REHABILITATION OF THE PSYCHIATRIC PATIENT IN MALTA

Dr J. Vella Baldacchino, M.D., D.Spec. PSICH:(Padua), M:F: Therapy (Mi)
Consultant Psychiatrist -- Mount Carmel Hospital

DEFINITION

PRESENT SITUATION IN MALTA

SHORTCOMINGS FROM IDEAL SITUATION

ROLE OF THE FAMILY

EXISTING FACILITIES IN MALTA i.e. HWH & HOSTEL
ROLE OF VARIOUS WORKERS INVOLVED

TO PREVENT CHRONICITY

TOKEN ECONOMY PROGRAMMES

DEFINITION

CRITERIA FOR ADMISSION TO HWH

The aim of treatment is to maximise the functional capacities of patients not merely to remove symptoms

In recent years, throughout most developed countries there has been a trend tomove from hospital care of the mentally ill to treatment in the community resulting in the closure of many big state psychiatric hospitals. This change in approach and mentality raised various issues which have to be addressed and carefully evaluated such as the issue of which target population is in need of rehabilitation.

In the wake of these developments, the wave of change did reach the Maltese Islands and a National Commission was set up in order to formulate a National Policy for Mental Health Reform. The policy document was launched on 2nd April 1995 and has as one of its declared objectives:

"to provide rehabilitative and community services to deinstitutionalise and reintegrate into the community suitable patients within Mount Carmel Hospital and Gozo Psychiatric Hospital"

Rehabilitation of the mentally ill continues to suffer from a low status despite the move toward treatment and housing in the community. Because the mentally ill do not use crutches or canes their handicap is generally not apparent and the relevant professions have failed to perceive the mentally ill as disabled and in need of rehabilitation.

The concept of rehabilitation and its location, system and methods of care have changed considerably. Not long ago, rehabilitation implied the preparation of patients living in mental hospitals for their transfer into the community. The separation between treatment, rehabilitation and ongoing care was quite clear, involving different interventions and different professions. The advent of community care, aiming to provide comprehensive and continuing care, co-ordinated by identified practitioners or teams in the least dependent setting requires a re-definition of the role of rehabilitation as well as evaluations of their effectiveness.

What is rehabilitation?

REHABILITATION ----- a definition

Bachrach states that

'psychosocial rehabilitation is a therapeutic approach to the care of mentally ill individuals
that encourages each patient to develop his or her fullest capacities through learning
procedures and environmental supports'

A wider and all-encompassing definition is that

'the goals of psychiatric rehabilitation include **establishing sustaining symptomatic improvement through medications and supportive psychotherapy, establishing or re-establishing full independent living skills and interpersonal supports through skills training, cognitive retraining, family psychoeducation, and peer support; and helping the individual achieve access to resources, such as financial entitlements and other opportunities through case management and vocational rehabilitation.'**

Rehabilitation is no longer defined by specific techniques or professions, but by an all-inclusive psycho-social approach aimed at a specific patient population (Muijen, 1994).

Bachrach distinguishes eight essentials of rehabilitation: individualized care, attention to individual factors oriented towards patients' strengths, aiming to restore hope, looking at the vocational potential, offering a full array of social and recreational life, an active involvement of patients in their own care and ongoing care.

Rehabilitation is the process of **identifying** and **preventing or minimizing** the causes of the severe social disablement which often accompanies psychiatric disorders while at the same **helping the individual to develop or use his or her talents and thus acquire confidence and self-esteem through success in social roles (Wing, 1980).**
Rehabilitation, therefore, necessitates a long-term commitment to the individual patient.

In short, rehabilitation is the management of the long term mentally ill, and this most commonly concerns the chronic schizophrenic. It should aim at maximizing the functional capacities of patients and not merely to remove symptoms. In addition, it has to do with tertiary prevention, i.e. the reduction of chronic disability as a consequence of a psychiatric illness and therefore, to contribute to the resocialization of patients.

The following principles are considered to be basic to the practice of psychiatric rehabilitation and operate independently both of the setting in which they are practised and the professional discipline of the practitioner.

BASIC PRINCIPLES OF PSYCHIATRIC REHABILITATION

1. The primary focus of psychiatric rehabilitation is **on improving the psychiatrically disabled person's capabilities and competenceis.**

2. The benefit of psychiatric rehabilitation for the clinets **is behavioural improvements in their environments of need.**

3. Psychiatric rehabilitation is **atheoretical and eclectic in the use of a variety of therapeutic constructs.**

4. A central focus of psychiatric rehabilitation is **on improving vocational outcome for the psychiatrically disabled.**

5. **Hope** is an essential ingredient of the rehabilitation process.

