ORIGINAL ARTICLE

Developing an Integral Approach to Mental Health Assessment and Psychosocial Rehabilitation for Persons with Disabilities with Comorbid Mental Illness

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ABSTRACT

Introduction: Mental health professionals frequently face seemingly "no-win" situations when they are required to negotiate workable solutions, especially for persons with disabilities. Coming to grips with the complexity of assessing, coping, and adapting to the challenges of mental illness, and the need for embracing a psychosocial rehabilitation approach while engaging with the need for treatment and psychosocial disability, support can be dishearten for both persons and professionals. **Aim:** The aim of this study is to present the importance of an integral approach (IA) to mental health assessment and psychosocial rehabilitation for persons with disabilities with comorbid mental illness. **Scientific Methods:** Description and analysis of 28 clinical cases accommodated in home family, according to individual plan of care. It is also provided an action cycle analysis of IA. **Findings:** A total of 28 persons with disabilities with comorbid mental illness have shown some improvement in their autonomy, hope, and overall wellbeing as well as satisfaction with life after receiving services. **Main Results:** Significantly, a number of persons have shown progress from stages of being overwhelmed or struggling with disability to stages of living with or beyond disability. IA helps them to develop a transformed self which sees hope and possibility despite the vulnerabilities caused by their illness. **Implications and Suggestions:** This paper is an initial resource to assist professionals with the ongoing work to build the best possible system of support for people with psychosocial disability. However, the findings remain to be discussed widely by mental health providers if the suggested approach is conditional to the whole system of mental health service or directly to mental health providers.

Key words: Assessment, integral approach, mental health, psycho-social rehabilitation, persons with disabilities

INTRODUCTION

Over the past several decades, the deinstitutionalization of mental health services has taken place in Western countries, and as emphasized by Markström,[1] this has led to radical changes in how mental health care is provided. As a result of deinstitutionalization, Antony *et al*.[2] stated that most adults diagnosed with severe mental illnesses, such as schizophrenia, bipolar disorder, major depression, and the like, are now residing in the community. In this sense, it is referred directly to persons with disabilities living in home family even in Albania. Precisely, persons with disabilities show mental health problems that limit their capacity to perform certain tasks and functions (e.g., interacting with family and friends, interviewing for a job, and studying) and their ability to perform in various community roles (e.g., worker, resident, spouse, friend, and student).[3] Therefore, as Lin *et al*.[4] states, intellectually-disabled people require specific forms of health and special social services.

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Mental health professionals also frequently face seemingly "no-win" situations when they are required to negotiate workable solutions, especially for persons with disabilities and professional goals that may not be compatible, or when interventions result in value dilemmas.[5] Therefore, according to Anthony,[6] there are growing calls by consumers and professionals in disability services to create opportunities for empowerment and demedicalized practices. Coming to grips with the complexity of assessing, coping, and adapting to the challenges of mental illness, and the need for embracing a psycho-social rehabilitation approach[7,8] while engaging with the need for treatment and psychosocial disability, support can be dishearten for both persons with disabilities and professionals.

Furthermore, persons with disabilities with mental health problems (PDMHP) show positive capacities and inherent strengths that in principle are not wholly assessed concurrently when the negative symptoms appear. Throughout the literature,[9] differing and sometimes seemingly contradictory opinions exist on key issues including the underlying etiology of mental health problems, appropriate treatment approaches, primacy of the role of professional versus the patient in the helping process, the validity and utility of diagnosis, how much focus should be given to symptoms and deficits versus strengths and capacities, and what the best indicators of recovery are. This, as stated by Jacobson,[10,11] has become problematic for policymakers and mental health providers, and many of whom are eager to transform services to make them more recovery-oriented.

There are already a lot of approaches that encourage different perspectives to improve the skills of functioning for persons with disabilities.[12-15]

The sooner the person in care feels understood, the sooner he or she will calm down and become more trustful and co-operative.[16] Of course, the necessary precautions have to be taken to make sure no one gets hurt before this happens.[17,18] If working collaboratively with the person is not possible at first, the mental providers must return regularly, to see if engagement becomes possible. This means that a professional perspective is one potentially helpful way of understanding the person's experiences, but not the only possible way.[19] All difficulties must be discussed with the people in care if possible and with colleagues. If all else fail and no progress is made over a prolonged period, other sources of the relevant information are sought. Successful integration calls for all practitioners, including behavioral health and primary care, to cease working in isolation.[20,21] It demands shared accountability among all involved parties. None of that can be achieved without a system overhaul. Therefore, being consistent with the given evidence about what integration is, this paper proposes a coordinated integration strategy in partnership with the people we serve.[22] The collaborative care model provides a launching pad for doing so.

