Psychiatric Rehabilitation Methods

19

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Principles of Social Intervention

Psychosocial rehabilitation offers a number of program models, refined over years of research and practice, which aim to improve the social inclusion of people with serious mental illness and to reduce the symptoms of illness and the handicap which they create. But the field is more than a series of programs. Rehabilitation practice is based on a set of principles or values which we inherit from 200 years of social psychiatry. These principles, set out in Table 19.1, have been "rediscovered" in the great social movements in psychiatry of the past two centuries, the latest of these being the Recovery Model or Movement. The fact that these values have been rediscovered on several occasions tells us that they have been periodically abandoned, so it is important for us to recognize and accept the centrality of these principles to the work that we do. The best treatment models available will not thrive in a treatment setting which neglects the values on which they are based.

Moral treatment, made vivid by images of Pinel striking the chains from the inmates of the Bicêtre asylum in 1793, but better illustrated by William Tuke's contemporaneous development of the York Retreat, brought us the principle of minimal use of coercion and the understanding that patients' self-control can be enhanced by respectful treatment in a home-like environment and by rewards rather than punishment. Eighteenth-century private madhouse operators tried to outdo one another in optimism, by extolling the likelihood of recovery from mental illness if only family members would seek their services in a timely way (Warner 2004). These principles of moral treatment were lost during the era of large asylums in the nineteenth century, but the consumer-driven US mental hygiene movement, which established institutional reforms, reintroduced the notion of therapeutic optimism, and demonstrated the importance of collaborating "with leaders in education, law, religion and social work" (p. 743) (Beers 1932).

The Great Depression brought a return to institutional confinement, but the post-WWII northern European social psychiatry revolution, which preceded the introduction of antipsychotic drugs, opened the locked asylum doors, abolished mechanical restraints and demonstrated the benefits of early discharge from hospital and work therapy. British psychiatrists introduced the "therapeutic community" into psychiatric hospital wards across the country. Under this approach, staff shared power with patients in the running of the hospital units, nurses' abandoned their uniforms, staff and patient roles were blurred and, thus, the concept of patient empowerment was introduced into psychiatry (Warner 2004). The same approach was simultaneously

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Table 19.1 Principles of social interventions in psychiatry

Treatment approach
Multidisciplinary, flexible, empowering
Reduced reliance on drug treatment
Consumer participation in treatment
Family support and education
Treatment location
Local and accessible
In the community
Treatment setting
Small, domestic, normalizing
Encouragement of individual self-control
Reduction of coercion and confinement
Involvement of the larger community
Collaboration with other social agencies
Fighting stigma
Political advocacy
Respect for human rights
The importance of client communities
Empowerment: transfer of power from service providers to service users
The value of work
Therapeutic optimism
Understanding biological, psychological, social, cultural, and political-economic factors

being introduced into community practice in New York City. Fountain House, the first psychosocial clubhouse, was founded in the city in 1948 by ex-patients of Rockland State Hospital (Leff and Warner 2006). Members and staff worked together to run the program, creating, in the process, a form of institutionalized empowerment of people with mental illness which was to long outlast the hospital-based therapeutic community. The 1990s saw an explosion in the number of psychosocial clubhouses, both in America and around the world, and the introduction of another consumer-driven psychiatric social movement—the Recovery Model—a central tenet of which is empowerment. At this stage, we may take a look at the influence of the Recovery Model and at the value of the psychosocial clubhouse.

The Recovery Model

The Recovery Model is covered in detail in Chap. 7. The model, which is influencing service development in Britain, the USA, and elsewhere (Ramon et al. 2007), refers both to the subjective experiences of optimism, empowerment, and interpersonal support experienced by people with mental illness and their informal care providers, and to the creation of services that engender optimism about outcome from illness and a support for human rights. The roots of the movement may be found in both the consumer movement and in psychosocial rehabilitation. Consumers have reinforced the drive towards empowerment, collaboration, and recognition of human rights. Rehabilitation professionals, on the other hand, have emphasized the need for services that recognize the value of work and the sense of community in the lives of people with mental illness, and the importance of environmental factors in helping people with psychiatric disorders achieve their best functioning potential (Jacobson and Curtis 2000).

