

Psychosocial Rehabilitation Essay

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Psychosocial rehabilitation (PSR) facilitates hope, change, and recovery for individuals with severe and persistent mental illness. Unlike the medical model which uses medications to treat symptoms of the illness, the rehabilitation model concentrates on treating the illness through the different components of PSR (Allen, 2010, p. 2). Psychosocial rehabilitation promotes successful community integration, personal recovery and improved quality of life for individuals with mental illness ("PSR Canada," 2014). "The main principles consist of self-determination, person centered plans, and maintaining hope, and with these values in mind, we can reduce or even eliminate most of the barriers to PSR. The goal of PSR is to reinstate these abilities that may have been lost or never learned. Each person, with a severe and persistent mental illness, should restore their abilities for independent living, socialization, and effective life management skills" (Allen, 2010, p. 3). PSR directly focuses on the high risks that individuals with persistent and serious mental illness experience such as repeated hospitalizations, low levels of community function, unemployment, homelessness and increased utilization of hospital emergency rooms ("PSR Canada," 2014). Psychosocial rehabilitation refers to the technologies and services available to the person with mental illness helping them learn how to adapt to new life challenges, whereas recovery is the individual's lived experience of overcoming and accepting these challenges (Deegan, n.d.). A good differentiation of the two according to Deegan, (n.d.) is that "rehabilitation refers to the 'world pole' and recovery refers to the 'self-pole' of the same phenomenon."

Recovery is not a cure, it's how an individual learns to live with their mental illness ("Psychiatric Services," 2005). Recovery is a journey of transformation and healing that enables an individual with mental illness to live a full meaningful life in their community while striving

to achieve their full potential (Sundeen, 2013, p. 199). There are many different things people with mental illness are recovering from, not just the illness itself. Recurring traumas of the symptoms, medication side-effects, treatments and stigma associated with mental health services contact, negative prognosis and attitudes from professionals, lack of professional skills in helping rebuild themselves, 'them and us' attitudes that devalue and disempower individuals in their environments, services that are depressing and inadequate which encourage passivity, lack of engaging and valued activities in line with aspirations and interests, and the multiple discriminations, manifestations and social exclusion (Repper & Perkins, 2003, p. 49).

Psychiatric rehabilitation incorporates occupational, social, educational, cognitive and behavioral interventions to maximize self-sufficiency and produce long-term recovery (Sundeen, 2013, p. 200). Through community support and resources, individuals are taught how to live with their illness while receiving support from healthcare providers, the community, peers and family. PSR is made up of many different concepts, each resource has its own idea of what the core concepts are, however the ones that stood out were vocational, social, education and physical health. These all meet a variety of needs for individuals with mental illness. Vocational rehabilitation allows mental health consumers to overcome barriers to maintaining, returning to, or accessing employment, many of these individuals are on a fixed income through disability payments and having meaningful employment gives them a sense of self-worth, belonging and pride (Allen, 2010, p. 16). Social acceptance and mental health education are a part of PSR that helps society look past the disability of mental health and the stigma associated with it, allowing these individuals to become active in their communities. Physical health through exercise and medication compliance is also a major component of PSR, in some cases rehabilitation and

recovery may not be possible without medication, although at times it can also be a barrier (Allen, 2010, p. 16)

The rehabilitation and recovery model is premised on the principles of empowerment and self-determination. It's a holistic approach allowing service users to make their own choices regarding their healthcare. All interventions are focused on the strengths of the individual with the mental illness not the diagnosis of the illness (Allen, 2010, p. 12). PSR looks to the community for potential support instead of hospitalization; by doing this it maximizes the individual's feelings of self-worth putting them in control of their day-to-day activities through a person centered plan (PCP). The individual is responsible for a large amount of daily decision making, they must share input and help plan their recovery in the community (Allen, 2010, p. 11). Community support is critical for the individual's recovery, it's where they live, work and have friends and peers. The role of the mental health care provider is to facilitate the decisions made, help the individual to make informed choices, and advocate by identifying their rights and promoting their responsibilities (Allen, 2010, p. 13). Mental health providers must continually express positive support towards the individual while believing in their abilities to learn and grow. Hope is both recognizing and accepting the problem and having the strength to manage it (Allen, 2010, p. 12). Hope also plays an essential role in the recovery process by motivating people for a better future. It gives individuals the belief that they can and will overcome the obstacles and barriers they may come against. Hope is essentially internalized, however it can be fostered by family, friends, providers and peers. It is considered the catalyst of recover (Sundeen, 2013, p. 200).

