Psychiatric Rehabilitation

Second Edition

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Chapter 1

Introduction

How many times it thundered before Franklin took the hint! How many apples fell on Newton's head before he took the hint! Nature is always hinting at us. It hints over and over again. And suddenly we take the hint.
—Robert Frost

The essential elements of a psychiatric rehabilitation approach have been hinted at for well over a century. Psychiatric rehabilitation principles and ideas have periodically moved in and out of favor around the world, highlighted almost serendipitously as the mental health field progressed through various developmental phases. In particular, the last two decades have witnessed an explosion of interest in psychiatric rehabilitation.

The 1980s was a decade of transition, particularly in North America—a transition between the former era of deinstitutionalization and the era of rehabilitation. The 1980s sounded the death knell for whatever was left of the deinstitutionalization era while at the same time ushering in the era of rehabilitation. The decade of the 1990s was the decade in which psychiatric rehabilitation assumed its rightful place as one of the triumvirate of mental health initiatives: prevention, treatment, and rehabilitation.

Prior to this rehabilitation era, deinstitutionalization issues predominated in the professional journals and the popular press, in contrast to the limited space devoted to rehabilitation issues. However, preoccupation with deinstitutionalization in many Western industrialized nations has now shifted to a focus on rehabilitation.

The contrast between deinstitutionalization and rehabilitation can be characterized as the difference between focusing on how buildings function and focusing on how people function. Deinstitutionalization focused on closing buildings; rehabilitation focuses on opening lives. Deinstitutionalization focused on ending practices of patient restraints; rehabilitation focuses on getting personal supports. Deinstitutionalization focused on freeing people, while rehabilitation focuses on getting life in that person's freedom.

Deinstitutionalization opened the doors of the institutions and literally gave people a prescription for their medicine when they left. However, rehabilitation attempts to open the doors of the community and help people figuratively develop a prescription for their lives.

In contrast to the deinstitutionalization initiative, which focused on emptying buildings, it is easy to be excited and enthusiastic about rehabilitation, and its focus on improving quality of life. Interestingly, the deinstitutionalization goal of lessening the number of people in institutions, as well as lessening their length of stay, also can be realized by rehabilitation. Moreover, the distinct values and principles of rehabilitation guide practitioners to achieve this same outcome.

In the final analysis, deinstitutionalization was reduced to a single outcome: transferring patients to the community, a relatively easy task in comparison to rehabilitation. Deinstitutionalization opened the doors of the institutions and literally gave people a prescription for their medicine when they left. However, rehabilitation attempts to open the doors of the community and help people figuratively develop a prescription for their lives. The deinstitutionalization era was yesterday's focus. The rehabilitation era is upon us, guiding our current activities and endowing a vision for the future. Deinstitutionalization is now a historical fact. A return to the era that preceded it—to the institutionalization of large numbers of persons with psychiatric disabilities—is an economic impossibility. In this time of managed care, society simply will not pay for it.

The Field of Psychiatric Rehabilitation

The mission of the field of psychiatric rehabilitation is to help persons with long-term psychiatric disabilities increase their functioning so that they are successful and satisfied in the environments of their choice, with the least amount of ongoing professional intervention (Farkas & Anthony, 1989). The major methods by which this mission is accomplished involve either developing the specific skills the person

needs to function effectively and/or developing the supports needed to strengthen the person's present levels of functioning.

The term *psychiatric rehabilitation* is becoming routinely used in the North American mental health field, in both treatment professionals' jargon and administrators' program descriptions. In the decade of the 1990s, psychiatric rehabilitation began to take its place as a viable, credible service.

As a result of the field's increasing popularity, the term *psychiatric rehabilitation* has become so overused that it is now necessary to define both what it is and what it is not. The word *psychiatric* describes the disability that is the focus of the rehabilitation. This does not mean that treatment must be supervised by psychiatrists or that psychiatric treatment methods must be used. Initiating psychotherapy for people with serious psychiatric disabilities or impairment is not, per se, psychiatric rehabilitation. While therapy for people with psychiatric disabilities is often useful and important, it is not the same as psychiatric rehabilitation. The term *rehabilitation* reflects the focus of the field on improved abilities within a specific environment. In that respect, the field of psychiatric rehabilitation shares a common philosophy with the field of physical rehabilitation.

