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Original article

The impact on psychiatric rehabilitation of personal recovery-oriented approach

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SUMMARY

Objectives

Psychiatric rehabilitation focuses on the main disabling consequence of mental disorder and has the ultimate aim of helping the person to heal, meant as to control the symptoms, to remove the interpersonal and environmental barriers caused from disability, to recover the abilities to live independently, to socialize, and to effectively manage daily life and accept one-self limits. In recent years, rehabilitation services have been closely associated with the 'recovery' approach. Thus, the purpose of this article is to highlight the contribution in psychiatric rehabilitation of a virtuouse contamination with a recovery-oriented framework.

Methods

In this narrative review paper, we focus on a review of conceptual papers and empirical studies that proposed new methods or concepts or engendered important debate in the field of psychiatric rehabilitation. We used three online databases: PubMed, GoogleScholar, SCOPUS, and the following keywords: 'mental health rehabilitation' or 'psychiatric rehabilitation', 'mental health recovery' and 'mental health recovery-oriented practices' or 'mental health recovery-oriented interventions'.

Results

Since its development, psychiatric rehabilitation has undergone continuous evolutions in vision, mission, and principles. Born in the mid-eighteenth century, during the moral treatment era, and developed after the deinstitutionalization in the 1960s and 1970s, in the beginning, the task of the psychiatric rehabilitation was considered completed with the discharged of thousands of chronic patients from hospitals. It was soon clear that, for the discharget patients, there were not enough interventions, therapeutic programs or opportunities to spend time and socialize. In the 80s and 90s, the effort of traditional rehabilitation to achieve the goal to prevent or reduce social disadvantages and functional limitations and increase role performances was insufficiently achieved with a predominance of non-specific interventions. Later, non specific psychiatric rehabilitation interventions were reduced, and recovery values and principles were embodied in their vision. The concept that individuals with a psychiatric disability can live as normally as possible in society became an important goal of treatment. Nowadays, evidence shows that recovery-oriented approach and recovery-oriented interventions have positive health and social outcomes in people with severe mental illness.

Conclusions

The overall review of the interplay between rehabilitation and recovery-oriented practices highlights that the mission now is to further implement patients and their caregivers' engagement to collaborate in a treatment process that favors empowerment and provides support to disease management, psychosocial functioning, and personal satisfaction. However, recovery-oriented rehabilitation practices are still a matter of further development, and the concrete declination of these principles into everyday life seems to be still inhomogeneous and conditioned by local factors.

Key words: mental health services, personal mental health recovery, psychiatric rehabilitation, review

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Conflict of interest
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Introduction

Psychiatric rehabilitation focuses on the main disabling consequence of mental health disorder and has the ultimate aim to help the person to heal, meant as to control the symptoms, to remove the interpersonal and environmental barriers caused by disability, to recover the abilities to live independently, to socialize, and to effectively manage daily life and accept one-self limits [1-3].

In the last 30 years, mental health recovery has constituted a major theoretical and practical framework in mental health care [4]. However, there is still no general consensus on a single definition of the concept of recovery, that is a reason of dabate among the main stakeholders. Generally, recovery is distinguished in personal/subjective and clinical/objective. The guiding principles of personal recovery emphasize hope and a strong belief that it is possible for people with mental illness to regain a meaningful life, despite persistent symptoms. Thus, the approach does not focus on full symptoms resolution but promotes resilience and control over problems and life [5].

The purpose of this article is to highlight the contribution in psychiatric rehabilitation of a virtuose contamination with personal recovery-oriented framework. The review retraces the history of psychiatric rehabilitation since its very beginning, describes the main principles and processes of the psychiatric rehabilitation, highlights the interplay between psychiatric rehabilitation and personal recovery, and reports evidence of personal recovery-oriented approach.

Methods

Three methods for article identification were used: electronic database searching, web-based searching, and hand searching as a cross-check.

