

Rehabilitation Issues

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Every human being on this planet wants to have a good life. Enough joy in life, something to be proud of, to be loved by his or her parents; we want to be loved by our family. Maslow said: "Human life will never be understood unless its highest aspirations are taken into account. Growth, self-actualization, the striving toward health, the quest for identity and autonomy, the yearning for excellence (and other ways of phrasing the striving "upward") must by now be accepted beyond question as a widespread and perhaps universal human tendency ..." [1]. If we do not have a mother or father or siblings or even if we do not have fosterparents or lifeteachers in life that coach us, we want to be loved by the ones that can love us and we want to succeed in being happy in life. Some of us don't know our parents that well anymore because we decided not to talk to them anymore for various reasons. From the day we are born until the day we are hopefully old and die we want to look back at our lives and be happy about what we will have experienced in life.

When I ask you: where were you raised or where are you from? You'd probably answer this question by mentioning a town or a certain country'. I was born and raised in ... I would say I am from out of my mother. A friend of mine taught me this and I am very grateful for him telling me where I am from. Because that makes us all equal, right? But it doesn't mean that all chances are equal. Some have better chances to grow up towards adulthood more successfully than the other regardless of where they are from. This all has to do with internal and external factors in life. You were born somewhere on planet earth. After that we get to know your surroundings better. In life we get to know other people better and most of us get to know our parents better. We get to know our brothers and sisters better and if we are lucky we get to know our aunts and uncles our nieces and nephews etc. At nursery school we make new friends and later on in life we get to know our classmates, our your colleagues, our spouse and so on. We connect through Facebook, we meet people through activities, through our Activities of Daily Life (ADL) and every year, every day we have the opportunity to make new friends during our lives. This inspires me.

The social issue I would like to discuss is:

What can be the consequences when citizens with a chronic mental or physical disorder are obliged to do daytime activities like volunteering or paid work? Regardless of the degree of their disorder. Exceptions not included. How can incentives be put in place or is it possible to sanction the incomes of stakeholders? And what

does it yield for everyone involved: clients, relatives, companies, institutions, insurers, government, et cetera?

Background

I work as a mental health social worker at GGzE (Regional Mental Health Institution) De Grote Beek in Eindhoven. I work at the neuropsychiatry department. I mainly work with clients with a psychological and or psychiatric vulnerability. I try to structure their day and I try to support them. I ensure that they either reintegrate, remain stable or make a step ahead.

It concerns a target group with physical and mental problems. They are people with vulnerabilities that they can turn into strengths. Most importantly, the target group has disappeared from the labour process or from Activities of Daily Living (ADL), is often under-stimulated or over-stimulated. Most of them, like everyone else, just want to have a nice day and get through the day with some confidence. They want to be among people and often also want to do paid work. And if that is not possible, they would like to help out someone else or be creative. I think these are the struggles this target group faces.

The most important people involved in the client's life are primarily the client and his or her relatives, such as the parents. A baby is born, there is a father and a mother, the child ages, becomes more mature. At some point they notice that their family member, or their boyfriend or girlfriend, is not doing well and a physical or mental disorder is found.. Consequently, they will want to take action. That does not always work. Then you have more people involved: social workers, government agencies, social services and or institutions like GGzE where I work.

ADL's should be viewed as a cognitive approach to the assessment and care of the patient, not on paper as a list of boxes, but in the nurse's approach to and organization of her care [2]. In the relationship with the client I think it is very important that you investigate with questions like: "who is that client?" And make sure that the client feels taken seriously and understood. To not start immediately thinking in terms of solutions, but more like: "hey, I want to support you, I want to coach you and I want to be there for you. How can I ensure that you have a nice life or a nice day and what is needed for that in terms of involvement?" A client often has wishes, needs and thoughts. Often, he has already tried many things. He may have completed a degree in the past or may

have gained knowledge through family or working experience. When you discuss that, it is an important basis for a relationship. Interpersonal contact, see each other as equals. And that you look at that client not only as physically or mentally ill, but as a person; as a whole. As someone who can regain strength and regain confidence. I think that is important: that clients regain self-confidence and like to be motivated.

Interventions

Interventions are necessary because I assume mutual responsibility. Who is responsible for who? In principle, if conflicts arise, everyone is responsible. Or if there is sadness, it would be nice if everyone felt responsible. I think that if you yourself have little or no physical or mental disability, you will need much less motivation. Compare it with when you are sick at home, for example with the flu, then it becomes more difficult to go shopping or go to work. These clients have a more severe disability: sometimes their minds are extremely occupied or they suffer from a physical illness. In that case, interventions are a solid form of security for family, social workers, and for authorities. Organizations need motivation to activate clients. So you can start sanctioning by, for example, reducing benefits so that someone will lose the luxury of buying that package of tobacco or the tasty fries that he wants. So if someone is motivated to be active, with sanctions he will regain confidence and start moving forwards. It is good for clients, their relatives, health insurance, institutions and society in general.

