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Integrated Psychosocial Rehabilitation and Health Care for Older People with Serious Mental Illness

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Older people with serious mental illness (SMI) comprise a group with unique impairments and treatment needs. Despite effective pharmacological treatment, many individuals with SMI experience challenges across a variety of tasks and skills necessary for living independently in the community. These difficulties include poor basic self-care skills, community living skills, and social skills. These impairments are often compounded by lack of social support, which is strongly associated with admission to nursing home and long-term care placements (Bartels, Mueser, & Miles, 1997; Meeks et al., 1990). Functional impairments due to comorbid physical illnesses also increase the risk of placement in long-term care facilities (Burns & Taube, 1990; Meeks et al., 1990). Older adults with SMI often have multiple comorbid medical problems, which when coupled with poor health care result in poor health outcomes and earlier mortality (Bartels et al., 2004).

Psychosocial treatment is needed to improve functioning in these areas. Rehabilitative approaches such as skills training may be useful for older people with SMI because they are based on the premise that systematic teaching of life skills can reduce impairments in social and role functioning (Bellack, Mueser, Gingerich, & Agresta, 2004; Dilk & Bond, 1996; Hayes, Halford, & Varghese, 1995). In our judgment, an integrated program of health care management and psychosocial rehabilitation addresses the major deficits in older people with SMI and is essential to improving functioning in the community and avoiding restrictive residential placement.

Evidence Base

In recent years, programs have been developed specifically for older adults with SMI that focus on enhancing independent living skills and leisure skills, and expanding social networks (Pratt, Van Citters, Bartels, & Mueser, in press). However, many of these programs have not emphasized integration of both social rehabilitation and management of health care for older persons with SMI.

The Functional Adaptation Skills Training (FAST) program, developed by Patterson and colleagues (Patterson et al., 2003), is a 24-session skills training
group for middle-aged and older adults with chronic psychotic disorders. The skills addressed in this intervention are based on the needs and deficits of older people, including handling finances, medication management, using public transportation, communication, and planning. In a study of FAST, four board and care homes were randomly assigned to receive either FAST or usual care. Among the 32 residents who participated in the study, the individuals who received FAST demonstrated improved community living skills compared with the individuals who received usual care.

Granholm et al. (2005) developed and tested an integrated treatment program for older adults with schizophrenia that combines cognitive-behavioral therapy and social skills training. The largest study of this intervention involved 76 outpatients who were randomly assigned to treatment as usual or treatment as usual plus the 24-session integrated treatment program. Improvements were shown at posttreatment (6-months) in cognitive insight, positive symptoms, and leisure and transportation skills.

In 1997, we developed a pilot program to provide social rehabilitation (i.e., social skills training), and health care management in order to improve the community functioning of older people with SMI. The social skills training and health management (ST + HM) intervention was delivered over 1 year with the goal of improving social functioning, communication with doctors, and health management in order to reduce long-term or permanent institutionalization (Bartels et al., 2004). The ST component consisted of weekly skills training classes in conversation skills and medication self-management based on curriculum developed by Liberman et al. (1993) and Bellack et al. (2004). The HM component involved a nurse case manager who provided management of acute and chronic medical problems and helped participants to access preventive health care services.

Participants in the pilot study of ST + HM were recruited from a community mental health center and met New Hampshire state mental health disability criteria for SMI consisting of (1) a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, or treatment refractory depression and (2) persistent functional impairment requiring ongoing supportive services. The final study group consisted of 24 participants, half of whom were interested in participating in the skills training component and received ST + HM, half of whom received HM only.

Participants who received ST + HM demonstrated improved independent living skills, such as personal hygiene, food preparation, and health management skills, compared with the HM only group. Clients who received ST + HM also demonstrated improved social functioning and decreased inappropriate behaviors, whereas no such changes occurred in the HM only group. All individuals in the study received HM so only a pre–post comparison of improvements in healthcare was possible. Receipt of preventive health care increased from 71 to 100%. At the start of the study, 4 of the 24 (16.7%) people did not have a primary care physician whereas 100% of the sample had obtained a primary care physician by the end of the study (Bartels et al., 2004). Results of the pilot study of the ST + HM