During this period, special observations should be done as an integral care for mental health problems. Practicing special observations is suggested as it is the practice of maintaining an increased level of observation over particular patients when they are acutely ill (and may be at an elevated risk of self-harm, harming others or absconding) with the purpose of maintaining safety and reducing the risk of adverse incidents.[23] Hence, the negative consequences of serious mental conditions besides the obvious symptoms become a greater problem in general functioning of daily life.[24] and reinforce the need of the potential and of developing an integral approach (IA) to do a mental health assessment and to make possible psychosocial rehabilitation for PDMHP.[25]

To come into aid, this paper will present the importance of an IA to mental health assessment and psychosocial rehabilitation of PDMHP by drawing on aspects of Ken Wilber's integral theory.[26,27] The intention is to create a conceptual framework that brings together the competing ideological positions held by key stakeholders who have helped to shape the contemporary psychosocial rehabilitation paradigm. Wilber takes the idea of the "I," "we," "it," and "its" dimensions of reality and inserts them into a four-quadrant model. It suggests that all human knowledge and experience can be placed in a four-quadrant grid, along the axes of "interior-exterior" and "individual-collective." Based on Wilber *et al*.[28] explanations, it is one of the most comprehensive approaches to reality, meta-theory that attempts to explain how academic disciplines and every form of knowledge and experience fit together coherently.

METHODOLOGY

Qualitative data were collected through systematic and special observation procedure and the action cycle analysis of IA. 28 PDMHP were included. They all live in home family.

Table 1 summarizes the characteristics of the participants. For four variables, the duration of mental health problem, the number of hospitalizations, and the median are here reported rather the mean, because of the wide range of values and the small sample size.

Measure

A systematic and special observation procedure based on individual plan of care was developed to explore the development of mental health assessment and psychosocial rehabilitation through the IA. It included a series of issues following the individual plan of care recording the major dimensions: Autonomy in basic life responsibilities, hope, and overall wellbeing as well as satisfaction with life.

Follow-up procedures were implemented after each individual plan of care to explore the unique aspects of each person with disabilities' psychosocial rehabilitation experience. They

Table 1: Participant characteristics (*n*=28)

Characteristics	*n* (%)
Demographic variables	
Gender	
Male	15 (53.57)
Female	13 (46.42)
Mean age (years)[1]	28.8
Marital status	
Single	28 (100)
Married	0
Separated	0
Divorced	0
Education	
Less than basic education	28 (100)
Less than high school	0
Living arrangements	
Living in home family with caregivers	28 (100)
Independent living	0
Clinical variables	
Diagnosis	
Moderate mental retardation with conduct disorder	15 (53.57)
Severe mental retardation with conduct disorders	9 (32.14)
Schizophrenia	4 (14.28)
Median duration of illness (years)[2]	7
Median number of psychiatric hospitalizations[3]	4

Ranges: [1]13–44 years old, [2]3–15 years, [3]1–10 hospitalizations

were directed toward the strengths of the persons, their past and present successes, and their current and future challenges. The Systematic and Special Observation Procedure was based on the literature of medical and social sciences and professional standards. The observations are well recorded by keeping notes down immediately after the demonstration of any given signs or symptoms.

The analysis

An action cycle analysis of IA and a constant, reiterative comparative method were used to analyze the data. A four-step method was used to analyze the data.

First, each systematic and special observation procedure was broken down into individual meaning units.

Second, similar individual meaning units were regrouped under a unifying theme.

Third, underlying characteristics were identified for each theme.

Finally, a summary table was built to compare themes and their related characteristics within and across participants, which led to the identification of distinct profiles characterizing the experience of developing IA.

Action cycle analysis of IA

Each Holon can be seen from within (subjective and interior perspective), from the outside (objective and exterior perspective), and from an individual or a collective perspective. According to Wilber,[26,27] all Holons are needed for real appreciation of a matter. Hence, all four perspectives offer complementary, rather than contradictory, perspectives. It is possible for all to be correct, and all are necessary for a complete account of human existence: Each by itself offers only a partial view of reality. Wilber[26] uses this grid to categorize the perspectives as follows:

