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How important is the patient's environment in psychiatric rehabilitation?

Introduction

Charting the history of rehabilitation and recovery, Dr Gavin Francis describes how – even when there is no cure for illness or disability – "it can still be possible to 'recover' in the sense of building towards a life of greater dignity and autonomy" (1). Key to rehabilitation, argues Francis, is where it takes place; it is imperative to "optimise the environment around the patient to make it more conducive to healing" (1). Psychiatric rehabilitation, which aims to maximise the quality of life and social inclusion of people with severe mental illness (SMI), takes place in a range of environments including inpatient units and supported housing (2). These services stand in contrast to the institutional approach to managing psychiatric illness that endured into the twentieth century (3). This essay will ask whether the environments in which psychiatric rehabilitation currently takes place succeed in "fostering self-esteem, confidence, emotional literacy" and promoting social inclusion (2). Using the biopsychosocial model, I will assess the importance of the environment in psychiatric rehabilitation for individuals' biological, psychological and social wellbeing and explore how aspects of the patient's environment may be exploited to aid recovery.

What is rehabilitation psychiatry?

Psychiatric rehabilitation serves patients with a diagnosis of severe and enduring mental illness resulting in functional impairments that require long-term care. The ultimate purpose of rehabilitation is to re-integrate the individual into the community. Clients of rehabilitation services most commonly have a diagnosis of schizophrenia, although intellectual disability, personality disorder and physical health challenges may further complicate the picture (2). Referrals to rehabilitation services are often made when an individual with SMI is unlikely to benefit from further time in an acute ward environment, but cannot be discharged into the community.

After referral, inpatient management is multi-disciplinary and aims to "maximise an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future" (4). This involves addressing any physical health needs, optimising medical regimens and working with patients to improve their self-care and life skills to prepare them for transfer to community services.

Where does psychiatric rehabilitation take place?

The rehabilitative environment has undergone major changes since the second half of the twentieth century. The establishment of asylums in the early nineteenth century reflected a more humane

impulse to house people with mental illness in environments more conducive to recovery and care than prisons (5). However, by the turn of the twentieth century, the ambitions of the first asylums – grand buildings constructed away from industrialised areas – had given way to overcrowded institutions (6). These conditions precipitated the closure of mental hospitals in favour of treating patients in the community, a move heralded by the Mental Health Act of 1959 which abolished the Lunacy and Mental Treatment Acts (1890-1930) and the Mental Deficiency Acts (1913-1938). From the 1960s onwards, large asylums were closed down and inpatient bed numbers were slashed as patients were integrated into the wider hospital network or managed in the community (7). The environments in which psychiatric rehabilitation now take place should, according to NICE guidelines, follow a step-wise model of decreasing intensiveness and restrictiveness correlated with improvements in the patient's condition (8). A typical pathway may involve moving from an acute ward to a high-dependency unit to community rehabilitation in supported housing (9).

While there is consensus that the de-institutionalisation of mental healthcare was overdue, the services which replaced it are not without criticism. Out of area placements may entrench social isolation; the lack of range in services results in patients residing in unnecessarily restrictive environments; and the importance of cultivating independent living skills may be overlooked (10). Indeed, some have argued that we are witnessing "re-institutionalisation" in which patients are confined to overly interventionist inpatient care due to the absence of follow-up services (6, 10). The question of the environment – inpatient and community-based – is central to assessing the effectiveness of psychiatric rehabilitation to facilitate the recovery of the patients it serves.

The environment in psychiatric rehabilitation

What is the importance of the environment in psychiatric rehabilitation? The place where an individual lives is both a causative and a complicating factor in the development of mental health problems. Poor quality housing, overcrowding, lack of daylight and a neglected physical environment are all associated with poor mental health (11). Compared to those without mental health problems, individuals with SMI are twice as likely to be unhappy with their housing and four times as likely to report that their housing worsens their health (12). Given this association, it is key, as Dr Steffan Davies argues, that the influence of the clinical environment on wellbeing is "considered and managed in the same way as any other aspect of treatment" (13). I would extend this argument to community services and to the transitions between different care settings. Each environment may influence the patient's outcome: it is not just what is done to support an individual, but *where* it is done. Because rehabilitation involves sustained periods in wards, units or supported accommodation, it is particularly important to ensure that the patient's environment best facilitates their recovery. Indeed, one study of patients in the West Midlands found that only one in ten users of rehabilitation

services were living in independent accommodation within 10 years of admission to an inpatient unit (14).

To assess the importance of the environment in psychiatric rehabilitation, a holistic evaluation is essential. The biopsychosocial model of illness is used here to provide a framework for investigating the influence of the patient's environment on their biological, psychological and social wellbeing (15).

i. Biological

As Šprah *et al*. describe, "comorbidity between mental and physical disorder conditions is the rule rather than the exception" (16). In addition, physical comorbidity is associated with readmission for psychiatric patients, with diabetes, cardiovascular disease and liver disease among the health conditions linked to a higher risk of hospitalisation (16, 17). The relationship between physical and mental illness is exacerbated by the adverse effects of many psychotropic medications, including weight gain, obesity and associated sequelae (18).

