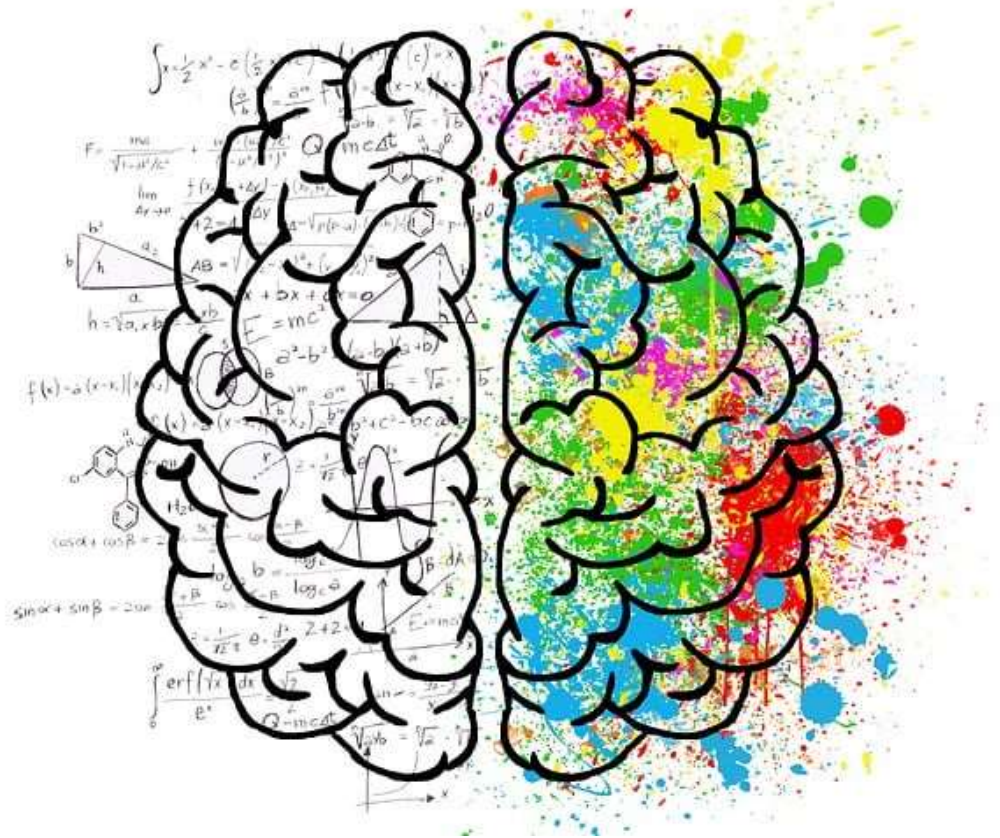


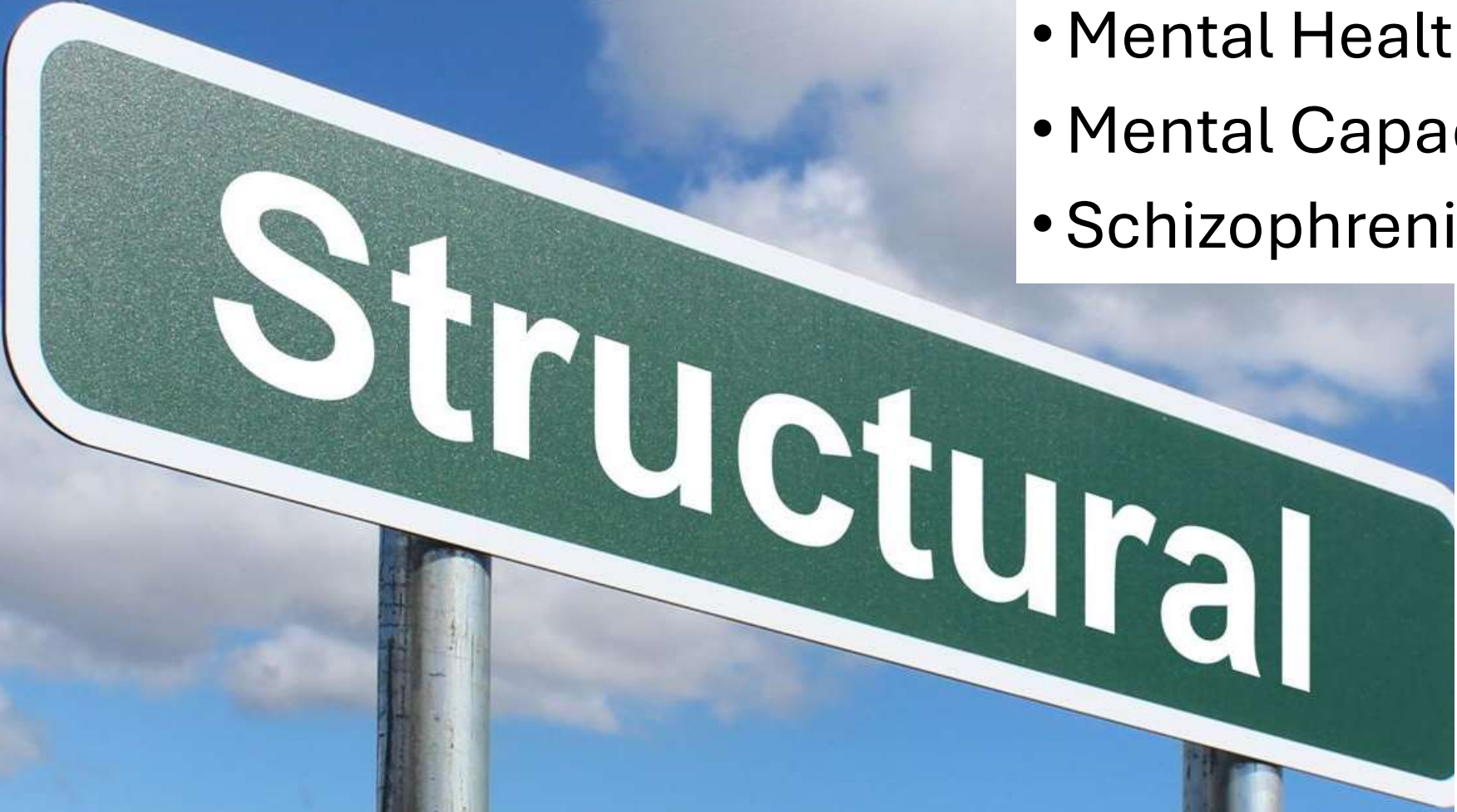
BMHP6029

Psychopathological Classifications and Provisions

Week 3 Mental Capacity and Schizophrenia

2026





Structural

- Mental Health Acts
- Mental Capacity Acts
- Schizophrenia

Purpose of Mental Health Legislation

- Provide a lawful framework to assess, admit, treat and safeguard people with mental disorder
- Permit detention and treatment when criteria are met; protect rights, dignity and least-restrictive care
- Scope: MHA applies to treatment for mental disorder; MCA applies to decisions where a person may lack capacity



Powers of Mental Health Legislation

- The powers within the mental health acts could be enforced by the following people only
 - Approved mental health professionals (AMHPS)
 - Approved / responsible clinician (RCs)
 - Doctors and professionals have the capacity and authority to make recommendations
 - Police roles under specific sections (e.g., 135/136)



Key Principles (Code of Practice)

- Least-restrictive option & maximising independence
- Empowerment & involvement: support people to participate in decisions, involve carers where appropriate
- Respect & dignity; equality and non-discrimination
- Purpose, effectiveness, efficiency and equity in care
- Document views, wishes and rationale for decisions



The principles of mental health

- The mental health act tells professionals what they are required to do. The mental health act code states how an individual is required to do it.



Mental Health Act

The Mental Health Act 1983

The Mental Health Act 2007



Mental Capacity Act

Mental Capacity Act 2005

All professionals are required to abide by the mental health act by **law**.

