Psychosocial rehabilitation and recovery: exploring the relationship
Susan Pepper
VICSERV

© Psychiatric Disability Services of Victoria (VICSERV) Inc.

Evidence from outcome studies shows that psychosocial rehabilitation services play a crucial role in the mix of services available to people living with a psychiatric disability, as they undertake their individual journeys to recovery. There is a growing understanding and appreciation of the specific contribution made by particular types of services, as well as the need for a variety of services for people who need them.

This article looks at some of the research evidence to answer the questions: does participation in a psychosocial rehabilitation program make a difference to recovery rates, to relapse prevention, to keeping people well?

Limitations of this paper
One writer (Iyer et al 2005) comments that “the outcome literature on psychiatric rehabilitation is voluminous.” With that in mind, I make no assertion that this literature review is comprehensive, but I have included articles from current scholarly publications. There are reports of several research projects, small and large, as examples of the type of research which is being undertaken. I have also included the results of three meta-analyses of the literature with the same or a similar focus (Commonwealth of Pennsylvania 1999; Bustillo et al 2001; Barton 1999). Unfortunately, none of the research projects described is Australian.

Recovery is possible
Underlying this article is the assumption that recovery from mental illness is possible. Courtenay Harding (2000) has analysed ten long term studies into recovery from mental illness, some spanning two to three decades, from around the world. In the summary of her finding she says

> Each [study] provides significant evidence confirming the wide heterogeneity of outcome, and each finds that approximately one-half to two-thirds of people with schizophrenia can achieve a state of significant improvement or even recovery. (p 20-21)

The term ‘recovery’ is used in varying ways, however there is a broad consensus about its meaning, and the domain it describes. Dun and Fossey (2002 p45) have written “the concept of recovery . . . draws strongly from consumers’ first-hand accounts, in which recovering is seen as a deeply personal process of adapting and overcoming the challenge of psychiatric disability to live a satisfying, and hopeful life.”

Iyer (2005 p 43) writes “Recovery means overcoming the functional disabilities of severe mental illness and achieving the best possible quality of life.”

What is Psychosocial Rehabilitation?
The terms ‘psychosocial rehabilitation’ and ‘psychiatric rehabilitation’ are also used variously. The Psychiatric Disability Support Standards published by the Victorian Government (2000) define psychosocial rehabilitation as involving
the provision of on-going support that assists the person with psychiatric disabilities to experience an improved quality of life, learn or relearn the skills of daily living, participate to their maximum extent in social, recreational, educational and vocational activities and live successfully at an optimal level of independent functioning in the community.

William Anthony of The Centre for Psychiatric Rehabilitation at Boston University writes

*The outcomes of psychiatric rehabilitation are fairly unique and specific relative to other mental health interventions. Psychiatric rehabilitation ultimately attempts to improve role performance or status in people’s living, learning, working, or social environments. While there might be important ancillary outcomes (such as symptom reduction, increased skill performance, changes in service utilisation) the goals of psychiatric rehabilitation services are changes in role performance.* (Anthony et al 2002 p49-50)

Describing the work of Psychiatric Disability Rehabilitation and Support agencies in Victoria, Denise Wissmann (2005) said

*We help people to learn to accept their mental illness, to learn to live with it, to learn the skills to cope with it and to gain a picture of themselves as valid and valued outside their diagnosis. We do this through: the development of a crucial therapeutic relationship, which workers develop with clients; the provision of a safe place to be - in terms of our day programs and residential programs; peer support where people can be with other consumers who have also gone through the same process; personal development programs; and skills development.*

How psychosocial rehabilitation is delivered varies greatly, and the literature reviewed included a wide range of programs and approaches to psychosocial rehabilitation. For example, in one program (Baker et al 1999) participants had to attend a centre five days a week for six hours, with optional attendance at the weekends. In another, the program consisted of around 20 sessions with a worker spread over twelve months (van Busschbach & Wiersma 2002). Some programs focussed on living skills, while others focussed on employment or housing.

Many factors affect the design and delivery of the programs, including the influence of the existing mental health system as well as budgetary and philosophical considerations. There is also a wide variety of ways in which programs are implemented, and this raises the issue of identifying the qualities that make a difference. What are they, and how are these embedded in the philosophy and practice of service delivery?