It is therefore key that care plans for individuals with SMI take a "whole systems approach" that acknowledges and alleviates the influence of poor physical health on psychiatric rehabilitation and overall quality of life (4). One benefit of the intensive rehabilitative setting that may be required at the outset of an individual's care is the opportunity to support them to better their physical health. However, recent evidence shows that the standard of physical healthcare provided in rehabilitation units requires improvement, with premature mortality remaining a pressing issue for this patient group (14).

Psychiatric rehabilitation must provide a setting in which to monitor and treat physical health conditions and make lifestyle interventions such as smoking cessation and dietary advice (8). The advantage of the inpatient environment should be in facilitating multi-disciplinary input, allowing different specialties to collaborate. Effective management of physical health conditions is key to giving patients the tools for long-lasting recovery and preventing readmission. If services can succeed in integrating care of the body as well as the mind, there is a strong case for the importance of the inpatient rehabilitation environment in addressing the 'biological' aspects of wellbeing.

ii. Psychological

The environment can support the psychological factors involved in an individual's recovery in two ways. First, physical aspects of the environment can be engineered to promote psychological wellbeing. Second, inpatient units and community services provide safe spaces in which to adjust medical regimens and involve patients in psychological therapies.

"New hospitals," observes Dr Gavin Francis, "have much in common with airports and supermarkets: low plastic ceilings, little natural light, retail forecourts, windows that don't open, and views, where they exist, giving on to car parks" (1). These physical characteristics may mean that opportunities to diminish distress and cultivate optimism creating better spaces that make use of the continuity between wellbeing and the environment are lost. Where possible, environments should be optimised to enhance patients' psychological wellbeing. As NICE advises, this includes avoiding barriers to sleep, such as noisy wards and non-essential night-time checks (8). Bringing the outdoors into units, for example using plants and artwork, and ensuring that spaces are well-lit are evidence-based recommendations for enhancing the ward environment (2, 19).

The psychiatric rehabilitation setting is also psychologically important because it provides an opportunity to "find the best medication regime to minimise symptoms without producing distressing side-effects" (2). The patient's residence in an inpatient environment for several weeks or months affords clinicians greater oversight over treatment efficacy and any adverse effects, allowing them to tweak medications and engage patients in shared-decision making that cultivates "self-esteem [and] confidence" (2). The patient's residence in a specialist unit also means that they may be more likely to see the same staff. The environment may therefore facilitate better continuity of care that enhances the quality of the doctor-patient relationship, a key factor in treatment adherence which, when poor, increases the risk of worse long-term outcomes for people with SMI (20).

Of course, pharmacological treatment is only one part of psychological management. The environment can further support psychological aspects of rehabilitation by providing a space in which to access psychological therapies including Cognitive Behavioural Therapy (CBT), family intervention and group therapy, for which the presence of other patients would be instrumental. As with medical interventions, the intensive rehabilitation environment means that staff can monitor the impact of therapies on patients and support them if therapies provoke troubling thoughts or feelings. However, it is also essential to psychological wellbeing that when patients are ready to move on from intensive facilities, community-based services are available to them. Patients report that the more 'normal' their living environment, i.e. the least restrictive and smaller-scale their accommodation, the higher their quality of life (21). For patients still residing in inpatient settings, the sense that there is somewhere for them to progress to is critical to fostering "hope for the future" (4). As I will discuss later in this essay, this, unfortunately, is not consistently the case.

iii. Social

The environment is particularly instrumental to individuals' social recovery and wellbeing. Social exclusion is a key issue for people with SMI: they are more likely to lack sources of support and struggle to maintain relationships (22). The exclusion people with SMI face is characterised both by individuals having smaller social networks and by the isolation engendered by lack of an independent life that includes, for example, work (23). In terms of occupation, the employment rate of people with a mental health condition is 10-15% lower than those without (24). Rehabilitation psychiatry therefore has two levers for achieving its tenet of social inclusion: first, to cultivate skills geared toward helping people to lead fulfilling, independent lives and second, to support individuals to build connections with others.

To prepare an individual to lead an independent life after discharge, inpatient services must encourage patients to "acquire or develop the skills and confidence to live successfully in the community" (25). It is essential that the inpatient environment is exploited to equip patients with the means to cope with activities of daily living (such as cooking, self-care, budgeting and laundry) and meaningful activities, training and education that may help them to gain supported or sheltered employment. Art therapy, for example, has been successfully used to complement pharmacological interventions in people with mental illness, helping individuals to develop communication skills that will aid life after discharge (25, 26). However, art therapy has not been consistently delivered in rehabilitation units (4). To allow patients to graduate to greater autonomy, psychiatric rehabilitation services must deliver on their ambition of skills development.

