A Primer *on the* Psychiatric Rehabilitation Process

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Preface

We have been practicing, teaching, writing, and/or researching the field of psychiatric rehabilitation for more than three decades. Early in our careers, the psychiatric rehabilitation field we entered had not achieved consensus on its underlying philosophy, had not integrated its research studies into a substantial knowledge base, had few model service programs and sources of funding in existence, had not developed a rehabilitation practice technology, nor articulated the psychiatric rehabilitation process. Gradually over the years, considerable agreement developed on the fundamental philosophy, principles, and values of psychiatric rehabilitation; a significant body of research shaped the knowledge base; funding options increased; a variety of model service programs were created, researched, and disseminated; pre-service and in-service training programs came into existence; a psychiatric rehabilitation technology was increasingly utilized; and the process of psychiatric rehabilitation described.

Regardless of the name of the program model, the discipline or background of the practitioner, the source of funding or the setting in which people are working, people who help people with severe mental illnesses improve their functioning and gain valued roles in the community should be aware of the essentials of the psychiatric rehabilitation process and how to work with it.

Importantly, consistent with this progress in psychiatric rehabilitation, recovery from severe mental illnesses became a fact—not a hope. In this recovery era, implementing the process of psychiatric rehabilitation has achieved greater prominence. The process of psychiatric rehabilitation, as this primer will describe, is designed to help people *be successful and satisfied in the living, working, learning, and social environments of their choice*. The President's New Freedom Commission on Mental Health (2003) envisioned a future "*when everyone with a mental illness will recover* and is helped *to live, work, learn, and participate fully in their communities"* (emphasis added), a phrasing strikingly consistent with the outcomes emphasized in psychiatric rehabilitation. Unique to the psychiatric rehabilitation process is its targeted focus on assisting people to gain or regain valued roles in their communities, as reinforced in the President's New Freedom Commission report. It is difficult to see how the recovery vision will ever be achieved without wider implementation of psychiatric rehabilitation services.

Recently, the psychiatric rehabilitation field has tended to focus on rehabilitation program models (such as Clubhouse, ACT, IPS) and the program policies and procedures that faithfully guide the models' implementation. These policies and procedures include such dimensions as the correct mix of disciplines, the place where services are offered, the structure of the work day, etc. *In a complementary way, the psychiatric rehabilitation process focuses on the nature of the helping interaction between the practitioner and the consumer that occurs within* any *psychiatric rehabilitation program model and setting*.

The psychiatric rehabilitation process focuses on the nature of the helping interaction between the practitioner and the consumer that occurs within any psychiatric rehabilitation program model and setting.

However, in order to integrate of the psychiatric rehabilitation process into various program models and to capitalize on its critical role in promoting recovery, there must be a fundamental understanding of the basic psychiatric rehabilitation process and its evidence base. We are amazed at the lack of a thorough comprehension of what the psychiatric rehabilitation process is and is not, and the empirical base underlying the process. *Regardless of the name of the program model, the discipline or background of the practitioner, the source of funding or the setting in which people are working, people who help people with severe mental illnesses*

improve their functioning and gain valued roles in the community should be aware of the essentials of the psychiatric rehabilitation process and how to work with it. Yet uncertainty often reigns about the fundamental process of psychiatric rehabilitation.

We have developed ways to teach providers, including consumer-providers, both the fundamentals and the nitty gritty of the competencies required to deliver the processes. The field continues to confuse brief workshops, overviews, or discussion groups for the intensive training and supervision over time required to change daily practice. Organizational structures, such as job descriptions, record keeping formats, and quality assurance mechanisms often are forgotten when attempting to embed the psychiatric rehabilitation process in an organization so that the process can be delivered reliably over time.

