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## Psychiatric Rehabilitation: Key Issues And Future Policy

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by William A. Anthony

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Medical practitioners have long recognized the critical importance of treating the consequences of physical illness as well as the illness itself.<sup>1</sup> This concept did not take hold in the mental health arena until decades later, when the deinstitutionalization movement gained momentum, and increased numbers of persons with severe psychiatric disabilities changed residence from the back ward to the back street to, in many cases, the main street.<sup>2</sup>

With increasing visibility, the functional limitations of some of these persons quickly became apparent; in 1977 the National Institute of Mental Health (NIMH) launched the Community Support Program (CSP). The CSP was designed as a pilot federal/state collaboration to explore strategies for delivering community-based services, including rehabilitation, to persons with severe psychiatric disabilities. National data on the persons initially served by the CSP illustrate the extreme functional limitations of this group. For example, median yearly income was \$3,900; 50 percent received Social Security benefits; approximately 10 percent were competitively employed, and only 9 percent of the unemployed were actively searching for work; 88 percent were not married; and 71 percent rarely or never engaged in recreational activities with others.<sup>3</sup> A more recent survey of CSP clients found a similar level of disability.<sup>4</sup>

A national survey of families of persons with mental illness also attests to the functional incapacities of this population.<sup>5</sup> Families reported that only about 5 percent of their family members with psychiatric disabilities were employed full time, even though 92 percent had a high school education and 60 percent either had post-high school training or had attended college. In interviews of ninety-nine long-term patients of a community mental health center,

George Spivak and colleagues reported that the group was "distinguished by low levels of educational, financial, and vocational achievement; only 13 percent were working more than half-time, even though at intake about two-thirds were judged capable of work."<sup>6</sup>

While such data from the 1980s on the functioning of persons with severe psychiatric disabilities indicated the need for rehabilitation, rehabilitation services were typically not provided.<sup>7</sup> For example, a group of 550 patients discharged from two state hospitals were followed for one year. Most received some type of case management, individual therapy, and chemotherapy, but only a small minority received rehabilitation services. The authors of this study concluded, "It is highly likely that many more patients than currently receive them could benefit from social and vocational services. A much higher proportion than those who received rehabilitation-oriented services was assessed as needing these services by the social workers at the time of discharge from the hospital."<sup>8</sup>

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### What Is Psychiatric Rehabilitation?

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During the past two decades the field of psychiatric rehabilitation has developed a unique philosophy, knowledge base, and technology, as well as a number of well-known program applications. Policymakers who wish to introduce or improve psychiatric rehabilitation within their system should become aware of these conceptual, empirical, and technological developments.

**Conceptual developments.** The term *psychiatric rehabilitation* has become so pervasive in the mental health field—indeed, so overused—that it has become necessary to clarify both what it is and what it is not. "Psychiatric" describes the disability that is the focus of rehabilitation. It does not mean that the service must be provided by psychiatrists or that it must use psychiatric

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treatment methods. “Rehabilitation” reflects the focus of the approach: to improve functioning in a specific environment. The overall mission of psychiatric rehabilitation is to help persons with psychiatric disabilities to become successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention.<sup>9</sup> Many techniques and settings are used in the rehabilitation of psychiatric disabilities (such as social skills training and clubhouses). However, these techniques and settings—often referred to as “psychosocial rehabilitation”—share common principles and philosophy.<sup>10</sup> I use the terms psychosocial and psychiatric rehabilitation interchangeably in this essay, reflecting current use in the field.

Psychiatric rehabilitation has expanded considerably the way in which people with severe mental illness are both perceived and served. Practitioners of psychiatric rehabilitation focus on treating the consequences of the mental illness rather than just the illness *per se*. The psychiatric rehabilitation field has relied on the World Health Organization (WHO) classification of the consequences of disease to provide the conceptual framework for describing the impact of severe mental illness.<sup>11</sup> WHO has developed a model of illness that focuses not only on the

illness (impairment) but also on the consequences of the illness (disability and handicap). Consistent with the WHO concepts of impairment, disability, and handicap, proponents of psychiatric rehabilitation contend that mental illness not only causes impairment or symptoms but also causes the person significant disabilities and handicaps.<sup>12</sup> These terms, now often referred to as impairment/disability/disadvantage, have come to be known as the rehabilitation model (Exhibit 1).