The mental health act code of practice 2008

The mental health act code of practice 2015 (revised version)

The Mental Health Act (2007)

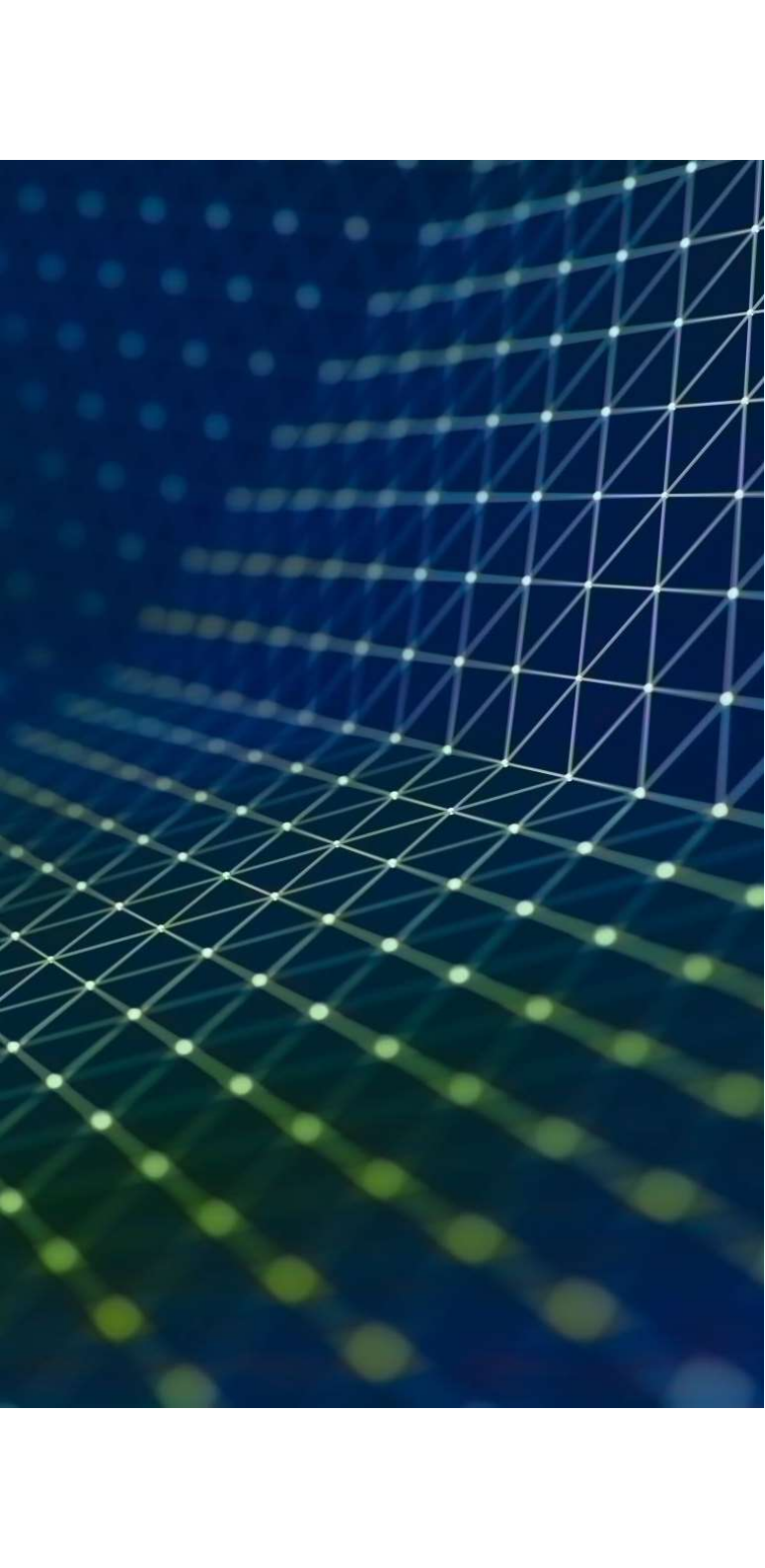
- When a patient can be given treatment even if they do not want it
- When they can be held in a hospital for assessment or treatment for your mental health disorder
- What the patient's rights are
- Treating patients fairly and equally



MHA 1983 (as amended 2007): Core Provisions



- Section 2 – Detention for assessment (up to 28 days), requires 2 medical recommendations and AMHP/nearest-relative application
- Section 3 – Detention for treatment (initial 6 months, renewable)
- Section 4 – Emergency admission for assessment (up to 72 hours) when delay risks harm
- Sections 135/136 – Powers of entry and removal to a place of safety



Key Changes from 1983 act in 2007 Amendments

Unified definition of 'mental disorder' (disorders or disabilities of the mind)

Wider professional roles: creation of AMHP; RC role not limited to psychiatrists

Community Treatment Orders (CTOs) introduced

Refinements to nearest-relative provisions and displacement

Help people be safe (MHA, 2007)

Treat people in
places that are safe
Help them get help
by referring to the
correct agencies and
support

Section 136

If police need to take someone away from public places to keep them safe from themselves or others,

- 1) Police will keep the person in a place of safety until an approved mental health professional can examine the person
- 2) A police station should only be used as a safe space if there is nowhere else to take that person.

Section 47

- Ministry of justice orders a person to be transferred from prison to hospital for treatment
- You can be kept under this section for up to 6 months.

Section 135

- Placed under this section if there is reasonable cause to suspect you have a mental health disorder and
 - you are being ill treated or neglected
 - unable to look after yourself and live alone.
- A magistrate can issue you a warrant authorising a police officer (with a doctor and approved mental health professional to enter any premises where you are being kept and take you to a place of safety.

What are your rights

You don't have a choice in being sectioned

You can apply to be discharged from hospital if you think you are ready

This can be done by applying to the Mental Health Tribunal

You or a family member or carer can apply to the MHT

The final decision is made by either a responsible clinician

The person who has overall responsibility for your care in hospital

Rights When Detained

- Information about detention, rights and how to appeal
- Right to apply to the Mental Health Tribunal (MHT)
- Access to advocacy (IMHA)
- Safeguards around consent to treatment (e.g., Second Opinion Appointed Doctor – SOAD)



Community Treatment Orders (CTOs)

- An order made by an authorised psychiatrist
 - Enable supervised treatment in the community following detention under Section 3
 - May include conditions (e.g., residence, engagement with services)
 - Recall to hospital possible if risk or health criteria met
-

Changes in MHA Legislation (1983 to 2007)

	Mental health act 1983	Mental health act 2007
Definition of mental disorder	Mental illness, mental impairment, psychopathic disorder and severe mental impairment.	Any disorder or disability of mind
Professional Roles	- Approved social workers - Responsible medical officer	- Approved mental health professionals - Responsible clinician
Nearest Relative	Roles and duties of nearest relative	- Hierarchy system on how is considered nearest relative - Patient has right to displace nearest relative - Patient has right to apply to courts

	Mental health act 1983	Mental health act 2007
Treatment	Detainment Rationale: “likely to alleviate or prevent deterioration”	- Detainment Rationale: “appropriate medical treatment test”. - Definition of treatment was operationalized - Consent to treatment: second person opinion and restrictions on section 58A treatments
Supervised community Treatments	Section 25 “after-care under supervision	Supervised Community Treatment for individuals detained under section 3 and 37
Advocacy		Independent Mental Health Advocate for detained patients

How would the changes in the 2 mental health acts change the care and support for individuals with mental health disorders?



Mental Capacity Act (2005): Overview



Protects and empowers people who may lack capacity for specific decisions



Five statutory principles guide all actions and decisions



Capacity is decision-specific and time-specific; always maximise capacity first



The act is in place to support individuals and their carers to make a decision, based on the best interest of the client.

5 Statutory principles of Mental Capacity Act (2005) Section 1

A person must be assumed to **have capacity** unless it is established that they lack capacity.

A person is not to be treated as unable to make a decision unless **all practicable steps** to help him to do so have been taken without success.

A person is not to be treated as unable to make a decision merely because he makes an **unwise decision**.

An act done, or decision made, under this Act for or on behalf of a person must be done, or made, in **their best interests**.

Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be **as effectively achieved** in a way which is less restrictive of the person's rights and freedom of action.

Assessing Capacity (Functional Test)

- Does the person have an impairment or disturbance in the functioning of mind or brain? (diagnostic test)
- If yes: can they understand, retain, use/weigh relevant information, and communicate a decision? (functional test)
- Record efforts to enhance capacity (timing, communication aids, environment)

Best-Interests Checklist (s.4 MCA)

- Avoid assumptions based on age, appearance, condition or behaviour
- Consider person's wishes, feelings, beliefs, values and any advance statements
- Consult with family/carers/IMCA where appropriate
- Weigh risks/benefits; can the decision be delayed until capacity returns?
- Choose the least-restrictive alternative

Putting MCA in practice (Beale, Lee-Davey, Lee, & Keene, 2022)

Mr A is a 47-year-old man who has been detained under section 3 of the MHA 1983 for the past 3 months. He has a diagnosis of schizophrenia and this is his fifth admission to hospital. He is being treated with a depot antipsychotic and occasional benzodiazepines for agitation. He is slowly improving but remains psychotic and does not believe he is unwell. His consent to treatment is due. Over the past few weeks he has been complaining of intermittent epigastric pain and nausea, and has had episode of melaena. Blood tests have shown a mild anaemia. He has lost some weight since admission. You have discussed the situation with a gastroenterologist, who advises that Mr A should have an endoscopy. Mr A refuses this.

Discuss the case of Mr A and see how the principles may apply.

How will you approach the assessment of capacity regarding Mr A's physical and mental health?



