Recovery in Schizophrenia

Outline

- History
- Definition
- Recovery outcomes
- Journey of recovery
- Role of Psychiatrist
- Stigma/Advocacy
- Conclusion

History of Recovery

- Demonic possession
- 1798 – Philippe Pinel – characterize “mental derangements” as diseases – humane treatment approach
- 19th century – 45 to 90% recovery (Pinel, Tukes, Dorothea Dix)
- 20th century – Return of the “Dark Ages”
- Emil Kraepelin, Eugene Bleuler – little hope for recovery
- Pessimistic view – deterioration of SCZ:
  - Lack of effective treatment (malaria, lobotomies)
  - Eugenics (forced sterilization, T-4 program)

History of Recovery

- 1950s – Antipsychotics
- Deinstitutionalization
- Difficulty in reintegration & rehabilitation
- Psychosocial rehabilitation – stress on rehabilitation rather than medical treatment
- Psychiatric rehabilitation – integration of psycho-social and medical perspectives

History of Recovery

- 1970s – ex-patients regrouped
- 1973 - Conference on Human Rights and Psychiatric Oppression
- Awareness about recovery & rehabilitation
- Socio-political and medical movement
- 1991 – William Anthony – Recovery as the “guiding vision” (Recovery model)
- Recovery-oriented practice

Definition

- 1980s and 1990s – only medical approach – failure
- Evidence for “recovery” in 2/3rd patients
- Alternate programs and approaches:
  - Fountain House
  - Psychiatric rehabilitation at UCLA
  - “Housing first” programs
  - Dual diagnoses approach at NIMH
  - Client choice, empowerment & shared decision-making strategies

Definition

- 2 approaches to define recovery by Substance Abuse and Mental Health Services Administration **(SAMHSA)**:
  - 2006 – Journey of healing and transformation helping to live a meaningful life in a community while striving to achieve his/her full potential
  - 2011 – Process of change to improve health and wellness, live a self-directed life and strive to reach their full potential – 4 domains

Definition

- 4 domains to support a life in recovery:

1. Health
2. Home
3. Purpose
4. Community

- **Recovery** – "journey" of overcoming serious illness + "destination" of having a better life

Definition

- **Response** – some relief of symptoms and improvement in functioning
- Improvement arises from treatment
- **Remission** – period of complete relief of symptoms and return of full functioning or low mild symptoms which do no influence individual's behavior
- **Relapse** – return of symptoms, meeting diagnostic criteria for disorder after patient responded/remitted, but not recovered

Medical + Recovery Model

1. Illness → person – “Recovery is something a person does, not what an illness does”
2. Professionally driven → Client-driven: “Process in which client must engage in”
3. Deficit-based → Strength-based: “Recovery doesn’t happen when the person never has any more symptoms, even serious ones, but when they have the strength and resilience to handle whatever symptoms occur”

Recovery Outcomes

- Kraeplin – clinical long term improvement – 17% | long term recovery – 8-13%
- 1970s – studies challenging “SCZ equals poor outcomes”
- DSM-III: “complete return to premorbid level of functioning rare”
- DSM-5: “course and outcome may not be reliably predicted” – favorable in 20% of patients

Recovery Outcomes

- 1975 - International Pilot Study on Schizophrenia (IPSS)
- Complete remission after 2/more episodes after 2 years (11%) and 5 years (15%)
- 2/more episodes with residual symptoms after 2 years (18%) and 5 years (33%)

Recovery Outcomes

- 1987 – Vermont Longitudinal Research Project – 50-66% patients – improvement 20-30 years after rehabilitation and deinstitutionalization

Recovery Outcomes

- 1994 – Personal Assessment & Crisis Evaluation (PACE) – prevent/delay onset of psychosis – medication – maintenance of remission rate @ 80%; poor outcome in 25%

Recovery Outcomes

- WHO's International Study of SCZ – best predictor of symptoms and disability scores – duration of untreated psychosis
- Mixed evidence for maintenance on antipsychotics
- Country – East Asia - highest clinical remission rate – 84.4%; North America – highest functional remission rate – 35%
- Environmental factors – repeated opportunities for rehabilitation, positive expectations and relationships, family psychoeducation, good mental health care

