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Patient-Centered Care and Psychiatric Rehabilitation: What's the Connection?

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Introduction

Why should psychiatric rehabilitation practitioners take notice of the idea of patient-centered care? After all, it seems to be updated language describing the same old medical model of care provision, with the physician in charge and everyone else, including the patient, following in lock-step behind. Leplege et al. (2007) have noted that psychiatric rehabilitation practitioners have studiously avoided use of the term "patient-centered care." This may be because of the fact that patient-centered care does in some ways seem to keep the doctor in charge, despite rhetoric about enabling and empowering patients. The literature describing and advocating for the use of patient-centered care has been dominated by physicians and others working in medical settings, who refer to consumers of health care as "patients" and seem to keep control of health care processes in the hands of doctors. We in community mental health may see ourselves as better than that—we put our ideas about empowerment into practice, instead of just talking about them, right?

But why not embrace patient-centered care? In reality, despite the use of the word "patient," which many in the mental health community dislike, patient-centered care is a concept that gives primacy to the voice and concerns of the person using the health care service. Some commentators have made the observation that the mental health field is as guilty as the rest of health care of taking decision-making away from our clients and assuming that our clients cannot speak for themselves (Pincus et al., 2007). Finn and Jacobsen (2003) have noted that social workers in particular may be more likely to embrace the language of empowerment than its actual practice. Perhaps we would benefit from paying more attention to patient-centered care as a way to structure and evaluate our practice.

We in community mental health should make use of the idea of patient-centered care because it stresses many concepts that are important to us in our work. Noted scholars and advocates in health care have determined that patient-centered care is as important and relevant to mental health and substance use care as it is for phys-

ical health care (IOM, 2006). Adherence to patient-centered care has also been associated with higher satisfaction and in some cases better outcomes in terms of patients' experience of physical symptoms and adherence to care regimens (AHRQ, 2009). In spite of our disdain for the word "patient" to describe those who use our services, there may be aspects of this idea that could lend more integrity to what we do.

What is patient-centered care?

Patient-centered care is a way of planning, delivering, and evaluating health care that focuses on the needs of the user of service first of all, as opposed to focusing on the needs of the health care organization or provider (IOM, 2001). The term patient-centered care has its origins in conceptual writings of the 1960s (Balint, 1969). Patient-centered care in the 1960s was pioneered by psychiatrists working in the United Kingdom, who were training medical students and general practitioners to be more attentive to the emotional concerns of their patients (Balint, 1969). Primary care practitioners in Canada developed the idea of patient-centered care as a way of structuring patient-provider communication, to pay attention to the person and his/her experiences, not just the symptoms of the illness (Levenstein, J. H., McCracken, E. C., McWhinney, I. R., Stewart, M. A. & Brown, J. B., 1986). Developed in the early 1990s as a way of evaluating inpatient hospital stays (Cleary et al., 1991), patient-centered care has evolved into a system of ideas about how to deliver health care that is united by a drive to meet the needs of the service user. The Picker Institute (2010) has pioneered the use of questionnaires and other evaluation tools to assess the degree of patient-centered care in a variety of health care settings. Much of what motivates patient-centered care is a desire to restructure health care services so that service users truly feel that their preferences and needs are respected, and so that health care outcomes are satisfactory not only according to the provider's definition, but according to the user's, as well.

Why should community mental health practitioners care about this concept?

The notion of patient-centered care is relevant to community mental health professionals because it embodies many of the values and practices that we claim to embrace but do not always practice consistently. Patient-centered care offers a way to empower service users to take more control over health care interactions, and it suggests ways to restructure care to make the concerns of service users, not their providers, the primary motivator of care.

One of the most influential definitions of patient-centered care is that put forward by the Picker Institute in their book, Through the Patient's Eyes (Gerteis et al., 1993). This definition offers eight principles of patient-centered care and applies them to reform of health care practices and systems. This paper will outline the eight principles of patient-centered care as outlined in Through the Patient's Eyes (Gerteis et al., 1993) and apply them to psychiatric rehabilitation practice, with particular attention to the formulation of psychiatric rehabilitation practice as understood by Anthony, Cohen, Farkas, and Gagne (2002). The congruence of patient-centered care with Corrigan's (2003) definition of psychiatric rehabilitation will also be outlined. Following this will be a brief discussion of patient-centered care with involuntary clients.

Patient-Centered Care: Application to Psychiatric Rehabilitation.

The idea of patient-centered care should matter to psychiatric rehabilitation practitioners. Although psychiatric rehabilitation is not strictly a health care field, many of the professionals who work in this context come from health care, such as nurses, physicians, and occupational therapists. Psychiatric rehabilitation work is frequently reimbursed by health care funding sources. Therefore, even though patient-centered care reforms have mostly centered on physical health care, there is still much for mental health practitioners to learn.

