

What is psychiatric rehabilitation?

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Rehabilitation has been defined by the World Health Organization as the application of measures aimed at reducing the impact of disabling and handicapping conditions and enabling disabled people to achieve social integration (World Health Organization, 1980). Implicit in this definition are two components. First, an active process through which a person adapts or acquires the skills needed to mitigate the constraints of disease, and second, an acknowledgement that there may also need to be changes in the environment, including the attitudes of non-disabled people, if optimal social integration is to be achieved.

For Anthony, product champion of psychiatric rehabilitation in the USA, rehabilitation involves ‘improving the psychiatrically disturbed person’s capabilities and competence’ by bringing about ‘behavioural improvement in their environment of need’ (Anthony *et al*, 1984: p. 140). In subtle contrast Bennett (1978), whose views have strongly influenced UK practice, emphasised helping the individual adapt to their deficits in personal skills by ‘making best use of his residual abilities in order to function in as normal environment as possible’.

Psychiatric rehabilitation is frequently defined as the activity of a set of specialist services. An alternative formulation would be in terms of the needs or characteristics of people who would benefit from rehabilitation interventions. Wykes & Holloway (2000) defined the potential client group as ‘people with severe and long-term mental illnesses who have both active symptomatology and impaired social functioning as a consequence of their mental illness’. From this definition they argued that rehabilitation services should have the joint aims of minimising the symptoms of illness and promoting social inclusion.

In contrast to the concept of social inclusion, rehabilitation is deeply unfashionable and the term does not appear in any of the many mental health policy documents produced in the UK over recent years. Although the majority of mental health services in England have one or more dedicated rehabilitation in-patient unit and community team (Killaspy *et al*, 2005), the development of specialist rehabilitation services is very patchy.

Box 1.1 Simon's journey into a rehabilitation service

Simon is in his early 40s. He has had a diagnosis of schizophrenia for 15 years. He has been hospitalised five times, being compulsorily detained three times. A prominent feature of his illness is his unshakeable conviction that he is under constant surveillance by a government organisation. He believes he is followed wherever he goes and frequently sees people whom he believes to be these agents on the street and in local shops. Partly through fearfulness and partly through apathy, he spends most of his time alone in his flat. He takes no interest in his appearance or hygiene and has serious problems managing the upkeep of his flat, on which he owes a considerable amount of unpaid rent. He has not worked for many years. The view of some clinicians is that his is a pretty hopeless case. In the course of the long illness, he has received all the usual (and some not so usual) pharmacological and available psychosocial interventions, to apparently little effect.

Simon's view is just as bleak, if not more so. In the past 10 years he has had two consultant psychiatrists, whom he has seen mostly during his spells in hospital, and a string of trainee psychiatrists, seen fleetingly in an out-patient clinic. His main contact has been with a community psychiatric nurse but she moved away just as he was beginning to believe someone might have had his interests at heart. Conversations with mental health staff have mainly concerned medication or been disapproving of his lifestyle. He has picked up the air of hopelessness that surrounds his case, noticing that the enthusiastic promises of new treatments and new referrals (in which he had little faith anyway) have long since dropped away. Having been out of unemployment for many years, he does not believe that he is employable or, indeed, able to work and cannot see the point of attending a day centre to mingle with strangers or to work without reward. He feels quite powerless to do anything himself and has come to the view that there is little anyone else can do for him.

Following the psychiatric hospital closure programme, there is also now a much larger de facto system of continuing care within generic mental health and social care services: a 'virtual asylum'. Typically the contemporary pathway to a rehabilitation service involves many years of illness and disability (see Simon's story, related in Box 1). By this time the individual, their family and the supporting services at best will have low expectations and at worst may have lost hope altogether.

It is against this background of mutual hopelessness and mistrust that many specialist rehabilitation services come into play. And yet, it is the common experience of every professional with an interest in rehabilitation that such apparently intractable situations can be turned around to a surprising degree. The ingredients for this success are:

- the development of a culture of empowerment, healing and hope
- the provision of interventions to limit the impact of disability
- making adjustments to the environment that ease the burden of handicap.