The model calls for the provision of education about psychiatric disorders as a way to empower consumers to collaborate with service-providers in managing their own illnesses. Collaborative models, such as the psychosocial clubhouse and educational programs that involve both professionals and consumers as teachers, are seen as important elements of recovery-oriented services. The model has generated renewed interest in fighting stigma and the creation of user-run services that offer advocacy, mentoring and peer support via such mechanisms as user-run “warmlines” (peer-to-peer supportive chat-lines) and drop-in centers (Jacobson and Greenley 2001; Shean 2007).

The scientific evidence supports such central components of the recovery model as optimism about outcome, and the value of empowerment and peer support. One of the most robust findings in schizophrenia research is that 20% of those with the illness will recover completely and another 20% or more will regain good social functioning (Warner 2004). Much recent research suggests that working helps people recover from schizophrenia, and advances in vocational rehabilitation have made this more feasible (Leff and Warner 2006). A growing body of research supports the concept that empowerment is an important component of the recovery process and that consumer-driven services are valuable in

empowering the person with schizophrenia and improving outcome from illness (Warner 2010).

Psychiatric rehabilitation provides a road to recovery. The goal of rehabilitation is to help people with a disability enjoy the best and fullest life possible. It offers a route to working, making friends, having fun and taking on responsibilities—in short, full citizenship. The person with disability picks his or her personal objectives and the rehabilitation service aims to reduce the disability and make goal attainment and recovery possible. This chapter outlines some of the psychiatric rehabilitation models and approaches that mental health professionals and others have developed over the years, incorporating the values inherent in the Recovery Model and other social movements in psychiatry.

Vocational Services

There is good scientific evidence that working helps people recover from serious mental illness. At a macroeconomic level, we know that outcome from schizophrenia is worse (Warner 2004) and admissions to hospital of working-age adults with psychosis are greater (Brenner 1973) during periods of increased general unemployment. At the individual level, numerous controlled studies conducted since the early 1990s have identified improved nonvocational outcomes for subjects with serious mental illness who are working. Participation in an effective vocational program or having paid employment is associated with reduced psychiatric hospital admissions, reduced health-care costs and decreased positive and negative symptoms of psychosis. Successful work programs lead to increased quality of life, improved self-esteem, enhanced functioning, and an expanded social network (Leff and Warner 2006).

The Psychosocial Clubhouse

The psychosocial clubhouse is a consumer-driven rehabilitation model with a strong vocational focus which harnesses the benefits of client empowerment to increase members' skills and work preparedness and assists members in obtaining employment. (The model is discussed in detail in Chap. 30.) From simple beginnings, Fountain House in New York City achieved an international reputation, receiving hundreds of visitors a year. By 2009 there were 330 clubhouses in 27 countries around the world. Central components of the model are democratic decision-making and governance and the "work-ordered day"—a structured 8-h day in which members and staff work side-by-side on clubhouse work. The clubhouse is a space owned by the members, not the treatment system (Beard et al. 1982; Macias et al. 2001). Empowerment, treating the person with mental illness with respect, absence of coercion (membership must be voluntary), and the importance of work are central principles.

The emphasis on work is evident in the employment programs generated by psychosocial clubhouses. Initially, these work programs took the form of transitional employment programs in which temporary (3–9 months) part-time job placements were found for members in local businesses. Job coaches learned how to do the job, trained the member, and provided long-term support to him or her in the position. More recently, these placements have taken the form of continuous supported employment, in which the job placement is permanent. The approach has grown into a successful model with broader reach than the clubhouse.

Supported Employment and Individual Placement and Support

Supported employment, and its more recent refinement, individual placement and support (IPS), have been proven effective, in a large number of studies conducted in North America and several other countries, with rates generally running from 50 to 75% compared to control rates of 9–40% in placing and maintaining people with mental illness in competitive work (Bond et al. 2008). This vocational approach is discussed in more detail in Chap. 25. The core principles of the model include a focus on competitive, rather than sheltered, employment; rapid job search,

instead of extended preemployment assessment and training; integration of the vocational and treatment services; paying attention to clients' job preferences; and providing time-unlimited, individual job support (Bond 2004). Inherent in this approach are some important principles of social intervention—involving the community (in this case, employers) in assisting the social integration of people with mental illness, using a noninstitutional approach (no sheltered workshops), and showing respect for the person's preferences and strengths.

