

The Modern Face of Rehabilitation

“Successful activity creates satisfaction, inner and outer calm; inactive loafing around produces bad moods, moroseness, excitability; these in turn lead to frequent conflicts with those around them, to verbal and physical conflicts, and to prolonged exchanges of insults and perorations. All therapy should be geared to returning the patients to life in the community, by nurturing the residual parts of a formerly healthy being. Life was literally activity; therefore all patients would have to be mobilised into activity too. Upon admission patients were assigned work immediately on an ascending scale of difficulty and individual responsibility. The first level meant simple mechanical tasks; the highest one was equivalent to open employment. Patients were encouraged to pursue such hobbies as gardening, music, painting, photography or foreign languages. They introduced the capacity to work as an indicator of recovery.”

This long quote is not from a recent textbook of psychiatric rehabilitation but from a paper published 80 years ago.¹ It is rather disquieting that only some of these clearly rational recommendations have been implemented, mainly in the developing world. It took at least half a century for psychiatry to accept rehabilitation as an overarching concept in the management of the mentally ill. Rehabilitation is not a glamorous subject in psychiatry and receives far less financial support and intellectual input than other subspecialties. It is fair to assume that without the involvement of non-governmental organisations, charities and religious organisations, rehabilitation, particularly community-based services, would be collapsing even in places with well-developed mental health systems like Hong Kong.

At first sight, the modern concept of psychiatric rehabilitation — or psychosocial rehabilitation as it has been more aptly called recently — does not differ much from the 80-year-old approach quoted above. The current concept also aims to enable persons with persistent and severe psychiatric illness to function in the community in terms of work, leisure and social contacts with the least possible involvement of mental health professionals. A closer look at the recent literature, however, also reveals a paradigm shift in psychosocial rehabilitation, with the emphasis moving from the narrow medical-nosological model to a broader one focusing on the individual's functional strengths and weaknesses — a social functioning model.² As the US President's Freedom Commission on Mental Health put it, “helping affected persons to achieve functional recovery is the main purpose of the mental health care system”.³ It is important to emphasise that psychosocial rehabilitation is not a set of techniques but a process “that facilitates for individuals who are impaired, disabled or handicapped by

a mental disorder to reach an optimal level of independent functioning in the community.”² The validity of this functional model rests on the repeatedly confirmed finding that apart from exceptionally poor-prognosis psychoses, there is a weak correlation between symptomatology and functional outcome.⁴

This new model — or strategy or way of thinking about our patients — attempts to appreciate patients in their totality, as human beings and not purely as patients in need of psychiatric intervention. If psychiatric services were to fully embrace the emerging model of psychosocial rehabilitation, there would be far-reaching implications for clinical practice. In addition to the usual routine enquiry about symptoms and drug side-effects, psychiatrists should explore the ill person's quality of life and all of its ramifications, including work conditions, leisure time, social contacts, sexual life and the person's satisfaction with all these and other areas of day-to-day existence, and the even more challenging issues of spirituality. On the local scene, there are at least 3 major obstacles to taking such a broad-based, holistic view of psychiatric care. First, current professional training does not prepare psychiatrists to develop a culturally appropriate psychosocial approach in their practice. Second, the 5-10 minutes average consultation time at outpatient clinics is barely enough to cover the basic clinical problems. Third, the frequent rotation of young doctors hinders the development of a rehabilitative viewpoint and also prevents the establishment of an empowering, motivational partnership between psychiatrist and patient. Realistically, for the time being we have to settle for a modest aim, which was summarised for American psychiatrists in the following way: “a properly trained psychiatrist will be able to prescribe psychosocial interventions, such as social skills training, as well as prescribe medication. This does not mean that the individual psychiatrist should be able to do everything from social skills training to vocational rehabilitation to psycho-education to family support. It does mean, however, that the psychiatrist must know what is needed and where it can be found and must be able to play a role in directing a team of professionals who can serve these patients.”⁵

In this issue of the Journal, 2 papers relate to psychosocial rehabilitation. A study by So et al⁶ illustrates one of the basic tenets of modern rehabilitation — that rehabilitative interventions should be present from the very first encounter with the patient throughout the whole treatment process. The study assesses the efficacy of a brief psycho-educational programme for caregivers of patients with first-episode psychosis. The results are encouraging in that the intervention increased participants' knowledge and coping skills and reduced their burden of care. These

beneficial effects were still detectable at the 6-month follow-up. Hopefully, psycho-education will be a standard part of the management protocol for early psychosis services in Hong Kong.

It is easy to eloquently muse about rehabilitation, peppering the discourse with phrases like social inclusion, empowerment, choice, mutual trust, participation, consumerism, shared values and the like. Sometimes, however, the harsh realities of clinical practice defy these well-meaning but flowery expressions. Wong and Chung's paper deals with the toughest segment of our clientele, conditionally discharged patients, the majority of whom are multiply disadvantaged and want nothing to do with what mental health services can offer.⁷ The relative failure of community rehabilitation is indicated by the fact that one-fourth of subjects were readmitted within a year. These patients pose a serious dilemma for us as we have to find a balance between coercion and persuasion, personal freedom and independence and the individual's and the society's interests. This paper should pave the way to finding a mutually satisfactory manner in which to engage this group of difficult patients.

There should be no doubt that considerably more research is needed in this area to find culturally appropriate community rehabilitation techniques within the broad

strategic framework of psychosocial rehabilitation.

References

1. Simon H. Aktivere Krankenbehandlung in der Irrenanstalt [in German]. *Allg Z f Psychiat* 1927;87:98-128.
2. World Health Organization. Psychosocial rehabilitation: a consensus statement. Geneva: World Health Organization; 1996.
3. The President's New Freedom Commission on Mental Health. Achieving the promise: transforming mental health care in America, final report. Website: www.mentalhealthcommission.gov/reports/Finalreport/toc_exec.html.
4. Anthony WA, Cohen MR, Farkas M. Psychiatric rehabilitation. 2nd ed. Boston: Center for Psychiatric Rehabilitation; 2002.
5. Cancro R. The introduction of neuroleptics: a psychiatric revolution. *Psychiatr Serv* 2000;51:333-5.
6. So HW, Chen EY, Chan RC, Wong CW, Hung SF, Chung DW, Ng SM, Chan CL. Efficacy of a brief intervention for carers of people with first-episode psychosis: a waiting list controlled study. *Hong Kong J Psychiatry* 2006;16:92-100.
7. Wong YC, Chung DW. Characteristics of and outcome predictors for conditionally discharged patients in Hong Kong. *Hong Kong J Psychiatry* 2006;16:109-16.

Prof GS Ungvari

Department of Psychiatry

The Chinese University of Hong Kong

Shatin, New Territories, Hong Kong, China