# The Mental Health Recovery Star:
## Validation study and features of the Italian version

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**SUMMARY. Aim.** The MHRS is a tool for assessing the recovery process of patients suffering from mental illness through a collaborative approach. The aim of the study is to describe the features of the tool and report the results of the Italian validation study. **Methods.** The study involved 117 service users assessed in two phases a month apart. In addition to the MRHS, the *Health of the Nation Outcome Scales* (HoNOS), *World Health Organisation Quality of Life-BREF* (WHOQoL-B) and *Global Assessment of Functioning* (GAF) were used. The acceptability of the tool by service users and keyworkers was assessed, in addition to its main psychometric properties, including assessment of readings assigned jointly using intraclass coefficients and concurrent validity using the Pearson correlation coefficient. **Results. The** MHRS demonstrated temporal stability in all areas. Significant correlations were found between the MHRS and the most similar areas of the scales used. Inter-rater reliability was not studied sufficiently. Overall the MHRS was deemed a satisfactory and easy tool to use. Joint evaluations were mostly completed in less than 45 minutes. **Conclusions.** The MHRS is deemed acceptable by service users and keyworkers, and is characterised by practical and useful visual aids. It contributes to identifying patient recovery pathways and encourages a collaborative approach between users and keyworkers. The results of the evaluation of the psychometric properties appeared promising but were not exhaustive. Although further efforts could be directed at examining these aspects, and consideration should be given to traditional methods for measuring the overall subjective/objective recovery approach, the valuable collaborative contribution of the MHRS in empowering users and supporting keyworkers in their role as case managers cannot be denied.

**KEY WORDS:** evaluation tools, recovery, mental disorders, Mental Health Care

## INTRODUCTION

The subject of co-production has changed the concept of welfare (1), and when it comes to health services, especially mental health services, its synergy with the recovery model (2) has acquired broad consensus. In this framework, the involvement of users in the co-production of medical interventions is an issue which is debated in numerous documents from authorised agencies and organisations (3). The *National Institute for Health and Care Excellence* deals with the subject using two guidelines – one specifically for mental health, with a focus on improving the experience of service users through their active participation in service delivery, and the second relating to pathways that contribute to improving the health effects of interventions jointly constructed through community engagement with direct beneficiaries (4,5). The concrete manifestation of these principles in the day-to-day provision of mental health services still seems to be inconsistent and affected by local factors, and this is also the case in Italy (6). Based on these assumptions, and with a view to reassessing models and interventions in psychiatric services, it would appear useful to provide keyworkers, who interact with users and their families every day, with easy-to-use tools that steer their activity towards methods based on co-production and recovery.

In recent decades the concept of recovery (7) has gradually acquired increasing importance in mental health research and policy. As stated by Slade et al. (8), mental health services should reshape their role and facilitate the user recovery process. In particular, the recovery process provides a transformation opportunity for services, by encouraging the increased participation of service users and involving them in the definition of their own care objectives (9).

The MHRS fits into this context, and is a tool which is useful to keyworkers and case managers for constructing and monitoring personalised rehabilitation and care plans, while keeping the focus on users and optimising their pathway. The MHRS was developed by *Triangle Consulting* in conjunction with the *Mental Health Providers Forum* in the UK, where it was the subject to evaluation of its psychometric properties (11) and found application in a wide range of services

and projects, to the point of being considered for defining outcome measures within government *Payments by Results* projects.

The tool is becoming widespread in English-speaking countries and two initiatives are in progress to make it available in other languages - French, Danish and, through this study, Italian.

The aim of our contribution is to illustrate the main features of the MHRS and outline the results of the Italian evaluation. The study was carried out as part of a collaboration project involving services in the third sector and public health facilities in Lombardy, and was co-funded by *Fondazione Comunità Bresciana*.

*Associazione il Chiaro del Bosco* (www.ilchiarodelbosco.it) was the research contact organisation.

**METHODS**

The collaboration project which led to the Italian evaluation of the MHRS involved services in Lombardy provided by four government mental health departments - *UOP 23 DSM ASST Spedali Civili* in Brescia , *DSM ASST* in Garda, *DSM ASST* in Crema and *DSM ASST* in Vallecamonica - and two third sector organisations (*Associazione il Chiaro del Bosco*, and *Cooperativa Liberamente*). The collaboration was set up through a shared letter of intent and work commenced following extensive training on the use of MHRS and research into the use of additional tools included in the project.

