REHABILITATION: LOOKING BACK, LOOKING FORWARD.

Discover Recovery: Mental Health Rehabilitation Symposium
Monday 23 June 2008

Geoff Smith
Medical Director, WA Centre for Mental Health Policy Research
Adj. Assoc. Professor, Centre for Disability and Society, School of Health Sciences, Curtin University
Looking Back ….


Pre-Asylum

Some private ‘madhouses but mentally ill largely dependent on family, almsgiving, Poor Law provisions
Development of large asylums in country areas around cities [70%+ of inmates discharged within 1 year of admission]
Looking Back ….

Development of assessment and short-term treatment units [e.g. Heathcote Hospital]
Dramatic decline in psychiatric bed numbers through discharge long-stay patients

Deinstitutionalisation
Shift in service provision to the community with the development of traditional CMHCs
Change in the structure and mix of MHS including:
- closure stand-alone hospitals & transfer beds to general hospitals
- growth ‘new’ community services [eg. EIP, Assertive Outreach, CAT]
- growth NGO service sector
- growth of consumer-carer movement & emergence of ‘Recovery’
What is Psychiatric Rehabilitation?

Underpinned by WHO classification of functioning:

- Impairment [problems with body function]
- Disability [activity limitation]
- Handicap [participation restriction]
What is Psychiatric Rehabilitation?

Many definitions:

Application of measures aimed at reducing the impact of disabling and handicapping conditions and enabling disabled people to achieve social integration.

WHO [1980]

The formal principles and active specialised strategies within a comprehensive mental health system, and external to the system, that supports people with a mental illness to address difficulty in their life roles and participation restriction in society.

A Recovery Vision for Rehabilitation, Office of Mental Health, WA [2004]
What is Psychiatric Rehabilitation?

Different views on ‘boundaries’ between treatment, rehabilitation and support services:

• *A Recovery Vision for Rehabilitation*, Office of Mental Health, WA [2004]
  - Treatment – focussed primarily on impairment
  - Rehabilitation - focussed primarily on disability and handicap

• *Framework for Rehabilitation for Mental Health*, NSW Health [2002]
  - Clinical Rehabilitation – specific interventions that assist people to recover from mental illness by improving role functioning, increasing ability and, or, decreasing disability and developing skills and resources that are specific to individual needs
  - Disability Support - Interventions that are aimed at the maintenance of role functioning, life skills and independence
Although the term *Recovery* has been variously used, the most widely accepted definition is:

“a deeply personal, unique process of changing one’s attitudes, values, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.”

Anthony, 1993
Rehabilitation in this era of Social Inclusion is about:

- Engendering hope and optimism
- Assisting/coaching people on their journey
- Allowing them to shape their own direction and pace through full participation in their management plans
- Focussing on strengths and not weaknesses
- Recognising that families, friends, neighbours and other agencies such as housing, education, employment may have just as profound an impact on long-term outcomes as any intervention delivered by MHS
In essence:

- Recovery is not about ‘cure’ but about finding a life that is satisfying and fulfilling for each person
- Process of recovery can occur even in the face of continuing symptoms of illness
- For many service users their contact with MHS is much more like a journey than an episode of care
Looking Back .... At Rehabilitation

Concepts of psychiatric rehabilitation have changed over the years as the organisation of mental health services has moved from one based on hospitals to one based on specialist community teams.

- Ideological shift [Barton, Goffman, Wing]
- Primarily hospital-based
- Fuelled by development effective medications
- Massive shift of L/S patients to hostels, group homes in the community
- Development of centre-based rehab programs & sheltered workshops
- Concept of ‘re-settlement’
Concepts of psychiatric rehabilitation have changed over the years as the organisation of mental health services has moved from one based on hospitals to one based on specialist community teams.