This chapter will provide a brief and critical outline of how these three key ingredients can be provided; specific elements of the rehabilitation process are described in more detail throughout this book. The ‘what is rehabilitation?’ of the chapter title is clarified by answering ‘how can we best carry out rehabilitation?’. Throughout the chapter the focus is on rehabilitation services. It is important to emphasise that the task of rehabilitation can, of course, be undertaken in a wide range of alternative services and settings, or indeed in no particular setting at all. To an important extent rehabilitation is as much an approach or attitude of mind as it is a treatment technology.

Promoting a culture of healing and instilling hope

Rediscovering recovery

Long before the discovery of effective medical and psychological treatments for psychosis it was known that better outcomes could be obtained if people were treated with respect and dignity and in settings that emphasised collaboration between staff and patients. This understanding was seen in the moral treatment provided in the best early 19th-century asylums and in the social psychiatry revolution of the 1950s. It has re-emerged in the current ‘recovery’ paradigm, which has its origins in the consumer/ex-patient empowerment movement (see Roberts & Wolfson, Chapter 2, this volume). In this latest formulation, a distinction is drawn between the technologies of rehabilitation and the process of recovery: ‘the lived or real life experience of persons as they accept and overcome the challenge of the disability’ (Deegan, 1988: p. 11). This recovery process is understood to be unique to the individual. In large part it is the discovery of a purpose and meaning to life. It calls for active involvement in daily life, the assumption of personal responsibility, the exercise of choice and a degree of risk-taking. The individual may find purpose and meaning through work, in personal relationships or even through political action or advocacy on behalf of others. Importantly, there is no assumption of ‘cure’ in the sense of entirely escaping symptoms or impairments; instead, the emphasis is on achieving a fulfilling existence despite enduring disability.

From a service delivery perspective, these ideas emphasise the critical importance of collaboration in therapy, of choice rather than coercion, positive reinforcement of success rather than punishment for failure and a shared involvement with professionals in how the service is provided. From a staff perspective, this is the difference between viewing a patient as a person who happens to have schizophrenia and labelling him or her ‘a schizophrenic’. This is a subtle but important distinction as it opens the door for conversations about what might be attempted or achieved despite the diagnosis or such and such symptom or experience. This focus and emphasis on the possibility of success rather than of failure,

looking forward rather than back and making much of small steps are the ingredients of hope that in turn fuel self-esteem and self-respect.

Empowerment

In addition to instilling hope, a core task of psychiatric rehabilitation is empowerment. Empowerment is both something provided externally by the way services are structured and an internal psychological state of self-worth, self-confidence and courage to take calculated risks and to take responsibility for them. In terms of how services are structured, empowerment is facilitated both by ensuring that therapeutic interventions are collaborative, negotiated and their purpose transparent and by encouraging people with mental illnesses to take more personal responsibility for setting goals, working to achieve these and making decisions.

Much of what is involved in recovery is the business of picking up lost social roles – as tenant, employee, friend and so forth. In this respect, dependency is not an entirely bad word. It is typically the starting point of recovery, although it is not without risks, both in terms of being let down by those on whom the individual depends and in sapping initiative and self-directed action. In the recovery model, the aim is to move from dependency towards progressively more personal responsibility for choices and goals and their associated risks.

Principles into practice

In the case of someone entering a typical rehabilitation service, changes in the person's experience might begin the moment he (or she) is admitted to the unit. Instead of a frantic acute ward here is a relaxed, even-paced setting with a clear purpose to the day. Staff are interested in him as a person, his views are taken seriously and therapeutic arrangements occur when they are scheduled. He is expected to contribute to the life of the unit and it is clear that his contribution is valued and matters. Although he may not be entirely convinced that treatment is likely to be helpful, he might be pleased none the less that its purpose is explained and it is delivered at a pace that he can manage. During the course of his stay his experiences are listened to seriously and as much, if not more, attention is paid to the successes in his life than to the consequences of his illness. It is within this context that technical interventions that may have been tried and failed in the past may now succeed.