The study plan involved the completion of the MHRS with at least 100 patients in contact with the psychiatric facilities belonging to the organisations that participated in the project.

The study was split into two evaluations (T0 and T1) carried out approximately 1 month apart using the tools outlined below. Social demographic/clinical characteristics and the *Clinical Global Impression* - CGI (12) were measured for all individuals, the MHRS was completed, and HoNOS (13, 14), WHOQOL-B (15) and GAF (16) were administered. These evaluation tools were implemented while trying to adhere to the clinical assessment routine for the various services and enabled comparison with most of the areas outlined in the MHRS.

On completion of the first evaluation (T0), the acceptability of the tool by the keyworker and user in completing the MHRS was assessed. Two items specially constructed on a 5-point Likert scale were used - the first rated level of satisfaction (ranging from Not at All to Very Satisfied) and the second rated level of difficulty (ranging from Very Difficult to Very Easy). Finally, the time required for the joint completion of the MHRS was noted.

After giving their informed consent, patients were consecutively recruited from those cases requiring management with the creation of a formal care plan in accordance with Lombard Region criteria, as outlined in the latest Regional Mental Health Project (17).

All relevant keyworkers (case managers) were involved in the study and trained in the use of the MHRS.

**Description of the Mental Health Recovery Star (MHRS) characteristics**

The MHRS was developed through the use of qualitative and quantitative methods in accordance with a participatory action research model outlined by the authors of the tool (10), which involved researchers, keyworkers and the users of residential facilities and day services in the London area. The tool is considered a measure of personalised holistic outcomes, with a focus on a recovery-orientated approach (18). The MHRS measures the service user's recovery path through discussion guided by scale descriptions and a visual map, to encourage the identification of the point users feel they have reached in their 'journey of recovery'. Furthermore, it enables individuals to track their own progress and plan the actions required to meet their objectives regarding change (19,11,18). There are two main elements of the MHRS. The first is a star-shaped 10-point diagram showing life domains underlying the recovery process which are allocated a reading (figure 1 and box 1). The second is the Journey of Change (figure 2), which outlines five stages on the road to

recovery, each of which is split in two and described with specific readings for each area. Attributing a reading to each area involves analysis and discussion between the case manager and the patient, in order to understand the current situation and define a personalised care plan together. After deciding initial readings and agreeing objectives for change, the evaluation is carried out again after a suitable period of time. This is therefore a method for evaluating, agreeing and supporting personalised pathways for users of psychiatric services through their direct involvement.

The tool is characterised by its use of simple language with no clinical terminology, and its informal style with concrete examples assisted by the use of graphics.

The full MHRS tool contains various aids - a user guide containing the description of the 10 life domains and the corresponding Journey of Change stages; a guide for organisations with completion instructions and FAQs; The Star diagram for recording readings; a form for recording action plans and interventions in priority areas for the patient.

The MHRS was translated into Italian following authorisation from the authors, and was translated and adapted according to various recommendations in the relevant literature (10). This procedure involved a forward translation into Italian by native Italian experts in mental health, a back translation into English by native English translators sourced by the authors in London, a final revision phase (21-24) and use of the official MHRS format provided by *Triangle Consulting*, which holds copyright for the tool.

Two days' training is required to learn how to use the MHRS and enable keyworkers to work directly with service users, as outlined by its authors.

In Italy the organisation authorised by *Triangle Consulting* to distribute the material and provide training on using the MHRS is the *Associazione il Chiaro del Bosco* (www.ilchiarodelbosco.org), which set up a team of trainers consisting of keyworkers in mental health services, in addition to service users and their relatives.

**Data analysis**

Means and standard deviations were calculated for the social demographic/clinical variables in the sample and keyworker characteristics.

Inter-rater reliability was tested in a special session using the tool on completion of training, during which the keyworkers participating in the study gave independent readings for a clinical case discussed and described in detail. Reliability was estimated by calculating Cohen's kappa coefficient and comparing pairs of readings from all participants. It was not possible to measure additional clinical cases.

The test-retest reliability obtained in conjunction with the MHRS service user and keyworker was evaluated using the intraclass correlation coefficient, testing the null hypothesis r=0.70.

Concurrent validity was assessed using the Pearson correlation coefficient.

Finally, the frequency analysis was carried out to estimate levels of satisfaction, difficulty in using the tool, and administration times.

All information collected was entered into a database and analysed with SPSS version 26 for Windows.

