

Psychosocial/Psychiatric Rehabilitation (PSR) Education in Postgraduate Psychiatry and Occupational Therapy Training: A Commentary

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Abstract

Psychosocial/Psychiatric Rehabilitation (PSR) facilitates recovery of people with serious mental illness (SMI). Yet there is not much research on how to provide effective PSR education and training. We address PSR education and training in two relevant professions – psychiatry and occupational therapy. Further study of PSR education and training is needed.

Introduction

Throughout the late twentieth century there was a shift in mental health care towards recovery-oriented models of care [1,2]. These models use a client/consumer/person focused approach, which aligns well with psychosocial/psychiatric rehabilitation (PSR) as a formalized model of care. This model aims to support individuals with serious mental illness (SMI) in developing meaning within the environments they deem important for their functioning and social roles [3,4]. As professionals working within mental health care, the likelihood of working with individuals with SMI is high. As a result, knowledge of the PSR model is important for those working within mental healthcare. Yet there seems to be scant rigorous study or research of how healthcare professionals are educated and trained to provide PSR, and the outcomes of such training.

Two professions for which PSR is arguably particularly applicable are psychiatry and occupational therapy. Psychiatry operates across multiple dimensions within the bio-psycho-social model of illness conceptualization. There are various theoretical underpinnings within psychiatry, some of which espouse a focus on recovery-oriented models of care more than others, e.g., by using a shared decision making approach [5]. Occupational therapy emphasizes enhancing individuals' functional abilities in various environments to enable participation in occupations (personally meaningful tasks/activities) and maximize performance or potential [6].

This commentary aims to address PSR education and training opportunities in postgraduate (residency) psychiatry and occupational therapy graduate programs and suggest future directions for enhanced PSR education and training opportunities (recognizing that, using an adult education framework, education focuses particularly on awareness and knowledge, whereas training focuses particularly on skills and attitudes).

PSR in Postgraduate Psychiatry Training (Psychiatry Residency)

In Canada, the Royal College of Physicians and Surgeons mandates the training requirements for psychiatry residents. In its most recent curriculum outlining training requirements, the Royal College discusses that a core or mandatory requirement includes 3-6 months in "severe and persistent mental illness and its rehabilitation" (p.3) and provides examples such as Forensic Psychiatry or Assertive Community Treatment Teams [7]. Despite this mandatory requirement involving work with people who have SMI, there is no requirement of or suggestion for PSR education and training. Although PSR principles may be inherent in specific rotations, there is no guarantee a resident will be exposed to these rotations and there is geographic variability amongst and between different training programs at different universities. In an editorial co-authored by the third author of this paper, there was discussion of one PSR fellowship (post-residency training) within Canada at Western University [8].

A review of the peer reviewed literature yielded few results discussing rehabilitation education within psychiatry residency. Terms including, psychosocial rehabilitation, PSR, residency and education in databases such as PubMed and Google Scholar were searched. One article discussed the implementation of a program for psychiatry residents with a rehabilitation focus at the University of Massachusetts [9]. The program was a two-year horizontal curriculum embedded within training, with ongoing supervision incorporating didactic and clinical exposure elements. A second article discussed the need for PSR involvement of psychiatrists and suggested that residency would be an ideal time for this [10]. It noted that some American psychiatry residency programs incorporate a longitudinal experience where residents are involved with a community treatment team one day per week over the course of their residency.

Given the broad interpretation applied to the severe and persistent mental illness training requirements in Canada, there is likely variability in this among training programs. For example, in the training program of the first author (KM), there are some formal

education sessions on PSR incorporated into the curriculum, and working with an ACT Team is an option, although not chosen by all residents.

PSR in Occupational Therapy Education

The training for the occupational therapy profession in Canada and in some other countries has experienced a major shift from a four-year undergraduate degree to an accelerated, two-year graduate program, effective 2008, to meet the new accreditation standards of the Canadian Association of Occupational Therapists (CAOT). Occupational therapy and PSR share similar philosophical foundations and both emphasize person-centeredness and service user goals [11]. Still, PSR education in occupational therapy training has also undergone changes over the years.

Another review of the peer reviewed literature yielded few results discussing PSR education within occupational therapy programs. Terms including, psychosocial rehabilitation, PSR, occupational therapy and education in databases such as PubMed and Google Scholar were searched. One article discussed a 7-week course, looking at the philosophy, research and clinical practice of PSR developed by the Centre for Psychiatric Rehabilitation, Boston University. Before transitioning to a graduate program, this course was implemented for 3 years in the undergraduate occupational therapy program of Western University in Ontario, Canada [12]. Basic goals of this course were (1) To educate learners on the relevant opportunities of working with those with mental illness; and (2) To encourage person centered and other positive attitudes towards this population.

Currently, most occupational therapy educational programs contain a term dedicated to the study of mental health and counselling techniques. Within this area of study, education on PSR principles, approaches, and use, along with its relationship to occupational therapy, may be addressed using lectures, shared experiences of community clinicians, large- or small-group simulations or activities and more; however, teaching of such PSR may not occur in all programs.

PSR education may also be learned from a mandatory mental health clinical placement that is required for graduation in Canadian occupational therapy programs as part of completing 1000 hours of supervised clinical experience. However, not all placements occur in settings where PSR would be practiced, e.g., in acute inpatient settings. Evidence-based practice projects may be another way by means of which some students are exposed to PSR principles, research and practice. A learner's educational experiences involving PSR will likely be variable as there is no universal, uniform curriculum.

Future Directions

It seems that there is scant research on PSR training within psychiatry residency and occupational therapy programs. Despite the lack of formal research within these areas, both the first and second authors are aware of educational initiatives within this area based upon their first hand experiences. From this standpoint, we do know that the experience and exposure to both formal and informal teaching and clinical experiences relating to PSR principles is variable. Without formal research or program evaluation, it is difficult to know if the current practice of training in PSR is sufficient. Perhaps research first needs to address this gap before we can fully assume changes are needed.

Despite this, as both of these professions often provide team-based care to people who have SMI, understanding opportunities for PSR education and training and relevant collaborations between such professions appears important.

Further, although psychiatry and occupational therapy often work closely together, there is no joint or mutual education or standard terminology uniting them. The International Classification of Functioning, Disability and Health (ICF) published by the World Health Organization can act as a springboard from which all relevant professions can learn to speak a common language regarding service user health states and particularly psychiatric disability and related PSR [13,14]. In order for consistency to occur across professions, addressing the principles of PSR in occupational therapy, psychiatry, and other relevant educational and training programs is likely needed. Having a common language for approaches to care across all such professions may prevent duplication of effort within a care team and increase effective collaboration of service providers in care planning towards service user recovery. Future work could look at the further dissemination of ICF across professions and the development of a common language for similar approaches to care for people with SMI.

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