Limiting disability: processes and services

Impairment, disability and handicap

The recovery paradigm within mental health services is fashionable. Much less fashionable is an analysis of the complex effects of mental illness on the individual. It is helpful in understanding these effects to make a distinction

between impairment, disability and handicap. In the context of severe mental illness, impairments comprise the positive and negative affective and cognitive symptoms of the illness (e.g. distressing auditory hallucinations, social withdrawal, depression and impaired concentration, all commonly experienced by someone with schizophrenia). Disabilities are the difficulties an individual experiences in performing everyday tasks (e.g. shopping, cooking and functioning at work) as a result of impairment. Handicap is the disadvantage and exclusion from social roles as a consequent of impairments and disabilities but also of external factors such as stigma, alienation from friends and family, unemployment, homelessness and poverty. (People with severe mental illnesses have also commonly experienced significant social disadvantage before becoming ill.) An additional and important issue is the individual's personal reaction to the impairments, disabilities and social disadvantage they experience as a result of an episode of illness. This often comprises depression and despair or, conversely, denial that there are problems that need to be addressed. Adverse personal reactions can compound and amplify the effects of illness on an individual.

Simon (Box 1.1), for example, suffers severe disabilities in terms of self-care, occupational functioning and social skills as a consequence of the symptomatic and cognitive impairments of his illness. Even if the severity of the symptomatic impairments could be reduced, there would remain much work to do in order to rebuild Simon's self-esteem, confidence and day-to-day coping skills. Handicaps from the illness will already have arisen – perhaps debt, unemployment and alienation of friends and family. Thus, it should come as little surprise that managing symptomatic impairment alone is not enough. The stigma, shabby accommodation and poverty Simon has experienced will erode self-esteem, destroy confidence and promote disability: instilling hope becomes a central requirement for Simon's chances of recovery from his illness.

Vulnerability, stress, coping and competence

Another useful way of conceptualising the focus of psychiatric rehabilitation is to consider the vulnerability–stress–coping–competence model (Anthony & Liberman, 1986). In this model, biological vulnerabilities predispose to illness when the person is exposed to environmental stress (e.g. interpersonal tensions or life events). Even if the biological vulnerability is impervious to intervention, the triggering and maintaining stressors can be mitigated by medication or by interventions that teach skills to cope with arousal or that provide buffering support. Rehabilitation can aim to reduce exposure to stress, to optimise protective factors and to develop living and coping skills.

Organising rehabilitation services

The ideal rehabilitation service provides a comprehensive, continuous, coordinated, collaborative and patient-oriented approach. Interventions

are linked to individualised needs assessments and to the personal goals of patients, each step negotiated and aiming at end-points that are personally meaningful and desired.

A key aspect of effective rehabilitation is the recognition that peoples' behaviour varies substantially from one situation to another. In general, task performance is more stable than social behaviour, and simple skills are more transferable than complex ones. Many of the improvements seen in a narrow rehabilitation setting are transient responses to the particular characteristic of that environment and do not readily transfer or generalise to more complex settings and situations. Therefore, rehabilitation assessment should focus more on an individual's capacities rather than fixed behaviours and should ideally be carried out across a wide spectrum of settings and conditions, in an attempt to work out what may be achieved under optimal conditions and what problems are likely in suboptimal conditions. People should be prepared for the environments in which they will be expected to function, and in general it is better to rehabilitate in the real situation than in the contrived setting of the hospital clinic.

It is also worth distinguishing long-term targets from short-term goals. The former are often couched in fairly broad terms, whereas the latter are the stepping stones to take the person where they want to go. Short-term goals need to be 'SMART' (specific, measurable, achievable, realistic and time-limited) and set in collaboration with the patient, relatives and other relevant people. With these short-term goals in mind specific interventions can then be devised that aim to produce a series of consistent, if modest, achievements backed up by frequent praise, encouragement and support. Watts & Bennett draw attention to the need to avoid setting goals that are unrealistically high or demoralisingly low. It is important to emphasise the individual's positive capacities and achievements, not only for the good this does self-esteem but also as 'the most effective antidote to the paternalistic attitudes that develop when psychiatric services try merely to care for long term patients' (Watts & Bennett, 1991: p. 12).