Not ones to give up, *A Primer on the Psychiatric Rehabilitation Process* is yet another attempt on our parts to clear the confusion. It spells out, in a succinct and straightforward way, the psychiatric rehabilitation process and the underlying content that we and our colleagues at the Boston University Center for Psychiatric Rehabilitation have been developing, demonstrating, teaching, and disseminating. Anyone who works with people with severe mental illnesses in any capacity should be familiar with the process of psychiatric rehabilitation. For those who directly practice and study in the psychiatric rehabilitation field, and who want considerably more expertise, various training and technical assistance resources are available for you, on or off-site, written and electronic. Helpful references and resources are provided in the appendices of this primer.

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President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, final report* (No. Pub. No. SMA-03-3832.). Rockville, MD: U.S. Department of Health and Human Services.

Introduction

Purpose of This Primer

The purpose of this primer is to describe the complex process of psychiatric rehabilitation in its most straightforward and parsimonious way, in order to improve the implementation, practice, and study of psychiatric rehabilitation. To advance the understanding of the psychiatric rehabilitation process, the primer strives to make perfectly clear the major steps of the process. The primer is composed of three sections:

- Understanding the Background and Process of Psychiatric Rehabilitation;
- Tracking the Psychiatric Rehabilitation Process; and
- Recording the Psychiatric Rehabilitation Process.

Several appendices provide examples to further one's understanding of the process.

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Intended Audience for This Primer

The primer is useful to a variety of individuals. For example, it can be useful to:

- **Consumers**—as a way to comprehend the process so that they can become more involved in the process.
- **Practitioners**—as a checklist to track and record the process so that they implement the process most efficiently and effectively.
- **Supervisors**—as a way to guide the practitioners' implementation so that the practitioners are more skilled and supported.
- **Trainers**—as a way to assess what additional expertise is needed by practitioners and supervisors so that training is targeted to the individual's need.
- **Program and system administrators**—as a blueprint to design program and system structures so that the implementation of the psychiatric rehabilitation process is initiated and sustained.
- **Researchers**—as a guide for when they study the process so that their research hypotheses are related to the actual process being implemented.
- **Funding bodies**—as a way to ensure that the evidence-based rehabilitation processes being funded are actually occurring.

Underlying Assumptions of This Primer

In presenting only the minimum amount of information needed to understand and implement the psychiatric rehabilitation process, this psychiatric rehabilitation primer is based on the following assumptions:

- Individuals who need additional skills and knowledge with respect to certain steps in the process will seek out the needed information. To facilitate additional learning, helpful examples, resources, and references appear in the appendices.
- The successful implementation of the process is dependent on the individuals' engagement or interpersonal skills (e.g., observing, listening, and responding). Information on training to assess and upgrade these skills is available at: www.bu.edu/cpr/training/
- "Principled leadership" is helpful in making sure the process is skillfully implemented. Information on technical assistance for leaders is available at: www.bu.edu/cpr/products/

Psychiatric Rehabilitation Origins

Psychiatric rehabilitation emerged as a significant field of practice and study during the 1970s and 1980s, in part as a response to the tragedies of the deinstitutionalization movement, which beginning in the 1950s, discharged large numbers of state hospital patients to an unsupportive community. In essence, deinstitutionalization accomplished a single outcome: transferring patients with severe mental illnesses to the community, a relatively easy task in comparison to the goals of rehabilitation. Said another way, deinstitutionalization opened the doors of the institutions and literally gave people a prescription for their medicine when they left. Rehabilitation attempts to open the doors of the community and help people figuratively develop a prescription for their lives.

People Who Use Psychiatric Rehabilitation Services

As a result of deinstitutionalization, most adults diagnosed with severe mental illnesses, such as schizophrenia, bipolar disorder, major depression, and the like, are now residing in the community. These individuals are the primary recipients of psychiatric rehabilitation services. Psychiatric rehabilitation helps persons who have experienced severe psychiatric disabilities, rather than concentrating on individuals who are simply dissatisfied, unhappy, or "socially disadvantaged." Persons with psychiatric disabilities have diagnosed mental illnesses that limit their capacity to perform certain tasks and functions (e.g., interacting with family and friends, interviewing for a job, studying for tests) and their ability to perform in various community roles (e.g., worker, resident, spouse, friend, student).