**RESULTS**

**Participant characteristics**

A total of 11 mental health departments were involved, which included 4 (36%) psycho-social rehabilitation centres (local clinics), 2 (18%) day centres and 5 (45%) residential psychiatric facilities with support levels ranging from medium to high in the province of Brescia. 42 keyworkers from these facilities collaborated in the study: 20 (48%) professional educators, 14 (33%) qualified nurses, 5 (12%) psychiatrists and 1 (2%) psychologist. The average age of the keyworkers was 40.71

(SD 7.47) with an age range of 26 to 57 years old. Average years of service was 12.46 (SD 7.36) with length of service ranging from 2 to 37 years. All keyworkers involved in the research had been trained in the use of MHRS.

117 service users participated in the study, who were each provided with a chronological personalised treatment/rehabilitation plan. The patients mainly came from psycho-social rehabilitation centres (83; 70%), day centres (16; 14%) and residential psychiatric facilities (18; 16%).

The main socio-demographic and clinical characteristics of the sample are outlined in tables 1 and 2 respectively.

## Reliability

Inter-rater reliability (42 participants) was studied in part with the data available. This was measured through Cohen's kappa coefficient and was greater than 0.7 in all combinations, with negligible error variance. This should be considered insufficient however, given the absence of additional case study evaluations.

MHRS test-retest reliability was studied using two consecutive measurements. As shown in table 3, the correlation between readings in the two evaluations is significant, indicating temporal stability for all areas.

## Concurrent validity

Concurrent validity was tested using the Pearson correlation coefficient, with reference to the joint T0 evaluations.  Significant correlations were observed between the MHRS and the scales used in the study in similar, comparable areas.

The MHRS mental health area correlates with the following factors: GAF ($r= 0.25$, $p<0.01$), behavioural problems-HoNOS ($r= -0.27$, $p<0.01$), symptoms-HoNOS ($r= -0.47$, $p<0.01$), socio-environmental area-HoNOS ($r= -0.44$, $p<0.01$), psychology-WHOQOL-B ($r=0.27$, $p<0.05$), social area-WHOQOL-B ($r= 0.30$, $p<0.05$), environmental area-WHOQOL-B ($r= 0.29$, $p<0.01$), physical area-WHOQOL-B ($r= 0.29$, $p<0.05$) and general quality of life-WHOQOL-B ($r= 0.31$, $p<0.01$). The MHRS self-care area correlates with: GAF ($r= 0.27$, $p<0.01$), symptoms-HoNOS ($r= -0.36$, $p<0.01$), socio-environmental area-HoNOS ($r= -0.56$, $p<0.01$), psychology-WHOQOL-B ($r= 0.32$, $p<0.01$), environmental area-WHOQOL-B ($r= 0.29$, $p<0.05$), physical area-WHOQOL-B ($r= 0.26$, $p<0.05$) and general quality of life-WHOQOL-B ($r= 0.28$, $p<0.01$). The MHRS life skills area correlates with: GAF ($r= 0.32$, $p<0.01$), socio-environmental area-HoNOS ($r= -0.35$, $p<0.01$). The MHRS social network area correlates with: GAF ($r= 0.32$, $p<0.01$), behavioural problems-HoNOS ($r= -0.30$, $p<0.01$), symptoms-HoNOS ($r= -0.38$, $p<0.01$), socio-environmental area-HoNOS ($r= -0.46$, $p<0.01$), psychology-WHOQOL-B ($r=0.34$, $p<0.01$), social area-WHOQOL-B ($r= 0.34$, $p<0.01$), environmental area-WHOQOL-B ($r= 0.35$, $p<0.01$), physical area-WHOQOL-B ($r= 0.33$, $p<0.01$) and general quality of life-WHOQOL-B ($r= 0.37$, $p<0.01$). The MHRS work area correlates with: GAF ($r= 0.22$, $p<0.05$), symptoms-HoNOS ($r= -0.27$, $p<0.05$), socio-environmental area-HoNOS ($r= -0.25$, $p<0.05$), environmental area-WHOQOL-B ($r= 0.25$, $p<0.05$), general quality of life-WHOQOL-B ($r= 0.29$, $p<0.01$). The MHRS personal relationships area correlates with: GAF ($r= 0.32$, $p<0.01$), symptoms-HoNOS ($r= -0.30$, $p<0.01$), socio-environmental area-HoNOS ($r= -0.32$, $p<0.01$), physical area-WHOQOL-B ($r= 0.23$, $p<0.05$), psychology-WHOQOL-B ($r= 0.34$, $p<0.05$), environmental area-WHOQOL-B ($r= 0.24$, $p<0.05$) and general quality of life-WHOQOL-B ($r= 0.81$, $p<0.01$). The MHRS dependencies area correlates with: behavioural problems-HoNOS ($r= -0.38$, $p<0.01$), symptoms-HoNOS ($r= -0.29$, $p<0.01$), social area-WHOQOL-B ($r= 0.24$, $p<0.05$), environmental area-WHOQOL-B ($r= 0.83$, $p<0.05$), general quality of life-WHOQOL-B ($r= 0.30$, $p<0.01$). The MHRS responsibility area correlates with: behavioural problems-HONOS ($r= -0.42$, $p<0.01$), socio-environmental area-HoNOS ($r= -0.36$, $p<0.01$). The MHRS identity/self-esteem area correlates with: GAF ($r= 0.23$, $p<0.05$), symptoms-HoNOS ($r= -0.43$, $p<0.01$), socio-environmental area-HoNOS ($r= -0.40$, $p<0.01$), social area-WHOQOL-B ($r= 0.51$, $p<0.01$), general quality of life-WHOQOL-B ($r= 0.33$, $p<0.05$). The