Historically, mental health treatment has intervened at the impairment stage. Somatic and psychological treatment tries to alleviate the signs and symptoms of pathology. In analyzing the early conceptual differences between treatment and rehabilitation, Louis Leitner and James Drasgow pointed out that in general, treatment is directed more toward minimizing illness and rehabilitation more toward maximizing health.<sup>13</sup> Eliminating or suppressing an impairment does not automatically lead to more functional behavior. Likewise, a decrease in disability does not automatically lead to reductions in impairment, although this could occur.<sup>14</sup> Interestingly, chronic or severe physical impairment does not always mean chronic disability and disadvantage, although physical or mental impairment in-

**Exhibit 1**  
**The Rehabilitation Model For Severe Mental Illness**

	Stages		
	Impairment	Disability	Disadvantage
Definitions	Any loss or abnormality of psychological, physiological, or anatomical structure or function	Any restriction or lack of ability to perform an activity and/or role in the manner or within the range considered normal for a human being (resulting from an impairment)	A lack of opportunity for a given individual that limits or prevents the fulfillment of a role that is normal (depending on age, sex, social, or cultural factors) for that individual (resulting from an impairment and/or a disability)
Examples	Hallucinations, delusions, depression	Lack of work adjustment skills, social skills, or ADL skills, which restricts one's residential, educational, <sup>a</sup> vocational, and social roles <sup>a</sup>	Discrimination and poverty, which contribute to unemployment and homelessness

Source: W.A. Anthony, M.D. Cohen, and M.D. Farkas, *Psychiatric Rehabilitation* (Boston: Boston University, Center for Psychiatric Rehabilitation, 1990).

<sup>a</sup>ADL is activities of daily living.

creases the risk of chronic disability or disadvantage.

The clinical practice of psychiatric rehabilitation, just like its counterpart in physical rehabilitation, comprises two broad intervention strategies: development of clients' skills and development of clients' supports. Various program models emphasize one or both of these interventions. For example, advocacy programs may focus on the support dimension so that clients are not restricted in their attempts to function in the environments of their choice. Social skills training programs, by definition, emphasize improving competency. Clubhouses, while recognizing the need for improved skills, focus more strongly on the support dimension in their attempts to foster an accepting and active milieu.

The assumption of rehabilitation practice is that if people's skill levels and/or the supports in their immediate environments are changed, those with psychiatric disabilities will be able to perform the activities necessary to function in specific roles of their choice. The inclusion of the "disadvantage" category in the conceptualization of severe mental illness recognizes that the restricted range of opportunity experienced by many mentally ill persons contributes to the person's rehabilitation outcome. Such opportunity deficits may result from discrimination, lack of economic resources, disincentives, and lack of reasonable accommodations. Successful rehabilitation can occur not only by fostering change in clients and their immediate environments, but also by advocating change in those opportunity restrictions that affect large numbers of persons with psychiatric disabilities.

**Empirical developments.** Increasingly, data on the consequences of severe mental illness complement the emerging consensus about the philosophy of psychiatric rehabilitation. These data provide significant empirical support for the following seven points.<sup>15</sup>

(1) People with long-term mental illness can be maintained in the community with minimal use of inpatient services. (2) People with long-term mental illness can be helped to function more successfully in the commu-

nity with interventions to enhance skills and supports. (3) Measures of skill and support, more so than psychiatric diagnoses and particular symptom patterns of persons with long-term mental illness, determine how well a person functions in the community. Thus, clinical assessments must focus on the person's skills and supports as well as on symptoms.

