Needs and Opportunities in Rehabilitation

Rehabilitation in psychiatric conditions: 2—Psychological approaches and support, the family, and activities

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Rehabilitation programmes are sometimes criticised for not being active enough: people may be just occupied rather than rehabilitated, as someone said to me. On the other hand, programmes that are too active, with high expectations, may exclude the more disabled. There are many psychological methods for tackling the problems of individuals and groups in very specific ways and methods of providing therapeutic environments—see, for example, Shepherd¹ (p 261), Hall,¹ and Griffiths.²

Psychological methods

Of the many different methods, behaviour therapies¹ (including social skills training^{4,5} and desensitisation; cognitive therapy^{6,7}; group and family therapy; psychodrama; and milieu or social therapy^{8,10}) are the most relevant. Many successes have been reported, though the evidence is not always clearcut, with the various methods. But an important problem is how improvements can be maintained after the therapy has ceased, and how they can be generalised to the real world.

Behaviour modification (see last article, p 982, for its use in the Maudsley hostel ward) may raise ethical issues, and guidelines have been formulated.¹¹ The token economy method¹² I have described in the context of head injury (23 March, p 913); at St Andrew's Hospital, Northampton, it is said to improve the quality of life of chronic schizophrenic patients and to provide a structure for improved care by staff; but in these patients its effects tend not to persist once it is no longer used. Token economy methods have been found to have value in some day care programmes^{13,14} (though some psychiatrists believe they have little place), as have behavioural approaches more generally.^{15,16} Social skills training can help people with social difficulties, including work problems (see later article)¹⁴; at one half way house I visited it is given by occupational therapy aides in the context of everyday life.

Something more than limited behavioural changes may be needed, however—some more pervasive “skill” rather than specific “skills,” which will be more readily generalised to different real life situations.⁵ Thus many workers are moving towards the shaping of perceptions and judgments as well as behaviour. The self instruction or positive self talk that forms part of cognitive therapy has versatile possibilities,^{16,7} though this is not yet well established except perhaps for the relaxation approach to anxiety control. A booklet called *Coping With Depression*, adapted from one for American readers by A T Beck and R L Greenberg, has been produced for patients at the Royal National Orthopaedic Hospital, Stanmore.

In social therapy the social environment is designed in such a way as to be therapeutic.^{8,9} The study of institutionalism by Wing and Brown was an important demonstration of the value of this approach.³⁶ Therapeutic communities proper, emphasising the therapeutic potential of all activities and interactions, demand personal growth and change in clients and staff alike; participation and “reality confrontation,” with frequent community meetings to analyse events, are important features.^{9,10} Some statutory and voluntary hostels and units (day^{17,17a} as well as residential) are run on these lines. Some of the basic principles, such as activity, responsibility, and freedom, have been pervasive, and are held to be important for any rehabilitation programme even if, as some psychiatrists believe, therapeutic communities themselves are not appropriate—since they focus on emotional problems more than on practical coping or support with outside stresses. Some research (see, for example, refs 16 and 18) has found the therapeutic community approach less successful in chronic patients in day care than behavioural methods; it may be unsuitable for some, including apathetic people.⁹ But promising results with chronic patients in a London local authority community mental health service have been reported recently^{17a}; and some psychiatrists believe that these approaches are widely important—one benefit being that they improve the morale and attitude of staff working with what usually appear to be unrewarding patients.

A mixture of approaches is the best policy in the view of several workers I have come across; no one approach is supreme, concludes Shepherd¹ (p 283), and broad based treatment packages are needed with behavioural, cognitive, and emotional components, especially in the face of longstanding difficulty with relationships. Expectancy, feedback, and social attention, he suggests, are important elements common to different methods.¹⁹ In general, psychological techniques emphasise careful assessments of both assets and problems that provide the basis for planning individual programmes. Specific goals are then worked out and various techniques used to deal with the specific difficulties. With this approach staff have both a clear focus and feedback on the effectiveness of the methods. But more research, starting from testable hypotheses, to evaluate different methods is clearly needed.

