CONSENSUS STATEMENT ON
REHABILITATION OF PERSONS IMPAIRED BY MENTAL DISORDERS

Introduction

All known medical diseases vary both in severity and duration. While early diagnosis and prompt treatment are always essential, the vast majority of diseases are nevertheless chronic in their manifestations. This chronicity requires not only initial treatment but long-term management. The purpose of all long-term medical management is to minimize the current and future impact of the disease on the person's life and to maximize the quality of life including that of family and friends. The goal is for the patients to reach their highest level of normal independent functioning. The mental illnesses do not differ in these respects. Nevertheless, there are important differences which must be considered such as role function. The World Psychiatric Association (WPA) recognizes that mental illness, by its very nature, impacts not only on cognitive, affective, and personality factors but also on many important role functions. In many societies, the major adult roles are work and reproduction. Even mild psychiatric disorders such as anxiety and phobic disorders can affect either or both of these vital role functions. It is essential, therefore, that psychiatric assessment and treatment includes the areas of work and socialization. As in all diseases, an important additional goal of treatment is for the patient to maintain a healthy self-image.

The concepts of primary, secondary, tertiary, and quaternary prevention have relegated rehabilitation to quaternary prevention, i.e., at the interface between disability and handicap. This conceptualization while simple and clear is also static, sequential, and linear. The interrelationships amongst disorder, disability, handicap, and stigma are complex, dynamic, and nonlinear.

Rehabilitation is the long-term management of disease symptoms and the full range of their sequelae in an effort to reduce or to eliminate the resulting disabilities and handicaps. Psychiatric Rehabilitation is not restricted to a set of interventions such as a day hospital or drop-in center, but rather to the full range of biopsychosocial tools available to maximize functioning and to reduce disability and handicap. This reduction will also reduce stigma. The prediction by the World Bank is that affective disorders will soon be the single greatest contributor to the loss of disability adjusted life years (DALY). When schizophrenia, substance abuse, and dementia are added, it becomes obvious that psychiatric rehabilitation is economically as well as morally essential. The economic argument rests on the fact that most psychiatric disorders--unlike many other medical disorders--tend to strike young adults and hence to impact on the most economically productive years.

The high prevalence of mental illness and the need for appropriate long-term rehabilitation of the many individuals suffering from the more chronic mental illnesses required the WPA to develop a Consensus Statement on Rehabilitation of Persons Impaired by Mental Disorders. This Consensus Statement is neither procrustean nor de fide. It is a general statement of the presently agreed upon evidence-based understanding of psychiatric rehabilitation, which will continue to evolve and change over time. Disorders which tend to resolve more quickly and completely will not require certain rehabilitative techniques which will be essential for more severe and persistent disorders. The applicability of the several sections of this Consensus Statement in different parts of the world will vary as a function of many factors including economic development, professional resource availability, national priorities, and the particular culture.

Goals

As indicated earlier the goal of psychiatric rehabilitation is to improve the quality of the lives of the people suffering from the consequences of mental disorders. The reduction of disability, handicap, and stigma along with the prevention of relapse are all directed at enhancing the quality of life. This goal recognizes not only the

importance of the quality of life of the affected individual, but also the quality of life of that person's family and friends. An improvement in quality of life leads to enhanced social and economic productivity for the affected person thereby reducing stigma. Rehabilitation of psychiatric disorders can therefore be economically useful to a society because it can reduce economic dependence thereby converting a tax consumer to a tax producer. Beyond any fiscal consideration, the moral measure of a society is its concern for its members in distress. Persons suffering from serious mental disorders are a major public health problem and the amelioration and prevention of disability must have a high priority. Mental health is a fundamental human right.

It is important also to recognize that the variation in severity and duration of psychiatric disorders must be considered. The disabilities of an individual suffering from a moderate anxiety disorder are quite different from those of an individual suffering from a severe and persistent mental illness. It follows that the needs of the patient, family, and society will vary also as a function of the severity of the problem. What is essential is the recognition that the needs of the patients, their families, and their societies will require the integration of one or more interventions including biologic, psychosocial, educational, legislative, etc. The biologic intervention usually takes the form of psychoactive medications, while the psychosocial may involve various interventions ranging from psychotherapy to social skills and/or vocational training. Education of the patient, caregivers, and society at large can be of great importance. Legislative action may, for example, be necessary to prevent discrimination against some mental patients and to promote employment opportunities.

