A meaningful day: integrating psychosocial rehabilitation into community treatment of schizophrenia

Caroline Crosse

ABSTRACT

While many of the overt symptoms of schizophrenia may be controlled by medication, the associated psychiatric disability requires ongoing psychosocial rehabilitation and support in the community. The general practitioner can play a crucial role in this rehabilitative process, through

- encouraging good physical health in the person with schizophrenia;
- referring the person to a local day program and other psychiatric disability support services;
- educating the person about the diagnosis and practical self-help;
- involving families and referring them to support organisations and group therapy programs; and
- encouraging use of local community facilities and employment training, where appropriate.

MJA 2003; 178: S76–S78

BEING PART OF SOCIETY, enjoying good family relations, a healthy lifestyle, or having a satisfying job ... these are not just a collection of rehabilitation goals but are what most people aspire to. All too often, schizophrenia profoundly disrupts these expectations — social isolation is a daily reality for most people with psychotic disorders. The majority of people with psychotic disorders have lost essential life roles that normally provide self-esteem and meaning. Eighty-four per cent are separated, divorced, widowed or single; 85% are reliant on welfare benefits; 72% do not have a regular occupation; and 45% live in institutions, hostels, supported housing or crisis shelters, or are homeless.[1] A psychotic episode also affects those involved with the person affected.[1] The bewildering and distressing symptoms, admission to hospital and administration of medication, combined with lack of understanding, cause significant trauma for all involved.[2] It is crucial that managing people with schizophrenia include integrated rehabilitation services that respond promptly and appropriately to the needs of the individual and the family.

Ideally, rehabilitation services should include:[3]

- psychological treatments (eg, cognitive behaviour therapy), if appropriate;
- education about the illness and how to cope with symptoms and the effects of disability;
- family therapy;
- support for carers;
- psychosocial rehabilitation;
- accommodation and employment support;
- specific skills development;
- assistance to link in to community resources; and
- help to learn how best to manage and come to terms with the illness.

These all take time, and hinge on the presence and efficient coordination of committed teams.

The general practitioner can play a crucial role in promoting psychosocial rehabilitation for people with schizophrenia — whether acting independently or as part of a shared-care program with an Area Mental Health Service.

Physical health

Morbidity and mortality are high among people with schizophrenia.[4,5] Withdrawal from, and loss of interest in, the world around them, loss of ability and confidence to engage socially, side effects of medication (eg, weight gain, sedation), high smoking rates and low income all contribute to low levels of general health among these people,[6,7] and further isolate them from the rest of the community.

Before any progress can be made in improving physical health, people with schizophrenia must be motivated to change.[8] Their loss of interest in the world around them is often reflected by loss of interest in their physical condition. It is important that they receive as much encouragement as possible and that everyone involved is aware that progress may be very slow.

Recommendations

- Conduct preventive health checks regularly, especially for signs of heart disease and diabetes, and for any infectious diseases (eg, hepatitis) if risk factors are present;
- Refer patients to smoking cessation programs, dietitians, recreational programs and other services, as appropriate.

Education

After a first episode of schizophrenia, the doctor needs to investigate what happened and allow the patient to express the confusion and anger that is commonly felt. The doctor needs to reassure the patient that schizophrenia is not "the end of the world", but a medical condition that can be treated and is experienced by other people as well.

Mental Illness Fellowship Victoria, Clifton Hill, VIC.
Caroline Crosse, BA (Hons), Western Region Manager.
Reprints will not be available from the author. Correspondence: Ms Caroline Crosse, Mental Illness Fellowship Victoria, PO Box 359, Clifton Hill, VIC 3068. ccrosse@mifellowship.org

It should not be assumed that a person who has been given a diagnosis of schizophrenia will understand what it is. Furthermore, people are affected by the community's lack of understanding and stigma about the illness, and may be reluctant to accept the term "schizophrenia" if they associate it with a "split personality" or other false stereotypes of mental illness that are widely prevalent in the community.[9]

Recommendations

- Be aware that management is likely to be more effective if the patient understands the diagnosis and the reasons for treatment;
- Do not assume that because someone has been diagnosed with a mental illness he or she understands the illness;
- Provide information about diagnoses and treatments. For example, SANE Australia produces a range of educative material on schizophrenia and other mental illnesses in easy-to-read language (www.sane.org).