Mental Capacity Act (2005)

- The deprivation of liberty safeguard was eventually introduced
 - Providing the least restrictive treatment option
 - Ensure the best interest of the patient is always taken into consideration
 - Ensure an individual has the right to appeal in courts if required
 - Ensure an individual is in place to represent the patient

“C led a life that ‘sparkled’, characterised by impulsive and self-centred decision-making. She had four marriages, numerous affairs and spent money recklessly. Her life revolved around her looks, men and material possessions. Aged 49 she was diagnosed with breast cancer and underwent a lumpectomy and radiotherapy. She also suffered a relationship breakdown, leading to the loss of her business and home and resultant significant debt. C unsuccessfully attempted suicide.... She has been placed on dialysis, but maintains her desire to die. Those caring for her are cautiously optimistic of recovery.... The Medical profession consider that C lacks capacity and wish to enforce treatment on her...in her best interest” (Smith and Parkhouse, 2020, p.87). Based on real life case in London in 2015.

Discuss whether the medical profession should be allowed to enforce the treatment on C.

Use the information covered so far on Mental Capacity Act in your discussion.



Assessing capacity

Factors to be considered in assessing for capacity

- General intellectual ability
- Memory
- Attention and concentration
- Reasoning
- Information processing
- Verbal comprehension and expression
- Cultural influences
- Social context
- Ability to communicate.

First Stage

- Identifying if there is an impairment or disturbance in the functioning of the individual's brain
- The level of impact such impairment would have on one's decision-making skills.



Second Stage

- It would be determined that an individual is not able to make a decision if:
- They are unable to understand the information about the decision that has to be made
- They are unable to remember information
- They are unable to use the information received to evaluate the consequences of their decision
- Unable to communicate their decision effectively

Legal Power of Attorney and Safeguarding

- **Independent Mental Capacity Advocate (IMCA)**
 - Works with the decision maker
 - May challenge decision maker
 - Communicates based on client's wishes, beliefs and values.
- **Decision Maker**
 - Next Kin in Family
 - Request through legal documentation
 - Assign specific decision-making power to the decision maker
 - Involve IMCA in decision making process
 - Court may choose one, if one was unable to decide due to lack of capacity
- **Advanced Decision**
 - Decisions based on limitations placed on future treatments





What are the impacts of the MHAs, MCAs?

How did each act affect the everyday living of individuals with mental health disorders?

How did each act change the training, provisions and support?

What are the factors in determining the successful implementation of the MHA and MCA?

Are the MHA and MCA fit for purpose? From the introduction of the first MHA in 1983, DSM has gone through four updates whereas ICD changed from version 9 to 11.

Where can you find research literature to answer the questions above?

Forum Activity: Mental Health Act

Information and relevant links about this activity can be found in Moodle Week 3 tile.

Download this poster template from:
[billboard8_48x36.pptx \(live.com\)](https://www.live.com/billboard8_48x36.pptx)

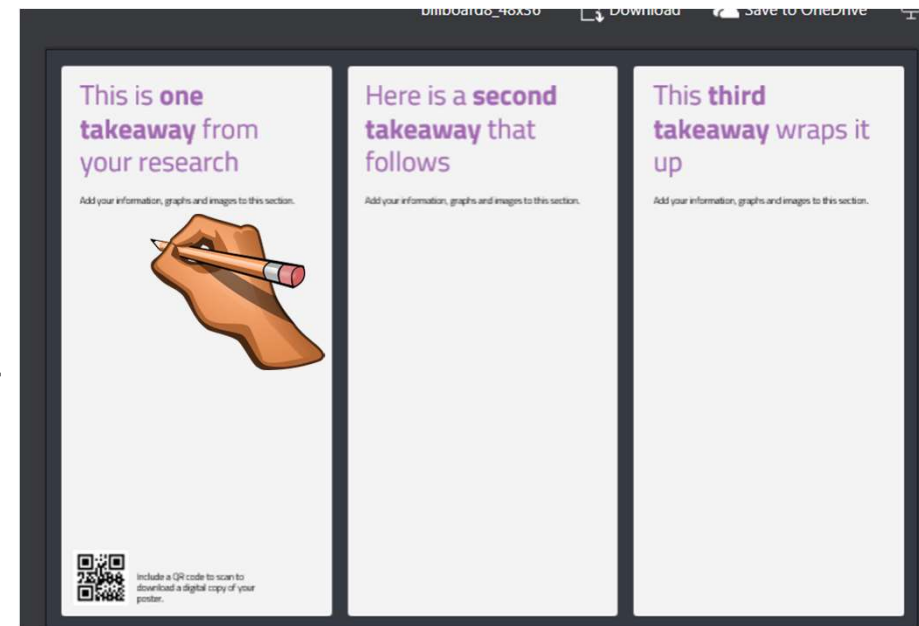
Choose one of the documents/blogs on the mental health act.

Read and summarise the key points.

Turn the key points into three takeaway messages and add them to the poster template.

Make sure to provide citations and references.

Save and upload your poster on the week 3 forum.



Contemporary debates on Schizophrenia



Schizophrenia

– ICD-11

Overview

(6A20)



Disturbances across thought, perception, self-experience, cognition, volition, affect and behaviour



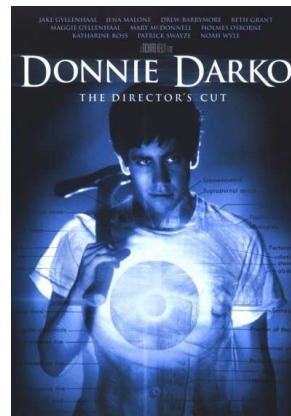
Core features include persistent delusions, persistent hallucinations, thought disorder, and experiences of influence/passivity/control



Active phase $\geq$ 1 month with functional impairment; exclude mood disorders, substance/medical causes

Portrait of a schizophrenic

“Someone who has psychotic experiences is different from normal people, because his brain (note that the stereotype includes the presumed gender of the individual) is damaged or different, probably because of his genes. He is “a schizophrenic,” who is not understandable, is dangerous, has no legitimate voice and requires control through drugs that target the underlying brain disorder” (Cooke and Kinderman, 2018 p. 59).



How Schizophrenia Affects My Life



How do your impression of these individuals compare to your initial description of a person with schizophrenia?

How do these individuals compare to Cooke and Kinderman's stereotypical portrait of a person with schizophrenia?

What does 'schizophrenia' mean?

In 1910, the Swiss psychiatrist Paul Eugen Bleuler (d. 1939) coined the term 'schizophrenia' from the Greek words schizo ('split') and phren ('mind').

However, whilst people with schizophrenia can experience symptoms that affect their thought processes and perceptions of the world around them, such as **delusions** and **hallucinations**, they do not have two separate personalities.

What is Schizophrenia?



- Schizophrenia is a **severe long-term** mental health **condition**. Schizophrenia is more common than people think, affecting about 1 in every 100 people, affecting around 20 million people worldwide (WHO, n.d.).
- It causes a range of different psychological symptoms, characterised by distortions of thought, perception and emotion, language, sense of self (WHO. n.d.), behaviour and social withdrawal.
- Some may describe schizophrenia as a type of **psychosis** as the person may not always be able to distinguish their own thoughts and ideas from reality.

Schizophrenia $\neq$ psychosis

- Schizophrenia and psychosis may be confused for one another, but they're not the same. Schizophrenia is a mental health condition — psychosis is a collection of symptoms, distorted thoughts and perceptions, leading to a break from reality (National Institute of Mental Health, n.d.).
- During an episode of psychosis, a person may hear voices, see things that aren't real, or believe things that aren't true. Psychosis is related to several mental health disorders, including schizophrenia, severe depression and bipolar disorder. It is also linked to Parkinson's disease, Alzheimer's disease and related dementias (National Institute of Mental Health, n.d.).

Trends and figures

- Affects around 24 million worldwide (Jaeschke et al., 2017; World Health Organisation, 2022)
- Onset peaked in early 20s (Jongsma et al., 2019)
 - Onset in childhood is extremely rare
- Gender differences (Jauar, Johnstone and McKeena, 2022)
 - Affects more men than women (1:0.70)
 - Sharp increase and steep decline in men
 - Later onset and flatter trend with age observed in more women than men (Ochoa et al., 2012)

