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Recovery

Open Forum

Recovery From Schizophrenia: A Concept in Search of Research

Robert Paul Liberman, M.D.
Alex Kopelowicz, M.D.

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Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems

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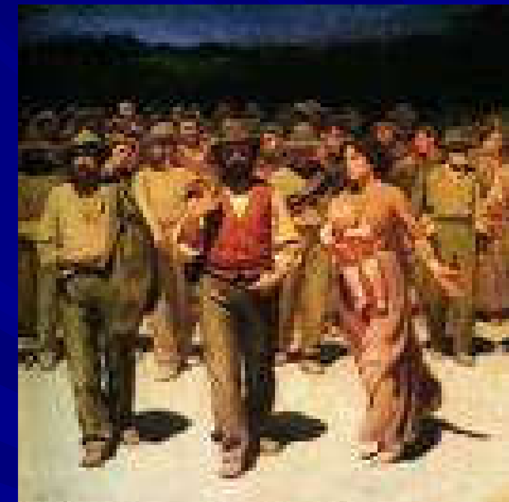
An understanding of recovery as a personal and subjective experience has emerged within mental health systems. This meaning of recovery now underpins mental health policy in many countries. Developing a focus on this type of recovery will involve transformation within mental health systems. Human systems do not easily transform. In this paper, we identify seven mis-uses ("abuses") of the concept of recovery: recovery is the latest model; recovery does not apply to "my" patients; services can make people recover through effective treatment; compulsory detention and treatment aid recovery; a recovery orientation means closing services; recovery is about making people independent and normal; and contributing to society happens only after the person is recovered. We then identify ten empirically-validated interventions which support recovery, by targeting key recovery processes of connectedness, hope, identity, meaning and empowerment (the CHIME framework). The ten interventions are peer support workers, advance directives, wellness recovery action planning, illness management and recovery, REFOCUS, strengths model, recovery colleges or recovery education programs, individual placement and support, supported housing, and mental health trialogues. Finally, three scientific challenges are identified: broadening cultural understandings of recovery, implementing organizational transformation, and promoting citizenship.

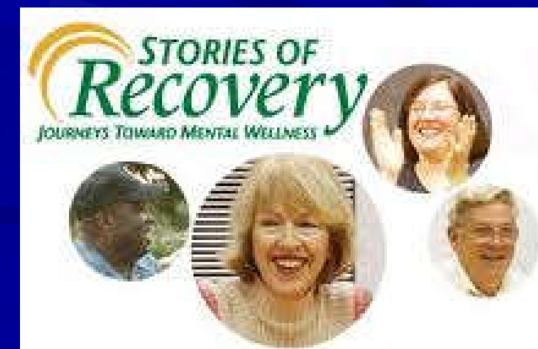
Key words: Recovery, mental health services, peer support workers, advance directives, wellness recovery action planning, individual placement and support, supported housing, mental health trialogues, organizational transformation, promoting citizenship

Il background storico del Recovery

- *Il ruolo dei processi di de-istituzionalizzazione*



- *Il superamento dell'idea di cronicità e il contributo delle ricerche longitudinali*



- *La testimonianza dei "consumers/survivors"*

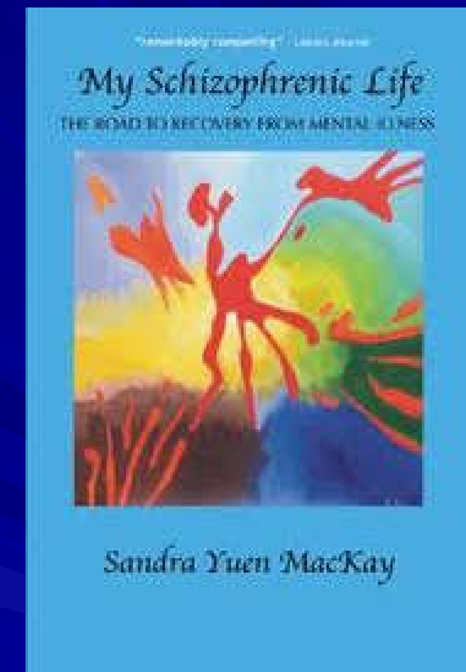
Long-term studies: people can recover from severe mental illness

Study	Sample Size	Follow-Up (in years)	% Significantly Recovered
Bleuler (1972)	208	23	53%-68%
Huber et al. (1979)	502	22	57%
Ciompi & Muller (1976)	289	37	53%
Tsuang et al. (1979)	186	35	46%
Harding et al. (1987)	269	32	62-68%

1. Bleuler (1978). The Schizophrenic Disorders. New Haven, Yale Press
2. Huber et al (1975). Long-term followup…Acta Psychiatrica Scand. 53:49-57.
3. Ciompi & Muller (1976). Lebensweg und alter…Berlin. Verlag Springer.
4. Harding et al. (1987). Vermont longitudinal study…Am. J. of Psychiatry 144: 718-735.
5. Tsuang,M. et al (1979). Long-term outcome…Arch. Gen. Psych. 36:1295-1301

Long-term studies: people can recover from severe mental illness

Study	Sample Size	Follow-Up (in years)	% Significantly Recovered
Hinterhuber (Austria)	157	30	75%
Kreditor (Russia)	115	20	84%
Marino (Bulgaria)	280	20	75%
Ogawa (Japan)	140	23	57%
Total of 9 studies	2028	20-37	66%



Patricia Deegan, psicologo clinico

Direttore NorthEast Independent Living Program

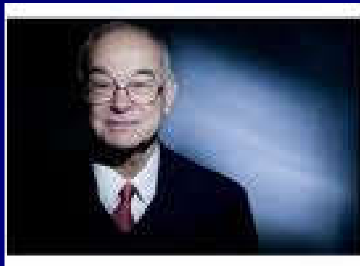
Robert Liberman, Direttore UCLA Center for Research on Treatment & Rehabilitation on Psychosis

Attivisti del Recovery Movement

Ex pazienti

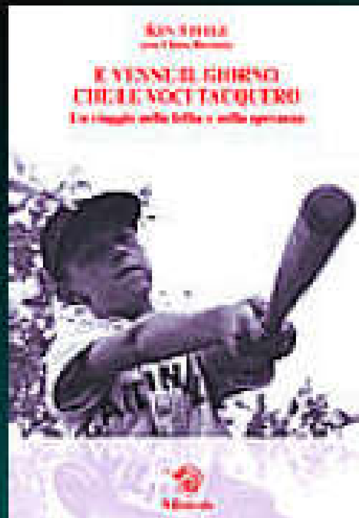
Dan Fischer, psichiatra

Direttore National Empowerment Center Massachusetts



Fred Frese, psicologo

Professore associato University NorthEastern Ohio College of Medecine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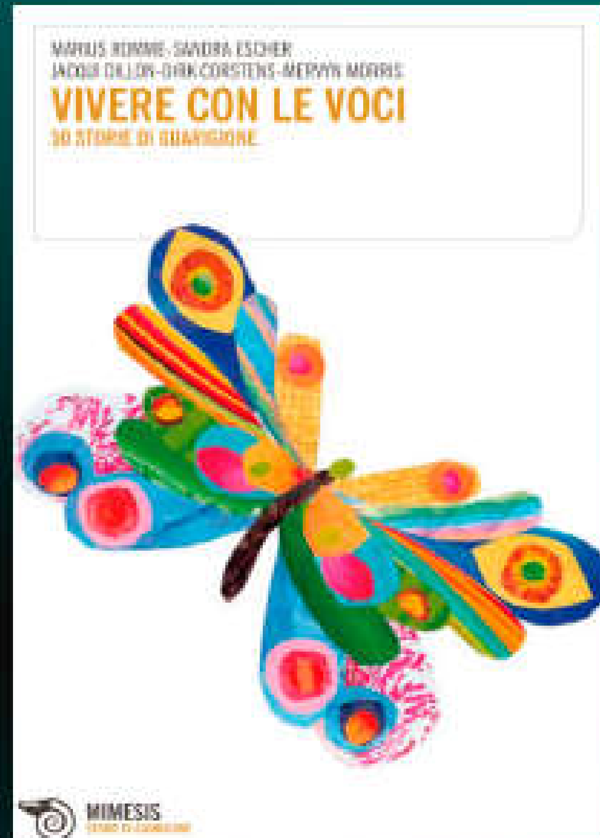
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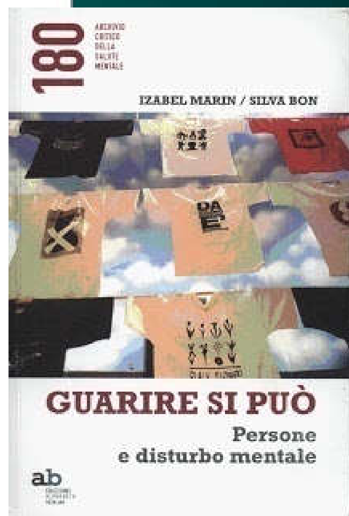
50 STORIE DI GUARIGIONE
MIMESIS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e disturbo mentale
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Storie di recovery
Percorsi ed esperienze
nella riabilitazione psichiatrica
LIVE

