

PSYCHIATRIC REHABILITATION IN THE 21ST CENTURY: A PERSONAL VIEW

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ABSTRACT

The 21st century will see dramatic changes in medicine including psychiatry. Scientific advances and social development will definitely change the scenario of psychiatric rehabilitation and perhaps the public attitude towards mental patients in society. Mental health professionals should prepare themselves for such changes.

Key words: *21st century; Psychiatry; Rehabilitation.*

INTRODUCTION

The world is forever changing and most of the changes in the 'health of the nation' during the past millennium have occurred within recent decades. People live longer, but not necessarily happier and safer, lives since longevity brings more diseases, both physical and mental. The world is also experiencing great technological development, and medicine is no exception. However, this does not mean the world is a better place in which to live. Though the danger of a nuclear war is not so imminent, there are still frequent dangers of nuclear fall-outs, which would bring a lot of medical casualties, in the short-term as well as in the long-term. In addition, the gap between rich and poor has remained the same, if not widened. Fortunately, there is a move towards human rights (which includes patients' rights) and this could have a significant bearing in the development of health services.

CHANGING SCENE IN PSYCHIATRY

In the area of psychiatry, the 21st century is likely to experience development of the trends mentioned above. Many experts have already expressed their views about future developments in psychiatric rehabilitation. For example, the recently published 'Rehabilitation Programme Plan' estimated that there would be about 100,000 psychiatrically disabled persons with different mental disorders requiring services.¹

In order to meet the increased demand for the services, there will be an additional 738 hospital beds, 600 long-stay care home places, 200 half-way house places and 6 extra after-care workers. Psychiatric services for the elderly (especially day hospitals), community psychiatry and other subspecialties will be consolidated. Hopefully, a seamless service can be established between primary care doctors and specialists, with better coordination and cooperation between the medical, welfare, and educational organisations. However, these are only marginal changes and rather short-term (for the next 5

years), without any discussion about long-term development. On the qualitative side, standards for optimal care based on clinical evidence will be established,² and health economics using outcome measures will be taken into consideration when allocating resources.³ Hopefully, more efficient or cost-effective quality services will be established, and variations across different non-governmental organisations will be streamlined.

Lee had already mentioned some of the challenges for psychiatry in Hong Kong as the 20th century drew to an end.⁴ Based on the World Mental Health Report⁵ and the global health statistics,⁶ Lee discussed the increased prevalence of schizophrenia and, more importantly, depression.⁴ Other mental health problems include teenage suicide, substance abuse, deliberate self-harm, domestic abuse, post-traumatic stress disorder, eating disorder, juvenile conduct problems, homelessness, and dementia. In order to be a bit more radical with a look into the next century and beyond, I would like to present some personal viewpoints on 'psychiatric rehabilitation' to help stimulate discussion.

SCIENTIFIC ADVANCEMENT

The most noticeable development is in the area of psychopharmacology. More and more medications are being developed, based on better understanding of the brain cognitions and human behaviour with the help of neuro-imaging techniques, including positron emission tomography. With better understanding of brain receptors, novel medications have been developed. This is most evidenced by the production of the second- and third-generation antidepressants such as nefazodone, venlafazine, mirtazapine, etc.⁷ Understanding of the dopamine and serotonin systems has also revolutionised the management of schizophrenia, with the development of atypical anti-psychotics such as olanzapine, quatiapine, risperidone, etc.⁸ Perhaps discovery of the functions of the glutamate receptor will produce even more effective antipsychotic medications. In the next millennium, the emphasis will perhaps be directed more at dementia

treatment. Already, anti-Alzheimer's medications such as tacrine, donezapil, rivastigmine, and others, are being developed,⁹ and more are being investigated. All these medications will improve the rehabilitation prospects for patients enabling a better response to adjunctive psychosocial interventions. As a result, psychiatrists with expertise in neuroscience and use of medications will be most welcome for the multi-disciplinary approach to rehabilitation.

Since anti-Alzheimer medications are mentioned, it would seem that the main emphasis on psychiatric rehabilitation in the next century will be on people with dementia. For the past few decades, the main concern has been for people with schizophrenia, and marked progress has been made in their rehabilitation. Meanwhile, the next hurdle is the causation¹⁰ and treatment of cognitive deficits; if these are tackled then rehabilitation would become much easier. Therefore, the next targets of rehabilitation are most likely to be people with genuine brain damage, namely those with dementia and mental retardation. For the dementia group, many advances have been made in the understanding and treatment of Alzheimer's disease. However, there is also an increasing number of brain-damaged persons, mainly due to traffic and industrial accidents. Perhaps before a definitive cure for AIDS is found, there will be an increasing number of patients with degenerative brain functions secondary to HIV infection. Rehabilitation facilities should therefore be ready to receive and care for these categories of patients.

Another area of development will be people on the other side of the spectrum of diagnoses — those with non-psychotic conditions. Even patients with mood or anxiety disorders suffer from psychosocial disabilities and are also responsive to rehabilitation. Though the Government has no immediate plan to provide therapeutic group training for these patients as stated in the Rehabilitation Programme Plan,¹ the growing number of such patients willing to stand up for their rights would surely make their voices heard in the future. Besides, the care of these 'minor' psychiatric disorders could defuse the stigma of mental disorders since such 'minor' psychiatric disorders are so common in the community, it is difficult to discriminate against them without negative repercussions for oneself or one's family members.