The will and the pressure to adopt new methods are there—if only because the inadequacy of the old practices is all too clear—and so, on the whole, is the know how. But progress is slow. Funding and posts for clinical psychologists are sparse, and other staff who should be trained to implement programmes—occupational therapists, nurses, social workers—are already overstretched. Netherne Hospital, for example, plans a behaviour modification ward for patients who have not responded to any treatment; but the plan is held up because another psychologist has not yet been funded. Moreover, since psychological therapies usually should not be isolated or “once for all” activities, they require ample and appropriate facilities in the environment as a whole. More staff trained in this way for day care and for hostels and so on are a particular need, and so are professionals who can give expert

guidance to families—teaching them, for instance, how to relate therapeutically with a disturbed relative, or how to reinforce desired behaviour.

Counselling and support

Despite the monumental problems caused by a psychiatric illness and its consequences, and often the lack of supportive or intimate relationships, one sometimes hears it said of individual patients that drugs are the thing and counselling (see Ekdawi,² p 133) is irrelevant.

Support in a general sense is, of course, the aim of modern psychiatric services; and sometimes there is individual counselling and therapy or group work, or both. But some patients whose needs are unmet go to great lengths to get regular, supportive counselling. The Camberwell survey found even practical counselling insufficient.³ There is a need for more specific training for counselling among selected professionals, including staff supervising hostels, group homes, and so on; Creer *et al* comment that training of staff in general is not now always conducive to developing such skills.³ Clearly a counsellor should be readily available and not always changing, but these ideals are not realised. A long term counsellor or “key worker” should be assigned to every patient and family—whether a social worker, community psychiatric nurse, occupational therapist, or other staff member.²¹ NHS GPs cannot be reimbursed for the cost of using counsellors, and a report from MIND urges that some form of recognition should be given to workers providing counselling and psychological or psychotherapeutic support.²⁰

Group discussions may also be supportive, though threatening and stressful for some. Many hospital wards, hostels, and day centres do have them but discussions are often confined to practical issues. One psychiatrist thought that there was a lack of the necessary skill, willingness, and recognition of need rather than shortage of time and staff. Walker and Proctor describe programmes of brief psychotherapy based on day hospitals in Bristol and Bridgwater; there is both individual and group work, with a lot of emphasis on families and couples.²² At a day hospital in Newham weekly discussion groups for schizophrenic outpatients have among other things enabled attenders to share frightening experiences such as hearing voices; the groups are on the lines of an outpatient group therapy programme that has been successful in Dublin,^{23,24} and also the informal “coffee and psychotherapy” approach that has been found to work with some very withdrawn and deprived schizo-

phrenics in the United States.²⁵ The Unicentre day centre in Oxford is an example of a supportive place to go.²⁶ At the Vineyard day centre in Richmond an informal “tranquilliser withdrawal support group” is linked with the relaxation class (see below) and members telephone each other between meetings.

Support means having someone to turn to, whether an individual or the staff of a drop in centre open 24 hours a day. Every service should ensure—but many do not—that something or someone is available for every patient in the community. The Maudsley Hospital has a “ward support system” for those who have left, which is always open.²⁷

For those who could never be helped to create their own supportive relationships, networks of support of various kinds must be provided (the Maudsley ward support system offers this in an accepting way for both the lonely and the socially disengaged²⁷). Voluntary “befrienders” can be valuable here, especially when befriending is based on common interests and the giving is not all one way. More generally, there has been much research—and much more is needed—on the content of support in different types of case and what is needed to make it effective.²⁸ Those with no social competence, who cannot easily draw on support even if it is there, really need help of a more fundamental kind, such as social skills training.

