The Now and The Future: Advancing Practice in Psychosocial Rehabilitation

An educational event presented by Psychosocial Rehabilitation BC, in partnership with the British Columbia PSR Advanced Practice – Jan 24, 2014

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Psychosocial Rehabilitation BC and the British Columbia PSR Advanced Practice would like to thank BC’s Ministry of Health for their on-going support and commitment to the implementation and sustainability of PSR practices throughout the province.

We would like to thank all of today’s presenters and esteemed guests for their effort and dedication to PSR.

Our gratitude is also extended to Douglas College for hosting the Advanced Practice, as well as today’s events.
Psychosocial Rehabilitation (PSR): Key Tools for Recovery

PSR Advanced Practice Webinar and PSR BC Conference, January 24, 2014

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Psychosocial Rehabilitation (also psychiatric rehabilitation or PSR): Promotes personal recovery, successful community integration and satisfactory quality of life for persons who have a mental illness or mental health concern.

PSR services and supports are collaborative, person directed, and individualized, and an essential element of the human services spectrum. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice and include a wide continuum of services and supports. (PSR/RPS Canada, 2013)
PSR approaches are evidence-based best and promising practices in the key life domains of Employment, Education, Leisure, Wellness and Basic Living Skills as well as Family Involvement and Peer Support and Peer Delivered services.

Because of their demonstrated effectiveness and recovery orientation, these approaches should be widely available to people living with long term mental illness and/or substance use problems.
PSR approaches build upon the assessed strengths of persons rather than their deficits and problems. In other words PSR approaches are strengths based—they are based on the assessment of a person’s strengths as the basis for individualized goal setting and recovery. This is a major difference from traditional, illness based approaches which focus on problems and deficits.

PSR approaches are collaborative; person directed and individualized. They assist individuals in rediscovering skills and accessing the community resources needed to live successfully and with a self-identified quality of life. Accordingly, PSR approaches involve the client setting goals rather than goals being set by others.

PSR approaches support people to have a meaningful life focus on the determinants of good mental health, including employment, education, social supports, basic living skills, leisure and wellness.
PSR approaches generally place persons in their chosen goal settings such as jobs and housing and then train and support them in those settings. Similarly, other training, such as social skills training takes place in the person’s natural environments.

PSR approaches are supported by scientific evidence as effective. PSR approaches include a number of best practices, which are strongly supported by evidence, such as supported employment and wellness programs, as well as promising practices with emerging evidence, such as peer support programs. PSR approaches promote recovery with full community living and improved quality of life. Some call this: “getting a life”.

Distinctive and Defining Features of PSR approaches
The concept of recovery is reshaping the fields of mental health and substance use services. Recovery is not a new concept; it has been the dominant philosophy and major goal of physical rehabilitation for many years. Despite physical impairments such as those associated with spinal cord injury, people have hope and become active agents in their own recovery to live a fulfilling and satisfying life.

A recovery approach to people living with mental illness or substance use problems emphasizes and supports a person's potential for recovery. Recovery is generally seen in this approach as a personal journey rather than a set outcome, and one that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning. Other names for the concept are recovery model or recovery-oriented practice.
Because PSR approaches are effective and person centered, these approaches provide important tools to be used by individuals, families and practitioners to assist in supporting individual recovery. From a mental health and substance use systems perspective, these approaches are important and key to the transformation to effective, person centered systems which will result in greater client wellness, educational, and employment outcomes, increased social support and successful community living.

In turn, the adoption of these approaches will result in reduced system costs associated with emergency admissions, hospitalizations, social assistance and law enforcement.
PSR Approaches in the domains of Employment, Education, Leisure, Wellness and Basic Living Skills are evidence based as effective and important to the recovery of persons living with serious mental illness.

This section of the presentation reviews this evidence and provides guidance for the development of PSR services and programs for these life domains.
If work makes people living with mental illness sick, what do unemployment, poverty, and social isolation cause?