Electronic literature searches used three online databases: PubMed, GoogleScholar, SCOPUS.

The following keywords were selected: 'mental health rehabilitation' or 'psychiatric rehabilitation', 'mental health recovery' and 'mental health recovery-oriented practices' or 'mental health recovery-oriented interventions'.

The result was a pool of scientifical articles, guidance documents, and books both in Italian and in English from 1980 to 2019. The selection resulted in 35 references: 20 articles, 10 books, and 5 guidance and procedures documents for mental health organizations.

Results

The historical evolution of psychiatric rehabilitation

The first vision of psychiatric rehabilitation was closely connected with the philosophical ideas of Humanism, civil liberties, individualism, freedom of choice and personal responsibility born in the mid-eighteenth century. The rehabilitative principles were inspired by a combination of liberal democracy, the search for happiness, the diffusion of public health interventions, and the rebellion to the horrible condition of the confinement of the mentally ill in prisons and hospices for the poor [1].

In the era of the "moral treatment", reformers such as Samuel Tuke of the Quarter York Retreat in England and Dorothea Dix in the United States believed that moving the mentally ill from overcrowded urban areas to rural settings would improve the patient's abilities and mood. The proponents of the moral treatment took in the importance of compassion, cleanliness, work, and activities planned to improve thoughts, feelings, and behaviors. The founders of psychiatric hospitals believed that patients could recover if the institutions had given them the opportunity to behave normally [1,2,6].

Unfortunately, as the population grew rapidly in the second half of the nineteenth century, hospitals became crowded, custodial and therapeutic nihilism increased, and – in the meanwhile – the living conditions of psychiatric hospitals worsened. In the mid-90s the introduction of psychotropic drugs raised optimism on the possibility to discharge the patients from large psychiatric hospitals into their communities [2].

Thus, in the 1960s and 1970s, the deinstitutionalization process, supported by experts all over the world (e.g. Basaglia, 1968; Cooper, 1979; Foucault, 1961; Goffman, 1961; Szasz, 1984) has been developed, leading to the discharge of thousands of chronic patients from large psychiatric hospitals [1]. In the beginning, when the large mental hospitals closed, there was the grown of the idealistic belief that the task of psychiatric rehabilitation was completed [3]. However, this belief was not in line with the real state of mental health services, as for ex-patients there were a few services or therapeutic programs that offered opportunities to spend time, socialize or have fun.

In the 80s and 90s the model of Ciompi and collaborators, who planned rehabilitative programs and the evaluation of their outcomes considering housing and work activity, became a reference for mental health services [7]. However, the model did not produce sufficient effective professionals' capacity building in terms of providing to the patients skills generalizable to everyday life [8].

Thus, the traditional approach to psychiatric disability usually consisted of a dynamic combination of pharmacotherapeutic, psychotherapeutic and containment interventions (hospitalization), not enough personalized, specific and structured to appropriately achieve the goal to preventor reduce social disadvantages and functional limitations or increase role performance [2].

However, in the last few years, psychiatric rehabilitation has undergone profound changes, that have led to a

progressive reduction of non-specific interventions, and of local experiences not supported by evidence of efficacy [9].

Nowadays, clinicians and researchers in the field of psychiatric rehabilitation have structured a fairly consolidated theoretical-practical corpus, decreeing with a certain delay *the end of the entertainment* desired by Saraceno already in 1996 [10].