Encouraging social inclusion does not stop at helping patients to develop the skills and confidence essential to life in the community. A "whole systems approach" acknowledges that the connections we share with family, friends, colleagues and the wider community "fulfil many of our immediate and personal needs and contribute to our well-being" (4, 27). Inpatient care necessarily extracts an individual from the place where they are living and surrounds them with unfamiliar faces, compounding the isolation often created by mental illness. To mitigate this, it is essential that patients remain embedded in some sense of community, crucially by being able to receive visitors. Allowing patients to be treated in an environment in which they can also maintain connections with close contacts may make rehabilitation more effective; family engagement with a patient's treatment, for example, is associated with better outcomes for people with psychotic disorders (28).

Unfortunately, many people's psychiatric rehabilitation involves not only being moved out of their current living situation but also being moved miles away from their local area in an out of area placement (OAP) (29). OAPs undermine efforts to enhance patients' social inclusion, distancing them from family, friends and the local services from which they have been referred and to which they

should eventually be discharged. While OAPs may be unavoidable in cases where the complexity of an individual's needs cannot be met by local services, many patients are sent out of area not because facilities do not exist, but because demand consistently outstrips capacity. 91% of OAPs at the end of December 2021 were considered inappropriate, meaning that the OAP was due to a local bed being unavailable (29). The consequences of OAPs for patients may be devastating, including diminished contact with usual support networks, lack of opportunity to reintegrate gradually into their local community and ultimately rehabilitation that is "less meaningful and takes longer"(10). For refugees and migrants, cultural and language dislocation can compound feelings of alienation (30). An inpatient unit can be engineered to support rehabilitation, but if the environment in which *that* environment is located alienates an individual from their support network – i.e. if the unit is out of area – social exclusion is likely to endure.

Transfers between environments and an integrated model for psychiatric rehabilitation

This essay has examined psychiatric rehabilitation environments discretely. In this final section, I will look briefly at the transitions between environments and the challenges they present. I will also suggest that psychiatric rehabilitation can look to another clinical model – palliative medicine – for an example of an integrated service that co-ordinates patient care across a number of specialist and community-based environments.

Psychiatric rehabilitation requires a "total system approach" that allows patients to move smoothly through stages of rehabilitation (31). Better transitions can be achieved by involving patients in decisions about next steps, by the effective transfer of information between teams, and by accommodating the patient 'in area' to allow for greater flexibility between inpatient and community-based services (32). If a patient needs to be re-admitted, the aim should be to find a bed within the local area, to lessen feelings of displacement and afford some continuity in clinical and personal relationships.

The "smooth transitions" for which NICE advocates cannot be achieved without addressing the "serious lack of a range of appropriate residential settings" (31). Psychiatric rehabilitation requires a dynamic approach to an individual's care plan: the next step in their rehabilitation pathway should be finely tuned to their current level of need. Environments need to be more adaptive to the changing capabilities of an individual as they begin to regain skills, confidence and autonomy. Research has shown that a dearth of appropriate move-on accommodation is frequently cited as a reason for people being kept in "overly restrictive settings for much longer than they need", risking greater institutionalisation rather than fostering independence (10, 31). If individuals cannot move on when they are ready to – an essential part of their recovery – how can rehabilitation psychiatrists

realistically aim to "promote hope and maintain enthusiasm and therapeutic optimism" (2)? It is vital that there is renewed investment in additional step-up and step-down services that broaden the range of environments in which care is offered.

While the outcome for patients in psychiatric rehabilitation is, of course, very different to those receiving palliative care, the co-ordination between specialist units (hospices), general hospitals and community-based treatment demonstrates a flexible approach that adapts to changing individual needs and preferences (33). In addition, the attention to physical space in the modern hospice movement exemplifies good practice in exploiting the influence of environment on wellbeing (34). In aiming to address an individual's "total pain", including psychosocial and spiritual distress, palliative medicine research has shown that a "home-like environment" lessens patients' physical, emotional, social and spiritual suffering (19). Aspects of environmental design in the modern hospice movement, including allowing access to nature (e.g. through a window or indoor plants), displaying artwork, providing natural light, giving people privacy and hiding medical equipment, have been shown to improve symptoms (19). This approach, which promotes the kind of treatment setting evoked earlier in this essay, should inform the psychiatric rehabilitative space and encourage practitioners to harness the power of the environment to improve quality of life.

Conclusion

This essay has argued that inpatient and community environments are crucial to psychiatric rehabilitation. Exploring the biological, psychological and social aspects of wellbeing and recovery, I have sought to show how important the environment is, and how important it is to get the environment right. Inpatient services allow clinicians to address a patient's needs with an intensive, multi-disciplinary approach. Equally important are the provision of community-based care to which a patient may progress and the transitions between environments. To return to Dr Gavin Francis, the thread that must run through each environment is the "continuity between the body we inhabit and the environment that sustains us" (1). Poor quality accommodation and out of area placements negatively influence the wellbeing of those they should sustain. The environment should present a therapeutic opportunity to be maximised. For patients with SMI who spend such prolonged periods in services, it is particularly important to make use of this opportunity. As I have argued, taking care over the environment's physical and geographic aspects can enhance patients' dignity, optimism and autonomy, and ultimately hasten their return to the community.

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