

HANDBOOK OF
PSYCHOSOCIAL
REHABILITATION

ROBERT KING,
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Chapter 1

KEY CONCEPTS AND DEFINITIONS

Robert King, Chris Lloyd and Tom Meehan

Overview of chapter

The purpose of this chapter is to identify and discuss some of the key terms and concepts that will be found throughout this handbook. The aim is to enable the reader to gain an understanding of how we are using certain terms and why we think that the concepts behind the terms are central to mental health practice. Part of the chapter is concerned not just with defining terms but also with enunciating the three core values inherent in contemporary rehabilitation that inform our thinking. These values are:

- Rehabilitation takes place within the framework of a commitment to recovery
- Rehabilitation takes place within a biopsychosocial framework, and
- Rehabilitation takes place within the framework of evidence-based practice

The meaning of the core concepts of recovery, biopsychosocial, and evidence-based practice is set out here, together with a discussion of the implications of each value position for practice. The reasons why we have decided upon using the terms 'practitioner' and 'client', the

two key people in the rehabilitation relationship, will be discussed.

Recovery and rehabilitation

Recovery

Recovery has become a core concept in contemporary mental health practice and has taken on some reasonably specific meaning, some of which departs from common usage. In mental health practice there are three dimensions of recovery - an objective dimension that best corresponds with common usage, a subjective dimension that is more specific to the mental health practice environment, and a service framework dimension that combines elements of both the objective and the subjective dimensions.

Recovery as an objective phenomenon

This kind of recovery implies a reduction in the objective indicators of illness and disability. It does not imply full remission of symptoms or the absence of any disability but rather objective evidence of change in this direction. By objective evidence we refer to a range of indicators such as whether or not a person continues to meet diagnostic criteria for a specified illness, scores on standardised measures of symptoms, social functioning or quality of life, changes in employment status or other objective indicators of social functioning, rates of hospital usage or usage of other kinds of clinical services, and dependence on social security. When we see evidence that a person is maintaining

consistent positive progress on one or more of these indicators without evidence of reversal on others, we can say that there is objective evidence of recovery. These kinds of indicators are commonly used both to collect epidemiological data on recovery from mental illness (see Chapter 2) and to determine the evidence base for effectiveness of psychosocial rehabilitation programmes (see below and also Chapter 14).

Recovery as a subjective phenomenon

As a result of attention to the voices of people who have experienced mental illness, it has become clear that objective indicators of recovery do not always correspond with the subjective experience of recovery. The experience of mental illness is not just one of symptoms and disability but equally importantly one of major challenge to sense of self. Equally, recovery from mental illness is experienced not just in terms of symptoms and disability but also as a recovery of sense of self (Davidson & Strauss, 1992; Schiff, 2004). Recovery of sense of self and recovery with respect to symptoms and disability may not correspond. A person may continue to experience significant impairment as a result of symptoms and disability but may have a much stronger sense of self. Inversely, symptoms and disability may improve while sense of self remains weak. The mental health consumer movement has advocated for the subjective dimension of recovery to share equal importance with the objective dimension in the clinical environment (Deegan, 2003). This implies much closer attention to the psychological and spiritual wellbeing of the person with mental illness than is characteristic of the standard service environment. It also has implications for evaluation of the effectiveness of mental health services (Anthony et al.,

2003; Frese et al., 2001). The subjective dimension of recovery is explored in depth in Chapter 3.

Recovery as a framework for services

Anthony (1993) called for recovery to be the 'guiding vision' for mental health services. He argued that practitioners can only assist people suffering from mental illness to achieve recovery if they both acknowledge the importance of the subjective dimension of recovery and if they actually believe in the possibility of recovery. This call for a change in service philosophy argued that traditional services, operating more within a medical model and focusing purely on objective indicators of recovery, were failing to instil and sustain the experience of hope that was central to the possibility of recovery. In other words, if practitioners are not themselves hopeful it is difficult for those who are looking to them to facilitate recovery to develop hope. In the absence of hope and a belief in the reality of recovery, services will focus on basic maintenance only and not provide any inspiration for people with mental illness to achieve and grow (Turner-Crowson & Wallcraft, 2002). Advocates for recovery as a framework for services have also looked to epidemiological data that show that recovery is a reality for many people with the most severe disorders even when objective indicators are used, and evidence that well-developed mental health services can contribute to rate of recovery (for example, DeSisto et al., 1995a, 1995b; Harrison et al., 2001; Harding, Brooks et al., 1987). Resnick et al. (2004) have suggested that the polarity between biomedical and recovery models may be unfounded, and that it is possible to provide treatment that is mutually reinforcing.