- Interior individual perspective (upper-left quadrant) - interprets people's interior experiences and focuses on "I" (here, it is referred to the experience of a person with disabilities who suffer from mental health problems)
- Interior plural perspective (lower-left) - seeks to interpret the collective consciousness of a society or plurality of people and focuses on "We" (here, it is referred to the persons with disabilities who suffer from mental health problems and identify themselves as a group with similar problems)
- Exterior individual perspective (upper-right) - represents one's objective individual exterior, physical "it" dimension that can be observed by oneself or anyone else and treats the internal experience, decision making or volition of the subject as a black box (here, it is referred as the exterior influences on individual perspective of persons with disabilities who suffer from mental health problems)
- Exterior plural perspective (lower-right) - focuses on the behavior of a society (i.e. a plurality of people) as functional entities seen from outside, for example, "They" (here, it is referred to all the professionals included in the professional behavior and actions toward the mental health needs, assessment, and interventions of persons with disabilities).

Understanding the mental health assessment process

Assessment is central to mental health service for persons with disabilities and is the foundation in which the professional care is delivered. It is a decision-making process based on the collection of information [Table 2] that gives an overall estimation of the consumer and their circumstances.[29]

Understanding the psychosocial rehabilitation

Rehabilitation has emerged as a comprehensive approach with a combination of treatment modalities that have the purpose of addressing multiple impediments and overcoming disabilities. It is a goal-oriented process, with the aim of enabling intellectually-disabled people to reach an optimum mental, physical, and/or social functional level, thereby providing them with the tools required to change their lives in their daily contexts.[32] The World Health Organization[33] defined psychosocial rehabilitation as: "psychosocial rehabilitation is a comprehensive process that offers the opportunity for individuals who are impaired, disabled or handicapped by a mental disorder to reach their optimal level of independent functioning in the community." It is grounded strongly on the belief in the empowerment of intellectually disabled people, and it identifies the individual's goals on the grounds of which a plan is developed to meet these goals. From this rehabilitation perspective, it is important to extend support as long as possible.

Table 2: Stages of assessment process based on collection of information

Indicators	Description
Systematic and special observation	Complete and incomplete symptoms and signs: Physiological Social Situation background Psychological
Evaluation of symptoms and signs	Objective - characterized symptoms, factors, causality Subjective - nature, frequency of the symptoms
Classification	General, common, particular, and concomitant symptoms
Stratification	The division in categories and sub-categories on the basis of one or more chosen criteria: Basic and determinative symptoms
Psychoclinical Reporting	The clinical psychologist prepares the report which is included: The systematic and special observation of symptoms and signs, evaluation, classification, and stratification of symptoms
Consulting with nurse	The clinical psychologist consults the report and the general mental health status with the nurse
Referring to the doctor of the family	The clinical psychologist and the nurse refer the case to the doctor of the family. For the doctor of the family, it is important to understand which symptoms (physical or mental) appeared first and what followed further. This helps to understand the process of evolution of the mental health problems and underlying other chronic diseases and then refers the case to the psychiatrist
Psychiatric consultation	The psychiatrist takes into consideration the psychoclinical report and the recommendation of the doctor of the family but also by showing clinical empathy[30] and by making a short psychiatric interview (general, emergency, and consultation evaluations for clinical purposes), Vergare *et al*.[31]] evaluate the symptoms according to their relative value for the purpose of forming an individual picture

Furthermore, this support should not be withdrawn when the client improves[34] because this group of people are at the risk of developing chronicity and do require prolong inpatient treatment because of the problematic psychopathologies of the illness.[35] As Song and Hsu[36] also state, the stage a service user reaches might be transitory because rehabilitation is a journey of spiral progress. Psychosocial rehabilitation is a multidimensional therapeutic measure which requires active participation of many persons, for example, patients, caregivers, mental health professionals, social network, administration, and policymakers, so forth.

According to Cnaan *et al*. and Cook and Razzano,[37,38] psychosocial rehabilitation is not only a therapeutic endeavor, but in true sense, it has some reformatory connotation too. It offers an important adjunct to pharmacotherapy[39] and may offer unique benefits to patients with psychosis. The goal of these interventions is to enable individuals to achieve the highest feasible quality of life by ensuring that they can perform the physical, emotional, social, and intellectual skills required to live in the community.[40,41]

Therefore, like any of the various services used for PDMHP [Table 3], the psychosocial rehabilitation process can be understood best by segmenting the process into the four sequential phases of diagnosing (assessing), planning, intervening (treatment), and follow-up and management. This sequencing is not to imply that the logical conceptual flow of the four phases describes how neatly the treatment process unfolds in practice. In practice, steps may be skipped or omitted, and regression and plateauing may occur.However, by understanding the logic and the flow of the psychosocial rehabilitation process (as given at Table 3) allows the stages to be followed, guided by the caveat that implementing service processes designed to help persons with disabilities with mental health problems remains an art as well as a science.