Results of DOSMD

Course and outcome descriptor	Percentage patients in developing countries[a] (*n* = 467)	Percentage patients in developed countries[b] (*n* = 603)
Remitting, complete remissions	62.7	36.8
Continuous or episodic, no complete remission	35.7	60.9
Psychotic <5% of the follow-up	18.4	18.7
Psychotic >75% of the follow-up	15.1	20.2
No complete remission during follow-up	24.1	57.2
Complete remission for >75% of the follow-up	38.3	22.3
On antipsychotic medication >75% of the follow-up	15.9	60.8
No antipsychotic medication during follow-up	5.9	2.5
Hospitalized for >75% of follow-up	0.3	2.3
Never hospitalized during follow-up	55.5	8.1
Impaired social functioning throughout follow-up	15.7	41.6
Unimpaired social functioning >75% of follow-up	42.9	31.6

[a] Colombia, India, Nigeria.
[b] Czech Republic.

Recovery Outcomes

- 1981-82 - Study for Factors Associated with Course and Outcome of Schizophrenia (SOFACOS) in India
- Verghese et al. @ Lucknow, Madras and Vellore
- Results at 2 and 5 years follow-ups: 67% patients – good outcome
- Madras Longitudinal study by Thara: continuation of SOFACOS in Madras (25 year follow up study)
- 32/47 – partial/total remission
- Good outcome - 27%, intermediate – 52%, poor- 19%.

Evidence-based Practices

- Pharmacotherapy
- Assertive Community Treatment (ACT)
- Supportive Employment (SE)
- Cognitive Behavioral Therapy (CBT)
- Cognitive Remediation
- Family Psychosocial Intervention
- Housing First (HF)
- Illness Self-Management Training

Evidence-based Practices

- Wellness Recovery Action Planning (WRAP)
- Integrated Schizophrenia and Substance Use Disorder Treatment Models
- Motivational Interviewing (MI)
- Electroconvulsive Therapy (ECT)
- Low-Frequency Repetitive Transcranial Magnetic Stimulation (rTMS)
- Crisis Intervention Team Model and Mental Health Courts

Pharmacotherapy

- FGAs - 25-70% reduction in annual relapse rates of +ve symptoms
- SGAs – comparable, but not better results
- FGAs and SGAs – neither effectively treat primary –ve symptoms or cognitive impairments
- Functional impairment d/t +ve symptoms seem to improve
- CATIE - 74% discontinued APs before 18 months
- Non-pharmacological therapies important in recovery

Assertive Community Treatment

- Individualized approach to deliver care for functional impairment
- Multidisciplinary staff, integration of services, team approach, low client-staff ratio, medication management, focus on everyday concerns, rapid access, time-unlimited services
- Not a recovery-oriented practice

Assertive Community Treatment

	Effectiveness of ACT Compared with Control Conditions (No. of Trials [%])		
Parameter	**Better**	**No Different**	**Worse**
Psychiatric hospital use	17 (74%)	6 (26%)	0
Housing stability	8 (67%)	3 (25%)	1 (8%)
Symptoms	7 (44%)	9 (56%)	0
Quality of life	7 (58%)	5 (42%)	0
Social adjustment	3 (23%)	10 (77%)	0
Jail/arrests	2 (20%)	7 (70%)	1 (10%)
Substance use	2 (33%)	4 (67%)	0
Medication compliance	2 (50%)	2 (50%)	0
Vocational functioning	3 (37%)	5 (63%)	0
Patient satisfaction with services	7 (88%)	1 (12%)	0
Family members satisfaction with services	2 (67%)	1 (33%)	0

Supported Employment

- Competitive employment, individualized job support, integrating mental health and employment services
- Reduction in OPD treatment, improvement in self-esteem
- Inconsistently associated with positive outcomes – symptom severity, hospitalization, life satisfaction, global well-being

Cognitive Behavioral Therapy

- Decreasing positive symptoms in chronic, non-recent onset patients
- Sustained even after completion of treatment
- Belief modification, focusing/reattribution, normalizing psychotic experiences

Others

- **Cognitive Remediation:**
  - Cognitive training and rehabilitation
  - Improve cognitive processes
- **Family Psychosocial Intervention:**
  - Reduce criticism/hostility/over-involvement
  - Illness education, coping skills training, crisis intervention, emotional support for at least 6-9 months
  - Reduction in relapse by 25-50%

Others

- **Housing First:**
  - Permanent housing – basic human right
  - Progressive housing program – outreach to permanent
- **Illness Self-Management Training:**
  - Psychoeducation - not consistently associated with behavior change
  - Skills training – improvement in social functioning