Family

Family members and other carers need to be recognised for the role they play in helping maintain a patient's mental health and need to be included in the overall rehabilitation plan. It is also important that they receive education, support and training in how best to support the patient. As people tend to respond positively to recommendations made by their GP, it is important for GPs to know of and refer people to support organisations, as well as to generic carer support provided by the Carers Association. Family group therapy, when available, may substantially reduce symptoms and frequency of episodes in the patient, as well as improving the mental health of the entire family.[10-13]

Recommendations

- Listen to family members and include them in the "treatment team" whenever appropriate;
- Inform families about support organisations such the Mental Illness Fellowship (www.schizophrenia.org.au) and Carers Association (www.carers.asn.au);
- Refer families to a group therapy program if available.

Psychosocial rehabilitation programs

Psychosocial rehabilitation is often the key to reintegration.[14] Self-confidence is one of the first casualties of a psychotic episode, accompanied by the feeling of loss of control over one's life. Support to develop and achieve realistic goals is often the start of the process of recovery.

Once clinical interventions have stabilised symptoms, the sense of loss resulting from the illness can be depressing in itself. Patients feel confused and distressed by the illness itself, the intervention of crisis teams, and sometimes involuntary admission to hospital. Family members can inadvertently increase the sense of powerlessness by being overprotective and "doing for" rather than "doing with" the person.[15] It is important that the person's dignity is not disabled through the process of engaging with the mental health system, and that the patient is treated with respect and as an adult at all times.[16]

An essential component of reintegration is an environment that promotes the individual's sense of control. Patients must be perceived and treated by all as playing an active role in their own rehabilitation.[17] They need to feel that this is not just something else that "happens to them", but a support system to help them learn to pick up the threads of their life again.[18,19]

Too often the illness is the only thing "going on" in the person's life and all conversations seem to revolve around it. Social networks often fall away, and the only contact many people with mental illness have is with their treatment team and family. Loneliness, isolation and a sense of helplessness can trigger a relapse or a retreat to risky alternatives such as drugs and alcohol. Despite increasing the likelihood of relapse, these alternatives can seem attractive: not only do they "anaesthetise" the person to the experience of the illness and provide a sense of personal control, they may also provide a peer identity group (and one that is not defined by mental illness). It is therefore very important for treatment services to intervene early to displace this vacuum with positive activity, and for the person to become engaged with the wider community, not with the drug subculture or other people who take advantage of vulnerable members of society.

Federal-government-funded Carer Respite and Disability Employment services are widely available in Australia. Community-based psychosocial rehabilitation programs — such as day programs, outreach and supported accommodation agencies — are state funded, and ideally work in partnership with Area Mental Health Services to provide the individual with a continuum of care.[20] Availability of these services varies widely between states and between different regions within each state.[21] It is important for GPs to refer people consistently to such services. Information about locally available services can be obtained from the Area Mental Health Service or mental health branch of the state health department.[22]

The advantage of day programs, in particular, is that they are structured to meet the psychosocial rehabilitation needs of people with illnesses such as schizophrenia, and one of the primary goals of people accessing a day program is to make friends. Connecting and socialising with others can be the point at which many people stop stigmatising and thus isolating themselves. For people not confident enough, or unwilling, to access a day program, outreach support workers and volunteer organisations that match volunteers with clients can help reconnect the threads. Reviving and sharing people's interests helps to redefine their self-image and life plan.

Recommendations

- Refer people with schizophrenia to a local day program or other form of psychosocial rehabilitation. This may provide them with a "gateway" back into the community;

Further information

General practitioners can obtain further information regarding clinical or community support for people with schizophrenia from:

- The local Area Mental Health Service
- Divisions of General Practice
- State Mental Illness Fellowship or Schizophrenia Fellowship
- State Mental Health Association
- SANE Australia

■ Find out about other forms of support provided by a range of agencies. This will provide a more flexible range of resources for referral. (For further information sources, see Box.)

■ Where psychiatric disability-specific agencies do not exist, encourage people with schizophrenia to access other, more generic resources, such as neighbourhood houses (ie, local organisations that provide social, educational and recreational activities in a welcoming, supportive environment).

Work and meaningful occupation

Employment reintegrates people back into the community, provides an independent income and a sense of identity, and fills an empty day with purpose and activity. Unpaid voluntary work can also help fulfil this role.

CentreLink can refer people to federally funded generic Disability Employment Support agencies to help find suitable work. The workplace needs to be more accommodating to the unique demands of psychiatric disability. For people with schizophrenia, a major barrier to coping with a job is their understandable reluctance to disclose the illness. This increases the sense of pressure at work and also denies them the right to their equivalent of "ramps and lifts" for people with a physical disability.

