Recovery and Empowerment of Persons With Severe Mental Disorder

A Narrative Review

By

Ernesto Baena Ruiz, Eric M.J. Morris, Carol Harvey,
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Prologue

The personal recovery approach and model, in its current configuration, has a relatively short history. It emerged in the second half of the last century, after the processes of psychiatric deinstitutionalization, and as an alternative to the medical model prevailing up to that time.

The medical model, centered on the illness, was based on the health professionals’ power over everything concerning the patient's care and treatment. In contrast, the personal recovery model focuses on health, strengths and the person’s own ability to recover and manage the illness.

The concept of empowerment was specifically proposed in the middle of the 1980s. Since then, it has been extended as a paradigmatic approach applied to different population groups, including the group of persons with severe mental disorders (SMD).

In this book is presented a narrative review of current models of recovery and empowerment, and the impact of these models on the attention of persons with SMD and on assistance policies.

In the book, we review conceptual frameworks, research findings, key predictors of recovery and empowerment, evaluation instruments and criteria, and user and families' perspectives on recovery and empowerment.

This book represents a collaboration between all the named authors. Ernesto Baena Ruiz and Eric M.J. Morris coordinated the project, and Carol Harvey wrote the introduction.

Introduction

It is difficult to overstate the importance of the concept of recovery to our understanding of people who live with mental health conditions and their experiences and aspirations. At first, recovery from mental disorder was conceptualized, using a clinical (or sometimes functional) lens, as the elimination or reduction of symptoms and return to premorbid levels of function (Bellack, 2006).

Contemporary ideas of recovery, often referred to as personal recovery, emerged in the USA in the 1970s and 1980s through first person accounts of the lived experience of mental health problems and through the accompanying consumer and human rights movements (Deegan, 1996). However, it is evident that the origins of the recovery movement in mental health can be traced back to "humanistic philosophers, social activists and compassionate clinicians over the past couple of hundred years" (Davidson 2010; Roberts & Boardman, 2013, p400).

In this book are described many of these varied historical influences and the roots of today's conceptualizations on recovery, some reaching back even further into the past.

Publication of long-term follow-up studies of people living with conditions such as schizophrenia, which demonstrated that recovery was possible (Harding et al., 1987), was a particularly important development. These studies are outlined in this book. They helped to challenge prevailing pessimistic notions concerning the chronicity and persistence of mental health conditions which were widespread in the first half of the 20th century.

Recovery from, and living well with, mental health conditions has been an increasingly important and influential consideration since then to varying degrees, and at different times, around the world. There is now considerable international support for enabling personal recoveryorientated mental health service delivery. One example is the QualityRights specialized training resource developed by the World Health Organization (WHO, 2019). Therefore, the extensive review provided in this work on the history, concepts, paradigms and models, measurement and research underpinning personal recovery in mental health are very timely. As described by the authors, the meaning of recovery can be different for each person and hence, definitions of recovery abound. As noted by the World Health Organization (WHO, 2019, p33) in a conceptualization made on recovery, "For many people recovery is about regaining control of their identity and life, having hope for their life and living a life that has meaning for them whether that be through work, relationships, spirituality, community engagement or some or all of these".

This illustrates the multidimensionality and subjectivity of the recovery experience which understandably contributes to these varied definitions of recovery. Similarly, subjective experiences feature within one particularly influential definition proposed by Leamy et al. (2011), summarized using the acronym CHIME. The CHIME conceptual framework is composed of five recovery processes: connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. In relation to the process of empowerment, this book also provides a detailed discussion of the concept and approach to empowerment.

Whilst acknowledging the diverse definitions of recovery and the associated challenges presented to its meaningful measurement, this should not deter us from engaging with the concept of recovery, as encouraged by the authors of this book. Many studies of recovery are helpfully brought together here for the reader, but it is also clear that personal recovery as a process and outcome should be even more central to mental health research.

A greater role for mental health users in all aspects of the research process as well as an increased emphasis on qualitative research is likely to be beneficial in achieving this (Killaspy et al., 2022).

