Practice of and services for psychosocial rehabilitation of people with schizophrenia in Belgium

Pratica e servizi della riabilitazione psicosociale di persone con schizofrenia in Belgio

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Summary

Schizophrenia has long been regarded as a chronic disabling disorder with an almost inevitable negative outcome. However, recently, several long-term studies suggested that recovery might be possible for first-episode as well as chronic schizophrenic patients. Although the importance of rehabilitation interventions, aiming at reintegrating schizophrenic patients in society, is increasingly recognised, a substantial proportion of these patients still does not have access to rehabilitation services.

Objectives

The aim of the present study was to study the practice and offer of rehabilitation interventions and services in Belgium.

Methods

A standardized questionnaire was sent out to all Belgian individual psychiatrists and to those working in general hospital psychiatric wards, in psychiatric hospitals and in community mental heath centres whose patients are affected by schizophrenia In a significant proportion (> 10%).

Results

Although rehabilitation was generally regarded as an important concept of care, systematic screening and training of relevant skills was far from generally available. The assessments of abilities necessary for rehabilitation were assessed by only slightly more than half of the respondents. The availability of training in rehabilitation skills was even more limited: less than half of the respondents mentioned giving training in one of the four rehabilitation domains questioned, and only 32% provided training in Activities of Daily Living (ADL) as well as in vocational, social and independent living skills.

Conclusions

We can therefore conclude that although the importance of rehabilitation is increasingly being recognised, the systematic assessment of patients' abilities and training in necessary skills have yet to develop on a larger scale.

Key words

Psychiatric rehabilitation • Schizophrenia • Psychiatric services • Survey

Riassunto

La schizofrenia è stata a lungo vista come un disturbo debilitante cronico con un esito quasi inevitabilmente negativo. Tuttavia, vari studi a lungo termine recenti suggeriscono che la guarigione possa essere possibile sia per pazienti al primo episodio, sia per quelli con schizofrenia cronica. Sebbene l'importanza degli interventi riabilitativi miranti all'integrazione sociale dei pazienti con schizofrenia sia sempre più riconosciuta, un'ampia percentuale di questi pazienti ancora non ha accesso ai servizi riabilitativi.

Obiettivi

Lo scopo di questo studio è stato indagare le pratiche e l'offerta di interventi e servizi riabilitativi in tutto il Belgio.

Metodo

È stato inviato un questionario standardizzato a tutti gli psichiatri belgi in privato e nei servizi pubblici, inclusi i reparti di psichiatria negli ospedali generali e negli ospedali psichiatrici, nonché nei servizi territoriali di salute mentale i cui utenti sono costituiti da pazienti con schizofrenia per almeno il 10%.

Risultati

Anche se la riabilitazione è in genere vista come un concetto importante della cura, vi è ancora insufficiente disponibilità di valutazioni sistematiche e di formazione specifica. Le valutazioni delle abilità necessarie per la riabilitazione sono state effettuate da poco più della metà di quelli che hanno risposto al questionario. La disponibilità dell'offerta formativa risultava ancora più limitata: meno della metà dei rispondenti hanno menzionato la fornitura di formazione in uno dei quattro domini riabilitativi richiesti e solo il 32% ha fornito formazione nelle attività della vita quotidiana e nelle abilità vocazionali, sociali e del rendersi indipendenti.

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Conclusioni
Pertanto, possiamo concludere che nonostante il crescente riconoscimento dell'importanza della riabilitazione, la valutazione sistematica delle abilità dei pazienti e la formazione nelle abilità necessarie sono lungi dall'essere sviluppate su una più ampia scala.

Parole chiave
Riabilitazione psichiatrica • Schizofrenia • Servizi psichiatrici • Indagine

Introduction

Schizophrenia is a serious mental disorder that generally surfaces a first time during adolescence or young adulthood. The first psychotic episode seriously disrupts the normal developmental process and prohibits fundamental goals to be reached, making it difficult for the affected individual to take up his previous life and re-connect to peers once the psychotic symptoms have cleared. The severe symptomatology, the frequent occurrence of relapses and the serious disruption of normal developmental processes, have led schizophrenia to be regarded as a chronic disabling disorder with an almost inevitable negative outcome. The chance of a complete symptomatic or functional recovery was considered minimal.

In recent years, this gloomy vision has gradually been changing. Several long term studies paint a more positive picture of long term schizophrenia outcome and suggest that recovery might be possible for first-episode [1-3] as well as chronic schizophrenia patients [4-7]. Continuous comprehensive care proved a key element to obtain a favourable long term outcome.