- Development new ‘Rights-based’ MH legislation
- Development of community-based rehab programs, primarily organised around skills centres
- Primary focus still on people ‘late’ in their illness
- Development of new interventions in US – Assertive Community Treatment, Supported Housing & Supported Employment
- Concept of ‘Normalisation’
Looking Back …. At Rehabilitation

Concepts of psychiatric rehabilitation have changed over the years as the organisation of mental health services has moved from one based on hospitals to one based on specialist community teams.
“The majority of people with persisting psychotic disorders now live in the community, but only a minority attain a level of functioning and well-being that is commensurate with good quality of life ..... The need for therapeutic, housing, rehabilitative and support measures that are likely to have an impact on the course of their disorders and their social adjustment remains largely unmet.
There is at present international consensus that, even in the absence of primary prevention and radical cure, much of the disability and distress associated with the psychotic disorders can be prevented or reduced if the effective interventions and management strategies that exist today are widely available and applied consistently and systematically over the various stages of the illness.”

[Jablensky A, et al, 2000]
People Living with Psychotic Illness

- Peak onset of the psychotic illnesses is in youth [15 to 25]
- Jablensky and his colleagues [1997 National Survey] found:
  - 71% follow a chronic or intermittent course with incomplete recovery between episodes
  - 72% were unemployed
  - 52% had moderate to serious occupational & domestic dysfunction
  - 84% were single and 59% had difficulty socialising
  - 45% were living in institutions, hostels, group homes or homeless
  - 30% reported a history of alcohol abuse and 24% daily cannabis use
  - 52% had at least one inpatient admission within the previous year
  - 19% had participated in rehabilitation or other programs aimed at improving their functioning
Estimated that there are around 7,000 people [15-65] with psychotic illnesses in WA at any point in time

- 5,000 with a chronic or intermittent illness
- 3,600 admitted at least once each year [10% LOS 12+ months]
- 1,400 use Emergency Departments each year
- Make up 60-65% of CMHT clients and 70-80% of workload
- Over 3,000 in institutions, hostels, group homes or homeless
United States

Number of leading academics/research centres in the US that have been very actively involved in the development of evidence-based interventions for the management and rehabilitation of people with mental illness.

Major contributions in areas such as:

- Supported employment
- Supported Housing
- Assertive community treatment
- Integrated treatment for co-morbid substance abuse
- Recovery
But ....

“People with schizophrenia can be helped greatly with Pharmacological and psychosocial interventions that are known to be effective. Several interventions are now supported by research ........ However, few patients actually receive these evidence-based interventions because they are not provided in routine mental health settings. Therefore, implementing effective treatments in mental health treatment programs is a critical challenge for the field.”

*Evidence-based treatment of schizophrenia.* Drake RE et al 2000
United Kingdom

- Rehabilitation became ‘unfashionable’ and, despite focus on severe mental illness, few mental health professionals specialise in rehabilitation [eg. less than 1 psychiatrist per 1M population in 2000]
- NHS has mandated that all local areas must develop 3 specialist teams to complement the existing, traditional CMHTs:
  - Crisis Resolution and Home Treatment Team [prevent or shorten admissions]
  - Early Intervention in Psychosis Teams [new presentations of people aged 14 to 35 with psychotic illnesses]
  - Assertive Outreach Teams [for difficult to engage service users]
  - Further ‘guidance’ on management of co-morbid substance abuse been added
But …

“The challenge now is to understand how rehabilitation ideas fit into these new service structures”.

*Mapping and classifying rehabilitation services. Shepherd [2006]*
### Current Concept & Practice … A Victorian Perspective

The Victorian adult community mental health system has a number of standard service components, which are recognisable across the Area Mental Health Services. Its specialist service model has strongly influenced development in the UK.