Recovery and people with severe mental disorders

Due "modelli" alternativi o complementari :

1. Il punto di vista dei "professionisti":

Recovery *dalla malattia*; recovery come *esito*

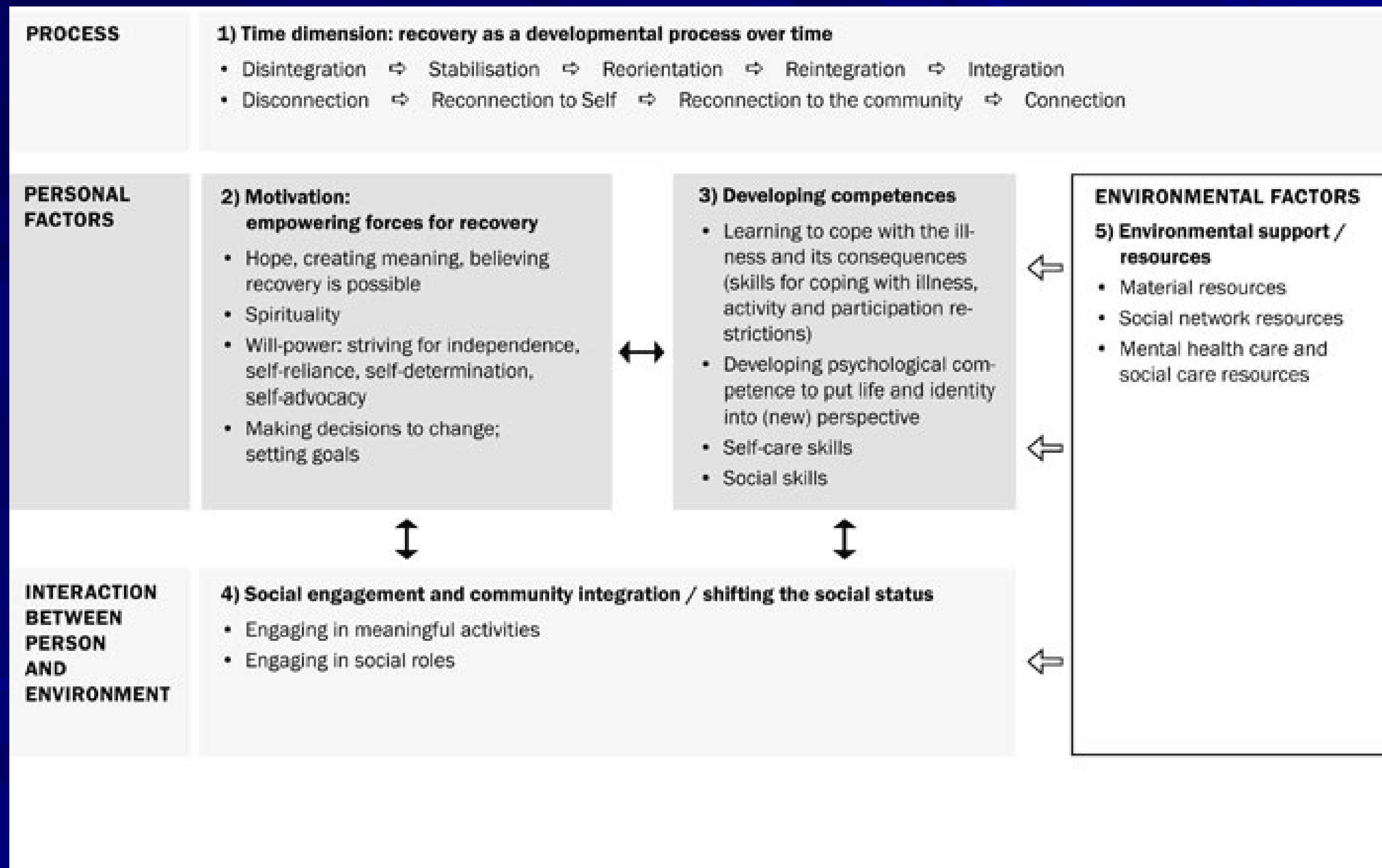
- **Basato su evidenze cliniche ed epidemiologiche**
- **Correlato con gli interventi professionali**
- **Farmacoterapia**
- **Riabilitazione psicosociale**

2. Il punto di vista degli "utenti":

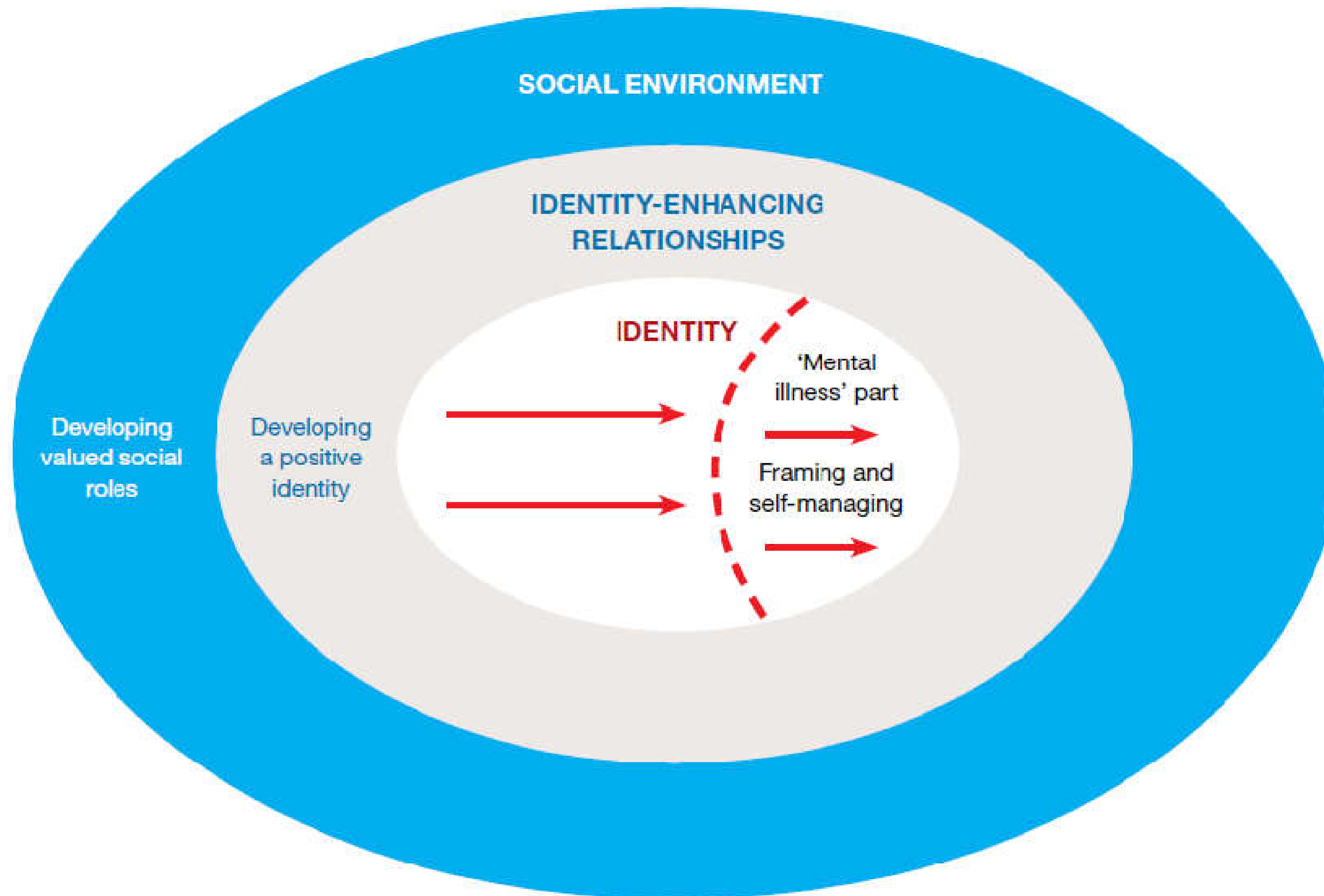
Recovery *nella* malattia; recovery come *processo*