The family

Whether supportive or destructive, the family needs to be seen and if possible involved right from the start. One psychiatrist I met said that this was one of the things that had impressed him most in his career, yet the practice was far from widespread. But in some units the family of every patient admitted is offered support or therapy of some kind. Regular contact, not just occasional interviews, is usually needed. But in Edwards's survey only about a quarter of day hospitals and a tenth of day centres (no voluntary units) were in regular contact with families.²² Some of the best services, and also voluntary bodies, such as the National Schizophrenia Fellowship, arrange groups for support and guidance of relatives. In one survey 90% of households suffered hardship (physical and mental ill health and other problems) with a schizophrenic member living at home.²⁹ Some relatives evolve successful ways of coping even with chronic schizophrenia, and professionals as well as other relatives learn from them (Kuipers and Priestly³⁰). A family study at Netherne Hospital found relatives to be mainly on good terms with chronically disturbed family members living at home, but their expectations tended to be too low.³¹

In the Camberwell survey many of the unmet needs of relatives sprang from inadequate assessment.³ One woman regretted that social workers were no longer available to give her long term emotional support and help based on close knowledge of patient and family; instead there were family meetings, with the patient present, which were not a substitute for “a continuous one to one relationship through which she could obtain help in her own right.”³ Creer *et al* argue for the latter approach but point out the difficulties—scarcity of social workers experienced in psychiatric community care and changed patterns of work and training.³

Both schizophrenic and depressive patients are much more vulnerable if their families are critical or overinvolved, as studies of relapse rates in “high expressed emotion” and “low expressed emotion” families have shown.³² A neutral but supportive atmosphere is best. The effects of high expressed emotion on the vulnerable person may be tempered by drugs and by his or her partial separation from the family.³³ Useful strategies are suggested by this work: assessing family attitudes and, when they are unfavourable, making special efforts about drugs, finding an occupation or a day centre, and—ideally—helping the family to change (see box). Family therapy with the relatives of chronic schizophrenic patients has also had promising results.³⁴ But supportive family counselling is much more widely needed and possible.³⁵ Simply providing support and a sympathetic ear is a realistic basis because in family research it has not been entirely clear which precise ingredients of the interventions are important.

Working with families

A controlled trial of social therapy was carried out by Leff and others³³ with the families of people suffering from chronic schizophrenia and at high risk of relapse, despite medication, because they lived in close contact with relatives with “high expressed emotion.”³³² In the experimental group the aim was to modify critical attitudes and overinvolvement of relatives and reduce face to face contact to less than 35 hours a week. None of the eight patients in families where at least one of the aims was achieved relapsed during the nine months, but six of the 12 control patients relapsed. Now in a further study the effectiveness of education and a relatives' group is being compared with that of education and family therapy sessions in the home (in both cases fortnightly). An American study with chronic schizophrenic patients by Falloon and others also had good results, though the authors interpret them cautiously.³⁴ Their family therapy sessions were to lessen tensions and improve the families' problem solving skills in coping with causes of stress; therapists aimed to improve the expression of positive and negative feelings, reflective listening, requests for behaviour change, and reciprocity of conversation.

Activities

In the study of long stay schizophrenics by Wing and Brown inactivity was found to increase disability and it was the factor of "work and occupational therapy" that chiefly distinguished those who did and did not improve.³⁶ But both in and out of hospital even now some people just "mope about."³⁷ An industrial unit may provide more interaction between people than many occupational therapy settings,³⁸ and day care services are often criticised for not having enough work units. Work is powerful therapy.¹ I will discuss work in the next article but one and consider here occupation and activity in a wider sense.

"Returning patients to full usefulness if not to full employment" when jobs are scarce was a topic of a conference on work and occupation.³⁹ One ex-patient, for instance, was enabled to find satisfaction by helping a handicapped child; and members of a day centre I came across started a creche to help working mothers. All statutory and voluntary services should surely give thought to how genuine help like this could be given by some clients.

