Florida State Hospital, sued the hospital and staff for confining him for 15 years against his will. The decision means that it is unconstitutional to commit for treatment a person who is not imminently a danger to himself or others and is capable to a minimal degree of surviving on his own.[24]

An example of involuntary commitment procedures is the Baker Act used in Florida. Under this law, a person may be committed only if they present a danger to themselves or others. A police officer, doctor, nurse or licensed mental health professional may initiate an involuntary examination that lasts for up to 72 hours. Within this time, two psychiatrists may ask a judge to extend the commitment and order involuntary treatment. The Baker Act also

requires that all commitment orders be reviewed every six months in addition to ensuring certain rights to the committed including the right to contact outsiders. Also, a person under an involuntary commitment order has a right to counsel and a right to have the state provide a public defender if they cannot afford a lawyer. While the Florida law allows police to initiate the examination, it is the recommendations of two psychiatrists that guide the decisions of the court.

In the 1990s, involuntary commitment laws were extended under various state laws commonly recognized under the umbrella term SVP laws to hold some convicted sex offenders in psychiatric facilities after their prison terms were completed.[25] (This is generally referred to as "civil commitment," not "involuntary commitment," since involuntary commitment can be criminal or civil). This matter has been the subject of a number of cases before the Supreme Court, most notably *Kansas v. Hendricks* and *United States v. Comstock*[26] in regard to the Adam Walsh Child Protection and Safety Act, which does not require a conviction on sex offences, but only that the person be in federal custody and be deemed a "sexually dangerous person".[27]

Controversy about liberty

The impact of involuntary commitment on the right of self-determination has been a cause of concern.[28] Critics of involuntary commitment have advocated that "the due process protections... provided to criminal defendants" be extended to them.[29] The Libertarian Party opposes the practice in its platform. Thomas Szasz and the anti-psychiatry movement has also been prominent in challenging involuntary commitment.

A small number of individuals in the U.S. have opposed involuntary commitment in those cases in which the diagnosis forming the justification for the involuntary commitment rests, or the individuals say it rests, on the speech or writings of the person committed, saying that to deprive him of liberty based in whole or part on such speech and writings violates the First Amendment. Other individuals have opposed involuntary commitment on the bases that they claim (despite the amendment generally being held to apply only to criminal cases) it violates the Fifth Amendment in a number of ways, particularly its privilege against self-incrimination, as the psychiatrically examined individual may not be free to remain silent, and such silence may actually be used as "proof" of his "mental illness".[30]

Although patients involuntarily committed theoretically have a legal right to refuse treatment, refusal to take medications or participate in other treatments is noted by hospital staff. Court reviews usually are heavily weighted toward the hospital staff, with the patient input during such hearings minimal. In *Kansas v. Hendricks*, the US Supreme Court found that civil commitment is constitutional regardless of whether any treatment is provided.[31]

Alternatives

Accompanying deinstitutionalization was the development of laws expanding the power of courts to order people to take psychiatric medication on an outpatient basis. Though the practice had occasionally occurred earlier, outpatient commitment was used for many people who would otherwise have been involuntarily committed. The court orders often specified that a person who violated the court order and refused to take the medication would be subject to involuntary commitment.

Involuntary commitment is distinguished from conservatorship and guardianship. The intent of conservatorship or guardianship is to protect those not mentally able to handle their affairs from the effects of their bad decisions, particularly with respect to financial dealings.[32] For example, a conservatorship might be used to take control of the finances of a person with dementia, so that the person's assets and income are used to meet his basic needs, e.g., by paying rent and utility bills.

Advance psychiatric directives may have a bearing on involuntary commitment.[33] [34]

Individual state policies and procedures

US military

The service member can be held under the so-called Boxer law.

California

5150 (Involuntary psychiatric hold)

District of Columbia

In the District of Columbia any police officer, physician, or mental health professional can request to have you evaluated at St. Elizabeths Hospital, where to physician on duty can hold the patient for up to 48 hours. A family member or concerned citizen can also petition the Department of Mental Health, but the claim will be evaluated prior to the police acting upon it. In order to be held further, a request must be filed with the Department of Mental Health. However, this only can keep the patient involuntary admitted for up to seven days. For further commitment, the patient is evaluated by a mental health court, part of family court, for which the public defender assists the patient. This can result in the patient being held up to one year at which point the patient returns to mental health court.

This is different for someone first admitted to St. Elizabeths Hospital due to criminal charges. If found to not ever become competent for trial, they will be evaluated via a Jackson hearing for possible continued commitment to protect the public. If they have been found not guilty by reason of insanity, their dangerousness is evaluated at a Bolton Hearing.