- **Basato sui racconti in prima persona e studi qualitativi**
- **Correlato con alcuni interventi professionali ma anche self-help, cure informali, sforzi personali e "salute positiva"(resilienza, speranza, auto determinazione, etc.)**

Understanding Recovery from Psychosis: A Growing Body of Knowledge



Wilken JP, Tidsskrift for Norsk Psykologforening, 2007



Slade M, 2010

Five Stages in the Recovery Process

Impact of Illness	The person is overwhelmed and confused by the disabling power of the illness. **The task is to decrease the emotional distress by reducing the symptoms.**
Life Is Limited	The person has given into the disabling power of the illness and is not ready/able to make a change. **The task is to instill hope, a sense of possibility, and to rebuild a positive self-image.**
Change Is Possible	The person is beginning to question the disabling power of the illness and believes that his/her life can be different. **The task is to empower the person to participate in his/her recovery by beginning to take small steps.**
Commitment to Change	The person is challenging the disabling power of the illness and is willing to explore what it will take to make some changes. **The task is to help the person identify his/her strengths and needs in terms of skills, resources and supports.**
Actions for Change	The person is moving beyond the disabling power of the illness and is willing to take responsibility for his/her actions. **The task is to help the person use his/her strengths and to get the necessary skills, resources and supports.**

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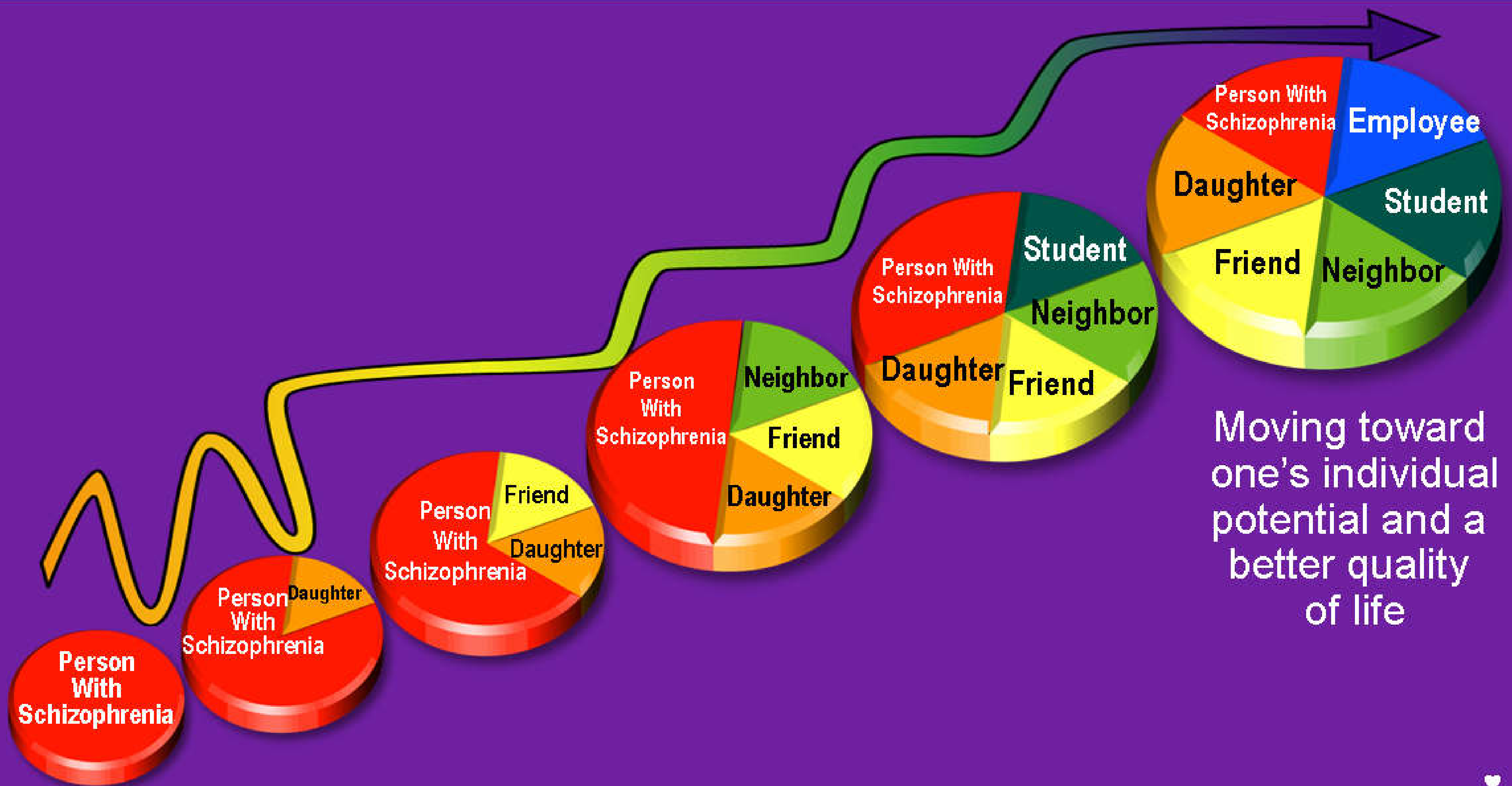
Le fasi del processo di recovery

6 D. Jose et al. / Asian Journal of Psychiatry xxx (2015) xxx–xxx

Table 3
Stages of recovery.

Stages of trans-theoretical model	Spaniol et al. (2002)	Andresen et al. (2006)	Noiseux and Ricard (2008)	Henderson (2011)
1. Precontemplation 2. Contemplation	1. Overwhelmed by disability	1. Moratorium 2. Awareness	1. Experiencing Illness 2. Igniting spark of hope 3. Developing insight	1. Recuperation 2. Moving forward 3. Getting back
3. Planning	2. Struggling with disability	3. Preparation	4. Activating the instinct to fight Back 5. Discovering keys to wellbeing	
4. Action	3. Living with disability	4. Rebuilding	6. Maintaining equilibrium between external and internal Environment	
5. Maintenance	4. Living beyond disability	5. Growth	7. Perceiving light at the end of the tunnel	

Optimizing Outcomes: The Process of Recovery[1]



1. Anthony WA. *Psychosocial Rehabilitation Journal*. 1993;16(4):11-23.
2. Adapted from: The Village. Available at: http://www.village-isa.org/Overview/psr_circle.htm.