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The work of current researchers and practitioners will determine whether psychiatric rehabilitation remains a viable, credible field of study and practice around the world, or merely a historical footnote. At present, many mental health professionals recognize the need for a rehabilitation intervention to complement existing treatment interventions. However, this recognition of need does not mean that psychiatric rehabilitation is well understood or well practiced. Because all types of mental health disciplines practice psychiatric rehabilitation, and because relevant research and conceptual articles appear in a wide range of professional journals, psychiatric rehabilitation has been, until recently, difficult to define and understand.

In the chapters that follow, the current state of the psychiatric rehabilitation field will be examined. *Psychiatric Rehabilitation* traces the history of psychiatric rehabilitation in terms of relevant historical developments and discarded myths. The current status of psychiatric rehabilitation is overviewed in terms of its research base, its conceptual foundation, underlying philosophy, technology, and existing practice. Highlighted is the psychiatric rehabilitation technology that facilitates:

- the comprehensive training of practitioners;
- the development of clinical procedures and protocols;
- the monitoring and evaluation of practice;
- the development and replication of programs;
- the empirical investigation of the essential ingredients of psychiatric rehabilitation; and
- the integration of a comprehensive psychiatric rehabilitation approach into mental health service systems.

The Persons in Need of Psychiatric Rehabilitation

Psychiatric rehabilitation focuses on persons who have experienced severe psychiatric disabilities rather than on individuals who are simply dissatisfied, unhappy, or "socially disadvantaged." Persons with psychiatric disability have diagnosed mental illnesses that limit their capacity to perform certain tasks and functions (e.g., interacting with family and friends, interviewing for a job) and their ability to perform in certain roles (e.g., worker, student).

Within this group of people are subgroups, such as young adults (e.g., Bachrach, 1982b; Harris & Bergman, 1987b; Pepper & Ryglewicz, 1984), persons from cultures labeled a minority (Ruiz, 1997), persons who are homeless (e.g., Farr, 1984; Salit, et al., 1998), or persons otherwise impoverished (e.g., Ware & Goldfinger, 1997), elder citizens (e.g., Gaitz, 1984), persons with both a severe physical disability and severe psychiatric disability (e.g., Pelletier, Rogers & Thurer, 1985), persons with developmental disabilities (e.g., Eaton & Menolascino, 1982; Reiss, 1987), and persons with substance abuse problems (e.g., Foy, 1984; Mercer-McFadden, Drake, Clark, Verven, Noordsey & Fox, 1998; Struening & Padgett, 1990; Talbot, 1986).

The psychiatric rehabilitation philosophy and technology described in this book are relevant to serving each of these subgroups. Whether the subgroups are categorized by age (e.g., senior citizens, young adults), location (e.g., homeless, independent apartments), culture, or additional diagnoses (e.g., physical disabilities, developmental disabilities, substance abuse), the psychiatric rehabilitation approach of focusing on improving abilities and role performance is a useful way to serve these subgroups. Practitioners who provide rehabilitation service to

those unique subgroups need to master the knowledge base specific to these groups in addition to being experts in psychiatric rehabilitation.

Defining the Population

During the 1970s and early 1980s, several attempts were made in North America to define psychiatric disability. Together these definitions converged to create a consensus definition of psychiatric disability. Three separate definitions were developed: the Community Support Program of the National Institute of Mental Health's definition (NIMH), the Rehabilitation Service Administration's (RSA) definition of severe disability, and Goldman's (Goldman, Gattozzi & Taube, 1981) definition.

The Community Support Program (CSP) identified the "chronically mentally ill" as its target group. The term *chronically mentally ill* or its acronym—*CMI*—is no longer used because of the discriminatory label and pessimistic expectations connoted by this term. Based on several years of CSP projects, NIMH developed an operational definition of adults addressed by the CSP initiative (National Institute of Mental Health, 1980). This definition identifies important characteristics of people with psychiatric disabilities, and is noteworthy for its dominant influence on the mental health field (see Table 1–1).

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Another definition was provided by Goldman et al. (1981). They described persons who have a severe mental illness in terms of diagnosis, disability, and duration. Goldman et al. (1981) identified the group as having a severe mental disorder (e.g., typically psychosis) with moderate to severe disability (e.g., functional incapacity) of prolonged duration (e.g., a period of supervised residential care).

A definition of disability used by RSA is described in the 1973 Rehabilitation Act. The act defines it as a "disability which requires multiple services over an extended period of time." One specific impairment cited as causing a disability is mental illness. A disability is defined as a condition that limits a person's activities or functioning. Persons with severe disabilities are the first priority of service, as mandated by the Rehabilitation Act of 1973.