Principles

Psychiatric rehabilitation of persons with mental disorders involves a large body of knowledge including treatment of acute exacerbations, long- term management, and service organization. It often requires a commitment to involve the patients and the families in the work of the professional. The patient is not a passive consumer of services but rather an active participant in the process. It is necessary not only to work with the individuals and their families, but to work with the environment as well. This latter activity differs in some ways from traditional health care delivery. It involves collaborating with multiple agencies and government, as well as recognizing the legitimate concerns of the community in which the patient resides. Rehabilitation of psychiatric patients is a complex multidisciplinary process involving extensive and intensive collaborations including biologic, psychosocial, vocational, educational, and legislative. In this sense, it is the antithesis of the traditional medical model. The range of services required can not be delivered by a single person and not even by a single discipline. The proper organization of the necessary services into a system is critical. The system must be prepared to match the services offered to the patient's needs.

In summary, the practice of psychiatric rehabilitation--particularly in the severe and persistent disorders--requires a broad range of clinical skills and knowledge. There is the need to organize various services as seamlessly as possible and then to manage the mix. It is essential to integrate different areas of expertise in a clinically effective manner. Education of patient, family, and public are part of the task. Practitioners must also advocate for the patient and the family, while also trying to influence legislation. Clearly, the task is both large and complex.

Only a multidisciplinary team can approach the problem, but a multidisciplinary team must have some form of hierarchical organization in order to function effectively. While many different models can be utilized, there must be both authority and accountability. In an ideal world, such a team will be led by a psychiatrist with specialized training and expertise in rehabilitation theory and methods. In a less resource rich environment, the team leadership will have to be assumed by individuals with less extensive training. In any case, the team must report to a responsible agency which is usually governmental. The nature of disability in mental disorders often requires dual reporting to agencies representing health and social welfare issues. Ideally, this responsibility would not be split, however, at the present time, it is separate in most countries. The need to merge these functions more seamlessly is apparent.

As indicated, the team must have a leader to function effectively. When the ideal choice of a psychiatrist trained in rehabilitation is not available, then the team leader must have adequate training in several areas. Among these is a basic knowledge of psychoactive drugs and their side effects. The leader must also be

knowledgeable about educating patients to accept their medications. The leader must know the early signs of relapse and how to prevent beginning relapse going into severe illness. This also involves education of patient and family to be alert to warning signs. The team leader must be familiar with the methods of psychosocial skills training and their implementation. Vocational training is often a critical component of recovery and the leader must be knowledgeable about the means of vocational training available in that particular setting. The education of the patient in the proper use of leisure time is also important to recovery and is another responsibility of the team leader. Housing is frequently an important issue and it is also the responsibility of the team to assist the patient in securing appropriate housing. A vital function of the team is education of the patient, the caregiver, the society, and the government. All of these skills must be present in a team leader.

Methods

The goal of maximizing independent functioning requires obtaining and maintaining control of the psychiatric symptoms that lead to disability. These symptoms are often conceptualized in terms of descriptive psychopathology such as hallucinations and delusions. This is a simplistic understanding of psychiatric disorders. Loss of functioning, such as impaired concentration, can be a major target for rehabilitation. Excessive timidity, which can impair role function, may also be an appropriate target symptom. Recognition of the existence of external barriers, such as stigma, also requires psychiatric attention to impact on these barriers. In order to sustain adequate role functioning it is necessary for psychiatric rehabilitation to deal with not just the problem of psychopathology narrowly defined, but the impairments, disabilities, handicaps, and stigma that are associated with psychiatric illness.

Pharmacotherapy

Many of the psychopathologic symptoms can be managed by modern pharmacotherapy. It is important to recognize that it is unwise to exclude the newer and more expensive pharmacologic agents on the basis of initial cost considerations alone. These compounds can have superior efficacy, fewer side effects, and greater compliance leading thereby to reduced long-term costs and better care. Psychiatric patients have a right to the most effective treatments available with the least side effects. Many psychiatric interventions ranging from institutionalization to pharmacotherapy can produce undesirable effects, which effects can also lead to stigma. It is essential to avoid the negative consequences to the person of excessively prolonged and/or repeated hospitalization. It is also important to ameliorate or eliminate the undesirable effects of pharmacologic agents by utilizing the lowest effective dose. Patient compliance is maximized when the treatments are acceptable to that patient. Patient compliance with pharmacotherapy is greater with the newer antidepressant and antipsychotic compounds, because of their more benign side-effect profiles, leading thereby to lower rates of relapse and rehospitalization and ultimately to both improved quality of life and cost savings. This is an important consideration for both acute treatment and longer-term rehabilitation. Education of the patient and family as to the importance of long-term psychotropic treatment and to its side effects and their management are essential components of proper care.