**Outcomes**

When we are talking about outcomes what do we mean? How do we measure them? In a comprehensive article Iyer (2005) discusses many of the issues - what is being measured, and how? Three underlying factors are identified: firstly, the “pervasiveness of mental illness”, meaning that the effects of mental illness can affect an individual in many ways; secondly, the “heterogeneity of mental illness” - that people have different symptoms, different abilities and disabilities, different responses to interventions, and indeed are offered or given varying interventions. Thirdly, the complex nature of psychiatric rehabilitation - the variety of settings, of programs, of input, stakeholders and so on.
Is relapse prevention a sufficient outcome or should the measure be recovery? Debra Rickwood (2004) found, during a consultation process with consumers and carers, that relapse and relapse prevention were ill-defined terms, often with negative associations.

*Within the medical literature, relapse prevention generally refers to illness management through compliance with medication regimes* (p 11).

*Beyond awareness of early warning signs and complying with medications there was, however, no clear view regarding what else relapse prevention might entail* (p 12).

So with many open-ended questions, what does the literature tell us about the effectiveness of psychosocial rehabilitation?

**THE STUDIES**

The projects vary greatly in the way in which psychosocial rehabilitation programs were delivered, the number of people involved, and the time frame within which the research was undertaken. The larger scale programs described involved hundreds of people, as statewide programs were developed to replace the long stay, and usually large, psychiatric institutions. Other research projects involved groups of under 100 people, and some as few as 35 people.

The descriptions focus on programs that have several components - housing support, living skills, and so on, rather than being evaluations of individual programs such as supported employment services alone.

1. **Maine-Vermont Longitudinal Comparison Study, USA**
   (Harding 2000)
   Conducted over 32 - 36 years, the Maine-Vermont Longitudinal Comparison Study is the study undertaken over the longest period reported in the literature, and is possibly the longest study in the field ever undertaken. It tracked the differences in outcome between people with a psychiatric history in two American states, Vermont and Maine. The major difference in the experience of the two groups was that in one state, Vermont, the participants “had been part of a comprehensive model rehabilitation demonstration program, [while] the Maine patients had experienced traditional custodial care.” (Harding 2000 p. 33)

   In her results Harding (2000 p 33) reported three very strong findings. The people who had received rehabilitation had both much stronger community and work functioning, as well as substantially reduced symptoms.

2. **Statewide program in South Carolina USA**
   (Curlee M, Connery J & Soltys S 2001)
   This paper reviews the coordinated development of a statewide psychosocial rehabilitation system to support the deinstitutionalization of long-term psychiatric patients from South Carolina Hospital.

   The new community based program, called Towards Local Care or TLC was established between 1993 and 2000. It followed the outcomes for 558 people with a mental illness who were discharged from hospital and settled into community accommodation. The program aimed to develop community psychosocial rehabilitation programs and supported community housing before people were moved out of a hospital setting.
The results are impressive. Eight years after the commencement of the program, none of the 558 ex-patients has become homeless, and there is only one in prison. Acute rehospitalisation by the group decreased 89% over the rate before the implementation of the program. What did the Towards Local Care program do that worked?

Information was obtained on each person’s history, financial status, and discharge living preferences along with a current clinical and functional assessment by hospital and community staff. This data was utilised to formulate the residential options and community psychosocial services necessary for the discharge of these persons. (p 363)

All associated with these projects knew that in order for the TLC psychosocial rehabilitation projects to be successful, the programs would need to be built around supported housing projects which provided the individuals with the right amount of support and supervision to maintain themselves in the community. (p 364)

The ultimate goal was to have all clients living independently alone or with the roommate or family of his or her choice in a private home, apartment, or rooming house. As well as providing appropriate and satisfactory housing, other services available were individual/group therapy, living skills, leisure/recreational activities, educational programming, and vocational training. Case management used an intensive outreach approach.

The authors attribute the effectiveness of the program to several factors, including that each client was carefully evaluated before discharge, and individualised psychosocial programming was provided, based on this information. Another crucial factor they identified was the development of services before the clients were discharged.

3 Center for Individual Rehabilitation and Education, Holland
(van Busschbach & Wiersma, 2002)
In this Dutch study the effectiveness of a rehabilitation intervention program, (based on the Boston University model) was considered. The program was not as extensive as with the South Carolina or Vermont-Maine studies, in that it involved only 35 patients over a twelve month period. The effectiveness of the rehabilitation program was explored using the following questions
• is goal attainment achieved and are clients satisfied?
• are needs of care met and is dependency upon care decreased?
• do quality of life and global functioning improve?