Maryland

In Maryland any person may request, via a Emergency Evaluation form, that another individual be evaluated against their will by an emergency room physician for involuntary admission. If the judge concurs, he will direct the police to escort the individual to the hospital. A licensed physician, psychologist, social worker, or nurse practitioner who has examined the patient or a police officer may bring a potential patient to the emergency room for forced evaluation without approval from a judge. The patient may be kept in the hospital for up to thirty hours. If by then two physicians, or one physician and one psychologist then decide that the patient meets the Maryland criteria for an involuntary psychiatric admission, then he or she may be kept inpatient involuntarily for up to ten days. During this time an administrative law judge determines if criteria for longer civil commitment are met:

- a person has a mental illness;
- a person needs inpatient care or treatment;
- a person presents a danger to themselves or to others;
- a person are unable or unwilling to be admitted voluntarily;
- there is no available, less restrictive form of care or treatment to meet the person's needs.

Virginia

As of 2008 Virginia was one of only five states requiring imminent danger in order to involuntarily commit someone. But after the Virginia Tech Massacre, there was significant political consensus to strengthen the protections for society and allow more leniency in determining that an individual needed to be committed against their will.

- the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any
- the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future, (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs

"Imminent danger" was found to have too much variability throughout Virginia due to vagueness. The new standard is more specific in that substantial likelihood is more clear. However, in order to not limit potential detainee's freedoms too much it is characterized by the time limit of near future. "Recent acts" is legally established to require more than a mere recitation of past events.

Politically motivated abuses

At certain places and times, the practice of involuntary commitment has been used for the suppression of dissent, or in a punitive way.

In the former Soviet Union, psychiatric hospitals were used as prisons in order to isolate political prisoners from the rest of society. The official explanation was that no sane person would declaim against Soviet government and Communism. British playwright Tom Stoppard wrote *Every Good Boy Deserves Favour* about the relationship between a patient and his doctor in one of these hospitals.

The government of the United States employed involuntary commitment against a political dissenter once. In 1927 after the execution of Sacco and Vanzetti a demonstrator named Aurora D'Angelo was sent to a mental health facility for psychiatric evaluation after she participated in a rally in support of the anarchists.[35]

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External links

- National Mental Health Consumers' Self-Help Clearinghouse (http://www.mhselfhelp.org/)
- Victorian legislation and parliamentary documents (Australia) (http://www.dms.dpc.vic.gov.au/Domino/Web_Notes/LDMS/PubLawToday.nsf?OpenDatabase) - search using "mental health act" for the latest version of the act
- Mental health review board site (Victoria, Australia) (http://www.mhrb.vic.gov.au/) - the official site of the MHRB
- Keys to Commitment (A Guide for Family Members) by Robert J. Kaplan, J.D. (http://www.psychlaws.org/GeneralResources/article218.htm)
- State-by-state chart of U.S. commitment laws (http://www.psychlaws.org/LegalResources/statechart.htm)
- Psychiatric Imprisonment in Oregon (http://www.progress.org/fold265.htm)
- Rogers Law (http://www.psychlaws.org/LegalResources/CaseLaws/Case3.htm), concerning involuntary treatment/commitment in Massachusetts
- Comprehensive Journal Article Discussing Civil Commitment Law and Reform Regarding Sex Offenders (http://www.freewebs.com/adamshajnfeld)
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- National Alliance on Mental Illness (http://www.nami.org)
- Unjustified Psychiatric Commitment in the USA (http://www.antipsychiatry.org/unjustif.htm)

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Recovery model

The **Recovery Model** as it applies to mental health is an approach to mental disorder or substance dependence (and/or from being labeled in those terms) that emphasizes and supports each individual's potential for recovery. Recovery is seen within the model as a personal journey, that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning. Originating from the 12-Step Program of Alcoholics Anonymous and the Civil Rights Movement, the use of the concept in mental health emerged as deinstitutionalization resulted in more individuals living in the community. It gained impetus due to a perceived failure by services or wider society to adequately support social inclusion, and by studies demonstrating that many can recover. The Recovery Model has now been explicitly adopted as the guiding principle of the mental health systems of a number of countries and states. In many cases practical steps are being taken to base services on the recovery model, although there are a variety of obstacles and concerns raised. A number of standardized measures have been developed to assess aspects of recovery, although there is some variation between professionalized models and those originating in the psychiatric consumer/survivor/ex-patient movement.