Narrative Synthesis of Recovery Processes

Connectedness
- Peer support and support groups
- Relationships
- Support from others
- Community

Hope and optimism
- Belief in recovery
- Motivation to change
- Hope-inspiring relationships
- Positive thinking and valuing success
- Having dreams and aspirations

Identity
- Rebuilding positive sense of identity
- Overcoming stigma

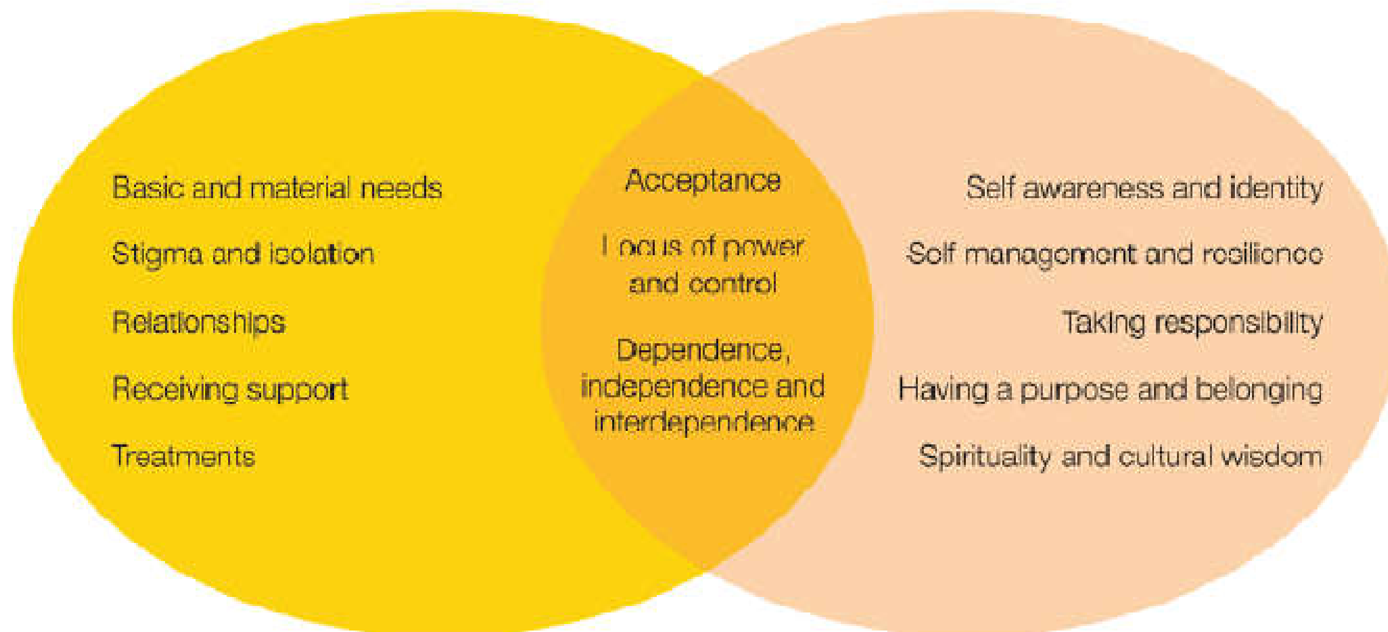
Meaning
- Meaning in mental 'illness experience'
- Spirituality
- Meaningful life and social roles
- Meaningful life and social goals

Empowerment
- Personal responsibility
- Control over life
- Focusing upon strengths

Leamy , M et al (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis BJPsych 199:445-452

rethink

Figure 3: Recovery mediators of contextual and personal themes



Characteristics of the recovery journey

- Active process
- Individual & unique process
- Non-linear
- A journey
- Stages or phases
- A struggle
- Gradual process
- Life-changing experience
- Recovery without cure
- Aided by supportive environment
- Multidimensional
- Trial and error process
- Can occur without professional intervention

Leamy M, Bird V, Le Boutillier C, Williams J, Slade M (2011)
A conceptual framework for personal recovery in mental health: systematic review and narrative synthesis,
British Journal of Psychiatry, **199**, 445-452.

"Se una percentuale così alta di persone migliora, perché non ne incontro nessuna ?"

Davidson, 2015

Perspectives

The Clinician's Illusion

Patricia Cohen, PhD; Jacob Cohen, PhD

• There are several diseases, including schizophrenia, alcoholism, and opiate addiction, for which the long-term prognosis is subject to disagreement between clinicians and researchers and also among researchers. Part of this disagreement may be attributable to a difference in the population they sample. The clinician samples the population currently suffering from the disease (a "prevalence" or census sample), while research samples tend to more nearly represent the population ever contracting the disease (an "incidence" sample). The clinician's sample is biased toward cases of long duration, since the probability that a case will appear in a prevalence sample is proportional to its duration, hence "the clinician's illusion." The statistical mechanism of this bias is illustrated and its consequences detailed. Other sources of sampling bias in clinical and research samples are briefly described and partial remedies are suggested.

(*Arch Gen Psychiatry* 1984;41:1178-1182)

There are several diseases for which there exists a great disparity in the prognostic expectations of practicing clinicians and investigators of the natural history of the disease. This difference in perspective sometimes leads clinicians to reject formal investigations as invalid or at best irrelevant to the patients they treat. It similarly leads some researchers to view clinicians as unable to surrender clearly invalid ideas about the nature of the problems and prognoses of their patients. Although doubtless some of these discrepancies arise from the difference in their professional roles vis-a-vis patients, another possibly major source of this difference is a function of a sampling problem that has not been generally appreciated.

In this article, illnesses in which this bias is most likely to be found are identified and a neglected methodologic problem that could account for the disparity wholly or in large measure is illustrated. In addition, several other sources of bias or discrepancy that may further complicate and obscure the problem are discussed. Finally, this same problem is shown to be reflected in inconsistencies among research findings. Current research reports in psychiatry often do not allow a proper consideration and correction of the bias. Recommendations for future research and research reports are made.

A 1962 example of a disputed prognosis is available for alcoholism.[1] Although it is not the intent of this article to draw substantive conclusions, it seems likely that the debate regarding the long-term outcome of treatment programs for alcoholics[2,3] has been fueled by the conviction of many clinicians that the research findings of the studies in question did not coincide with their clinical experience. Nevertheless, the preponderance of the research findings with regard to the long-term outcome of alcoholism[4,5] seems to support the Sobells' findings[2] in a general way. That is, they indicate that at least half of all serious alcohol abusers recover completely, many without formal treatment. Furthermore, in contrast to conventional clinical wisdom, a fair proportion of these once-alcoholics have returned to social drinking rather than to abstinence.

A similar debate exists with regard to prognosis in schizophrenia. The traditional view is that schizophrenia is a chronic, deteriorating, and more or less incurable disease. Among clinicians, the most favorable outcome estimate is the "⅓, ⅓, ⅓" rule: one third will get better, one third will stay the same, and one third will get worse. The *DSM-III* of the American Psychiatric Association is even less sanguine, stating that "a complete return to premorbid functioning is unusual—so rare, in fact, that some clinicians would question the diagnosis. . . ."[6] Thus, the issue of prognosis is addressed, in part, by defining the illness in such a way as to resolve it. In sharp contrast, studies of the natural history of schizophrenic illness suggest a much more favorable prognosis than the "one-third will get better" rule.[7-9]

There are a number of other conditions in which a parallel discrepancy exists in the prevailing view of clinicians and results from clinical trials when compared with the evidence produced by research into the natural history of the condition. For example, Schacter[10] has found what many lay people know firsthand, namely, that many people are obese at some time in their life but return, with or without professional help, to a weight within or close to published normal standards on a more or less permanent basis. Similarly, in contrast to the experience of services designed to help people quit smoking, it has been found that more than 60% of those heavy smokers who tried to quit no longer smoked.[10]

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From the New York State Psychiatric Institute, Columbia University School of Public Health (Dr P. Cohen), and New York University (Dr J. Cohen), New York.

Reprint requests to New York State Psychiatric Institute, 722 W 168th St, New York, NY 10032 (Dr P. Cohen).