It is important to encourage people to become active by linking in with local resources. Without these community links, support services run the risk of becoming mini-versions of the old psychiatric institutions: the individual doesn't get to access community resources, and the community doesn't have the opportunity to engage with and include people with a mental illness. Local neighbourhood houses, leisure centres, training centres, employment programs, volunteer options and local clubs should all be part of the life plan, so that support services are seen clearly to assist people to reintegrate into society rather than act as a substitute for it.

Recommendations

■ Encourage realistic consideration of work and practical steps in preparation for it, such as enrolment at a day program and referral from CentreLink to a Disability Employment Support agency;

■ Be aware that any meaningful occupation, such as unpaid volunteer work, can give people a social role, as well an opportunity to engage with the community and prepare for the challenges of entering the paid workforce.

Conclusion

While medication plays an essential role in controlling the symptoms of schizophrenia, the psychiatric disability associated with the condition has a profound impact on cognitive and social functioning as well as physical health, creating a barrier to reintegration. The GP can play a major role in reducing the impact of these factors through assertive monitoring of physical health and referral to psychosocial rehabilitation and other community support services. Timely intervention and ongoing support can make the difference between isolation and relapse and being able to re-establish a meaningful life as part of the community.

Competing interests

None identified.

References

1. Jablensky A, McGrath J, Herrman H, et al. People living with psychotic illness: an Australian study 1997–98. Canberra: Commonwealth Department of Health and Aged Care, 1999. Available at: http://www.health.gov.au/hsdd/mentalhe/resources/reports/pdf/psychot.pdf (accessed Mar 2003).
2. Warner R, de Girolamo G. Schizophrenia. Geneva: World Health Organization, 1995.
3. SANE Australia. SANE blueprint guide to psychosocial rehabilitation. Melbourne: SANE Australia, 2001.
4. Coghlan R, Lawrence D, Holman CDJ, Jeblensky AV. Duty of care: physical illness in people with mental illness. Perth: University of Western Australia, 2001.
5. Lambert T, Velakoulis D, Pantelis C. Medical comorbidity in schizophrenia. *Med J Aust* 2003; 178 Suppl May XX: S000-S000.
6. Davidson S, Judd F, Hocking B, et al. Cardiovascular risk factors for people with mental illness. *Aust N Z J Psychiatry* 2001; 35: 196-202.
7. SANE Australia. The SANE SmokeFree Kit. Melbourne: SANE Australia,1998.
8. MindBodyLife. Available at: http://www.mindbodylife.com.au (accessed Feb 2003).
9. Jorm AF, Korten AE, Jacomb PA, et al. "Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Med J Aust* 1997; 166: 182-186.
10. Falloon I, and Associates. Family management of schizophrenia: a study of clinical, social, family and economic benefits. Baltimore: Johns Hopkins University Press, 1985.
11. Leff J, Berkowitz R, Shavit N, et al. A trial of family therapy v. a relatives' group for schizophrenia. *Br J Psychiatry* 1989; 154: 58-66.
12. Leff J, Berkowitz R, Shavit N, et al. A trial of family therapy versus a relatives' group for schizophrenia. Two-year follow-up. *Br J Psychiatry* 1990; 157: 571-577.
13. McFarlane W, Lukens E, Link B, et al. Multiple-family groups and psychoeducation in the treatment of schizophrenia. *Arch Gen Psychiatry* 1995; 52: 679-687.
14. Anthony WA, Cohen MR, Farkas MD. Psychiatric rehabilitation. 2nd ed. Boston: Center for Psychiatric Rehabilitation, 2002.
15. Barrowclough C, Tarrier N, Johnston M, et al. Distress, expressed emotion and attributions in relatives of schizophrenia patients. *Schizophr Bull* 1996; 22: 691-702.
16. Australian Health Ministers' Conference. National mental health policy. Canberra: Commonwealth Department of Health, Housing and Community Services, 1992.
17. Deegan P. Recovery: the lived experience of rehabilitation. *Psychosoc Rehabil J* 1988; 11: 11-19.
18. Anthony WA. Integrating psychiatric rehabilitation into managed care. *Psychiatr Rehabil J* 1996; 20(2): 39-44.
19. Anthony WA, Liberman RP. The practice of psychiatric rehabilitation: historical, conceptual and research base. *Schizophr Bull* 1986; 12: 542-559.
20. Victoria's mental health service: the framework for service delivery. Melbourne: Victorian Department of Health and Community Services, Psychiatric Services Division, 1994.
21. SANE Australia. The SANE mental health report. Melbourne: SANE Australia, 2002.
22. Ireland G, Morgan P. A cost-benefit analysis of a clubhouse program: report to the South Australian Health Commission. Adelaide: University of South Australia, and Melbourne: SANE Australia, 1996. ❑