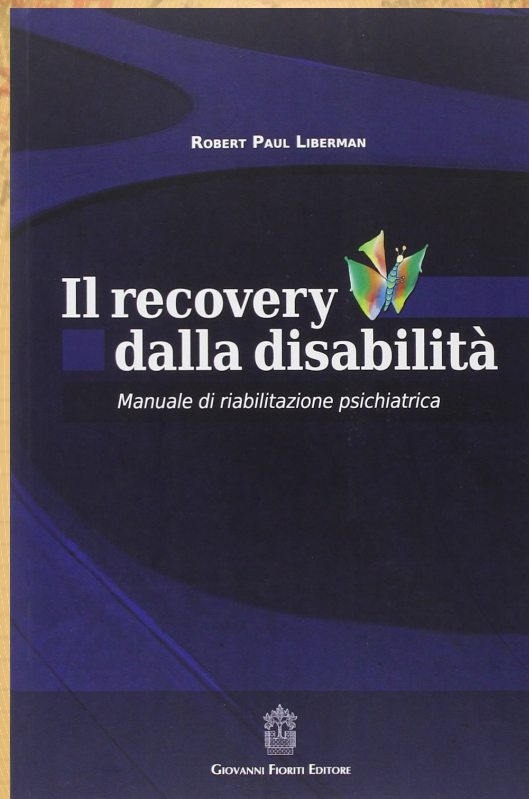




RECOVERY E EVIDENZE **SCIENTIFICHE**

dott. CLAUDIO SANTILLI
ASUR Marche – Area Vasta n. 1
DSM sede di Pesaro



**“La disabilità è il punto da cui partiamo,
il recovery è la nostra destinazione
e la riabilitazione la strada che percorriamo.”**

I vizi di fondo della riabilitazione psichiatrica

- Mancanza di procedure metodologiche accreditate, valutabili e riproducibili
- Esclusione della riabilitazione dalla fase iniziale della presa in carico
- Sottovalutazione della partecipazione dell'utente nella definizione dell'obiettivo
- Scarsa importanza attribuita alla selezione e alla formazione degli operatori
- Ripetizione di attività scisse dagli obiettivi di vita
- Considerare riabilitati gli utenti che hanno sviluppato competenze idonee alle aspettative degli ambienti istituzionali
- Scarsa importanza attribuita alla ricerca di risorse
- Sottovalutazione dell'auto-mutuo-aiuto
- Assimilazione della riabilitazione psichiatrica a specifiche strutture

Evidence Based Medicine (EBM)

Uso coscienzioso, esplicito e giudizioso delle migliori evidenze aggiornate per prendere decisioni riguardo alla cura dei pazienti.

Evidence Based Practice (EBP)

Prendere decisioni per la promozione della salute o sulla cura integrando le migliori evidenze disponibili con l'esperienza professionale, le caratteristiche, lo stato, i bisogni, i valori e le preferenze dei pazienti, che siano compatibili con il contesto ambientale e organizzativo.

Level	Therapy/Prevention, Aetiology/Harm	Prognosis	Diagnosis	Differential diagnosis/symptom prevalence study	Economic and decision analyses
1a	SR (with homogeneity*) of RCTs	SR (with homogeneity*) of inception cohort studies; CDR† validated in different populations	SR (with homogeneity*) of Level 1 diagnostic studies; CDR† with 1b studies from different clinical centres	SR (with homogeneity*) of prospective cohort studies	SR (with homogeneity*) of Level 1 economic studies
1b	Individual RCT (with narrow Confidence Interval‡)	Individual inception cohort study with > 80% follow-up; CDR† validated in a single population	Validating** cohort study with good††† reference standards; or CDR† tested within one clinical centre	Prospective cohort study with good follow-up****	Analysis based on clinically sensible costs or alternatives; systematic review(s) of the evidence; and including multi-way sensitivity analyses
1c	All or none§	All or none case-series	Absolute SpPins and SnNouts††	All or none case-series	Absolute better-value or worse-value analyses ††††
2a	SR (with homogeneity*) of cohort studies	SR (with homogeneity*) of either retrospective cohort studies or untreated control groups in RCTs	SR (with homogeneity*) of Level >2 diagnostic studies	SR (with homogeneity*) of 2b and better studies	SR (with homogeneity*) of Level >2 economic studies
2b	Individual cohort study (including low quality RCT; e.g., <80% follow-up)	Retrospective cohort study or follow-up of untreated control patients in an RCT; Derivation of CDR† or validated on split-sample§§§ only	Exploratory** cohort study with good††† reference standards; CDR† after derivation, or validated only on split-sample§§§ or databases	Retrospective cohort study, or poor follow-up	Analysis based on clinically sensible costs or alternatives; limited review(s) of the evidence, or single studies; and including multi-way sensitivity analyses
2c	"Outcomes" Research; Ecological studies	"Outcomes" Research		Ecological studies	Audit or outcomes research
3a	SR (with homogeneity*) of case-control studies		SR (with homogeneity*) of 3b and better studies	SR (with homogeneity*) of 3b and better studies	SR (with homogeneity*) of 3b and better studies
3b	Individual Case-Control Study		Non-consecutive study; or without consistently applied reference standards	Non-consecutive cohort study, or very limited population	Analysis based on limited alternatives or costs, poor quality estimates of data, but including sensitivity analyses incorporating clinically sensible variations.
4	Case-series (and poor quality cohort and case-control studies§§)	Case-series (and poor quality prognostic cohort studies***)	Case-control study, poor or non-independent reference standard	Case-series or superseded reference standards	Analysis with no sensitivity analysis
5	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on physiology, bench research or "first principles"	Expert opinion without explicit critical appraisal, or based on economic theory or "first principles"