(4) Increased collaboration among agencies and settings—in other words, more effective use of existing resources—can improve the community functioning of persons with long-term mental illness. (5) Improved functioning in one area of a person's life does not indicate that the person's functioning in other life areas has been similarly affected. (6) Interventions to develop skills and supports may take time to have an effect on the community functioning of persons with long-term mental illness. The longer the research follow-up period, the more dramatic the effect of these interventions. (7) The typical prognosis for persons with long-term mental illness may not be increasing deterioration between episodes, but rather gradual improvement over the long term. A chronic or severe impairment does not mean total or lifelong disability.<sup>16</sup>

**Technological developments.** Based on the conceptual and empirical developments in psychiatric rehabilitation, a psychiatric rehabilitation technology has evolved. There are a number of technologies that can be broadly conceived of as psychiatric rehabilitation in orientation, and many have developed to a point at which they can be taught, monitored, and evaluated. They can change staff competencies and program structures in ways that benefit clients. Examples include developing psychosocial rehabilitation centers, client-operated self-help programs, rehabilitation programs in postsecondary settings, supported employment programs, and assertive community treatment programs; teaching clients medication management and social skills and teaching in-service and prospective personnel how to set overall rehabilitation goals, conduct functional assessments, teach skills, and do case management; and conducting family psychoeducational groups.<sup>17</sup> Some of

these program-level technologies are well known in the mental health field—for example, the Program of Assertive Community Treatment (PACT) model and the Fountain House model.<sup>18</sup>

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## Challenges For Policymakers

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The rapid conceptual, empirical, and technological developments in psychiatric rehabilitation make it an approach to service delivery that can no longer be ignored. Psychiatric rehabilitation is a service that has an appeal to both clients and their advocates. For example, a national survey of members of the National Alliance for the Mentally Ill (NAMI) and other studies have reported that families of mentally ill individuals experienced the greatest need for improved social and vocational rehabilitation services.<sup>19</sup> Similarly, a survey that included consumer advocates indicated that rehabilitation approaches have the most impact on persons with severe psychiatric disabilities.<sup>20</sup>

Effective integration of psychiatric rehabilitation into mental health systems depends on the skills, knowledge, and attitudes of the various personnel who interact with the client; the programs used by the personnel; and the service systems that support the people and programs.

**Personnel issues.** While programs may refer to themselves as rehabilitation programs, and systems may consider themselves rehabilitation oriented, if the personnel are not trained and experienced in rehabilitation, then rehabilitation will not be practiced. The field of psychiatric rehabilitation has a history of employing practitioners with a high school diploma or bachelor's degree who have been trained on the job and who demonstrate the necessary expertise to provide psychiatric rehabilitation. The focus on the deficits of current university-based training programs in no way diminishes the contributions of these practitioners. However, program administrators continue to lament that graduates are not able or willing to make immediate and effective contributions to psychiatric rehabilitation practice.

The simple fact is that professional schools of psychology, social work, nursing, psychiatry, occupational therapy, and rehabilitation counseling are not training their students in psychiatric rehabilitation. Effective implementation of psychiatric rehabilitation as part of mental health systems requires that it be taught within professional training programs.<sup>21</sup> Further, universities must ensure that graduates of their training programs, in addition to the unique contributions of their discipline, can relate, teach, and support in the context of a caring and hopeful attitude. And lastly, we must provide graduates with in-service training programs. Only then can psychiatric rehabilitation be a viable component of mental health systems.

Another major impediment to a broad rehabilitation approach in mental health systems is the resistance of staff, many of whom have been trained as psychotherapists, who diagnose and treat psychopathology instead of treating the consequences of mental illness. Psychiatric rehabilitation and psychotherapy are very different endeavors; they focus on different client characteristics and work toward different outcomes. Indeed, without additional training, most psychotherapists could not practice rehabilitation even if they wanted to. With new rehabilitation training, however, psychotherapists can be skilled clinicians, albeit with a different emphasis.<sup>22</sup> By mastering such technologies as rehabilitation goal setting, functional assessment, skills teaching, and programming, psychotherapists can become valuable psychiatric rehabilitation practitioners. I emphasize here, however, that retraining in psychiatric rehabilitation does not make a psychotherapist any less a clinician; rather, one becomes a clinician with a different diagnostic and intervention focus.