Social Firms (or Affirmative Businesses)

Another vocational model which has gained strength in recent decades is the social firm. Social firms, or affirmative business as they are known in North America, are businesses created with a dual mission—to employ people with disabilities and to provide a needed product or service. The model was developed for people with psychiatric disabilities in northern Italy in the 1970s and, by diffusion, has gained prominence throughout Europe and Australasia. Independent of European influence, affirmative businesses have also developed in North America (especially Canada) and East Asia. Over a third of employees in social firms are people with a disability or labor-market disadvantage. Every worker is paid a fair market wage, accommodations are made for disabled workers' needs, and all employees have the same rights and obligations. Hard to achieve, but important nevertheless, the business must operate eventually as a viable concern, free of subsidy. Advantages of the social-firm model include opportunities for empowerment and the development of a feeling of community in the workplace (Warner and Mandiberg 2006).

The first social firm was set up in 1973 as a worker cooperative for previously hospitalized patients during the deinstitutionalization of San Giovanni Hospital in Trieste in northeastern Italy. Within 10 years, the business, which employed workers to clean public buildings, was employing 130 workers. Over the next 20 years, a consortium of businesses was developed which included a café, a restaurant, a transportation business, a building renovation company and many others, with an annual income of $14 million. The family-style Hotel Tritone, one of the early businesses, proved to be particularly successful and has been franchised. All office- and street-cleaning contracts for the municipality of Trieste are currently awarded to social firms. Over 300 people with disabilities or disadvantages, half with mental illness, are currently employed in the Trieste cooperatives and earn a full market wage, and another 200 people diagnosed as having mental illness hold training positions reimbursed by governmental stipend (Warner and Mandiberg 2006).

The model has spread widely in Italy and interest in social firms has increased throughout Europe. By 2005, there were over 8,000 such enterprises in Europe with 80,000 workers, 30,000 of whom had psychiatric or other disabilities. In Germany, second only to Italy in number of social firms, there were over 500 such companies in 2005, with a combined workforce of over 16,000 employees, 50% of whom had disabilities. Before 1997, there were just six social firms in Britain. Since then, with the assistance of the support group Social Firms UK, the number has grown to more than 150, nearly half of which are considered "emerging" social firms, meaning that they still use some subsidy and are not yet financially self-sustaining. Catering and horticulture are the largest business sectors. Irish Social Firms, in Dublin, illustrates the importance of business viability. In the 1990s, this consortium operated a restaurant, a lunch counter, a wool shop, and a furniture store, but these businesses have closed in recent years because of the subsidy required to sustain them (Warner and Mandiberg 2006).

Social firms may achieve success by finding the right market niche. Many gain a market edge by competing for contracts with public agencies, such as hospitals, which often have a special interest in the social inclusion of people with disabilities or a strategic need to be seen to serve the public interest. They may also have practical market advantages. A cleaning business in Pordenone, in northern Italy, successfully developed contracts with public facilities because the unionized workforce it replaced was relatively inefficient.

The market niche may come from workers' special qualities. People with disabilities, for example, may have unusual reserves of empathy and patience when employed as home health aides. The public orientation of social firms can help them earn contracts through a willingness to tackle community problems—such as salvaging abandoned motor scooters to clean up a run-down section of the city (Warner and Mandiberg 2006).

Social firms often select labor-intensive business options to maximize employment while minimizing capital investment. Common choices include cleaning services; handmade products, such as wooden toys; organic food production that is not driven by investments in machinery and fertilizer; car washes; and bicycle repair. At times, however, a social firm consortium may choose to develop a business that is profitable but employs relatively few people with disabilities in order to use these earnings to offset other losses (Warner and Mandiberg 2006). A profitable venture of this type is the consumer-oriented pharmacy in Boulder, Colorado (Leff and Warner 2006).