Patient-centered care embraces respect for the individual's needs, preferences, and values. These are important to psychiatric rehabilitation, as well. Psychiatric rehabilitation practitioners strive to create individualized plans of treatment that are based on the service user's preferences and values. More and more, treatment planning is becoming a partnership—conducted in an atmosphere in which not only can professionals respect the needs of the service user, but also create conditions for the service user to assume and express his or her own

power. Anthony et al. (2002) discuss the primacy of partnership with service users in Principle 6 of their textbook, Psychiatric Rehabilitation: "Active participation and involvement of individuals in their rehabilitation process is the cornerstone of psychiatric rehabilitation (p. 85)." This principle aligns smoothly with the patient-centered care value of respecting individuals.

Information, communication, and education—this is another patient-centered care principle. Psychiatric rehabilitation providers definitely believe in open lines of communication between provider and service user, as well as that service users should have unbiased, complete information about their treatment options. As a part of this, psychiatric rehabilitation practitioners often adopt the role of educator. Education enhances treatment choices. For example, service users should have information about the treatment choices they are being offered, the evidence base behind the treatments, and the expected outcomes of those treatments. This makes the notion of choice more meaningful. Anthony and Huckshorn (2008) discuss the role of information and communication in mental health organizations and the importance of good communication to competent practice.

Access to care is a fundamental principle of both patient-centered care and psychiatric rehabilitation. Access includes having care provided in clients' communities, in locations where clients feel comfortable, as well as care offered to clients in their home environments. This could include care offered in a shelter, in a neighborhood coffeehouse, or in a client's house or apartment. Access also includes the provision of care that is affordable. Clients need to be able to afford premiums for health insurance coverage as well as co-payments for services provided. In Anthony et al.'s (2002) Principle 5, the importance of improved outcomes in a variety of service areas and disciplines is emphasized. Achieving improved residential, educational, and vocational outcomes depends on access to appropriate and affordable care options.

Emotional support to cope with fear and anxiety is an important patient-centered care principle. Psychiatric rehabilitation practitioners believe in the essential role of emotional support in the health care process, particularly in mental health care, where a person's entire sense of reality can be undermined by his symptoms (Sharfstein & Dickerson, 2006). The stigma that still exists toward individuals with mental illness is another reason why emotional support is so critical (Corrigan, Watson, Byrne, & Davis, 2005). Service users need to feel accepted and welcomed at the places where they obtain services. Anthony et al. (2002) further accentuate the need for hope among psychiatric rehabilitation practitioners, which enhances emotional support for service users.

Another principle of patient-centered care is involvement of family and friends in the care process. This is important in psychiatric rehabilitation, as well, as we enlist support from people such as family, friends, and significant others who can assist in the rehabilitation process. To the extent that the service user desires such involvement, it is important to include family and friends in treatment planning, goal setting, and rehabilitation processes. Family and friends can help users to determine goals for themselves, and they can also assist in advocating for users' needs and rights. Advocates from organizations such as the National Alliance on Mental Illness and the Depression and Bipolar Support Alliance continue to hold community mental health providers accountable for involving support persons in treatment planning and care processes.

Physical comfort may not seem immediately relevant to community mental health, but it is. In agency settings such as waiting rooms, drop-in centers, and clinician offices, an atmosphere of comfort and security is vitally important. In addition, in its conceptualization of physical comfort, the Picker Institute includes support for activities of daily living (Picker Institute, 2010). Often, psychiatric rehabilitation practitioners are involved in assisting service users with activities of daily living and instrumental activities of daily living. Furthermore, psychiatric rehabilitation providers play a role in helping users of our services to obtain housing that is safe and comfortable. Physical comfort can help service users to cope effectively with sensory input and to feel secure in their environment.

Continuity and secure transition between settings applies to psychiatric rehabilitation practice, as well. As service users make transitions from inpatient psychiatric settings to the community, we want to ensure that they obtain the support that they need. Continuity between providers and clear directions on transferring care from one setting to another can make the difference between stability and chaos for a service user coming out of an acute care facility. Community mental health users also frequently make transitions to and from different kinds of housing arrangements, such as going from assisted living to an independent apartment setting. Assuring that service users are able to make these transitions in a stable, healthful way is important to what we do.

Case managers at community-based mental health agencies do a great deal of coordination and integration of care for service users. They provide linkage of physical and mental health services, income and housing support, and vocational and educational services. They also provide support for dealing with paperwork associated with different services and programs that people may use. Coordination and integration of care is based on the user's choice of services. Without this coordination of care, many service users would get lost in the system.

Application of Patient-Centered Care to Corrigan's Model of Psychiatric Rehabilitation

How does patient-centered care apply specifically to the theory underlying psychiatric rehabilitation practice? An examination of patient-centered care principles through the framework of Patrick Corrigan's (2003) model of psychiatric rehabilitation gives important insights into this question.