Rehabilitation

Rehabilitation refers broadly to restoration of functioning and is used widely in the field of health. Psychosocial rehabilitation refers more specifically to restoration of psychological and social functioning and is most frequently used in the context of mental illness. It is based on two core principles (Cnaan et al., 1988):

- People are motivated to achieve independence and self confidence through mastery and competence
- People are capable of learning and adapting to meet needs and achieve goals

[Table 1.1](#) outlines some of the key features of psychosocial rehabilitation as set out by Cnaan et al. (1988, 1990). More recently, Corrigan (2003) has revisited Cnaan's principles and provided systematisation of the rehabilitation process having reference to the goals, strategies, settings and roles that are involved.

In some contexts, the term rehabilitation is used interchangeably with recovery and can be an unintentional or incidental process. However, throughout this book, the term rehabilitation is reserved for application to a purposeful programme designed to facilitate recovery. This may be a self-help or peer support programme but often it will be a programme that involves a mental health practitioner. As it is used in this sense, rehabilitation differs from recovery. Whereas recovery may take place in the absence of any specific programme, rehabilitation always implies purpose and specific goals. Rehabilitation may focus on objective indicators of recovery such as symptoms or measures of social functioning. It may also focus on subjective recovery as in recovery of a sense of self or of a sense of purpose. Often it will focus on both, and the general philosophy of this book is that it will be most successful when both dimensions of recovery are taken into

account, and when rehabilitation programmes are delivered within a recovery framework whereby the practitioner has a belief in the recovery of the person with mental illness, and with generating and maintaining hope.

Table 1.1 Principles of psychosocial rehabilitation

1.	All people have an under-utilised capacity, which should be developed
2.	All people can be equipped with skills (social, vocational, educational, interpersonal and others)
3.	People have the right and responsibility for self-determination
4.	Services should be provided in as normalised an environment as possible
5.	Assessment of needs and care is different for each individual
6.	Staff should be deeply committed
7.	Care is provided in an intimate environment without professional, authoritative shields and barriers
8.	Crisis intervention strategies are in place
9.	Environmental agencies and structures are available to provide support
10.	Changing the environment (educating community and restructuring environment to care for people with mental disability)
11.	No limits on participation
12.	Work centred process
13.	There is an emphasis on a social rather than a medical model of care
14.	Emphasis is on the client's strengths rather than on pathologies
15.	Emphasis is on the here and now rather than on problems from the past

After Cnaan et al., 1988, 1990.

Multidisciplinary service delivery: the biopsychosocial model of mental health

This handbook is designed for multidisciplinary practitioners. What do we mean by multidisciplinary and what implications does this term have for psychosocial rehabilitation?

First, let us introduce a related concept: biopsychosocial. Biopsychosocial is a term that was introduced into the field of mental health practice (Engel, 1980; Freedman, 1995; Pilgrim, 2002) to draw attention to the implications of two key characteristics of mental illness:

- Mental illness affects multiple domains or systems and not just one system. Specifically, the biological, psychological, and social systems of the person with mental illness are all likely to be implicated.
- The three systems are interlinked. They do not operate in isolation from each other. Whatever happens in one system is likely to have implications for the other.

As Pilgrim (2002) pointed out, the holistic and humanistic premises of the biopsychosocial model have a long history in mental health care that predates the introduction of the term by Engel (1980).

A multidisciplinary approach to psychosocial rehabilitation means being able to think multisystemically. This includes being both aware and respectful of the possible contributions of other mental health practitioners who have specific expertise in one or other domains (Lieberman et al., 2001). It also means having a capacity to facilitate access to services across different domains, and communicate with practitioners who have specialist skills in these different domains. In some situations it means working in a multidisciplinary team, whereby practitioners with different kinds of expertise routinely communicate and consult. However, multidisciplinary practice is more about the use of a biopsychosocial framework and development of an attitude to practice than the presence or absence of a team.

Practitioner, clinician, case manager, mental health professional

There is some variability in the term used to describe the person who is trying to facilitate the recovery process. We have decided to adopt the term practitioner throughout this book but terms such as clinician, case manager, and mental health professional could also be applicable. Practitioner is the term we have decided to use. The term is defined as 'one who is engaged in the actual use of or exercise of any art or profession'. It implies both expertise and purpose in a designated field but is very broad with respect to field. Practitioner has an honourable history in the health sciences, being used to refer to medical and nursing practice, but is also applied much more broadly in the practice of a wide range of professions, trades and arts.

The term clinician was considered but rejected because it implies a clinical service environment. Psychosocial rehabilitation can be delivered in clinical environments as part of a mix of services that might include medication, psychotherapy, and even inpatient care. However, it can also be delivered in non-clinical community services that have no medical or other clinical components. The term clinician is therefore too narrow to accommodate the range of relationships we have in mind. We do not wish to exclude clinicians and, indeed we suspect that people who identify themselves as clinicians, whether nurses, psychologists, occupational therapists or even medical practitioners, will form a major group amongst our readers. We believe that this group can also identify as mental health practitioners or psychosocial rehabilitation practitioners.