Secondary Prevention

Some psychiatric disorders are severe and recurring. As in all recurring diseases important goals are to prevent relapse and progression of the illness and in particular to prevent hospitalization. One method of prevention is to educate the patient and the family to identify and manage the precipitating life events. While the specific events will vary across cases, their recognition and prompt intervention can often prevent relapse. What is helpful is the fact that precipitating factors tend to be similar or identical within a given case. Furthermore, the early signs and symptoms of relapse tend to be identical in the same person. Hence, early detection of symptoms and prompt intervention are important modalities. Symptoms frequently can be detected while they are still mild in their manifestations particularly by family members and by patients. Intensive intervention in these early stages can prevent progression of illness to a more serious level. This method of prompt intervention--secondary prevention--is equally valid in milder forms of mental illness as well. While

conceptualized as secondary prevention, it is an integral part of a rehabilitative approach to the disorder.

Community Care

The goal of maintaining the patient in the most natural environment puts an emphasis on community-based care. In order to maintain the patient in the community, in more severe disorders, it is necessary to offer support not only to the patient but to the family, which often is a key provider of rehabilitation. Education of the patient, family, and community are critical elements in being able to maintain the more seriously ill patients outside of an institutional setting. In countries where the extended family system is prevalent, it should be used to the benefit of the patient's rehabilitation. In order to maintain such patients successfully in the community, there must be adequate opportunities for self-help, support, vocational training, and work as well as adequate opportunities for social skills training. The more severely ill usually require such specialized services. There are patients who can not compete in the labor market and who will require some social assistance. Finally, we must not forget the importance of psychological rehabilitation in all cases to maintain the patient's self-esteem and healthy pride.

Housing

There are situations, e. g., high expressed emotion families, in which it is in the patient's and/or family's interest to have housing separate from the family. In some instances the illness compromises the patient's ability to act. Access to appropriate housing and the right to determine what is appropriate are essential parts of the rehabilitative process for such people. The specific nature of that housing will vary within and across countries and cultures. Where such housing alternatives are not available, the reduction of face-to-face contact between the patient and the family can be utilized as an alternative strategy.

Leisure Time

An often neglected aspect of psychiatric rehabilitation is the satisfactory use of leisure time. While only the patient can define what is a personally satisfying use of leisure time, it is essential that the health care/social welfare system recognize that it is an important consideration. The public perception of how psychiatric patients use leisure time can either contribute to stigma or to its reduction.

Summary

In summary, psychiatric rehabilitation can be understood conceptually as the ongoing treatment of those aspects of psychiatric disorders which tend to be persistent and which can lead to impairment. Psychiatric rehabilitation requires an organization of medical, educational, vocational, and social services that maximizes the fit between the clinical needs of the patient and the available resources. The methods involve various admixtures of specific techniques ranging from the biologic (e. g., good psychopharmacology), to psychotherapy, to vocational and psychosocial skills training, to cognitive remediation, to support groups, and to education for the patient, the family, and the community. Finally, rehabilitation should include advocacy. Advocacy by influencing legislation and public perceptions is not only of immediate value to the patients and their families, but helps to reduce stigma and thereby to reduce handicap and disability.

Stigma

The term stigma originally referred to a sign that identified an individual so marked. Gradually the sign became associated with an undesirable or shameful quality. Stigmatization is often a form of social control and therefore may be of value in a given culture. Unfortunately, many medical illnesses have been associated with stigma, so that the individual suffering with that illness was blamed and/or ostracized. In many cultures mental illnesses are associated with stigma that then creates handicaps and other negative consequences for the patients. The combination of better treatment, better outcomes, and education offer hope for the ultimate

elimination of stigma. The WPA has led the way in the effort to eradicate it through the development of educational programs aimed at the public, the families, and the professionals.