6. The deliberate increase in **client dependency can lead to an eventual increase in the client's independent functionion.**

7. **Active participation and involvement of clients** in their rehabilitation process is sought.

8. The two fundamental interventions of psychiatric rehabilitation are **client improving vocational outcome for the psychiatrically disabled.**

(Anthony, 1984)

Who needs psychiatric rehabilitation?
To identify a target population some basic considerations have t be observed.

-- the definition should permit the distinction between disease and functional disability and agreement should be reached as to which should have precedence

-- consensus needs to be reached as to which mental disorders and under which circumstances should these be classified as chronic mental patients

-- the definition should include the time factor implicit in the word "chronic" and agreement should therefore be reached on the required duration of the illness or disability. The definition should make an allowance for the possibility of periodic fluctuations thereby including persons who have relapses and episodic exacerbations.

-- definition should also permit the prediction of future episodes of illness or disability

-- the definition should minimize the criterion of previous hospitalization and treatment as criteria of chronicity

-- the definition should include a broad heterogeneity within the target population. Those who can be defined as chronically mentally ill vary widely in their diagnosis, therapeutic history and functional levels and treatment needs.

In order to be included in the definition of chronic mental illness, the concept of mental illness it should be made to comprose various types of disability. In contemporary literature it appears that chronic mental patients suffer from more than one source of disability. Disability resulting from the illness itself, from the individual's unique response to his illness and from the extrinsic influences of society should all be taken into consideration.

Pepper et al. in 1981 state that chronicity of the young is not a new configuration of illness but is a result of a new combination of factors:
such as the difficulty of establishing stable relationships; few or no support and a consequent social and psychological weakness frequently psychotic and vulnerable to stress.

According to Goldman (1981), chronic patients are persons who suffer from severe and persisting mental and emotional disorders that interfere with their functional capacity relative to their primary needs of everyday lifelike looking after themselves, ability to form interpersonal relationships and their performance ability and who frequently require to be hospitalized for long periods of time.

Jablensky (1984) identifies chronic patients as follows:
on the pattern of the course of the illness; total duration of psychotic episodes; quality of remissions; degree of social disability.

Giel (1986)

Treating illness involves the eradication of symptoms; managing disability calls for rehabilitation to improve functioning.
e.g. hallucinations as symptoms are the target of psychopharmacologic and psychotherapeutic treatments to remove them whereas hallucinations as disabilities might best be handled by not talking about them on the jobor in social situations.
When sick in hospital, requiring medical as well as other treatments they are patients
When the acute phase is over and they need rehabilitation to help improve their functioning, they are clients, although they may continue to need medical monitoring of symptoms and medication and thus be patients as well.
Relapse occurs in 30 to 50 of patients in their year after hospital discharge (Falloon et al. 1978a; Hogarty et. al. 1979; Schooler et al., 1980).

It may be concluded that the continuation of neuroleptic drug therapy during the community aftercare of patients who have recovered from acute exacerbations of schizophrenia substantially reduces the risk of subsequent decompensation. However, the protection afforded is only partial, and at least one-third of drug taking patients relapse over the course of a year.

Milieu Therapy

The milieu of the ward combined with well-organised occupatinal therapy appeared to provide a major therapeutic effect. Removal of the patient from an overburdened home environment at times of exacerbation may help explain this effect.

The therapeutic community model was developed as a somewhat different method of providing an environment in which the patient could develop more mature coping methods and enhance his or her interpersonal skills (Cumming & Cumming, 1962). The entire inpatient unit functioned in a manner that resembled a large, democratic family system.

Improved social functioning rather than reduction of psychopathology may be more appropriate goals for such interventions. Is is also evident that concomitant neuroleptic drugs do not appear to interfere with the process of psychotherapy, but may indeed interact in a potentiating fashion.

Behavioural Psychotherapy

Improved interpersonal functioning may lead to significant benefits for the patient regardless of the persistence of delusions or hallucinations. It should be remembered that the aim of treatment is to maximize the functional capacities of out patients, not merely to remove symptoms. Psychotherapeutic interventions in the management of florid episodes of schizophrenia may be invaluable in preserving the interpersonal functioning of the individual and expediting the rehabilitation process once the symptoms have abated.