In general, treatment at first focuses on symptomatic control, symptomatic remission and the prevention of psychotic relapse through the use of antipsychotic medication. Treatment non-adherence is often problematic despite the proven effectiveness of antipsychotic agents for symptom reduction [8-10] and relapse prevention [8 11 12]. To optimally prevent relapse, antipsychotic treatment therefore needs to be supplemented by psycho-education, the creation of a supportive environment and the acquisition of coping skills to minimize the influence of stressors. Symptomatic control, relapse prevention and stress-management constitute only some aspect of psychiatric rehabilitation. Socio-professional (re)integration is an additional focus of psychiatric rehabilitation. Additionally, psychiatric rehabilitation aims at reintegrating schizophrenic patients in society and allowing them to live a life as normal as possible. This requires offering patients the opportunity to re-acquire the skills necessary for education continuation, working, socialising, independent living etc. The latter rehabilitation aspects are generally only addressed after obtaining symptomatic stability even though there is growing evidence that it is highly important to deal with these topics from the first contact [13].

The wide variety of topics that need to be tackled during rehabilitation highlights the biopsychosocial character of the concept and makes it conceivable that rehabilitation is best offered by a multidisciplinary team with complementary abilities. The evidence for the effectiveness of psychiatric rehabilitation is accumulating. With adequate interventions, social and vocational rehabilitation could be obtained by about half of the first-episode patients and one third of more chronic patients [7 14 15].

Although the importance of rehabilitation interventions is increasingly recognised, a substantial proportion of patients with schizophrenia does not have access to rehabilitation services [16 17]. In a naturalistic study by Fredenrich-Mühlebach et al. [18] 40% of patients with schizophrenia did not have any vocational or educational perspectives at discharge from hospital. Depending on definition criteria, between 22% and 90% of patients do not receive continuity of care after discharge [19]. These results show that rehabilitation services are far from generally available. Evidently, large differences between countries may exist with respect to the availability and organisation of rehabilitation services.

Organisation and practice of care in Belgium

Belgium is a small country (30,528 square km) but with more than 10 million inhabitants. The unitary Belgium of 1830 gave birth to a current, more complex structure on three levels: the upper level comprises the federal state, the Communi-

ties and the Regions; the middle level is occupied by the Provinces; and the lower level is that of the Communes.
Accordingly, Belgium is made up of three Communities (the Flemish Community, the French Community and the German-speaking Community), three Regions (the Flemish Region, the Brussels-Capital Region and the Walloon Region), 10 Provinces and 589 Communes [20].
The responsibility for health services is split between the federal state and the Regions. The health system in Belgium is free and liberal: patients have a free choice of doctor and treatment facilities. There is, however, an obligatory, state-funded insurance system administered by private-sector mutual organizations. Patients pay a small percentage of the cost of treatment in addition to the insurance premium [22].
In Belgium, hospitals can be classified into two categories: general and psychiatric. In 2005, there were 215 hospitals, of which 146 were general and 69 psychiatric [21]. Psychiatric hospitals can be owned by local authorities or be privately owned. The number of psychiatric beds allowed per 1000 is set by the government. The payment of hospitals depends on bed occupancy [22].
As in most countries in Western Europe, psychiatric treatment has been provided mostly in hospitals (psychiatric hospitals or psychiatric ward in a general hospital). However, there has been a shift towards deinstitutionalization and community care. In 1990, an important reform was carried out in the Belgian psychiatric sector, aimed at cutting back on psychiatric beds and substituting these with new provisions aiming to stimulate the social integration of patients. This reform is reflected in medical statistics. In 1990 there were 21.800 beds in psychiatric hospitals available for adults with mental illness. In 2008 this figure decreased unto 15.716 beds [23].
Today different alternative community services for the rehabilitation and re-socialization of long-term mentally ill in Belgium exist: sheltered housing, day-and night-hospitals, day activity centers, community mental health centers and psychiatric care units, besides more recent pilot projects for psychiatric home care and Assertive Community Treatment. Vocational rehabilitation for most patients starts in the hospital. Independent training services are rare [21-23]. There are now (statistics of 2006 for the Flemish Region) for example 2.300 beds for long-stay patients in small psychiatric care units and 2.450 places in sheltered housing [23]. With the continued expansion of mental health care centres and psychiatric departments within general hospitals as well as the advent of alternative community services, psychiatric hospitals acquired another function. Previously, psychiatric hospitals had an important residential function, but the focus has shifted to active treatment and rehabilitation.
The Belgian health care system is complex and specifically the psychiatric care system is not very transparent, nor well studied [21-23]. Alongside, two waves of deinstitutionalisation principles of rehabilitation have gradually been introduced since the early '90. This went hand in hand with the creation of new services for people with long-term mental illness such as sheltered housing in the community, psychiatric care units for elder patients, general promotion of community care and more recent pilot projects for psychiatric home care and Assertive Community Treatment [23].
However, there has been no systematic evaluation of how and where psychiatric/psychosocial rehabilitation is being offered to patients in daily practice. The aim of the present study is to nationwide study the practice and offer of rehabilitation interventions and services in Belgium.