There are numerous synergic factors that have determined these changes [2,9]. We enlist 5 main contributes due to the remodeling of rehabilitation in mental health following the deinstitutionalization process. 1) The psychiatric rehabilitation has gained more and more respect in the academic field, with an increased inclusion in scientific production [1]. From 1945 to 2019 19.465 papers focused on psychiatric rehabilitation have been published (data obtained using the keyword "Psychiatric Rehabilitation" in the online database *Pubmed*) see Figure 1. 2) New epidemiological and clinical evidence regarding the heterogeneity of the schizophrenic and severe mental illnesses course have set specific and personalized standards for rehabilitative interventions [9,11]. 3) Rehabilitative activities become evidence-based, including the evaluation of the outcomes of the disease, an aspect that has not always been adequately considered in clinical practice in the past [12]. 4) The dissemination of accredited rehabilitation methods and the results achieved by them [2]. Several authors have shown that, when a rehabilitation treatment was added, appreciable outcomes were achieved even in the presence of undercurrent admissions [13], in the work functioning [14], autonomy in living and resumptions of studies [15]. 5) The results of studies that involved users and family members proved the added value provided by subjects not involved in professional and institutional care showing that they can more sharply identify the most needed kinds of rehabilitation treatment [2].

Other factors are linked to new discoveries and developments in disciplines that indirectly have an impact on mental health rehabilitation, such as 1) The contamination of psychosocial intervention techniques with specific psychotherapeutic approaches, such as the cognitive-behavioral approach [16] whose efficacy has been demonstrated [9]. 2) The introduction of atypical antipsychotics that had less extrapyramidal adverse effects, an aspect that has contributed to stigmatizing patients, and decreased the negative symptoms, major obstacles to involvement in social networks [17]. 3) The delivery by the community of more support and resources that can help the users to achieve their goals and increased

