

"SCHIZOPHRENIA 1992" -SOCIAL TREATMENT ASPECTS

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INTRODUCTION

This paper aims at sharing the information and insights gained from the international conference " Schizophrenia 1992: Poised for Change ", with particular reference to social treatment for people with schizophrenia. A brief account of the conference will be depicted, followed by a discussion of social treatment for schizophrenic patients.

This international conference was organized by the British Columbia Mental Health Society and the Department of Psychiatry, The University of British Columbia. It was held in Vancouver Trade and Convention Centre, Canada from July 19 - 22, 1992. About 1500 delegates of various different professionals, viz. psychiatrists, social workers, nurses, occupational therapists, mental health administrators and academicians, came from 33 countries and districts to attend this four-day conference.

The conference featured a faculty of internationally renowned scientists and mental health practitioners to present their views, experiences and research findings in the study of treatment and rehabilitation approaches to schizophrenia. In each plenary session, a set of three distinguished speakers presented papers from three different perspectives, i.e. biological, psychological and social. The presentations would then be supplemented with workshops and symposia.

In addition, partnership activities and public addresses would be held in the evening sessions. On the other hand, exhibition and poster sessions were on display in the Exhibition Hall, together with video library and slide preview.

SOCIAL REHABILITATION

In this section, the focus would be placed on the papers and research findings presented from the social perspective in the treatment and rehabilitation of people with schizophrenia.

DEINSTITUTIONALIZATION

Any discussion on social rehabilitation for mentally ill persons should touch on the concept of deinstitutionalization. According to L.L. Bachrach from the University of Maryland, USA, the movement of deinstitutionalization in the United States could be traced back to 1955. The assumptions of deinstitutionalization are threefold :

- 1) community care is more humane;
- 2) it is more therapeutic; and
- 3) it is less expensive and more effective.

However, she emphasized that community care is not a benign treatment for all mentally ill patients, some still require hospital care.

In the service planning for the mentally ill, she presented six principles for consideration. They are : -

1. services for persons suffering from schizophrenia must be individually tailored, mass planning" must be avoided;
2. for those individuals who require it, hospital care must be readily accessible;
3. services must be planned within the context of prevailing cultural norms;
4. outcome measures must be relevant and realistic;
5. persons suffering from schizophrenia must be themselves involved in service planning to the fullest extent possible;
6. continuity of services is essential; time-limited service provision must be avoided.

COMMUNITY TREATMENT

The movement of deinstitutionalization has led to the emergence of community treatment for the mentally ill. Community treatment has indeed become both the dominating concept and approach in the treatment and rehabilitation of psychiatrically disabled persons in the United States and Canada. According to M.A. Test from the University of Wisconsin, USA, the adoption of community treatment could be traced back to 1972 in the United States. There are three service guidelines for community treatment. First, the primary focus of treatment is in the community, not hospital. Second, comprehensive services should be rendered, i.e. illness management and coping skills training, with a supportive environment. Third, services should be organized and delivered to reach clients.

The Training in Community Living (TCL) [also known as the Program of Assertive Community Treatment, or PACT] has become a national model of community care in the United States. Two major studies were conducted in 1972-1976 and 1978-1992 respectively to evaluate the impact of long-term community treatment on young adults with schizophrenic disorders. The treatment results of the TCL were said to be effective in reducing time in institution, greater independent living, lesser symptomatology, and modest advantage in work/social functioning. The model was said to be economically feasible. The treatment implications of the findings are :

- 1) careful individual assessment;
- 2) involvement of patient in community support programme; and
- 3) long-term education by staff who know patient well.

In this model, the services are rendered by the Core Service Team which comprises of 14 interdisciplinary staff, i.e. psychiatrist, social worker, nurse and occupational therapist. The team is responsible for 120 young adults with schizophrenic disorders, and provides round-the-clock service. Areas of assessment and training plan include psychiatric symptomatology, living situation, activities of daily living, employment, social relationship, leisure time and others.

Assertive Outreach Programme is another widely used approach in the rehabilitation of the mentally ill. The rationales of this approach are :

- 1) increase engagement rate;
- 2) decrease drop-out rate;
- 3) suitable for reluctant client and
- 4) client can show what problems to ask for concrete help.

Team approach is emphasized with the advantages to enhance continuity of treatment, group problem-solving and reduce staff burn-out. Assessment and training in natural setting was also emphasized with the following rationales. First, client is more motivated. Second, behaviour is more realistic. Third, environmental factors can be assessed. Lastly, it could avoid institutional dependency.