Psychosocial rehabilitation is the most successful treatment model for individuals with mental illness. It facilitates hope, change, and recovery by focusing on the individual and not their illness. This essay illustrates the importance of a comprehensive psychosocial rehabilitation assessment and an extensive treatment plan for a female with a history of paranoid schizophrenia.

### **Case Study:**

D.S. is a 52 year old Caucasian female who presented to the Penticton Regional Hospital's emergency room via the RCMP under section 28 of the mental health act. She lives alone in a condo where her neighbors have become concerned about her recent behavior and called the police. The RCMP found her running down the hallway of her apartment building screaming at the neighbors accusing them of ruining her furniture, painting the soles of her shoes and breaking into her apartment when she wasn't looking or was out. The neighbors don't know much about her other than she had just recently moved to the Penticton area. The hospital staff ended up sedating her prior to the community crisis response team's arrival, so her assessment was delayed until the next morning. (CCRT where the writer is currently placed for her practicum, does all psych assessments in the ER and community assessments while working under the ER doctor and psychiatrist on call) RCMP gathered her medications and information and CCRT called D.S.'s emergency contact to gather collateral on her until they were able to assess her.

On assessment D.S. is a 52 year old female currently living on a disability pension. She states she was diagnosed with paranoid schizophrenia in her twenties, and was brought to the hospital by the police after accusing her neighbors of ruining her things. She was restless during the interview, rising frequently from her chair, looking around the room and commenting on the furniture.

She looked her stated age of 52, but her clothes would have been appropriate for a much younger person: although quite obese, she wore blue tight pants and a flowered halter top which showed a bare midriff and worn out boots with spiked high heels. Her general level of grooming was very poor her short gray hair was matted on both sides of an irregular part. She was cooperative throughout the interview however her speech was rapid and high pitched at times and her judgment and insight seemed poor as evidence by her statement “I’m not sick! It’s my neighbors, they dig holes in my couch and paint the bottom of my shoes when I’m not home, they are the criminals, and they must be stopped!”

She admits to approximately ten hospitalizations over the last twenty years with what sounds like an exacerbation of her paranoid schizophrenia. Client states she is on a number of medications including Clozapine 500mg/day, Paliperidone 9mg/day, Prozac 40mg/day, Clonazepam 1mg 3x/day and Imovane 7.5-15mg at bedtime. She also admits to a sporadic history of drug and alcohol use in her past, blood work from the ER showed an ETOH level of 80mg/dL, but she denies substance abuse problems or treatment thus far. Dr. Sheran assessed her in the ER and has agreed to take her on as a client.

Once stabilized D.S. was referred to Mental Health Services by Dr. Sheran who was concerned about her lack of resources in the community. Mental Health Services met with client to discuss psychosocial rehabilitation and resources in the community that are available to her and will work with her to find a suitable treatment plan.

**Recovery Plan:**

Recovery plans address unique individual needs consistent with the person’s hopes, values and aspirations while developing a support network ~~of personal~~ to help improve the patient’s quality of life. All areas of their life are looked at including social, occupational, residential, educational,

spiritual, financial and intellectual areas and changes are made where needed (PSR Canada, 2010). The person centered plan for the client above is based on her strengths and needs in the community. Since she is new to the community a full assessment should be made using a tool such as the client self-appraisal of needs and interests from Vancouver Community Mental Health Services. (2011). Tools like this help collect objective data such as banking, money, medical, housing, meals, transportation, responsibilities, supports, mental and physical health, cognition, medications, shopping, stress management, activities, leisure, education, work, relationships, spirituality, self-care, home management, addictions, communication, legal, and community/cultural connections to evaluate what areas of the clients life need improvement and what supports they already have in place (Vancouver Community Mental Health Services [VCMHS], 2011).