The study relied on interviews with clients before and after a year of rehabilitation. Each client received on average 20 contacts with their rehabilitation worker. The researchers reported that “clients evaluated the rehabilitation intervention as very positive and were highly satisfied with it. They were more satisfied with the rehabilitation intervention than with the care received during the year before” (van Busschbach & Wiersma, 2002 p 65).

Although acknowledging the limitations to the study because of the small number of clients involved, and the naturalistic design, the researchers reported (p 68)

The evaluation of this rehabilitation program indicates that the method was successful in helping the majority of clients achieve their self-chosen goals on important life-domains.
Further, it solved a number of perceived needs and produced a better match between care given and care received.

While symptomatology did not improve, it did not worsen. The researchers also considered the issue of synchronisation of “symptomatological and functional level. In this sense the program was not just a facilitator of change but mobilised a potential: where a person did feel better after some time, his or her level of functioning could be one or more steps behind.”

4 Street dwelling individuals, New York
(Sheren et al 2000)
This study tested a psychiatric rehabilitation approach for organising and delivering services to 91 street dwelling persons with severe mental illness in New York City. Some participants were referred by outreach teams, while others were “recruited directly from the streets of midtown and downtown Manhattan through direct observation by highly trained research interviewers”. A control group was established who were offered information about ‘the existing array of homelessness and speciality mental health services in New York City’ but did not receive access to additional services.

The program offered the participants was that developed by The Center for Psychiatric Rehabilitation at Boston University. “This technology and its underlying values emphasize individual choice, continuity in relationships, and skills development and support to foster achievement of personal goals (Sheren et al 2000, p. 1874).” The program, called Choices, had four features

1. Outreach and engagement, designed to foster the development of rudimentary relationships between the Choices staff and the homeless individuals.

2. Invitation to attend and join the Choices Center, a low-demand environment where desirable resources (eg showers, food) were available for only the experimental study participants from 7am to 7pm daily. Assistance was available to access appropriate services, as well as support in developing individual rehabilitation plans.

3. Respite housing.

4. In-community or on-site rehabilitation services to assist individuals in finding and maintaining community-based housing. (Sheren et al 2000, p. 1874)

Research participants were followed intensively for 24 months by research interviewers. They were tested every six months using measures of service use, quality of life, health, mental health, and social psychological status.

Analysis of the data collected was complicated by “the difficulties of following extremely mobile street-dwelling individuals”. The results looked at the areas of housing status, ability to meet basic needs, quality of life and psychological status. The researchers concluded

that the experimental program was more successful in serving and housing individuals with severe mental illness who lived on the streets than was the standard treatment system in Manhattan. At a minimum, the results indicate that, with an appropriate service model, it is
possible to engage disaffiliated populations, expand their use of human services, and improve their housing conditions, quality of life, and mental health status.

5 **Intensive psychosocial rehabilitation program, Baltimore USA**
(Baker *et al* 1999)
This study examined the outcomes of 44 people, mostly African Americans who participated in an intensive psychosocial rehabilitation program based in a community mental health centre. The research participants were required to attend five days a week, with optional attendance at the social gatherings held on the weekends.

*After receiving a 'full breakfast' the program continued with an hourly schedule of classes that included instruction in personal grooming, housekeeping skills, cooking, office skills, computer skills, adult education topics, and vocational rehabilitation tailored to the specific needs of each participant.* (p 3)

Participants were assessed before participation in the program commenced, after six months, and finally after completion of the program (24 months). The assessment included the length of time the person stayed out of hospital, frequency and depth of social relationships, dysfunction at work, the presence of symptoms, the ability to maintain personal hygiene, and the ability to participate in leisure activities.

The reported results were broken into three groups - people with schizophrenia alone, those with a dual diagnosis of schizophrenia and problematic substance use, and patients with a mood disorder.

Statistical tests indicated a substantial and significant increase in level of functioning over the two years for all groups, and the researchers claimed

*The results provide evidence for the effectiveness of an intensive psychosocial rehabilitation program for urban black patients with chronic psychiatric illness, including those with a dual diagnosis.*

6 **Literature review: Clinical, social and cost-benefits of psychiatric rehabilitation services**
(Commonwealth of Pennsylvania, Dept of Public Welfare 1999)
This review analysed fifteen articles published between 1984 and 1998 that described and evaluated psychosocial programs. Their overall conclusion was that participation in the programs improved ‘functioning’ of the participants.

