

INTEGRATING PSYCHIATRIC REHABILITATION INTO MANAGED CARE

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Psychiatric rehabilitation is a necessary service component in any managed care system that is designed to serve persons with severe mental illness. The focus of the present paper is to discuss the what, where, why, how, when, and who issues related to integrating psychiatric rehabilitation into a managed care system. The psychiatric rehabilitation process and outcomes are briefly overviewed and differentiated from other needed managed care services (What). Settings for psychiatric rehabilitation are identified (Where). The rationale for psychiatric rehabilitation in managed care is addressed by focusing on medical necessity, research findings, and the value base of psychiatric rehabilitation (Why). Issues in measuring psychiatric rehabilitation outcomes and process are discussed (How). Readiness for rehabilitation is conceptualized as both a client measure and as a program/system measure (When). The characteristics of personnel needed to implement psychiatric rehabilitation within managed care are noted (Who). In summary, the absence of psychiatric rehabilitation services in a managed care system is logically, empirically and ethically unacceptable.

In the 1970s psychiatric rehabilitation was not an essential service of community mental health centers (U.S. House of Representatives, 1963). While it may be an essential service ingredient now (National Institute of Mental Health, 1987), psychiatric rehabilitation services were not considered critical during the

period of rapid deinstitutionalization and the development of community mental health centers. It appears that in the early development of managed care, system designers might need to be informed of the relevance of psychiatric rehabilitation to the managed care system. Otherwise, the exclusion of psychi-

atric rehabilitation services from a major system initiative will once again occur.

In order for psychiatric rehabilitation to be integrated successfully into a managed care system, system planners must have the answers to a number of key questions. These questions include: a) *What* are the outcomes and processes of psychiatric rehabilitation? b) *Where* can psychiatric rehabilitation be practiced? c) *Why* is psychiatric rehabilitation needed in a managed care system? d) *How* are the outcomes and processes of psychiatric rehabilitation measured? e) *When* is a psychiatric rehabilitation intervention indicated in managed care? f) *Who* can practice managed care? Knowledge with respect to these questions will facilitate the introduction of psychiatric rehabilitation into the managed care system.

What Are the Outcomes and Processes of Psychiatric Rehabilitation?

The outcomes of psychiatric rehabilitation are fairly unique and specific relative to other mental health service interventions. Psychiatric rehabilitation ultimately attempts to improve role performance or status in consumers' living, learning, working or social environments. While there might be important ancillary outcomes (such as symptom reduction, increased skill performance, and changes in service utilization), the consumers' goal in psychiatric rehabilitation services are changes in role performance.

Role performance outcomes can be distinguished from other service outcomes. For example, Cohen, Nemec, Farkas, & Forbess, (1988) have differentiated the client outcomes achieved by other service system components as follows: treatment = symptom relief; crisis intervention = personal safety assured; case management = services accessed; enrichment = self development; rights

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protection = equal opportunity; basic support = personal survival assured; self help = empowerment. Each unique intervention can also impact consumer outcomes that are the specific targeted outcomes of other interventions (just as psychiatric rehabilitation may have important ancillary outcomes), but it is important to distinguish the unique consumer outcomes of each service in order to keep track of the contributions of each service component to managed care. It is absolutely necessary to identify the consumer outcomes that each service is expected to achieve (Anthony, 1992).

In a comprehensive service system such as managed care, these individual services may combine to facilitate the consumers' recovery from mental illness—which is the quintessential vision of mental health service systems (Anthony, 1993). The possibility exists that the outcome of the entire system of services can be more than the specific outcomes of each service. For example, symptoms may be alleviated not only to reduce discomfort, but also because symptoms

may inhibit recovery; crises may be controlled not only to assure personal safety, but also because crises may destroy opportunities for recovery.

Managed care system developers must understand that the vision toward which they are working is *not* the vision of previous decades—community maintenance, symptom control, or providing certain services—but a vision of promoting recovery. The research of Harding and others (reviewed by Harding & Zahniser, 1994) has shown recovery to be an empirically reasonable vision—and one certainly consistent with a rehabilitation approach in managed care.