[Psychiatric rehabilitation services] focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

Psychiatric Rehabilitation Defined

As psychiatric rehabilitation services and concepts have become more common in helping people with severe mental illnesses regain their valued roles, the necessity of developing a standard definition of psychiatric rehabilitation became apparent. On September 29, 2007, the following definition was approved and adopted by the Board of Directors of United States Psychiatric Rehabilitation Association (USPRA), the major professional association of the field of psychiatric rehabilitation.

> Psychiatric rehabilitation promotes recovery, full community integration, and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed, and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. *They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.* (emphasis added)

Psychiatric Rehabilitation Process Explained

As described in the last sentence of the above definition, the process of psychiatric rehabilitation is deceptively simple to explain. Basically, the process of psychiatric rehabilitation seeks to help people determine the living, learning, working, and social roles they wish to achieve (goals). Next, people are helped to identify what they need to do and what they can do well (skills) and what they have or need to have (supports or resources) in order to achieve their goals. They are then helped to develop those skills and/or supports unique to achieving their goals. Described most parsimoniously, the psychiatric rehabilitation process helps people to choose their goals and then get the necessary skills and supports they need to reach their goals. Simple to describe, yet it does not mean the process is simple to implement. Nevertheless, the complexity involved in implementing the process makes it important to describe the process in as straightforward a manner as is possible.

The psychiatric rehabilitation process helps people to choose their goals and then get the necessary skills and supports they need to reach their goals.

In order to explain the process most simply and to facilitate the involvement and understanding of the persons served and their families, the Boston University Center for Psychiatric Rehabilitation also has explained the psychiatric rehabilitation process from the service recipient's perspective as a Choose-Get-Keep (CGK) process. In other words, *from the perspective of the people being served,* the psychiatric rehabilitation process helps people choose their goals, get or achieve their goals, and/or keep their goals, depending on their needs and wants.

Psychiatric Rehabilitation Program Models, Settings, and Disciplines

The psychiatric rehabilitation process is implemented in a variety of program models, in many different places or settings, and by most mental health disciplines. That is to say, the psychiatric rehabilitation process can be implemented in any program model, any location or setting, or by any person, as long as the primary outcome is to help people become more "successful and satisfied in living, working, learning and social environments of their choice." Psychiatric rehabilitation program models; such as ACT, Clubhouse, or IPS, can implement the psychiatric rehabilitation process within their defined program structure. Any mental health setting; such as hospitals, psychosocial rehabilitation centers, day programs, drop in centers, community mental health centers, etc., potentially can be a place in which the psychiatric rehabilitation process is conducted and psychiatric rehabilitation outcomes achieved. People from any discipline or background (including consumers of mental health services) can learn to implement, supervise, train, administer, or research the psychiatric rehabilitation process. To repeat, the psychiatric rehabilitation process is implemented independent of program model, setting, or discipline, but certainly can and should be supported by the program's organizational structures.

The psychiatric rehabilitation process can be implemented in any program model, any location or setting, or by any person, as long as the primary outcome is to help people become more successful and satisfied in living, working, learning and social environments of their choice.

The Impact of Psychiatric Rehabilitation on the Mental Health Field

The field of psychiatric rehabilitation introduced to the field of mental health new knowledge with respect to the inherent strengths of people with severe mental illnesses, the negative consequences of serious mental conditions besides the obvious symptoms, and reinforced the idea of the potential for recovery from these illnesses. Prior to the advent of psychiatric rehabilitation, the positive capacities of people with severe mental illnesses typically were

ignored, and the negative effects of severe mental illnesses were seen primarily as causing symptomatic impairments of mood or thought. The psychiatric rehabilitation paradigm enlarged the negative consequences of severe mental illnesses to recognize not only symptom impairment but also dysfunction, disability, and disadvantage; and on the flip side, to build on people's functioning, abilities, and advantages. Furthering the influence of the psychiatric rehabilitation paradigm, the Community Support Program, initiated by the National Institute of Mental Health (NIMH) in the late 1970s, stressed the importance of psychiatric rehabilitation services as a critical part of a group of services designed to address the comprehensive needs of people with serious mental illnesses. From a psychiatric rehabilitation perspective, the mental health system must not only be concerned with how to impact the person's impairment or symptoms, but also the person's ability to perform tasks (dysfunction), roles (disability), and deal with the discrimination and poverty (disadvantage), which a person with a severe mental illness often experiences. (See TABLE 1).