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ACTA PSYCHIATRICA SCANDINAVICA

Editorial

Recovery, psychosis and psychiatry: research is better than rhetoric

Recovery has been defined as '*a personal process of overcoming the negative impact of diagnosed mental illness/distress despite its continued presence*' (1, p. 2). The approach has received many endorsements. In the UK, policy states that '*Services of the future will talk as much about recovery as they do about symptoms and illness*' (2, p. 24), and professional groups such as psychiatrists (3) and nurses (4) have embraced the rhetoric. Internationally, the approach has been formally adopted in New Zealand (5), the Republic of Ireland (6) and USA (7), among others. Guidance is being disseminated (1) and editorials written (8). Recovery is in vogue.

What are the defining characteristics of a recovery-focussed mental health service? Recovery is understood to mean something different to either sustained remission or cure – it is a way of '*…living a satisfying, hopeful, and contributing life even with the limitations caused by illness*'. (9, p.527). Goals are user-defined and therefore individual and sometimes ethically challenging for staff to work with. Staff have an optimistic and hope-inducing view about the ability of people to find meaning in their experiences – to generate a story or narrative about themselves which leads to a future beyond (though possibly including) mental illness. Language is different, because staff recognise the power of language to shape belief, and do not want to limit change by imposing an explanatory illness model when other models may be more helpful to the individual.

The policy and practice implications of recovery-focussed service have been explored elsewhere (10–13). At its simplest, this will mean clinicians basing decisions less on professionally-defined goals and more on listening to *and acting on* the service user's wishes.

If recovery-focussed mental health services differ from traditional services, what has been the response to this call to change? Several responses can be identified. Some researchers have insisted on symptomatological and functional improvement (rather than patient-defined criteria) as the sole indicator of recovery (14, 15). Others commentators express the view that the term 'recovery' is vacuous – '*a redefinition of the term* 'recovery' in order to give hope is to build hope on illusion' (16, p. 48). Services have appropriated the term without meaningfully changing their function, *e.g.* re-labelling rehabilitation services as 'Recovery and Rehabilitation Services'. These responses are all consistent with an aim of maintaining the *status quo*. They may be the most appropriate responses, but the paucity of evidence means that it is currently impossible to have an informed debate.

Empirical research is needed. We therefore propose a research programme to identify the costs and benefits of developing recovery-focussed mental health services.

Recovery research needs to combine methodological rigour with not disadvantaging recovery-focussed approaches by evaluating them using methods and outcome criteria which are biased towards traditional working practices. We identify three strands to this research programme: identification and prevalence; outcome measures and evaluation methodologies; and interventions and cost-effectiveness.

First, the active ingredients of recovery-focussed mental health services need to be established. As well as working practices, the ingredients will include staff attitudes, values and beliefs. This represents a change from the current modernist approach to describing services (i.e. they are fully characterised by what they do), in recognising that mental health services involve people, both using them and working in them, so *how* staff work also matters (17).

Once identified, the active ingredients will inform the development of fidelity scales, which assess adherence by the service to the active ingredients required for a mental health service to be recovery-focussed. This approach to ensuring treatment fidelity is a standard approach to identifying whether a service model is actually implemented (18), a necessary element of evaluation (19). These fidelity scales can then be used to establish national baseline prevalence estimates of the extent to which services are recovery-focussed.

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A Systematic Review and Meta-Analysis of Recovery in Schizophrenia

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Objective: **Our primary aims were (*a*) to identify the proportion of individuals with schizophrenia and related psychoses who met recovery criteria based on both clinical and social domains and (*b*) to examine if recovery was associated with factors such as gender, economic index of sites, and selected design features of the study. We also examined if the proportions who met our definition of recovery had changed over time. *Method:* A comprehensive search strategy was used to identify potential studies, and data were extracted for those that met inclusion criteria. The proportion who met our recovery criteria (improvements in *both* clinical and social domains and evidence that improvements in at least 1 of these 2 domains had persisted for at least 2 years) was extracted from each study. Meta-regression techniques were used to explore the association between the recovery proportions and the selected variables. *Results:* We identified 50 studies with data suitable for inclusion. The median proportion (25%–75% quantiles) who met our recovery criteria was 13.5% (8.1%–20.0%). Studies from sites in countries with poorer economic status had higher recovery proportions. However, there were no statistically significant differences when the estimates were stratified according to sex, midpoint of intake period, strictness of the diagnostic criteria, duration of follow-up, or other design features. *Conclusions:* Based on the best available data, approximately, 1 in 7 individuals with schizophrenia met our criteria for recovery. Despite major changes in treatment options in recent decades, the proportion of recovered cases has not increased.**

Key words: schizophrenia/psychosis/recovery/outcome studies/prognosis/epidemiology

It is widely accepted that a proportion of ir who develop schizophrenia have a favorable p Symptoms can abate over time, and a prop those with schizophrenia attain good outcor range of clinical and functional outcomes (eg, e employment, and relationships). The precise p of cases that have favorable outcomes is le understood. To a large degree, this relates to ur about how to measure multifaceted outcome "recovery." Considering how much research has been allocated to exploring the *onset of* (eg, prodrome and early psychosis), it is ap that a comparable degree of research scrutin accorded to the *recovery of psychosis.*[1] With r the remission of clinical symptoms, operatic criteria are now available.[2-4] However, symptor are only one component of the many facets of Many consumer-based groups conceptualize re a *personal* journey (ie, a subjectively evaluate dealing with symptoms over time) rather than point *outcome* (completely recovered vs illness).[5] In contrast to most clinical symptoms, related to recovery do not lend themselves t reliable metrics.[6,7]

Regardless of the ongoing debate around how and measure recovery,[3] we argue that there is case to continue to explore clinical and functi comes of schizophrenia from an epidemiologica tive. In recent years, systematic reviews of the in prevalence,[9] and mortality of schizophrenia[10] l published. Of the 4 key epidemiologic indicator to understand the dynamics of disorders such a phrenia in a population (incidence, prevalence, r

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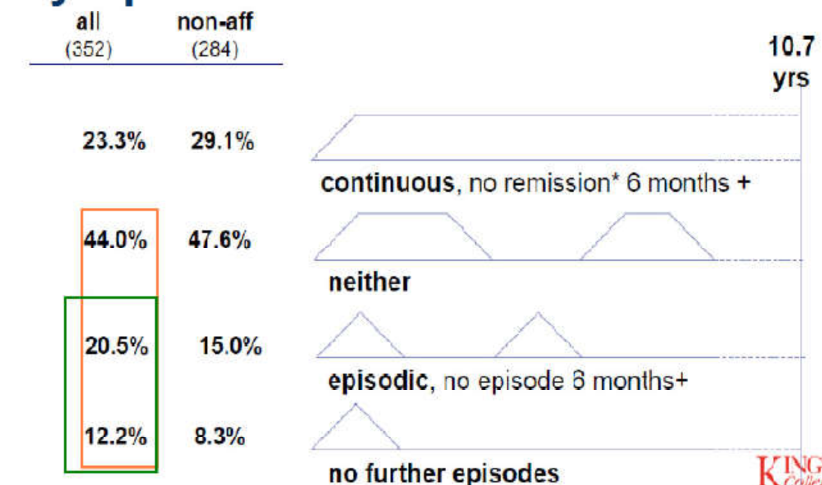
Relapse and recovery following first episode psychosis: findings from the AESOP 10-year follow-up study

Institute of Psychiatry at the Maudsley



*remission absence of symptoms at threshold level

Details of studies included in the review.