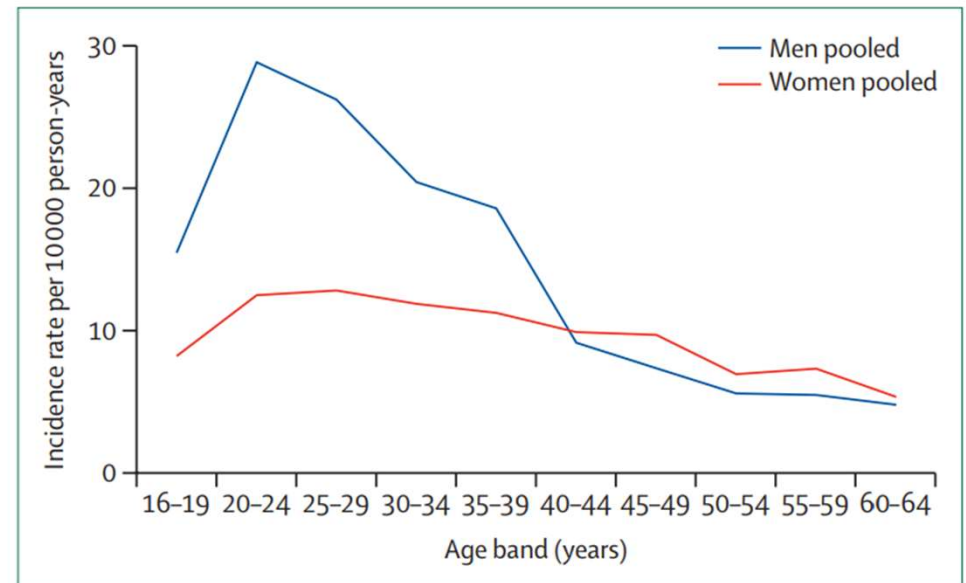


Figure 1: Pooled incidence of schizophrenia by age and sex in England, 1950-2009

Adapted from Kirkbride and colleagues.⁷

ICD-11 Classification of Schizophrenia 6A20

- Schizophrenia is characterised by disturbances in multiple mental modalities, including thinking (e.g., delusions, disorganisation in the form of thought), perception (e.g., hallucinations), self-experience (e.g., the experience that one's feelings, impulses, thoughts, or behaviour are under the control of an external force), cognition (e.g., impaired attention, verbal memory, and social cognition), volition (e.g., loss of motivation), affect (e.g., blunted emotional expression), and behaviour (e.g., behaviour that appears bizarre or purposeless, unpredictable or inappropriate emotional responses that interfere with the organisation of behaviour). Psychomotor disturbances, including catatonia, may be present. Persistent delusions, persistent hallucinations, thought disorder, and experiences of influence, passivity, or control are considered core symptoms. Symptoms must have persisted for at least one month in order for a diagnosis of schizophrenia to be assigned.
- The symptoms are not a manifestation of another health condition (e.g., a brain tumour) and are not due to the effect of a substance or medication on the central nervous system (e.g., corticosteroids), including withdrawal (e.g., alcohol withdrawal)

Symptoms of Schizophrenia

Positive symptoms

Known as psychosis or the psychotic syndrome

Hallucinations
Delusions
(persecution, grandeur, control).
Formal thought disorders

Negative symptoms

Absence or reduction of normal behaviour (Correll & Schooler, 2020)

Flattened emotional response
Poverty of speech
Lack of initiative and persistence
Social withdrawal.

Schizophrenia: ICD-11 vs DSM-5-TR

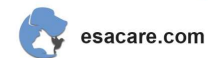
Aspect	ICD-11 (WHO)	DSM-5-TR (APA)
Overall approach	Dimensional, person-centred, emphasis on functioning and lived experience	More categorical, symptom-threshold driven
Core symptom requirement	≥2 psychotic symptoms present most of the time for ≥1 month	≥2 psychotic symptoms for a significant portion of time over ≥1 month
Key symptom weighting	At least one core psychotic feature (e.g. delusions, hallucinations, disorganized thinking, passivity experiences)	At least one must be delusions, hallucinations, or disorganized speech
Symptom domains	Explicit recognition of positive, negative, cognitive, and behavioural domains	Focus on positive symptoms; negative and cognitive symptoms less foregrounded
Duration criteria	Continuous or episodic disturbance over several months, with ≥1 month active phase	Continuous signs for ≥6 months, with ≥1 month active phase
Functional impairment	Strong emphasis on social, occupational, and personal functioning	Functional decline required but less explicitly contextualised
Subtypes	Removed; encourages individual symptom profiling	Removed; subtypes no longer used
Cultural applicability	Designed for global use, including low-resource and non-Western settings	Primarily oriented to North American clinical and research contexts
Clinical utility	Supports multidisciplinary, recovery-oriented assessment and care planning	Strong utility for diagnostic standardisation and research

Searching activity

- Research the following terms:
- **Delusion**
- **Hallucinations**

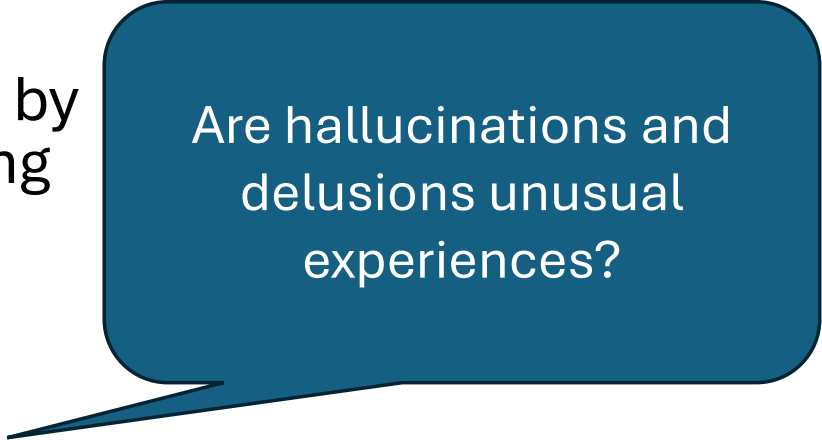
Symptoms of a schizophrenic episode include:

- 01 False and unreal beliefs
- 02 Hearing voices
- 03 Disorganized thinking and meaningless speech
- 04 Bizarre behavior and movement
- 05 Social withdrawal and poor hygiene
- 06 Suicidal thoughts/tendencies



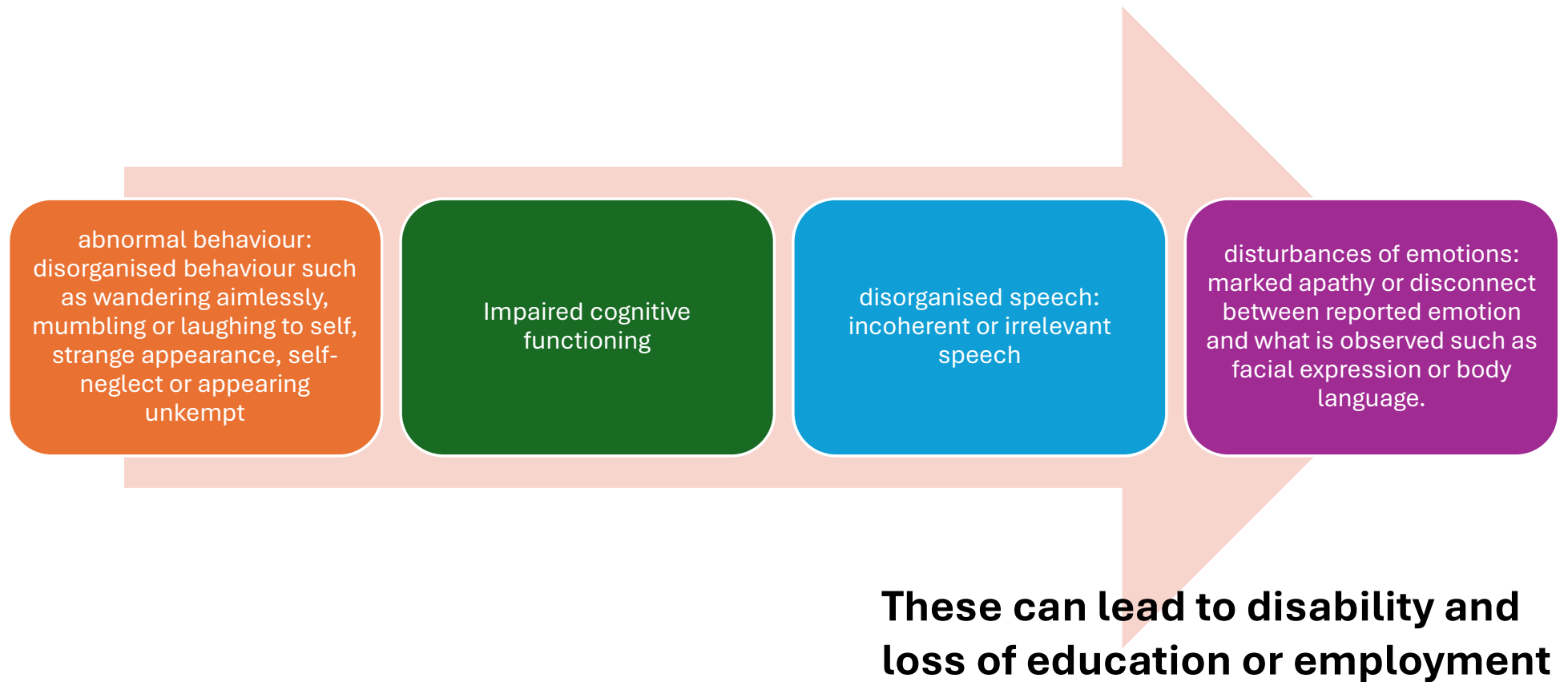
Hallucinations and Delusions

- **Hallucinations:** Hallucinations are experiences that appear real but are created by your mind. They include seeing things, hearing voices, or smelling things others around you don't experience.
- **Delusions:** A delusion occurs when you believe something despite evidence or facts to the contrary. They are fixed false beliefs or suspicions not shared by others in the person's culture and that are firmly held even when there is evidence to the contrary



Are hallucinations and delusions unusual experiences?