Others

- **Wellness Recovery Action Planning (WRAP):**
  - Peer-led, self-management program
  - Holistic health, wellness, strengths, social support
  - Symptom reduction, improvement in health and QOL
- **Integrated SCZ and SUD Treatment Models:**
  - Multidisciplinary approach to target both aspects
  - Reduction in SUD – stable remission

Others

- **Motivational Interviewing (MI):**
  - Resolve ambivalence – stimulate behavioral change
  - Rapport building, reflective listening, assessing motivation for change, gap between baseline and desired behavior, improving self-efficacy for change
- **ECT:** AP failure
- **rTMS:** acute treatment of auditory hallucinations

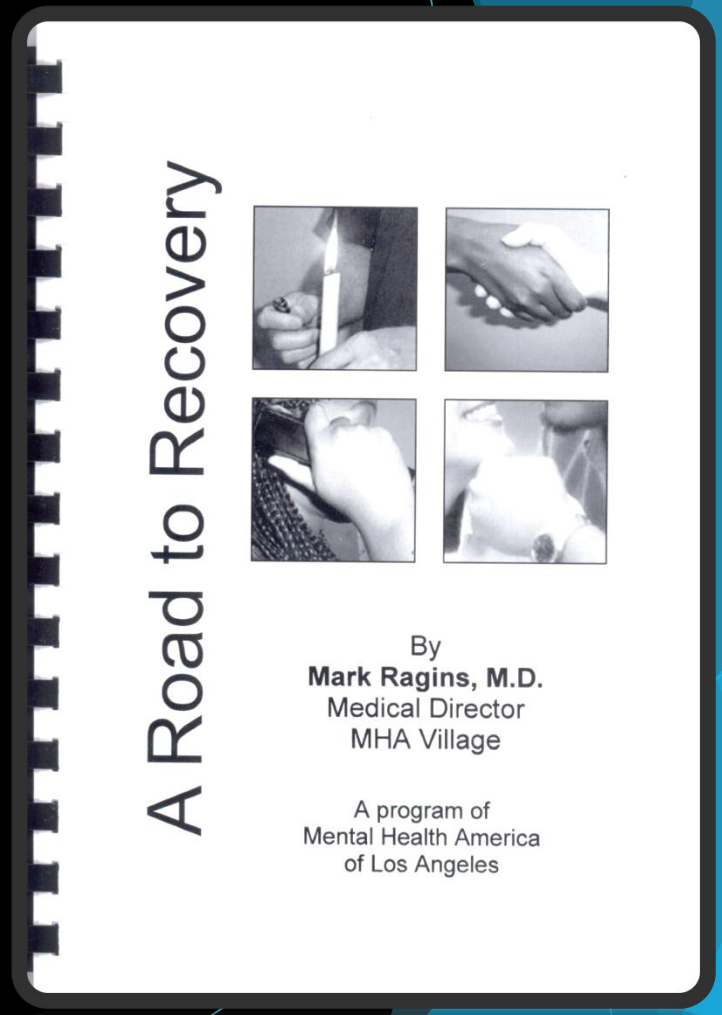
Others

- **Crisis Intervention Team Model and Mental Health Courts:**
  - Training for CIT officers and call dispatchers & central psychiatric emergency drop-off sites
  - MHC – divert people with serious mental illness from criminal justice system to community treatment; voluntary

Journey of Recovery

- Mark Ragins: A Road to Recovery

1. Stage 1: Hope
2. Stage 2: Empowerment
3. Stage 3: Self-Responsibility
4. Stage 4: Having Meaningful Roles in Life



Role of Psychiatrist

- **Person-centered formulations instead of illness-centered diagnoses:**
  - Individualized focus on causative events
  - Narrative recognized as their story - shared story forms basis for treatment collaboration
- **Relationship-based services:**
  - Assess barriers in forming trusting relationships, overcome them and form and sustain treatment relationship

Role of Psychiatrist

- **Trauma Informed Care:**
  - Triggering event, empathy, “coping techniques”
- **Goal-driven Medications and Treatment:**
  - Medications enable self-help coping techniques
  - Cessation of treatment when medication not required to attain and maintain goals
- **Shared Decision Making:**
  - Collaborative effort
  - Combined expertise & motivations of patient and staff