MHRS trust/hope area correlates with: symptoms-HoNOS (r= -0.33, p<0.01), socio-environmental area-HoNOS (r= 0.34, p<0.01), physical area-WHOQOL-B (r= 0.24, p<0.05), environmental area-WHOQOL-B (r= 0.23, p<0.05), general quality of life-WHOQOL-B (r= 0.31, p<0.01).
The HoNOS-Disability factor was excluded completely from the analysis as it has no similarities to the MHRS areas.

**Acceptability**

Overall the MHRS was deemed a satisfactory tool and easy to complete for both keyworkers and service users. Specifically, the tool was judged satisfactory/very satisfactory by 40 (96%) keyworkers and 99 (85%) service users, neither satisfactory/unsatisfactory by 2 (4%) keyworkers and 16 (14%) service users, and not very satisfactory/unsatisfactory by no keyworkers and 2 (1%) users. Furthermore, the tool was judged easy/very easy to complete by 23 (55%) keyworkers and 63 (54%) service users, neither easy/difficult by 18 (43%) keyworkers and 38 (32%) service users, and difficult/very difficult by 1 (2%) keyworker and 16 (14%) users. The joint keyworker/service user Star reading was carried out in less than 45 minutes by 101 (86%) users participating in the study and between 45 to 90 minutes in the rest of the sample (n=16; 14%).


**DISCUSSION**

The aim of our study was to illustrate the main characteristics of the MHRS and its acceptability, and to outline the preliminary results of the Italian evaluation of the tool.

As observed in other studies (11, 25), the MHRS measurement was deemed acceptable for most users and keyworkers in terms of levels of satisfaction and being easy to complete. Only two service users reported dissatisfaction with the tool, and a few service users and one keyworker felt it was difficult to complete. Most of the sample completed the joint Star reading in less than 45 minutes. This demonstrates that it would also be suitable for outpatient facilities, where the use of relatively quick tools that fit in with consultation times would be convenient.

Considering the collaborative nature of the tool, the study of test-retest reliability was assessed by examining the reading obtained in agreement between the keyworker and the user, demonstrating good test-retest reliability, as was found in an evaluation study in the United Kingdom (11). Inter-rater reliability was not studied sufficiently and represents an important constraint in this study. Killapsy et al. (11) studied the inter-rater reliability of the tool sufficiently and only the MHRS work area demonstrated acceptable inter-rater reliability, demonstrating insufficient inter-rater reliability overall.

The concurrent validity of the MHRS appears acceptable. Most areas of the tool correlate with general quality of life and level of functioning. Killapsy et al. (11) also highlighted convergent validity with a measure of social functioning. In our study, in addition to the WHOQOL-B, many areas of the MHRS reported significant correlations with three of the four HoNOS factors. To this effect, Lloyd et al. (26) define the MHRS in terms of outcome measures useful for assessing how an individual changes during recovery.

The tool's bottom-up approach has facilitated a tool structure aimed at meeting the requirements of service users and providing an important collaborative tool, however this can create problems in relation to expectations regarding its psychometric properties (27). There is undoubtedly a shared need for improved comprehension and examination of the psychometric characteristics of the MHRS, and there is still broad debate characterised by opposing outcomes (11, 25, 26, 28, 29). The approach used by Killaspy et al. (2012a) was criticised in terms of methodology (10, 27, 30) and with respect to the underlying philosophy (31). Doubts were raised on the need to apply inter-rater reliability criteria to validate a tool mainly designed for joint patient-user measurement rather than staff evaluation (29). Dickens et al. (27), though noting very good internal consistency, observed low item redundancy and, as with other authors, noted the absence of a suitable evaluation of the change scale (11, 27).