In addition to hallucinations and delusions, common experiences may include:



Negative Symptoms and treatments (Correll & Schooler, 2020)

Higher prevalence of negative symptoms are related to men, unemployed, and people with reduced functioning

Majority of patients with schizophrenia may show prominent negative symptoms. Clinicians need to rule out conditions also share presentation of negative symptoms

- Medical conditions such as multiple sclerosis or Parkinson's disease
- Psychiatric conditions such as depression, anxiety, obsessive compulsive disorder, posttraumatic stress disorder, autism, intellectual disability, substance misuse

Patients rarely complain about negative symptoms due to lack of insight. Therefore clinicians are less aware of their impact.

Efficacy of Medication and CBT is less clear



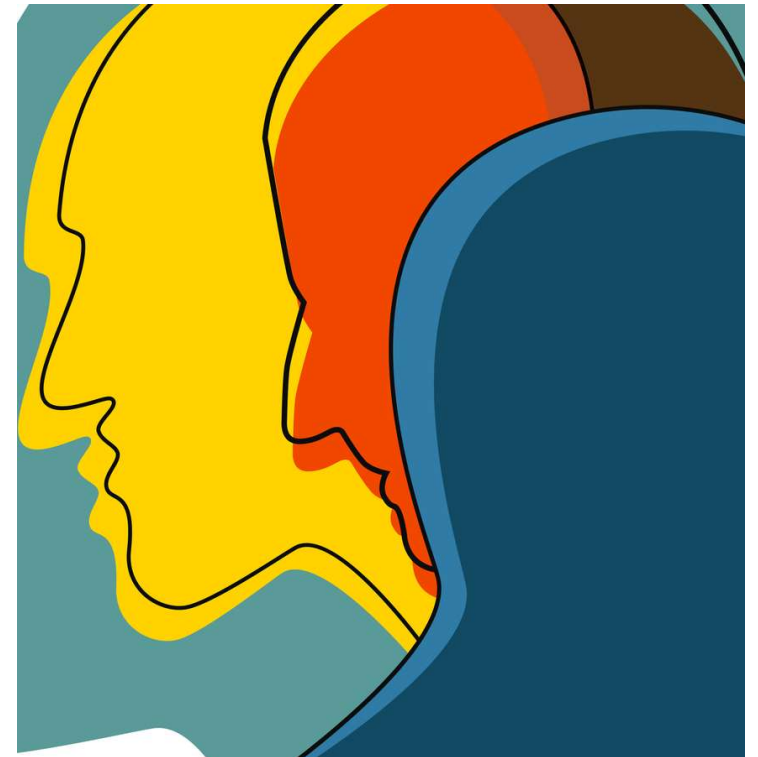
Video: What is schizophrenia?



Source: https://www.youtube.com/watch?v=K2sc_ck5BZU

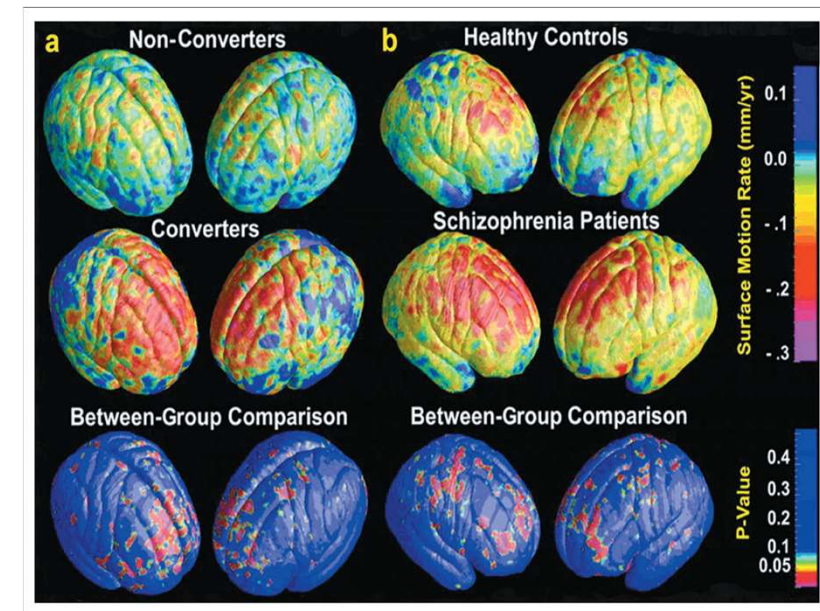
Causes of schizophrenia

- Did ICD-11 identify the cause in its definition?
- Research has not identified one single factor. It is thought that an interaction between genes, neurological and a range of environmental factors may cause schizophrenia (Jauhar et al., 2022).
- Psychosocial factors may also contribute to schizophrenia but to a less extent.



Causes of schizophrenia

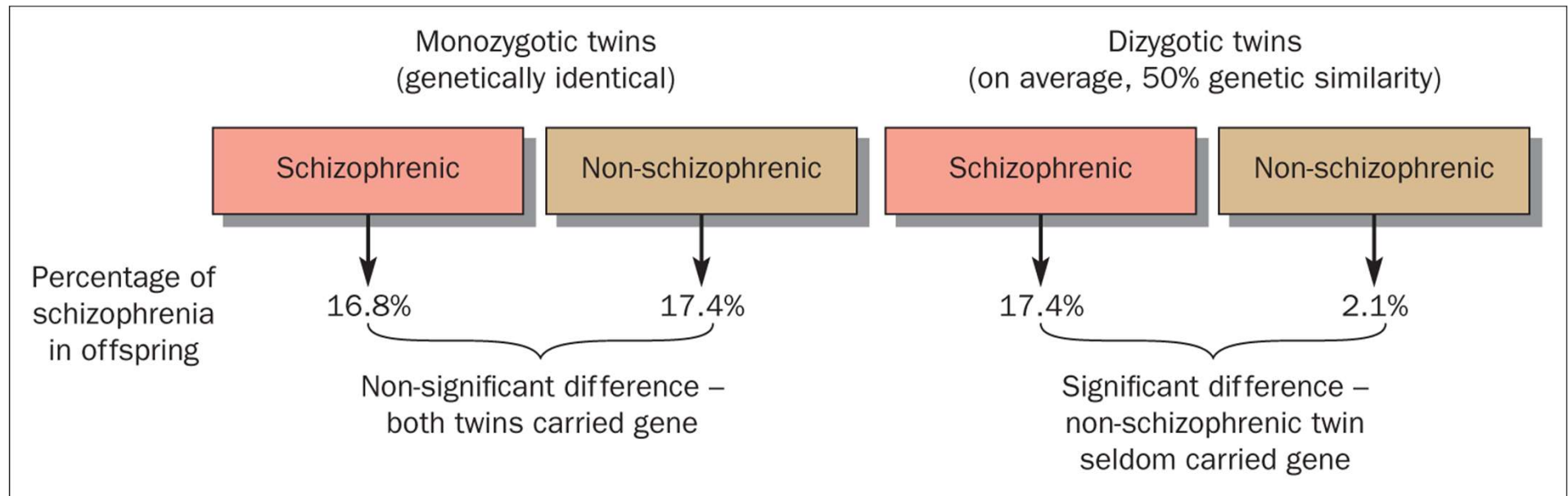
- Recent studies have suggested that imaging tests completed on people with schizophrenia may show abnormalities in certain brain structures.
- Ongoing research in this area continues. Chemical abnormalities in the brain are believed to be responsible for many of the symptoms seen in schizophrenia (Martin & Carlson, 2023). But note the exclusion criterion about biochemical cause in ICD-11
- Researchers also believe low levels of certain brain chemicals that affect emotions and behaviour may contribute to this psychiatric disorder: the dopamine hypothesis



