

Editorial

Cite this article: Craig TJ (2019). Social care: an essential aspect of mental health rehabilitation services. *Epidemiology and Psychiatric Sciences* **28**, 4–8. <https://doi.org/10.1017/S204579601800029X>

Received: 22 May 2018

Revised: 22 May 2018

Accepted: 22 May 2018

First published online: 17 July 2018

Key words:

Institutionalisation; peer support; psychosocial rehabilitation; supported employment; supported housing

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Abstract

This study is aimed at the importance of social care in rehabilitation. A brief overview of the social care theme is used as the methodology. There is a tension in mental health care between biological and psychological treatments that focus on deficits at the individual level (symptoms, disabilities) and social interventions that try to address local inequalities and barriers in order to improve access for service users to ordinary housing, employment and leisure opportunities. The history of mental health care tells us that social care is often underfunded and too easily dismissed as not the business of health care. But too much emphasis on a health model of individual deficits is a slippery slope to institutionalisation by way of therapeutic nihilism. Rehabilitation services follow the biopsychosocial model but with a shift in emphasis, recognising the vital role played by social interventions in improving the functional outcomes that matter to service users including access to housing, occupation, leisure facilities and the support of family and friends. In conclusion, rehabilitation is framed within a model of personal recovery in which the target of intervention is to boost hope and help the individual find a meaning to life, living well regardless of enduring symptoms.

Rehabilitation: balancing models of care

An important aim of psychiatric rehabilitation is to enable the social inclusion of people suffering from severe and persistent forms of mental disorder (Barbato, 2006). To this end, much is made of the 'biopsychosocial' model of brain, mind and social processes in the aetiology and treatment of mental illness. The first two components of the model presume that a defect or problem lies with the individual and treatment involves changing the faulty brain or mind processes. In contrast, from a social perspective, the cause and maintenance of mental problems lie outside the individual (e.g. childhood trauma or the toxic influence of stigma and discrimination), and it is change in these external social conditions that is most needed. But dealing with these external factors is a far more daunting task than one with a purely individual focus. It involves working with multiple actors with differing vested interests and agendas and what may be good for alleviating mental health problems may run counter to how a society responds to inequality. Small wonder then that more attention and resource is given to interventions aimed at changing the individual even if the obvious defect lies externally in abusive relationships, discrimination or structural failings of society.

But the emphasis on individual deficits has led us down some dispiriting paths. Perhaps the worst of these was the therapeutic nihilism that contributed to the growth of the hospital asylum system in the late 1800s where 'incurables' languished in asylums with scant attention to the possibility that the crowded, regimented and neglectful environments were actually worsening symptoms and function. The recognition of this and the deinstitutionalisation movement that followed owed much to Goffman's (1961) description of the impoverished lives of incarcerated patients, the 'institutional neurosis' described by Barton (1966) and studies that showed how the negative symptoms of schizophrenia decreased as the social environment of the hospital improved and increased when it deteriorated (Wing & Brown, 1970). It also grew from the work of psychiatrists and other health workers who took a more deliberately social focus to the delivery of care. The first steps towards deinstitutionalisation had begun before Goffman and some time in advance of the discovery of antipsychotic medication with some institutions in the UK and USA adopting social milieu therapies, 'open door' policies and shortening lengths of stay (Warner, 1985).

The asylums all closed or radically reduced in size by 2010. These closures were not without concern as many psychiatrists thought that patients would fare badly away from the asylum, relapsing, becoming homeless or being a danger to themselves or others. Opposing this were arguments that these fears were grossly exaggerated and that many of the behavioural problems associated with mental disorders and learning disability might even improve were the disabled provided with the same conditions of housing, leisure, education and occupation and follow the normal rhythms of life as enjoyed by any other citizen (e.g. Wolfensberger, 1972). The process of resettlement that followed was something of a compromise. The individual deficit

model was addressed by providing a ‘train then place’ approach aimed at addressing the deficits and strengthening the skills needed for community life, with an emphasis on personal care, shopping and cooking. The transfer from the asylum was to multi-occupancy residential care and group homes that provided as a ‘home for life’ with continuing supervision provided by asylum staff who moved out with the patients. A process of resettlement rather than rehabilitation. Nevertheless, despite the compromise, outcomes were better than many hoped. A key evaluation of the closure of two asylums carried out by the Team for the assessment of Psychiatric Services (TAPS) showed that only 10% of the discharged patients were back in hospital at 5-year follow-up, very few became homeless (Trieman *et al.* 1999) and the majority had further improved skills of daily living and enriched social lives (Leff & Trieman, 2000).