TRIALS EsPLICATIVI

TRIALS PRAGMATICI

- Pazienti selezionati
- Centri specializzati
- Esiti specifici
- Follow-up a breve termine
- Condizioni ideali

- ✧ Pazienti non selezionati
- ✧ Centri non specializzati
- ✧ Esiti generici
- ✧ Follow-up a lungo termine
- ✧ Condizioni reali

RECOVERY “OGGETTIVO”

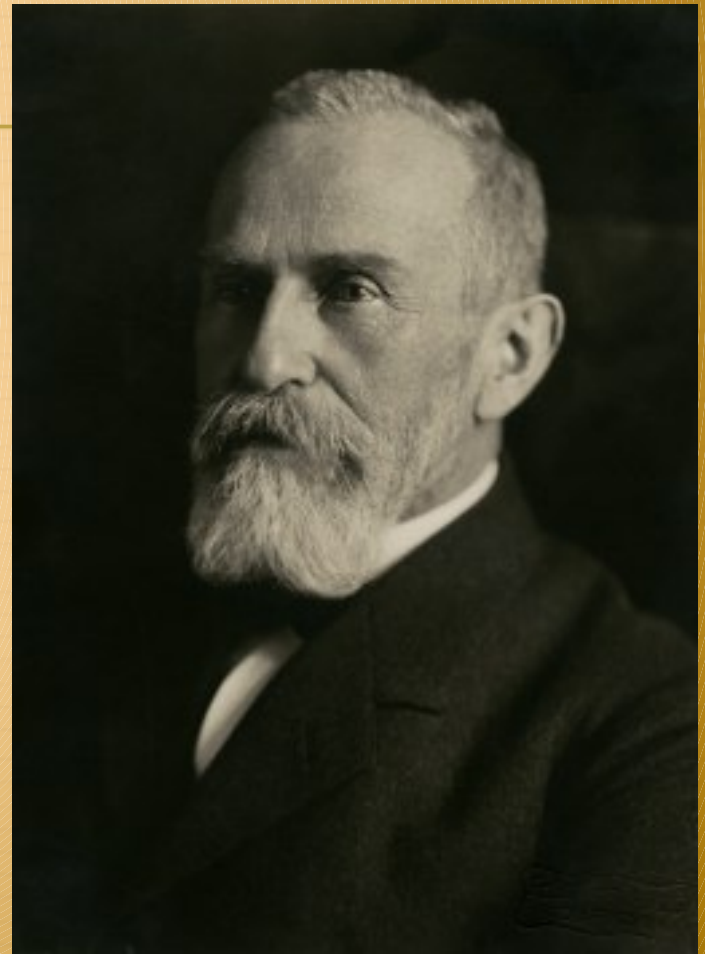
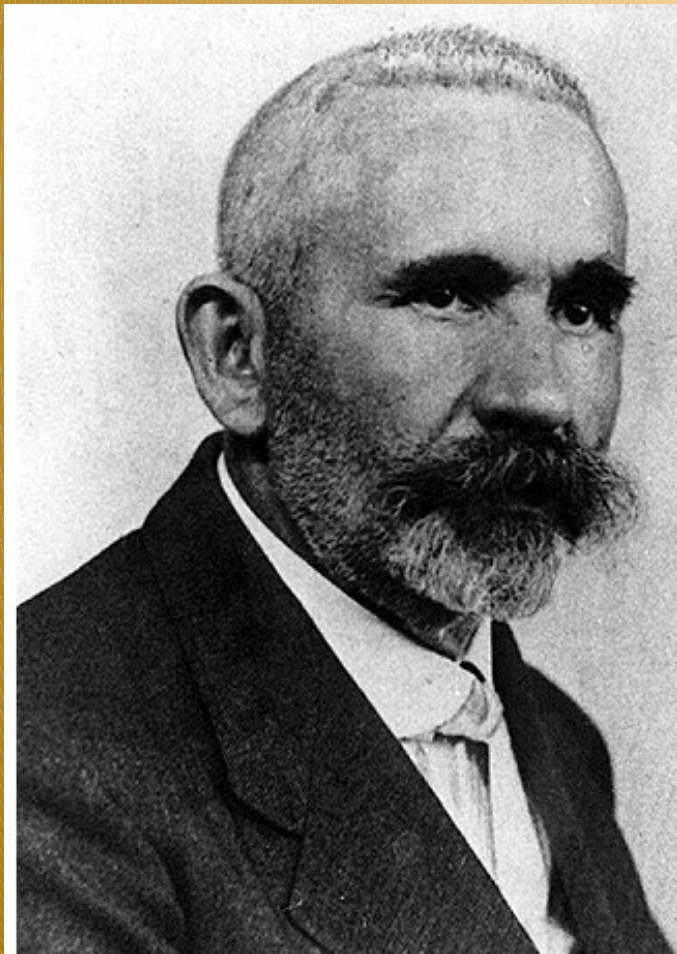