- Joe Marrone
Employment is very important in the recovery of persons living with serious mental illness and substance use problems. In fact, employment is often cited as the most important need. There is a significant literature base demonstrating the importance of ‘work’ in supporting people to live successfully in their communities. For example, Bush, Drake, Xie, McHugo, and Haslett (2009), in a ten-year longitudinal study, found greatly reduced hospital and service system costs for individuals who were in stable job situations.
In the past twenty years there has been a substantial change in approaches to employment of persons living with serious mental illness and substance use problems. The previous approach emphasized prevocational training to prepare individuals for later employment when they were “ready”.

Current Supported Employment approaches do the opposite and are based on first placing clients in jobs and training and coaching them in the actual job situations. In other words, there has been a major shift from “train and place” to “place and train” approaches. The main reason this shift has occurred is because of abundant, strong evidence that Supported Employment approaches are much more effective in terms of outcomes, particularly successful employment (Becker & Drake, 2003).
Prevocational training consists of pre-employment and education support to develop and improve the basic work habits, skills, and behaviours of those accessing services. Prevocational services are aimed at preparing an individual for paid or unpaid employment. The training typically teaches generic work related skills rather than training specific skills for a certain job. This may include training in such basic skills as improving attention span, motor skills as well as teaching job performance concepts such as attendance, endurance, task completion, problem solving and safety.

Volunteer work provides important opportunities for clients in prevocational training to increase independence, improve community and social integration, enhance skills and gain job confidence.
Evidence for Prevocational Training:

Because of the dominance of Supported Employment, there is little current literature on Prevocational training approaches. However, one fairly recent study of a Prevocational Training program was conducted by Matt, Bellardita, Fischer, and Silverman (2006).

This study reported the program to be helpful for clients trying to re-enter the job market. However, the entry and completion rates for the program were low with less than a third of participants completing the program.
Transitional employment involves placing people in job placements in the community, often on a time-limited basis. Job placements may include work crews where clients work together to provide a service with some staffing support. Alternatively the client may be placed in a community job and the business is given assurance there will be back-up to help ensure the work is completed.

Some employment centres and vocational programs as well as Clubhouses offer Transitional Employment programs. Clubhouse models have documented components in the Clubhouse International Standards. However this approach to service delivery is provided in both Clubhouses and other community settings.
Employment
Transitional Employment

Clubhouse Based Employment Programs:
The Clubhouse model originated with the establishment of Fountain House in New York City in 1943 when a small group of former psychiatric hospital patients formed a group to help each other live in the community. The success of Fountain House in facilitating recovery through social support and activities, and through providing prevocational and vocational opportunities has led to the widespread adoption of the model throughout the world.

A number of studies have demonstrated that clubhouses are effective in improving outcomes for members. In fact Clubhouses are now recognized as an evidence based practice. For example, Di Masso, Avi-Itzhak and Obler (2001) in an evaluation of a Clubhouse program found it to be effective in enhancing work attainment and employment status while reducing psychiatric hospital admissions among its members.
The most widely used and researched Supported Employment (SE) model is Individual Placement and Support (IPS). IPS is a “Place and Train/Support” model that supports individuals to find competitive employment based on their goals.

As with other SE approaches, IPS emphasizes initial obtainment of work, followed by support after placement to assure job success.

The effectiveness of IPS depends on the model being implemented with a high degree of fidelity. Fidelity scales have been developed and validated by the Dartmouth Supported Employment Research Centre. The most recent version is the Supported Employment Fidelity Scale also known as the IPS 25. The IPS 25 and its manual are available at: http://www.dartmouth.edu/~ips/page19/page19.html. In addition to its primary use in evaluating implementation fidelity, this scale is valuable as a template or guide for developing and implementing high fidelity IPS programs.
Specific Components of IPS:

• **Focus on Competitive Employment:** Agencies providing IPS services are committed to competitive employment as an attainable goal for people with serious mental illness seeking employment.

• **Eligibility Based on Individual Choice:** Participants are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, level of disability, or legal system involvement.

• **Integration of Rehabilitation and Mental Health Services:** IPS programs are closely integrated with mental health treatment teams.