Method

A working group reviewed the current published evidence of rehabilitation interventions. Based on this evaluation, a structured survey (a standardized questionnaire) was created, aiming to assess the current clinical practice as well as the services offered both in hospital and ambulatory settings.
The anonymous survey was available in Dutch and French and a total of 1,000 surveys were sent out to all Belgian individual psychiatrists, psychiatric wards in general hospitals, psychiatric hospitals and community mental heath centres and individual psychiatrists. The survey was not sent to psychiatrists with only an ambulatory psychotherapeutic practice. Only clinicians with a significant proportion of patients with schizophrenia were targeted: the survey had a screening sheet to identify and eliminate clinicians with low case-loads of patients with schizophrenia (a patient population

TABLE I.
Offer of care and services for people with schizophrenia. *Offerta di cure e servizi per persone con schizofrenia.*

	All (n = 100)	Ambulatory (n = 28)	General hospital (n = 24)	Psychiatric hospital (n = 48)
Specific rehabilitation setting	73%	60.7%	58.3%	87.5%**
Ambulatory (n = 73)	57.5%	58.8%	78.6%	50.0%
Partial hospitalization (n = 73)	65.7%	58.8%	50.0%	73.8%
Residential (n = 73)	74.0%	76.5%	42.8%	83.3%**
Network of care for psychosis	56%	50.0%	62.5%	56.2%
Early detection/intervention team	18%	10.7%	12.5%	25.0%
Specific residential program for early psychosis/first episode	58%	39.3%	54.2%	70.8%*
Discharge management	72%	42.9%	70.8%	89.6%***
Ambulatory consultation	94%	89.3%	100%	93.4%
Continuity of care after discharge	59%	39.3%	66.7%	66.7%*
Depot clinic	49%	35.7%	75.0%	43.7%**
Sheltered housing	83%	78.6%	54.2%	100%***
Psychiatric care unit (older patients)	62%	60.7%	41.7%	72.3%*
Case-management service	23%	21.4%	16.7%	27.1%
ACT team	16%	14.3%	8.3%	20.8%
Systematic involvement GP	66%	64.3%	66.7%	66.7%
Systematic offer for children of patients with mental illness	44%	39.3%	29.2%	54.2%
Offer for forensic patients	34%	21.4%	25.0%	45.8%
Involvement of consumer organizations	45%	35.7%	29.2%	58.3%*
Innovative project ongoing	48%	42.8%	58.3%	45.8%

* $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$.

TABLE II.
Practice of systematic assessments of clinical aspects. *Pratica di valutazioni sistematiche degli aspetti clinici.*

	All (n = 100)	Ambulatory (n = 28)	General hospital (n = 24)	Psychiatric hospital (n = 48)
Symptomatology with rating scales	16%	3.6%	20.8%	20.8%
Clinical assessment domain:				
Criteria of remission	45%	39.3%	54.2%	43.7%
Side-effects	78%	78.6%	79.2%	77.1%
Suicide risk	73%	75.0%	79.2%	68.8%
Physical health monitoring	90%	75.0%	92.7%	97.9%**
Screening metabolic abnormalities	89%	82.1%	87.5%	93.7%
All 5 domains	62.8% (n = 78)	76.2% (n = 21)	55.6% (n = 18)	59.0% (n = 39)

** $p \leq 0.01$.

consisting of less than 10% of people with schizophrenia). These clinicians did not had to fill in the actual survey. Participants could send the survey to the study coordinators or post their response online on a dedicated website, with a unique logon for each participant.
Descriptive statistics were calculated for the survey-items. For these statistics the statistical package of SAS (Statistical Analysis System, Carey NC) was used. Between-group differences were evaluated through chi-square tests for categorical variables. Given the exploratory nature of the study, it was decided not to correct for multiple comparisons.

