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Editorial: Understanding and Measuring Recovery

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In 2003, 25 years after Rosalynn Carter chaired the first Presidential Commission on Mental Health, she testified before the New Freedom Commission on Mental Health, chaired by Michael Hogan.[1] When asked what the greatest advance had been in the intervening years, she said it was adopting the belief that people with serious mental illness could recover.

As heterogeneous as people with schizophrenia are, so too are their paths to recovery. Recovery may proceed along multiple domains: psychotic symptoms, cognitive capacities, functioning in terms of independent living in the community, competitive employment, social and intimate relationships (''a home, a job and a date on the weekend''), physical health, economic health, and other aspects of quality of life.[2] To the extent we recognize and respond to the diverse domains of a person's life, we will help people in the work of crafting a life.

We comment on this series of reports describing the challenges of measuring recovery from schizophrenia and identifying predictors of recovery. We offer these comments as public mental health system administrators charged with promoting recovery, including knowing whether the services being purchased with public funds are promoting recovery. Such knowledge requires measurement. Is the intervention being carried out with fidelity? As both administrators and as evaluators/researchers, we look to our colleagues in the field to offer measurement tools of immediate practical significance to consumers and clinicians.

Frese et al[3] depict an evolving concept of recovery from schizophrenia. They note that the medical model of the 1950s had to be expanded to include social aspects of the disorder because of the supports needed by people with serious mental illnesses whose residences were shifted during the era of deinstitutionalization from the hospital to the community. Medical care alone was not adequate to allow community living, and soon it became apparent that the ''psychosocial'' aspects of these disorders could not be divorced from medical considerations, thereby prompting more holistic views of recovery from schizophrenia.

Frese and colleagues[3] go on to note that with the report of the President's New Freedom Commission in 2003, a clinical emphasis on recovery became not only possible but also expected. As administrators and public policy decision makers, we must ask ourselves how to engender this optimism in staff who may view success as showing up for a day treatment program 5 days per week. These authors also call our attention to the damage that can be wrought by isolating our vision to the psychosocial aspects of recovery and ignoring the nature of the illness from which the person is recovering: it would be just as short-sighted to ignore the illness as it has been to ignore the person with the illness. They illustrate this point by listing the Substance Abuse and Mental Health Services Administration's recovery principles, which read so generically that one could address them all without attending to a person's need for medical treatment. Adopting a view of recovery that marginalizes the fact that there is an illness to recover from can perversely serve a payer's fiscal interests. We see this, eg, when a managed care organization hires peer counselors (often with great fanfare) while leaving large numbers of clinical positions unfilled. The article by Frese et al[3] reminds us not to let assertions of being a recovery-focused system be a cover for shoddy attention to distressing disease symptoms.

Frese and colleagues[3] also provide brief bios of themselves and some of the other consumer leaders of the recovery movement who are mental health professionals. They use these personal descriptions to illustrate the divergence of opinion on recovery, particularly with respect to the importance of the biological aspects of schizophrenia. These opinions speak to the diversity of values we all face when trying to achieve balance in policy and practice for mental health systems of care. Several of the other articles in the series grapple with the need for language and measures that could provide the diversity to assess programs for their effectiveness toward recovery.

Harvey and Bellack[4] propose a language for discussing recovery. They start with what most understand about functional recovery and then examine how its component parts might be measured, noting the value judgments this entails. They also remark, in essence, that it is easier to look for your keys under a lamppost than in darker,

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but more likely, places. For example, cognitive performance measures have detailed norms but, at least as yet, are of little use in measuring recovery from schizophrenia. In contrast, no such norms exist for those measures consumers (and public policy leaders) value, namely residential independence, employment, and a social life. While measures of cognitive functioning may have high reliability, they lack validity and meaningfulness with respect to measuring functional impairment in real-world activities, the domains most important to consumers and their families.

Harvey and Bellack[4] introduce a notion of "breadth of success" perhaps to counter a narrow emphasis on symptoms. They assert that doing "pretty good" in a variety of important life domains constitutes being recovered, which has great face validity because lives are lived in many areas. They also broaden considerations to include effort and societal barriers as significant influences on paths to recovery. As treatment professionals, we cannot just say "good enough" when someone's symptoms are gone or minimally intrusive, yet the person has no job or home or friends. The schema proposed by Harvey and Bellack[4] allows functional remission (being pretty good across multiple domains) to be measurable at the same time as clinical remission.