The closure of the asylum also invigorated normalisation beliefs in which most people suffering from mental health problems would be able to live independently in the community, availing themselves of all the opportunities for daily living and needing contact with mental health services only in acute, relatively circumscribed episodes. Future supported living, if needed at all, should be a temporary step on a pathway to independence. Policy documents eschewed the use of terms such as ‘long-stay’, ‘rehabilitation’ and ‘continuing care’. The 1999 National Service Framework in England (DoH, 1999), for example, supported the introduction of new teams focused on early intervention, crisis care and assertive outreach, all geared towards preventing and managing acute crises and minimising chronicity. At the same time, over half of the existing mental health rehabilitation services that had followed the asylum closure programme were disinvested, rebadged, or reconfigured to supply the workforce for these new teams (Mountain *et al.* 2009). But contrary to expectations, the new services did not prevent the emergence of chronic disability. As many as 15% of people with a first episode psychosis treated by the new early intervention teams remained chronically disabled (Craig *et al.* 2004). Community mental health services struggled to meet the needs of people suffering from complex co-morbidities of psychosis with substance abuse, intellectual disability and physical ill health which although making up a modest fraction of caseloads, consumed as much as 50% of mental health and social care budgets (Killaspy, 2014). So instead of reducing over time, specialist housing for the mentally ill has actually increased. By 2014, it was estimated that more than 60 000 people in England lived in some form of supported accommodation ranging from nursing and residential care with 24 h staffing, through supported accommodation with staff visiting or on site. The number of residential care beds is now at the highest level it has been since 1972 (Sutaria *et al.* 2017), much of these provided by independent sector for-profit organisations and in forensic locked long-stay units located miles away from the patient’s usual home. This sort of ‘trans-institutionalisation’ has been reported across Europe (Priebe *et al.* 2005). There are also rising numbers of people with mental health problems in prison. One report from the USA in 2014 estimated that just 5% of all incarcerated mentally ill people were in mental hospitals and 95% in penal institutions (Bark, 2014).

Where are we now?

The tension between a focus on putting right individual deficits of illness *v.* one that emphasises the importance of choice and a less paternalistic more empowering approach to daily living continues to the present. The latter is most clearly manifest in the principles

of personal recovery seen as learning to live well, to gain hope, meaning and purpose to life despite continuing mental health problems (e.g. Slade, 2009). The tension is reflected in current rehabilitation practice in respect of supported housing and employment and in the promotion of better personal relationships.

A decent place to live

The resurgence of institutions is disappointing because it flies in the face of the rehabilitation ideal that service users should live in familiar locations close to amenities, friends and family. This is echoed by most service users who say they wish to live independently in their own home supported if needed by visiting staff (Richter & Hoffmann, 2017a). Instead we hang on to the model of rehabilitation we used for closing the mental hospital, following a ‘stairs and landings’ approach in which the user makes a slow progress towards ever lower levels of support and has little personal choice as to where he lives. In fact, progress can seem quite arbitrary as some housing providers insist on move-on every 3 years even if this is only a sideways move to identical provision. A recent survey in England examined the characteristics of three types of provision of supported housing – residential care, supported housing (typically group homes) and ‘floating outreach’ (independent tenancies with visiting support). As might be expected, residential care catered for those with the most needs and was the most expensive, and floating outreach had fewer severely needy residents and was the least costly. There was a gradient in terms of community integration with residential care the least integrated. Service users in all three accommodation types were satisfied with the care they received. But there was also a gradient in quality of life, which was highest in residential and supported housing reflecting the fact that greater community exposure also went with increased risks to personal safety (Killaspy *et al.* 2016).