Further, the lack of studies focused exclusively on the relational context of recovery, including the perspective of family members concerning the recovery approach, is highlighted within this publication and requires urgent attention.

It is undoubtedly true that recovery can be experienced despite ongoing symptoms and incapacities, and without recourse to mental health treatment and service delivery (Deegan, 1996; Roberts & Boardman, 2013). Nonetheless, this book emphasizes the centrality of psychosocial interventions to supporting many users in achieving meaningful recovery.

Our recent systematic review and narrative synthesis of the literature on social interventions for people living with severe mental illness, highlighted the benefits to users of delivering social interventions within a recovery-oriented framework (Killaspy et al., 2022).

There is a synergy between psychosocial interventions, thoughtfully delivered that are recovery-oriented and likely to involve service users and their supporters in a respectful and collaborative way, and service user and family involvement in mental health services. The involvement of service users and their families and supporters can help to maintain this strong focus on recovery orientation in services.

Thus, recovery and humanistic and collaborative approaches to mental health practice are broadly aligned and, rightly, are strongly emphasized throughout this book.

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Part One

Recovery Approach In Severe Mental Disorder

- Concept of recovery
- Models of recovery in mental health
- Clinical guidelines and recovery recommendations
- Predictors of recovery
- Impact of stigma and self-stigma on recovery
- Research and studies focused on recovery
- Measurement of recovery
- Recovery and new technologies
- Cultural diversity in the perception of recovery
- Perspectives of the users and family members on recovery
- Current recovery paradigms
- Final observations on recovery approach

Chapter 1
Concept of Recovery

To carry out this conceptual approach, it seems appropriate to briefly describe how the term “recovery” has been considered. Its etymological consideration and some considerations made from mythology and philosophy are reviewed.

Etymologically, the term recovery derives from the Latin word “recuperatio”; action and effect of taking back something lost. But this first etymological approach is only partially related to the current approach to recovery in mental illness. The use of the term by Roman society was mainly confined to the field of private law.

For this reason, it is necessary to make a second etymological approach to the term recovery, which leads to the concept of “remedy". In ancient times, the recovery of the person with SMD was associated with the use of some remedy. The current conceptualization of the term recovery and its multidimensionality (restoration, autonomy and competence, personal decision-making, individual rights) does not resemble its original conception.

To resort to mythology as an explanatory model, and particularly to Greek mythology, rich in images and metaphors, is something very frequent. Regarding the recovery of mental illness, it is obligatory to turn to the “Myth of Asclepius” (“Ασκληπιός” in Greece. “Aesculapius” in Rome).

Asclepius, considered God of Medicine, was the product of one of the many love affairs of the god Apollo, among them with the princess Coronis. Apollo entrusted the education of the young Asclepius to the centaur Chiron, who for years instructed him in the practice of medicine.

According to the myth, Asclepius acquired great skill, and practiced medicine based on healing plants whose success in the recovery of the sick, caused many shrines to be erected in his honour in different areas of Greece.

In which temples and sanctuaries, patients were allowed to rest and sleep near the playrooms ('abaton'), where prophetic dreams took place. According to the myth, patients during their stay in the abaton of the temples could feel the presence of Asclepius, providing them with therapeutic advice and remedies that contributed to their recovery.

In relation to the importance of the doctor-patient link bond in the recovery process, there is also a significant mythological reference. It is the "Myth of Trophonius", who after the bloody event with his brother Agamedes, flees and takes refuge in a cave in the village of Lebadeia, in the region of Boeotia.

According to the myth, Trophonius was a kind of qualified medical assistant, able to change the temperament of a given subject, to an opposite polarity. Thus, the persons with SMD (catatonics, severely depressed), were led to his presence with the aim of their recovery.

The ways people with severe mental health problems were attended to in the Greek temples erected in honour of Asclepius, could be the antecedent of the first and honourable manifestations of care for persons with severe mental illnesses in asylum contexts and places that did not only contemplate their confinement.

In Spain, for example, it is worth mentioning the experience of Valencia in the 15th century, promoted by Father Joan Gilabert Jofré (1350-1417), who, on his way to the cathedral of that city, saw how a group of boys insulted and stoned a psychotic man.