Role of Psychiatrist

- **Activated Patients Promoting Their Own Recoveries:**
  - Talking to others
  - Securing life
  - Encouraging emotions
  - Coping skills
  - Engaging in pleasurable activities
  - Improve physical health
  - Encouraging going to work

Role of Psychiatrist

- **Taking Strengths Seriously and Building Resilience:**
  - Social determinants of health
  - Protective factors
  - Self-efficacy
  - Resilience by finding strength in struggles

Role of Psychiatrist

- Help Them Trust Us
- Help Them Regain Control of their Lives
- Help Them Rebuild their Life
- Help Them Heal
- Take the Long View
- Help Them Move On

Peer Support Specialist

- **Peer support** - emotional support offered by a person with mental health condition(s) to another who has similar mental health condition(s) so as to effect beneficial change
- **Peer Support Specialists (PSS)** – active in their mental health recovery and potentially have obtained a PSS certificate

Peer Support Specialist

- 18th century – “moral treatment era” – humane treatment
- 1935 – Alcoholics Anonymous
- 1970s - Mental Health Recovery Movement – involvement of patients in their own care
- 1990s – PSS
- Identifying goals, teaching new skills, advocating, job coaching, providing counselling, documenting clinical interactions

Peer Support Specialist

- PSS disclose their mental health conditions, serve as role model, more approachable
- Educate non-PSS clinicians regarding methods
- Effective in engaging people in care, reducing emergency visits and hospital admissions, reducing substance use
- Drawbacks – job related stress impacting PSS, client confidentiality
- Unique on-the-job challenges

Involuntary Treatment

- 1880– 1950s: 5x increase in psychiatric patients - limited resources during World Wars and Great Depression – overcrowded, horrendous conditions
- Psychiatrists – undisputed authority to commit people to facilities – restraints, medications, shock therapies
- WW2 – COs given jobs at public psychiatric hospitals – highlighted poor conditions via media
- 1963 – Community Mental Health Centers Act – started deinstitutionalization

Involuntary Treatment

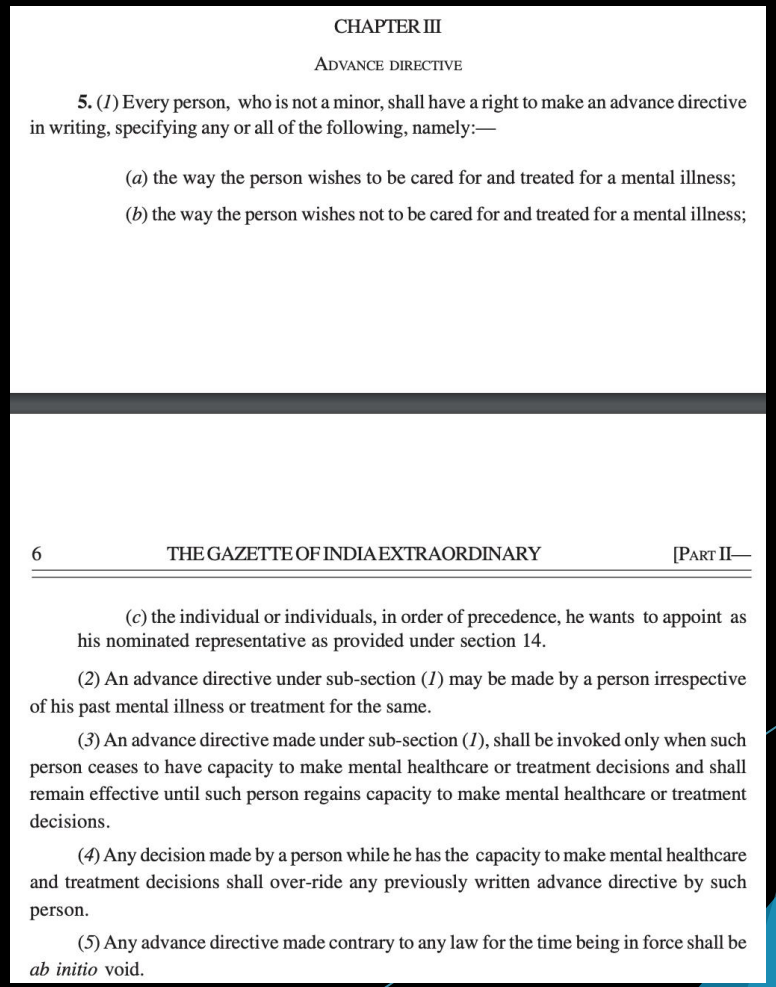
- 1969 & 72 - Lanterman-Petris-Short Act & Lessard decision in Wisconsin – courts to decide involuntary treatment
- 1980 – state laws made it difficult to treat mentally ill persons without proving them to be of imminent danger
- Pts. released from hospitals organized to help formulate laws against involuntary treatment
- Fear that some recently freed mentally ill would engage in dangerous behaviors and put behind bars
- 2014 – 10x seriously mentally ill persons criminally incarcerated in jails than public psychiatric hospitals