- Remissione prolungata dei sintomi
- Coinvolgimento in attività costruttive e produttive
- Autonomia nelle piccole cose della vita quotidiana
- Buoni rapporti con i familiari
- Attività ricreative
- Relazioni soddisfacenti con i pari

RECOVERY “SOGGETTIVO”



- Processo di trasformazione
- Capacità di scelta, assunzione di responsabilità, ottimismo
- Cambiamento di obiettivi, conoscenze, abilità, ruoli e immagine di sé
- Empowerment, forza spirituale



FATTORI DI CONFONDIMENTO

倮 Provenienza geografica (UK, USA)

倮 Outcomes

倮 Strumenti di valutazione

倮 Criteri diagnostici

倮 Drop-out

One Hundred Years of Schizophrenia: A Meta-Analysis of the Outcome Literature

James D. Hegarty, M.D., M.P.H., Ross J. Baldessarini, M.D.,
Mauricio Tohen, M.D., Dr.P.H., Christine Waternaux, Ph.D., and Godehard Oepen, M.D.

Objective: This study was undertaken to assess the twentieth-century literature on outcome in schizophrenia for historical trends that might be associated with changes in diagnostic and therapeutic practice and to test the hypothesis that both improved biological treatment and changes in diagnostic criteria have influenced outcome. Method: Meta-analysis of the international literature on outcome in schizophrenia or dementia praecox from 1895 to 1992 identified 821 studies; 320 of these, with 51,800 subjects in 368 cohorts, met the inclusion criteria for the study. Results: Only 40.2% of patients were considered improved after follow-ups averaging 5.6 years (range=1–40). Outcome was significantly better when patients were diagnosed according to systems with broad criteria (46.5% were improved) or undefined criteria (41.0% were improved) rather than narrow criteria (27.3% were improved). The proportion of patients who improved increased significantly after mid-century (for 1956–1985 versus 1895–1955, 48.5% versus 35.4%), probably reflecting improved treatment as well as a broadened concept of schizophrenia. However, in the past decade, the average rate of favorable outcome has declined to 36.4%, perhaps reflecting the re-emergence of narrow diagnostic concepts. Conclusions: Overall, less than half of patients diagnosed with schizophrenia have shown substantial clinical improvement after follow-up averaging nearly 6 years. Despite considerable gains in improvement rates after mid-century, there has been a decline since the 1970s. These historical changes probably reflect improved treatment, shifts in diagnostic criteria, and selection bias related to changes in health care.

