Assessment and Planning for Psychosocial and Vocational Rehabilitation

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INTRODUCTION

The rehabilitation of persons with severe and persistent mental disorders that falls under the rubric of psychosocial rehabilitation has historically involved the worlds of mental health, vocational rehabilitation, and community programs. Although these entities had distinct functions in the past, it has become apparent that their efficacy hinges on a collaborative process based upon a biopsychosocial model.

Psychiatry, through the mental health system, has typically focused on the biological aspects of mental disorders and their amelioration, at times without regard for the psychosocial consequences imposed by mental illness and/or consequent to a diagnosis of mental illness. While using the nomenclature of psychosocial interventions, studies emanating from a psychiatric framework have focused primarily on drug efficacy, family education, and day treatment programs which result in less frequent or less extensive periods of hospitalization, and greater periods of symptom remission and time in the community. The few exceptions to this overall focus can be found in the work done as part of the Fairweather Lodge movement (Fairweather, 1980) and the Assertive Community Treatment model (PACT) developed in Madison, Wisconsin (Stein & Test, 1980). However, a proper discussion of these two approaches is not in the purview of this paper. First, they have been previously documented in a most comprehensive manner. Second, both programs arose out of a concern primarily for residential and social support services for persons with long-term mental illness. Vocational
interventions are valued mainly for their therapeutic effects (symptom remission and reduction of hospitalization), much as is the case with the majority of programs that emanated from a traditional mental health system approach. And third, assessment as practiced arose primarily out of the traditional psychiatric diagnostic interview process, that is, a concern for major psychiatric symptomatology as the basis for treatment interventions.

Vocational rehabilitation as a system, in its quest for employment outcomes has been primarily concerned with the "social" component of the model, one's place as a wage earner and tax payer in society. The federal legislation that lays the foundation for the State/Federal VR system makes it explicitly clear that employment is the ultimate outcome measure used to judge the system's viability for the taxpayer.

Psychosocial rehabilitation programs have downplayed the importance of the "bio" and "social" in favor of the "psycho," that is, the individual's sense of belonging and personal well-being. By definition psychosocial rehabilitation is the "process of facilitating an individual's restoration to an optimal level of independent functioning in the community" (Cnaan, Blankertz, Messinger & Gardner, 1988, p. 61). The process emphasizes the wholeness and wellness of the individual and encourages his or her active participation as a group member. It sees itself as the antithesis of the medical model, with a stress on skill building and social supports as opposed to symptom reduction, professional expertise, and concern with diagnosis.

It is our bias that the significance of an integrated model that includes an appreciation for the biological basis of most of the major psychiatric disorders can no longer be disregarded or demeaned. That having been said, our task is to examine the "psychosocial" legs of our triad, which must have equal footing if the combined effort is to succeed. It is hard to imagine the practicality of a three-legged stool with one leg more dominant than the other two.

The focus of this chapter is on those aspects of the rehabilitation process, specifically the functions of assessment and planning, that have fallen within the domains of psychosocial and vocational rehabilitation. Both systems have their own history, one emerging directly as a result of the deinstitutionalization of persons with mental illness from public institutions and the other (vocational rehabilitation) from work with persons with physical disabilities of war origin. Thus, the assessment and planning processes have traditionally been somewhat at odds. This was the case until the recent advent of supported employment, a concept that has bridged the gap between these somewhat disparate philosophies of rehabilitation.

In this chapter, we look briefly at those historical differences as they manifest themselves in assessment and planning efforts in particular. We then describe the various methodologies, examining their validity and reliability where possible. In detailing specific methods we offer specific strategies that appear to have clinical utility particularly in the assessment process and in the planning of rehabilitation programs that have employment as an outcome goal. Because research on efficacy is highly limited in the field of psychiatric rehabilitation, in most cases it will be possible only to address what appear to be essential ingredients if assessment and planning efforts are to yield beneficial results for those persons so engaged. What must be avoided, however, both in the present and