The judicious combination of pharmacological and psychological treatments is, of course, an essential ingredient of rehabilitation practice. These topics are covered in detail elsewhere in this volume. Here we will just outline important approaches to treatments that will reduce impairment and disability and services that address key areas of handicap, housing and employment.

Minimising impairment and disability

Pharmacological management

The past decade has seen many advances in the pharmacological treatment of severe mental illness (see Sweeting, Chapter 10, this volume). Currently, the vogue is to use the newer atypical antipsychotics. These drugs are as effective, at least in the short term, as traditional treatments, but have

fewer troublesome extrapyramidal side-effects (Davis *et al*, 2003). (The exception is clozapine, which is undoubtedly more effective than other antipsychotics.) The initial enthusiasm with which the atypicals were greeted by many rehabilitation psychiatrists has waned somewhat now that the majority of patients have already received these 'new' drugs before their first contact with rehabilitation services.

We have also seen the emergence of longer-term side-effects of atypical antipsychotics with protracted use. Of these, weight gain is probably the feature of most concern to patients. It is difficult to predict for the individual but sadly it is associated with a younger age and a good clinical response to treatment (Jones *et al*, 2001). The prevalence of diabetes in people with schizophrenia is almost twice that in the general population and may be further increased by some antipsychotic drugs (Baptista *et al*, 2002). These caveats aside, there is clearly an important role for the expert management of psychotropic medication in severe and enduring mental illness, not only for the control of symptoms but also for the management of co-occurring depression and cognitive impairment.

Cognitive-behavioural interventions

Cognitive-behavioural interventions have wide applicability for enduring mental illness (see Turkington & Arjundas, Chapter 12, this volume). For schizophrenia, for example, their main aim is to reduce distress and disability, and to help patients develop an understanding of their illness (Fowler *et al*, 1995). Individuals are encouraged to re-evaluate their beliefs through a gradual process of reviewing the evidence and constructing alternative explanations and to identify and manipulate factors that contribute to symptom maintenance. The therapist works collaboratively, taking an active enquiring stance towards the patient's account of their experiences. Direct confrontation of delusions is avoided, as this has been shown to be counterproductive. Moderately severe thought disorder can be tackled by disentangling the most emotionally relevant themes and helping the individual focus on these using thought-linkage techniques. The therapist encourages the patient to develop and use a variety of coping strategies, including anxiety management, activity scheduling and attention control, to reduce the occurrence and duration of hallucinations and of distressing experiences of anxiety or suspiciousness (Tarrier, 1992). An impressive number of randomised controlled trials have now been carried out, from which it appears that the approach reduces both positive symptoms and the risk of relapse (Pilling *et al*, 2002a).

Family interventions

In the UK, there has been a long-standing interest in the effect of the family environment on major mental illness. This has led to the development of family interventions of established efficacy in terms of preventing relapse and readmission and increasing adherence to pharmacological treatment.

It appears that interventions carried out with a single family at a time have superior outcomes at 1–2 years than those delivered to several families together (Pilling *et al*, 2002a), regardless of whether the single-family interventions are based explicitly on a behavioural model or on more systemically oriented approaches. By and large, later studies have produced less positive results than the earliest investigations, possibly because the early studies were led by charismatic enthusiasts (Mari & Streiner, 1994) or there has been increasing use of the less-potent delivery of the interventions to groups of families (Pilling *et al*, 2002a). It remains a challenge for family interventions to put this research into routine clinical practice (see Fadden, Chapter 11, this volume).

Skills training

Interventions aimed at correcting deficits in daily living skills such as poor personal hygiene, problems managing the home or dealing with finances are ubiquitous in rehabilitation practice, forming the basis for the daily work of nurses and occupational therapists in most if not all services. Many of these interventions involve simple advice, coaching and modelling. The more elaborate schemes draw on operant conditioning theory. In the most elaborate but now largely defunct approach, programmes were developed in which patients collected tangible rewards ('tokens') for performing desired behaviours. These were hugely complex programmes that were very difficult to implement and have proven untenable outside of very specialised settings. Furthermore, the skills acquired in the hospital or clinic often failed to generalise to daily living situations, and the latter had far more complexity than could be managed by a simple contingency-based reward system.