D.S. was taken on by a case manager from Mental Health Services who helped assess her needs and together they came up with the following strengths and weaknesses. D.S. already had a bank account where her disability money was deposited ~~into~~ each month. Her medical and medications were also covered by disability so there was no concern for prescription medication or therapy bills. She lives in a safe, affordable apartment where her living skills are strong in the areas of home management, self-care and meals. She does not have access to transportation and her ongoing paranoia makes the city bus system unbearable causing her to miss her last meeting with Dr. Sheran. D.S is new to the area with no family or friend support and limited interest in activities outside of her home. D.S is an educated woman with a history of working as a book keeper for many years in her past town however, the paranoia had gotten so bad she could no longer work and ended up on disability. D.S states she misses working and the feeling of doing something meaningful. Her cognition and communication are intact, English is her first language

and she has good concentration and problem solving abilities. She has no children or pet responsibilities and states no religion or spirituality affiliation. She is lacking in community connections and other mental health resources and her C.A.G.E assessment showed possible addiction support may be needed for her alcohol consumption.

From the assessment of her strengths and weaknesses the following support and goals will be put into place. First, D.S. needs help with transportation for groceries, shopping and appointments. The goal is for her not to miss any appointments with Dr.Sheran so the strategy to achieve this goal is to assign her a support worker that will help with taking her shopping and getting her to appointments on time. Second, community support and interest in activities seems to be severely lacking. The goal is to help her find enjoyable activities and socialize in a safe environment. The strategy for this goal is to help her access Unity House which is the clubhouse for mental health consumers in Penticton. Unity House provides safe opportunities for people with mental illness to socialize, they offer drop-in meals, outings and activities. Unity House also provides access to education and information on community resources while encouraging a sense of empowerment and belonging. Since D.S is new to the area and does not have many opportunities to socialize this could be a great opportunity for her to meet people and experience a sense of support and belonging. Third, D.S. stated she missed working and wanted to do something meaningful without worrying she would be stigmatized by her illness. The strategy to help her achieve meaningful work is to put in a referral to Sandra Lucier who is the mental health advocate for PACE (Penticton and area cooperative enterprises). PACE offers vocational rehabilitation and paid employment for mental health consumers such as making hand crafted wood products, re-cycled clothing and collating services (brochure folding, mail outs and stuffing envelopes as contracted). The last issue brought up with D.S. was the C.A.G.E

assessment and her history of substance misuse. The goal is to address her current alcohol consumption issues and past addiction history. The strategy to achieve this goal is to connect her with a counselor at Pathways, which is the addiction resource center in Penticton. Pathways help individuals in the community dealing with substance and behavioral issues through education, counselling and referrals.

Evaluation of these goals will be followed up in weekly meetings to address any concerns or potential problems D.S may be facing. Weekly appointments with her case manager and psychiatrist will be made and D.S. will make extra appointments if necessary. Goals will be assessed at the one and three month mark where they will have either been met or still in progress. At completion a new assessment of strengths and weaknesses will be done to help D.S. make new goals within her recovery process.

Psychosocial rehabilitation is effective because it is individualized and focuses on the person not their illness by facilitating hope, change and recovery. The key to PSR is coordination of the different community supports, person-centered-planning, consumer empowerment, hope and self-determination, making sure needs are being met and assisting the clients in setting realistic goals, without these recovery is simply impossible (Allen, 2010, p. 17). The case study and recovery plan for the woman with schizophrenia above shows how the coordination of community services can expand one's quality of life.

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