Review

Consumer perspectives on the concept of recovery in schizophrenia: A systematic review

Diksy Jose [a,1], Ramachandra [b,2], K. Lalitha [b,3], Sailaxmi Gandhi [b,4,*], Geetha Desai [c,5], Nagarajaiah [b,6]

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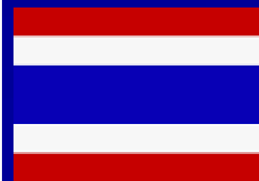

				connection with their environment
5	Tooth et al. (2003)	To understand the consumer perspectives on recovery	Qual-phenomenological 57 patients	Taking responsibility, having structure and organization, being like normal people, personal intention to living your life, process occurs in stages etc.
6	David et al. (2004)	To compare recovery concepts between professionals and general population	Quantitative survey	Significant difference between psychiatrist's and general population attitude towards recovery
7	Resnick et al. (2005)	To conceptualize and measure recovery orientation	Quantitative 1076 patients	Significant factors identified are: life satisfaction (.88), hope and optimism (.77)
8	Andresen et al. (2006)	To identify the stages of recovery based on consumer perception	Qual-grounded theory 94 patients	Five staged process. Stages are moratorium, awareness, preparation, rebuilding, growth
9	Jenkins and Song (2005)	To understand the subjective experience of recovery as reported by persons living with schizophrenia	Qual-ethnographic 90 patients	Process of awakening and improvement, gradual and non linear progression, incremental in nature with occasional set backs and subjective experience
10	Zanker (2008)	To explore the concept of recovery and reintegration relative to mental illness in low income countries	Qual-grounded theory 54 patients	Recovery is both process and outcome
11	Ng et al. (2008)	To understand the meaning of recovery as told by chronic schizophrenia patients	Qual-phenomenological 8 chronic schizophrenia patients	Multidimensional concept, full recovery is when the patient stops medication and has a steady job, disappearance of symptoms, independent living
12	Church et al. (2009)	To discover the meaning of mental health recovery to psychiatric survivors	Qual-grounded theory 10 patients	Recovery is a personal and collective journey and a site of struggle
13	Lysaker et al. (2010)	To compare the personal narratives of recovery with standardized scale	Qual-descriptive 103 patients	Wellness in relationship, enhanced connections, give and take relationship, self identification
14	Andresen et al. (2010)	To compare the consumer defined and clinical recovery measures	Quant-correlational 281 patients	Significant difference between clinical measurement and subjective experience of recovery
15	Noiseux and Ricard (2008)	To arrive at a theoretical explanation of recovery based on consumer perspectives	Qualitative 16 patients, 5 family members and 20 health professionals	Intrinsic, non linear progress, regain/rebuild sense of self on all biopsychosocial fields, manage imbalance between internal and external forces
16	Henderson (2011)	To understand West Australians' consumer perspectives about recovery	Qual-grounded theory 15 patients	Three phase process of adjusting or overcoming three fold losses: biomedical, psychological, and/or social
17	Coldwell et al. (2011)	To identify the contribution to	Qual-grounded theory	Complex process shaped by

The Psychiatrist (2010), 34, 465–470, doi: 10.1192/pb.bp.109.027409

Conceptualisation of recovery from psychosis: a service-user perspective

Lisa Wood,[1] Jason Price,[1] Anthony Morrison,[1,2] Gillian Haddock[2]

Box 1 Interpretative phenomenological analysis: key themes, subthemes and further themes of aspects important to a change in recovery.

Impacts on mental health

Reduction in symptoms of psychosis
- Preoccupation with experiences
- The content of experiences
- The frequency of experiences
- The duration of experiences
- The loudness of voices
- The origin of the experiences
- Perception of experiences
- Amount of distress
- Conviction

Emotional change
- Overcoming depression and low mood
- Feelings of happiness and enjoyment
- Overcoming anxiety and stress
- Overcoming anger and frustration
- Changes in the amount of emotions experienced

Self-change and adaptation

Personal change and belief
- Positive self-beliefs
- Redefining who you are
- Feeling less vulnerable
- Overcoming embarrassment
- Regaining personal freedoms and rights
- Having a positive outlook for the future

Behavioural change
- Improvements in sleep
- Energy and lethargy
- Motivation for change
- Reduction in self-harm and suicidal ideation
- Regaining independence
- Changes in drug and alcohol use

Social redefinition

Occupational change
- Stable living conditions
- Job seeking and maintaining employment
- Financial stability

Relationships and social behaviour
- Being less withdrawn and isolated
- Finding the ability to trust others
- Taking part in meaningful activities and hobbies
- Developing and depending on relationships with friends and loved ones
- Increasing social activity
- Overcoming being judged and stigmatised

Individualised coping mechanisms

Support and treatment
- Benefits of medication
- Benefits of therapies
- Peer support
- Support from loved ones and/or friends
- Receiving help from the mental health services
- Concerns over the side-effects of medication
- Importance of spirituality/religion

Understanding and control
- Help-seeking with experiences
- Recognising the early signs of becoming unwell
- Being able to cope with experiences
- Understanding your experiences and/or diagnosis
- Feeling empowered over your experiences
- Having control over experiences
- Thinking clearly about experiences
- Having control over own thoughts

Recovery and Severe Mental Illness: Description and Analysis

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- ***Hegarty**, 1994* — ***320 studi*** — ***40 %***
- ***Menezes**, 2006* — ***37 studi*** — ***42 %***
- ***Warner**, 2004* — ***114 studi*** — ***11-33 %***
- ***Jaaskelainen**, 2013* — ***50 studi*** — ***13,5 %***

CanJPsychiatry 2014;59(5):236–242

Scopi della ricerca S.I.R 2

FASE 1 - QUANTItativa

- Applicazione di strumenti per la misurazione del recovery utilizzabili nella pratica clinica

(Recovery Assessment Scale – versione italiana)

FASE 2 - QUALItativa

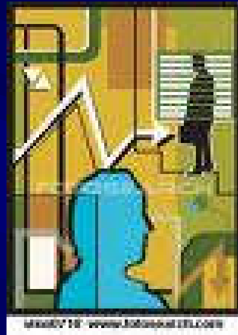
- Raccogliere il punto di vista degli utenti sugli elementi cruciali per il loro processo di recovery
- Identificare i fattori favorenti o ostacolanti il recovery, per poter *ri-orientare* i servizi psichiatrici al recovery

La ricerca S.I.R.2 (2012-13)

HoNoS

Health of the Nation Outcome Scale

(Lora, 2001)



Empowerment

SESM (Straticò,2007)

R.A.S.

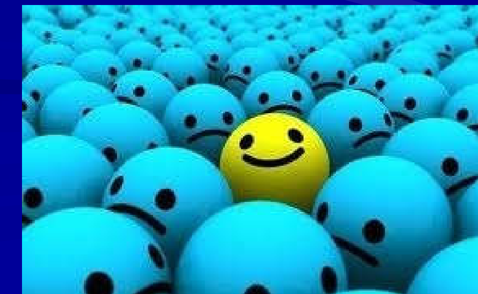
Recovery Assessment Scale

Autostima

Questionario R.S.E. (Prezza,1997)

Qualità della vita

MANSA (Priebe, 1999)



Intervista sui fattori di Recovery

Lombardia 3

Emilia-Romagna 1

Liguria 1

Piemonte 1

Lazio 1

Campania 1

Alto-Adige 2

Veneto 9

Dipartimento di Psicologia generale Università di Padova

Puglia 4

Molise 1

Marche 1

Tot=25 centri/11 regioni

Studio Italiano sul Recovery

SIR 2

Individuazione utenti

Raccolta dati anagr., clinici, cons. inf.