Results

Overall the response rate was 19.9% (199 of surveys were returned, of which only 8 were entered online). An estimate based on the available beds and the potential number of psychiatrists working in residential settings for psychosis indicates that about 50% of psychiatrists from psychiatric hospitals and 25% from general hospitals responded. Ninety-nine clinicians only filled in the screening sheet, indicating that less than 10% of their patients suffered from schizophrenia, and therefore did not had to fill in the standardized questionnaire. These

TABLE III.
Assessment of domains of autonomy and specific rehabilitation goals and interventions. *Valutazione dei domini di autonomia e specifici obiettivi ed interventi riabilitativi.*

	All (n = 100)	Ambulatory (n = 28)	General hospital (n = 24)	Psychiatric hospital (n = 48)
Autonomy central concept in care	90%	85.7%	91.7%	91.7%
Systematic assessment autonomy	78%	75.0%	75.0%	81.2%
Skills (n = 78)	82.1%	76.2%	77.8%	87.2%
Disability (n = 78)	80.8%	80.9%	83.3%	79.5%
Goals and needs of patient (n = 78)	80.8%	80.5%	77.2%	69.2%
Quality of life (n = 78)	73.1%	75.0%	66.7%	77.1%
All 5 domains (n = 78)	49.0%	76.2%	55.6%	60.0%
Assessments done informal	74%	75.0%	66.7%	77.1%
Formal rehabilitation assessments				
ADL and level of functioning	56%	57.1%	54.2%	50.0%
Social skills	62%	64.3%	70.8%	56.2%
Work skills	52%	57.1%	41.7%	54.2%
Skills for independent living	63%	67.9%	66.7%	58.3%
Assessment of all domains	22%	14.3%	20.8%	27.1%
Skills training				
ADL and level of functioning	49%	21.4%	37.5%	70.8%***
Social skills	43%	21.4%	37.5%	58.3%**
Work skills	46%	28.6%	20.8%	68.7%***
Skills for independent living	48%	17.9%	41.7%	68.7%***
Training of all domains	32%	12.5%	45.8%	53.6%***
Practice according to specific rehabilitation model	64%	46.6%	50.0%	60.9%**

TABLE IV.
Practice of specific psychosocial interventions and rates of vocational training and employment in patients with schizophrenia. *Pratica di specifici interventi psicosociali e tassi di formazione ed impiego in pazienti con schizofrenia.*

	All (n = 100)	Ambulatory (n = 28)	General hospital (n = 24)	Psychiatric hospital (n = 48)
Systematic family intervention	75%	64.3%	78.0%	81.2%
Systematic psychotherapy	85%	92.9%	70.8%	87.5%
Client-centered model (n = 85)	32.9%	50.0%	17.7%	28.6%
Behavioral model (n = 85)	58.8%	38.5%	58.8%	71.4%*
Psychoanalytic model (n = 85)	28.2%	34.6%	17.7%	28.6%
Systemic model (n = 85)	62.4%	57.7%	64.7%	64.3%
Other (n = 85)	14.1%	4.6%	11.7%	14.2%
Systematic psycho-education	73%	53.6%	66.7%	87.5%**
For patients (n = 73)	20.5%	20.0%	12.5%	23.8%
For families (n = 73)	1.4%	0%	6.2%	0.0%
For both (n = 73)	78.1%	80.0%	81.3%	76.2%
Cognitive therapy for psychosis	55%	25.0%	66.7%	66.7%**
Cognitive remediation	48%	14.3%	54.1%	64.0%***
Life-style intervention	80%	60.7%	87.5%	87.5%**
Early signs of relapse monitoring	51%	39.3%	54.2%	56.3%
Offer of vocational training	36%	17.8%	12.5%	58.3%***
Adapted work in sheltered workplace	25%	21.4%	16.7%	31.2%***
Offer of regional job-training	53%	46.4%	45.8%	60.0%
Offer of all three	13%	3.6%	0%	25%**
Employment of patients (mean% SD)				
Full-time work	6.3% (±8.0)	5.7% (±9.0)	6.0% (±5.1)	6.9% (±8.7)
Part-time work	8.6% (±12.2)	6.9% (±7.5)	8.1% (±7.9)	9.9% (±15.6)
Sheltered workplace	13.9% (±17.5)	17.2% (±24.0)	9.7% (±13.2)	14.0% (±14.6)
Job training or education	11.3% (±17.4)	10.1% (±16.6)	11.7% (±18.9)	11.7% (±11.7)
Total active	40.5% (±39.7)	40.0% (±35.5)	36.9% (±31.7)	42.6% (±45.5)