(Am J Psychiatry 1994; 151:1409–1416)

FIGURE 1. Mean Percentages of Schizophrenic Patient Cohorts Considered Improved in Follow-Ups of ≤ 10 Years, by Decades of Studies Reviewed^a

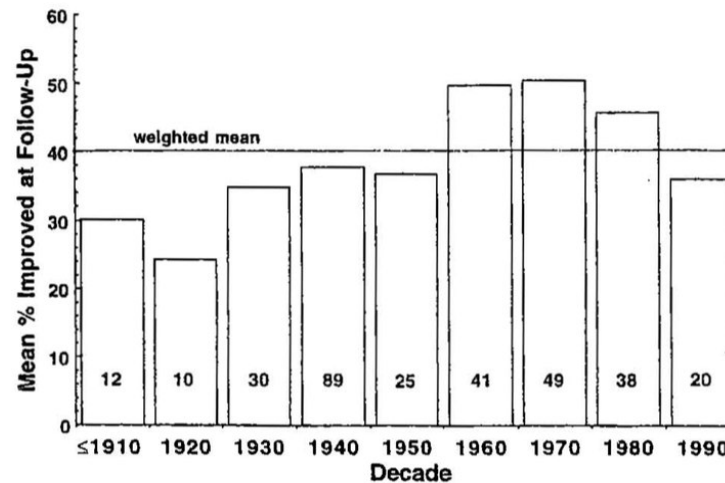


TABLE 2. Percentages of Cohorts of Patients in Schizophrenia Outcome Studies Who Had Improved at Follow-Up, by Treatment and Diagnostic System^a

Treatment	Cohorts Diagnosed by Kraepelinian Systems			Cohorts Diagnosed by Non-Kraepelinian Systems			Cohorts Diagnosed by Unspecified Criteria			All Cohorts		
	N	Mean	SD	N	Mean	SD	N	Mean	SD	N	Mean	SD
Neuroleptic	37	31.2	17.3	87	48.0	17.6	51	51.9	16.6	175	45.6	18.8
Convulsive	13	26.9	13.8	7	42.2	19.8	81	44.0	18.1	101	41.7	18.5
Nonspecific	30	22.5	11.1	10	34.0	17.5	39	32.4	14.6	79	28.9	14.5
Lobotomy	—	—	—	—	—	—	13	28.1	13.9	13	28.1	13.9
Total	80	27.3	15.1	104	46.5	17.3	184	41.0	16.9	368	40.2	17.6

^aWeighted analysis of variance found a significant effect for treatment ($F=14.6$, $df=3$, 364 , $p<0.0001$) and diagnostic system ($F=28.8$, $df=2$, 365 , $p<0.0001$) and no significant interaction between them ($F=1.1$, $df=4$, 362 , $n.s.$). Post hoc analysis indicated that the overall results with neuroleptic and convulsive treatments were better than with lobotomy and nonspecific methods (estimated difference=15.2, $SE=2.1$, $p<0.0001$) and that outcome in studies using Kraepelinian diagnostic criteria yielded lower improvement rates than studies using non-Kraepelinian criteria (estimated difference=19.2, $SE=2.0$, $p<0.0001$).

REVIEW ARTICLE

A systematic review of longitudinal outcome studies of first-episode psychosis

N. M. MENEZES*, T. ARENOVICH AND R. B. ZIPURSKY

*Schizophrenia Program, Centre for Addiction and Mental Health, Department of Psychiatry,
University of Toronto, Toronto, Ontario, Canada*

ABSTRACT

Background. Existing outcome literature has had an over-representation of chronic patients and suggested a progressive course and poor outcome for schizophrenia. The current study aimed to recombine data of samples from longitudinal studies of first-episode psychosis (FEP) to describe outcome and its predictors.

Method. A literature search (1966–2003) was conducted for prospective studies examining outcome in first-episode non-affective psychosis using the following key words: early, first, incident, episode, admission, contact, psychosis, schizophrenia, psychotic disorders, course, outcome, follow-up, longitudinal, cohort. These were pooled and analyzed using descriptive and regression analyses.

Results. Thirty-seven studies met the inclusion criteria, representing 4100 patients with a mean follow-up of 35.1 ± 6.0 months. Studies varied in the categories of outcome used, the most common being 'good' (54% of studies) and 'poor' (34% of studies), variably defined. In studies reporting these categories, good outcomes were reported in 42.2% (3.5%) and poor outcomes in 27.1% (2.8%) of cases. Predictors associated with better outcome domains were: combination of pharmacotherapy and psychosocial therapy, lack of epidemiologic representativeness of the sample, and a developing country of origin. Use of typical neuroleptics was associated with worse outcome. Stratification analyses suggested that populations with schizophrenia only, and those with prospective design, were associated with worse outcome domains.