Social firms offer some advantages over the supportive employment model. For example, they provide an opportunity for developing a sense of community in the workplace. A manager of a social firm in Trieste described this community feeling as "a small extended family." The supportive atmosphere may explain why the rate of transition from social enterprises into competitive employment is low in most countries (Seyfried and Ziomas 2005). Studies show that belief in an organization's social mission enhances worker participation and promotes organizational success (Warner and Mandiberg 2006).

Restoring Strengths and Abilities

Cognitive Behavioral Therapy for Persistent Psychotic Symptoms

Despite the long-held belief that it is a pointless exercise to try to dissuade people from holding tenacious delusional beliefs, recent research reveals that talking to people about their psychotic symptoms, and about their meaning to the individual, can lead to an improvement in symptoms. It emerges that gently challenging the evidence used by people with psychotic disorders to support their delusions, offering alternative viewpoints, testing reality, and enhancing coping strategies can be helpful. This approach is discussed in Chap. 13. A course of treatment may extend for ten or more sessions. After establishing a trusting relationship between therapist and patient, the therapist may gently test the patient's beliefs as in the following illustration:

Patient: "The Mafia has my house under surveillance."

Clinician: "Well, that is possible…. But why do you think it is the Mafia? Could it be some other organization? Or is something else happening altogether? How could we find out?" (Turkington et al. 2006) (p. 367).

Cognitive behavioral therapy has been shown to be effective for persistent psychotic symptoms in people who are resistant to treatment with antipsychotic medication (Wykes et al. 2008; Pinninti et al. 2010). The goal is not to persuade the patient that he or she has a mental illness. Rather, it is to reduce the severity of the symptom or the distress it causes. Patients are helped to identify coping strategies that may reduce both the cues and reactions to such symptoms as hallucinations or delusions. For one person, being alone or bored may be a cue to an increase in hallucinations; he or she can be taught to adopt strategies to reduce isolation or boredom. Others may learn to reduce auditory hallucinations by humming, conversing with others, or even reasoning with the voices and telling them to go away and come back later. Similarly, a person might be taught to test the reality of delusional beliefs against the therapist's interpretation of events and, for example, return to a church social group about which he or she had harbored paranoid fears (Tarrier et al. 1999). The approach does not reduce relapse rates in psychosis, but is effective in reducing distress resulting from positive symptoms (Garety et al. 2008).

CBT for persistent psychotic symptoms has been incorporated into the American Psychiatric

Association practice guidelines for the treatment of schizophrenia (American Psychiatric Association 2004) and into the Schizophrenia Patient Outcomes Research Team (PORT) recommendations (Lehman and Steinwachs 1998). A recent review of the literature concludes that we now have an effective psychotherapeutic intervention for people with schizophrenia (Turkington et al. 2006). Clinicians who have become accustomed to simply establishing the existence of hallucinations and delusions in their patients may now need to pay more attention to the content of these symptoms.

Cognitive Remediation

More attention has been paid, in recent years, to the cognitive symptoms of psychosis—such handicaps as decreased processing speed and poor attention, concentration, and working memory. Cognitive impairment, along with positive, negative, and affective symptoms, is a core feature of schizophrenia. The evidence suggests that it is correlated with work functioning, social relations and the capacity for independent living and is an impediment to gaining benefits from psychosocial rehabilitation (McGurk et al. 2007). Forthcoming editions of the Diagnostic and Statistical Manual for Mental Disorders are expected to direct more attention to cognitive deficits in psychosis. The increased attention to cognitive difficulties has stimulated greater attempts to rectify them. Pharmacological interventions have shown little effect on cognitive deficits (Marder 2006), but cognitive remediation programs, employing such strategies as repeated practice, teaching to improve cognitive functioning, strategies to compensate for impairments, and group discussion have shown some promise. Reviews of cognitive remediation in schizophrenia have suggested that the method produces modest benefits on cognition but has little or no impact on functioning (Krabbendam and Aleman 2003; Pilling et al. 2002). A recent meta-analysis concludes, however, that cognitive remediation produces moderate improvements in cognitive performance and functioning and that the impact on functioning is greater in studies that provide psychiatric rehabilitation in addition to cognitive remediation (McGurk et al. 2007). Most remediation programs now employ computer-based training among their methods, but such advances in technology do not appear to have improved outcomes appreciably. Programs that include strategy coaching have greater effects on functioning; this approach targets memory and executive functions by teaching such strategies as problem solving and chunking information to facilitate recall (McGurk et al. 2007).