Corrigan posits that psychiatric rehabilitation involves four key structures: goals, strategies, settings, and roles. The principles of patient-centered care can be applied to each of these four structures.

Goals

Psychiatric rehabilitation supports users' formulation of their own goals for the rehabilitative process. Goals that are important to many participants in psychiatric rehabilitation include independence in daily living and inclusion in the life of the community in which the client lives. Patient-centered care also involves respect for users' values, preferences, and expressed needs. In a patient-centered care setting, goals of the treatment process are determined by the desires of the service user, not the priorities of the professional. Also, in emphasizing physical comfort, patient-centered care supports safe, comfortable living environments, just as psychiatric rehabilitation practitioners seek such environments for those who use their services.

Strategies

Psychiatric rehabilitation includes the strategies of goal assessment, skills training and education, and provision of support. These strategies are congruent with a patient-centered care perspective. In patient-centered care, as in psychiatric rehabilitation, users determine what is important to focus on in the treatment process. Patient-centered care also involves provision of information and education to people, to support their capacity to make their own care decisions and to teach them skills for self-management. In addition, patient-centered care supports two-way communication between users and providers about the care process. Provision of support—emotional and practical support—is an invaluable strategy in both psychiatric rehabilitation practice and patient-centered care.

Settings

Psychiatric rehabilitation is a method of mental health practice that can take place in a wide variety of settings—especially outpatient, community-based, and residential settings. The goals and tasks associated with psychiatric rehabilitation are particularly portable (Cnaan & Blankertz, 1990), in that goals can be assessed and skills taught wherever people with mental illness may live, socialize, and work. Likewise, though patient-centered care had its origins largely in inpatient settings, the concepts and values of patient-centered care have translated to outpatient, community clinic, assisted-living, and rehabilitation settings.

Roles

Corrigan's main point about roles in psychiatric rehabilitation is that practitioners' roles are flexible and not strictly defined. Physicians play a specific role in prescribing medicines, but other providers on care teams may fulfill different roles at different times. This can apply to the concept of patient-centered care, as well, as attention to the needs and preferences of service users requires flexibility in the provision of services.

Involuntary Clients

How do we meet the needs of the service user—give back control—when the person is being treated involuntarily? Psychiatric rehabilitation practice gives us some clues. In working with involuntary service users, it is helpful to try to construct a "bridge" to the person by acknowledging that the person did not choose to seek care, but also attempting to determine what motivates him or her (Rooney, 2009). There may be common themes that can unite the provider of mandated treatment with the involuntary service user. People may recognize that they need safety and stability in their lives, but may disagree about how to achieve these goals. Providers may be able to implement a dialogue with the person to determine what can be agreed upon.

For example, patient-centered care works well with a motivational interviewing approach, in which the service user's concerns and values drive the dialogue (Miller & Rollnick, 2002). Behavior change is supported by a focus on the factors that matter most to the service user. Patient-centered care, with its emphasis on respecting the person's values, preferences, and expressed needs, as well as shared decision-making, provides a useful way to think about work with involuntary service users. This is especially important in mental health settings, where people may find themselves in treatment as a result of legal intervention designed to protect their safety, but often experienced as intrusive. When we can use the tenets of patient-centered care to seek common ground, we make adherence more likely.

Conclusion

We should learn from our colleagues in health care. They are definitely on the right track, in terms of taking patients' perceptions of their care seriously and using assessment instruments that put the well-being of patients first. We can take the principles of patient-centered care and translate them into standards and expectations that will enrich the quality of the care we provide and truly put service users in the center of the care process.

In addition, our colleagues in health care can learn from us. Our growing orientation toward recovery-based services, as well as models of shared decision-making and empowerment that have been pioneered by psychiatric rehabilitation providers, serve as wonderful examples for the rest of health care. As behavioral and physical health care become more integrated, using common models to inform service delivery and assessment of patient/client satisfaction will streamline care processes and ensure that our service users' preferences are valued and respected.

Not only do we need to embrace principles of patient-centered care in our service provision, but we need to be creative in developing ways of measuring our success in achieving these goals. The Picker Institute has demonstrated that asking health care clients about their satisfaction with services does not provide sufficient understanding of whether service users have truly experienced health care tailored to their needs; it is also important to ask about the

occurrence of specific actions on the part of health care providers (Picker Institute, 2010). In addition, psychiatric rehabilitation clients must be involved in planning services and determining criteria for their evaluation (Bechtel & Ness, 2010).

Patient-centered care has the potential to reduce health disparities, increase service users' role in decision-making, and improve health care processes and outcomes (Epstein, Fiscella, Lesser, & Stange, 2010). In general health care as well as in psychiatric rehabilitation practice, we have a long way to go to achieve true empowerment among those who use our services (Tomes, 2006). However, by applying principles of patient-centered care to the practice of psychiatric rehabilitation, it is possible to come a bit closer to the goal of providing equitable, empowering services to people with mental illness.

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