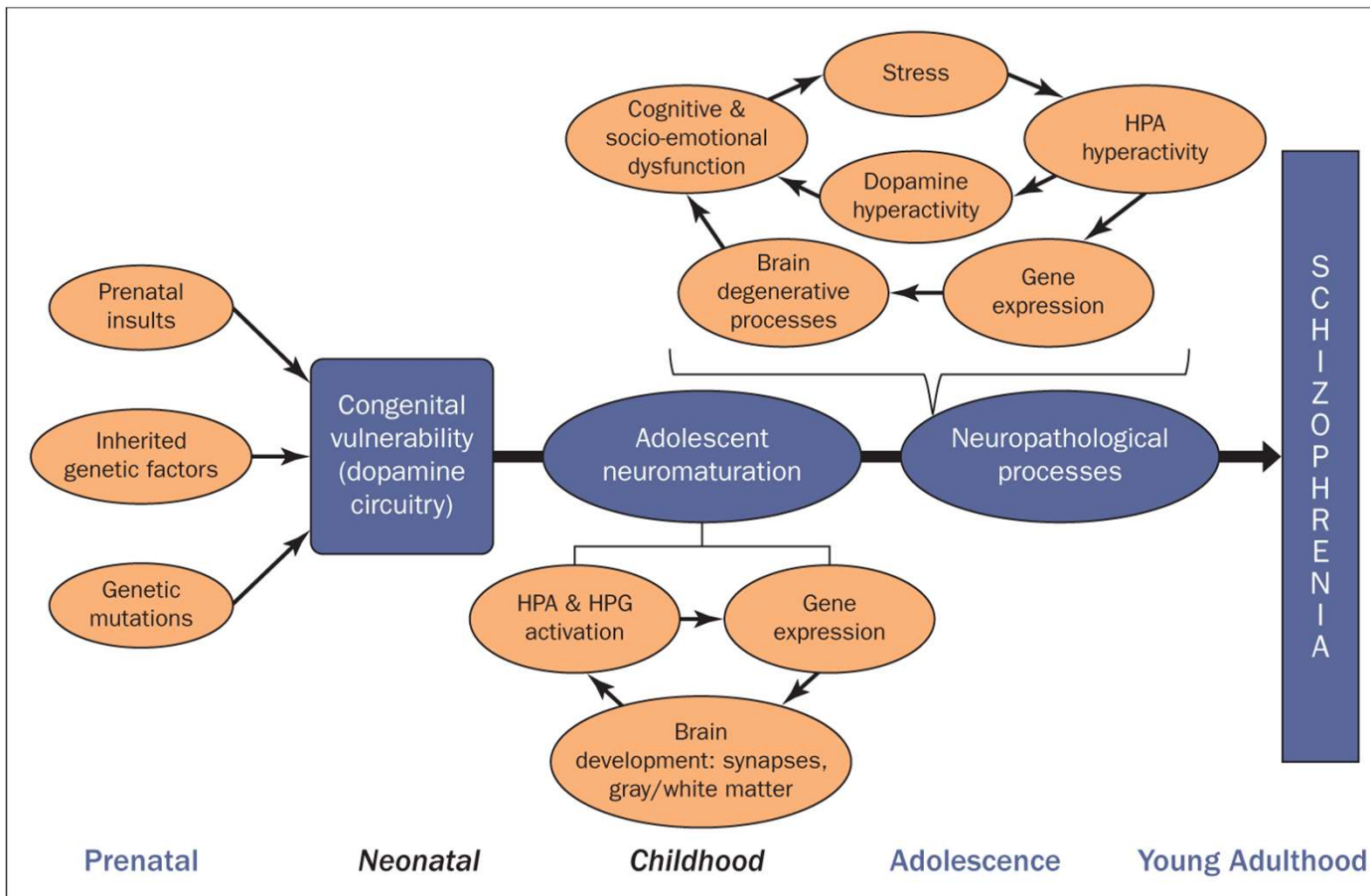
(Martin & Carlson, 2023)

Heritability of schizophrenia (Martin & Carlson, 2023)

- carrying a 'schizophrenia gene' does not mean that a person will necessarily become schizophrenic.
- The environment may be an important trigger for the activation of a biological predisposition.
- Polygenetic is the current thinking regarding genetic links in schizophrenia



Some of the risk factors for Schizophrenia (Martin & Carlson, 2023)



Exposure to toxins or a virus before birth or during early infancy that caused oxygen deficiency

The link to early childhood adversity is mostly established by retrospective studies. The link is not as clear when the data are obtained by longitudinal or prospective studies (Jauhar et al., 2022)

Using mind-altering drugs
high stress levels
Having an inflammatory or an autoimmune disease

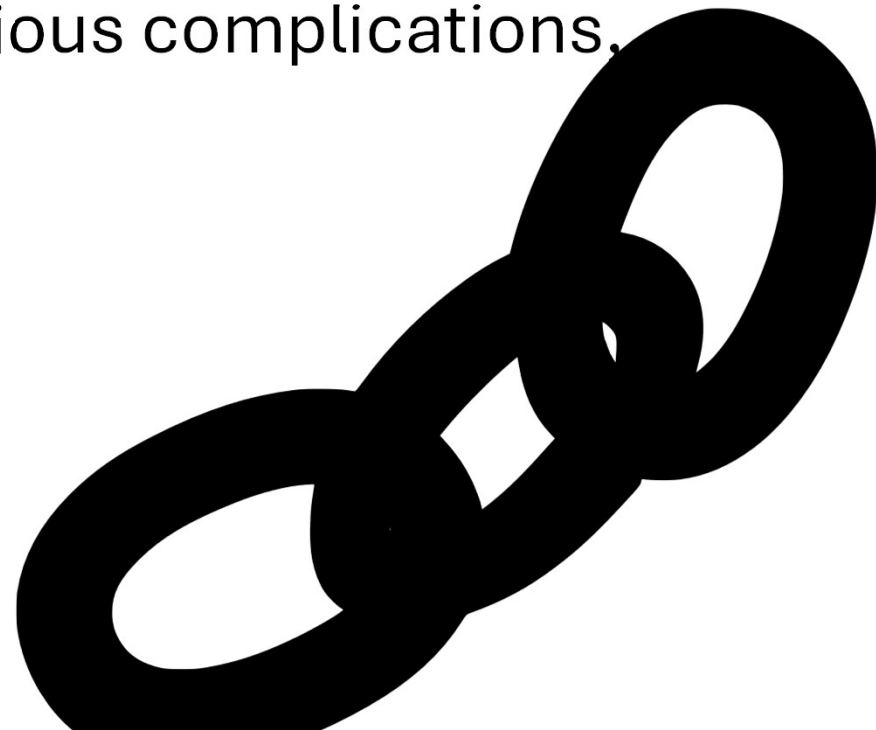
Source: <https://www.who.int/news-room/fact-sheets/detail/schizophrenia>

Schizophrenia complications

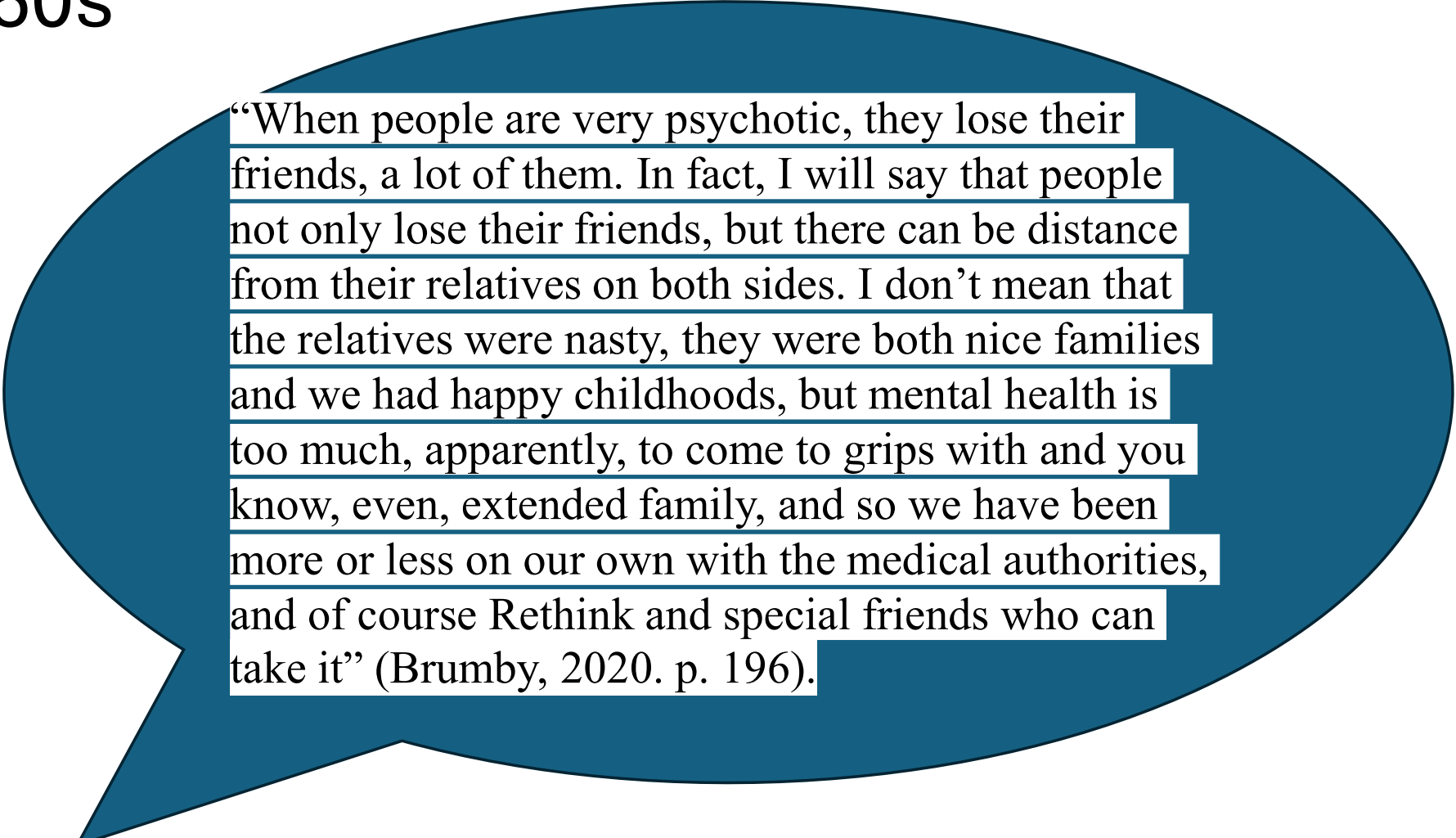
Schizophrenia is a severe mental illness that shouldn't be ignored or left untreated.