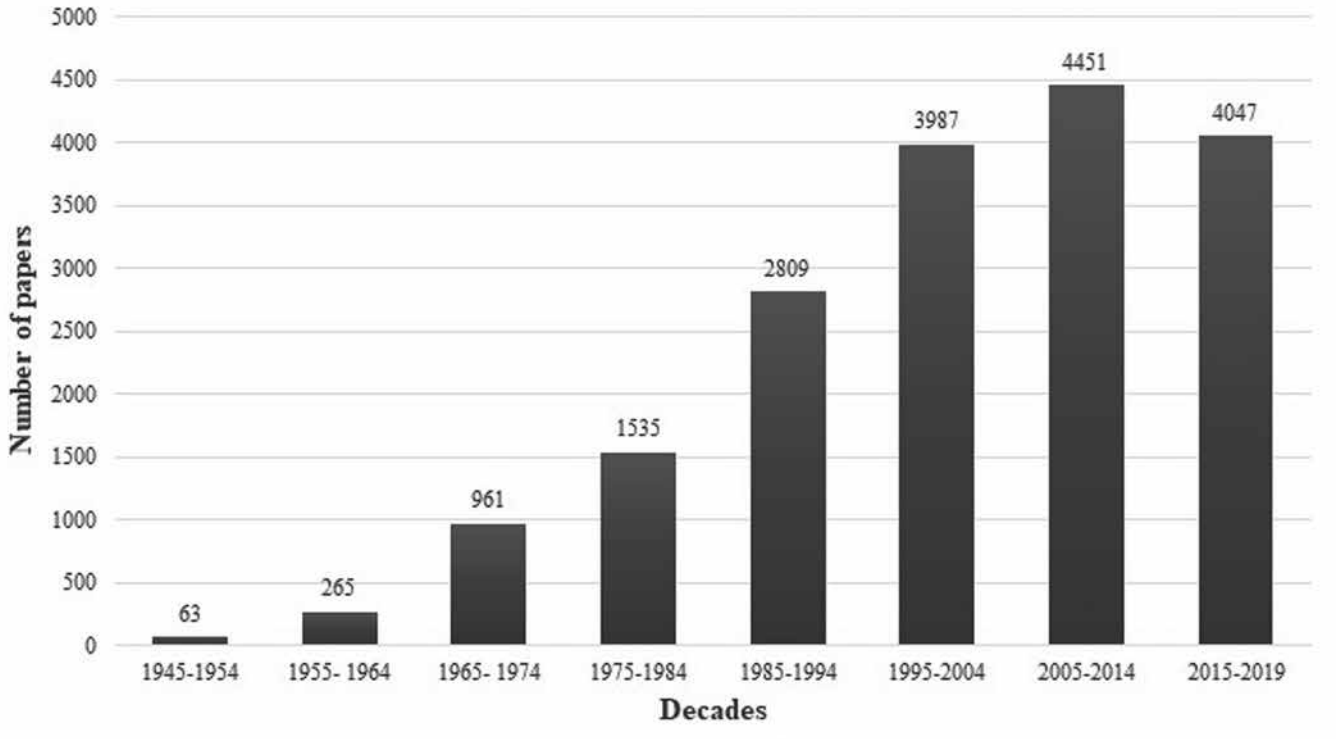

FIGURE 1. *The trend of number of papers published on "psychiatric rehabilitation" from 1945 to 2019 for decades (source PubMed).*

awareness that a change is required not only in the individual but also in the community [2]. 4) The switch from the 'Deficit Model' to the 'Strengths Model'. The founding assumption of the 'Strengths Model' is the identification of the users' strengths and of the environment rather than of the deficits. Several studies highlight positive outcomes deriving from the adoption of the 'Strengths Model' in mental health practice [1,8,9]. 5) The implementation of 'client-centered therapy' techniques [18] based on respect and partnership as a primary aim [2]. 6) The inclusion of social and work functioning deficits among the criteria used in the DSM-IV that highlights how mental disorders and their clinical symptoms also cause 'significant distress or impairment in social, occupational, or other important areas of functioning' [2,19].

Vision, mission, and goals of psychiatric rehabilitation

In the historical context previously described, psychiatric rehabilitation has been defined in many ways, in most cases characterized by general statements and paucity of well-defined procedures [2]. However, psychiatric rehabilitation might be considered a systematic synthesis of theoretical contributions from various fields of human sciences, based on a set of specific values having as a common denominator the 'concept of person rights', which should be the primary reference for anyone involved in the sector [20].

Psychiatric rehabilitation is one of the main approaches that act on disability, dysfunction, and handicaps [2], focusing on the main disabling consequences of a mental disorder such as the impairment of the ability to perform social roles [21]; its mission is to increase social and work functioning, to make people with disabilities able to play a valid successful and satisfactory role in the environment they choose (work, housing, school, social and recreational environments), requiring as little as possible continuous professional interventions [2,20].

According to the Royal College of Psychiatrists, psychiatric rehabilitation *'…at the present time, with the advent of new regulations in the field of mental health, has the task of assisting people with severe psychiatric disabilities who already live in the community to reach a life as autonomous and satisfying as possible'* [22].

Thus, the ultimate goal of psychiatric rehabilitation is to help the person to heal [21] with a series of actions such as 1) to remove interpersonal and environmental barriers caused by disability [2], 2) to facilitate the increase of social articulation through learning and use the social skills (instrumental, interpersonal, intrapersonal) that enable the individual to respond appropriately, and to adapt to the demands and needs, implicit and explicit, of oneself or of those with whom he lives [23], 3) to modify the environment in order to reduce stress factors as much as possible [2], 4) to ensure access to the responsibilities and social, professional and leisure opportunities as a citizen who participate in the community life [1], 5) to control symptoms, 6) to increase skills to live independently, 7) to effectively manage daily life and to accept one-self limits because, despite these, it is possible to live most experiences of other human beings [2].

Principles and process of psychiatric rehabilitation

Psychiatric rehabilitation based its own vision and mission on principles, that regulate the delivery of rehabilitative interventions, form the basic assumptions and the key concepts, and the ethics of the professionals [1,2]. They are also fundamental for the design, development, and implementation of rehabilitation treatments [1].