On the basis of these factors, reflection regarding a collaborative tool designed to measure a construct which is as complex and subjective as recovery (27) is required, and an attempt to consider various changes to the conventional idea of the validity and reliability of a measure (25). Eynon (31) suggests that, while its use may not be fully justified as a routine outcome measure, dismissing the use of the MHRS would be a great loss due to the tool's value in facilitating the reconstruction of narrative identity as part of the recovery process (32). Furthermore, the distinctive collaborative aspect of the MHRS could support the development of important therapeutic relationships (33) and enable service users to play an active role in their recovery (34).

**CONCLUSIONS**

The MHRS has been shown to be a satisfactory tool for service users and keyworkers due to its use of practical visual aids. It contributes to developing user recovery pathways and encourages a collaborative approach between keyworkers and users, which begins with an evaluation, which then leads to planning treatment/rehabilitation (35).  The tool has little overlap with other tools which have traditionally been used in mental health services, given its focus on achieving quality objectives (the active participation of users to give self-assessments and decide which objectives to work on in their personalised plan) and quantitative objectives (measuring change). This dual aspect is considered and discussed in experimental studies carried out by various authors (11, 27, 32), with conclusions that reflect the interest of the various researchers in emphasising one factor or another.

This article discusses the first quantitative research into the psychometric characteristics of the MHRS carried out in Italy. Overall the results have been encouraging, however over and above the specific constraint in our study (ineffective evaluation of inter-rater reliability), various considerations on the tool's psychometric properties cannot be omitted. Engaging in the typical collaborative nature of the MHRS between users and keyworkers and its recovery-orientated approach (27) is to be considered a highly valuable aspect and, despite uncertainty over the psychometric aspect, its continued use in mental health services is desirable.

The hope is that this study, along with information reported in the relevant literature, may contribute to raising awareness and encouraging further development of the MHRS, given its significant potential in clinical settings and the involvement of patients in their own recovery pathway.  It would also be hoped that it could contribute to practices orientated towards co-production in mental health services becoming widespread, to encourage the integration of viewpoints from all stakeholders, for both the wellbeing of our service users and the implementation of patient-focused organisations.