Dismayed, he would change the intended content of his sermon, and as narrated in the "Book Becerro" (medieval codex), he proclaimed: "In the present city, there are many pious works and of great charity, but there is one that is of great need, a hospital or house where the poor innocent and insane can be together, because it would be a holy thing and a very holy work, that in the city of Valencia a house or hospital be made where these sick and innocent, would be in such a way that they would not wander around the city nor could they harm themselves, nor would it be done to them".

Or the experience of, The House for the Insane of Zaragoza (Spain) in the 18th century. In the "ordinances" (instructions) of this institution, regarding how the treatment of the patients should be carried out, it was pointed out:

"Within the House, the insane men will be made to work in all the ministries and services that they could do according to their disposition; and insane women, in spinning, sewing, threading and other exercises. And the aldermen will take care, because we understand that there is a great need to take particular care in the cure of the insane, and being sick like the others, it is fair that the necessary remedies be applied to them".

In these hospitals, the patient's recovery was not considered, but neither was their exclusive confinement, and at least there was the idea of the human good as a higher goal.

Subsequent evolution of psychiatric care

This can be contrasted with how those considered insane were treated in the main in Europe. In 14th century, the first known European psychiatric institution (Bethlem Hospital. England, 1337) was established.

The treatment provided in Bethlem contemplated, among other things, the possibility that the English bourgeoisie, upon payment of a penny, could visit the hospital to contemplate the patients admitted, who were exposed to the public as if they were animals in a zoo (See Figure 1).

Figure 1: *Historical Attention To Severe Mental Disorder, Bethlem Royal Hospital (England, 1737)*

Engraving by William Hogarth (1697-1764)
(https://www.fundacionindex.com/gomeres/wp-content/uploads/2014/10/William_Hogarth_019.jpg)

In fact, this practice came to be known as "The Bethlem Show". The treatments given at the Bethlem, and later institutions were characterized by their ineffectiveness and aggressiveness. The patients were practically dispossessed of their human condition and dignity. In the Bethlem Hospital, the therapeutic objective was exclusively confinement. The patient's recovery was not contemplated; along with beliefs about incurability and moral degeneracy of the insane, there was also an economic influence. Recovery could mean a decrease in the income from his public exposure for general entertainment.

From the 16th century onwards, in the West is what is considered to be the “first psychiatric revolution”. The humanism that characterizes this Renaissance period places the focus of interest on the individual. Care to SMD gradually abandoned the previous demonological model to adopt a naturalistic and organicist perspective.

In the 18th century, the “second psychiatric revolution” was brought about by Philippe Pinel (1745-1826) and the “moral treatment” that he implemented at the Salpêtrière Hospital. The influence of Pinel and his moral treatment was later extended. It has been observed that this treatment constitutes the predecessor of modern occupational therapy.

The concept of recovery in philosophy

The conceptual and philosophical bases of the controversies related to the treatment of health, mental disorder and its recovery are already preconfigured in the framework of classical Greek philosophy.

During the mythological period, the Greeks practiced a psychosomatic medicine in which mental and physical symptoms were considered manifestations of the same disease. A moral concept of mental illness also appeared, as punishment due to some kind of guilt. This approach was later aggravated by the understanding of mental illness as a diabolical possession, since in the post-Platonic dualistic anthropology, dominant in the Middle Ages, the rational soul could not fall ill, since it belonged to the world of ideas.

In the post-mythological period, Thales of Miletus (624-546 B.C.) will argue for the existence of universals that transcend the particular nature of things. Heraclitus (544-484 B.C.) and Parmenides (540-470 B.C.) also wonder about the essence of these universals.

On the other hand, the atomistic theory of Democritus (460-370 B.C.) will open the way to biologistic currents, empiricism, associative psychology and the “behaviorist orientation”. Democritus asserted that the differences and properties of bodies were established according to the geometrical and mathematical relationships of the atoms that compose them.

He also explained “pleasure” in physical and mechanical terms, resulting from the movements of the atoms that constitute the soul, thus opening the way for a mechanistic and biologistic understanding of subjective experiences.