Another important distinction with respect to psychiatric rehabilitation outcomes is the difference between skill performance and role performance. In psychiatric rehabilitation, skill performance includes such dimensions as job interviewing skills, money management skills, and interpersonal skills. These measures of skill performance are in actuality process measures. Skill development occurs *so that* individuals will be more successful and satisfied in their chosen role. For several reasons improvements in skill performance cannot be a proxy measure for role performance—which is the fundamental consumer rehabilitation outcome. First of all, role performance can be impacted without skill improvements (for example, by simply making the environment more supportive or accommodating). Second, skills can increase but not to a level that impacts on role performance, or perhaps the targeted skills were not most relevant to role performance. In essence changes in skill and changes in role are two very different types of measures.

The process of psychiatric rehabilitation varies greatly in terms of its formality, specificity, and documentation. At its most generic level the practice of psy-

chiatric rehabilitation involves consumers figuring out the residential, vocational, educational, and/or social goals they want to achieve, and developing the skills and supports they need to reach their goals. In some psychiatric rehabilitation programs this process is helped to unfold in an indirect, less formal and documented manner (for example, clubhouses). In other psychiatric rehabilitation programs this process is directly facilitated and documented by a practitioner (for example, programs using psychiatric rehabilitation technology). Even with differences in how the psychiatric rehabilitation process is structured in various rehabilitation settings, process measures at a minimum should include information on consumers' goals and the skills and supports developed to reach those goals.

Where Is Psychiatric Rehabilitation Practiced?

Psychiatric rehabilitation can be practiced in any setting, including inpatient settings. Psychiatric rehabilitation is a process with specific consumer outcomes. The *focus*, not the *locus*, defines psychiatric rehabilitation (Stein, 1988). Confusing to the delineation of psychiatric rehabilitation practice is the fact that many settings that call themselves psychiatric rehabilitation settings do not employ a psychiatric rehabilitation process. Anthony, Cohen, and Farkas (1982) published an article entitled, "A Psychiatric Rehabilitation Treatment Program: Can I Recognize One if I See One?" This article was the first attempt to define ingredients common to all psychiatric rehabilitation programs. The title reflected the historical problem that rehabilitation programs were often rehabilitation programs in name only.

A further complication to identifying where psychiatric rehabilitation is practiced is the fact that many settings that call themselves psychiatric or psychosocial rehabilitation centers provide ser-

vices other than psychiatric rehabilitation. Typically these services are case management and crisis intervention. By defining the specific outcomes and processes of all managed care services, distinctions can be made about the types and range of services a psychiatric rehabilitation setting provides to a managed care system. Rehabilitation settings may be well positioned to provide more managed care services than just psychiatric rehabilitation.

Why Is Psychiatric Rehabilitation Needed in Managed Care?

Based on our knowledge of what psychiatric rehabilitation is, how it differs from other managed care services, and where it can be provided, the most obvious question can now be addressed: why should psychiatric rehabilitation be part of a managed care system of services?

First, its focus on improving role performance uniquely addresses a major part of the impairment of severe mental illness, i.e., the person's social and occupational dysfunction (American Psychiatric Association, 1994). Central to the medical diagnosis of severe mental illness are deficits in occupational and social functioning. Psychiatric rehabilitation is a medically necessary service as it is the one service intervention that specifically addresses these deficits. It would seem impossible to have a service system that does not focus on an area of functioning central to the diagnoses of the illness itself. Second, research findings support the notion that treatment interventions alone do not impact on the consumer outcomes targeted by psychiatric rehabilitation (Anthony, Cohen, & Farkas, 1990). For example:

1) Psychiatric diagnoses provide very little information that is predictive, prescriptive, or descriptive of the psychiatric rehabilitation process and outcomes.

2) Symptom reducing treatment (such as medication, hospitalization, dynamic psychotherapy) do not increase skills or supports, nor effectively impact on consumer rehabilitation outcomes.

3) Measures of symptoms and measures of skills are only slightly correlated.

In contrast to the above findings are those which show that a psychiatric rehabilitation intervention not only impacts on psychiatric rehabilitation outcomes, but also reduces the utilization of the most costly types of service, i.e., inpatient and day treatment services (Rogers, Sciarappa, MacDonald-Wilson, & Danley, 1995). In addition, psychiatric rehabilitation services are highly desired by consumers relative to other mental health services. Furthermore, research has shown that there is little relationship between improvements in functioning in one area (e.g., residential) and improvements in functioning in another area (e.g., vocational). In other words, you get what you pay for—or in managed care you don't get what you don't pay for!