History

In general medicine and psychiatry, recovery has long been used to refer to the end of a particular experience or episode of illness. The broader concept of "recovery" as a general philosophy and model was first popularized in regard to recovery from substance abuse/drug addiction, for example within twelve-step programs.

Application of recovery model concepts to psychiatric disorders is comparatively recent. By consensus the main impetus for the development came from the Consumer/Survivor/Ex-Patient Movement, a grassroots self-help and advocacy initiative, particularly within the United States during the late 1980s and early 1990s.[1] The professional literature, starting with the psychiatric rehabilitation movement in particular, began to incorporate the concept from the early 1990s in the United States, followed by New Zealand and more recently across nearly all countries within the "First World".[2] Similar approaches developed around the same time, without necessarily using the term recovery, in Italy, the Netherlands and the UK. Developments were fueled by a number of long term outcome studies of people with "major mental illnesses" in populations from virtually every continent, including landmark crossnational studies by the World Health Organization from the 1970s and 1990s, showing unexpectedly high rates of complete or partial recovery, with exact statistics varying by region and the criteria used. The cumulative impact of personal stories or testimony of recovery has also been a powerful force behind the development of recovery approaches and policies. A key issue became how service consumers could maintain the ownership and authenticity of recovery concepts while also supporting them in professional policy and practice.[3]

Increasingly, recovery became both a subject of mental health services research and a term emblematic of many of the goals of the Consumer/Survivor/Ex-Patient Movement. The concept of recovery was often defined and applied differently by consumers/survivors and professionals. Specific policy and clinical strategies were developed to implement recovery principles although key questions remained.[1] [4]

Concepts of recovery

Variation

There is some variation in how recovery is conceptualized within models. Professionalized clinical approaches tend to focus on improvement, in particular symptoms and functions, and on the role of treatments; consumer/survivor models tend to put more emphasis on peer support, empowerment and real-world personal experience.[5] [6] Recovery can be seen in terms of a social model of disability rather than a medical model of disability, and there may be differences in the degree of acceptance of diagnostic "labels" and treatments.[7] In psychiatric rehabilitation, the concept of recovery may be used to refer primarily to managing symptoms, reducing psychosocial disability, and improving role performance.[8] A review of the psychiatric literature suggested authors are rarely explicit about which concept they are employing; the reviewers called "rehabilitation" perspectives those which focused on life and meaning within the context of supposedly enduring disability, and "clinical" those which focused on observable remission of symptoms and restoration of functioning.[9]

A consensus statement on mental health recovery from US agencies, that involved some consumer input, defined recovery as a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. Ten fundamental components were elucidated, all assuming that the person continues to be a "consumer" or to have a "mental disability".[10] Conferences have been held on the importance of the "elusive" concept from the perspectives of consumers and psychiatrists.[11]

From the perspective of psychiatric rehabilitation services, a number of qualities of recovery have been suggested: recovery can occur without professional intervention; recovery requires people who believe in and stand by the person in recovery; a recovery vision is not a function of theories about the cause of psychiatric conditions; recovery can occur even if symptoms reoccur; recovery changes the frequency and duration of symptoms; recovery from the consequences of a psychiatric condition are often far more difficult than from the symptoms; recovery is not linear; recovery takes place as a series of small steps; recovery does not mean the person was never really psychiatrically disabled; recovery focuses on wellness not illness; recovery should focus on consumer choice.[12]

An approach to recovery known as the Tidal Model focuses on the continuous process of change inherent in all people, conveying the meaning of the experiences through water metaphors. Crisis is seen as involving opportunity, creativity is valued, and different domains are explored such as a person's sense of security, their personal narrative and their relationships. Initially developed by mental health nurses along with service users, Tidal is one of the few recovery models to have been researched rigorously. The Tidal Model is based on a discrete set of values (the Ten Commitments) and emphasizes the importance of each person's own voice, resourcefulness and wisdom. Since 1999, projects based on the Tidal Model have been established in the USA, Canada, Japan, New Zealand, Australia, Republic of Ireland, Scotland, Wales and England, where Tidal was originally developed. The Tidal Model has been used with a wide range of populations and is, arguably, the most widely used model of recovery.