The term case manager has a wide currency in mental health and has been used to refer to both clinical and non-clinical roles - even occasionally to provision of services by peers. However there are two problems with this term. These are best captured by the objection expressed by a person with mental illness at a conference: 'I'm not a case and I don't want to be managed'. It has the connotation of a bureaucratic rather than a personal relationship and it also has the connotation of control or at the very least responsibility that does not apply in many rehabilitation relationships. Some services are adopting the term 'care coordinator' as being somewhat less impersonal. However, like case manager, this term implies that clients cannot coordinate their own services. In some cases this will be a reasonable assumption and we have no objection to services using the term case management or care coordination. However, we think that there are many rehabilitation relationships that take place outside of this framework. Therefore, while many of our readers may be designated by their services as case managers, we hope they can equally see themselves as mental health practitioners.

Mental health professional is a broader term than clinician or case manager but may be narrower than practitioner. For some the term 'professional' implies membership of a recognised profession and evokes issues of registration or membership of a professional association. While we do not doubt that many if not most of our readers will identify themselves as professionals, we expect that there will be some people who find the term difficult to identify with. For example, some community organisations employ staff because they have life or work experience that equips them to work effectively in a psychosocial rehabilitation relationship with clients who have a mental illness. In some cases these staff will not possess qualifications that provide

entry into any professional association or enable registration or certification. Such people are practitioners but not necessarily mental health professionals.

Client and consumer/service user

One of the more vexing issues in mental health practice is the proper designation for the person with mental illness who is working with a mental health practitioner. The most common terms are 'client' and 'patient'. Both have drawn criticism. The term client has been criticised for evoking a different and more impersonal relationship – such as the relationship with a lawyer or a banker or accountant. It can also imply a very unequal level of expertise and a relationship in which the client is the passive recipient of information or advice or where the other person acts on behalf of the client. The term patient implies a more personal relationship but one that is even more unequal and in which the person with mental illness has a high degree of dependency. The term patient also evokes a medical model of care with focus on physical dimensions of mental illness but not on the social and psychological dimensions.

Two other terms have currency. The term 'consumer' or 'service user' is preferred by some service providers/consumers. These terms come from the broader consumer movement and imply that as a direct or indirect purchaser of services the person has rights and reasonable expectations concerning service quality. They are therefore relatively empowering compared with client or patient. However they suffer, even more than client, as a result of rendering the relationship impersonal and evoke analogies with purchasing a car or supermarket shopping. Some prefer the term 'survivor', which implies a degree of resilience in

the face of the major challenges of the illness. Survivor is most popular with people who have been unhappy with mental health services. Such people often see themselves as having survived not only the ravages of the illness itself but also the mental health system.

The issue of terminology is so difficult that it is not uncommon to hear people say in exasperation, *'I am not a patient or a client or a consumer or a survivor - I am a person'*. This kind of statement suggests that none of the terms is really satisfactory and each carries with it the risk of depersonalising the relationship. However, rehabilitation implies a relationship that is specific in its purpose and the term 'person' is not adequate to convey the qualities of this relationship.

In an attempt to learn more about how people affected by mental illness saw their relationship with mental health professionals and, in particular, how they preferred to be seen, we conducted a survey in which people were asked which of several terms they most identified with (Lloyd et al., 2001). Overall, we found that client was the preferred term but that it was somewhat context specific. People in acute inpatient care were more likely to identify themselves as 'patients', whereas people in community or outpatient settings were more likely to identify as 'clients'. In a similar study, McGuire-Snieckus et al. (2003) found that people surveyed in the UK identified with the term 'patient' when the context was seeing a general practitioner or psychiatrist and equally with the term 'client' or 'patient' when seeing non-medical mental health professionals. The terms 'consumer', 'service user' and 'survivor' were not favoured in either study. We think that the terms consumer and service user are probably best reserved for advocacy, service quality improvement and service management roles where the person is representing the wider group of mental health service consumers. They are less suitable for the

rehabilitation relationship, which is necessarily a deeply personal one.

Taking into account all these considerations, while acknowledging the limitations of the term, we think that client is the least unsuitable term for application in the context of psychosocial rehabilitation. We are typically dealing with a community rather than an inpatient context where services are primarily provided by non-medical practitioners. The focus is on psychosocial functioning and experience rather than physical functioning and illness. Throughout the book you will find the term client used, rather than patient, consumer or service user.