However, given that few service users have real choice in the accommodation provided, the lack of any controlled trial evidence for the benefit of this graded approach (Chilvers *et al.* 2006) and the fact that most service users express a preference for independent living, it has been suggested that we should replace the current ‘train then place’ approach by the opposite – give immediate access to independent housing then provide the support to enable the individual to maintain their tenancy and cope with the challenges of daily living. In the USA and Canada, new programmes focused on homeless populations, many who have complex mental health and substance use disorders, have done just that. In controlled trials, people rehoused in this way maintain their tenancies longer, have fewer returns to street homelessness and report high levels of satisfaction with their accommodation (Stefancic & Tsemberis, 2007; O’Campo *et al.* 2016). While there are no controlled trials of this ‘housing first’ approach specifically targeting people with long-term mental ill health, a handful of descriptive studies suggest that similar outcomes might be achieved (Richter & Hoffmann, 2017b).

While there is a continuing debate as to which approach will turn out to be most cost-effective in the long run, all are agreed that quality is crucial. Studies consistently show that residents prefer to live in safe neighbourhoods, in accommodation of a reasonable standard, close to community resources (Kirsh *et al.* 2009). They wish visiting staff to be respectful, to offer real choice and to provide a person-centred care (Kirsh *et al.* 2009; Andvig & Hummelvoll, 2015; Brolin *et al.* 2015). Many also express a desire for a longer term relationship with their support worker who

understands their needs and helps to provide a stable supportive atmosphere (Browne *et al.* 2008; Kirsh *et al.* 2009). Ensuring quality is one of the most important demands of leadership in rehabilitation, just as important today as it was in the time of Wing & Brown (1970) seminal studies of the asylum.

Personal relationships

There is no aspect of rehabilitation psychiatry that is not profoundly determined by personal relationships be that between service user and their therapists, support workers, families, peers and the myriad of other more passing acquaintances in the communities in which they spend their life. Given this, it should follow that a great deal of rehabilitation effort should focus on relationships. The obvious starting point is the quality of the service user–therapist interaction, ensuring treatment is both technically correct but delivered by staff who are respectful, compassionate and capable of maintaining hope (Slade, 2009). There is a place for ‘bio-psycho’ treatments such as social skills training and psychoeducation/family work (e.g. Pharoah *et al.* 2010). But it also means stepping outside the therapy framework to promote opportunities for social relationships regardless of the success or otherwise of psychological interventions.

Early champions of deinstitutionalisation hoped that discharge to the community would result in more social inclusion. But stigma and discrimination continue to be a major obstacle. The community has no particular reason to care and many reasons to make access to employment and leisure facilities difficult. In the early phases of deinstitutionalisation, day care centres provided some focus for social interaction but were heavily criticised because they maintained practices of segregation. Unfortunately, when they were closed, no successful alternative replaced them and many service users felt abandoned. A survey of intimate relationships and friendship among people with a diagnosis of schizophrenia found that almost all friendships were with people who also suffered from mental health problems or were informal carers of someone who had. The archetypical aloof, socially inept sufferers were present, but by far the dominant themes were of loneliness and a desire for company (Harley *et al.* 2011). This study highlighted the fact that service users value the support from peers who like them, have lived experience of mental health problems. Support from peers, either found personally or through participation in Recovery College or Clubhouse type programmes, is widely promoted as one way to meet this need. While the majority of studies may be too small to draw finite conclusions (Lloyd-Evans *et al.* 2014), several point to the value of shared experiences particularly with peers who have found a meaningful life despite ongoing disability. Peer support has been claimed to increase community integration and social functioning and to increase subjective empowerment, hope and recovery (Yanos *et al.* 2001; Cook *et al.* 2012). Some studies have also reported benefit in terms of reduced rehospitalisation (e.g. Min *et al.* 2007). As awareness of the benefits have grown, health care organisations around the world have adopted and funded peer support in some cases going so far as to employ service users to deliver specific aspects of care (Bradstreet & Pratt, 2010; Faulkner & Basset, 2012).