Furthermore, there is even a trend for the rehabilitation of 'unusual' or 'anti-social' human behaviour such as lying or deceit, pathological gambling, drug and alcohol abuse, etc. Such 'borderline' features have existed almost since human civilisation began. Instead of punishing such disruptive behaviour through the penal system, more and more of these persons are now cared for under the umbrella of psychiatric rehabilitation, mainly through psychological means (the so-called 'cognitive behavioural therapy'). There is a possibility that psychiatrists could even become social 'executioners' by rehabilitating people who are simply unhappy and lack self-confidence, or children who are disobedient with poor academic achievement.

Finally, with the flourishing development of the New Age Movement and new age religions, the relationship between mental functions and religious experience becomes more

intermingled. Mental health professionals often regard religion as non-scientific, but interests in such spiritual variables are already emerging in the field of psychotherapy¹¹ and suicide.¹² It would not be a surprise if psychiatrists of the next millennium engage the motivational power of various religions in the rehabilitation of psychiatric patients, especially those who are chronically institutionalised.

SOCIAL DEVELOPMENT

As mentioned already, there has been a political movement towards human rights in the 20th century. In the field of psychiatric rehabilitation, this movement is also developing fast. Not only do patients have the right to know about their disorders, but they also have the right to decide whether they are to be treated or not. Of course, this may not apply to those who are incapable of making valid cognitive judgements for themselves. Already in 1999, the Guardianship Board was established in Hong Kong to safeguard the welfare of such adult mentally disordered and handicapped persons. Further amendments of the Mental Health Ordinance will surely be made in this direction from time to time.

Since most patients are not willing to be detained in the hospitals (unless there is a drastic change in the ways hospitals are set up and managed), there would be a further trend towards management in the community. This would lead to a tremendous strain on service resources (finance and manpower), and may lead to societal unrest and problems if not properly handled. The establishment of a professional case-manager service would continue to develop, although this system appears very costly. The training of non-psychiatrists, semi-professionals and even lay people, including patients and support group members,¹³ is thus more evident, practical and cost-effective, and would most likely be the main task force or working partners for rehabilitation in the next century. That is why Professor Gavin Andrews predicts that the traditional role of psychiatrists as the central figure in service delivery will change.¹⁴

For the past 2 decades, people who speak up for psychiatric patients have been called 'advocates'. They have now diminished in importance as more and more patients are themselves willing to stand up. The fashionable term of the coming years is likely to be 'empowerment', meaning encouragement and support from the professionals to protect people's rights and dignities. More and more relatives of patients are also grouped together into a united front for better care and support for their disabled relatives. However, such self-help groups and organisations are sometimes so 'grown up' that they are able to counteract the medical paternalism.¹⁵

Alongside this trend is the 'demand' from patients and their carers for services not only for treatment of disease, but also for quality of life and personal satisfaction. There is already a quite justifiable demand for better and newer medications, but there may be a time when hotel services in the hospital and even in their homes are demanded. Since a united front would form a large voting population, patients and their carers would have a very strong lobbying power with the politicians for such demands. It is true that, at present, there could be

further improvement in the areas of employment, education, social recreation, etc., as evidenced by the development of supported employment and education¹⁶ and the training of talented patients in sports and music. But if taken too far, 'psychiatric disorder' could become a 'label' to solicit personal gains. It would perhaps not be long before patient consumers and relatives service users would organise annual conferences and international networks to determine what the psychiatrists and other professionals should do for them.

At present, one of the remaining barriers in psychiatric rehabilitation is the stigma towards mental patients which remains serious. Even though the general public (especially educated people) accept that these patients should be reintegrated into the community, they still have the problem of the NIMBY (not in my back yard) syndrome. Contact with successfully rehabilitated persons has been found to be positively correlated with positive attitude, (Lau J, 1999. Unpublished data) but unfortunately, the reverse is also true. Though the Government has spent quite a lot of money in public mental health education programmes, any positive results are easily nullified by the mass media publicising news of a few disturbed patients in public. In future, such health education campaigns will have to be more refined and interesting, using the most updated information technology skills, but should target special categories of persons (including medical personnel and primary school children). They should aim also at changing human behaviour rather than mere attitudes.

CONCLUSION

In the above discussion, I have not mentioned the advances in genetic studies, and the possibility of neuro-transplantation. These could dramatically alter medical practice, even towards the prevention and eradication of mental disorders without the actual need for psychiatric rehabilitation. I have also omitted the 'spiritual' or 'transpersonal' side of human behaviour. More and more studies are now attending to this area and its related phenomena, and this could affect the 'holistic management' of psychiatric patients.

In a way, the world is already changing so fast, and perhaps the speed of change will increase as more knowledge is gained. In the emerging 'brave new world' with the rapid development of virtual reality and sophisticated electronic equipment, including artificial intelligence, are we ready to change?

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