One skills training approach with a well-developed research base is the modular programme developed by Liberman and his colleagues at the UCLA Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation in Los Angeles, California. This behavioural programme teaches a variety of skills, including medication self-management, basic conversation skills, grooming and self-care, job-finding and interpersonal problem-solving. A broad range of interventions are employed, including videotaped demonstrations, role-play, exercises in real situations and homework practice (Wallace *et al*, 1985). Numerous clinical trials have shown benefits over standard care in terms of improved conversational skills, assertiveness and medication management (Heinssen *et al*, 2000). These methods have been successfully employed with patients on acute wards, individuals with residual symptoms and individuals with severe and persistent illness. Not surprisingly, given the focus on specific social behaviours, social skills training has only modest impact on symptoms, relapse and hospitalisation. Some studies have found no significant advantage over more traditional occupational therapy or group-based supportive psychotherapy. Evidence on the extent to which new skills learnt in specific programmes generalise

across settings or fade with time is sparse, although what there is points to a severe problem in generalisation from the classroom to real life. Some research indicates a benefit of including 'top-up' sessions and of carrying out some training away from the initial treatment setting (Eckman *et al*, 1992).

These formal programmes have proven much less popular in Europe than in the USA. A meta-analysis of randomised controlled trials of skills training found no consistent evidence for any benefit on relapse rate, global adjustment, social functioning or quality of life (Pilling *et al*, 2002b). There is, however, little reason to expect that an intervention aimed at improving self-care should have any effect on the incidence of relapse or rehospitalisation. Perhaps the prevailing view in the UK reflects a more widespread shift in recent years towards the cognitive end of the cognitive-behavioural spectrum of psychological interventions. Whatever the reason, it is striking that the interventions that comprise so much of nursing, occupational therapy and psychological practice in rehabilitation settings is so underresearched in the UK.

Cognitive remediation

Cognitive impairment in schizophrenia predicts poor rehabilitation outcomes. It is therefore an appealing thought that the remediation of the impairments of memory and executive function commonly seen in people with severe mental illnesses might facilitate skills training and contribute to improved social functioning (see Wykes, Chapter 14, this volume). Cognitive remediation seeks to retrain and improve processes of memory, attention and speed of information processing using a variety of 'exercise' programmes that were originally developed for neurological rehabilitation (after head injury or stroke, for example). In a study Wykes *et al* (1999) randomised individuals with chronic schizophrenia who had documented cognitive impairment to intensive cognitive remediation or to an 'intensive occupational therapy' control condition. Those receiving the intensive cognitive remediation attended for individual, daily, 1 h sessions that focused on executive functioning deficits (cognitive flexibility, working memory and planning). Some improvement in cognitive function was seen with both therapies, but a differential effect in favour of cognitive remediation was found for tests of cognitive flexibility and memory. Social functioning also tended to improve in those whose cognitive flexibility scores improved with treatment.

Benefits achieved in research settings do not necessarily transfer easily to routine care. An attempt was subsequently made to introduce cognitive remediation as a routine intervention within a rehabilitation team. A total of 23 staff received training but of these 13 subsequently moved to new jobs where it is unlikely that their cognitive remediation skills were used. Of the 16 clients who had been identified as suitable for cognitive remediation only 5 were willing and able to participate and only 2 completed the course, one

of whom was thought to have benefited substantially (Cupitt *et al*, 2004). In routine practice it would appear that many staff and clients find the course too demanding and would rather be doing something else.

Addressing handicap

A home of one's own?

Throughout the 1970s and early 1980s, rehabilitation came to be regarded as synonymous with resettlement of the long-stay hospital population. This narrow view was rightly criticised at the time, not least because of the danger that once resettled, the job of rehabilitation might be seen to be over. A range of accommodation options, from highly staffed residential homes to independent flats with visiting support, forms an essential ingredient of any modern psychiatric service (see Wolfson, Chapter 17, this volume). However, there is surprisingly little research into the relative benefits of different configurations of housing and support.

