Principles of Psychosocial Rehabilitation

The Principles

In 1985, the International Association of Psychosocial Rehabilitation Services (IAPRS) published the following definition of psychosocial rehabilitation as:

‘The process of facilitating an individual’s restoration to an optimal level of independent functioning in the community … While the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals. In many settings, participants are called members. The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational residential, social/recreational, educational and personal adjustment services.’ (Cnaan et al, Psychosocial Rehabilitation Journal, Vol. 11, No. 4: April 1988, p.61)

Cnaan et al state that psychosocial rehabilitation is based on a number of assumptions, including two essential ones:

1. People are motivated by a need for mastery and competence in areas, which allow them to feel more independent and self-confident.
2. New behaviour can be learned and people are capable of adapting their behaviour to meet their basic needs.

Cnaan and his co-authors completed an extensive literature search in order to extract thirteen principles. They believed that only services which utilised all or most of these could claim to be involved in psychosocial rehabilitation. These principles have been constantly re-examined and two more have been added. Principles 14 and 15 were added by the 1990’s, as they were believed to be so strongly integral to the processes of psychosocial rehabilitation to warrant separate listing.

When these fifteen principles were examined in detail by the community-managed sector in Victoria in 1992, it was decided to use the original set of principles as elucidated in Cnaan’s paper in the 1988 Psychosocial Rehabilitation Journal rather than the 1990 version (Cnaan et al, Experts’ Assessment of

Psychosocial rehabilitation Principles, Psychosocial Rehabilitation Journal, Vol, 13, No. 3, January 1990), as it reflected more precisely the original concept in a far more accessible language.

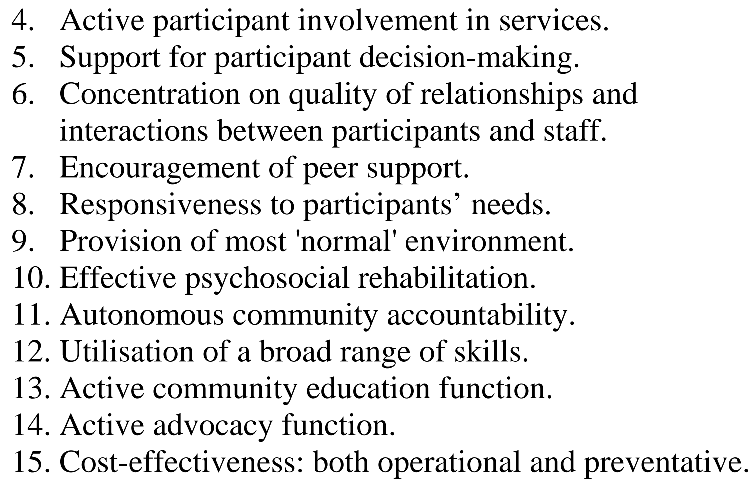
The fifteen U.S. Principles were:

1. Under-utilisation of full human capacity.
2. Equipping people with skills (social, vocational, educational, interpersonal and others).
3. People have the right and responsibility for self-determination.
4. Services should be provided in as normalised environment as possible.
5. Differential needs and care.
6. Commitment from staff members.
7. Care is provided in an intimate environment without professional, authoritative shield and barriers.
8. Early intervention.
9. Environmental approach.
10. Changing the environment.
11. No limits on participation.
12. Work-centred process.
13. There is an emphasis on a social rather than a medical model of care.
14. Emphasis is on the client's strengths rather than on pathologies.
15. Emphasis is on the here and now rather than on problems from the past.

It was felt that the two necessary conditions for effective psychosocial rehabilitation as it was known by the community-managed sector were first the generation of hope and second the facilitation of social relationships. It was stressed that these, together with the principles of psychosocial rehabilitation, were most effectively achieved in settings consistent with the charateristics of community managed disability support services quite separate and distinct from any clinical service.

In 1992, organisations further delineated themselves as distinct from clinical services by adopting a set of characteristics of Non-government, Community-managed Psychiatric Disability Support Services, which have remained as the cornerstone of service delivery and support for the community managed sector. They are:

1. Flexibility of structure and service models.
2. Non-obligatory attendance.
3. Support for mobility and choice of service options.



4. Active participant involvement in services.
5. Support for participant decision-making.
6. Concentration on quality of relationships and interactions between participants and staff.
7. Encouragement of peer support.
8. Responsiveness to participants’ needs.
9. Provision of most 'normal' environment.
10. Effective psychosocial rehabilitation.
11. Autonomous community accountability.
12. Utilisation of a broad range of skills.
13. Active community education function.
14. Active advocacy function.
15. Cost-effectiveness: both operational and preventative.