Psychiatric Rehabilitation in a Community Mental Health Center

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Introduction by the column editors: **Day treatment centers, day hospitals, and partial hospitals have been pillars of community mental health programs for persons with serious and persistent mental illness. More than 30 years ago, controlled studies documented the cost-effectiveness of day treatment programs, especially as a service for individuals who otherwise would have been hospitalized (1). Since that time, the number of inpatient psychiatric beds has contracted throughout the United States, and day treatment programs have become more essential in the continuum of services for persons with mental illness. Although individuals with acute and florid symptoms are still admitted to hospitals when they are suicidal or are so disabled that they require the safety, supervision, and security that inpatient settings provide, most people with serious mental disorders who are able to live in supervised residences with their families or on their own can benefit from partial hospital or day treatment programs.**

The first generation of day hospitals offered services similar to those available on inpatient units: supportive group therapy, social services, medication management, and community meetings. Many of these programs were inspired by the psychodynamic tradition, which emphasizes affective expression, socialization, and the development of insight. However, with the advent of psychiatric rehabilitation, services offered by day treatment programs have evolved toward specific goal setting for community reintegration, functional assessment, skills training, vocational rehabilitation, and family psychoeducation (2). The efficacy of psychosocial rehabilitation procedures has been documented in research projects and specialized settings (3). The authors of this month's Rehab Rounds column demonstrate the effectiveness of a day program in a typical mental health center that adopted the psychosocial rehabilitation model.

In February 2002, the day treatment program of the Hollywood Mental Health Center in Los Angeles was transformed from a program that provided long-term, custodial social and recreational services for 12 to 15 clients to a learning-based program emphasizing time-limited stays, consumer responsibility, and training in social and independent living skills for community reintegration. The revamped program serves 20 clients with three staff members. All clients concomitantly receive pharmacotherapy from the mental health center's psychiatrists and case management services. The program operates two days a week from 8:30 a.m. to 1:30 p.m., starting with a continental breakfast and ending with a light lunch prepared by the clients.

Client population

The clients vary considerably in diagnosis, symptom severity, and functional capacity and include persons with schizophrenia and schizoaffective disorder, delusional disorder, bipolar disorder, and recurrent and chronic depression. The clients range in age from 18 to 67 years, and the ethnic groups represented include African Americans, Latinos, and Asian Americans. The clients have had frequent rehospitalizations and suffer from social isolation and sustained periods of inactivity—for example, not being able to leave their residence, or sleeping or watching television for a major portion of the day. Many have a history of substance abuse. However, at intake each client is oriented to the prohibition on attending the program while intoxicated.

During the past year, 34 different clients have participated in the program; 97 percent of those referred by case managers and screened by the program director were accepted. Seven out of the group of 34 dropped out for lack of attendance or attending while intoxicated. Daily attendance since the program was revamped has averaged 69 percent. Duration of participation, which has varied from six to 12 months, is individually negotiated with each client on the basis of his

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or her progress toward rehabilitation goals and successful completion of the criteria for graduation. Graduation criteria include attainment of at least one personal goal in the community, successful completion of at least one of the skills modules, development of a realistic plan for community participation that includes a schedule of weekly activities, specific social supports, and significant improvement in community adaptation as defined by the Independent Living Skills Survey (4).

Program description

The program's keynote comprises twice weekly groups for training skills relevant for community adaptation. These groups include modules for community reentry, recreation, conversation skills, workplace fundamentals, and friendship and intimacy (3). Additional elements of the program are weekly meetings for positive reinforcement of progress toward goals, program planning by a consumer council, and a weekly group in which the therapist elicits examples of problem solving and individualized experiences practicing the skills learned in the modules.

To further promote the autonomy of clients and their active participation in shaping the program, a consumer council was developed to give clients work experience that simulates competitive employment. To be chosen for one of the three council positions, clients complete an employment application form, participate in a job interview, are provided with a job description, and are expected to attend weekly planning and review meetings. A modest honorarium is linked to the job of staff assistant, providing peer advocacy, peer counseling, and program planning. Staff work closely with the consumer council in leadership development, accountability, and personal growth. Council members have served as guest speakers at local rotary clubs, clinic events, mental health clinics, and professional conferences. The council also publishes a monthly newsletter and assists with arranging field trips to the community that enable clients to practice skills they have learned in the program.

