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**PSYCHIATRIC REHABILITATION**

**Introduction**

Psychiatric rehabilitation is the systematic application of interventions developed to reduce impairments, disabilities, and handicaps. The overall goal of psychiatric rehabilitation is “ to ensure that the person with psychiatric disability can perform those physical, emotional, and intellectual skills needed to live, learn, and work in his or her own particular community, given the least amount of intervention necessary from agents of the helping profession.” The major clinical interventions by which this goal is accomplished include psychotropic medications to reduce the positive symptoms of the disorder, the development of specific skills consumers need to function effectively in their lives, and /or the development of community supports needed to accommodate or strengthen the consumer’s present level of functioning.

**Concepts:**

* Sense of Hope…..PSR aims to actively reach out to consumers to engage them in the programme, focusing on consumer strengths, building their self-confidence, and instilling hope for recovery through a rehabilitation relationship that appreciates gradual and small successful experiences.
* Pragmatism……..PSR has a focus on helping consumers with the practical problems in daily life, including education, work, welfare payments, housing, family and social relationships, and stress management. Closely related to this pragmatism is an outcome orientation, wherein services are organized around specific, tangible goals.
* Skills training…….PSR emphasizes helping consumers acquire and apply practical interpersonal and illness management skills needed to achieve community adjustment.
* Integration of treatment and rehabilitation…..The treatment of psychiatric disorders was revolutionized during the last century by the discovery and development of psychotropic medications. While medications has become a mainstay of treatment for SMI to reduce symptoms and vulnerability to relapse, many experts agree that it work best in conjunction with practical psychosocial interventions.
* Continuity of care…… The chronic nature of SMI warrants provision of flexible, timely, and long-term support. For continuity of treatment efforts, it is also incumbent upon community providers and hospitals to work together.
* Community integration…..PSR stresses the importance of individualizing assessment, planning and intervention. Consumers, as experts of their own illness, are empowered to set their own goals and make informed decisions in their treatment and rehabilitation, and services are shaped to their preferences (e.g, helping consumers find jobs in the occupations they desire).

**The conceptual model of psychiatric rehabilitation**

This model introduces a way of understanding the nature and consequences of psychiatric disease that focuses on four components: pathology, impairment, disability, and handicap. The pathological disease state is considered to be the biological abnormalities in the nervous system that produce deficiencies in attention, cognition, information processing, and autonomic functions. Impairments resulting from these deficiencies include deficits in attention, concentration, and memory, as well as delusions, hallucinations, anxiety, depression and apathy. Disability arises when the psychiatric impairments create inabilities or limitations in performing roles and tasks expected of the individual within a social environment. Examples of psychiatric disabilities include poor self-care and poor interpersonal, problem-solving, or work skills. Handicap results when disabilities put the individual at a disadvantage; they are the result of stigma and discrimination and restrict full participation in the society.

**Strategies for rehabilitation interventions**

This model of psychiatric relapse, joined with the conceptual model of rehabilitation, suggests a coherent set of strategies for interventions. They include psychotropic medications to reduce positive symptoms and impairments, as well as an array of interventions and social supports to reduce stress resulting from impoverished interpersonal and social functioning, role expectations, and other environmental factor.

**The process**

Psychiatric rehabilitation begins with a good functional assessment. following the assessment, goals are developed with consumers. The next step is the development of a plan to teach skills designed to help consumers compensate for or overcome the symptomatic and cognitive impairments and disabilities that interfere with social and vocational performance. Teaching skills in this way can also help them improve their mastery over stress and reduce the probability of relapse. This training often includes skills in coping socially and emotionally, in independent living (e. g., hygiene, cooking, use of public transportation, use of recreational facilities, physical fitness), in problem solving, in interpersonal interactions, in self control, in improving family relationships, and in job-seeking and adjustment to work. While many psychological programmes offer training in social skills, it is important to distinguish between nonspecific group activities that engage consumers in socialization and techniques to teach skills. The learning disabilities experienced by many persons with psychiatric illness require the use of highly directive educational techniques. Two structured intervention focused on developing skills, direct skills teaching and skill programming, are used to address identified deficits. Direct skills teaching goes beyond modeling skills for the consumer and / or reinforcing approximate behaviors. As part of direct skills teaching, the practitioner prepares for instruction by outlining the critical knowledge to be taught and planning a lesson that incorporates activities that will lead to mastery of a designated skill. Coaching is used to ensure the consumer’s participation in the process.