• **Attention to Personal Preferences:** Services are based on clients’ preferences and choices, rather than providers’ judgments.

• **Personalized Benefits Counselling:** Employment specialists help clients obtain personalized, understandable, and accurate information about their income assistance, healthcare benefits, and other government entitlements.
Specific Components of IPS:

- **Rapid Job Search:** IPS programs use a rapid job search approach to help clients obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counselling.

- **Systematic Job Development:** Employment specialists build an employer network based on clients’ interests, developing relationships with local employers by making systematic contacts.

- **Time-Unlimited and Individualized Support:** Follow-along supports are individualized and continued for as long as the client wants and needs the support.

(Dartmouth Psychiatric Research Centre, 2013)
Evidence for Individual Placement and Support:

There is substantial support for the effectiveness of the IPS model, (see Moll, Huff, and Detwiler (2003); Twamley, Jeste and Lehman (2003); and Crowther, Marshall, Bond, and Huxley (2010)). These studies have consistently demonstrated better client employment outcomes in terms of job funding, tenure, and earnings compared to clients in traditional approaches including clubhouses and other transitional employment interventions.

The results are less conclusive in terms of other individual outcomes such as reduced symptoms and increased quality of life for people living with mental illness.

In addition to the well demonstrated effectiveness of the IPS approach for persons living with serious mental illness, IPS has also been shown to be effective for persons with concurrent disorders (Mueser, Campbell, & Drake, 2011).
In Canadian research, Latimer, E. A., Lecomte, T., Becker, D. R., Drake, R. E., Duclos, I., Piat, M., & ... Xie, H. (2006) compared individuals who were not currently employed and wished to work who received IPS, to those receiving traditional vocational rehabilitation which emphasized preparation for employment. The results demonstrated superior employment rates for those receiving IPS services (48% vs. 18%) and more hours worked for those employed with IPS services (126 v 71 hrs. per week).

In a British Columbia study, Oldman, Thomson, Calsaferri, Luke & Bond (2005) reported the results of transforming a sheltered workshop program in phases to an IPS model. While the sheltered employment program was in operation, fewer than 5 percent of participants achieved competitive employment annually. The annual competitive employment rate did not increase during a subsequent, prevocational training phase. However, in the IPS phase, 50 % of participants achieved competitive employment. These collective results suggest that the IPS model can successfully be implemented in Canadian settings.
Education

Education is not the filling of a pail, but the lighting of a fire.

- William Butler Yeats
Supported Education (SEd) refers to services and supports which assist persons living with mental illness and/or substance use problems in achieving their educational goals. The core components of Supported Education include career planning, academic survival skill building and connection to academic and mental health/substance use supports and services (Brown, 2002).

Supported Education services are recognized as “exemplary practices” which contribute significantly to the academic success, resilience (Hartley et al., 2010) and recovery for persons living with serious mental illness (Mowbray et al., 2005). The publication of a Handbook of Supported Education by Unger (1998) stimulated particular interest and research on the approach. Accordingly, in recent years, a significant amount of literature has been published in this area usually involving post-secondary educational programs.
Evidence for Supported Education:

In a major review, Mowbray et al. (2005) documented the evolution of the Supported Education model as well as the evidence for its effectiveness. This review summarizes the findings of several studies of Supported Education which have demonstrated increases in enrolment in postsecondary education as well as increased course completion and greater likelihood of re-enrolment in the following academic year.

In an Israeli study, Rudnick and Gover (2009) evaluated the effectiveness of combining Supported Education with Supported Employment. The Supported Education services consisted of offering study skills, cognitive remediation, social skills training, and computer skills. This was followed by Supported Education in a specific skilled occupation as well as post-training Supported Employment. The results demonstrated that nearly half of the participants had achieved competitive employment in their chosen area. These investigators concluded that interventions combining Supported Education and Supported Employment for participants who wish to pursue skilled trades appear to be effective in helping individuals obtain competitive employment.
The word recreation is really a very beautiful word. It is defined in the dictionary as "the process of giving new life to something, of refreshing something, of restoring something." This something, of course, is the whole person.