Perhaps the best-known British research was carried out into the closure of Friern Hospital (the former Colney Hatch Asylum) in North London and re-provision for its patients (for a summary of the main findings see Leff, 1997). Most of the former in-patients were placed in group homes with shared facilities. These settings were less regimented and restrictive than the hospital and were preferred by patients to the hospital ward. Living in the community had some advantages: low rehospitalisation rates and, for some, the opportunity to develop friendships with ordinary members of the public. Although individuals showed large fluctuations in symptoms over the follow-up, there was no overall change in psychiatric state for the whole sample and behavioural problems also remained stable. There was little difference in cost between hospital and community care once account was taken of the few patients with particularly challenging behaviours who could not be immediately discharged to the community.

Comparable outcomes of hospital closure programmes have been reported both elsewhere in Britain and internationally (for a comprehensive review see Fakhoury & Priebe, 2002)). The number of residents living in such shared accommodation has risen substantially in the past decade, in line with Europe-wide trends in psychiatric care (Priebe *et al*, 2005). Thus, the hospital asylum has come to be replaced by a 'virtual asylum' comprising a patchwork of residential and nursing home care, long-stay hospital accommodation and private-sector medium and low secure services (Holloway, 2004). These at best replace the asylum ward with more 'homely' environments but at worst substitute one order of neglect with another (Geller, 2000).

An alternative model might rely more on a partnership between the providers of ordinary public housing and mental health services, the latter coordinating and providing a range of training and treatment. Such 'mobile support' models are preferred by service users and carers (Carling,

1993). But this is not to say that such an approach guarantees a better outcome.

The default approach is not to provide continuing monitoring and care through a specialist rehabilitation service; rather, it is to leave the case management to already overstretched generic community teams or to inexperienced housing support workers who may have little appreciation of the complexity of severe mental illness. Without close attention there are real risks of neglect, abuse and institutionalisation in these settings (Carling, 1995).

No substantial evaluations of the mobile support model have been carried out in the UK. Limited evidence is available from the USA. In one thought-provoking study Susser *et al* (1997) randomised 96 homeless mentally ill men who were being rehoused to receive either 9 months of a 'critical time' service (comprising intensive case management, including tenancy support) or care as usual. At 18-month follow-up, the average number of homeless nights was 30 for the 'critical time' group and 91 for the group receiving usual services. Overall costs of care were similar in both groups (Jones *et al*, 2003). Attempts have also been made to implement and evaluate city-wide programmes. One such effort was sponsored by the Robert Wood Johnson Foundation and the US Department of Housing and Urban Development. This brought together housing and health authorities in nine US cities to provide and evaluate a comprehensive system of housing subsidy and mobile support for people with severe mental illnesses. The success of this programme varied widely from city to city, with some benefits in terms of quality of life but no substantial effect on clinical outcomes or rehospitalisation (Goldman *et al*, 1994). Social isolation and the lack of recreational opportunities were frequently cited problems in these programmes, any expansion in social contacts often being confined to health professionals and fellow residents (Friedrich *et al*, 1999).

A job to do

The importance of meaningful occupation and employment to recovery has been recognised since the dawn of 'moral treatment' (see Boardman & Robinson, Chapter 19, this volume). Shockingly, employment rates for people with severe mental illnesses in the UK are far lower now than in the 1950s (Marwaha & Johnson, 2004). There are many reasons for this, not least the profound changes in the nature of available work and the performance demands made on employees and employers in the modern economy. Mental health professionals may tend to overestimate the negative impact of employment on mental health and to underestimate their clients' capacity (Secker *et al*, 2001). Negative symptoms of schizophrenia, poor social skills and neuropsychological impairments have all been shown to impair performance at work. Medication side-effects can also be problematic: sedation can be a particular difficulty, although this is less of an issue in contemporary practice, where high-dose regimens are avoided.

The earliest models in the post-asylum era in the UK involved the transfer of the industrial therapy units and work crews into smaller, community-based offices on the high street that provided part-time poorly paid or unpaid occupation. Movement from these 'sheltered workshops' to competitive employment in the open labour market was rare and the model has fallen out of favour, although the risks of dependency and institutionalisation can be minimised by an emphasis on market orientation, employee involvement and regularly reviewed action plans. The better sheltered workshop still has a limited part to play in modern rehabilitation services for people with the most severe disabilities, who would not be accepted in any more open setting (O'Flynn & Craig, 2001).