TABLE I. *The seven principles of psychiatric rehabilitation.*

Carozza, 2006 [2]	Liberman, 2009 [1]
The functioning	The recovery of a normal life is possible for many people with psychiatric disabilities if the best rehabilitative practices are provided
The delivery of support	Impairments, disabilities, and handicaps can be reduced or overcome by integrating pharmacological, and psychosocial treatments with advocacy interventions in order to improve the clinical, professional, and scholastic and government policies
The environmental specificity	The individualization of treatment is the fundamental pillar of rehabilitation
The involvement	Rehabilitation is more effective when patients and families are actively involved
The choice	Building on the strengths, interests, and abilities of the patient is a cornerstone of rehabilitation
The outcome orientation	The integration and coordination of the interventions are essential in promoting rehabilitative progress
The confidence in people's growth potential	Rehabilitation takes time, progresses gradually, and requires perseverance, patience, and resilience by patients, families, and therapists

The principles derive both from conceptual bases and awareness of practical needs for interventions [1,2]. Thus, the fundamental concepts of psychiatric rehabilitation stimulate the development of practices, that are tested by research, and, in turn, provide empirical results [1].
The principles were elevated to a system by Anthony [20] and accepted, with general consent, by main thinkers of psychiatric rehabilitation [2]. Table I shows the 7 main principles that characterize psychiatric rehabilitation today.
To achieve the goals of psychiatric rehabilitation, a systematic work of inclusion and definition of a set of values has to be translated into a structured process constituted by different activities, all essential to achieving outcomes.
The first step is the rehabilitative diagnosis, which includes the evaluation of availability for rehabilitation, functioning and resources, and the definition of the global rehabilitative aim.
The second phase is the planning of the interventions that are focused on the development of skills and resources [2].
The last phase is the implementation of a range of interventions that make it possible for people with disabilities to use cognitive, emotional, social, intellectual and physical skills necessary to live, learn, work and function as normally and independently as possible in the community with minimal interference from symptoms.
The methods by which these goals are achieved are: medications, cognitive rehabilitation, and disease management interventions to eliminate or reduce symptoms; functional evaluation of all dimensions; to teach people specific skills; to organize and plan supporting environments and programs; to involve families; work rehabilitation; to provide accessible treatments and interventions; to provide special interventions for special people (for example for people with substance misuse); to provide professional and natural supports.
Rehabilitation interventions varies in shape, intensity, and duration depending on the type of psychiatric disorder and the degree of disability. Thus, the type and extent of treatment is modified according to a series of variables such as severity, chronicity, and co-morbidities of various disorders; response to drug treatment; intelligence, learning ability, social competence, cognitive functioning, growth and development process, level of education, cultural and ethnic background, social class and economic resources, family support and satisfaction with the current quality of life; changes in the availability of mental health services and community resources [1].

Recovery-oriented psychiatric rehabilitation

In recent years, psychiatric rehabilitation has been closely associated with recovery [6]. A recent definition of recovery-oriented psychiatric rehabilitation is *'…a whole systems approach to recovery from mental illness that maximizes an individual's quality of life and social inclusion by encouraging his skills, promoting independence and autonomy in order to give him hope for the future and leads to successful community living through appropriate support'* [3].
In a recovery framework, the vision of psychiatric rehabilitation is to make individuals with a psychiatric disability able to achieve recovery and live as normally as possible in society [1]. This implies to activate care pathways oriented towards personal recovery even when disabilities and difficulties of various kinds are present [6], and engage patients and their family members or caregivers to actively collaborate in a treatment process that promotes empowerment, disease management, psychosocial functioning, and personal satisfaction [1,2]. Valuing hope and optimism becomes fundamental, and the importance of good physical and mental health, the respect for individuals of all ages and cultures, and the right to live a life not defined by illness or diagnosis are values that should underlie all effective rehabilitation practices [4,6].
The recovery approach, as claimed by Slade and collaborators [24], offers an opportunity to use rehabilitation to encourage users to get involved in defining their care goals [25]. Rehabilitation interventions have to embrace measures that capture the direct experience of the service user, and mental health professionals have to address problems and difficulties in a manner that includes and recognizes the user's wishes and ambitions. Mental health organizations should also consider how users can take benefit of the role of peer experts, and service users should be consulted about the need for service developments, management, and design in a co-production perspective [6].
Moreover, psychiatric rehabilitation should be activated on one hand at the onset of a disorder to preserve the skills for everyday life and goals [26], and on the other hand for people with disabilities with longer-term mental health problems, to address the disabilities of users who have not made a rapid recovery and may experience difficulties in global functioning [6].
Rehabilitation interventions should be both evidence-based and based on the best rehabilitative practices; the combination favors significant improvements in attitudes and initiatives that promote empowerment, self-responsibility, hope, and user satisfaction, and quality life [1].
Recently, recovery-oriented approach and, particularly the shared decision-making process, has shown evidence in improving self-management, autonomy, and health outcomes of service users with mental health disabilities [27-31]. Moreover, it correlates positively with a re-