Table 1—The Psychiatric Rehabilitation Model: The Negative Impact of a Severe Mental Illness

Stages ➧	**I. Impairment**	**II. Dysfunction**	**III. Disability**	**IV. Disadvantage**
Definitions ➧	Any loss or abnormality of psychological, physiological, or anatomical structure or function	Any restriction or lack of ability to perform an activity or task in the manner or within the range considered normal for a human being	Any restriction or lack of ability to perform a role in the manner or within the range considered normal for a human being	A lack of opportunity for an individual that limits or prevents the performance of an activity or the fulfillment of a role that is normal (depending on age, sex, social, cultural factors) for that individual
Examples ➧	Hallucinations, delusions, depression	Lack of work adjustment skills, social skills, ADL skills	Unemployment, homelessness	Discrimination and poverty

Adapted from: Anthony, W.A., Cohen, M.R., & Farkas, M.D. (1990). *Psychiatric rehabilitation*. Boston: Boston University, Center for Psychiatric Rehabilitation.

Psychiatric rehabilitation brought into the field of mental health the unique value base of rehabilitation, which emphasized values; such as consumer involvement, consumer choice, consumer strengths and growth potential, shared decision making, as well as outcome accountability for providers. The inclusion of a psychiatric rehabilitation paradigm and the NIMH's push toward comprehensive community support services (as noted above) enlarged the purview of the mental health system and its values, and challenged the mental health field to think more expansively and respectfully about how to help people with serious mental illnesses. Outcomes related to residential, vocational, and educational statuses, and people's life satisfaction, as well as the effects of poverty and discrimination on people with mental illnesses became an increasing concern of the mental health field.

Psychiatric rehabilitation brought into the field of mental health the unique...values [of] consumer involvement, consumer choice, consumer strengths and growth potential, shared decision making, as well as outcome accountability for providers.

Differentiating Psychiatric Rehabilitation Services from Other Mental Health Services

Mental health services for people with severe mental illnesses are distinguished one from the other based on each service's unique content and outcomes. For example, when people's preferred outcome is improved role functioning, the primary service delivery process is rehabilitation; in contrast, when people's preferred outcome is symptom relief, the primary service delivery process is treatment; when people's preferred outcome is accessing needed services, the primary service delivery process is case management. Based in part on the NIMH Community Support Program initiative, TABLE 2 provides an overview of the major mental health services for people with severe mental illnesses and the content and outcome on which each service is focused primarily.

Table 2—Essential Services in a Recovery-Oriented System

Service Category	Description of the Content in the Process	Consumer Outcome
Treatment	Alleviating symptoms and distress	Symptom relief
Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
Case management	Obtaining the services consumer needs and wants	Services accessed
Rehabilitation	Developing consumers' skills and supports related to consumers' goals	Role functioning
Enrichment	Engaging consumers in fulfilling and satisfying activities	Self-development
Rights protection	Advocating to uphold one's rights	Equal opportunity
Basic support	Providing the people, places, and things consumer needs to survive (e.g., shelter, meals, health care)	Personal survival assured
Self-help	Exercising a voice and a choice in one's life	Empowerment
Wellness/Prevention	Promoting healthy lifestyles	Health status improved

Adapted from: Cohen, M., Cohen, B., Nemec, P., Farkas, M., & Forbess, R. (1988). *Psychiatric rehabilitation training technology: Case management.* Boston: Boston University, Center for Psychiatric Rehabilitation and Anthony, W.A., Cohen, M.R., & Farkas, M.D. (1990). *Psychiatric rehabilitation*. Boston: Boston University, Center for Psychiatric Rehabilitation.