- Bruno Hans Geba
Supported Leisure Services assist individuals living with serious mental illness or substance use problems to access and enjoy community leisure resources and activities. Supported leisure recognizes the importance of enjoyable leisure activities to quality of life and recovery. These services are also important in building social and leisure skills as well as social networks.

Evidence for Supported Leisure approaches:
Davidson, Shahar, Stayner, Chinman, Rakfeldt, & Tebes (2004) conducted a randomized controlled trial of the effects of a supported leisure program. In two of the conditions, participants were assigned to volunteer partners who facilitated their engagement in recreational activities. All participants were found to improve in terms of reduced symptoms, better self-esteem and overall functioning, particularly for individuals who had more contact with their volunteer partners.

Lloyd, King, McCarthy, and Scanlan (2007) studied the association between assessed motivation to engage in leisure activities and the self-reported perception of recovery in a sample of 44 Clubhouse members. A modest but significant relationship was found.
Basic Living Skills

Setting goals is the first step in turning the invisible into the visible.

- Tony Robbins
Mental illness and substance use problems can lead to people having difficulties in such basic living skills as personal hygiene, home cleaning, managing money, shopping, using public transportation, assuring personal safety, conversing, making friends and living independently.

Life skills programs attempt to teach these basic skills and thereby increase the success and quality of community living. Programs may include teaching and supporting a wide range of activities of daily living (ADL) and social skills such as maintaining personal hygiene and appropriate dress, using transportation, shopping, managing a home, planning, managing time and finances, strengthening social skills, developing healthy eating habits, taking medication, and navigating and accessing community services. Some programs also include matters relating to planning for personal safety such as understanding potential fire safety issues, coping with pressures to use substances, and learning ways to avoid victimization by others.
There is a substantial amount of literature on teaching basic living skills. A major contribution to this literature has been the work of Dr. Robert Liberman and his colleagues at UCLA, who have conducted a long term research program on teaching basic living skills to persons with serious mental illness. A number of related publications are available online at: http://www.psychrehab.com/publications.html. This research program has produced a large number of articles and books describing basic living skills teaching approaches, and training modules in the areas of:

- **Medication Management**: how to properly take medication
- **Symptom Management**: how to manage one’s symptoms
- **Recreation for Leisure**: how to use leisure time
- **Basic Conversation Skills**: how to conduct day-to-day interactions
- **Community Re-entry**: how to re-enter life in the community after hospitalization
- **Workplace Fundamentals**: how to maintain successful and satisfying employment
- **Substance Abuse Management**: how to prevent drug or alcohol relapse and live a satisfying, sober lifestyle
- **Friendship and Intimacy**: how to develop network of close and intimate relationships
As noted, Liberman and his group have published a large number of studies demonstrating techniques for teaching basic living skills (see Liberman, 2008 for a review). Kurtz & Mueser (2008) conducted a Meta-analysis of the Liberman group’s Social Skills Training interventions, examining effect sizes of Social Skills Training on client outcomes. They found a strong positive effect of training on the mastery of social skills, activities of daily living, role performance, community functioning and negative symptoms, with only a small effect on other symptoms and relapse risk.

These investigators concluded that Social Skills Training helps people with serious mental illness perform the activities of daily living, and improves general community functioning and thus should be provided as a component of a comprehensive psychosocial rehabilitation approach.
However, other research findings question the value of these training programs. For example, In a Cochrane Review, Tungpunkom, Maayan, & Spares-Weiser, (2011) compared the effectiveness of life-skills training, standard care and support groups. No significant differences were found on social performance, quality of life, or symptomatology.

Similarly, Gibson, D'Amico, Jaffe, & Arbesman et al (2011) carried out a systematic review of studies of social and general life skills training. These investigators concluded that while training can improve social skills and life skills, it does not lead to improvements in overall role functioning.

It was suggested that social and life skills training may be a useful adjunct to supported education and employment, but is of limited value in itself. The implication is that priority should be placed on “place and train” rather than “train and place” approaches.
Wellness

“Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.”