**Figura 1**
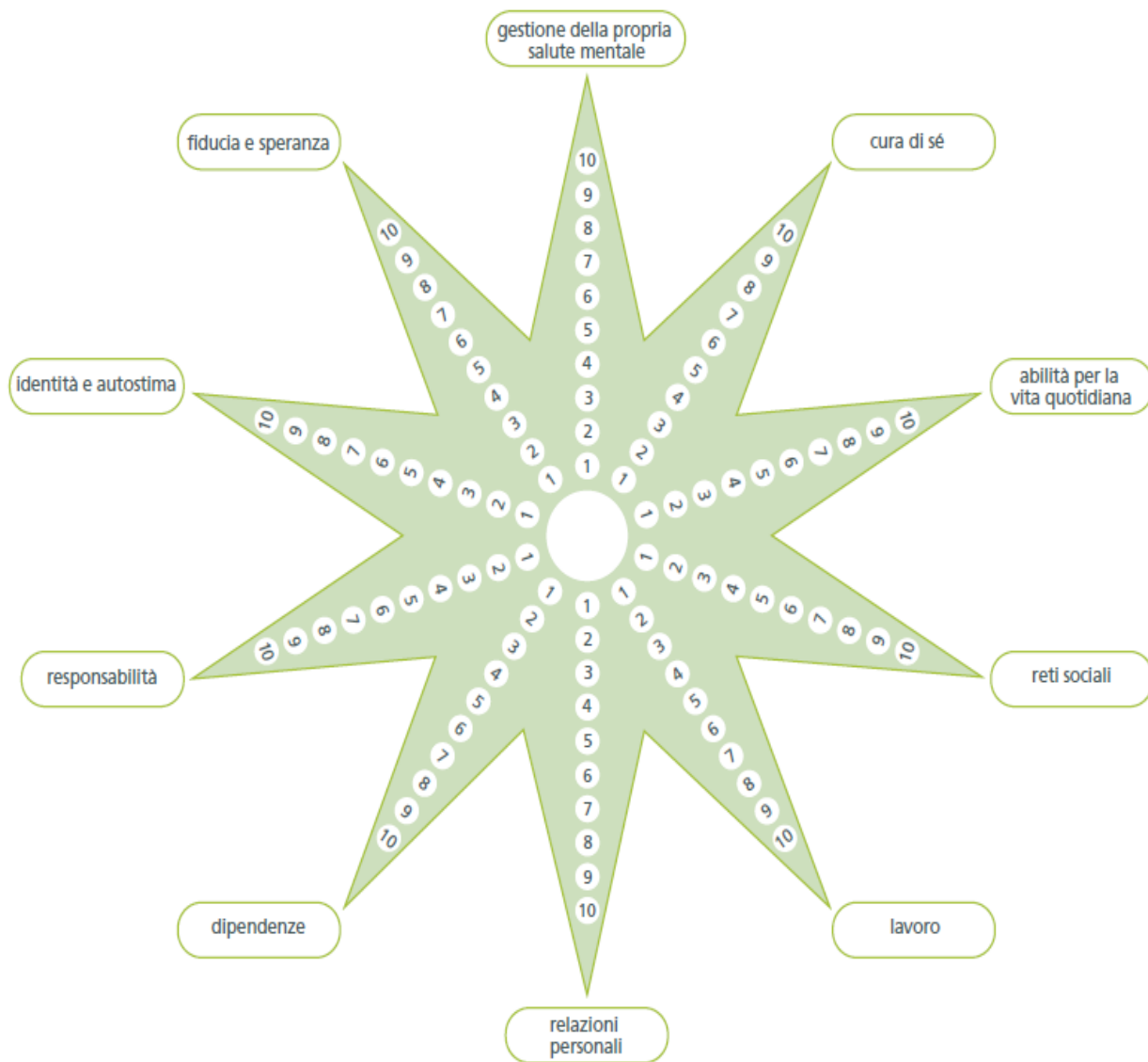
**Box 1**

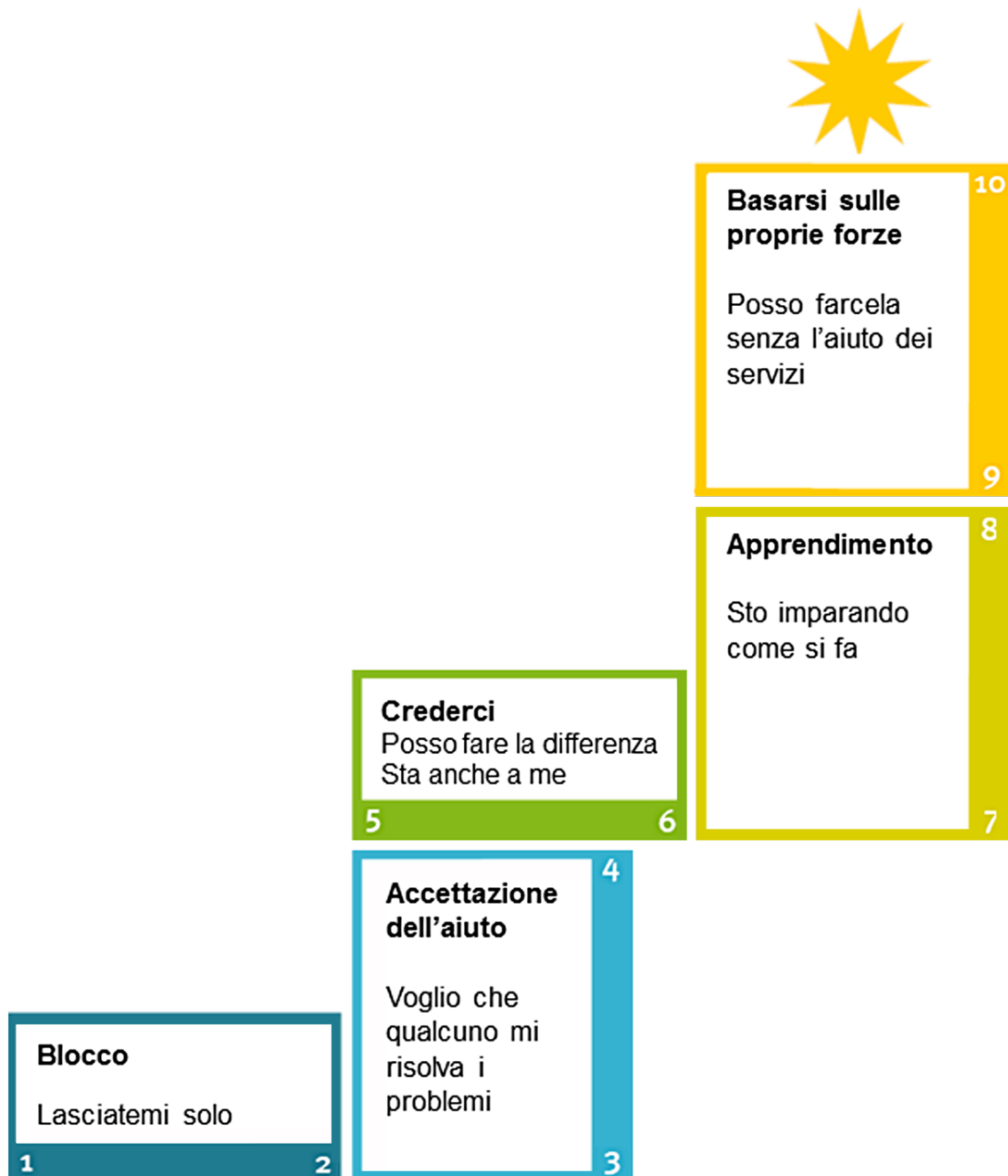| |
|---|
| **Le dieci aree della Recovery Star** |
| **1. La gestione della tua salute mentale**<br>L'area fa riferimento alla gestione della propria salute mentale e alla capacità di sviluppare di una vita soddisfacente e significativa, anche in presenza di eventuali sintomi.<br><br>**2. Salute fisica e cura di sé**<br>L'area fa riferimento alla cura di sé, in particolare della propria salute fisica, l'igiene personale, la gestione dello stress e al mantenimento dello stato generale di benessere.<br><br>**3. Abilità per la vita quotidiana**<br>L'area fa riferimento agli aspetti pratici della vita in autonomia: fare la spesa, cucinare, avere a che fare con i vicini, tenere in ordine il posto in cui si vive e gestire il proprio denaro.<br><br>**4. Reti sociali**<br>L'area fa riferimento alla rete sociale e all'essere parte di una comunità. Include la capacità di partecipare ad attività organizzate da servizi ed anche ad attività non istituzionali come il volontariato, partecipare a corsi, associarsi ad un club o a un circolo, partecipare alle attività della scuola, di una chiesa oppure di attività proposte da gruppi di amici.<br><br>**5. Lavoro**<br>L'area fa riferimento al rapporto personale con il lavoro. Considera il desiderio di lavorare, l'individuazione di ciò che si desidera fare, sviluppare le competenze e le qualifiche per avere un'occupazione, trovare e mantenere un lavoro. Oppure, se preferito o maggiormente indicato, dedicarsi ad attività di volontariato e/o altre attività occupazionali.