duction of the costs for the health systems [32] and overall makes mental health practices fit for the 21° century [28]. Thus, individualized and user-centered projects are indicated as quality objectives for mental health services in general [29,32,33], and in particular for mental health rehabilitation.

Research proves positive outcomes for people with mental health disorders adopting personal recovery-oriented interventions with a bulk of evidence such as 1) *peer support workers*, who are experts by experience who offer to users and families members a model of successful care path in a range of more or less formal approaches within mental health organizations; 2) *Advanced treatment directive*, a document that specifies a person's future preferences for treatment if the person loses the mental ability to make treatment decisions; 3) *refocus*, a program of research aimed to find ways of making community-based adult mental health services in England more recovery-oriented; 4) *the strengths model*; 5) *the individual placement and support (IPS) model*, a psychosocial intervention of supported employment, with a considerable body of evidence for effectiveness in helping people with severe mental illness to obtain and maintain competitive employment according to their preferences; 6) *the recovery colleges*, that offer educational courses about mental health and recovery designed to increase students' knowledge and skills to feel more confident in self-management; 7) *supported housing*, a rapid re-housing in independent accommodation for people with severe mental illness, according to their preferences; 8) *mental health trialogues*, community forums where service users, carers, friends, mental health workers, and others with an interest in mental health participate in an open dialogue [24].

Conclusions and future directions

The main limitation of the current paper is the chosen methodology for achieving the purpose, that was based on a series of key words. Subjectivity in the study selection might have lead to selection bias.

However, this methodology enabled to explore a large number of papers, selecting the most relevant conceptual papers and empirical studies in the field that introduced new methods or concepts or engendered important debate in psychiatric rehabilitation.

The findings of this review report that evidence shows how recovery-oriented rehabilitation, users' involvement, individualized and user-centered projects, and shared choices, have a positive impact on health outcomes. Current international guidelines and policy papers consider the recovery-oriented approach as the quality objective for psychiatric rehabilitation services [28,29,33]. These approaches have an increasingly powerful influence on everyday professional practice [6] and have been experimenting in different contexts [32].

However, recovery-oriented practices have not well spread and implemented yet in psychiatric rehabilitation [34]. Recovery-oriented practices and user involvement in the co-production of health interventions are still a matter of debate in numerous documents by qualified agencies and bodies [35], and the concrete declination of these principles in the daily practices of mental health services, even in Italy, seems to be still inhomogeneous and conditioned by local factors [27], such as different historical contexts and different organizational structures, and considerable uncertainty about the precise meaning of these concepts and their effective application in the practice of services [8]. However, optimism about recovery can be easily found in policy documents or guidelines for good clinical practice.

In conclusion, finding a way to adequately implement the recovery-oriented approach in psychiatric rehabilitation without dismantling but instead integrating the traditional rehabilitative approach is a difficult but important struggle for all the stakeholders involved in the process [1,6,8].

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