Plato (420-347 B.C.) establishes a dualism between the body and the soul, thus opening the way for the understanding of mental illness outside the body and in the realm of “the demonic”.

This view has survived to the present day in the form of stigma, as well as in the ambivalence and special sensitivity towards mental illness, and everything related to the psychiatric field.

Aristotle (384-322 B.C.) and Plato, respectively, will lay the philosophical foundations of idealism and realism, which will be the fundamental coordinates of the epistemological debate recurrent in psychiatry, between objectivism and subjectivism.

This type of thinking based on universals and particulars will allow the later appearance of psychiatric diagnoses based on categories, and the ongoing controversy as to whether these universal categories actually correspond to how nature is organized, or are fundamentally social conventions.

The approach to recovery from severe mental disorder is steeped in these ways of thinking about human beings, and still carries its influences, both positive (the idea of the human good as a higher purpose) and negative (the stigma attached to mental illness because of its relation to the demonic).

An appreciation of these etymological, mythological, and philosophical approaches forming the background to understanding recovery only takes us so far. Its more precise conceptualization in the field of mental health is complex.

Contemporary thinking about personal recovery involves an aim to help people with SMD to redefine their own life plan, which does not necessarily have to be the same as the one they had before the disorder. That is, it is not a matter of trying to recover the life as it was before, but of trying to give meaning to the life that one has at present.

Chapter 2

Models of Recovery in Mental Health

The Vermont Longitudinal Research Project by Harding et al. (1987), which was conducted in the mid-1950s and early 1980s, contributed importantly to the extension of the recovery approach and its conceptualization as a model. This study showed that two-thirds of the 269 patients participating in the study had either improved significantly or had recovered 25 years after their first evaluation, having undergone rehabilitation and community support programs. These observations prompted Anthony (1993) to argue that better understandings of clinical and functioning recovery should guide models of personal recovery.

Sowers (2012), makes a broad conceptual review of the recovery model, arguing its current value as a paradigm of care for people with SMD and the impact that this model has had on the approach taken by community psychiatry. In Broncano's (2016) contribution, a description of some theoretical models on recovery is offered. Among them:

- Wilber (2005), and his “quadrant model” in recovery (AQAL).
- Green (2004), and his framing of the main elements and components that facilitate the recovery.
- Lloyd et al. (2008), and their conceptualization of recovery framed in six dimensions.
- Pelletier et al. (2009), and their “global model” of recovery.
- Provencher and Keyes (2011), and their “two-continuum model” in recovery.
- Barker (2001), Barker and Buchanan (2010) and their “TIDAL” model of recovery based on the integration of present and future, through three dimensions: mastery of the self, mastery of the world, and mastery of others.

However, for some authors the historical development of this approach and various models of recovery, has lost its initial inspiration and ultimate objective, which was to restore to persons with severe mental disorders, their sense of dignity and respect, self-esteem and citizenship.

Davidson and González (2017), advocate for a paradigm shift in which the person "in recovery" remains at the center of choice and leadership of their own care, to co-development and co-evaluation of programs. Davidson and González (2017), outline four basic principles for carrying out recovery-oriented, user-centered care. The principles are:

- Recovery must identify and build on the strengths of the individual, their family and social network, as well as the resources and opportunities that exist in their community. For this reason, professionals first need to get to know the person, their family and friends and find out what their roles are within the community, as this provides the context for treatment and other interventions. The kind of life the person can live, where the person can live it, the strengths and resources that the person and their social network bring to these activities are important dimensions to consider in recovery-oriented planning and practice of care.
- Recovery focuses on informing, equipping, and empowering persons with a SMD to take an active role in the management of their illness. This should not minimize the role that family and significant others can play. The focus of recovery-oriented care shifts from what the professional needs to do to treat the illness to what the person and their loved ones need to know to manage the illness in everyday life.
- The planning and provision of recovery-oriented care are collaborative processes in which individuals and their loved ones are encouraged and enabled to play an active and meaningful role. Recovery-oriented care involves all parties taking an active role in all decision-making processes, including

decisions about who should be involved in the planning and the objectives on which the care is to be based.
- Recovery-oriented care delivery is based on a person-centered plan of care in which the individual and their loved ones play an integral role in association with healthcare professionals.