Adult education classes and other "normal" activities in the community are preferable to day centres for some but they may need explicit help in exploring the possibilities. A resource pack for ex-patients with information about local opportunities has been suggested, and North Manchester Health Authority, with Manchester Social Services, is developing a "mental health outreach project" using existing community resources rather than providing a "total environment."³⁷

Day centre activities are often dismissed as largely diversional (and some clients even find them childish⁴⁰) but clearly need not be so. The organisation Creative Day Care holds stimulating meetings for day care workers. I visited a day centre in Birmingham with a large array of activities, including therapeutic groups. Some groups are set up in response to a current need or interest, such as family problems; and there was an interesting poetry writing group in which members explored feelings and formed friendships. Impressive artistic work is in evidence there; arts and crafts should not be scorned—they may be intensely satisfying. Someone described a day centre's aim as "providing space for people to discover themselves" rather than handing out activities on a plate, and perhaps health and social workers should more actively strive to help mentally disabled people to pursue or discover real interests. I was involved with a small poetry group formed for the benefit of a severely abnormal man with real talent, who was helped by being a star contributor.

Relaxation and yoga are valuable activities that could be more widespread. I was impressed by a relaxation class at the Richmond day centre, where the exercises were done in an informal atmosphere that encouraged people to discuss their problems. Vigorous exercise appears to be helpful for aggression, depression, and poor self image in particular, but is hindered by the apathy and lack of energy that are so common.⁴⁰ I came across one hospital unit that had a jogging class, and games and keep fit classes are more common; but much more could be done to encourage physical activity outside hospital. Gardening is often therapeutic and the organisation Horticultural Therapy gives advice. Keeping pets, whether at home or in units, hostels and so on, is beneficial⁴¹ and the Society for the Study of Pets in Therapy is active here.

The future

A rehabilitation service, someone said, is a chain that may be only as strong as its weakest link. Although progress has been made in providing rehabilitation facilities, many of them excellent, since the 1975 white paper,⁴² services as a whole are patchy and important elements are often missing. There is a long way to go before the general standard approaches the level of the very good services.³⁰ Increasing facilities, including more training of staff in particular skills, should represent a better use of resources by lessening the need for more expensive forms of care. But meanwhile emptying mental hospitals is not the answer where the alternatives are inadequate.⁴³ Psychiatrists with a special interest in rehabilitation,

recommended by the Royal College of Psychiatrists,²¹ or with full time appointments are needed, not least to speak out for resources; their number is growing, but slowly.

Economy and standards of excellence call for more coordination and integration of services within and between the various agencies (including voluntary organisations such as MIND and the local associations for mental health)—with gradual upgrading of inadequate facilities. A "manifesto" from MIND, specifying over 160 components, calls for comprehensive local services that attend not only to the individual but also to his or her social network; it proposes mental health service development committees, "guardians of the ideal model of the new service," for policy and

The Vineyard Project, Richmond²²; stall at the local May fair. This day centre, supported by the Richmond Association for Mental Health and a local church and charities, and staffed by social workers aided by volunteers, offers varied activities and support groups (with individual counselling if needed) five days a week; it is not restricted to those with psychiatric problems. At the weekend some of the attenders take part in local activities together. A 30 minute video (VHS) cassette is available for purchase or hire from the centre (Congregational Church Crypt, The Vineyard, Richmond, Surrey).

strategic development, and also a unified budget for the unified facilities.²⁰ Good information about needs is crucial. A register of those needing services (a practice pioneered in Camberwell³¹) is recommended by the Royal College of Psychiatrists.²¹ This can provide a list of all the mentally disabled people in an area who need the periodic reassessment urged by Wing and Olsen.³⁰

Inevitably, more well designed research on rehabilitation methods is needed. But there are abundant well tried practices that could be more widespread. Knowledge of new approaches needs to percolate through to everyone who might be helped to make use of it—general practitioners, social workers, volunteers, relatives, for example—in however modest a form. The various day care facilities and also clubs and self help groups offer great scope for spreading ideas, given the vision and enthusiasm of the relevant professionals sowing the seeds.