The disorder increases the risk of serious complications, such as:

- self-injury or suicide
- anxiety
- phobias
- depression
- alcohol or drug use
- Relational problems within family



Family's experience of the disorder in the 1960s



“When people are very psychotic, they lose their friends, a lot of them. In fact, I will say that people not only lose their friends, but there can be distance from their relatives on both sides. I don’t mean that the relatives were nasty, they were both nice families and we had happy childhoods, but mental health is too much, apparently, to come to grips with and you know, even, extended family, and so we have been more or less on our own with the medical authorities, and of course Rethink and special friends who can take it” (Brumby, 2020. p. 196).

How has schizophrenia evolved through time?

- The history of schizophrenia is complex and does not lend itself easily to a linear narrative. Accounts of a schizophrenia-like syndrome are rare in records before the 19th century.
- The earliest cases detailed were reported in 1797, and 1809. Dementia praecox, meaning premature dementia (brain dementia of the young) was used by German psychiatrist Heinrich Schüle in 1886, and then in 1891 by Arnold Pick in a case report of hebephrenia (Disorganized schizophrenia, or hebephrenia, is a subtype of schizophrenia)
- In 1893 Emil Kraepelin used the term in making a distinction, known as the Kraepelinian dichotomy, between the two psychoses – dementia praecox, and manic depression (now called bipolar disorder).
- Kraepelin (1893) believed that dementia praecox was probably caused by a systemic disease that affected many organs and nerves, affecting the brain after puberty in a final decisive cascade. It was thought to be an early form of dementia, a degenerative disease. When it became evident that the disorder was not degenerative it was renamed schizophrenia by Eugen Bleuler in 1908.

Historical treatments

- The earliest attempts to treat schizophrenia were psychosurgical, involving either the removal of brain tissue from different regions or the severing of pathways. These were notably frontal lobotomies and cingulotomies which were carried out from the 1930s. In the 1930s a number of shock therapies were introduced which induced seizures (convulsions) or comas.
- Insulin shock therapy involved the injecting of large doses of insulin in order to induce comas, which in turn produced hypoglycaemia and convulsions.
- The use of electricity to induce seizures was developed, and in use as electroconvulsive therapy (ECT) by 1938. Stereotactic surgeries were developed in the 1940s.
- Treatment was revolutionized in the mid-1950s with the development and introduction of the first typical antipsychotic, chlorpromazine. In the 1970s the first atypical antipsychotic clozapine, was introduced followed by the introduction of others.

Treatment Overview



Antipsychotic medication – cornerstone for acute psychosis and relapse prevention (individualise benefits/risks)



Psychological interventions (CBT for psychosis; family intervention; social skills training) – variable effect sizes



Holistic care: physical health monitoring, substance-use support, housing, employment and education

Medications

Antipsychotic medication, is the most common treatment for schizophrenia: Dopamine blocker.

Medication can help stop:

- hallucinations
- delusions
- symptoms of psychosis
- If psychosis occurs, an individual may be hospitalized and receives treatments under close medical supervision.



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Effectiveness of medications

- For paranoid schizophrenia, seeking medical diagnosis and medications can be met with resistance
- What is the average length of time?
- Are there long term side effects?
- How did the patients with schizophrenia react to the medication?
- Jauhar et al's comprehensive review is recommended. Find it in the online reading list.



Recall our earlier discussion about MCA and the public's stereotypical view that individuals with schizophrenia are dangerous?



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Human Rights & Stigma

- People with schizophrenia frequently face discrimination and rights violations
 - Barriers to healthcare, education, housing and employment
 - Rights-based, recovery-oriented practice is essential
-

Human rights violations

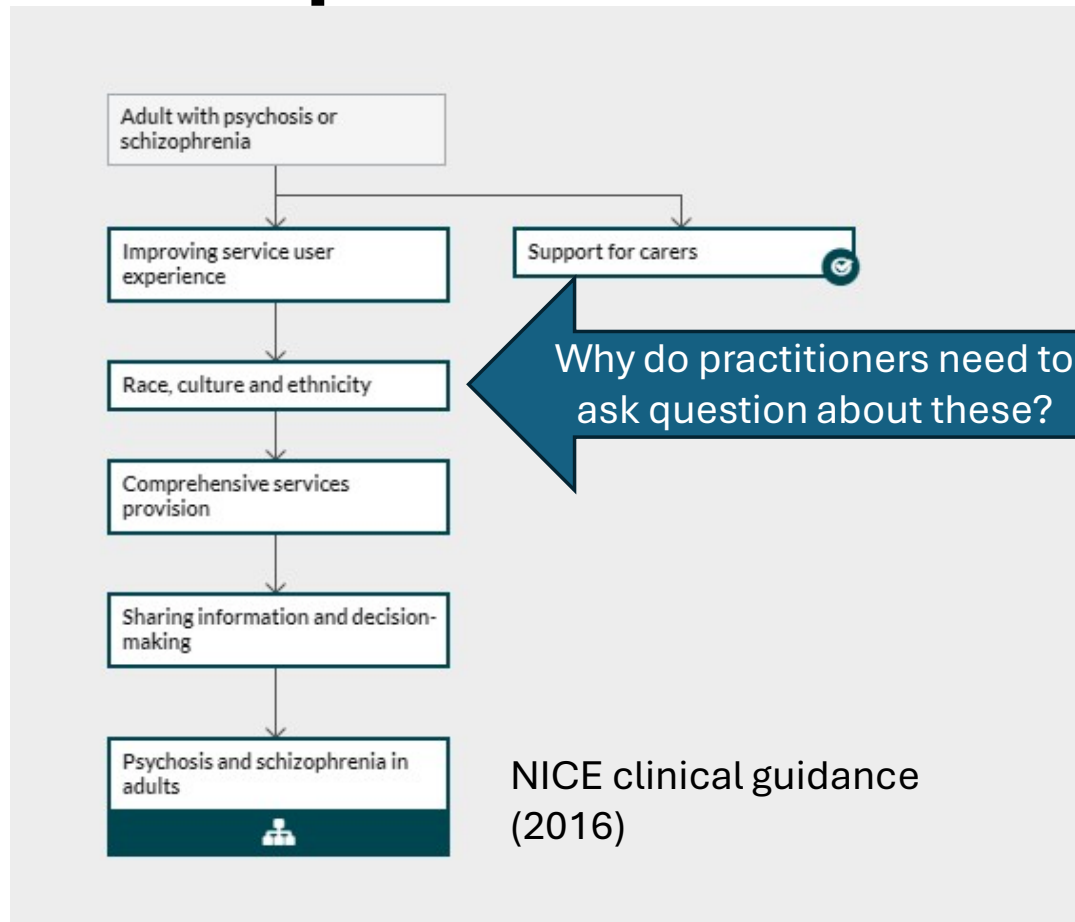
- “People with schizophrenia often experience human rights violations both inside mental health institutions and in community settings. Stigma against people with this condition is intense and widespread, causing social exclusion, and impacting their relationships with others, including family and friends. This contributes to discrimination, which in turn can limit access to general health care, education, housing, and employment.” (WHO, 2022)

- Source:
<https://www.who.int/news-room/fact-sheets/detail/schizophrenia>

I was labelled with all sorts: eating disorder not otherwise specified, major depressive disorder, borderline personality disorder, schizoaffective disorder and eventually schizophrenia . . . that was the one that knocked the stuffing out of me completely. What was the point in fighting if I was going to be suffering from a lifelong brain disease forever? (Sally Edwards quoted in Cooke, 2017, p. 12)

My family has been shamed and defamed by psychiatric diagnosis. Our lives, historical and present, are forever affected by it. We have felt different. We have felt defective and unacceptable. We felt that our genes were inadequate and shouldn't be reproduced. We felt that our diagnoses had to be hidden because others might think us dangerous or unpredictable. At times, we felt so 'other' that we had to hide our experiences even from one another. We lived with secrets and silence that reached into every corner of our lives.
(Thomas, 2013)

Principles of care for adults with schizophrenia



There is no cure for schizophrenia. Individuals diagnosed with this disorder will need lifelong treatment and care.

Treatments can control or reduce the severity of symptoms.

Schizophrenia is usually treated with an individually tailored combination of talking therapy and medicine.