These principles can be observed in the development of therapeutic models for psychosis. These therapeutic models have been extending their field of application through recovery-oriented interventions aimed at both users and caregivers, individually or in groups, in a face-to-face or online format. The following are examples of these recovery-oriented models:

- Acceptance and commitment therapy: This model aims at achieving psychological flexibility as opposed to rigidity through six basic processes; emotional acceptance, cognitive defusion, flexible attention to present moment, the subject as "I observer", action according to values, establishment of commitments (Castilho et al., 2015; Roldán et al., 2015; Butler et al., 2016; Stjernswärd and Hansson, 2018).
- Cognitive-behavioral therapy: From this model, attempts are made to restructure cognitive processes and attributional styles to improve coping with the disease (Semonella et al., 2020; Biliunaite et al., 2021).
- Systemic therapy: From this model, a holistic approach is taken to everything that surrounds the patient and their family system. Psychoeducational techniques, metaphorical techniques and circular questions are usually used in their interventions (Bressi et al., 2008; Kordas et al., 2015; López-Castillo and Valencia-Obando, 2019).
- Dialectical-behavioral therapy: For this model, open dialogue between users and the facilitating role of professionals are key elements in the approach to psychosis. Special importance is given to self-compassionate communication in the interventions (Kemp, 2018; Stoewsand and Gagliesi, 2019).

Because of its importance and because of the growing implementation of assertive community treatment (ACT) in mental health services, it is useful to describe in more detail the approach taken by this model. ACT was conceived in the early 1970s, and defined as a comprehensive care service provided in the community by a multidisciplinary team for the treatment, support and rehabilitation of persons with SMD who do not maintain regular contact with ordinary psychiatric services (Marx et al., 1973; Test and Stein, 1976). The model has been subject to subsequent adaptations and modifications. However, according to Morago (2006), the following elements have been identified in the literature as basic components of the ACT:

- Multidisciplinary team formed by professionals from various disciplines: The teamwork of these professionals is based on the realization of a proactive-assertive intervention for the establishment of contacts with patients in their own environment, providing comprehensive care and support, both at clinical and personal and social level, promoting the integration of people with SMD in the sphere of their family and community relationships, as well as access to public and private services.
- Low user/professional ratio (10-15:1): To ensure a personalized service that takes into consideration the needs and preferences of each user..
- "In situ" treatment: Professional contacts with users take place in their homes or in other places in their community environment, and not in mental health services.
- Frequency of contact with users, availability and duration of the service: Contact with users is usually very frequent and flexible. The service is available twenty-four hours a day and seven days a week to provide an immediate and effective response in the event of a crisis. The services offered by ACT teams do not have a predetermined duration, and are provided for as long as the user's needs so require. This factor allows the development of

medium and long-term therapeutic relationships, based on mutual trust between professionals and users.

- Symptom control. The ACT model postulates that the combination of appropriate medication and psychosocial techniques of proven efficacy helps to control the symptoms of mental illness, avoiding subsequent hospital admissions and the deterioration and social stigma derived from frequent relapses.

This holistic approach to assertive community treatment in SMD care will allow close monitoring of the patient's progress at different levels and areas (clinical, family, socio-community) and therefore to notice the changes, needs and also the signs of relapse that the user may present. Although the ACT model has a solid track record, some authors point out that there is a common perception in mental health that ACT, as currently practiced, has not lived up to the promise of fostering user empowerment and self-determination (Salyers et al., 2010).

Thus, although the basic philosophy of ACT is consistent with empowerment and recovery for persons with severe mental disorder, ACT may not always be practiced in a way that also encompasses recovery.

To this end, Salyers et al. (2010) examine two evidence-based practices: assertive community treatment, and illness management and recovery (IMR) with peer specialists as IMR professionals. Overall, there were no differences in patient outcomes at the ACT team level, however, patients exposed to IMR showed decreased hospital use over time.