One development of the sheltered workshop theme worth mentioning is the 'clubhouse' model. This emerged in America in the 1950s as a setting for support and preparation for employment. Clubhouse members are expected to participate in all aspects of the organisation, sharing responsibility with staff for maintaining the building, preparing meals, working in the office and greeting visitors. Following a period of pre-vocational training, employment placements are arranged in a variety of temporary jobs with mainstream employers, the employment contract being held by the clubhouse organisation and shared between members (Beard *et al*, 1982). The model has been criticised on the grounds that pre-vocational training is of limited value and that the shared job placements are largely limited to unskilled, low-grade positions (Bond *et al*, 1997).

Clubhouse and more traditional sheltered employment schemes have been overtaken in popularity by approaches that support people in finding and retaining ordinary 'open' employment. In Europe, many of the sheltered workshops have evolved or transformed into 'social firms' – small market-oriented business ventures that are run by and/or employ significant numbers of disabled people. There is some evidence for their commercial viability, high user satisfaction and reduced use of mental health services (Grove & Drurie, 1999).

In North America there has been considerable interest in programmes in which people with severe mental illnesses are placed and supported in open employment, an approach hailed as the most important development in vocational rehabilitation. Placements may involve a subsidy to the employer or modification of the job to take account of particular needs. The approach achieves high rates of competitive employment without increasing hospitalisation (Bond *et al*, 1997). On the downside, however, job turnover is high, the majority of placements are in low-paid unskilled occupations and a continuing high level of support is essential to job retention. A follow-up of an earlier research programme found that only a quarter of those whose support had terminated at the end of the programme remained in employment, compared with three-quarters of those whose support was maintained over the year (McHugo *et al*, 1998).

There have been several successful programmes in which people with mental illnesses have been employed in front-line caring roles, typically as case managers or case manager aids, both in the USA (Solomon & Draine, 1995; Mowbray *et al*, 1998) and in the UK (Craig *et al*, 2004). Despite these model programmes most services have a poor record in explicitly recruiting people who have mental health problems.

The evaluation of the various models of employment is methodologically difficult as they often involve small schemes with different local circumstances, patient populations and programme details. Nevertheless, there is now a fair amount of evidence available on what works and practice guidelines are beginning to emerge. These essentially boil down to managing the tension between the individual's rehabilitation needs on the one hand and the market-oriented demands of the job on the other. For example, coping strategies such as taking frequent short breaks to maintain concentration or minimise intrusive hallucinations can be problematical in the workplace and viewed poorly by employers (Cook & Razzano, 2000). Also, although a comprehensive assessment of an individual's suitability for a particular post may take several weeks, many employers demand maximum productivity from the outset. Finally, no one model is likely to be sufficient for all rehabilitation needs. Each approach is likely to be helpful to different people at different times in their recovery (O'Flynn & Craig, 2001).

Conclusions

It should be obvious that, although the thrust of this chapter has concerned people with chronic and persistent mental illness, the principles and ingredients of psychiatric rehabilitation are just as applicable to earlier stages of illness, when they may play an important role in preventing disability. The 2 or 3 years following first onset of severe mental illness have been identified as a critical period for intervention (Birchwood *et al*, 1998). It is during these early years that much damage is done to self-esteem and social networks, and education and employment opportunities may be lost for ever (see Power *et al*, Chapter 9, this volume).

Depression and anxiety are major causes of disability worldwide. The specific interventions for the management of severe neuroses and personality disorder are likely to be rather different from those described in this book, which is devoted to services for people with psychotic illnesses. However, the guiding principles of psychiatric rehabilitation – delivery of goal-directed therapy managed in partnership and provided in real situations in a culture of empowerment and optimism – remain the cornerstone of all branches of mental health care. These principles are therefore appropriate not just to services with a designated 'rehabilitation' label: they are applicable to all mental health services at any stage in an individual's contact with the mental health system.

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