Involuntary Treatment

- Police officers trained with NAMI to handle mentally ill
- CIT training programs, specialized mental health courts
- 1998 - Treatment Advocacy Centre (TAC) – roll back laws criminalizing mentally ill with dangerous tendencies and to treat them without consent [Assisted Outpatient Treatment (AOT)]
- Mental Health America, National Disability Network, National Coalition for Mental Health Recovery – oppose infringement on rights of persons with mental illness

Involuntary Treatment

- Mental Healthcare Act, 2017 - empower persons suffering from mental illness
- Recognises agency of people with mental illness
- Allows them to make decisions regarding their health, if they have appropriate knowledge to do so



CHAPTER III

ADVANCE DIRECTIVE

5. (*1*) Every person, who is not a minor, shall have a right to make an advance directive in writing, specifying any or all of the following, namely:—

(*a*) the way the person wishes to be cared for and treated for a mental illness;

(*b*) the way the person wishes not to be cared for and treated for a mental illness;

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(*c*) the individual or individuals, in order of precedence, he wants to appoint as his nominated representative as provided under section 14.

(*2*) An advance directive under sub-section (*1*) may be made by a person irrespective of his past mental illness or treatment for the same.

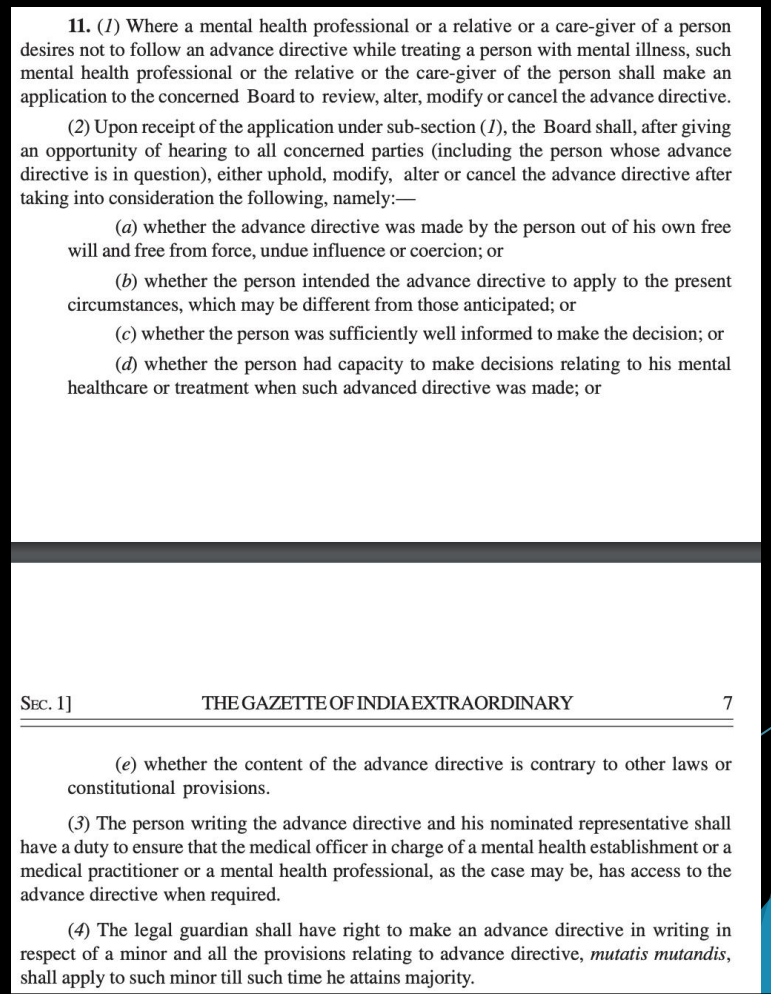
(*3*) An advance directive made under sub-section (*1*), shall be invoked only when such person ceases to have capacity to make mental healthcare or treatment decisions and shall remain effective until such person regains capacity to make mental healthcare or treatment decisions.