- World Health Organization
Wellness is a commonly used but complex, multidimensional concept which has many different definitions. Among these definitions, there is, however, general agreement that wellness refers to a desired state of physical, mental and spiritual well-being. Therefore, it is not the same as absence of disease. Wellness also involves making life style choices. Accordingly, life style modification may be necessary for people to achieve wellness.

While life style is an important determinant of wellness, it must be recognized that many people with mental illness and substance use problems cannot achieve wellness simply through modifying their life style. Often their life style is affected by symptoms which may include a lack of motivation or interest in everyday activities or relationships. Accordingly, achieving wellness will involve addressing their mental illness and/or substance use problems in addition to modifying life style.
Physical and Mental Illness:
Compared to the general population, persons living with serious mental illness, substance use problems, and concurrent disorders have a higher incidence of physical illnesses which are often related to some medication side effects and to life style factors such as lack of exercise, obesity and smoking. On average, people with severe mental illness die 10 to 15 years earlier than the general population. This is partly due to suicide and accidental death but the rates of cardiovascular disease including heart attacks, diabetes and respiratory diseases are as much as 60% higher in persons with serious mental illness (Richardson, Faulkner, McDevitt, Skrinar, Hutchinson & Piette, 2005).

These high rates of serious physical illness have led to a significant amount of research on how behaviour, which is risky to health, may be altered. Accordingly, in a review of the lifestyle modification for persons with serious mental illness, (Richardson et al, 2005) reported dramatic reductions in chronic disease rates, in the order of 60%, through increased physical activity (Richardson et al, 2005).
Healthy Eating, Active Living

There is a substantial literature which documents the beneficial effects of exercise for persons living with mental illness. As an example, Gorczynski and Faulkner (2011) reviewed the health benefits of exercise for people with schizophrenia. This review concluded that regular exercise programs for persons living with serious mental illness can have beneficial effects in terms of both better physical and mental health.

Faulkner, Cohn, and Remington (2010) reviewed weight management programs for people living with serious mental illness and found that both CBT and pharmacological adjunct therapies were effective in preventing weight gain. This review also found that CBT was effective in helping people lose weight. This research has important implications, since preventing weight gain is an important factor in preventing diabetes, stroke, and heart disease.
Smoking Cessation:
Smoking remains a major public health problem in Canada and other countries. Accordingly, there has been a major, worldwide research effort to find effective techniques for smoking cessation. Meta-analytic reviews suggest individual behavioral counseling (Lancaster & Stead, 2008) and Motivational Interviewing techniques (Heckman, Egleston, & Hofmann, 2010; Lai, Cahill, Qin & Tang, 2010) may have some value in assisting people to quit smoking.

In a Cochrane Review, Tsoi, Porwal, and Webster (2011) concluded that bupropion increases smoking abstinence rates as well as decreasing the rate of smoking in persons with schizophrenia. The authors failed to find convincing evidence that other interventions are useful in reducing or stopping smoking in people with schizophrenia.
Symptom and Medication Management:

Fernandez, Evans, Griffiths, & Mostacchi (2006) conducted a systematic review of the efficacy of educational interventions, relating to psychotropic medications. This review provided evidence that multiple education sessions, delivered at frequent intervals are more effective in improving knowledge relating to medications and insight into illness.

In a Cochrane Review of medication adherence interventions, Haynes, Ackloo, Sahota, McDonald, and Yao (2008), examined interventions for various health conditions, including serious mental illness. This review concluded that interventions that enhanced adherence were generally complex, and included multiple facets, including providing information, making care more convenient, giving telephone reminders, and providing other forms of individual follow up and support. However, the effectiveness of these interventions in terms of increasing adherence was generally modest.
**Metabolic Syndrome Management:**

People living with serious mental illness are at increased risk for metabolic syndrome which includes insulin resistance, high blood pressure and an increased risk for clotting. Metabolic syndrome is associated with high risk of cardiovascular disease, diabetes, and stroke.