Table 3: Stages of psychosocial rehabilitation process: Solutions to role functioning issues

Indicators	Description
Diagnosing and formulation	Functional assessment[42] Evaluating skill functioning Assessing rehabilitation readiness[43,44] Developing rehabilitation readiness Clinical formulation
Planning	Planning for skills development Supporting PDMHP in the planning process Involvement of the rehabilitation team Setting priorities Defining objectives and goals of rehabilitation and wellness for increasing function and quality of life Choosing the proper interventions Choosing the persons in charge Formulating the plan
Intervening	Direct skills teaching and educating Outlining skill content of needed skills[45] Planning the skill acquisition Programming skills use Psychotherapy/counseling
Follow-up and management	Commitment to change,[46] Personal closeness, Awareness of self, others, and environments Side effect of pharmacological therapy Relapse prevention plans Urgent care Monitoring care service Collaboration across the continuum of care make ongoing incremental change

PDMHP: Persons with disabilities with mental health problem

FINDINGS

Four themes framed the positive experience at 28 persons with disabilities with comorbid mental illness showing some improvement in their autonomy in basic life responsibility, hope, and overall well-being as well as satisfaction with life after receiving services according to IA. Based on these themes and their underlying characteristics, three profiles were identified:

Profile I: Psychosocial rehabilitation as uncertainty

Eight PDMHP belonged to Profile I. All PDMHP are unemployed. Among these three participants, two searched for work, and two of them were not interested in work.

Autonomy in basic life responsibilities

It was noticed a sense of personal vulnerability. On a functional level, they were overwhelmed by the presence of emotional problems in their lives. They reported difficulties in managing unstable symptoms, such as delusions, as well as mood swings, and stress, which led to disruptions in their daily living. They also had difficulties in maintaining regular health habits, such as eating balanced meals and sleeping enough. On an experiential level, participants had a poor sense of self-esteem and serious doubts about their abilities to make significant changes in their lives.

Hope

It was observed a low sense of hope. This was expressed in their ways of coping with emotional problems and stress, which were marked by the use of passive and avoidant strategies, and the heavy reliance on external resources. For example, one thinks that never will have a family. Three of the four PDMHP reported superficial contacts with family members and friends. They provided some explanations for their difficulties in building close relationships with others. The low sense of empowerment in PDMHP with this profile was reinforced by their daily efforts toward the maintenance of a secure environment, in which self-protection was assured but self-development prevented.

Overall well-being

The majority of PDMHP reported that, despite all the emotional problems, they feel good. They try to maintain spiritual connections and are used to go to Church. For example, two of them stated: I believe in God. He helps us to keep going.

Satisfaction with life

Three of eight PDMHP with this profile viewed their present life as unclear. This included the two participants who searched for work and the other who was not interested in work. They were hesitant to project themselves into the future and had doubts about their abilities to achieve personal goals. In line with their vulnerable sense of self, they tended to report internal barriers to employment, such as difficulties with concentration and lack of confidence in vocational abilities.

Summary

PDMHP within this profile are uncertain about the possibility of being rehabilitated from mental health problems. Among others, the majority of them perceive themselves dependent on the medication.

Profile II: Psychosocial rehabilitation as an empowering experience

Eight PDMHP belong to Profile II. Their vocational status is the same. All the participants work on a part-time basis (5 h per day).

Autonomy in basic life responsibilities

PDMHP were in the process of expanding their sense of self. This implied the redefinition of a more active sense of self. They demonstrated a higher autonomy in completing the daily activities and wanted to exert more personal control over their lives by regaining former parts of the self. Setting goals helped them to target aspects of the self to be empowered. It can be underlined the development of healthier habits (for example, getting exercise, losing weight, and a desire to quitting smoking). Although these goals were attached to different life domains, having sufficient personal control over emotional problems was a crucial step in moving ahead in their experience.

Hope

PDMHP within this profile was involved in the task of building a sense of empowerment. Two outcomes revealed the emergence of self-empowerment. First, participants developed strategies to have better control over their emotional problems and to ask for psychological help. Second, they started to build their self-efficacy through participation in work. They have been trying all the time to perform a variety of behavioral and cognitive strategies to feel empowered in their struggles with emotional problems. To cope with stress, they used strategies to decrease stress, such as having a daily routine, writing a daily journal, taking a nap, or going out.