<table>
<thead>
<tr>
<th>Service Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Assessment and Treatment Teams</td>
<td>Operate 24 hours a day to provide urgent community-based assessment and short-term treatment.</td>
</tr>
<tr>
<td>Mobile Support and Treatment Teams</td>
<td>Intensive long-term assertive outreach teams that operate extended hours, 7 days per week.</td>
</tr>
<tr>
<td>Continuing Care Teams</td>
<td>This is the largest component and provides clinic-based, non-urgent assessment, treatment and continuing care.</td>
</tr>
<tr>
<td>Primary Mental Health and Early Intervention Teams</td>
<td>Consultation/liaison and training for GPs in the management of low &amp; high prevalence disorders and provision of short-term treatment for high prevalence disorders.</td>
</tr>
<tr>
<td>Homeless Outreach Services</td>
<td>Work in partnership with other agencies providing services to homeless people with mental illness using an assertive outreach approach.</td>
</tr>
<tr>
<td>Youth Program – Early Psychosis Services</td>
<td>Provides Early Intervention in Psychosis service for people aged 16 to 25.</td>
</tr>
</tbody>
</table>
Victorian Rehabilitation and Recovery Care System:

- Most developed system in Australia
- Clinical treatment and rehabilitation services provided primarily through the Continuing Care Teams and the Mobile Support and Treatment Teams [MST - 300 FTE servicing nearly 4,000 clients in 2002]
- AMHS also provide ‘slow stream’ rehabilitation beds in Community Care Units [CCUs - 333 beds replaced long-stay wards] and Secure Extended Care Units [SECUs - 103 beds replacing secure closed beds]
- Bulk of psychosocial rehabilitation and support services are provide through the NGO Psychiatric Disability Rehabilitation and Support Services [PDRSS]
Current Concept & Practice … A Victorian Perspective

Victorian PDRSS:

- More than 170 programs providing psychosocial rehabilitation and support for over 11,000 people [2003]
- Underlying principle of Recovery
- Programs assist people to achieve their life goals in key areas such as independent living, social relationships, recreation leisure, education, personal development, vocational activity and housing
- Services organised into 6 major program areas:
  - Home-based Outreach Services
  - Housing and Support Programs
  - Psychosocial Rehabilitation Day Programs
  - Planned Respite Care Services
  - Residential Rehabilitation Services
  - Mutual Support/Self-help Programs
Current Concept & Practice .... A Victorian Perspective

- Review of Victorian Rehabilitation and Recovery Care System identified Poor cross sector collaboration as a problem.

- Commenced new initiative to improve collaboration at all levels with particular attention to AMHS – PDRSS [Looking at strategies such as common assessment tools, common unique identifier, sharing information, rationalise PDRS providers operating in any one area]
Current Dilemmas ..... 

‘Separate’ or ‘Mainstream’?

“In the present context of mental health service organisation, it is worth asking whether separate rehabilitation services are worth preserving, or whether rehabilitation concepts should simply be integrated into mainstream provisions”.

Shepherd

If it is, how does rehabilitation fit into the new service structure with the development of specialist community teams [CCT, AO/ACT, EIP]?

And ...

What should be the relative roles of the public and NGO sectors?
Effective Interventions ....

- There are a number of interventions known to be effective across all stages of psychotic illness that are supported by research evidence.

- These interventions can be applied effectively across the various stages of the illness.
Effective Interventions ….

- Pharmacological Management
- Assertive Community Treatment
- Family Interventions
- Cognitive Behaviour Therapy
- Cognitive Remediation
- Training in Illness Management Skills
- Integrated Treatment for Co-morbid Substance Abuse
- Skills Training [‘place and train’]
- Supported Education
- Supported Employment
- Supported Accommodation
Early Intervention in Psychosis

- Early intervention for young people in their first episode of psychosis grew out of dissatisfaction with the ‘one size fits all’ approach, regardless of age or stage of illness.
- Built on observation that long-term outcome is strongly determined by what happens during the initial phase ['duration of untreated psychosis’]
- Shorter DUP associated with less severe positive symptoms, improved social functioning and quality of life.
- The development of special early intervention programs is rapidly spreading around the developed world
“Implementing the Youth Early Psychosis service requires more than adding just another component to the existing network of mental health services ..... [but] .... to work in a different way; to intervene at an earlier stage of the illness ....