In a study of obesity and metabolic syndrome in a psychiatric rehabilitation program, Tirupati and Chua (2007) found the prevalence of obesity to be 2 to 3 times that in the general population. Most of these individuals were not being actively treated for obesity and metabolic syndrome. These investigators recommend the active treatment of both to reduce morbidity and mortality and improve rehabilitation outcomes.
Illness Management and Recovery (IMR) Approaches and Relapse Prevention:
There is a large literature in this topic area which focuses on interventions and services with a goal of reducing the probability of relapse and hospitalization. Much of this literature has been published by Mueser and his colleagues, e.g. Mueser, Meyer, Penn, Clancy, & Salyers, M. P. (2006). Mueser, Corrigan, Hilton, Tanzman, Schaub, Gingerich, . . . Herz, M. I. (2002) reviewed services which facilitate recovery through assisting individuals to understand, manage and mitigate the effects of their mental illness. These services are psycho-education, which helps individuals and their families learn more about their condition; behavioural tailoring which helps individuals take medications as prescribed through daily routine; relapse prevention which helps individuals reduce relapse and re-hospitalization by identifying relapse triggers and warning signs and by developing preventive plans; and coping skills training, using cognitive behavioral therapy (CBT) to manage symptoms and stress.
Illness Management and Recovery (IMR) Approaches and Relapse Prevention:

As a result of this review, Mueser and his colleagues developed Illness, Management and Recovery (IMR) as an integrated approach which combines these and an additional, building social support networks. IMR is now a SAMSHA Evidence Based Practice approach (SAMSHA, 2010a) and has been widely implemented, particularly in the U.S. These services are provided on an individual or group basis over nine or ten months, generally in one hour sessions provided once a week. Individuals learn and discuss the new material in the context of their life goals.

In a subsequent review, Mueser et al. (2006) presented evidence suggesting clients in IMR programs experience major improvements in self-reported effectiveness in coping with symptoms as well as clinician assessments of improved global functioning.
Wellness, Recovery, Self-Management Approaches and Relapse Prevention (WRAP):

Self-management interventions provide individuals with the confidence and skills to manage their conditions on a day to day basis. Therefore, these are important interventions for preventing relapse and facilitating recovery.

The self-management approach which has become most widely used is Wellness Recovery Action Plan (WRAP: http://www.mentalhealthrecovery.com/wrap/), developed by Mary Ellen Copeland, e.g. Copeland (1997). WRAP is similar to IMR in helping individuals to identify relapse warning signs and triggers. WRAP participants develop a “wellness and recovery” action plan which includes coping skills to remain well and avoid relapse. Peer modeling and learning from the personal experiences of facilitators and participants is an important aspect of WRAP.
Wellness, Recovery, Self-Management Approaches and Relapse Prevention (WRAP):

Cook and her colleagues (Cook, Copeland, Jonikas, Hamilton, Razzano, Grey, & Boyd (2012) have conducted a major randomized controlled trial of WRAP compared to usual care in six Ohio communities.

The results demonstrated that peer facilitated, self-management training is effective in reducing symptoms while increasing hopefulness and quality of life. This demonstration of the effectiveness of WRAP is important given the wide dissemination of WRAP throughout the U.S., Canada and other countries.
Wellness, Recovery, Self-Management Approaches and Relapse Prevention (WRAP):

Similar positive results have been demonstrated in a Canadian study by Barbic Barbic, Krupa, & Armstrong, (2009). These investigators conducted a randomized controlled trial of the Boston Center for Psychiatric Rehabilitation’s Recovery Workbook with peer facilitation. Like the WRAP program, the Recovery Workbook offers information and skills, provides education about the recovery process and strategies, and helps participants develop an action plan. This study found significant increases in hopefulness, empowerment and aspects of recovery for ACT team clients receiving peer facilitated workbook sessions.
Integrated Approaches for Concurrent Disorders:

Many persons living with serious mental illness have concurrent substance use disorders. The most effective treatment strategies are integrated approaches largely developed and evaluated by Minkoff and Drake, Mueser and their colleagues (see Mueser, Torrey, Lynde, Singer & Drake, 2003; Minkoff & Cline, 2004 for reviews). These approaches have now evolved to become a SAMSHA Evidence Based Practice approach, Integrated Dual Diagnosis Treatment (IDDT), (SAMSHA, 2010b).