Conclusions. Outcome from FEP may be more favorable than previously reported, and treatment and methodological variables may be important contributors to outcome. Significant heterogeneity in definitions and methodology limited the comparison and pooling of data. A multi-dimensional, globally used definition of outcome is required for future research.

Table 2. *Summary of outcome rates, overall, and stratified by sample representativeness, follow-up duration, diagnosis and design*

	Studies reporting outcome (%)	Overall rate	Representative sample	Non-representative sample	0–2 years study duration	> 2 years study duration	Schizophrenia only	Broad dx included	RCT/quasi-experimental design	Prospective design
Good	54	42.2 (3.5)	35.6 (5.6)	50.3 (4.4)	48.0 (4.0)	24.6 (4.0)	31.2 (3.2)	50.7 (4.9)	55.7 (7.7)	39.8 (3.8)
Intermediate	25	34.7 (4.1)	36.7 (5.7)	30.7 (6.6)	28.7 (4.3)	54.5 (4.6)	42.4 (4.5)	27.0 (5.9)	32.9 (13.7)	34.8 (4.4)
Poor	34	27.1 (2.8)	27.6 (4.1)	26.4 (4.2)	25.9 (3.3)	30.8 (5.4)	30.7 (4.3)	23.7 (3.3)	22.2 (5.1)	27.4 (3.0)
Readmission	25	44.9 (7.0)	56.1 (17.1)	33.2 (6.5)	37.3 (4.9)	60.6 (23.3)	49.2 (10.0)	39.2 (8.9)	33.0 (8.3)	47.0 (9.1)
Relapse	21	45.2 (5.8)	N.A.	45.2 (5.8)	36.6 (6.6)	58.9 (8.8)	51.6 (6.3)	35.9 (11.8)	40.3 (6.2)	51.4 (11.7)
Employment/ Education	27	38.7 (4.7)	24.2 (4.0)	49.9 (4.6)	43.4 (6.4)	30.1 (5.6)	39.2 (5.9)	38.1 (8.1)	38.7 (5.1)	38.6 (5.9)
Functional recovery	11	41.7 (8.0)	39.3 (6.4)	43.6 (13.4)	43.6 (13.4)	39.3 (6.4)	36.7 (6.5)	46.6 (15.3)	38.7 (9.9)	42.7 (10.5)
GAF (mean)	31	54.7 (2.5)	48.6 (3.7)	60.1 (2.5)	54.1 (3.3)	56.5 (2.3)	55.5 (2.0)	54.1 (4.4)	65.7 (2.0)	49.8 (2.7)

Values are percentage outcome (S.E.) except for GAF values (mean).

GAF, Global Assessment of Functioning Scale; RCT, randomized controlled trial; N.A., not available; dx, diagnosis.