* $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$.

clinicians were more likely to be working in ambulatory settings (39.4%).
73% of respondents work in a setting with a specific rehabilitation service, ambulatory (57.5%), and/or in partial hospitalisation (65.7%) and/or residential (74%). Sixty-four percent claim to work according to a specified rehabilitation model, although only 24% identify or have a name for the model used. Ambulatory consultation is often available (94%), as well as sheltered housing (83%). Effective services such as early detection/intervention for early psychosis (18%), assertive community treatment (16%) or case-management (23%) are not readily available (Table I).
Evaluation of symptomatology through rating scales is almost non-existing in ambulatory settings and is reported by about one fifth of psy-

TABLE V.
Multidisciplinary rehabilitation teams. *Équipe di riabilitazione multidisciplinare.*

	All (n = 100)	Ambulatory (n = 28)	General hospital (n = 24)	Psychiatric hospital (n = 48)
Nurse	52%***	14.3%	45.8%	77.1%
Psychologist	62%**	42.8%	50.0%	79.2%
Social worker	58%**	39.3%	50.0%	72.9%
Occupational therapist	49%***	10.7%	45.8%	72.9%
Psychomotor therapist	35%***	10.7%	16.7%	58.3%
Educational therapist	4%	0.0%	4.2%	6.2%
Music therapist	22%*	7.1%	16.7%	33.3%
Creative therapist	31%	14.3%	37.5%	37.5%
Non-professional	13%**	3.6%	4.2%	22.9%
Consumer	6%	3.6%	4.2%	8.3%

* $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$.

chiatrists working in general or psychiatric hospitals. About half of the respondents systematically inquire remission criteria. Assessments of side-effects (78%) and suicide risk (73%) are more common and monitoring of physical health (90%) and screening for metabolic abnormalities (89%) especially occur frequently. 62.8% of psychiatrists systematically evaluate all five domains (Table II).

Almost all respondents (90%) consider autonomy a central concept of care and systematically (78%) and/or informally (74%) assess aspects of autonomy. Formal assessment of each of the skills regarded as essential for rehabilitation were done by slightly more than half of the replying psychiatrists. A complete assessment of all rehabilitation skills is however done by only 22%. Training in the different rehabilitation skills is offered by slightly less than half of the respondents but the availability of training programs differs as a function of clinical setting. As could be expected, skills training programs (training of all domains) are more readily available in psychiatric hospitals than in ambulatory settings ($p \leq 0.001$; χ^2 (df 2) = 16.5) (Table III).

As can be seen in Table IV, systematic family intervention is frequently offered as is systematic psychotherapy. Behavioural therapy and systemic analysis are the most frequently used therapeutic models. The frequency of use of behavioural therapy ($p \leq 0.05$; χ^2 (df 2) = 7.2) differs as a function of treatment setting as does the use of psycho-education ($p \leq 0.01$; $\chi^2 = 10.9$), cognitive remediation ($p \leq 0.001$; χ^2 (df 2) = 18.4), cognitive therapy for psychosis ($p \leq 0.01$; χ^2 (df 2) = 14.1) and life-style interventions ($p \leq 0.01$; χ^2 (df 2) = 9.0). All these interventions tend to be more obtainable in psychiatric and general hospitals than in ambulatory settings. Vocational training facilities are better developed in psychiatric hospitals as compared to ambulatory settings and general hospitals ($p \leq 0.001$; χ^2 (df 2) = 20.1). Even in psychiatric hospitals though, the availability of vocational training is reported by -at maximum- slightly more than half of the respondents while reported employment rates are low.

Sixty-four percent of the respondents reported using a systematic rehabilitation model. Most of these psychiatrists were part of a multidisciplinary team that included two or more additional specialised caregivers in 84.4% of cases and 3 or more specialised team members in 78.1% of cases. Multidisciplinary teams were larger and more varied in psychiatric hospitals. The representation frequency of the different disciplines in the multidisciplinary team for the total group of respondents and for the different settings is presented in Table V.

