

New directions for psychiatric rehabilitation in the USA

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American researchers have led the world in developing, evaluating, and disseminating evidence-based psychiatric rehabilitation practices for people with serious mental illness. Paradoxically, however, the USA lags behind most industrialized nations in providing access to high-quality mental health and psychiatric services. This essay examines several evidence-based practices developed in the USA, the spread of these practices, the barriers to ensuring availability to people who could benefit from these services, and some promising directions for overcoming the barriers. Factors influencing the growth and sustainment of effective client-centred practices include the availability of adequate and stable funding, committed leadership, and the influence of vested interests. Two strategies for promoting the spread and sustainment of well-implemented evidence-based practices are the adoption of fidelity scales and learning communities.

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In this essay we describe the status of psychiatric rehabilitation services in the USA and offer our recommendations for future directions. We examine this paradox: while the USA has led the way in developing, researching and disseminating evidence-based psychiatric rehabilitation services around the world (Corrigan *et al.* 2008), the quality of mental health treatment and rehabilitation services in the USA lags behind services in many other industrialised nations, much as does the overall US health care system. The USA consistently ranks far below most countries in a wide range of health indicators despite its much higher *per capita* expenditure for health care (Squires & Anderson, 2015). The US health care system is expensive, inefficient and diverse – essentially a non-system producing enormous disparities in care. Thus far, health care reform through the Affordable Care Act has not led to wider adoption of evidence-based care for Americans with serious mental illness (Olson *et al.* 2013).

Mental health services in the USA are funded through a combination of different private insurances (mostly for families covered by employer benefits and others receiving coverage through health exchanges) and public insurance through Medicaid, Medicare, benefits to military veterans and other programs. Only a minority of Americans with serious mental illness receive any mental health treatment at all (Wang *et al.* 2005). Private health insurance rarely

pays for psychiatric rehabilitation services. Among Americans with serious mental illness who do receive mental health and rehabilitation services most do so as clients in public mental health clinics funded primarily through Medicaid. People with mental health needs are often unhappy with available mental health services; approximately one-third of those who have contact with the mental health service system drop out quickly (Kreyenbuhl *et al.* 2009). Largely because of systemic problems, <5% of people with serious mental illness receive high-quality psychiatric rehabilitation services (Drake *et al.* 2009).

Despite the wide endorsement of recovery as a guiding principle of psychiatric rehabilitation (Anthony, 1993), state mental health agencies in the USA, through their state Medicaid plans, continue to support outdated psychosocial services, such as brokered case management services, day treatment and institution-based skills training. To maximise Medicaid reimbursement, mental health providers often offer predominantly group modalities even when clients prefer, and might benefit more, from individualised services. Moreover, state mental health spending includes sizeable allocations of funding for psychotropic medications, out of proportion to any benefits and to a large extent antithetical to recovery (Drake *et al.* 2008). The US mental health system serves vested interests rather than client interests.

This essay examines several evidence-based practices (EBPs) developed in the USA, the spread of these practices, the barriers to ensuring availability to people who could benefit from these services and some promising directions for overcoming the barriers.

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The evidence base for effective psychiatric rehabilitation practices

People with severe mental illness have the same life goals as everyone else. These goals include a safe, decent, affordable and permanent place to live, access to education and employment, friendships and community participation in leisure and growth activities. In other words, they want to live satisfying, functional, meaningful lives, not just be stable (Deegan, 1988; Drake & Whitley, 2014). To be client-centred, psychiatric rehabilitation should aim at realising these life goals. Are these goals attainable?

Experts defined evidence-based medicine as ‘the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients’ (Sackett *et al.* 1996). A 1998 conference of mental health leaders called for systematic attention to its application to psychiatric rehabilitation practices (Drake *et al.* 2001). Researchers, primarily from the USA, have identified a large and growing number of effective psychiatric rehabilitation practices (Corrigan *et al.* 2008; Dixon *et al.* 2010). Evidence-based models have been developed for many recovery goals, including employment (Marshall *et al.* 2014), independent living (Rog *et al.* 2014) and community living skills (Bond & Drake, 2015). Illness self-management approaches, such as the Wellness Recovery Action Planning, foster attainment of personal life goals (Cook *et al.* 2012). In other life domains, notably the interpersonal realm (social networks, friendship and intimacy), establishing EBPs has been more difficult (Davidson *et al.* 2004). More research is needed, of course, but the more serious issue is that practices for which the evidence is well established are not widely available. This gap between what practices are effective and which are actually available and delivered with high fidelity – what has been termed the science-to-service gap (Drake & Essock, 2009) – is the most pressing problem in the US public mental health system.