*The most commonly reported areas of improved functioning with psychosocial rehabilitation were:*

- **improved Global Functioning (5 of 6 studies),**
- **increased Employment (10 of 12 studies),**
- **increased Independent Living (7 of 10 studies),**
- **Social/Community Adjustment (4 of 7 studies),**
- **decreased Use of Community Resources (2 of 2 studies),**
- **decreased Hospital Admission Rates (7 of 9 studies),**
- **decreased Time in the Hospital (11 of 13 studies), and**
- **decreased Mental Health or Societal Costs (9 of 9 studies).**
The authors of this study also identified a range of factors that improved outcomes and provided cost savings.

7 Literature review: The psychosocial treatment of schizophrenia
(Bustillo et al 2001)
This study aimed to “update the randomized controlled trial literature of psychosocial treatments for schizophrenia.” It considered the research results published in 18 articles. As a starting point the writers acknowledged that, although pharmacological interventions have been shown to be effective in the treatment of acute psychosis, on their own they are not enough to prevent relapse.

They considered the research undertaken in five distinct areas: family therapy, assertive community treatment (case management), social skills training, supportive employment programs and cognitive behaviour therapy. They found the various psychosocial interventions effective in addressing specific issues, but that the benefits from one type of intervention were generally not transferable into others areas of a client’s life.

The results of their survey showed

- Family therapy and assertive community treatment have clear effects on the prevention of psychotic relapse and rehospitalization. However these treatments have no consistent effects on other outcome measures (eg pervasive positive and negative symptoms, overall social functioning, and ability to obtain competitive employment).

- Social skills training improves social skills but has no clear effects on relapse prevention, psychopathology, or employment status.

- Supportive employment programs that use the place-and-train model have important effects in obtaining competitive employment.

- Some studies have shown improvement in delusions and hallucinations following cognitive behaviour therapy. (p 163)

They concluded that once stable community living was established for an individual, then “a systematic rehabilitation effort for the majority of persons with schizophrenia is necessary” (p 172).

8 Literature review of outcomes and policy recommendations
(Barton 1999)
In this literature review the researcher reviewed outcome studies in the following domains: skills training, family psychosocial education, and supported employment. Barton (1999 p 525) concluded that

- Outcome research strongly supports use of psychosocial rehabilitation but is insufficiently developed to determine the effects of service components used at varying levels of intensity and the interaction of those components with client characteristics, medication levels, or phase of the illness.
He also discovered that cost-effectiveness studies showed that for people receiving psychosocial rehabilitation services there was an average of 50% reduction in the cost of care due to reduced hospitalisations.

**DISCUSSION**

Factors aiding recovery have been well identified over the past few decades. Even though the same factors may be consistently identified by people with an experience of mental illness, the role and significance of contributing factors vary from person to person. The studies discussed above reveal a range of outcomes for people living with a psychiatric disability from involvement with psychosocial rehabilitation programs. These include many of the aspects identified with recovery - decrease in dependence on acute clinical services, increased level of functioning, increased satisfaction with quality of life, increased levels of employment, and lower rates of homelessness.

The difficulty is in the detail - what role do each of the various services and aspects of services play? This is probably an impossible question to answer - the mix of factors would be different for each person, the degree to which one factor contributes to recovery would vary over time.

Some broad conclusions can be drawn from the literature.

*That clinical interventions alone are not enough to ensure recovery.*

The majority of persons with schizophrenia, even those who benefit from medication, continue to have disabling residual symptoms and impaired social functioning and will most likely experience a relapse despite medication adherence, hence it is necessary to integrate empirically validated psychosocial treatments into the standard of care for this population. (Bustillo *et al* 2001, p163)

Several writers made the point that gains in one area are not necessarily transferable into another area. For example, Silverstein (2000) writes

> . . . medications do not and can not address the social disability and skills deficit that many people with schizophrenia have, due to the social and cognitive consequences of having a psychotic disorder. . .

> It is generally agreed, therefore, that in addition to optimal medication treatment, schizophrenia patients require interventions that directly teach them the life skills to live successfully in the community.

Even the need for medication has been questioned. Silverstein refers to a program that demonstrated that in many cases “young patients undergoing their first or second psychotic episode can be successfully treated without medication in community residences with high staff-patient ratios that employ a treatment model based on existential psychological principles” (2000 pp 240-1).