Mausbach et al[5] review various instruments for measuring functional recovery among people with psychotic disorders. There is no gold standard. As believers in measurement-based interventions, we regard such instruments as vital. Measurement should let consumer and clinician know whether an intervention is having the desired impact so as not to waste the consumer's time or the system's resources. To be useful in routine practice settings, such measures must be able to be incorporated readily into treatment activities. These authors propose a 30-minute cutoff as the threshold for giving a scale an "A" rating for ease of administration. The disconnect here is that what is brisk to the researcher (a 30-minute assessment of functioning) will simply not fly in mental health systems as we know them. That said, we appreciate their widening the light under the lamppost by creating measures that reflect real-world functioning. This is an important work in progress.

The study of Wunderink et al[6] of predictors of recovery for people with a first psychotic episode tells a story with a 1-2 punch: treatment works and early treatment works much better. This Dutch study showed that recovery after 2 years was significantly associated with a short duration (mean 32 d) of untreated psychosis. The nonrecovered patients, in contrast, went approximately 10 times as long before entering treatment (321 d). Entering treatment within 32 days of the onset of a psychotic illness is staggeringly prompt by US standards. While the study design could not assign causality, the findings suggest the importance of early entry to treatment in promoting functional recovery. Clearly, this is an area where more research is needed to inform practice, and the National Institute of Mental Health is headed in this direction with its Recovery After Initial Schizophrenia Episode initiative.

Mohamed et al[7] use correlational data, some available from randomized trials conducted to address other primary outcomes, to make the case for helping people with schizophrenia gain insight into their illness and or the utility of medication in decreasing schizophrenia symptoms. Their finding that declining schizophrenia symptoms were accompanied by increasing levels of depression may also support the nonlinear and disparate aspects of recovery. The authors point out that the increase in depression as psychotic symptoms improve may reflect the emergence of individuals' recognition of the discrepancy between current and desired functioning. They note, optimistically, that this realization could motivate individuals to move on with their recovery. Leaders in clinical administration and policy have the challenge of helping frontline staff gain the clinical skills to recognize how to use such feelings to help promote a depressed individual's motivation for positive change.

Policy makers and program directors ask, "What treatments promote functional recovery for people with schizophrenia?" The report by Kern et al[8] makes a compelling case for the interaction between pharmacological and psychosocial treatments and concludes that the whole is greater than the sum of its parts. The authors stress the importance of remembering both the person and the illness as opposed to settling for symptom stabilization. Two of the psychosocial treatments considered (social skills training and cognitive behavioral therapy) have strong evidence bases to support them. The other 2 interventions considered, cognitive remediation and social cognition, have an emerging evidence base that does not yet meet the level of support needed from multiple randomized trials by separate groups of investigators.

The report by McGurk et al[9] makes a strong case that vocational rehabilitation plus cognitive remediation is more effective than cognitive remediation alone in improving work outcomes. The administrator with finite resources is left wondering whether the cognitive remediation platform itself adds value or whether a "vocational rehabilitation"–alone arm would have achieved the same results. The extent to which improvements in cognitive tasks result in improvements in functioning is an open and important question because cash-strapped public mental health systems consider where to invest resources for the greatest impact. Should these interventions be reimbursable services? If so, for whom, when, and under what conditions?

Kern et al[8] are careful to say that it may not be reasonable to ask cognitive training approaches, if used in isolation, to show an impact on functioning. Rather, it may be that some form of "talking therapy" may be necessary to facilitate the translation of gains from training exercises to real-world problems. The pharmacology studies summarized by these authors also make the case that

medications may be necessary but are not sufficient to improve functioning. They make the case like others that a recovery-oriented treatment should draw from broad yet individualized approaches—each with specified goals and objectives.

This ensemble of articles usefully characterizes efforts underway to move anecdote to science by improving methods for measuring recovery for people with schizophrenia and other serious mental illnesses. Indeed, as Mrs Carter suggested, we have entered the age of recovery and are now searching for good evidence of what works. To do so, we need clear definitions of the domains of recovery that are meaningful to consumers, families, and clinicians and reliable, feasible, and valid measures of response to interventions, whether these be biological, psychological, or social in nature. It is heartening to see this work underway because it can only deepen our understanding and commitment to building recovery-oriented services.

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