In my daily work I try to be meaningful for clients. That I do not give up once they have gotten out of ADL, have dropped out of volunteering or have had little experience with, for example, joy. I want to empower them so that they don't get neglected by society outside their living space. I mean: "never judge a book by its cover..." See the human being, see the possibilities and also see the talents. Those talents also often manifest internally; in the brain. Even if someone is paralyzed and bed-bound, then you should also talk to them and see what you can do in terms of activation. So, do not give up, do not throw them away, but involve them and ensure empowerment.

Effects of treatment

If people are already struggling, you do not want to make it even harder for them. On the other hand, how can you ensure that coaching and caring lead to empowerment, diversity, social equality and that it can contribute to a decent quality of life. Social change, individualization and globalization cause people to be occupied with themselves. It is important to establish a connection, that everyone is working together on their personal strength. The mission of GGzE is about making people grow again. How can you make people think again about their own growth, regardless of their experiences? How can we support this and what is needed in that regard?

I think that long-term treatment is about not giving up on trying to activate someone and stimulate participation. This determines what you will focus your interventions on. Long-term treatment is also about not giving people the chance to become passive or to become under-stimulated. So again the need to assure responsibility arises. For example through a letter sent by the government, to a client's home or at the institution where they are staying, stating that they must work for a few hours a day or else their benefits will decrease. This is often a way to get people in action again and for them to rebuild self-esteem. With mutual efforts this can be achieved.

The short-term effect is about regaining full participation in society. Because if someone receives that letter, and the institutions have to start taking responsibility too, things will start changing. This is what should be discussed. At GGzE De Grote Beek for example, there is a Bed and Breakfast. In this B&B clients can gain working experience, for example, as a cook, as a maid, or as a receptionist. The B&B receives guests who are staying on the premises overnight. There are more working experience facilities on the premises. There is a bookbindery and there is a graphic design office where people can be trained as a graphic designer.

Here on site, people can be stimulated by a job coach to, for example, prepare lunch and dinner together with supervisors and fellow clients. In turn, they become active, work nicely in the kitchen, smell other smells and they become healthy. After that, they eat together or give the prepared food to others who can eat it. There are also client councils and experienced experts are employed to help thinking about the labour market and daily activities. We also have beautiful gardens here. There is a gardening project where people can buy fresh produce and where clients work and do daily activities.

Group treatment is another form. It is about knowing who the target audience is, what they have in common, what the goal of the treatment is. This is to be discussed within the group and with interdisciplinary care providers. It should also be discussed with volunteer organizations, the social services, and with people from several institutions. Together you ensure how obligations towards activation can be met.

Experiences and expected results

When I studied social work, I worked together with Latifa Bali, a colleague and fellow student at the University of Applied Sciences in Utrecht. During our study and work we noticed that social workers often tried to initiate activation, but that the activation process stagnated because clients chose to do so. Sometimes out of fear or due to lack of schedule they stop doing daytime activities or volunteering jobs. Consequently, the client would spend the entire day on a balcony smoking cigarettes or drinking beer. Latifa and I then thought: what should we do about this? We wondered what would happen if someone with a physical or mental disability would be forced by law to do daytime activities, volunteering or even paid work. Then this social issue arose in our head. We then elaborated on this for our education and work.

Actually, this social issue occurs everywhere, worldwide. Everywhere people are at home, here on our premises, in hospitals, at rehabilitation centres, at patient organizations, at the social services... Really everywhere! It can also occur when a social worker notices that a client in his own home has no social contacts or is in bed all day. Or shouldn't someone with schizophrenia leave the house to do something? Here you come back to that obligation to be activated. For clients activation provides physical and mental well-being. It can also take away the worries of close relatives because they are supported by the entire health care system. I think activated people start to feel less restricted, less insecure, and more wholesome. Because as a social worker or as a relative you form a bond together and the client will be held responsible, the conversation about activation is to be had. People are often stigmatized by their physical or mental disability. It regularly occurs that someone who is in a wheelchair or is limping is stared at. Integration and activations contributes to the client regaining self-esteem.

The social workers, institutions and governments benefit from more attention for and communication about this issue. They also will be held responsible by law. And, hopefully, people will become healthier. It creates awareness for health insurance companies that they have an impact on vulnerable citizens. When people are being activated, they have less time to smoke cigarettes and they have less chance of becoming depressed at home. So if they are activated, it will cost health insurance companies less; money better spent elsewhere. It also leads to savings through reduction of medication. Eventually, all together we need to ensure that the client can fulfil his

obligations. So, with the help of his loved ones, counsellors, and the government we can make them more active, healthier and happier.

References

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2. Roper N, Logan W, Tierney A (2000) *The Roper-Logan-Tierney Model of Nursing: Based on Activities of Living*, Churchill Livingstone, London.

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