In many locations, the implementation of social and community support teams (SCST) have also been established. These teams are usually composed of psychologists, social workers and educators, who offer interventions in the patients' environment and home in order to improve their quality of life, domestic autonomy and community integration.

Ballesteros and Bertina (2016) conducted an interesting study aimed at analyzing the effectiveness of socio-community interventions of SCST. They used various measurement instruments and evaluated 275 users attended by eight SCST of the Community of Madrid (Spain), over 3 years of intervention, analyzing different variables (personal autonomy, symptom management, number of hospital admissions, duration and voluntariness of hospital admissions).

The results showed improvements in the reduction of symptoms and social adaptation, as well as in the reduction of hospital admissions, increasing the voluntariness of such admissions. The authors also made an estimation of the economic impact of this reduction in hospital admissions.

Ballesteros and Bertina (2016) point out that in the year prior to the start of their rehabilitation process with the SCST, 123 patients had hospital admissions with an average stay of 22 days. This generated an approximate healthcare expenditure of 822.501 euros. At the end of the first year of intervention with the SCST, only 55 patients were admitted to the hospital and the average stay was 11 days, resulting 181.500 euros in health care costs. The resulting savings would exceed 640.000 euros. The authors conclude that the annual operating cost of an SCST is 175.172 euros, therefore, the savings generated would allow the financing of an SCST for more than three years.

Recovery is a process with a markedly subjective character and may be different for each person. Interpretative phenomenological analysis (IPA) has been suggested as a suitable method for examining this process. The central objective in IPA is to explore how persons make sense of their significant life experiences and how they construct their narratives.

In recovery, an essential element is the process of meaning-making. Making sense of the past, the condition or disorder, and making sense of life beyond the illness is essential in recovery (Terry and Cardwell, 2015; Kassai, 2020). Individuals tend to interpret their past events, present situations and future plans using cultural narrative models as a resource (Hänninen, 2004). Patients who have made this redefinition of their life project may be better prepared to cope with the mental disorder..

As noted, the recovery model emerged after the psychiatric deinstitutionalization processes of the mid-20th century. Advances in pharmacological treatments helped patients to maintain longer periods of clinical stability, reduce the adverse effects of the old treatments and improve their overall functionality.

As a consequence, new demands arose on the part of patients and their families aimed at their social and occupational integration, which could not be covered exclusively by pharmacological treatment. In this regard, it is worth noting the contribution of Ruiz (2017).

In this context, the incorporation of psychosocial treatments in the attention of SMD became very important. All this led to a reorientation of health policies in the field of mental health and to the restructuring of health care services.

Anthony (1992) reviewed the main elements of psychosocial intervention and the criteria to be followed for its implementation in care services. As a starting point, Anthony (1992) warns about the need to incorporate some elements to the concept of psychosocial rehabilitation itself, referring specifically to the concepts of “disability” and “disadvantage” that SMD usually implies.

Anthony (1992) echoes Leitner and Drasgow's (1972) point that standard treatment is aimed at minimizing illness, while psychosocial rehabilitation is aimed at maximizing health. He also warns that removing or eliminating an impairment does not automatically lead to functional improvement. Similarly, an improvement in disability does not automatically lead to a reduction in impairment, although it may contribute to it. Anthony (1992) points out that the empirical evidence at the time of writing indicated that:

- Persons with severe mental illness can be maintained in the community with minimal use of hospital services.
- Persons with severe mental illness, in the long term, can function successfully in the community with psychosocial supports and interventions aimed at improving their skills.
- Functional assessment, rather than psychiatric diagnosis or the particular pattern of symptoms, will be the long-term determinant of adequate functioning in the community. Therefore, clinical assessments should focus not only on symptomatology, but also on the skills and supports available to the patient.
- To improve the long-term community functioning of persons with severe mental illness, a reorientation and optimization of care resources will be necessary.
- Improvement in functioning in one area of life does not indicate that the person with serious mental illness is functioning adequately in other areas of life that have also been affected.
- Psychosocial interventions and their effect on the community functioning of persons with serious mental illness require time. The longer the intervention time the greater the effect.
- The typical prognosis of a possible increase in interepisode deterioration is not confirmed. Gradual long-term improvement and recovery is possible. Chronic or severe impairment does not mean total or lifelong disability.