Education

The long-term management of all medical illnesses, including psychiatric, requires staff education. The hospital-based, acute care model is useful for pneumococcal pneumonia, but of no value for the long-term management of hypertension let alone for most aspects of a serious and persistent mental illness. Patient and caregiver involvement is absolutely essential for rehabilitation. The goal remains to maximize normal role functioning. Towards this end, not only must professional personnel be educated appropriately, but services must be integrated with long-term management in mind. Personnel must be educated to realize and to accept that improvement in role functioning is often slow and sometimes incomplete. Agencies must accept the uncertainty of the time necessary for elements of the process to be completed. The setting of rigid deadlines and time constraints is usually counterproductive. Finally, mental health workers must be encouraged to deal with legislative and other policy making bodies in order to influence health priorities and the manner of their implementation. This is a shift from the traditional role of the health worker and requires both education and support.

Certain aspects of psychiatric rehabilitation can be implemented by health care workers with modest training under good supervision. By analyzing the tasks involved in psychiatric rehabilitation one can often reduce them to simple components that can be implemented in community-based programs by individuals with moderate training. These health care workers should be supervised by better-trained individuals who monitor their activity. This is of particular importance in developing countries that may lack the resources to mount a more expensive program.

An important aspect of all medical rehabilitation, including psychiatric, is the dissemination of information which is useful for health promotion. Health promotion includes information on physical exercise, diet, smoking, alcohol, drugs, etc. At the societal level, it is important to promote participation in community-based activities and involvement in meaningful social tasks and networks. Psychologically, it is important to promote self-esteem, optimism, and hope for recovery. The education of nonprofessional caregivers concerning life stresses which are likely to act as precipitating events for relapse is also of importance. Caregivers also require support and just as the family of a diabetic must learn about dietary management so must the family of a chronic schizophrenic learn about medication and psychosocial management. A major attractive feature of both information dissemination and health promotion is that they are relatively inexpensive.

Research

While much research has been done on the psychosocial aspects of rehabilitation, many of the studies lack the rigor of the biologic studies. Nevertheless, it is certain that medication and psychosocial approaches are not in conflict but actually complement each other. It has also been demonstrated that proper rehabilitation reduces relapse and rehospitalization in the more serious illnesses. Rehabilitation improves the quality of life as measured by the patients and their families. Much still needs to be done. Some priorities include the need to identify subtypes of psychiatric disorders that are more responsive to:

a) existing specific medications
b) newly developed medications
c) existing specific psychosocial interventions
d) newly developed psychosocial interventions

More research is necessary to identify the appropriate mix of biologic and psychosocial interventions in particular individuals. We do not yet know how to assess an individual so as to determine his or her precise rehabilitative needs in advance of implementation. Another high priority is the development of culturally

sensitive cost/benefit analyses of rehabilitation.

The WPA & Psychiatric Rehabilitation

The WPA has long been an active force in the rehabilitation of people impaired by mental disorders. For over a decade, the WPA has had a Section on Psychiatric Rehabilitation which has made significant efforts to educate both the public and professionals. A major programmatic effort of the WPA has been on the reduction of stigma, which reduction is essential to the amelioration of handicap. Stigma can be internalized by the patients and their families as well as existing in the community. It is not unusual to see the offspring of psychiatric patients fearing to marry lest they pass on their "bad genes." The educational programs of the WPA have long emphasized the importance of understanding the limits of our knowledge concerning mental disorders and it continues to lead the international community in its efforts to inform in a responsible fashion.

Recommendations

Psychiatric rehabilitation has emerged in many countries in different ways. This emergence reflects energy, creativity, and spontaneity. If the field is to develop to its full potential, there is the need to define its content and to draw its boundaries in a sharper and more homogeneous fashion. Physicians must be able to prescribe rehabilitation in the same ways as they do physical therapy, selecting those particular modalities needed by the patient. It is not necessary for the physician to be able to deliver every aspect of rehabilitation but it is essential for the physician to be able to prescribe. It follows then that the training of the general psychiatrist must include more training in rehabilitation. Broadly applicable standards for the field must be developed and disseminated. There is an equal need to develop leaders in the field. These goals can be best achieved through the establishment of university-based, multidisciplinary training centers which through the process of education and accreditation will develop the practitioners and future leaders of the field.

Suggested Readings:

Cancro, R. and Meyerson, A. T. Prevention of Disability and Stigma. In: Maj, M. (Ed.) Evidence and Experience in Psychiatry. Wiley: Sussex, 1999.

Flexer, R. W. and Solomon, P. Psychiatric Rehabilitation in Practice. Andover: Boston, 1993.