Social Skills Training

Social skills training is a method of teaching people with serious mental illness who have social and emotional skill deficits how to improve these basic skills. The approach, which is based on behavioral learning principles, was developed by Robert Liberman in the 1960s (Liberman 2008). The method has enjoyed some popularity in the USA but, although the social skills manual has been translated into 23 languages, it has not been adopted to any great extent in other countries (Liberman 2008).

In a typical course of training, after establishing a therapeutic alliance and conducting a behavioral assessment, the trainer and trainee will establish long- and short-term goals for dealing with a specific interpersonal problem and develop a scenario to achieve these goals through role-playing with other members of the group. The patient is encouraged to perceive how he or she might have handled a situation differently in the role play and earns positive feedback for improvement in skills. When the patient is demonstrating sufficient skill, he or she may be given homework to practice with people outside the class. The final, and perhaps most difficult, step is to assist the patient in generalizing improvements in social skills into everyday, real-life settings (Liberman 2008). It is the doubts about whether this process of generalization can be accomplished successfully, that has put a damper on the diffusion of the approach more broadly. A meta-analysis of studies of social skills training published in 1996,

revealed that although the approach was effective in teaching patients interpersonal and assertiveness skills, few studies have examined whether training in the hospital setting generalizes to social interactions in the community (Dilk and Bond 1996). For whatever reason, adoption of the model has not been strong and Liberman himself reports that "its use is still limited to a relatively small number of behaviorally oriented practitioners" (Liberman 2008) (p. 271).

Working with Families

Behavioral Family Management

Behavioral family management or the psychoeducational approach to working with families of people with serious mental illness is covered in detail in Chap. 28. The approach is based on the robust results of research conducted in several countries in the developed and developing worlds. This research reveals that people with schizophrenia living with relatives (by birth or marriage) who are critical or overinvolved (referred to in the research as high "expressed emotion" or EE) have a much higher relapse rate than those living with relatives who are less critical or intrusive (Leff and Vaughn 1985; Parker and Hadzi-Pavlovic 1990). Some studies have shown that relatives who are less critical and overinvolved exert a positive therapeutic effect on the person with schizophrenia, their presence leading to a reduction in the patient's level of arousal (Tarrier et al. 1979; Sturgeon et al. 1984). There is no indication that the more critical and overinvolved relatives are abnormal by everyday standards. It is more likely, in fact, that the families in which people with schizophrenia do well have adapted to having a person with a psychotic illness in the household by becoming unusually low-key and permissive (Cheek 1965; Angermeyer 1983).

Several studies have shown that family psychoeducational interventions can lead to a change in the level of criticism and overinvolvement among relatives of people with schizophrenia and a reduction in the relapse rate (Berkowitz et al. 1981; Falloon et al. 1982). Effective interventions provide three basic ingredients: (1) detailed information about the illness for the family and patient, (2) help for the family to develop problem-solving mechanisms, and (3) practical and emotional support (Leff and Vaughn 1985; Falloon et al. 1982; McFarlane 2002; Leff 1996).

Family psychoeducational approaches have all proven highly effective in reducing the rate of relapse in schizophrenia. The approach, however, has not disseminated at all broadly in community psychiatric practice anywhere in the world. Only 7% or fewer people with schizophrenia in the USA, for example, get involved in a family intervention program (Lehman and Steinwachs 1998). There are a number of explanations for this. In many areas, few people with schizophrenia live with family. In addition, organized attempts to disseminate the model to mental health managers and providers have been almost nonexistent because, unlike psychopharmaceutical products, no one stands to make a profit from marketing the approach, and those who could benefit most, organizations of families of people with serious mental illness, have often considered any form of family intervention to be stigmatizing and have not lobbied for dissemination of the model. Recently, however, the National Alliance on Mental Illness in the USA has launched a Family-to-Family education program on mental illness taught by trained family members which has been shown to be effective in enhancing coping and empowerment of families (Dixon et al. 2011).