*For most service users, no one intervention or type of support is enough on its own, and psychosocial rehabilitation is an important aspect of a mix of services; and interventions or services need to be targeted to meet specific needs.*
That a combination of interventions or support services is required by most people is well
established. The services mix also need to be designed individually - the ‘one size fits all’
approach to psychosocial rehabilitation does not work.

*The psychiatric rehabilitation service intervention complements not only treatment but all of the
other interventions critical to helping people with psychiatric disabilities recover.* (Anthony et al
2002 p14)

Within the broad framework of psychosocial rehabilitation, a range of services needs to be
available and the mix tailored to the needs of each client. For example, if someone wants to
continue formal education, then supported educational programs are both useful and necessary
to maximise the possibility of success. If someone want employment outcomes, then supported
employment options will increase the likelihood that the person will achieve their employment
goals, including retaining the job, and so on.

In their review of ‘psychosocial treatments’ in the American Journal of Psychiatry Bustillo et al
2001, p 163) say that psychosocial interventions need to be specific to the desired outcomes.

*Patients who wish to work should be referred to a vocational rehabilitation agency for supported
employment. No other psychosocial or pharmacological treatment has been shown to promote
competitive employment.* (Bustillo et al 2001, p 173.)

*Reviews of supported employment have found consistently positive employment outcomes but
have found no evidence that employment gains are generalised to other outcomes.* (Barton
1999 p 528)

**That there needs to be sufficient funding, and planning, to meet the demands of the service
users, and range of services.**

In the report on the deinstitutionalisation process in South Carolina (Curlee et al 2001), the
researchers strongly credited the success of the program to the establishment of services just
before they would be needed so that when people were discharged, the services were available.
Consultation with people about their individual preferences was also fundamental to the success
of the process.

**There is much research still to be done**

There is still much to research in the field of psychosocial rehabilitation, especially in Australia. In
Victoria where there are well established programs offering psychosocial rehabilitation in a
variety of settings targeting many desired outcomes, there is great potential for research on all
aspects of psychosocial rehabilitation.

Mueser and fellow researchers (2002, p 1280) wrote

*little controlled research has been done on the broader dimensions of recovery such as
developing hope, meaning, and a sense of purpose in one’s life.*

Silverstein (2000 p. 241) writes
it is safe to say that all studies of medication effectiveness have been conducted without the benefits of the full arsenal of effective psychiatric rehabilitation interventions. Thus, we still do not know the impact that rehabilitation interventions can have relative to pharmacology in treating people with schizophrenia.

Bustillo (2001 p.172) suggests that research is needed to “guide the optimum sequencing and combination of specific services.”

**The consumer perspective**

One of my observations from these studies is the resounding absence of the voice of the service user. They are generally ‘done to’ rather than being reported as participating actively in making decisions about their own care - one of the major factors which is both a process and indicator of recovery. One of the common assumptions in the literature is that clinicians or other workers need to know what services to provide or refer their client to. The South Carolina program (Curlee et al 2001) demonstrated the importance of consultation with the consumers about their needs so that the desired and necessary rehabilitation and support was provided.

In a qualitative study Mancini and his co-researchers asked 15 consumer providers about their theories on factors facilitating and impeding recovery from psychiatric disabilities. After analysing the data they collected, they reported that

> recovery is dependent upon several environmental and personal factors. Supportive relationships, meaningful activities and alternative treatments all facilitated recovery for these individuals. (Mancini et al 2005 p 54)

Supportive relationships, meaningful activities and the ability to try different activities and determine what works best for you, are three of the significant benefits available to consumers from participation in various psychosocial rehabilitation programs. For many, many consumers, the availability such services is fundamental to their achieving and maintaining wellness, and an acceptable quality of life.

**References**


Rickwood D 2004, *Pathways of recovery: preventing relapse - a discussion paper of the role of relapse prevention in the recovery process for people who have been seriously affected by mental illness*, Australian Govt, Dept of Health and Ageing, Canberra ACT.


van Busschbach J, Wiersma D 2002, Does rehabilitation meet the needs of care and improve the quality of life of patients with schizophrenia or other chronic mental disorders? *Community Mental Health Journal* 30 (1) Feb.


Wissmann D 2005, Australia, *Senate Select Enquiry into Mental Illness Hansard*, AGPS, Canberra ACT.