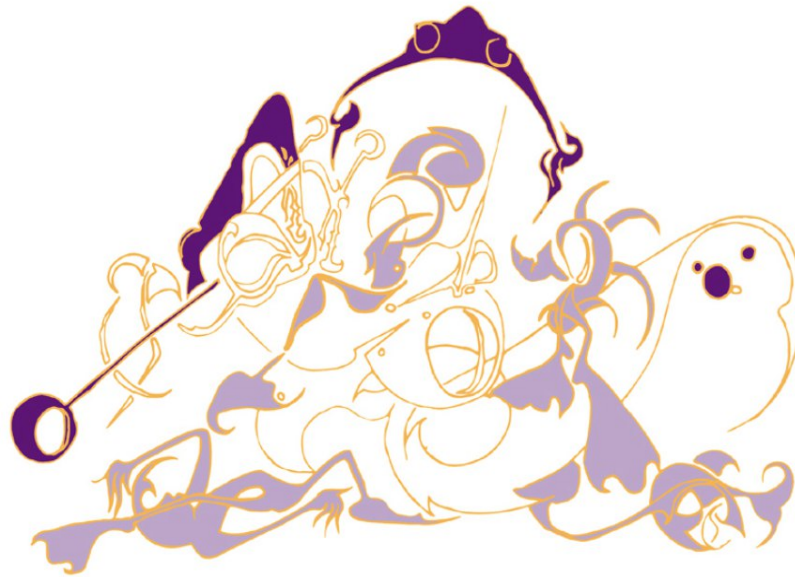
Table 3. *Multivariable model results*

Outcome variable	Independent variable	F statistic	Degrees of freedom	p value
Good outcome	Age	0.33	1, 7	0.59
	Combination therapy	4.29	1, 18	0.05
	Design	<0.01	1, 18	0.96
	EPI representative	8.26	1, 18	<0.01
	Follow-up duration	5.25	1, 8	0.06
	Origin type	12.66	1, 18	<0.01
Poor outcome	Pharmacotherapy	16.68	2, 14	<0.01
	Tx-naïve at entry	10.78	2, 14	<0.01
GAF	Combination therapy	3.77	1, 9	0.08
	Study design	2.75	1, 9	0.13
	EPI representative	0.34	1, 9	0.58
	Origin type	0.54	1, 9	0.48
	Substance use permitted	0.12	2, 9	0.89
	Tx at entry	21.70	1, 9	<0.01
Employment/education	Combination therapy	6.55	1, 8	0.03
	EPI representative	9.81	1, 8	0.01

GAF, Global Assessment of Functioning Scale; EPI, epidemiological; Tx, treatment

Recovery from Schizophrenia

Psychiatry and Political Economy



Richard Warner

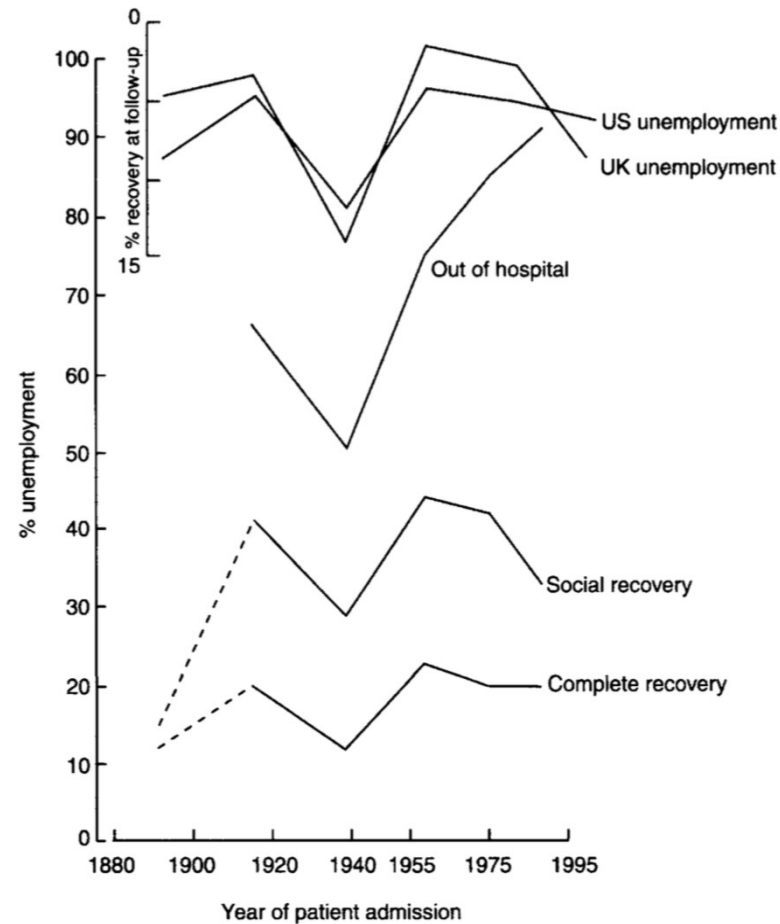


Figure 3.1 Outcome from schizophrenia in Europe and North America as reflected in 114 studies, and average unemployment (inverted) for the USA and the UK for the same time periods

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A Systematic Review and Meta-Analysis of Recovery in Schizophrenia

Erika Jääskeläinen^{*,1,6}, Pauliina Juola¹, Noora Hirvonen^{1,2}, John J. McGrath^{3,4}, Sukanta Saha³, Matti Isohanni¹, Juha Veijola¹, and Jouko Miettunen^{1,5,6}

¹Department of Psychiatry, University of Oulu and Oulu University Hospital, Oulu, Finland; ²Information Studies, Faculty of Humanities, University of Oulu, Oulu, Finland; ³Queensland Centre for Mental Health Research, the Park Centre for Mental Health, Wacol, Australia; ⁴Queensland Brain Institute, University of Queensland, St Lucia QLD 4072, Australia; ⁵Institute of Health Sciences, University of Oulu, Oulu, Finland

⁶These authors contributed equally to the article.