**Developing the plan for skill teaching**

1. Prioritizing goals. Consumers may have several goals they wish or need to achieve. Decisions must be made about which to begin work on first. “the criteria of rehabilitation urgency, client motivation, and client level of skill functioning are used to assign priorities to the skill areas and to select the specific area in which the rehabilitation programme will begin”. Rehabilitation urgency refers to those skills needed by the consumer to survive in the environment, but which he or she currently does not have or to degree needed. The deficits in the consumer’s environment should also be considered, because, for example, that environment may offer few rewards for change. Part of the plan would be to enhance the rewards available to the consumer.
2. Develop the overall plan. This plan guides all of the skills teaching. It identifies professional staff member who develops, teaches, and monitors program will focus on the acquisition of new skills or on better applying skills the consumer has in some measure but that might be expanded or used in a different setting. The plan for skill acquisition usually includes smaller steps. Consumers with seriously impaired functioning often need very detailed plans. Larger behavioral steps are usually used in skill application programs and their focus is on reinforcement and monitoring.
3. Develop Major programme steps. After developing the overall plan, major programme steps needed to reach the goal are identified. This includes defining the consumer’s present functioning and needed skills in observable terms, involving the consumer in programme development, and using brainstorming to identify steps in the plan. The steps are written in behavioral terms and sequenced from beginning to end so that each step brings the consumer closer to accomplishing his or her goals.
4. Develop secondary steps. Some consumers need great detail in their plans to accomplish goals. Secondary steps break major programme steps into smaller components and specify smaller behavioral changes. Secondary steps are developed in the same way as major steps. The consumer’s level of functioning determines the amount of detail to be included in secondary steps. Anthony and colleagues provide a guide to determining the need for secondary steps. They suggests asking the consumer, “what must you do in order to perform this step?” they suggest that if the consumer can accurately explain or demonstrate what must be done, secondary steps are unnecessary. If the consumer is unable to answer the question, secondary steps and sequencing are necessary. When implementing a skills acquisition plan with a consumer, practitioners must be sure that they understand the skill well enough to teach it. This may involve including secondary steps for the practitioner. The mental health professional “must be able to explain each secondary step (tell), demonstrate(show), and arrange for a situation in which the client can practice this step (do)”.
5. Develop time lines. Time lines for a accomplishing major steps are developed with consumers. Setting time lines has three advantages:
6. It increases consumers expectations of themselves,
7. It gives them a target to aim for and guide to keep them on schedule, and
8. It serves as the criterion by which performance can be evaluated and differential reinforcement administered.
9. Develop reinforcement steps. Long –term reinforcement, such as accomplishing one’s goal, may not be sufficient to keep the consumer motivated and on track in the short term. Therefore, short-term reinforcements may be needed as well. These must be individualized and perceived as rewarding by the consumer, and they must be modified when they are not working. Reinforcements might include such things as special food, watching TV, and getting together with friends. In addition to material reinforcements that consumers identify as rewarding, positive attention from mental health professionals may also act as reinforcement.
10. Implement teaching steps. The first step in teaching is to give the consumer as overview of the skill. This overview provides the consumer with the definition of the skill, its importance, and how it is performed, to set the stage for the learning process. The next step is to teach the skill by

explaining and demonstrating it. Finally, the practitioner has the consumer practice the skill.

1. Monitor the Consumer’s Performance. The consumer’s performance must be monitored to provide accurate information on progress. This includes identifying who will monitor performance, specifying where and when monitoring will takes place, and agreeing on how feedback will be given. There is a specified way to give feedback. First, the consumer critiques his or her own performance. Then the practitioner offers his or her evaluation. The consumer describes ways that the performance may be improved and then the practitioner does the same. Finally, the consumer practices the skill again.
2. Evaluate outcomes. The outcome goal has been achieved if monitoring reveals that the consumer is performing the skill appropriately, at the right time, and in the right environment.

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