Each of the preceding definitions shares common elements—diagnosis of a mental illness, prolonged duration, and functional or role incapacity. Although there has been a developing consensus about the defining characteristics of persons who have experienced a psychiatric

disability, there has never been a consensus on the precise operational definition of these characteristics (Bachrach, 1988a). The predominant characteristics of the individuals who are the focus of this book reflect Goldman's description of a severe mental disorder resulting in disability of prolonged duration. These dimensions transcend traditional diagnostic categories and describe a group of people characterized by significant vocational or social deficits and neurotic responses to sources of stress (Summers, 1981).

The American Psychiatric Association's Fourth Edition of the *Diagnostic and Statistical Manual for Mental Disabilities* (1994) recognizes the importance of functional and role performance in its classification of mental disorders. The adult diagnostic categories considered severe (e.g., forms of schizophrenia, mood disorders, personality disorders) are uniquely defined by a person's difficulty in social or occupational functioning. For example, the diagnostic criteria for schizophrenia includes social/occupational dysfunction: "...since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or selfcare are markedly below the level achieved prior to onset" (p. 285). For major depressive disorders the diagnostic criteria include the following: "The symptoms cause clinically significant distress or impairment by social, occupational, or other means of functioning" (p. 327). For personality disorders the general diagnostic criteria includes the following: "The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning" (p. 633).

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Regardless of whether the definition arises from a medical definition, a rehabilitation definition, a mental health definition, or an empirically derived definition, there exist people with a mental illness who are simply not interacting well in their living, learning, social, and/or working environments (Adler, Drake, Berlant, Ellison & Carson, 1987; Dion & Anthony, 1987; Pepper & Ryglewicz, 1988). It is these persons who benefit from psychiatric rehabilitation.

As the definition of a severe mental illness and psychiatric disability achieves increasing consensus and specificity, the numbers of individuals with this condition can be estimated more accurately. The Substance Abuse and Mental Health Services Administration (SAMHSA)

Table 1–1
The Community Support Program (CSP):
Definition of Group Addressed

1. Severe Disability Resulting from a Mental Illness

People receiving CSP services typically meet at least one of the following criteria:

- Have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).
- Have experienced a single episode of continuous, structured, supportive residential care other than hospitalization for a duration of at least 2 years.

2. Impaired Role Functioning

People receiving CSP services typically meet at least two of the following criteria on a continuing or intermittent basis for at least 2 years.

- Are unemployed, are employed in a sheltered setting, or have markedly limited skills and a poor work history.
- Require public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help.
- Show severe inability to establish or maintain a personal social support system.
- Require help in basic living skills.
- Exhibit inappropriate social behavior, which results in demand for intervention by the mental health and/or judicial system.

From: National Institute of Mental Health. (1980). *Announcement of community support system strategy development and implementation grants* (pp. iii, iv). Rockville, MD: Author.

bases their estimates of psychiatric disability on a definition that also includes functioning in the definition: "…a diagnosable mental, behavioral, or emotional disorder…that has resulted in functional impairment which substantially interferes with or limits one or more major life activities." (IAPSRS, 1997) SAMHSA uses the term "severe and per-

sistent mental illness" similar to the way this text uses the term "psychiatric disability."

In order to operationalize the definition and derive estimates from epidemiological data, SAMHSA defined major functional impairment as one of the following:

1. Either planned or attempted suicide at some time during the past 12 months;
2. *or* lacked a legitimate productive role;
3. *o*r had a serious role impairment in their main productive roles;
4. *or* had serious interpersonal impairment as a result of being totally socially isolated, lacking intimacy in social relationships, showing inability to confide in others and lacking social support (IAPSRS, 1997).

Based on their definition, SAMHSA estimated that approximately 2.6% of the population of the United States have a serious and persistent mental illness or a psychiatric disability. Figure 1–1 is the typical way to visually compare the estimated percentages and numbers of people who have a serious and persistent mental illness, a serious mental illness, or any mental illness. A more recent estimate reports an even higher percentage of people with a severe mental illness (Center for Mental Health Services, 1998). The bottom line is that, despite discrepancies, the estimates of the number of people in the United States with psychiatric disabilities is enormous, as is the financial impact. For example, people with psychiatric disabilities account for a large share of claims and costs in both private and public long-term disability programs (Salkever, Goldman, Purushothaman & Schinogle, 2000), and the total cost of mental illnesses to the United States has been estimated to be as high as 150 billion dollars annually (Garske, Williams & Schiro-Geist, 1999).