Psychosocial intervention

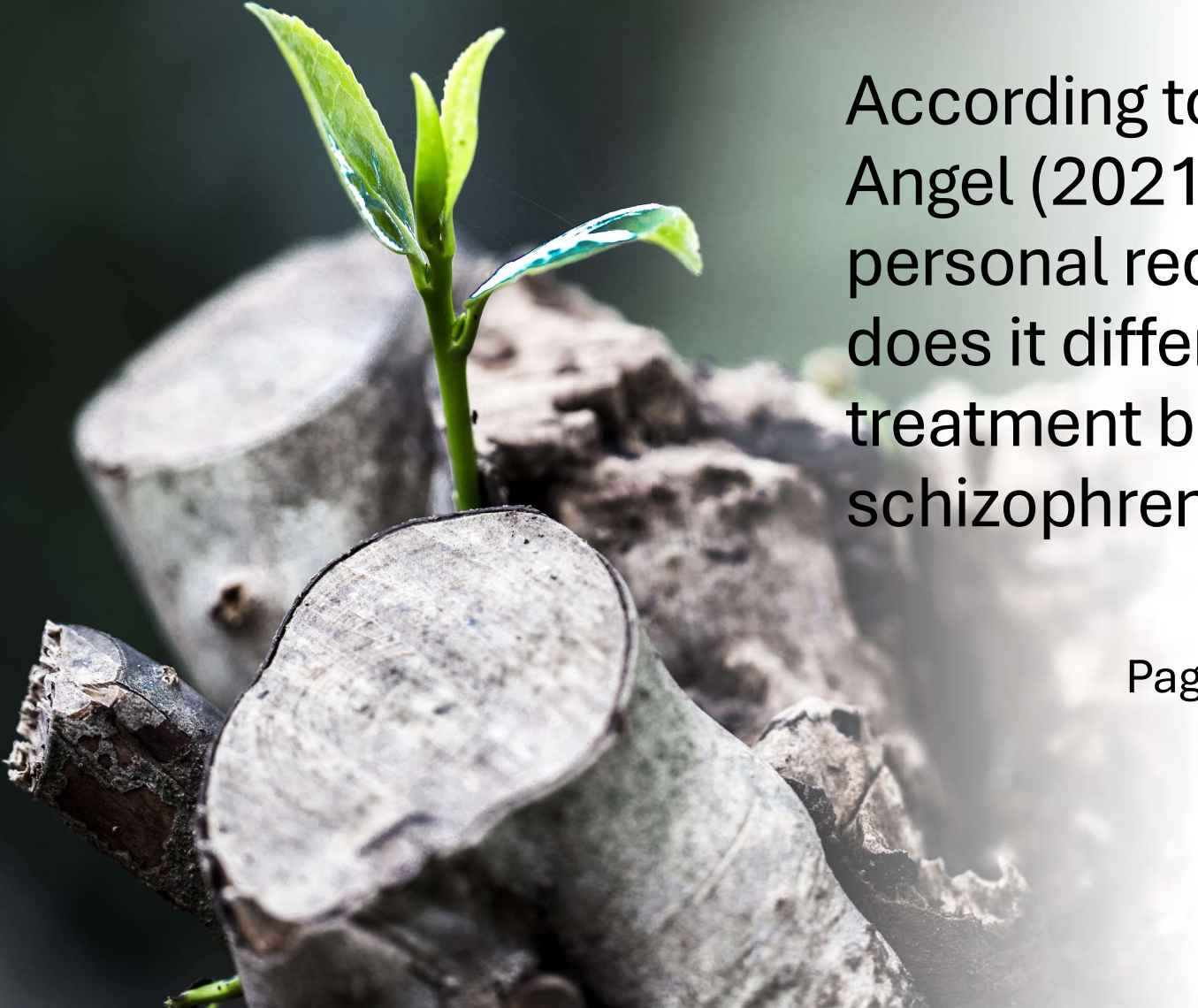
- Psychosocial intervention includes individual therapy to help people with this condition cope with stress and illness.
- CBT is commonly used tool in psychosocial intervention (see graph) but the effect size for schizophrenia is small in recent meta-analyses (Jauhar et al., 2022)
- To a less extent, social training may improve social and communication skills. Family therapy and support are important.
- More on CBT to follow



Recovery: Clinical vs Personal

- Clinical recovery: symptom remission, relapse prevention and functioning
- Personal recovery: living a meaningful life with or without ongoing symptoms
- Frameworks: e.g., Libermann & Kopelowicz; integrate peer-led support and lived experience





According to Damsgaard and Angel (2021), what is personal recovery and how does it differ from the formal treatment based recovery for schizophrenia?

Page 3

What is Libermann and Kopelowicz's recovery model for schizophrenia (2002; 2005)?



Download and read page 3 in Damsgaard and Angel's paper (2021) from the online reading list on Moodle.



Damsgaard, J.B. and Angel, S. (2021) "Living a Meaningful Life While Struggling with Mental Health: Challenging Aspects Regarding Personal Recovery Encountered in the Mental Health System". *Int. J. Environ. Res. Public Health*, 18, 2708. <https://doi.org/10.3390/ijerph18052708>



What is the duration of sustained recovery?



Contemporary Debates

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Utility and limits of the disease model; dimensional approaches

Interpreting brain imaging findings and progression claims

Hearing Voices movement; reframing experiences and agency



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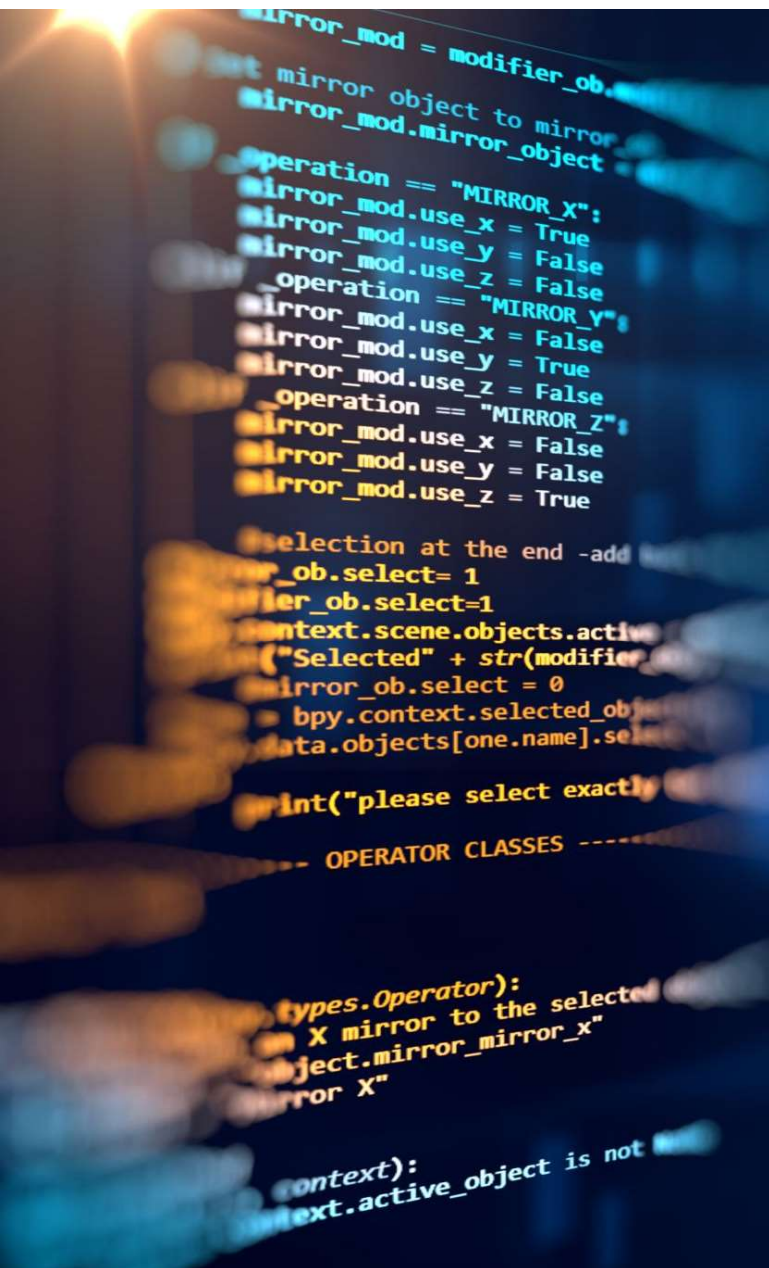
“The idea of schizophrenia may be doing more harm than more harm than good” (Cooke & Kinderman, 2018. p.54)

Effectiveness of treatments

Cannabis as cause of schizophrenia

Childhood adversity as cause of schizophrenia

whether there is progressive brain change after onset



Further Reading & Resources

- Module reading list (Week 3): MHA Code of Practice; MCA Code; NICE guidance
- ICD-11 MMS: Schizophrenia (6A20) for diagnostic detail
- Local Trust policies on consent, capacity and CTOs