Overall well-being

It was observed a positive change in daily habits, trying to maintain the balance in following the work, staying with the others, and connecting with others within homes family and with others outside. They showed a sense of usefulness to others, which helped them to develop positive feelings about themselves.

Satisfaction with life

PDMHP are observed to have had a sense of self-efficacy and pride in their work. They have shown to rely primary on caregivers for social support. Three of them show interest to get married.

Summary

PDMHP within this profile feel empowered, with hope. Among others, the majority of them perceive themselves as self-sufficient but still need emotional and social support and advice in coping with their emotional problems.

Profile III: Psychosocial rehabilitation in process

Twelve PDMHP belong to Profile III. Their vocational status is the same, and they are all unemployed but follow social and therapeutic activities in the daily center.

Their striking differences from the rest of the individuals in autonomy in basic life responsibilities hope and empowerment, overall well-being, and satisfactions with life led us to distinguish them from other PDMHP. Moving beyond disabilities is a hard and long journey for all participants. The rediscovery and reconstruction of an active sense of self are perceived as a healing journey in process, which involved connecting with former aspects of self and building on them. They were trying hard to hope about their ability to not only deal with difficult situations but also to learn from them and to be supported from the whole professional staff.

Summary

PDMHP within this profile feel them within the system of rehabilitation still in process, an ongoing process. Among others, the majority of them perceive themselves as putting the self into action and being in search of one's self but still need medical, emotional, and social support and advice in coping with their emotional problems.

The findings of the current study produced mixed results. On the one hand, the IA brought about significant though small improvements in reducing mental health problems at persons with disabilities. More promising changes were observed in two process components (autonomy and hope) and one outcome component (overall well-being) during and after the psychosocial intervention.

Given the emphasis on goal orientation, strengths assessment, and hope inducement of IA, it is not surprising to note the positive outcomes regarding the two process components. Since autonomy and hope are associated with general well-being,[44,47] the enhancement of these elements likely contributed to the improvement in participants' overall well-being.

Implications and suggestions

The findings actually have some important implications for the effectiveness of IA-based practice. Clearly, the findings provide only preliminary evidence of the applicability and development of IA for people with disabilities with comorbid mental illness. The study had a number of limitations.

First, with the small sample size, it is difficult for the statistical tests to acquire the adequate power to detect statistically significant changes.

Second, the IA was implemented for 3 years, but due to emergent mental health situations, the procedure is not followed strictly through all the time. This fact might be of importance to realize the full potential of IA.

Finally, the absence of a control group precludes any definitive conclusions.

Despite the limitations, the preliminary findings suggest that a more rigorous design with a control group is warranted. In future applications, it will be useful to exclude the emergent clinical cases from following rigorously the IA and examine even other effects of mental health status in the long run.

However, the findings indicate that, with the multidisciplinary equip patience and collaboration, this practice is achievable and it can be applied in a disability population who suffer from mental health problems.

CONCLUSION

The aim of this study was to present the importance of an IA to mental health assessment and psychosocial rehabilitation for persons with disabilities with comorbid mental illness. Based on the data derived from the action cycle analysis of IA, the study provides qualitative evidence since significantly a number of persons with disabilities have shown progress from stages of being overwhelmed or struggling with disability to stages of living with or beyond disability. From the interior individual perspective, it has been possible to interpret 28 person's interior experiences focusing on "I am trying" despite mental illness. On the other hand, from the interior plural perspective, the participants were seen seeking to interpret the collective consciousness of a society or plurality of people and focus on "We" - understanding that there are even other persons in the society who are suffering from the same mental illness. Furthermore, from the exterior individual perspective, it was evidenced that a high percentage of participants referred even to the external influences who were even positive as well as negative. Finally, from the exterior plural perspective, it was evidenced a focus on the multidisciplinary behavior by making them to assess their needs and to receive the proper interventions.

Hence, it results that the IA helps the persons with disabilities with comorbid mental illness to develop a transformed self which brings hope and possibility despite the vulnerabilities caused by their illness. Nevertheless, one should bear into mind the content given in this paper: The persons with disabilities are not "cured" or free from mental health problems, but they can lead more satisfying, hopeful, and contributing lives despite their illness.

Thus, the current paper is an initial resource to assist mental health professionals with the ongoing work to build the best possible system of support for people with psychosocial disability. However, the findings remain to be discussed widely by mental health providers if the suggested approach is conditional to the whole system of mental health service or directly to mental health providers.

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