Something to do

The importance of occupation to recovery can be traced to the very earliest writings on psychiatric rehabilitation. By the late 1960s, most hospital asylums had ‘industrial therapy’ units that

provided a range of manual occupations aimed at preparing residents for work in factories and shops outside hospital. When the asylums closed, some of these units survived as sheltered workshops that later morphed into social firms in which most of the workforce were people with long-term mental disorders but who were paid the going rate for the job. Early attempts at vocational rehabilitation followed a ‘train then place’ approach on the assumption that service users had deficits needing to be addressed before job placement could be attempted. In practice, despite considerable effort, these work-readiness interventions helped only very few into employment and all were reliant on financial subsidy. In the 1980s approaches such as Individual Placement and Support (IPS) dispensed with job preparation going straight to helping the service user find a job that pays at least the minimum wage and is available on the open market. Once secured, training and support is provided to the employee and employer (Drake *et al.* 2012). This approach requires staff who are willing to leave the comfort of the clinic and set about providing the employee and employer support to maintain employment. There are now several international randomised trials providing positive evidence for the success of in terms of cost-effectiveness, job performance and good personal outcomes including fewer hospital admissions (e.g. Modini *et al.* 2016).

Although there is a pleasing amount of evidence in support of IPS, any implementation is influenced by the state of the local economy and by obstacles such as the ‘welfare trap’ whereby people may lose benefit payments when they move into employment (Boardman & Rinaldi, 2013). Clinical staff often express fears that open employment will precipitate relapse. Although these fears are unfounded, it is true that the approach is not right for everyone. As many as 50% of service users who attempt IPS will not manage the demands of employment because of cognitive impairments such as those that are present in people suffering from schizophrenia. Studies are underway in which interventions to address these impairments are provided. In one randomised trial, service users in a supported employment (SE) programme were randomised to receive cognitive remediation (CR) or SE alone. Those who received the CR were much more likely to sustain work, have more jobs, work more hours and earn more than service users who had SE alone (McGurk *et al.* 2007). Similar findings have been reported for combinations of CR and other aspects of psychosocial rehabilitation (Wykes *et al.* 2011). A possible example where the train then place model still applies. But even if successful, CR and IPS are not sufficient. There will always be some people who will benefit from alternative models of occupation – including traditional SE. Here as in all aspects of rehabilitation, the balance between therapy and social care provision is a key.

Conclusions

Rehabilitation services that balance all elements of the biopsychosocial model are as needed today as they were at the height of the closure of the hospital asylum. A great deal of doing rehabilitation involves actions to modify environments – for example, assistance with personal care, domestic chores, grocery shopping and so forth. The aim may be to enable service users to perform these self-care tasks themselves but experience tells us that all too often these goals of self-management are abandoned because it is easier or quicker for the carer to do and in so doing to institutionalise. Support risks dependency but long-term relationships are key to recovery. Empowerment involves letting the individual

make potentially risky decisions, but staff will be clobbered if the risk is manifest in anything greater than a trivial mishap and personal recovery is sometimes misunderstood or misused as a justification for withdrawal of care. The only protection against these unintended consequences is clear leadership from the top, a shared understanding by all members of the rehabilitation team and their managers of the goals and procedures of rehabilitation and regular audit of the quality of environments and standards of care against national benchmarks (e.g. Killaspy *et al.* 2012).

While the principles of rehabilitation apply across modern mental health services, they continue to be best expressed in specialist rehabilitation teams that take a genuinely whole systems approach, delivering integrated biological, psychological and social interventions with a clear focus on improving function and quality of life in an atmosphere of hope and empowerment (Killaspy *et al.* 2005). Proper attention to social outcomes is a key to rehabilitation and arguably, the outcomes most valued by service users and their families.

Acknowledgement. None.

Financial support. None.

Conflict of Interest. None.

Funding. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

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