Lack of evidence-based psychiatric rehabilitation practices

According to reports from state mental health leaders in their annual reports for the Federal Block Grant, approximately 2% of clients with serious mental illness enrolled in the public mental health system have access to evidence-based psychiatric rehabilitation services, a statistic that has remained steady in reports over the last decade (Bruns *et al.* 2016). Service gaps occur at three levels: states that have not adopted practices into their state plans, limited penetration within states that have adopted a practice and limited capacity to

serve clients within programs once practices are established.

States began adopting EBPs in the early 2000s. After this initial effort, however, the uptake of EBPs levelled off or declined over the next decade (Bruns *et al.* 2016). Many states have made only minimal progress.

The national data sets compiled by Bruns *et al.* (2016) provide the most comprehensive snapshot of the spread of EBPs in the USA. These data, based on self-reported surveys that state leaders completed on an annual basis for federal reporting purposes, are the only systematic information we have for most practices. These annual surveys provide only rough estimates of the spread of EBPs and virtually no information on penetration at the client level.

A 2015 national survey on the prevalence of evidence-based employment services known as Individual Placement and Support (IPS) (Johnson-Kwochka *et al.* submitted) yielded greater detail. Of the 50 states and District of Columbia, 38 (75%) offered IPS services, reporting a total of 523 IPS programs nationwide. The state IPS program penetration rate (number of IPS programs per 10 000 people) ranged from 0.01 to 1.67 ($M=0.36$, $S.D.=0.37$) in the 38 states reporting IPS services. IPS programs vary widely in size, but two large IPS surveys suggested an average program caseload size of about 60 (Bond *et al.* 2012; Kim *et al.* 2015). Using these figures, we concluded that over 30 000 clients with serious mental illness in the USA received IPS services in 2015. Given that the 2010 US Census reported roughly 200 million working-age Americans, and assuming 5% of the population, or about 10 million people, had a serious mental illness, the percentage of Americans with serious mental illness receiving IPS is approximately 0.3% – a tiny fraction of the 70% who want to work and could potentially benefit.

Why do American citizens lack access to EBPs despite abundant national resources? We next examine several key barriers and facilitators to adoption, implementation, sustainment and expansion of evidence-based psychiatric rehabilitation programs, drawing on a framework shown in Table 1. This table is adapted from a framework developed in a national study examining implementation and sustainment of EBPs (Torrey *et al.* 2012).

What are the barriers?

Many factors have prevented the spread of evidence-based psychiatric rehabilitation services. Since the 1950s, psychiatric rehabilitation services in the USA have been underfunded, requiring program leaders to access a patchwork of federal, state, local and

Table 1. Operational definitions for implementation/sustainability factor domains

Domain	Definition
Financial	Agency finances, agency resources, state or national budgetary policies, reimbursement mechanisms, or general economic trends promote/inhibit spread of evidence-based practice (EBP)
Leadership	Leader actions promote/inhibit novel and productive solutions to challenges; ensuring practitioner have necessary resources to provide services; expressing enthusiastic support for EBP
Prioritisation	Support for EBP from staff, clinical team, agency leadership, or state/city/county mental health agencies promote/inhibit EBP
Quality improvement	Systematic monitoring of program fidelity and client outcomes and use of data are/are not provided via financial incentives and penalties, administrative rules and regulations, ongoing supervision and feedback on practices
Workflow	Work flow is/is not structured so that routine procedures enable EBP (e.g., integration of services, documentation burden, physical environment, or non-financial policies)
Workforce	Appropriately credentialed practitioners and supervisory staff with necessary mastery and training are/are not available for team to function with fidelity to the model
Training and technical assistance	Training, technical assistance and resource material specific to the EBP are/are not available on an ongoing basis through a technical assistance centre, which provides training to new employees, ongoing onsite training, consultation and a regular schedule of workshops to ensure a well-educated work force

private funding sources, each with its own set of eligibility requirements, funding caps, time limits and documentation procedures. The lack of adequate and predictable funding is the most significant barrier to adopting and sustaining EBPs (Seffrin *et al.* 2009; Wiltsey Stirman *et al.* 2012). State Medicaid plans often make it far easier to finance outmoded services than evidence-based rehabilitation services. Despite its mandate to promote quality of care, the Centers for Medicare and Medicaid Services, which is the federal agency responsible for giving guidance to states on their Medicaid plans, has been timid in providing clear instructions that would empower state leaders to pursue evidence-based rehabilitation services. Medicaid funding typically incentivises group services over individualised services, clinic-based services over community-based services and medication-related services over non-pharmacological self-management approaches.