(*4*) Any decision made by a person while he has the capacity to make mental healthcare and treatment decisions shall over-ride any previously written advance directive by such person.

(*5*) Any advance directive made contrary to any law for the time being in force shall be *ab initio* void.

Involuntary Treatment

- Mental health professional/ relative/care-giver does not wish to follow the directive while treating the person, he can make an application to the Mental Health Board to review/alter/cancel the advance directive



11. (*1*) Where a mental health professional or a relative or a care-giver of a person desires not to follow an advance directive while treating a person with mental illness, such mental health professional or the relative or the care-giver of the person shall make an application to the concerned Board to review, alter, modify or cancel the advance directive.

(*2*) Upon receipt of the application under sub-section (*1*), the Board shall, after giving an opportunity of hearing to all concerned parties (including the person whose advance directive is in question), either uphold, modify, alter or cancel the advance directive after taking into consideration the following, namely:—

(*a*) whether the advance directive was made by the person out of his own free will and free from force, undue influence or coercion; or

(*b*) whether the person intended the advance directive to apply to the present circumstances, which may be different from those anticipated; or

(*c*) whether the person was sufficiently well informed to make the decision; or

(*d*) whether the person had capacity to make decisions relating to his mental healthcare or treatment when such advanced directive was made; or

SEC. 1] THE GAZETTE OF INDIA EXTRAORDINARY 7

(*e*) whether the content of the advance directive is contrary to other laws or constitutional provisions.

(*3*) The person writing the advance directive and his nominated representative shall have a duty to ensure that the medical officer in charge of a mental health establishment or a medical practitioner or a mental health professional, as the case may be, has access to the advance directive when required.

(*4*) The legal guardian shall have right to make an advance directive in writing in respect of a minor and all the provisions relating to advance directive, *mutatis mutandis*, shall apply to such minor till such time he attains majority.

Stigma

1. **Linguistic and cultural heritage**
   - Possessed by demons; dangerous, weird, incapable
   - Pejorative, demeaning words
   - Nomenclature – **consumers**, **client**, survivors, C/S/X, **patients**, service user, recipient
2. **Laws, rules and regulations**
   - Social security, other disability programs
   - 1990 – Americans with Disabilities Act - prohibits discrimination

Advocacy

1. Exposure to persons who are open about being in Recovery from serious mental illness
2. Join others with similar condition – NAMI
3. Avoid using terms “crazy”, “nuts”, “loony” – discipline oneself and then others, beginning with those in the mental health community

Conclusion

- Goal - reach one's full potential through Recovery
- Provide person with mental illness a menu of all available treatments and interventions backed by scientific evidence
- No discrimination in Rights
- End discrimination against persons with mental illness by avoiding derogatory terms

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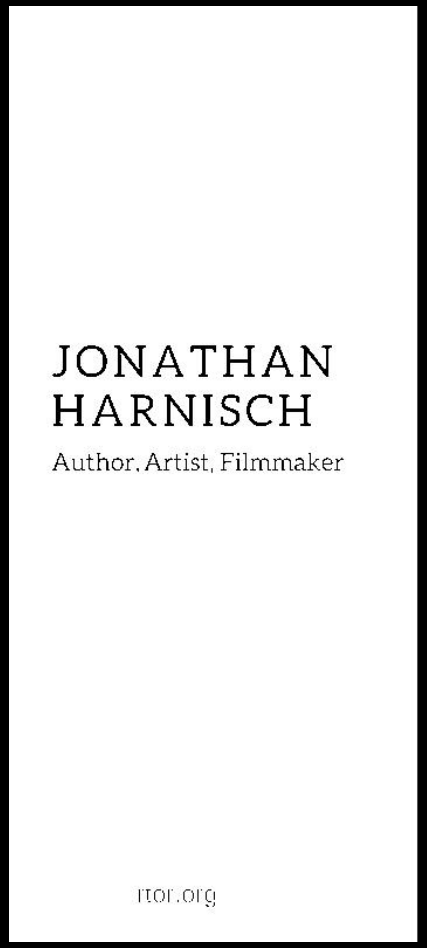

"I have schizophrenia. I am not schizophrenia. I am not my mental illness. My illness is a part of me."

#myMHrecovery

Thank You