In evidence supporting integrated approaches Drake, Mueser, Brunette & McHugo, (2004) reviewed 26 controlled studies and concluded that integrated approaches are effective in terms of engaging people in services and in motivating and assisting them to develop the skills and supports for recovery. The authors also concluded that integrated residential treatment, especially long-term (one year or more) is helpful for individuals who do not respond to outpatient concurrent disorder interventions.
Enhancing clinical tools and techniques are evidence based practices which improve the functional abilities of clients, particularly cognitive functioning and/or reduce the symptoms and deficits associated with severe mental illness and substance use problems.

These tools and techniques can significantly improve the outcomes for clients in psychosocial rehabilitation services and programs.
PSR and Cognitive Remediation and Training:
Cognitive remediation and training is intended to improve the cognitive functioning of individuals. A substantial research literature exists which documents the effectiveness of cognitive remediation and training techniques.

For example, to examine the effects of combined cognitive remediation and vocational rehabilitation in persons with concurrent disorders, a randomized controlled trial was conducted by McGurk, Mueser, DeRosa, and Wolfe (2009).

Regardless of the presence of concurrent disorders, individuals receiving the combination of cognitive rehabilitation and vocational rehabilitation improved the most on both cognitive and vocational measures.
**PSR and Cognitive Behaviour Therapies:**

Cognitive behaviour therapy (CBT) is a generic term applied to an increasing number of therapies which are usually directed at reducing the positive symptoms of psychosis; i.e., hallucinations and delusions. There is a growing literature which documents the effectiveness of these therapies.

For example, Gould, Mueser, Bolton, Mays & Goff, (2001) conducted a meta-analysis of 17 treatment outcome studies of cognitive therapy for psychotic symptoms in schizophrenia. The findings suggested that CBT is a promising behavioural strategy for decreasing the severity of delusions and hallucinations or helping clients to cope with these symptoms.
PSR and Motivational Interviewing:
There is substantial literature in the application of Motivational Interviewing (MI) techniques, particularly in the treatment of substance use problems. MI techniques have evolved from Rogerian Client Centred Therapy. Motivational Interviewing is defined as a collaborative form of personal therapy intended to enable, facilitate, and strengthen an individual’s motivation to change.

Meta-analyses conducted by Burke, Arkowitz & Menchola, (2003), and a Cochrane Review by Smedslund, Berg, Hammerstrom, Steiro, Leiknes, Dahl & Karlsen (2011) all document the effectiveness of Motivational Interviewing in effecting positive behaviour change in clients with alcohol and other substance use problems.
“Family” is defined as anyone in the support network of the person with mental illness or substance use problems, such as parents, partners, siblings, offspring, as well as anyone else close to the individual who can potentially play a support role. Essentially, the individual him or herself defines who constitutes family in their life.

Families have needs associated with understanding the nature of the mental illness or substance use problem and their role to support individuals in care and treatment.

There is substantial evidence that family psycho-education is very effective in supporting recovery and should be an integral part of a comprehensive psychosocial rehabilitation approach. Therefore, in order for families and individuals to benefit from these interventions, family members need to be involved as active contributors to the individual’s support network in the first place, to the fullest extent possible.
Family Involvement and Support

While evidence about the process of family involvement is still accumulating, the “pyramid model” has been put forward as a guiding conceptual Framework (Mottaghipour & Bikerton, 2005). Their pyramid model has multiple levels, which include:

- At the most basic level, involving families in the assessment process (by eliciting information)
- Explaining the benefits of family involvement to the person with lived experience, and exploring the possibilities for negotiating that involvement, either presently or at a later date
- Moving further up the pyramid, building on family involvement is based on family psycho-education and consultation with the family about the treatment plan
- Finally, the model suggests that for a minority of families, family therapy may be indicated.
Family Involvement and Support
A significant evidence base exists to document the importance of family psycho-educational interventions particularly in reducing relapse and re-hospitalization of persons living with serious mental illness. Based on early work by Dr. Ian Falloon and his colleagues (e.g. Falloon, Boyd & McGill, 1984), family psycho-education is designed to provide family members with the knowledge and skills to understand serious mental illness and to relate more positively and appropriately to their affected relative.