*To whom correspondence should be addressed; Department of Psychiatry, PO Box 5000, FIN-90014 University of Oulu, Finland; tel: +358-40-7474376, fax: +358-8-336 169, e-mail: erika.jaaskelainen@oulu.fi

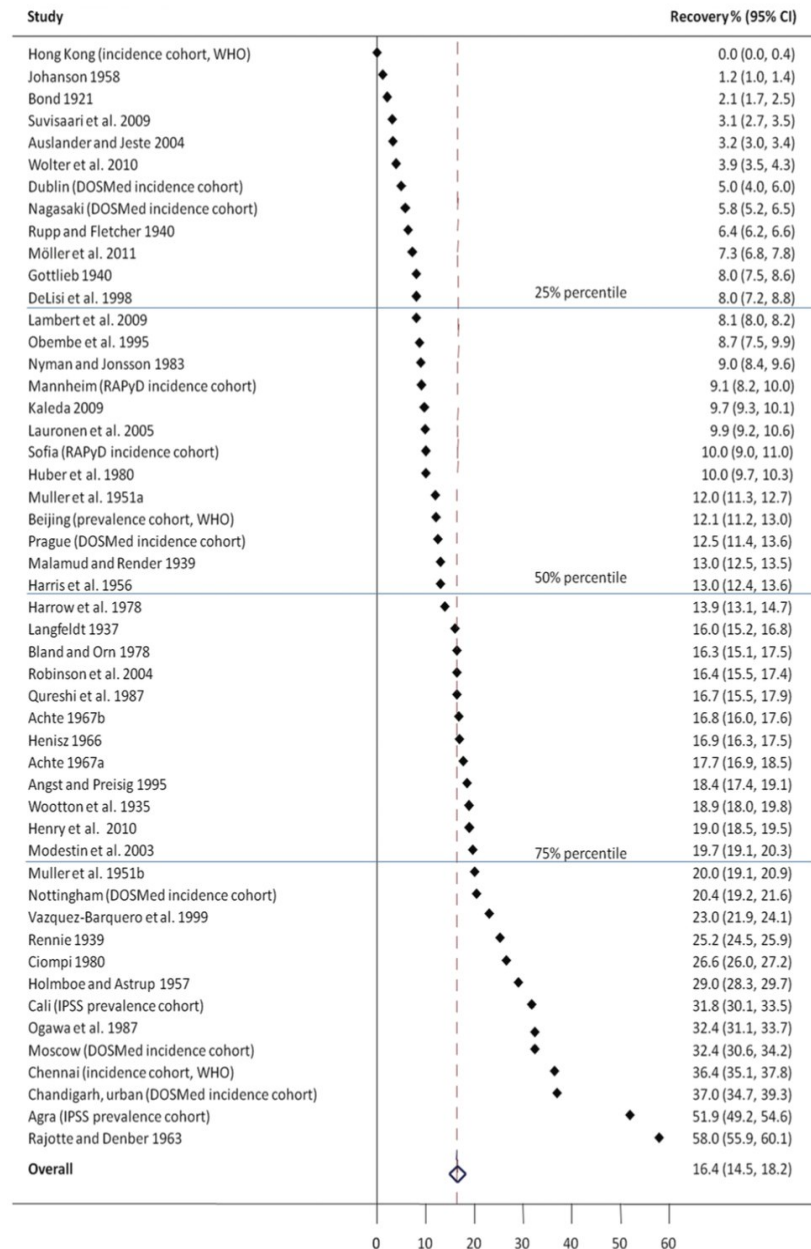


Fig. 2. Recovery percentage for included studies.

ASSERTIVE COMMUNITY TREATMENT



- Offrire servizi nell'ambiente naturale dei pazienti
- Team multidisciplinare collegati tra loro (servizi sanitari, sociali, abitazione, lavoro, monitoraggio, prevenzione, urgenze)
- Max 10 pazienti per case-manager
- Assistenza 24 ore su 24

ASSERTIVE COMMUNITY TREATMENT



- ✧ Efficacia nel ridurre le ospedalizzazioni
 - ✧ Miglioramento della sintomatologia
 - ✧ Aumentata aderenza alla terapia psicofarmacologica
-
- 倮 Difficoltà replicazione modello
 - 倮 Maggiore efficacia nei pazienti con alti tassi di ospedalizzazione
 - 倮 Efficacia sul campo lavorativo in relazione alla presenza di specialisti nel team