State mental health directors experience myriad pressures: legislators demand cost cuts, industry lobbyists want to expand pharmacology, families prioritise protecting vulnerable patients, providers often desire to maintain current services and so on. EBPs may be low on the list. Furthermore, these leaders have such short tenure in their jobs that continuity of system development suffers. The public mental health workforce is typically not prepared to deliver EBPs, and state funds for retraining have been severely diminished.

Pharmaceutical companies have aggressively and successfully marketed many new and costly antidepressant and antipsychotic medications initially hailed as having both greater efficacy and fewer side

effects. Studies subsequently have disproved these claims, and companies have paid large settlements to the Department of Justice related to false advertising. The heavy marketing and adoption of these drugs had a further negative effect; funding for community rehabilitation services shrank precipitously as state mental health agencies allocated increasing proportions of their budgets for the new medications (Drake *et al.* 2008). Compounding this problem is the federal law forbidding the Centers for Medicare and Medicaid Services from negotiating with pharmaceutical companies on the price of medications, in contrast to other nations.

What are the facilitators?

Notwithstanding slow progress, several developments may give optimism. Payment is of course the chief vehicle for reform. Government and private insurers are currently shifting from paying for the amount of services to paying for valued outcomes. If implemented broadly, these payment changes should decrease ineffective and harmful services and promote those that actually help people.

The federal government and private foundations have helped to promote EBPs by sponsoring demonstrations, such as the National Evidence-based Practices Project (McHugo *et al.* 2007). Demonstrations are often short-lived when states do not sustain funding and leadership. State leaders can influence the spread of EBPs through establishing standards,

incentivising effective services, aligning policies and monitoring services (Finnerty *et al.* 2009). Two strategies that have helped many states are the adoption of fidelity scales and learning communities.

Program fidelity refers to provision of services consistent with objective criteria defined by a program model. Since the late 1990s, researchers, mostly in the USA, have developed, validated and refined a series of EBP fidelity scales (McHugo *et al.* 2007), including scales for IPS (Bond *et al.* 2012), assertive community treatment (Monroe-DeVita *et al.* 2011), Housing First (Gilmer *et al.* 2013) and Illness Management and Recovery (McGuire *et al.* 2012). These scales have enabled state authorities to monitor programs and to ensure quality. Many of these scales have been widely adopted, and some states require programs to be certified by achieving high fidelity to receive enhanced rates for provision of evidence-based services (SAMHSA, 2015).

A 'learning community' is defined as a network of organisations with a shared goal of improving treatment for a specific medical condition, facilitated by regular communication (for example, meetings, teleconferences and newsletters) and collection and dissemination of objective information about procedures and outcomes, with a long-term commitment to quality and expansion (Bond *et al.* 2016). Learning communities build on and systematically integrate the individual implementation strategies identified in Table 1 (prioritising EBPs, fidelity monitoring, training and technical assistance, provision of adequate funding). Learning communities can promote dissemination of information, quality of implementation, sustainment and expansion of evidence-based programs (Bond *et al.* 2016).

The courts have also helped. A 1999 US Supreme Court case – the Olmstead decision – has promoted expansion of evidence-based psychiatric rehabilitation services (Burnim, 2015). Based on the Americans with Disabilities Act of 1990, the Court ruled that states must provide community services to enable people with disabilities to live in their own homes instead of institutions or congregate facilities. This decision has also been interpreted to encompass full social inclusion. Subsequently, the US Department of Justice has forced numerous states to provide statewide dissemination of a range of evidence-based psychiatric rehabilitation services, including assertive community treatment, supported housing and IPS supported employment (Burnim, 2015).

Conclusions

In the decade ahead, how can psychiatric rehabilitation leaders transform the US service system to actualise

the goal of helping people with serious mental illness lead productive, meaningful and satisfying lives and full integration into the community? The failure to implement our service systems to align with this vision is not for lack of an evidence base. The core principles of psychiatric rehabilitation and associated EBPs have been well described (Corrigan *et al.* 2008). Change must come from political action. People with psychiatric impairments, their families and their many supporters, unshackled from stigma, will need to demand better services – high quality, evidence-based, person-centred services – rather than ideological tropes. Training institutions, providers and state and local infrastructures will transform when the public demands reach a threshold.

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Conflict of Interest

None.

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