Most of the work cited above was published in the 1980s or early 1990s, and little development of the model has occurred in the past 15 years. However, the advent of the internet has opened the door to new possibilities for disseminating the model. Recent publications describe a Web-based psychoeducational intervention for people with schizophrenia and their families (Rotondi et al. 2005, 2010). The approach offers a secure internet forum for family members and consumers led and moderated by trained facilitators and an online library of educational resources. A randomized controlled trial of the approach led to a large reduction in positive symptoms in the consumers and a growth in knowledge about schizophrenia in both patients and family members

(Rotondi et al. 2010). Online delivery of family psychoeducation may have a promising future.

The Confidentiality Barrier

There is a simple approach which would have a big impact on the involvement of families in treatment—talk to them. Too often family members discover that they cannot get basic information about their relative when they call the hospital or clinic. They are told that the information is confidential and protected by statute. Common sense and common courtesy, at the least, should tell us that every patient, upon admission, should be asked if he or she would like to sign a release of information form allowing staff to communicate with specific family members. This is rarely done in US hospitals and clinics. Even without a signed permission to release information, communication is possible. As Robert Liberman writes:

> Too many practitioners pay obeisance to a misguided conception of privacy and confidentiality. There is no violation of confidentiality when a clinician *solicits information from family members*. Can anyone picture an internist or surgeon failing to invite a close family member to provide confirming and converging information regarding the patient as a key element in diagnosis and choice of treatment? Relatives are lucky if they get in to see the professional responsible for the patient's treatment, much less hear of the patient's diagnosis and prognosis. Plainly speaking, relatives are ignored by mental health professionals (Liberman 2008, p. 299).

Housing Strategies

Integrated Versus Clustered Living

Supported housing models are discussed at length in Chap. 29. As in other areas of rehabilitation practice, housing models are influenced by values. One value-based issue which comes into play in devising approaches to housing is the question of whether it is better to utilize the mutual support that exists in client communities or to pursue the more usual principle of "mainstreaming." To avoid creating mental health "ghettoes," service planners often seek to place people with psychiatric disabilities in dispersed housing. They hope that by dispersing people in the broad community, community members will provide some of the needed support. This rarely happens, however, and the people with mental illness often have to turn to mental health professionals for support. For some, the more direct route to social inclusion and successful community living may be through enclave communities of people with the shared experience of mental illness.

A program in Santa Clara County, California, explored this notion in the 1980s and 1990s (Mandiberg 1995). Instead of dispersed housing, clients' apartments were located so that no one was more than 5 min walking distance from the other residents—neither dispersed nor overly clustered. In the geographic center of the housing, a space was rented for community activities. Instead of residential supervisors, staff were hired as community organizers and told that their task was to help foster a mutually supportive community. The success of the Santa Clara County clustered apartment approach reminds us that the mutual support available in client communities may be turned to advantage and should be considered as an option in developing housing strategies for people with serious mental illness.

Summary

Values—both hidden and evident—shape our psychiatric rehabilitation models, and the recovery movement provides a series of values which have been guiding this work. Recognition of the importance of empowerment for consumers of psychiatric services heightens our interest in the clubhouse model and other cooperative programs. An emphasis placed on work rehabilitation can move us from a day-treatment approach towards the supported employment model and, thus, change many other aspects of a rehabilitation service. A value placed on mutual support among clients vs. mainstreaming will direct us toward a clustered apartment program or increase our interest in social firms over supported employment.

A concern with human rights and with minimizing coercion encourages us to design small, open-door, domestic facilities for acute care, whereas an emphasis on cost-efficiency will lead us to develop large, locked facilities with the capacity to use restraints and seclusion. Recognizing the importance of families will guide our interactions with caregivers, and optimism about outcome from illness will color everything we say and do. Some US psychiatric residency training programs, however, offer no education on psychiatric rehabilitation models—none at all. This is a value that bears closer scrutiny.

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