For many, "recovery" has a political as well as personal implication—where to recover is to find meaning, to challenge prejudice (including diagnostic "labels" in some cases), perhaps to be a "bad" non-compliant patient and refuse to accept the indoctrination of the system, to reclaim a chosen life and place within society, and to validate the self.[13] Recovery can thus be viewed as one manifestation of empowerment. An empowerment model of recovery may emphasize that conditions are not necessarily permanent, that other people have recovered who can be role models and share experiences, and "symptoms" can be understood as expressions of distress related to emotions and other people. One such model from the US National Empowerment Center proposes a number of principles of how people recover and identifies the characteristics of people in recovery.[14]

Recovery may be seen as more of a philosophy or attitude than a specific model, requiring that "we regain personal power and a valued place in our communities. Sometimes we need services to support us to get there".[15]

Concerns

Some concerns have been raised about recovery models, including that recovery is an old concept, that a focus on recovery adds to the burden of already stretched providers, that recovery must involve cure, that recovery happens to very few people, that recovery represents an irresponsible fad, that recovery happens only after and as a result of active treatment, that recovery-oriented care can only be implemented through the addition of new resources, that recovery-oriented care is neither reimbursable nor evidence based, that recovery-oriented care devalues the role of professional intervention, and that recovery-oriented care increases providers' exposure to risk and liability.[16] There have also been tensions between recovery models and particular "evidence-based practice" models in the transformation of US mental health services based on the recommendations of the New Freedom Commission on Mental Health.[17]

The New Freedom Commission's emphasis on the recovery model has been interpreted by some critics as saying that everyone can fully recover through sheer will power, and therefore as giving false hope to those judged unable to recover and implicitly blaming those people judged unable to recover.[18] However, the critics have themselves been charged with undermining consumer rights and failing to recognize that the model is intended to support a person in their personal journey rather than expecting a given outcome, and that it relates to social and political support and empowerment as well as the individual.[19] Other criticisms include that the recovery model can be manipulated by officials to serve various political and financial interests including withdrawing services and pushing people out before they're ready; that it is becoming a new orthodoxy or bandwagon that neglects the empowerment aspects and structural problems of societies and primarily represents a middle class experience; that it hides the continued dominance of a medical model; and that it potentially increases social exclusion and marginalizes those who don't fit into a recovery narrative.[20]

Various stages of resistance to recovery approaches have been identified amongst staff in traditional services, starting with "Our people [first of all, they aren't 'your people'] are much sicker than yours. They won't be able to recover" and ending in "Our doctors will never agree to this"—but ways to harness the energy of resistance and use it to move forward have been proposed.[21] Staff training materials have been developed, for example by the National Empowerment Center.[22] [23] [24] [25]

Assessments

The data-collection systems and terminology used by services and funders are typically incompatible with recovery frameworks, so methods of adapting IT resources or paper forms have been developed.[26] It has also been pointed out that the Diagnostic and Statistical Manual of Mental Disorders (and to some extent any system of categorical classification of mental disorders) uses criteria, definitions and terminology that are inconsistent with a recovery model, and therefore does not promote a culture in which people can improve and recover. It has been suggested that the DSM-V requires greater sensitivity to cultural issues and gender; needs to recognize the need for others to change as well as just those singled out for a diagnosis of disorder; and that it needs to adopt a dimensional approach to assessment that better captures individuality and does not erroneously imply excess psychopathology or chronicity.[27]

A number of standardized questionnaires and assessments have been developed to try to assess aspects of the recovery journey. These include the Milestones of Recovery (MOR) Scale, Recovery Enhancing Environment (REE) measure, the Recovery Measurement Tool (RMT) and the Recovery Oriented System Indicators (ROSI) Measure,[28] the Stages of Recovery Instrument (STORI),[29] and numerous related instruments.[30]

Elements of recovery

It has been emphasized that each individual's journey to recovery is a deeply personal process, as well as being related to an individual's community and society.[7] A number of features have been proposed as often being core elements, however:

Hope

Finding and nurturing hope has been described as a key to recovery. It is said to include not just optimism but a sustainable belief in oneself and a willingness to persevere through uncertainty and setbacks. Hope may start at a certain turning point, or emerge gradually as a small and fragile feeling, and may fluctuate with despair. It is said to involve trusting, and risking disappointment, failure and further hurt.[7]

Secure base

Appropriate housing, a sufficient income, freedom from violence, and adequate access to health care have also been proposed.[31] It has been suggested that home is where recovery may begin but that housing services and the "continuum of care concept" have failed to flexibly involve people and build on their personal visions and strengths, instead "placing" and "reinstitutionalizing" them.[32]