**Program issues.** Skilled personnel need to practice in programs that allow them to use their skills. Personnel training and program restructuring must go hand-in-hand. Too often newly trained personnel work in programs that are "rehabilitation" in name only. Psychiatric rehabilitation is not specific to particular settings, however. Pro-

grams can be found in community residential alternatives, community mental health centers, psychosocial rehabilitation centers, and inpatient settings. During the past fifteen to twenty years, rehabilitation programs were often defined by the program site. In the ongoing debate about whether community-based programs were better than hospital-based programs, some observers felt that a rehabilitation environment could not exist within a hospital setting. Rehabilitation was deemed, by definition, to occur only in community-based settings. No matter how innovative a hospital environment was, no matter how little a community-based program represented rehabilitation values, the program located in the community was the only one viewed as a rehabilitation program.

The philosophy and technology of psychiatric rehabilitation are certainly community focused. People with or without disabilities generally wish to live, learn, socialize, and work in the real world of the community, not in the artificial world of an institution. Yet even though psychiatric rehabilitation is always community focused, it need not be community based. The fact does remain, however, that it is difficult to generalize skills learned in the hospital to the community setting of one's choice. Close staff and program linkages between the hospital and community settings are an attempt to overcome this problem.

Effective psychiatric rehabilitation can be provided within the variety of settings where clients are served (for example, in a hospital that works with community mental health agencies). Despite the characterization of the setting as rehabilitation oriented, however, it is often not clear whether the setting actually contains psychiatric rehabilitation programs, is simply a variation of a traditional treatment program now offered in a community setting, or is the same treatment program with a new name. For example, some programs are called rehabilitation programs because they serve clients with long-term psychiatric disabilities (for example, aftercare and outpatient programs); conduct group therapy sessions that focus on functioning (for example, day treatment

centers with communication groups); provide activities in which clients interact (for example, crafts or socialization classes); or provide clients with intensive support to keep them from being hospitalized (for example, intensive case management). Although the programs may be called "rehabilitation," they may not be psychiatric rehabilitation programs at all.

Policymakers need to know what constitutes a psychiatric rehabilitation program and develop quality assurance mechanisms to ensure that programs identified as such accurately reflect the principles of the field. Ram Cnaan and colleagues have reported on a series of studies designed to identify and analyze fifteen principles basic to psychiatric rehabilitation.<sup>23</sup> These principles include opportunities for client self-determination, equipping clients with skills, modifying the environment, emphasis on the here-and-now, and emphasis on clients' strengths. Using these principles as a basis, policymakers could define the principles specific to each type of rehabilitation program and then use those principles to design and monitor the progress of all psychiatric rehabilitation programs.

**System issues.** One of the most significant policy concerns is that the various system functions (planning, funding, management, program development, human resource development, coordination, evaluation, and advocacy) work in concert to implement a psychiatric rehabilitation initiative. For example, system policy should not encourage the development of new psychiatric rehabilitation programs without a plan for new program dollars or for diverting existing program dollars to the rehabilitation initiative; likewise, a viable rehabilitation program initiative must include a quality assurance mechanism capable of assessing process and outcome.

While each system-level function must eventually be compatible with psychiatric rehabilitation, all of these system functions will not begin to change at the same time nor with the same intensity. Policymakers who are initiating a psychiatric rehabilitation approach within their systems should start with those system functions in which

personnel seem the most eager to change, as well as those functions that are currently most compatible with the new direction. For example, if the director of the human resources development unit wishes to convert the majority of the unit's training dollars to educating personnel statewide about psychiatric rehabilitation, then he or she would include a major training initiative early on; or if the state mental health director and vocational rehabilitation director have a good relationship and are committed to vocational rehabilitation opportunities for persons with mental illness, then they might pursue interagency coordination.

While all system-level functions are crucial, perhaps the most problematic is funding. Psychiatric rehabilitation services are seriously underfunded in most states, as they are often not perceived as critical, mainstream mental health services. In addition, psychiatric rehabilitation does not seem to easily "fit" Medicaid requirements. Indeed, the Health Care Financing Administration (HCFA) recently questioned the legitimacy of funding almost all psychiatric rehabilitation services. Currently, Medicare and most private insurance companies do not fund psychiatric rehabilitation. State vocational rehabilitation agencies fund short-term rehabilitation services for only a small minority of persons with severe mental illness.