Finally, new attitudes need to take stronger root. Being a "patient," someone said, is a demanding role, and some are "patients" all their lives. How can social and educational approaches to rehabilitation become stronger than the medical model?

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Addresses

- British Association of Art Therapists 13c Northwood Road, London N6 5TL (concerned with training; gives advice to prospective employers)
- British Institute of Industrial Therapy 99 Leigh Road, Eastleigh, Hants SO5 4DR
- Creative Day Care C/o Studdert-Kennedy Day Centre, Spring Gardens, Worcester (concerned with many aspects of day care; holds meetings and workshops and has newsletter and directory of day care organisations)
- Good Practices in Mental Health Project 67 Kentish Town Road, London NW1 8NY (databank, with publications on various localities covering a wide range of statutory and voluntary services—mainly small scale, or components of larger services—for people with mental illness or stress related problems and their families)
- Horticultural Therapy Goulds Ground, Vallis Way, Frome, Somerset BA11 3DW (gives help and advice to hospitals, day centres, residential homes, sheltered employment projects, etc, and to disabled people at home; has a training centre at Warwickshire College of Agriculture for occupational therapists, care staff, etc, interested in horticulture as therapy)
- Mental Health Foundation 8 Hallam Street, London W1N 6DH (promotes and finances research and community care projects)
- MIND (National Association for Mental Health) 22 Harley Street, London W1N 2ED (NB also local associations for mental health—addresses from MIND)
- National Schizophrenia Fellowship 78-79 Victoria Road, Surbiton KT6 4NS (with local groups concerned with the welfare of sufferers and relatives)
- Richmond Fellowship 8 Addison Road, London W14 8DL (has residential homes and hostels, some of them therapeutic communities, and runs courses for residential care staff and other mental health and pastoral care workers)
- Society for Companion Animal Studies New Malden House, New Malden, Surrey KT3 4TB

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Is immunisation against influenza justified?

As Dr Joad used to say, "It all depends on what you mean by justified." Several manufacturers produce vaccine made from killed influenza A and B virus. All are highly purified—some are disrupted to produce fewer reactions and some include only the subunits (HA and N) that form the virus surface and induce immunity. These last produce minimal reactions and are particularly suitable for children. All vaccines contain viruses of the current serotypes and produce good antibody responses, and most people find the occasional local or the rare systemic reactions acceptable. Vaccine reduces influenza attack rates by 70-80% for at least the following season. So we have good vaccines which may properly be used in a wide range of patients.¹ Whether their use is justified or not depends on the clinical state of the vaccinee and his attitudes and those of the doctor.

Naturally vaccination only prevents disease due to influenza A or B (perhaps 5% of all respiratory disease) and not all influenza like illnesses. Nevertheless, influenza virus infections are particularly dangerous to patients with chronic chest disease or cardiac decompensation, and vaccination prevents influenzal pneumonia and death in groups of elderly subjects who would have included some with such diseases.² Vaccinating patients with

chronic diseases, as recommended by the DHSS, therefore seems justified, particularly if the signs suggest that an influenza epidemic may be in the offing. Vaccination of children with, for instance, fibrocystic disease or diabetes is also recommended, even though there is no formal proof of benefit in such groups. For reasons that are not understood it seems that children may gradually lose the immunity conferred by vaccination if this is repeated annually,³ but this observation has not yet been shown to be generally true. Furthermore, healthy adults, even those likely to be heavily exposed such as nurses, often think that they would rather put up with the occasional attack of "flu" than have the nuisance and possibly the expense of vaccination that in many years will have no effect since influenza epidemics do not occur every year, and have been particularly mild in recent years. Careful analysis suggests that the benefits, if any, of using vaccine in this way are marginal and such use of vaccine is generally not justified or recommended.—D A J TYRRELL, director MRC common cold unit, Salisbury.

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