Anthony (1992) also points out the need for specific training of professionals in this field. Finally, this work addresses the criteria that should guide the implementation of these models in care plans, stressing that their consideration in such plans should not be a “simply legislated” recommendation but should be carefully planned.

As has been indicated, in the development of psychosocial treatments another factor that had a special impact and influence was the advance in the field of psychopharmacology. With this, new demands arose on the part of patients and their families aimed at their social and occupational integration, for which pharmacological treatment was clearly insufficient. And it was precisely this deficiency, another of the reasons that contributed to the spread of psychosocial treatments to cope with:

- Negative symptoms.
- Treatment-resistant positive symptoms.
- Social and cognitive dysfunctions associated with the disease.
- The burden sustained by family members.

Dixon et al. (2010) provide a comprehensive review of evidence-based psychosocial interventions for people diagnosed with schizophrenia. This was the third set of recommendations of the PORT (2009) guideline on this type of treatment.

The authors performed an updated review of the areas of psychosocial intervention outlined in previous recommendations, adding some new areas, and summarising the evidence. As a starting point, Dixon et al. (2010) indicate that in most of the recommendations psychosocial intervention is conceived and integrated as a complementary and associated treatment to standard treatment. The detailed review made by Dixon et al. (2010) of the range of psychosocial interventions deserves special consideration and attention.

The following is a description of the recommendations for each area reviewed, the criteria and formats of intervention and the results of the evidence.

Assertive Community Treatment (ACT)

Formats:

Care services should include assertive community treatment in their clinical practice. This intervention should be provided to individuals who are at risk for repeated hospitalizations or who have housing problems.

Key elements of ACT include: a multidisciplinary team, shared caseload among team members, direct service delivery and high frequency of patient contact, low patient/professional ratios, and integration of patients in the community environment.

Evidence:

ACT significantly reduces hospitalizations and contributes to improved housing conditions for individuals with schizophrenia. Coordination, integration, and continuity of care can be substantially improved through ACT. ACT programs emphasize patients' strengths and adjustment to community living, provide them with support and avenues for consultation with their natural networks, and provide the proximity necessary to ensure that patients remain in the treatment program.

The studies have demonstrated the effectiveness of ACT in reducing the number of days of hospitalization with respect to standard care. In turn, individuals assigned to the ACT groups, compared to individuals in control groups, use less emergency services and more outpatient services, including financial assistance and housing.

Labor Rehabilitation and Supported Employment

Formats:

Supportive devices should aid individuals with SMD who have employment expectations, both in obtaining and maintaining competitive employment that is compatible with their condition. Key elements of supported employment include: learning job skills, individualized job development, job search training, availability of supports, and integration of employment supports into mental health services.

Evidence:

The studies have consistently demonstrated the effectiveness of supported employment for persons with schizophrenia, in accessing competitive employment, working longer hours, and earning better wages than people who did not receive supported employment.

Social Skills Training

Formats:

Care services should include in their clinical practice specific training and coaching programs for persons with schizophrenia who present deficits in their social interactions, independent living and community functioning. These programs can vary widely in content, but generally include: interpersonal skills training, use of modeling techniques, rehearsal and corrective feedback, and positive reinforcement. These training skills should be supplemented with strategies that promote their appropriate application and generalization in the patient's community setting.

Evidence:

There is sufficient evidence to indicate that individuals with SMD can learn a variety of interpersonal and daily living coping skills using structured programs. Social skills training produces significant effects on proximal measures of skill as well as on more distal measures of community functioning. The evidence is weak or mixed regarding the effects of such programs on relapse or symptomatology.

Several studies have reported retention of trained skills for periods of up to one year. However, the number of studies that include follow-up data is too small to draw confident conclusions regarding their longer lasting permanence over time. Social skills training has been shown to be adaptable to a wide range of areas including interpersonal skills in work settings and drug refusal skills.