

THE NEED OF STRUCTURED PROGRAMS IN PSYCHIATRIC REHABILITATION IN HONG KONG

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SUMMARY

In recent years increasing attention has been paid in Hong Kong to the development of rehabilitation services for people with psychiatric disabilities. The most persistent challenge facing rehabilitation workers is relapse. As a result, one of the most pressing needs at this stage in the development of rehabilitation services is the formulation and implementation of structured rehabilitation programmes. These programmes are good predictors of reduced re-institutionalisation and community integration and can facilitate adaptation to stress. Some of the difficulties inherent in developing and implementing such programmes are discussed. The need to continually evaluate the effectiveness of these programmes is underlined.

INTRODUCTION

For the past decades, there has been an increasing attention to the rehabilitation of the care of the mentally ill. 'Rehabilitation' is defined as the process of identifying and preventing or minimizing the negative effects of prolonged hospitalization; meanwhile helping the individual to develop and use his or her talents, which in turn enhances confidence and self-esteem through success in social roles (Wing & Morris, 1981). However, rehabilitation nowadays is no longer limited to hospital patients, and should include those out-patients who suffer from the problems of having a chronic psychiatric illness.

According to Gelder et al (1983), there are three kinds of problems in this area:

- i. impairment of function directly due to psychiatric illness, e.g. social withdrawal, slowness, etc.;
- ii. secondary disadvantages e.g. unemployment, poverty, as well as stigma attached to the illness;
- iii. adverse personal reactions e.g. low self-esteem, expectations of failure and helplessness.

The latter two items are caused not only by the illness, but the long-term psycho-social effects of having the illness.

REHABILITATIVE OR TREATMENT PROGRAMS

There are many rehabilitative treatment programs for the psychiatrically ill (Gow, 1989). Basically, they can be divided into the following categories:

- a. individual, family, group, milieu or community programs;
- b. behavioral, cognitive-behavioral, humanistic techniques, token economy; and more recently;
- c. psycho-education, especially to the relatives (Falloon et al, 1985).

Many of these techniques are still in experimental stage, and Hemsley (1978) warned of the danger of application without understanding the patients' basic impairment may either fail or actually make the symptoms worse.

More practically, rehabilitative programs are aimed for specific categories of patients and their relatives, and directed at specific areas of social deficits. Gelder et al (1983) mentioned the following items for consideration:

- a. persistent symptoms;
- b. unusual behaviour;
- c. activities of daily living;
- d. occupational (& domestic) skills;
- e. personal attitudes and expectations; and
- f. social circumstances of the patients.

When we plan our programs, we should also consider the short-term & long-term requirements of the patients.

STRUCTURED REHABILITATIVE PROGRAMS

In the local experience, there have been quite a number of rehabilitative programs conducted by various helping professionals and welfare agencies. A review of such programmes of the Mental Health Association of Hong Kong

found that many activities have been organised, aiming at socialising the patients, training in their daily activities, budgeting, job seeking, etc. Unfortunately, they are all 'unstructured' programs and are often 'conductor' or therapist-dependent. They lacked detailed planning for each session of the program, and were not systematic or controlled. There were usually no standard measures for evaluation, and were often not generalisable to other settings.

One argument for this *lassie faire* approach is that no two patients are the same, and therefore any comparison will be meaningless. It is true that rehabilitative programs should ideally be individualized, taking into consideration the individual's impairment, his unique social disadvantages and also his personal reactions (Wing & Morris, 1981), but even so, there is still room for systematic, structured programs to develop. Furthermore, there are often a number of patients with similar deficits, and by grouping them together for targeted therapy, it can save a lot of social resources and be more cost-effective. Besides, there are important therapeutic factors such as 'universality, altruism, modeling, etc.' (Yalom, 1972) which are of practical use for well prepared groups.

Of course, there are a lot of problems in systematic, scientific research, especially in the field of psychiatric rehabilitation (Mak, 1988). However, the importance far outweighs the difficulties. Hoi & Gow (1989) used lifelong education as the rationale for structured programs, and they stated 'all individuals ought to have organized and systematic opportunities for instruction, study and learning at any time throughout their lives'. Besides, a well-conducted structured rehabilitative program has the following advantages:

- i. it allows further improvement and development of the techniques;
- ii. it provides training for staff, so that the technique can be used by other qualified personnels;
- iii. it can avoid personal bias, so that the real needs of the patients are measured and measured more accurately;
- iv. it allows scientific evaluation so that the results could be communicated to others (e.g. through publications); and
- v. with the knowledge gained from one program, one can generalize the skills to other patients or other settings.

Bachrach (1980) defines a good program as a 'planned demonstration effort that tests the application of distinctive, often innovative, programmatic strategies to the care of the chronic mental patients'.

PRECAUTIONS IN DESIGNING STRUCTURED PROGRAMS

Understanding the importance of structured programs does not mean that the rehabilitative programs can be carried out successfully. One very common pitfall in this

aspect is the copying of similar programs from other sources (e.g. from those programs used for the training of 'activities of daily living' of the mental handicaps), or from overseas versions (e.g. training in social skills in the U.K.). The former is often just inappropriate or transferable, while the latter neglects the important issue of cultural variations in psychiatry. The attitudes of the patients and the therapists maybe different and thus the needs are different. For example, teaching a patient to drive may be an essential way of improving the patient's socialising skill in the States, but this skill is a luxury to many normal person in Hong Kong. Besides, there are the problems of resource availability. Therefore, overseas studies can only be used for reference, and workers in Hong Kong must develop their own local, unique programs for their patients, with consideration of the available (usually limited) manpower and other resources.

Even with indigenous programs one should allow enough space for modification or improvement. There is also a need for good co-ordination, as quite often many types of helping professionals are involved, and the patients' relatives are just as important. One should beware of individual variations and fluctuations, both from the patients as well as from the therapists, some of whom can be quite charismatic. This could be minimised by prior proper matching and by using an anonymous therapist (a person not involved in the direct management of the patients), and by monitoring his skills. Ideally, a manual of conducting the particular program should be prepared in detail so that the ordinary therapist can follow easily and systematically.

Then there is the issue of co-existing individual programs conducted by other people simultaneously; or by events beyond the control of the programmer (e.g. drastic change of drugs, sudden loss of work, rehospitalisation, etc.). All these could seriously affect the results of the individual program. Therefore, an adequate number of cases should be recruited beforehand, and the duration of the whole program should not be too long.

Last but not the least, the aims of such structured programs should not be too high at the beginning, and one should start from those programs which are simple enough to be measured objectively, yet of real use to the patients. Freeman (1986) suggested 'a series of limited objectives need to be defined, together with a program of specific action to reach them, proceeding by trial and error until an optimum level is reached'. Finally, 'flexibility' is an important word to remember, and one should accept and learn from one's failures, and be prepared to change, after systematic evaluation of the work.

CONCLUSION

In the above discussion, the authors have mentioned about the importance of structured rehabilitative programs, and the need to develop specific programs to suit the local setting and culture. There have already been too many

well-intended projects developed by our colleagues which go in vain, not because of lack of expertise or manpower or time, but because the results are just not amenable to scientific evaluation. Though there are practical difficulties in conducting genuine structured programs, the tremendous importance of distinguishing real effective rehabilitative programs from pseudo-effective ones make such difficulties worth tackling.

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P.S. Since the drafting of this paper, the Hong Kong Family Welfare Society had reported on a project of a 'structured' program titled 'Cognitive-Behavioural Group Therapy' for psychiatric out-patients. The study found that such programs are useful and the Society also produced a structured manual for use by other workers in the field.

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