Evidence based practice, efficacy and effectiveness

Evidence based practice (EBP) is a core value of contemporary psychosocial rehabilitation (Dixon & Goldman, 2004; Drake et al., 2001, 2003). It asserts that priority must be given to practices that are either known to contribute in a positive way to recovery or at least are reasonably likely to contribute to recovery. EBP is distinguished from practice by tradition, whereby rehabilitation practices are maintained because 'this is what we have always done'. EBP emerged in part from a critical movement in medicine (Davidson et al., 2003; Liberati & Vineis, 2004; Sackett et al., 1996) that questioned the value of established procedures such as tonsillectomies and hysterectomies that were commonly believed to be helpful but had not been subjected to rigorous investigation. EBP has also been influenced by the 'scientist-practitioner' model (Chwalisz, 2003), which was developed within the profession of psychology. The scientist-practitioner employs an empirical scientist approach to practice, designing interventions based on the

best possible information, measuring the impact of the interventions, and then modifying the interventions in response to information about their impact.

EBP operates from the premise that once an intervention has been demonstrated to be effective with a specific problem, it should be able to be implemented to good effect whenever that problem is present. However, practitioners should remain alert to the impact of the intervention and not simply assume it will be effective in every case. In this sense every practitioner within the EBP framework is also a scientist-practitioner, or in other words a consumer of research. EBP is developed through formal research and is disseminated through research reviews, practice guidelines and formal training. This handbook is designed to disseminate EBP.

In EBP, all evidence is not equal and there are established hierarchies of evidence (Trinder, 2000). These hierarchies provide a guide to the robustness of the evidence. At the bottom of the hierarchy are single case reports. These are better than no evidence but are weak for two reasons:

- They may not be generalisable – what works for one person might not work for another. The single case-study may depend on highly individual characteristics of the client, the practitioner or their introduction and may not be replicable for other people or in other settings.
- There may be no causal relationship between the intervention and the outcome – the change observed in a single case report may be attributed to the intervention when it was actually caused by something separate from the intervention.

Formal evaluation of interventions is designed to investigate these two issues – their generalisability and the causal relationship between intervention and outcome. Until this has been clearly established, the intervention has a weak evidence base. Near the top of the hierarchy are

randomised controlled trials (RCTs). These are especially good at resolving the issue of causality. If we take a group of people who share a common problem and half are randomly allocated to receive an intervention and the other half either continues with usual care or gets a placebo intervention, then we are likely to attribute any difference between their outcomes to the effect of the intervention. If a series of RCTs with different researchers in different settings yield similar outcomes, the evidence is especially persuasive because both the causality of the intervention is established and the generalisability or robustness of the intervention is demonstrated.

Between the single case study and the many times replicated RCT are a range of evidence types that are located in the middle of the hierarchy. These include observational studies and longitudinal studies where generalisability may be reasonably well demonstrated and causality is likely but not highly likely as in the RCT.

Practitioners need to develop some basic skills to read and interpret research (Lloyd et al., 2004). There are many factors that impact on the relevance of research findings to clinical practice (Essock et al, 2003; Lloyd et al., 2004; Tanenbaum, 2003). These include:

- The similarity of the research environment to the practice environment. This is sometimes referred to as the efficacy versus effectiveness issue. Research studies often use carefully selected study groups and deliver the intervention in atypical environments. In general, the effect of interventions in a research setting (efficacy) is usually greater than its effect in a practice setting (effectiveness). An intervention is not really evidence based for practice until it has demonstrated that it remains efficacious in a practice setting.
- The nature of the comparison condition. Many interventions are better than nothing but the EBP

practitioner really wants to know if they are better than what she or he is doing now. It may not make sense to change practice until it can be demonstrated that a new intervention is superior to what is often termed 'usual care', and not to no treatment at all.

- The importance of fidelity and adherence to treatment protocols. Some forms of EBP appear to be sensitive to variations in implementation. If this is the case, the practitioner has to be sure that it is possible to implement the intervention exactly as specified.
- Much of the existing research on EBP was conducted without an understanding of the recovery vision and implemented prior to the emergence of the recovery framework. This means that focus has mostly been on objective indicators of recovery and it is possible that some evidence based interventions are less effective if evaluated against recovery vision criteria.

Whenever possible, this handbook will alert you as to the state of the evidence with respect to the above issues. However, practitioners must be wary of excessive reliance on textbooks or published treatment guidelines. The evidence is constantly changing and being an evidence-based practitioner implies a commitment to remaining alert to developing the evidence base rather than assuming a static evidence base.

Conclusion

This chapter has introduced some of the core concepts that inform the approach taken throughout this handbook. These concepts are explored in relation to psychosocial rehabilitation whereby a recovery orientation, a biopsychosocial approach and evidence based practice constitute a values framework. We have briefly examined some of the terminology that is currently used in mental

health service provision. The terms client and practitioner are preferred in the context of this handbook.

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