>= 40% (2-5)

Criteri UCLA

60% (3 – 10)

Non criteri UCLA

FASE 1

RAS, SESM, MANSA, HoNOS, RSE

Utenti in Recovery (n.65)

Utenti non in Recovery (n.151)

Familiari di utenti in Recovery (n.45)

FASE 2: Intervista

Fattori favorenti il recovery

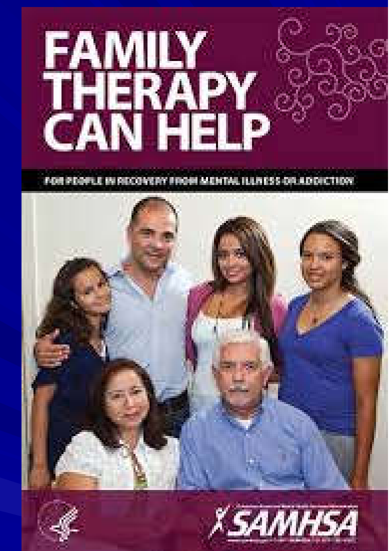
- *ABILITA' DI GESTIONE DELLA MALATTIA*
- *PERSONE DI SUPPORTO*
- *FARE ATTIVITA' SIGNIFICATIVE*
- *DETERMINAZIONE*
- *SENSO DI CONTROLLO*
- *VISIONE POSITIVA DEL PRESENTE E FUTURO*

Fattori ostacolanti il recovery

- *STIGMA INTERNO ED ESTERNO*
- *SINTOMI PERSISTENTI*
- *MANCANZA DI RISORSE*
- *OSTACOLI LEGATI AL SERVIZIO*
- *GESTIONE EVENTI STRESSANTI*

Cosa dicono i familiari

- ***SOLLIEVO E INCERTEZZA***
- ***FARE I CONTI CON CIO' CHE SI E' PERSO***
- ***OSTACOLI: FREDDEZZA, DISTACCO, DISINTERESSE***
- ***RISPETTO E STIMA NONOSTANTE TUTTO***
- ***ESSERE RESI "ESPERTI", PARTECIPI E CONSAPEVOLI***



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Conference paper

RECOVERY – RESHAPING OUR CLINICAL AND SCIENTIFIC RESPONSIBILITIES

Michaela Amering

Medical University of Vienna, Department of Psychiatry and Psychotherapy, Vienna, Austria

SUMMARY

Context: *Advocacy for Recovery has been joined by research offering new perspectives on mental health policy, treatment, rehabilitation and anti-discrimination efforts.*

Objectives: *Chances and challenges of a Recovery model for the mental health field will be presented and discussed.*

Key messages: *Recovery is currently widely endorsed as a guiding principle of mental health policy. New rules for services, e.g. user involvement and person-centred care, as well as new tools for clinical collaborations, e.g. shared decision making and psychiatric advance directives, are being complemented by new proposals regarding more ethically consistent anti-discrimination and involuntary treatment legislation as well as participatory approaches to evidence-based medicine and policy.*

Recovery advocacy has been joined by research on recovery and resilience resulting in new data on the long-term perspectives of people experiencing common as well as severe mental health problems. Definitions of remission and recovery as well as the concept of chronicity are under debate. Research questions regarding recovery as a process as well as an outcome warrant scientific efforts enabling the integration of different perspectives as well as different methodologies.

Conclusions: *Consequences and challenges of the Recovery model need to be tackled from different perspectives by clinicians, researchers, policy makers and – essentially - users and carers and their representatives in order to be fully explored and brought to life.*

Key words: *recovery – evidence base – user involvement - trialogue*

PERSPECTIVE

World Psychiatry 14:1 - February 2015

Recovery, not progressive deterioration, should be the expectation in schizophrenia

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doi:10.1093/schbul/sbt034

AT ISSUE

Does Long-Term Treatment of Schizophrenia With Antipsychotic Medications Facilitate Recovery?

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Editorial

LONG-ACTING INJECTABLE (DEPOT) ANTIPSYCHOTICS AND CHANGING TREATMENT PHILOSOPHY: POSSIBLE CONTRIBUTION TO INTEGRATIVE CARE AND PERSONAL RECOVERY OF SCHIZOPHRENIA

Miro Jakovljević

University Hospital Centre Zagreb, Department of Psychiatry, Zagreb, Croatia

* * * * *

	Provider-Determined		Consumer-Determined
	Coercive	Paternalistic	Recovery-Oriented
Program regulatory mechanisms	Contingencies (punishment focus) Enforced dependency	Contingencies (reward focus) Incentives for dependency	Non-contingent Incentives for autonomy and personal accountability
Associated practices	Mandated psychotropic medication Deficit-focus, Boilerplate treatment plans, Coercive treatments (threats of hosp., outpatient commitment, restraints) No consumer input on org. Minimal choice	Emphasis on medications Maintenance-focus Some individualization in treatment Clinician-driven treatment (with input from consumer) Pro forma mechanisms for consumer input Moderate choice (e.g., medication type)	Medications part of overall treatment plan Recovery-focus Individualized (e.g., consumer's own words) Consumer-driven (with input from clinician) Consumer input basic to org. Consumer as source of control
Impact on consumer's self-regulation	Non-intentional, Feelings of incompetence, Lack of control, Helplessness	Compliant, External motivation (based on other's expectations), Dependent	Self-agency Internal motivation Independent

Less Recovery Oriented ⟷ More Recovery-Oriented

How can we *use* diagnosis to *support* people in their recovery?

Guidance from the Devon Recovery Research and Innovation Group (D-RRIG)

How can we learn *to* live well?

A guide to core courses and key principles for a Recovery Learning Community

Guidance from the Devon Recovery Research and Innovations Group (D-RRIG)

Illness Management and Recovery

An Evidence-Based Practice

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

I cinque elementi fondanti dell'IMR

- *Il Recovery*

Motiva al cambiamento e aiuta ad individuare obiettivi significativi

- *La gestione della terapia*

Migliora la possibilità che i pazienti assumano la terapia come prescritto

- *Le strategie di prevenzione delle ricadute*

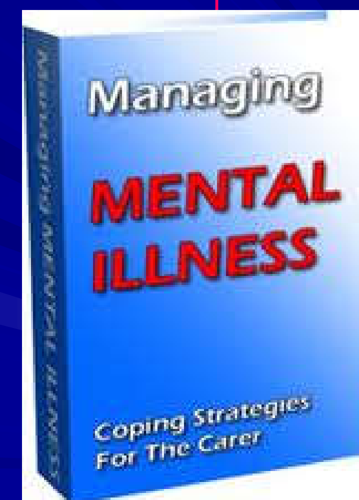
Riducono le ricadute
Riducono le ospedalizzazioni

- *Le strategie di gestione dei sintomi persistenti*

Riducono la severità dei sintomi persistenti
Riducono le esperienze stressanti legate ai sintomi

- *La psicoeducazione*

Migliora le conoscenze dei pazienti sulla malattia mentale e sul recupero
Fornisce informazioni sul trattamento



RECOVERY SUPPORT TASKS

The job of mental health professionals

1. Fostering relationships
2. Promoting well-being
3. Offering treatments
4. Improving social inclusion

Slade M (2009) *The contribution of mental health services to recovery*, Journal of Mental Health, **18**, 367-371.

Psychosocial treatments to promote functional recovery

Social skills training	• Coinvolge un numero di dimensioni importanti per il recovery • Presenta ampi effetti sul funzionamento nella comunità
Cognitive Behavioural Therapy	• Efficace nella riduzione dei sintomi positivi e negativi • Include alcuni aspetti del funzionamento nella comunità e della QoL
Cognitive Remediation	• Integra trattamenti specifici per migliorare target diversi (es. cognizione e abilità lavorative) • Coerente con il modello del recovery
Social Cognition Training	• Gli individui possono migliorare le prestazioni in una serie di processi cognitivi e sociali collegati al successo nel funzionamento sociale (es. percezione emotivo-affettiva)

QoL, quality of life

Kern et al. Schizophr Bull 2009;35:347–361

Background on Recovery and Recovery Orientation

- How can MH programs enhance feelings of competency?
  - Skills-based interventions (ADLs, work skills, social skills)
  - Employment
  - Self-management of mental illness (coping with symptoms)

Mancini et al, 2010

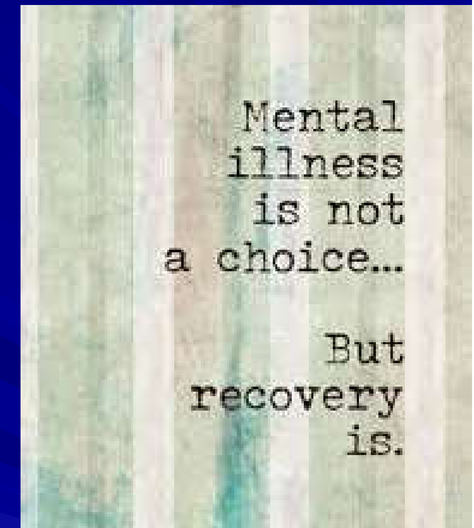
Background on Recovery and Recovery Orientation

- How can MH programs enhance feelings of relatedness?
  - Family-based interventions (psychoed. groups, contact w/ family members)
  - Focus on community integration (non-mental health activities)
  - Fostering relationships among consumers (group outings; special events)

Mancini et al, 2010

Quali interventi promuovono il recovery ?