SUPPORTED EMPLOYMENT



- Supporto continuativo per facilitare il successo in un'occupazione competitiva
- Assistenza e problem-solving da parte specialisti (*job coach*)
- “*Place and train*” anziché “*Train and place*”

SUPPORTED EMPLOYMENT



- Efficacia nell'ottenere lavori competitivi, lavorare più ore, guadagnare di più
- Nessuna evidenza di correlazione tra lavoro supportato e aumento dello stress, riacutizzazione dei sintomi o altri outcomes negativi
- ✧ Mancanza di dati sul mantenimento del lavoro nel lungo termine e sull'indipendenza economica

SOCIAL SKILLS TRAINING



- Individuale, familiare o di gruppo
- Diverse attività di apprendimento (istruzioni comportamentali, role modeling, esercizi sul campo, feedback correttivi, rinforzi positivi)
- Trasferibilità del modello dal setting clinico a quello ambientale

SOCIAL SKILLS TRAINING



- ✧ Buona efficacia sul funzionamento sociale
- ✧ Esportabilità del modello in etnie e culture differenti
- 倶 Scarsa evidenza di efficacia degli effetti indiretti sulla remissione dei sintomi, i tassi di ricaduta o le riospedalizzazioni
- 倶 Pochi dati sul mantenimento nel lungo termine

TERAPIA COGNITIVO-COMPORTAMENTALE



- Individuale o di gruppo, durata da 4 a 9 mesi
- Azione sui pensieri disadattativi per modificare convinzioni e automatismi
- Insegnamento abilità di coping

TERAPIA COGNITIVO-COMPORTAMENTALE



✧ Efficacia sui sintomi positivi e negativi

倮 Minore evidenza di efficacia su sintomi depressivi, suicidalità, perdita di speranza, insight, tasso di ricadute, riospedalizzazioni

倮 Pochi dati sugli esordi psicotici e le fasi acute

INTERVENTI DI TOKEN ECONOMY



- Incentivi materiali per i comportamenti adattivi (denaro, buoni acquisto, gettoni, coupon, punti) uniti ad apprezzamenti
- Contratto comportamentale e individuale
- Assenza di punizioni

INTERVENTI DI TOKEN ECONOMY



- Efficacia nel miglioramento dell'igiene personale, delle interazioni sociali, della partecipazione ad attività all'interno di strutture residenziali
- ✧ Pochi dati su pazienti al di fuori di strutture residenziali

PSICOEDUCAZIONE FAMILIARE



- Educazione sulle malattie mentali
- Gestione dello stress
- Problem-solving
- Sostegno sull'uso di risorse della comunità

PSICOEDUCAZIONE FAMILIARE



- Efficacia sui tassi di ricaduta e riospedalizzazioni
 - Efficacia sugli esordi psicotici
 - Efficacia sull'aderenza al trattamento, sullo stress percepito
 - Efficacia sui familiari (stress, relazioni)
-
- ✧ Minori evidenze di efficacia per interventi di durata inferiore a 6 mesi

INTERVENTI ANCORA IN CERCA DI EVIDENZA



- Cognitive remediation
- Supporto dei pari e servizi gestiti dai pari
- Interventi per aumentare l'aderenza alla terapia antipsicotica
- Trattamenti psicosociali per esordio psicotico recente

TAKE HOME MESSAGES



- Dal 10 al 40% dei soggetti affetti da schizofrenia può raggiungere un recovery oggettivo
- Quantificare il recovery soggettivo implica allargare il campo dell'evidenza agli studi qualitativi
- Numerosi interventi psicosociali hanno mostrato la loro efficacia
- Nei prossimi anni si prevede un maggior numero di evidenze
- Importanza di un aggiornamento costante, critico e consapevole

BIBLIOGRAFIA

Carozza P. *Principi di riabilitazione psichiatrica*. Franco Angeli. 2006.

Dixon L.B. et al. *The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements*. Schizophrenia Bulletin. 2010.

Hegarty J.D. et al. *One hundred years of schizophrenia: a meta-analysis of the outcome literature*. American Journal of Psychiatry. 1994.

Jaaskelainen et al. *A systematic review and meta-analysis of recovery in schizophrenia*. Schizophrenia Bulletin. 2013.

Liberman R.P. *Il recovery dalla disabilità*. Giovanni Fioriti Editore. 2012.

Menezes N.M. et al. *A systematic review of longitudinal outcome studies of first-episode psychosis*. Psychological Medicine. 2006.

Warner R. *Recovery of schizophrenia: psychiatry and political economy*. Routledge. 2004.