The modules used in the program are the ones that were developed and empirically validated by the social and independent living skills program of the University of California, Los Angeles (5). That program uses motivational dialogues, videotaped modeling, role playing based on the skills demonstrated in the videos, problem-solving exercises, and in vivo assignments. The learning activities of the modules were designed to overcome the cognitive deficits of persons with serious and persistent mental illness by using active and procedural learning, because most of the clients who participate in the program do not readily process or absorb verbally mediated information. Monthly participation in social and recreational activities in the community is planned by the consumer council to expose clients to "healthy pleasures" that they might use after graduation from the program.

Impact of the program

At the time of program entry and at six-month intervals thereafter, each client sets realistic, personal goals that motivate program attendance, are linked to the services provided by the program, and reflect clients' desires to improve the quality of their lives in the community. Examples are socialization goals (such as making at least one new friend, going out on a date, or going with friends to restaurants); vocational and educational goals (for example, obtaining a driver's license and a car as a means to travel to a job, completing a course toward a high school diploma, obtaining a volunteer job, returning to college to obtain a bachelor's degree, or making the transition from a volunteer job to paid employment); and health-related goals (such as overcoming agoraphobia and leaving home for shopping and recreation, losing weight, adhering to a prescribed medication regimen, or keeping one's apartment clean and tidy by overcoming procrastination).

Seventeen clients out of 20 (85 percent) successfully achieved their individual goals within six months of setting them. Five out of seven clients who sought employment (71 percent) obtained part-time jobs in the competitive sector. Comparison of the program with its predecessor program was not possible, because that program did not use empirical benchmarks of clinical changes.

Evidence of the acquisition of skills taught in the modules comes from pretest to posttest improvement in scores for each module: improvement has averaged 30 percent. Moreover, generalization of social and independent living skills has been frequently noted by reports of clients engaging in autonomous social and recreational activities, using prescribed medications more reliably, completing community college or adult high school courses, obtaining and sustaining jobs, volunteering with charitable agencies, dating, and making new friends. More active community involvement, increased social interaction, and improved verbal expression, assertiveness, and communication skills have been observed.

Fifteen months after its inception, the psychosocial rehabilitation program was the recipient of the Los Angeles County Department of Mental Health's Program of the Year Award, a significant achievement given that there are hundreds of programs throughout the county. New elements are periodically added to the program to enhance the scope of services and improve outcomes. For example, a family and caretaker educational series was introduced one evening a week, when clients' family members and other natural caregivers can attend, supplementing the home visits already being conducted. Also, a spiritual enhancement group was successfully implemented.

The consumer council collaborates with the staff in planning and implementing the annual Mental Health Month ceremonies each May. Graduation, complete with diplomas and a reception in a local restaurant, is a celebration, recognizing genuine improvements in clients' lives. Graduations are held every six months, and graduates are eligible to join an alumni association and a transitional peer support group. It is envisaged that the members of the consumer council as well as graduates of the program will expand their role to serve as mentors, which will involve them as teaching

assistants during skills training, providing peer counseling and advocacy, and taking a more active role in coleading groups at the center and in the community.

Afterword by the column editors: How does a typical community mental health center adopt innovative, evidence-based services that substantially improve the quality and outcomes of its programs? At the Hollywood Mental Health Center, a key element in the transformation of a day treatment program to a psychosocial rehabilitation program was the input of a psychologist who was competent in educational and behavioral treatments and who assumed leadership when the previous director retired. Other influences that aided the change were the involvement of psychology interns and postdoctoral trainees, public-academic consultation from an expert in rehabilitation, and sustained administrative support from the management of the mental health center. In addition, a needs assessment was carried out with input from clients and staff that contributed to the design of the new program and galvanized "ownership" by all stakeholders.

The generalizability of this program's utility is high given its comparability with a wide range of day treatment and partial hospital programs throughout the world, in terms of its scope, client-staff ratios, and varied client population (diagnosis, length of illness, age, and ethnic group) (6). Other day programs in the county have adopted this program's rehabilitation focus and have used the modules for training in social and independent living skills. The staff—social workers, paraprofessionals, and psychologists—are of disciplines similar to those of most community mental health programs.

It is noteworthy that half the clients were able to achieve employment as a function of their personalized goals, skills training, job placement, and staff supports. Day programs should not be supplanted invariably by supported employment, for a number of reasons. Many clients who are referred for day treatment are not interested in working. In addition, improvements in quality of life can be achieved by rehabilitation interventions other than job placement and support. Finally, employment can become an attainable goal through experiences in achieving nonvocational goals with consequent increases in self-confidence and self-efficacy (7). ♦

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