Forensic Scholars Today

Volume 5 | Issue 4 Article 6

2019

A Reintroduction to Psychiatric Rehabilitation

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This article, the first in a series, will reintroduce you to psychiatric rehabilitation. If you work in or interact with mental health services, you are likely already familiar with certain-aspects of psychiatric rehabilitation. Common services that utilize psychiatric rehabilitation principles are Assertive Community Treatment (ACT) teams, community support programs, and residential mental health treatment. The successive articles will explore the principles, philosophy, and interventions that are a part of the psychiatric rehabilitation model of care. This article will define psychiatric rehabilitation, its history, and its purpose in the scope of mental health services.

What Do We Mean by Psychiatric Rehabilitation?

Psychiatric rehabilitation is rooted in the belief that people can and do recover from psychiatric disorders. The field of psychiatric rehabilitation can sometimes be confused with specific services or programs, which is a mischaracterization of this branch of psychology. Psychiatric rehabilitation is made up of three key elements: the focus on people with psychiatric disabilities, implementing a therapeutic approach, and help people to increase their life functioning. If we focus on the latter element of rehabilitation, as a field that helps people regain functioning, this creates a rich parallel to medical recovery (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). We often associate undergoing “rehabilitation” with someone who is experiencing a serious medical illness or injury. As we translate this idea to mental health, psychiatric rehabilitation is the business of helping people manage the symptoms and challenges associated with their disorder. It is focused on the recovery of functioning and life goals.

The field of psychiatric rehabilitation is a discipline within psychology that has benefited from years of growth stemming from mainstream psychology. Because mental health and wellness are more than the treatment of symptoms, the field is dedicated entirely to the overall quality of life. Psychiatric rehabilitation is focused on the quality of life of people with mental illness, working on areas of social, interpersonal, educational, and vocational goals all in the context of managing a mental health disorder (Corrigan et al., 2008).

Psychiatric rehabilitation is also founded on the principles of “recovery,” not necessarily the common definition of being in recovery from drugs or alcohol, but defining what one’s life will be. Recovery from mental illness falls into two distinct camps. The first is the remission of symptoms based on treatment with medication and other psychological services. The second, based on recovery principles, is getting back to or redefining one’s life with mental illness. The latter

teaches coping methods and managing symptoms while reaching personal goals and having a good quality of life (Morin & Franck, 2017).

How Did Psychiatric Rehabilitation Get Its Start?

Though the concepts of psychiatric rehabilitation have existed for the better part of the past century, the formal acknowledgment of it as a unique field of psychology is much more recent. Though we could start further back, deinstitutionalization is a good place to begin. Fundamental changes in mental health care grew from the mid-1950s until the 1970s, the growth of community mental health and community support centers arose in the wake of deinstitutionalization (Anthony, Cohen, Farkas, & Cagne, 2002). With the movement to deinstitutionalize people with mental illness wrapping up in the 1980s and improvements in psychiatric medications, the path was opened up for more creative community-based services to enter the scene. As Anthony et al. (2002) explained, “Deinstitutionalization focused on closing buildings; rehabilitation focuses on opening lives. Deinstitutionalization focused on ending practices of patient restraints; rehabilitation focuses on getting personal supports” (p. 2). Moving forward into the 1990s and 2000’s we have seen continued growth of self-help, peer support, and evidence-based practices, such as Illness Management and Recovery curriculum. In addition, the National Alliance on Mental Illness (NAMI) and the United States Psychiatric Rehabilitation Association (USPRA) were founded (Corrigan et al., 2008). These institutions continue their work to empower mental health consumers and providers of recovery-oriented services.

Why Psychiatric Rehabilitation?

Repeated psychiatric hospitalizations and utilization of high-intensity services are often a reality of severe mental illness. These services are often restrictive and medically focused on stability, safety, and effective discharge planning. Traditional outpatient mental health services, such as psychotherapy, often do not singularly meet the needs of people with severe mental illness. Rehabilitative services are focused on keeping people with mental illness out of the hospital and living in the community (Chang, Heller, Pickett, & Chen, 2013). Psychiatric rehabilitation service modalities are focused around in-home, residential, employment, group programming, and other community-based services (Bond & Drake, 2017). Bond and Drake (2017) remind us that some psychiatric rehabilitation modalities are evidence-based, bolstering their place in the sphere of respected practices. Research supports the role of social support and psychiatric rehabilitation-oriented services to help patients effectively live in the community and reach personal goals. The interventions in psychiatric rehabilitation are focused on community integration, activities of daily living, building social support, developing skills, social skills training, and gaining increased independence.

Naturally, for many people with severe mental illness, these services are a fitting next step after a hospitalization or other intensive services and as an adjunct to outpatient psychotherapy and psychiatry (Desai et al., 2014). Chang et al. (2013) explains that people with severe mental

illness are likely to continue to experience symptoms even when they are being treated. Psychiatric rehabilitation provides coaching, skill-building, goal planning, restoration of functioning, and vital supports for people striving to manage and overcome their mental health symptoms (Corrigan et al. 2008). In addition, this modality of care seeks to empower people with mental illness to overcome the social, economic, and emotional impact on their lives. Hope and support are cornerstones of psychiatric rehabilitation (Moran et al., 2014). Patricia Deegan (1996), a psychologist and mental health advocate reminds us that "There is more to the recovery process than simply recovering from mental illness. We must also recover from the effects of poverty and second-class citizenship. We must learn to raise our consciousness and find our collective pride in order to overcome internalized stigma" (p. 96).

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Jeremiah Schimp, Ph.D., CPRP has been working in the mental health field for the past 14 years, holding leadership positions in community and residential programs. He currently holds the position of intake supervisor at an intensive residential treatment program with Regions Hospital in St. Paul, Minnesota. He oversees admissions, supports programming, provides training, and staff development. In addition, he is an adjunct psychology instructor at Concordia University – St. Paul and University of the People. He teaches counseling, research, personality, cognitive psychology, and health psychology. Jeremiah's research and training interests are in the area of burnout and resiliency in mental health workers. He has provided training on burnout to groups of mental health providers at conferences and workshops. He earned his Ph.D. in psychology from Walden University with a specialization in health psychology. He obtained his master's in counseling psychology and post-secondary teaching certificate from Bethel University and bachelor's in psychology from Cornerstone University. Jeremiah is a Certified Psychiatric Rehabilitation Practitioner.

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