A major goal is to reduce the stress or Expressed Emotion (EE) in the family situation as well as strengthening family coping ability through skill training and support. Lowering the EE reduces the likelihood of the relative relapsing and being re-hospitalized. Pitschel-Walz, Leucht, Bäuml, Kissling & Engel, (2001) conducted a meta-analysis of 25 family psycho-educational studies. The results were a 20% reduction in relapse and re-hospitalization with family psycho-education. Similarly, Pilling et al. (2002) in a meta-analysis comparing family psycho-education with other interventions found that it had the largest and most enduring effects in terms of reduced relapse and re-hospitalization.
Peer Support and Peer Delivered Approaches

The past decade has seen major interest in and the development of Peer Support and Peer Delivered approaches. In part, the emergence of these approaches has been due to increased advocacy by and for people with lived experience of mental health challenges and/or substance use issues. It is also due to the influence of the recovery movement and, more recently, the result of research findings demonstrating the effectiveness of these approaches.

What is particularly significant about these approaches is that lived experience is no longer a barrier but is now an asset for peer support workers. Peer Support and Peer Delivered services are now considered to be core services which should be available to all clients who can benefit from them.
There is now a substantial literature documenting the effectiveness of peer support programs for persons living with mental illness. In a recent review of the literature commissioned by the Mental Health Commission of Canada, O’Hagan, Cyr, McKee & Priest (2010) concluded that people with lived experience can offer major benefits to each other through developing personal resources and belief in self. Not only does peer support improve the quality of life of people with lived experience, it also significantly reduces symptoms, reduces hospitalization and the use of mental health, medical and social services.

There is also substantial literature documenting the effectiveness of peer support for the recovery of persons living with substance dependence. This literature is reviewed and summarized by White and Kurtz (2006). These authors emphasize that combining peer support with other substance use services significantly increases their effectiveness.
References


Coffee Break!
Continental breakfast and refreshments served in Room 2214
Welcome Back!

The Now and the Future: PSR BC 2014
What is the PSR Advanced Practice?

The purpose of the PSR Advanced Practice (PSR AP) is to support clinicians and managers responsible for providing PSR services.
PSR Advanced Practice: Community of Practice

The PSR AP supports the field by:
- Transferring evidence-based knowledge
- Providing expert clinical consultation
- Developing/presenting training and education events
- Developing website/resources
- Specific project management roles (as for the PSR Provincial Advisory Committee)
What is the Community of Practice?

The BC PSR Community of Practice is YOU! It is made up of all individuals who have a professional and personal stake in the growth of PSR services in the province.

- Clinicians
- People who access services
- Educators
- Community Agencies

- Managers/Coordinators
- Family Members
- PSR Practitioners
- Policy Makers
PSR Advanced Practice: Community of Practice

Meet the panel...
1. How can we best make PSR services and programs available to persons with serious mental illness and/or substance use problems in BC? What would be an effective strategy to engage with health authorities?
2. Where do you see the greatest successes currently taking place in PSR? Where in health services do we need to see more PSR in practice?
3. How can the PSR Advanced Practice best meet the needs of the field?
4. How can we make the connections to establish an active PSR Community of Practice in BC? What obstacles might we need to be aware of?
5. What goals or vision do you have for PSR in BC over the next year? 5 years? 10 years?
PSR Advanced Practice: Community of Practice

Questions from the audience? (physical and virtual)
Close of webinar

Thank you to all who attended
More webinars will be available in the coming months!

Lunch Time!

served in Room 2214
PSR BC Board of Directors AGM in 2201
The Now and The Future: Advancing Practice in Psychosocial Rehabilitation

An educational event presented by Psychosocial Rehabilitation BC, in partnership with the British Columbia PSR Advanced Practice – Jan 24, 2014

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