The majority of states have now opted to include psychiatric rehabilitation services under the Medicaid category of "other diagnostic, preventive, and rehabilitation services." This "rehab option" permits states to cover a range of rehabilitation services under Medicaid, including both in-program and off-site services. Unfortunately, state policymakers vary considerably in their understanding and use of the rehab option. To develop and implement the rehab option, policymakers must be aware of the terminology that is acceptable to Medicaid, how to bill Medicaid, and how to ensure that new Medicaid dollars do not simply replace existing state dollars so that no new services are added. The National Mental Health Association (NMHA) has become a reliable source of current information on the rehab option.<sup>24</sup>

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## Concluding Comments

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Policymakers who wish to begin or to improve psychiatric rehabilitation services must be aware of the fragile nature of this field. Because the thrust of the mental health field has long been to treat the impairment, not the consequences of the impairment, psychiatric rehabilitation is not embedded in the traditions and practices of mental health care. Without strong leadership committed to a rehabilitation vision and system functions designed to reinforce this vision, psychiatric rehabilitation will not be made a central part of the system.

Psychiatric rehabilitation in mental health practice typically takes three or more years to become embedded in mental health care systems. Psychiatric rehabilitation system initiatives cannot simply be legislated or ordered; they must be carefully planned. Also, systems vary in their level of readiness for change. Before attempting to change a system, policymakers should assess the major system players' "felt need" for the change. Do they believe that their system is functioning well with respect to disability and disadvantage, or do they believe that these issues are not the appropriate focus of a mental health division? When the need for change is not felt, policymakers must focus on strategies for developing that felt need. These strategies might include interaction with other systems that are in the process of change and interviews with clients and family members involved with these systems.

Policymakers should ensure that any major system initiative is driven by the clients' goals, not the system's goals. Often clients are not even asked how they would like to see services change. Part of the problem in attaining clients' perspectives is that many people do not believe that persons with psychiatric disabilities have meaningful, realistic goals. Even if system planners recognize the validity of clients' goals, agency and systemwide goals still prevail. An example of a system-planning initiative driven by clients' goals is a recent statewide survey of such goals conducted jointly by the Massachusetts Department of Mental Health and the Boston University Center for Psychiat-

**Exhibit 2**  
**Primary Focus Of Mental Health Services For Persons With Severe Mental Illness**

Mental health services and outcomes	Impact of severe mental illness		
	Impairment (symptoms)	Disability (role dysfunction)	Disadvantage (limited opportunity)
Treatment (symptom relief)	•		
Crisis intervention (safety)	•		
Case management (access)	•	•	•
Rehabilitation (role functioning)		•	•
Enrichment (self-development)			•
Rights protection (equal opportunity)			•
Basic support (survival)			•
Self-help (empowerment)			•

ric Rehabilitation.<sup>25</sup> Consumer respondents to this survey indicated a strong preference for normal living situations (apartments and homes) versus group homes. The state’s commissioner of mental health, at a press conference announcing the survey results, stated that the department will deemphasize group housing and move to a supported housing approach.<sup>26</sup>

If policymakers are serious about targeting the consequences of mental impairment, especially the chronic nature of impairment, then they must complement their existing services with effective rehabilitation services. To move in this direction, they can look to the emerging psychiatric rehabilitation database for support and direction. While psychiatric rehabilitation is an important service delivery initiative, it is but one of many mental health services critical to treating a person’s impairment, disability, and disadvantage. William Kennard and colleagues have provided a cogent description of how the current repertoire of mental health services addresses the consequences of severe mental illness.<sup>27</sup> In their scheme, the more recently developed services focus their attention on disability and disadvantage (Exhibit 2). In a well-planned system, each essential service is analyzed with respect to its capacity to ameliorate people’s impairments, disabilities, and disadvantages.

Psychiatric rehabilitation is but one service delivery component (albeit an important

one) in a comprehensively planned service system; its conceptual, empirical, and technological base is unduplicated by other services. A comprehensive service system of the 1990s must contain a psychiatric rehabilitation service delivery component.

*This Perspective reflects the knowledge generated and/or analyzed by staff at the Center for Psychiatric Rehabilitation, Boston University.*

NOTES

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