<br><br>**6. Relazioni personali**<br>L'area fa riferimento alle relazioni personali significative. Si individua una relazione in cui si vorrebbe che le cose fossero diverse (con un famigliare, un amico stretto o un compagno/a) e si valuta il grado di vicinanza che si desidera avere.<br><br>**7. Comportamento legato alle dipendenze e all'uso di sostanze**<br>L'area fa riferimento a qualsiasi comportamento legato all'uso di sostanze come alcool, droghe o altre forme di dipendenza (gioco d'azzardo, shopping, etc.). Prende in considerazione la consapevolezza di tali problemi e un eventuale impegno per ridurne i danni.<br><br>**8. Responsabilità**<br>L'area fa riferimento alle responsabilità riguardanti il posto in cui si vive (casa o altro tipo di struttura). Include il pagamento dell'affitto, andare d'accordo con i vicini o gli altri ospiti della struttura e considera la presenza di eventuali problemi con la legge.<br><br>**9. Identità e autostima**<br>L'area fa riferimento al senso d'identità personale e all'autostima. Considera la percezione di sé, la consapevolezza delle risorse personali, dei propri limiti e più in generale dell'accettazione di sé.<br><br>**10. Fiducia e aspettative positive**<br>L'area fa riferimento alla percezione di fiducia personale e alle aspettative positive per il futuro. Prende in considerazione il credere in se stessi, la fiducia negli altri e l'aspettativa di trovare delle possibili soluzioni. |
| Adattato da *Mental Health Providers Forum* (36) |