PSYCHOSOCIAL INTERVENTIONS IN COMMUNITY REHABILITATION

Psychosocial rehabilitation has focused predominantly upon two areas -

1. Work and
2. Interpersonal skills.

Work Rehabilitation

The belief that work has an important role in recovery from schizophrenia stems from evidence of the predictive value of premorbid occupational attainment in determining the community outcome of patients and from clinical evidence that structured daily activities appear to prevent social deterioration and possibly lead to a reduction in some persistent symptoms.

Patients living in high-tension households also appear to benefit from the separation from unsupportive family members through escape to a comfortable work environment (Vaughn & Leff, 1976).

There is very little evidence that vocational rehabilitation interventions have any measurable impact on the probability of patients' obtaining employment in the community. (Anthony et al., 1972; Griffiths, 1974).

Vocational training programs that specialize in assisting persons with schizophrenia to acquire marketable skills are a much needed source.

Day treatment

It has been suggested that day treatment programs may benefit any patient who spends a large portion of his or her time in contact with family members who display high "high expressed emotion". (Vaugh & Leff, 1976).

They provide a program of structured occupational and recreational activities directed toward normalization of community functioning.

The psychodynamic milieu, with its emphasis on intrapersonal exploration, appears to be too stressful for the majority of sufferers of schizophrenia.

The behavioural approach to day treatment emphasizes well-defined, functional goals in the rehabilitation of patients with schizophrenia (Falloon & Talbot, 1982; Liberman & Bryan, 1977), goals are carefully negotiated with individual patients concerning their social and vocational functions such as conversational skills, handling criticism from supervisors, joining a social club.

Four main types of facilities are necessary for an adequate rehabilitation programme:

Staffing
Accommodation
Occupational and social therapies
Support services

It is commonly acknowledged that 4 - 6 hostel places per 100,000 of the general population are required for short-term care and rehabilitation and 15-24 places for long-stay accommodation which are to include staffed homes, unstaffed accommodation and supervised lodgings.

Concept of misplaced 'new chronic' in-patients i.e. patient who did not in the psychiatrist's opinion need to be in a hospital but could be elsewhere if there where adequate facilities.

In the HWH setting the Social Worker has the following duties:

1. To assess the home environment including family situation
2. Assess work situation
3. Help find accomodation
4. Help the resident deal with various agencies e.g. Social Secutrity, Housing and Inland Revenue Depts.
5. Psychosocial counselling.

Another important member of the multidisciplinary team is the Occupational Therapist, who is responsible for the assessment, formulation and impementation of OT programmes. The OT should liase with other team members regarding goals, on-going progress and changes in programmes.

The following are some of the goals of the OT:

1. Physical well-being
2. Activities of Daily Living (ADLS) such as dressing , personal care and hygiene, use of the public transport, domestic skills such as budgeting, cooking, cleaning, laundry and safety within the home
3. Social Skills Training e.g. manners, communication and job applications
4. Cognitive and Perceptual Training
5. Time Scheduling
6. Work-related activities
7. Home Visits
8. Liasing with family and relatives
9. Organizing groups

Rehabilitation of psychiatric patients is thus necessary in order to recuperate as much of pt's functioning as possible so as to enable him to return to the community as soon as possible.

Alternative facilities to the existing hospital setup is probably the most important task of Social Psychiatry. These should include the setting up of day hospitals and day centres, night hospitals, centres for crisis situations and houses for long-stay patients.

Existing structures are not only highly inadequate but may also prove to be harmful since they increase the pt's disability or invalidity which they should be treating thereby giving rise to institutionalization.

Thus it is imperative to create novel alternative structures in order to be able to implement the above.

The following principles apply to the issue of skill generalization:

1. Use the natural reinforcers present in the environment of need to reward appropriate responses in the training environment;

2. Provide support services to follow along the client in the environment of the need;

3. Teach support persons the skill of selective reward to be applied in the environment of need;

4. Teach the client to identify intrinsic motivation as a replacement for extrinsic reward;

5. Increase the delay of reward gradually;

6. Teach in a variety of situations;

7. Teach variations of response in the same situations;

8. Teach self-evaluation and self-reward;

9. Teach the rules or principles which underlie the skill;

10. Use gradually more difficult homework assignments;

11. Involve the clinet in setting goals and selecting intervention strategies.

(Cohen, Ridley, and Cohen)

Current Local Situation

The only structure currently available is the Half-Way House which is outside the walls of Mount Carmal Hospital but which administratively and bureaucratically, forms an integral part of the hospital setup. At present the HWH accommodates 17 male and 18 female residents. In the vicinity of the HWH is a hostel which can accomodate 12 female residents but which at present is functioning as an open ward housing patients from another ward because of refurbishing of the psychogeriatric ward.