Another reason psychiatric rehabilitation is needed in a managed care system is the useful set of principles and values that psychiatric rehabilitation brings to the managed care field. Since its inception, psychiatric rehabilitation leaders have explicated the field's basic principles. Recent research suggests strong consensus in the field as to what these principles are (Cnaan, Blankertz, Messinger & Gardner, 1990). These principles include: a) equipping clients with skills; b) emphasizing client self determination; c) using the resources of the environment; d) emphasizing social change; e) providing differential assessment and care; f) emphasizing employment g) emphasizing the here and now; and h) providing early intervention. Many of these principles reflect the consumer driven, pragmatic, real world ori-

entation that managed care appears to emphasize, and as such psychiatric rehabilitation principles should reinforce the direction managed care is taking.

Also, underlying these principles are the values that psychiatric rehabilitation has historically emphasized—including treating the individual with dignity and respect, in a caring and compassionate way. These values are important in any mental health system, and certainly in managed care.

How Are the Outcomes and Processes of Psychiatric Rehabilitation Measured?

Psychiatric rehabilitation practice fits well within the managed care emphasis on measurement and accountability. As a matter of fact, psychiatric rehabilitation as a field appears to be ahead of managed care in terms of consumer outcome measurement. The major professional organization in psychiatric rehabilitation, the International Association of Psychosocial Rehabilitation Services (IAPRS), has achieved consensus on the most critical outcomes of psychiatric rehabilitation, and has developed a tool to measure these outcomes (IAPRS, 1995). This measurement tool is currently being field tested in a number of psychiatric rehabilitation sites around the country. Outcomes evaluated by the tool include such dimensions as vocational status, residential status, and financial status.

The Center for Psychiatric Rehabilitation at Boston University is developing, field testing, and implementing a management information system which incorporates many components of the IAPRS instrument—specifically outcomes for rehabilitation interventions targeted at people's residential, educational, and vocational goals, as well as measures of service utilization. Measures of process will also be added to this instrument. The Center for Psychiatric Rehabilitation has redefined

the measurement of the psychiatric rehabilitation process to reflect the consumers' perspective, i.e., the consumers' process of *choosing, getting, and keeping* their living, learning, working, and/or social goals. Process measures assess the particular choose, get, and keep activities in which the consumer is engaged, as well as the time and resources spent in each part of the process (Center for Psychiatric Rehabilitation, 1995).

In terms of measuring outcomes for the *entire* managed care system of services, of which psychiatric rehabilitation services are an important component, Anthony (1995) has tried to capture the overall, comprehensive outcomes of managed care within the phrase "in recovery, with places to be and symptom free." This phrase is meant to serve as a simple guideline for managed care evaluation. It encapsulates the quintessential importance of developing new meaning and purpose in one's life and of being able to function in one's environment of choice, as well as reducing the symptoms and crises of severe mental illness. "In recovery" highlights one's capturing anew feelings of personhood and self-respect. "Places to be" reflects the necessity of being involved in and belonging to places where one can live, learn, work, and socialize. "Symptom free" speaks to the need to alleviate the pain and discomfort that accompany severe mental illness and to release the thinking and feeling potential of individuals. Taken together, these three types of outcomes incorporate the external and internal functioning of persons with severe mental illness. By keeping managed care's outcome focus on the phrase *in recovery, with places to be and symptom free*, measurement tools will tend to incorporate the symptom alleviating capacity of treatment and crises intervention, the real world focus of other system components, such as rehabilitation and case manage-

ment, and the overarching consumer vision of recovery.

When Is Psychiatric Rehabilitation Practiced in a Managed Care System?

Do all consumers want psychiatric rehabilitation? Of those who do, are they all equally ready for rehabilitation services? The answer is *no* to both of these questions. Consumers vary with respect to their interest in psychiatric rehabilitation. At times their focus may be on resolving crises, eliminating symptoms, or developing important insights. Or they may desire rehabilitation assistance in only one environmental area, for example, the residential area. Experts in psychiatric rehabilitation do not need to be members of every consumer's service team, nor do all consumers need to access psychiatric rehabilitation programs. Consumers simply may not be ready for rehabilitation and may need help to become ready. At the Center for Psychiatric Rehabilitation at Boston University we have developed a technology to train practitioners to assess and develop rehabilitation readiness (Cohen, Farkas, Forbess, & Cohen, 1995; Cohen & Mynks, 1993; Surles, 1991).