Table VI gives an overview of the different clinical and rehabilitation activities that can be offered to

TABLE VI.
Different clinical and rehabilitation activities that can be offered to patients and their use as reported by responding psychiatrists. *Varie attività cliniche e riabilitative che si possono offrire ai pazienti e loro uso riportato dagli psichiatri che hanno risposto.*

	All (n = 100)
Clinical assessments	
Criteria of remission	45%
Side-effects	78%
Suicide risk	73%
Psychotherapeutic interventions	
Systematic family intervention	75%
Systematic psychotherapy	85%
Systematic psycho-education	73%
Rehabilitation assessments	
Systematic assessment autonomy	78%
Assessments done informal	74%
ADL and level of functioning	56%
Social skills	62%
Skills for independent living	63%
Assessment of all domains	22%
Skills training	
ADL and level of functioning	49%
Social skills	43%
Work skills	46%
Skills for independent living	48%
Training of all domains	32%
Offer of vocational training	36%
Adapted work in sheltered workplace	25%
Offer of regional job-training	53%
Offer of all three	13%
Employment of patients (mean% SD)	
Full-time work	6.3% (±8.0)
Part-time work	8.6% (±12.2)
Sheltered workplace	13.9% (±17.5)
Job training or education	11.3% (±17.4)
Total active	40.5% (±39.7)

patients and their use as reported by responding psychiatrists for the total group of respondents.

Discussion and conclusion

One of the central principals of rehabilitation is a commitment to help persons with severe mental illness to live their lives to the fullest extent possible [24], to assure that the person can perform those physical, emotional, social and intellectual skills needed to live, learn and work in the community, with the least amount of support necessary from medication or helping clinicians [25]. Symptoms, especially negative, and cognitive dysfunctions seem to be key determinants of community outcome [26-30]. Therefore, symptomatic control, remission and treatment adherence generally are the primary goals of schizophrenia treatment. However, the systematic assessment of remission criteria (45%) and especially the use of rating scales to evaluate symptomatology (16%) were reported by less than half of the respondents. On the other hand, interventions intended to increase treatment adherence (psycho-education, family interventions, etc.) were rather common (75%).

The monitoring of side effects and physical health is wide-spread in the Belgian health care system (up to 90%). This is not evident as it seems that the somatic well being of people with a severe mental illness has been neglected for decades [31], and still is today [32-38]. While patients with a severe mental illness are known to have an increased risk of physical health co-morbidities, their physical well-being often goes unnoticed by health care professionals [39-44]. Many psychiatrists consider their primary function to be the provision of clinical care in terms of symptom control and are reluctant to monitor physical health despite the presence of physical health issues [45]. Nevertheless, to take care of the physical health of the patients with schizophrenia can also be considered as part of the rehabilitation goal.

Although most respondents (90%) consider autonomy as a central concept of care and formally or informally assess one or more aspects of this concept, the assessments of abilities necessary for rehabilitation (activities of daily living (ADL), social and vocational skills, skills for independent living) were assessed by only slightly more than half of the respondents, while only 22% reported

assessing all four rehabilitation domains questioned.

The availability of training in rehabilitation skills is even more limited: less than half of the respondents mention giving training in one of the four rehabilitation domains questioned, and only 32% provide training in ADL as well as in vocational, social and independent living skills. All these forms of therapy require extensive training [46]. It seems that the applicability of rehabilitation skills training and other forms of therapy is limited by the clinician's training, time, and resources. This probably explains the difference in consideration, assessment and training results.

The rehabilitation team of a psychiatrist working according to a specific rehabilitation model is generally multidisciplinary although the size of the teams varies between ambulatory services, general and psychiatric hospitals with, as could be expected, larger teams in psychiatric hospitals.

In Europe, estimates of employment rates in people with schizophrenia range from 8 to 35% [47]. Given the equally low employment level of our patient population (40.5%), the need for vocational training is obvious but is not generally offered, despite the fact that a growing body of evidence suggests that social and vocational interventions effectively enhance social and vocational functioning for individuals with schizophrenia [48]. Different forms of vocational training appear to be offered more frequently in Belgian psychiatric hospitals as compared to other settings but even in psychiatric hospitals vocational guidance is far from generally offered.

Summarizing, one can state that, although rehabilitation, together with related concepts like autonomy, is generally regarded an important concept of care, systematic screening and training of relevant skills is far from generally available. When differences between care settings are observed, they generally reflect the more comprehensive rehabilitation package available in psychiatric hospitals. It is remarkable that even a systematic assessment of symptomatology is generally rather infrequent, even though symptomatic control is supposedly the primary focus of care, and extremely relevant for rehabilitation.

Although these data are based on a limited number of respondents since only one fifth of the surveys were returned, we can preliminarily conclude that the importance of rehabilitation is increasingly being recognised, but that systematic assessment of the patients' capabilities and patients' training in necessary skills have yet to be developed on a larger scale.

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