**Figura 2**

**LA SCALA DEL CAMBIAMENTO**



**Basarsi sulle proprie forze**
10
9

Posso farcela senza l'aiuto dei servizi

**Apprendimento**
8
7

Sto imparando come si fa

**Crederci**
Posso fare la differenza
Sta anche a me
5
6

**Accettazione dell'aiuto**
4
3

Voglio che qualcuno mi risolva i problemi

**Blocco**
1
2

Lasciatemi solo

**Tabella 1**

| Caratteristiche sociodemografiche (n.117) | | | |
|---|---|---|---|
| Sex | M | 66 | 56% |
| | F | 51 | 44% |
| Età | Media (ds): 41,62 (11,1)<br>Min-Max: 18-66 | | |
| Stato civile | Celibe/nubile | 92 | 79% |
| | Separato/divorziato | 13 | 11% |
| | Coniugato/a | 11 | 9% |
| | Vedova/o | 1 | 1% |
| Titolo di studio | Medie | 56 | 48% |
| | Superiori/Prof | 44 | 38% |
| | Elementari | 11 | 9% |
| | Laurea | 6 | 5% |
| Occupazione | Non occupato | 79 | 68% |
| | Lavoro protetto | 11 | 9% |
| | Casalinga | 11 | 9% |
| | Pensione lavorativa | 6 | 5% |
| | Lavoro full time | 3 | 3% |
| | Lavoro part time | 3 | 3% |
| | Studente | 3 | 3% |
| Invalidità civile | Si | 88 | 75% |
| | No | 29 | 25% |
| Situazione abitativa | Fam. Origine | 56 | 48% |
| | Solo | 20 | 17% |
| | Fam. Costituita | 20 | 17% |
| | Struttura residenziale | 18 | 15% |
| | Altra sistemazione abitativa | 3 | 3% |

**Tabella 2**

| Caratteristiche cliniche (n.117) | | | |
|---|---|---|---|
| Diagnosi principale (criteri DSM IV) | Dist. Bipolare I | 53 | 45% |
| | Schizofrenia | 27 | 23% |
| | Dist. Schizoaffettivo Bipolare | 26 | 22% |
| | Dist. Depressivo Magg. | 4 | 4% |
| | Altri disturbi psicotici (Dist. Delirante/psicosi NAS) | 4 | 4% |
| | Dist. Personalità (schizotipico/borderline) | 3 | 2% |
| N. di problemi in asse 4 | Media (ds): 1.15 (1.18)<br>Min-Max: 1-5 | | |
| Familiarità psicopatologia | Si | 54 | 46% |
| | No | 63 | 54% |
| Età d'esordio | Media (ds): 23,41 (7,71)<br>Min-Max: 6-41 | | |
| Età primo contatto | Media (ds): 25,81 (7,28)<br>Min-Max: 6-45 | | |
| CGI | Lievemente/Moderatamente ammalato | 71 | 61% |
| | Notevolmente/gravemente ammalato | 46 | 39% |

**Tabella 3**

Correlazione tra due valutazioni nel tempo (attendibilità test-retest) della MHRS

| Area | Coefficiente di correlazione intraclasse (IC 95%) |
|---|---|
| Gestione della salute mentale | 0,76 (0.58-0.88) |
| Cura di sè | 0,71 (0.49-0.83) |
| Abilità per la vita quotidiana | 0,79 (0,60-0,87) |
| Reti sociali | 0,71 (0.49-0.84) |
| Lavoro | 0,89 (0,84-0,92) |
| Relazioni personali | 0,71 (0.49-0.84) |
| Dipendenze | 0,84 (0,79-0,90) |
| Responsabilità | 0,84 (0,79-0,90) |
| Identità e l'autostima | 0,78 (0,59-0,85) |
| Fiducia e la speranza | 0,78 (0,59-0,85) |
| >0,7 considerato accettabile | |

**GRUPPO REX.IT**
*UOP23-ASST Spedali Civili Brescia*
-De Carli Paola
-Lussignoli Miriam
-Seggioli  Giuseppe
-Tosi Delia Rita
-Villa Giovanna
*DSM ASST del Garda*
-Ferrazzoli Ivana Orsola
-Gavelli Laura
-Marelli  Sara
-Migliorati Simonetta
-Saviotti Francesco
*DSM ASST Crema*
-Pegoraro Marco
*DSM ASST Vallecamonica*
-Spandre Vincenzo
-Zindato Vincenzo
*Associazione Liberamente*
-Liscidini  Ilaria
-Radici  Ruggero
*Associazione Il chiaro del bosco*
-Rossella Micheli

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