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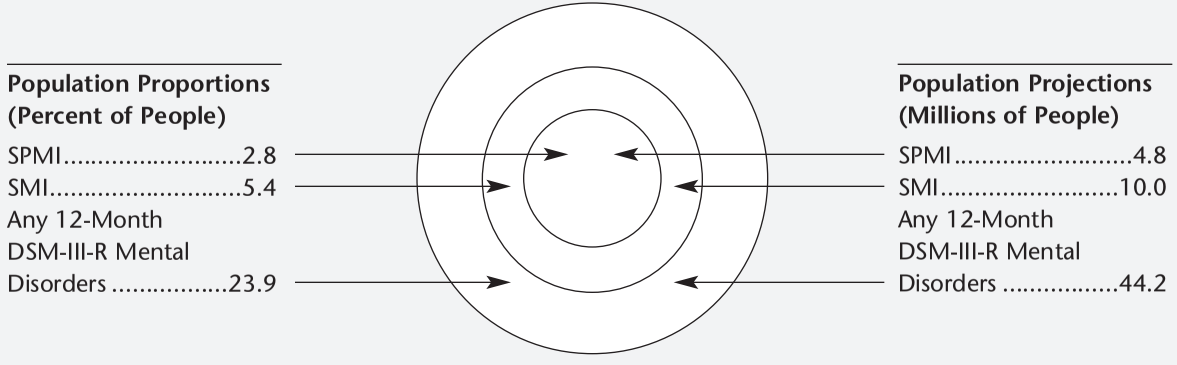
Worldwide estimates of the current and future impact of severe mental illnesses has increased dramatically. A new internationally used statistic called the DALY, the "disability-adjusted life year," is a measure of a year of healthy life lost to a particular disease, either through premature death or disability. The most significant result from measuring disease by DALYs is the new prominence it gives to the negative impact

Figure 1–1
Estimated Household Population (Ages 18+) 12-Month Prevalences and Population Projections of DSM-III-R Severe and Persistent Mental Illnesses (SPMI), Serious Mental Illnesses (SMI), and Any Mental Illness Based on Pooled Baltimore ECA/NCS Data



These estimates are based on extrapolation from household surveys and consequently exclude homeless people and residents of institutions such as nursing homes, prisons, and long-term care facilities. An estimated 2.2 million additional persons in these excluded sections are thought to have SMI, for 12.2 million in the total population.

From: International Association of Psychosocial Rehabilitation Services. (1997) *New Prevalence Estimates of Serious Mental Illness 3*(1). Columbia, MD: Author.

of severe mental illnesses. For example, major depression, typically not mentioned in international health rankings, is currently the fourth-leading contributor to DALYs, and is projected to be ranked as the second leading contributor by the year 2020 (Knox, 1996; Karel, 1996).

Psychiatric rehabilitation has long been associated with helping people with forms of schizophrenia. This association arose because early work done in the late 1970s focused on residual inpatient groups (typically people with schizophrenia) who were considered difficult to deinstitutionalize (Bachrach, 1986a). As inpatients were transferred to the community and more rehabilitation services were delivered in the community, rehabilitation began to become associated with helping people who had psychiatric diagnoses that ran the gamut of serious mental illnesses (e.g., severe depression, personality disorder, dual diagnosis, etc.).

In summary, since the 1970s the description of a severe mental illness has included the negative impact on an individual's occupational, social, and residential roles. As this understanding and description of a "serious and persistent mental illness" has become increasingly prominent over the last several decades, so too has the field of psychiatric rehabilitation. Psychiatric rehabilitation is the only mental health service that specifically emphasizes improving role performance and is based on a conceptual model that recognizes the negative consequences of a severe mental illness in terms of impairment, dysfunction, disability, and disadvantage. (Chapter 4 describes the conceptual model underlying psychiatric rehabilitation.) This text uses the term "person who has experienced a severe psychiatric disability" or "person with a psychiatric disability" to underscore the emphasis that psychiatric rehabilitation places on the individual rather than the diagnosed illness. Terms such as "consumer," "client," and "patient" are used sparingly in the text depending upon the role being described.

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Distinctions between Treatment, Rehabilitation, and Other Service Interventions

During the 1970s and 1980s it was important to make distinctions between psychiatric rehabilitation interventions and psychiatric treatment interventions in order to identify *and* promote the unique and