People differ in terms of their rehabilitation readiness just like they differ in terms of their readiness for college, or for a physical fitness program, or for a vacation. Readiness is a reflection of consumers' interest in rehabilitation and their self confidence, not their capacity to complete a rehabilitation program. Persons who are ready for active involvement in rehabilitation activities rate high on five dimensions of rehabilitation readiness: perceived need, commitment to change, self-awareness, environmental awareness, and support of significant others.

Providers of managed care—often case managers—must help potential recipients of rehabilitation services determine

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their level of readiness so that when rehabilitation interventions do occur they begin where the person is, rather than where the program is. Unlike other concepts of readiness, rehabilitation readiness is not a capacity measure, nor an assessment made solely by the practitioner, nor used to exclude individuals from services; it is prescriptive of the next service step (Cohen, Anthony, & Farkas, in press).

The purpose of a readiness assessment is not to label or exclude people from participation in rehabilitation services; rather, it is to help persons determine whether they wish to participate actively in rehabilitation activities at this time,

and, if needed, to engage in activities to develop their readiness. It makes no sense, from both a therapeutic and a cost perspective, to attempt to begin rehabilitation with everyone. For those who are interested but not ready to begin, involvement in readiness development activities—at home, in a psychosocial rehabilitation center, in day treatment, or when confined to an inpatient setting—make programmatic and fiscal sense.

The concept of rehabilitation readiness can also be applied to programs that wish to operate psychiatric rehabilitation services in a managed care system. Programs vary in terms of their readiness to implement psychiatric rehabilitation and may be lacking the commitment, culture, or capacity needed to conduct psychiatric rehabilitation services effectively and efficiently.

Commitment means that key leadership staff members believe in the necessity of psychiatric rehabilitation and the changes to the existing program that might be required. *Culture* means that the values for “the way things are done around here” are consistent with psychiatric rehabilitation values and principles. *Capacity* means that the structure of the program and skills of the staff members facilitate the implementation of psychiatric rehabilitation.

The Center for Psychiatric Rehabilitation at Boston University has, over a 15-year period, assessed and developed psychiatric rehabilitation programs around the world. In order to accomplish this task, the critical ingredients of psychiatric rehabilitation service delivery have been identified and used to assess the mission, process, documentation, and policies of over one hundred psychiatric rehabilitation programs across North America (Farkas, Cohen, & Nemec, 1988; Fishbein, 1988; Nemec et al., 1991). Unfortunately, many settings give lip service to rehabilitation rather

than give rehabilitation services to their consumers! The worst case scenario of understanding neither the concept of consumer readiness nor program readiness is that consumers who do not want and/or who are not ready for rehabilitation will receive rehabilitation from programs that are themselves not ready to deliver psychiatric rehabilitation. Managed care system planners must insure that state-of-the-art rehabilitation services are delivered to consumers who are themselves ready for these services.

Who Can Practice Psychiatric Rehabilitation?

The practice of rehabilitation is not credential driven. One need not have a specific credential to practice psychiatric rehabilitation. Rather, one must be interpersonally skilled and be able to set goals with consumers, assess and teach skills, negotiate with the consumers' support system (Anthony, Cohen, & Farkas, 1990). High school and college graduates can practice psychiatric rehabilitation provided they are selected and trained to do it. Consumers themselves can become excellent practitioners of psychiatric rehabilitation. Supervisors are typically master's level personnel. Critical for managed care system designers to understand is that most professionals *cannot* practice psychiatric rehabilitation effectively because they have never been trained to do it. Personnel training is the key for the effective and efficient implementation of psychiatric rehabilitation services within a managed care system.

Summary

Psychiatric rehabilitation is a necessary component of a managed care system. It would be ethically, empirically and logically unacceptable to implement a managed care system without psychiatric rehabilitation services.

It would be *ethically unacceptable* because service recipients with a severe mental illness have been diagnosed with an occupational and social dysfunction. Not providing psychiatric rehabilitation is tantamount to diagnosing an illness but deliberately withholding the needed treatment. It is, ipso facto, medically necessary.

It would be *empirically unacceptable* because it would ignore the data which suggests that treatment alone will not restore the functioning of people with severe mental illness.

It would be *logically unacceptable* because it makes no sense to diagnose individuals as disabled and then treat them as if they were not!

Psychiatric rehabilitation is an essential ingredient of managed care. Families, consumers, mental health administrators, practitioners, and researchers need to advocate for the integration of psychiatric rehabilitation into a system of managed care for people with severe mental illness. To do otherwise is *totally unacceptable*.

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