Self

Recovery of a durable sense of self (if it had been lost or taken away) has been proposed as an important element. A research review suggested that people sometimes achieve this by "positive withdrawal"—regulating social involvement and negotiating public space in order to only move towards others in a way that feels safe yet meaningful; and nurturing personal psychological space that allows room for developing understanding and a broad sense of self, interests, spirituality, etc. It was suggested that the process is usually greatly facilitated by experiences of interpersonal acceptance, mutuality, and a sense of social belonging; and is often challenging in the face of the typical barrage of overt and covert negative messages that come from the broader social context.[33]

Supportive relationships

A common aspect of recovery is said to be the presence of others who believe in the person's potential to recover, and who stand by them. While mental health professionals can offer a particular limited kind of relationship and help foster hope, relationships with friends, family and the community are said to often be of wider and longer-term importance. Others who have experienced similar difficulties, who may be on a journey of recovery, can be of particular importance. Those who share the same values and outlooks more generally (not just in the area of mental health) may also be particularly important. It is said that one-way relationships based on being helped can actually be devaluing, and that reciprocal relationships and mutual support networks can be of more value to self-esteem and recovery.[7]

Empowerment and Inclusion

Empowerment and self-determination are said to be important to recovery, including having self control. This can mean developing the confidence for independent assertive decision making and help-seeking. Achieving social inclusion may require support and may require challenging stigma and prejudice about mental distress/disorder/difference. It may also require recovering unpracticed social skills or making up for gaps in work history.[7]

Coping strategies

The development of personal coping strategies (including self-management or self-help) is said to be an important element. This can involve making use of medication or psychotherapy if the consumer is fully informed and listened to, including about adverse effects and about which methods fit with the consumer's life and their journey of recovery. Developing coping and problem solving skills to manage individual traits and problem issues (which may or may not be seen as symptoms of mental disorder) may require a person becoming their own expert, in order to identify key stress points and possible crisis points, and to understand and develop personal ways of responding and coping.[7]

Being able to move on can mean having to cope with feelings of loss, which may include despair and anger. When an individual is ready, this can mean a process of grieving. It may require accepting past suffering and lost opportunities or lost time.[7]

Meaning

Developing a sense of meaning and overall purpose is said to be important for sustaining the recovery process. This may involve recovering or developing a social or work role. It may also involve renewing, finding or developing a guiding philosophy, religion, politics or culture.[7] From a postmodern perspective, this can be seen as developing a narrative.[34]

National policies and implementation

United States and Canada

The New Freedom Commission on Mental Health has proposed to transform the mental health system in the US by shifting the paradigm of care from traditional medical psychiatric treatment toward the concept of recovery, and the American Psychiatric Association has endorsed a recovery model from a psychiatric services perspective.[35] [36]

The US Department of Health and Human Services reports developing national and state initiatives to empower consumers and support recovery, with specific committees planning to launch nationwide pro-recovery, anti-stigma education campaigns; develop and synthesize recovery policies; train consumers in carrying out evaluations of mental health systems; and help further the development of peer-run services.[37] Mental Health service directors and planners are providing guidance to help state services implement recovery approaches.[38]

Some US states, such as California (see the California Mental Health Services Act), Wisconsin and Ohio, already report redesigning their mental health systems to stress recovery model values like hope, healing, empowerment, social connectedness, human rights, and recovery-oriented services.[39]

At least some parts of the Canadian Mental Health Association, such as the Ontario region, have adopted recovery as a guiding principle for reforming and developing the mental health system.[31]

New Zealand and Australia

Since 1998, all mental health services in New Zealand have been required by government policy to use a recovery approach[40] [41] and mental health professionals are expected to demonstrate competence in the recovery model.[42] Australia's National Mental Health Plan 2003-2008 states that services should adopt a recovery orientation[43] although there is variation between Australian states and territories in the level of knowledge, commitment and implementation.[44]

UK and Ireland

In 2005, the National Institute for Mental Health in England (NIMHE) endorsed a recovery model as a possible guiding principle of mental health service provision and public education.[45] The National Health Service is implementing a recovery approach in at least some regions, and has developed a new professional role of Support Time and Recovery Worker.[46] A leading independent charity issued a 2008 policy paper proposing that the recovery approach is an idea "whose time has come".[20] [47] The Scottish Executive has included the promotion and support of recovery as one of its four key mental health aims and funded a Scottish Recovery Network to facilitate this.[48] A 2006 review of nursing in Scotland recommended a recovery approach as the model for mental health nursing care and intervention.[49] The Mental Health Commission of Ireland reports that its guiding documents place the service user at the core and emphasize an individual's personal journey towards recovery.[50]

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