REHABILITATION PROGRAMMES

Rehabilitation programmes in Canada are community-oriented with emphasis on skills training. The rehabilitation programme presented by the staff of the Riverview Hospital, British Columbia is a typical example. Wilson et al presented the Hillside Social Learning Programme which is a residential and day care treatment programme for psychiatrically disordered clients. It is modelled on psychosocial rehabilitation.

The programme is summarized in the following six points : -

1. Areas of skills training include :
 - a. social and assertive communication skills;

- b. stress and anger management skills;
- c. personal care skills;
- d. leisure;
- e. community preparation skills;
- f. medication management skills;
- g. human sexuality.

2. Positive interactive approach is used, i.e. positive reinforcement, contract and constructive feedback;
3. A focus on specific behaviour deficits within the framework of psychosocial rehabilitation;
4. A multidisciplinary approach within a primary nursing system;
5. Assistance in discharge planning;
6. Involvement of family and significant others in rehabilitation goals.

Prior to skills training, a Special level of Functioning Scale (SLOF) is used for assessment in the following subscales. A five-point scale is adopted for measurement.

- i. physical functioning;
- ii. personal care;
- iii. interpersonal relationship;
- iv. social acceptability;
- v. community living skill;
- vi. work skill;
- vii. inappropriate behaviour.

In another presentation by Buckberrough et al of the Emergency Mental Health Services, Victoria, two assertive case management programmes conducted in the British Columbia were compared. Project One was modelled closely after the Bridge Programme, and the Project Two was modelled after the TCL.

The comparison of these two models can be seen as in Table 1.

Table 1. Comparison between TCL and Bridge Model.

	<u>Growth-oriented</u>	<u>Survive-oriented</u>
Prototype	TCL	Bridge
Mission	Quality for life	Reduce homelessness
intervention	Skill training/ resource management	Primary resource management
Staffing	Multidisciplinary	Generalists
Ratio	8 : 1	10 : 1 or 15 : 1
Time Commitment	Unlimited	Variable
Team Availability	24 hr/ 7 days a week	9 to 5, weekdays
Who Provide	Nearly all by outreach team	Team assumes role of ensuing services received
Cost	High	Moderately high
Emphasis in Service	Include vocational, social & recreational aims	Basic needs, housing, Food & medications
Target Clients	All clients with serious mental illness	High risk groups and the homeless

PARTNERSHIP PROGRAMME

During the conference, partnership sessions were arranged. Accordingly, "partnership" is the alliance between consumers, families, mental health professionals, health care administrators and researchers. The author attended a partnership session, with the theme on " **Healing - through Partnership** ", in which two parents disclosed the tragedies of their sons who committed suicide, and a schizophrenic lady shared her story of suicidal attempt. It was an impressive experience that people with schizophrenia and their family members are more ready to speak for themselves. They are not afraid of revealing their identity as mental patients. On the other hand, they are more organized and assertive to exercise and advocate for their rights and services. There is a self-help group like the British Columbia Schizophrenia Society (B.C.S.S.). It is a voluntary and non-profit organization founded by the families and friends of people with schizophrenia in 1983. One of the stated objectives is to advocate on behalf of people affected by schizophrenia for better legislation and service. Another paramount objective is to provide support for the families of people with schizophrenia.

The services rendered by the B.C.S.S. include, for example, providing skills training which is necessary to empower the schizophrenics and their families to make choices that enhance their quality of life. Public education is another major service area. Indeed, the concept of "**consumer empowerment**" has become a current trend in psychosocial rehabilitation in the United States and Canada.

In Hong Kong, it would be high time to develop such self-help organizations to express their needs and their opinions on

policies and services affecting them. In fact, the 1992 Green Paper on Rehabilitation has recognized the rights of disabled persons to speak for themselves and to participate actively in the policy planning and service delivery. The community opposition to the establishment of mental health facilities, for example, an activity centre in Laguna City in 1993, has heightened a stronger need to organize recovered mental patients to advocate for their rights and services in the community. The non-governmental organizations rendering psychiatric rehabilitation services should adopt a proactive approach to promote self-help organization among the mentally ill. Simply public education is not enough.

CONCLUSION

It is an enlightening experience to attend this international conference. The impression is that psychiatric rehabilitation in Hong Kong is in line with the international trend of community treatment for psychiatrically disabled persons. However, in Hong Kong, psychiatric rehabilitation services are obviously hampered by inadequate resources allocated by the government. This involves the question of government's commitment and value-disposition. The development of psychiatric rehabilitation services, particularly social rehabilitation services, in Hong Kong has shown that the government attaches a low priority to rehabilitation services for the mentally ill. The administration of rehabilitation services is often by crisis management. The development of halfway houses in a significantly faster rate after the 1982 Un Chau Estate tragedy is a good case in point. These impressions are further reinforced after attending this international conference.