Youth Early Psychosis Status Report, Victoria, DHS
Learning from the Evidence …. 

Assertive Outreach, based on the Assertive Community Treatment model [Stein & Test], takes on people from CMHTs who present particular difficulties, such as:

- Poor engagement with services
- Non-adherence to treatment
- Recurrent acute hospital admission [‘revolving door’]
- Co-morbid substance abuse
- Risks to self and others
- Unemployed and not engaged in meaningful activities
Learning from the Evidence ….

Key principle of Assertive Outreach include:

- Multidisciplinary team
- Small case load [1:10]
- 24 hour coverage
- Locus of contact in the community
- Medication management
- Time-unlimited services
Learning from the Evidence ....

Benefits include:

- Reduction in time spent in hospital
- Increased housing stability
- Improved adherence to medication
- Reduced substance misuse
- Better vocational and social outcomes
- Increased satisfaction
By contrast, a Cochrane Review of *standard case management* found no measurable benefit apart from maintenance of contact and concluded that it was difficult to see how it could be retained as the ‘cornerstone’ of community mental health care.
Regardless of the what framework is adopted for service delivery, there are a number of key issues that need to be considered:

- Availability and systematic application of evidence-based interventions appropriate to the various stages of the illness. There has been over-reliance on the model of ‘generic’ case management at the expense of the delivery of protocols of evidence-based interventions by clinical ‘specialists’.

- Research from Early Intervention in Psychosis programs provides strong evidence for intervening as early as possible in a person’s illness. Evidence suggests that the duration of untreated psychosis is generally 2 to 3 years. Furthermore, people have traditionally been referred years later to rehabilitation services, generally after social exclusion has occurred. Services need to be encouraging access and engaging early with clients and their families rather than ‘gate-keeping’. This raises the question of the relationship between EIP and Rehabilitation.
• Consideration needs to be give to introducing Individual Care Plans for all clients. The Care Program Approach was adopted in the UK in 1989/90 to ensure that, after assessment, all patients received a care plan that aimed to meet their identified needs. The care plan, which could be delivered by a single professional or a multidisciplinary team, often in partnership with other agencies, would set out the role of each party. Clients, their families and the team of people involved in the client’s care would be involved in its development and regular review.

• The NGO sector in Victoria has proved very effective in delivering psychosocial rehabilitation and support services for people with mental illnesses. The PDRSS delivers a broad range of services, including a range of programs currently being delivered by MHS in other States/Territories. It is supported by a strong research and training and staff development sector.
What Might a Rehabilitation System Look Like?

There are a number of potential Models:

**Integrated Models**

- **Differentiated** (e.g., Fremantle)
  - CMHTs cover defined catchment area
  - CMHTs have primary responsibility for all clinical care
  - There is a ‘discrete’ rehabilitation team, but workers are ‘integrated’ within the CMHTs

- **Undifferentiated**
  - CMHTs cover defined catchment area
  - CMHTs have primary responsibility for all clinical care
  - Generic workers and no rehabilitation team
What Might a Rehabilitation System Look Like?

Separate Service Models

Course of Illness

- Early
- Middle
- Late

Traditional Model of Rehabilitation

- Early Psychosis Service
- Continuing Care
- Rehab Services

An Alternative Model of Rehabilitation

- Individual Care Plan
- Treatment
- Clinical Rehabilitation
- Disability Support
What Might a Rehabilitation System Look Like?

Separate service models raises a number of other questions:

- Whether services should be ‘delivered’ locally but ‘managed’ at area level.
- Relationship between other specialised services, particularly Early Intervention in Psychosis and Assertive Outreach and Rehabilitation services.

Other important issues for consideration:

- Place of inpatient programs and community-based residential programs
- Resourcing rehabilitation services
- Integration of care with NGOs and other agencies
- Role of the NGO sector – what are the advantages of going down the PDRSS path as in Victoria?
- Staff development and training