- ***Illness management and recovery***
- ***Supported housing***
- ***IPS***
- ***Rivedere le pratiche inefficaci alla luce dell'esperienza degli utenti***



Drake and Whitley, 2014

Pratica orientata al Recovery

(Davidson et al., 2009)

- Primarieta' della partecipazione
- Favorire l'accesso e il coinvolgimento
- Garantire la continuita' della cura
- Utilizzare una valutazione basata sui punti di forza
- Offrire una pianificazione individualizzata del percorso di Recovery
- Fungere da "guida per il Recovery"
- Conoscere e sviluppare l'inclusione comunitaria
- Identificare e affrontare le barriere al Recovery

Le strategie:

Conoscenza della Recovery, approfondite informazioni cliniche e personali degli utenti, conoscenza dei valori personali degli utenti e del Team, lavoro in partnership, training individualizzati alla Recovery, applicazione del Coaching, valorizzazione delle capacità individuali (Skills-Talents), supporto al raggiungimento di obiettivi

cambio della pratica

RECOVERY INDIVIDUALE

Come la cultura del recovery può incrementare l'efficacia delle EBPs

- Erogare le EBPs secondo i principali valori chiave del recovery
- Integrare le EBPs con le strategie finalizzate a sviluppare la motivazione al cambiamento e a stabilire obiettivi personali
- Promuovere le abilità e le attitudini del personale che favoriscono il processo di recovery

(Carozza, 2013)

Le Boutillier C, Leamy M, Bird V, Davidson L, Williams J, Slade M (2011) *What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance.* Psychiatric Services, **62**, 1470-1476.

Che i servizi di salute mentale siano "attraversabili"…

E non "autostrade senza uscita"…

Subjective, “individual” aspects of recovery

- ***Process of personal growth and development (new learning experiences)***

- ***To be able to cope with personal and social disabilities of the disease (anti-stigma)***

- ***Re-gaining motivation, self-esteem, hope, autonomy, empowerment, quality of life***

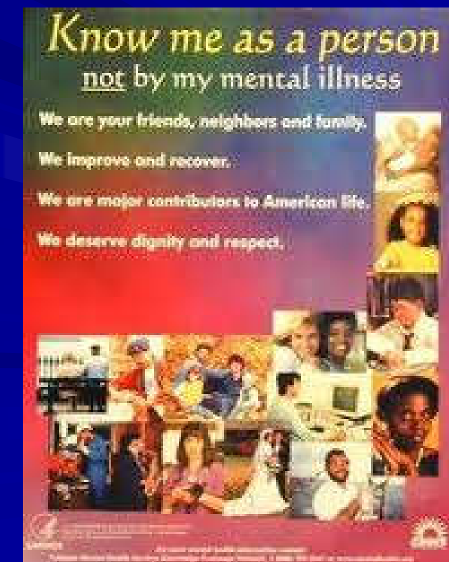
- ***Finding back to a satisfying and self guided life***

Schrank & Amering, 2007;
Brekke & Nakagami , 2010

Conclusioni…

- *La malattia mentale non è un destino*

- *La salute mentale non è per forza l'assenza di sintomi*



- *E' comunque possibile impegnarsi per una migliore qualità di vita*

- *Ai servizi di SM spetta di facilitare il recovery*

What outcomes are realistic

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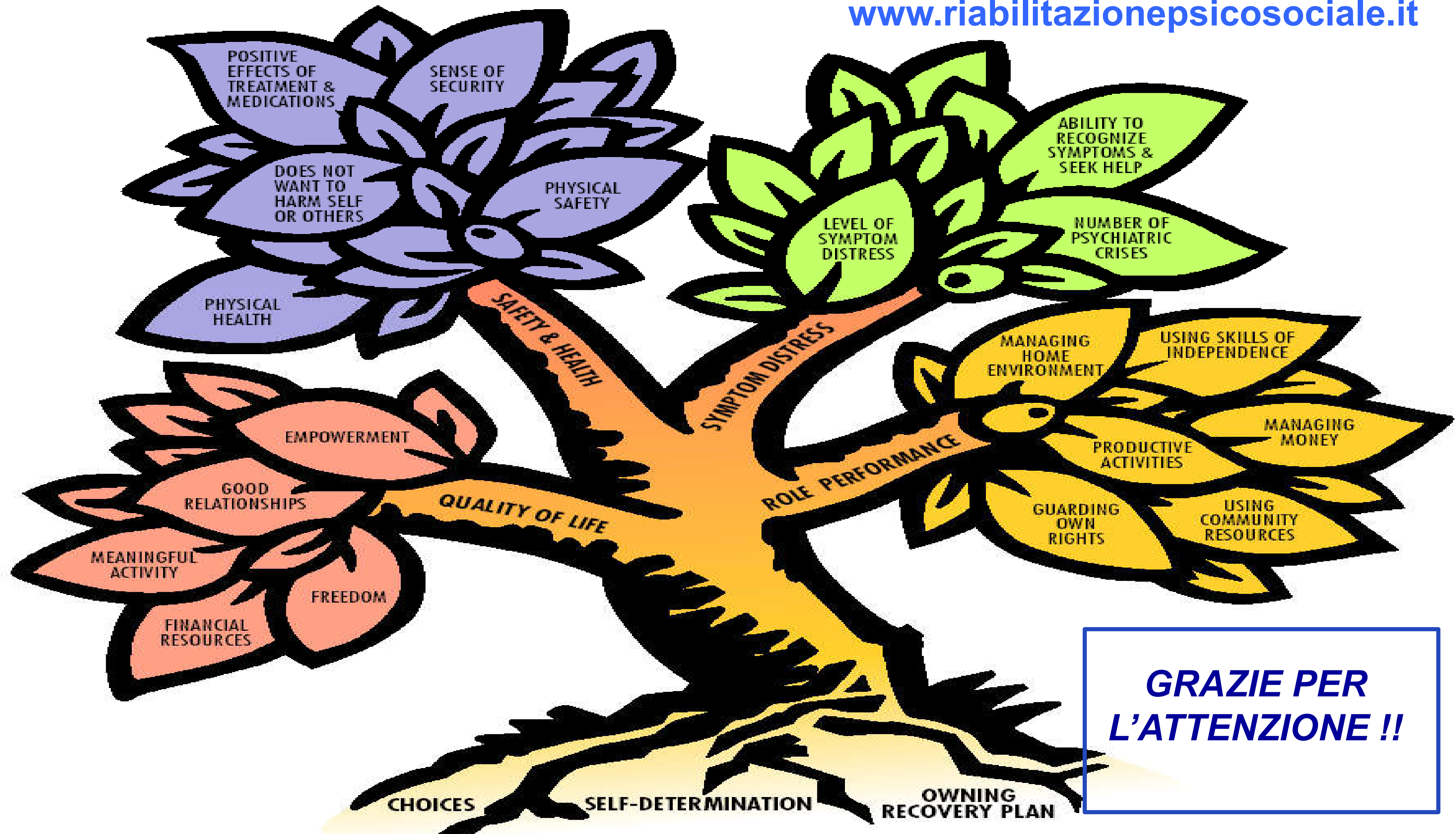

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GRAZIE PER L’ATTENZIONE !!