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#### ****Psychosocial Rehabilitation – Assertive Community Treatment****

The pace of change in the community mental health field is staggering. Twenty years ago we thought sheltered workshops were great. Today sheltered workshops have fallen into disfavour. Ten years ago we believed that day treatment programs were “it”. We’ve changed our minds about those too. It makes us wonder what will be the state-of-the-art ten years from now.

A similar transformation or evolution has happened in supportive housing. Twenty years ago, the Homes for Special Care system was the prominent form of supportive housing. Ten years ago, group homes which offered life skills training were heralded as the best choice for people disabled by mental illness. Today, permanent, normal housing with access to flexible supports is considered the ideal. All of these changes have several things in common. Reflected in these changes is the recognition that reduction of psychiatric symptoms alone is not enough; we also need to look at the whole person and how he/she functions in their home, work, school and social life. In addition to teaching people skills in relation to these settings we also need to increase environmental supports and resources. Just as the wheelchair-bound person needs ramps to enter a building, so too does the psychiatrically disabled person need modifications to their environment to support independent functioning. A very important factor in this evolution is the growing appreciation of providing choices and recognizing people’s preferences. How many more changes would we see if we gave the consumers the power to purchase the kind of treatment and support services they wanted.

The move away from a solitary focus on symptomatology to looking at one’s level of functioning in the world, brings with it the basic assumption or belief in hope. It has to because we do not have the ability to predict who will do well and who won’t. It also sets the stage for an approach that builds on strengths and abilities rather than emphasizing symptoms or illness.

Another common element in the evolution of community mental health is the true individualization of services. In the past we kidded ourselves that programs were individualized because we gave the consumer the choice of attending a budgeting or assertiveness training group in their day program, or because we assumed that one-to-one counseling meant individualization within a “prepackaged” program. Pre-set, time-limited programs were easy to administer but have shown poor results due to their inability to truly address individual needs. Dr. Wm. Anthony has often described these packaged programs by using the analogy of an optometrist handing a basketful of eye glasses to a patient and telling them to pick the ones they want. True individualized programs custom tailor their services to each person, much like the optometrist prescribing lenses for each patient. Getting away from the perceived need to congregate people in time-limited, prepackaged programs has done a lot to improve our ability to address individual needs and wants.

The common elements in these changes or evolution have combined to form a new clinical technology. Psychosocial rehabilitation (PSR) is currently considered one of the most promising intervention approaches in working with psychiatrically disabled adults. Unfortunately, there has also been a great deal of confusion about PSR. Over the last 30 years, hundreds of services and agencies have claimed they are using PSR. The rapid growth in the use of this approach has fostered many variations and innovations (some credible and some radical). There are, however, (at least in our minds) ten essential elements that characterize the PSR approach :

**Individualization :** services must be custom tailored to the individual. This means that program delivery must be very flexible and driven by individual choice.
**Hope :** belief in the potential to change and grow of even the most severely disabled individual. Within everyone is an untapped, under-utilized human capacity that should be developed.
**Client-directed :** people have the right and a responsibility for self-determination. This means the consumer makes the decisions including how long they receive the service.
**Focus on skills :** the core of rehabilitation is increased competencies through skill acquisition.
**Strengths and abilities :** an emphasis on current strengths and abilities and not on symptom reduction or problems from the past.
**Environmentally specific :** strengths and abilities must be assessed in relation to a specific environment. Skills must also be taught in relation to the environment in which they will be used.
**Environmental supports :** modifying the environment and building external supports are equally as important as skill teaching. This includes social change (changing attitudes,rights, laws, etc.)
**Partnership approach :** the creation of an intimate environment with no professional authoritative barriers is essential.
**On-going support :** programs should not be time-limited but geared to the individual.program delivery must be very flexible and by individual choice. History has shown us that many seriously mentally ill people succeed as long as support is provided on an on-going basis.
**Skills and supports in balance :** a person can only concentrate on improving/learning 1-2 skills at a time. Supports must be provided in any other deficit areas to enable the person to function until they master the current skills and can move on to learning or improving 1 or 2 more skills. Therefore, skills and supports are always in balance with one another.
It will be very interesting to watch the further evolution of this approach in the next ten years. One can expect even more significant changes to occur given the strength of the consumer movement and the recent heightened emphasis on PSR programming by the Ministry of Health.

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***PRACTITIONERS, CONSUMERS & APPLIED RESEARCHERS***

This private *NON-PROFIT* professional publication and associated web-based, information archive service is dedicated to the enhancement of practice, program development, program evaluation and innovations in mental health and substance abuse treatment programs worldwide.  Its goal is to provide a public forum for practitioners, consumers and researchers to address the multiple service needs of patients and families and help determine what works, for whom under a variety of circumstances.

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This peer reviewed Journal was created in 1996 by practitioners, mental health program managers and mental health consumers to provide international practitioners, scholars and consumers with a forum to publish and discuss their work in program development, evaluation research, policy innovations, and therapeutic practices that have been successful in their particular region and cultures. IJPR is not associated with any university or governmental institution, nor is it part of any ‘old boy’ or other professional network. It was created to provide information to an international readership about issues related to psychosocial rehabilitation and associated topics.

Articles on psychosocial interventions, psychopharmacotherapy, mental health primary care, institutional and community care innovations, decentralization, policy changes, community & regionally based systems, and program evaluation are given particular attention. However, all articles that relate to psychosocial rehabilitation will be considered.

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