Certain patients have been at the HWH since its opening about 14 years age defeating the whole aim of the place rendering it more or an annex of the psychatric hospital than an autonomous until where patients learn to a more independent so as to find their way back into the community. This has occurred because of various reasons which include lack of housing facilities, rejection by relatives, lack of financial independence and institutional neurosis (Barton, 1959). Thus several residents have remained waiting for years on end for a change in their lives. However, it should be pointed out that most of these residents have become so used to one another and to the staff that they are rather reluctant to relinquish their place at HWH and are not very keen on discharge.

Mode of Referral to HWH

Prior to transfer to HWH patients are referred by the respective firms, for a period of assessment and induction. This serves to enable the patient to orient himself/herself to the place and to accustom onself to the new tasks and responsibilities. Initially some patients, depending on the particular case, spend a number of days per week at the HWH, returning to their respective wards in the evening, whereas others spend a whole week at a stretch in order to expedite the process of assessment. This provides an opportunity for newly referred patients to meet and get to know the other residents. During this period the staff observe whether the patient is able to carry out tasks satisfactorily; whether he/she is able to give his share in certain group activities and whether he mixes adequately with the others.

If after such a trial period, which varies from one individual to the other, all the reports are favourable the and if a bed is available the patient is discussed at a monthly staff meeting and subsequently transferred on a permanent basis.

Ideally only patients with relatively good prospects of rehabilitation and reintegration in the community should be referred to the HWH, thereby ensuring a regular turnover of patients thus helping to lower the risk of burnout of both patients and staff.

A set of criteria was compiled in order to ensure the smooth running of the facility. It is an established policy that persons with serious personality disorders, problems of substance abuse, alcoholism and individuals with severe disability due to physical or mental causes, are not to be referred for rehabilitation at the HWH. It should be pointed out that this is not to discriminate against these categories of individuals but simply because of the existent limitations in terms of human resources and adequate structures. Exceptions to this rule were occasionally made on a one-off basis but did not give optimistic results. Patients who had already spent some three weeks at the Psychaitric Unit of SLH but who required further rehabilitation were occasionally permitted to enter HWH without having to undergo a prolonged stay on one of the acute wards of MCH.

The HWH is run by a multidisciplinary team comprising a psychiatrist, nursing staff, occupational therapists. Unfortunately at this point in time, because of staff limitations, the involvement and contributions by social workers in this very important rehabilitative unit is virtually non-existent. The same holds for psychologists. As much as possible decisions are taken jointly or after liasing with each other. Every member of the team is invited to give his/her assessment of a given situation so as to have a more complete view of the problem in question.

Monthly meetings are held for all members of the staff in order to discuss issues of common interest such as policy and running of the HWH. Moreover weekly group meetings are held for all the residents and the team where themes of general interest are discussed. It is a forum in which all residents are free to air their views about various topics and recently these groups were being facilitated by one of the residents.

For quite some time the HWH was catering for day-patients who are out-patients but who have been referred for a suitable rehab programme or in order to attend Occupational Therapy. These are patients who could easily be catered for in a day hospital or day centre but in the absence of these structures the HWH was the only facility available which could offer some form of rehabilitation.

Patient satisfaction is increasingly a key outcome measure, along with cost, hospital use, psychopathology, social functioning and quality of life.

Conclusion

What is emerging is that individual service components such as hostels and teams lead to greater patient satisfaction with no further deterioration and some improvements.

Better descriptions of services, the right methodology and proper outcome measures help us toward a better understanding of the association between process and outcome.

The most important lesson has been the understanding that the population of 'rehabilitation patients' consists of a group of people with greatly verying needs, requiring a wide rance of individualized interventions of a continuing but changing nature, co-ordinated by closely involved people.

'As long as prejudice and insensitivity permeate society's relations with those suffering from mental illness, any nimenclature can engender resentment'.