Psychiatric Rehabilitation as an Evidence-Based Process

The empirical base of the psychiatric rehabilitation process draws its evidence base from several lines of research. First of all, the psychiatric rehabilitation process is based on the research literature that shows that it is the person's self-determined goals and the presence of the skills and supports necessary to reach those goals, rather than the person's diagnosis and symptomatology, that relates most strongly to rehabilitation outcomes. Secondly, research on the psychiatric rehabilitation process itself has demonstrated an impact of the rehabilitation process on living and working outcomes, in particular. Furthermore, research on specific psychiatric rehabilitation interventions (such as supported employment) has affirmed certain components of the process, such as the importance of helping consumers set their own goals and providing critical supports to consumers. Lastly, the behavioral

It is the person's self-determined goals and the presence of the skills and supports necessary to reach those goals, rather than the person's diagnosis and symptomatology, that relates most strongly to rehabilitation outcomes.

science literature on how *all* people change and grow has provided evidence of the significance of various components of the psychiatric rehabilitation process. Behavioral science research has found that people are more apt to change positively:

- in the context of a positive relationship;
- when they set their own goals;
- are taught skills;
- receive support;
- have positive expectations or hope for the future;
- when they believe in their self efficacy.

All of these change elements evidenced from the behavioral science research literature are critical ingredients of the psychiatric rehabilitation process. Indeed these empirically-based elements of the psychiatric rehabilitation process, while necessary components of the psychiatric rehabilitation service process, also are relevant to the provision of other services. For example, people receiving treatment services often are *taught* medication use; people receiving case management services receive *support* to access the services they need; people receiving crisis services are helped to *believe in their own self efficacy*; people receiving most any service are helped when service providers build a *positive relationship* with the person they are helping. Research supporting the rehabilitation process (from 1972 to present) has been conducted routinely and synthesized by the Center for Psychiatric Rehabilitation; references related to the empirical base of psychiatric rehabilitation can be found in APPENDIX D.

The Critical Nature of the Helping Relationship

Paramount to a successful psychiatric rehabilitation process is the relationship between the practitioner and the consumer. Part of the efficacy of various rehabilitation interventions is the relationship that develops between the practitioner and the individual receiving help. The practitioner can facilitate the process by being a skilled listener who is empathic and respectful. By engaging (or connecting) with the consumer, the practitioner increases the chances of the psychiatric rehabilitation process helping the consumer achieve the desired goals. The findings with respect to the importance of the relationship to successful helping and learning outcomes is perhaps the most researched topic in all of behavioral science. The implementation of the psychiatric rehabilitation process demands an interpersonally skilled practitioner. The Recovery Promoting Relationship Scale developed by Zlatka Russinova (2006) at the Center for Psychiatric Rehabilitation is a useful and efficient way to measure the quality of the helping relationship from the perspective of the person being helped.

Paramount to a successful psychiatric rehabilitation process is the relationship between the practitioner and the consumer.

The Psychiatric Rehabilitation Process and Medicaid

Medicaid is a joint federal-state program that provides health care coverage for low income people. The federal government defines in broad terms the national guidelines for eligibility and covered services. Within these guidelines, each state designs the state's unique benefit packages and eligibility requirements. One of the optional services under Medicaid is "other diagnostic, screening, preventive, and rehabilitative services" (Title 19, Section 1905(a)(13). Using this option, all states have elected to provide psychiatric rehabilitation services intended to reduce disability and restore function. Medicaid law also clarifies (Title 19, Section 1901) that the goal of Medicaid rehabilitation is to *attain or retain* capability for independence or self care.

Consistent with Medicaid's criteria for rehabilitation, the psychiatric rehabilitation process helps people to preserve (retain) capacity for more independent functioning *but also* to reach or restore (attain) age appropriate functioning that either has been lost or never occurred because people's functional development was interrupted by severe mental illnesses. In psychiatric rehabilitation, we improve function and reduce disability caused by severe mental illnesses through the two pronged effort of developing skills and/or supports (similar to physical rehabilitation, where a person with hemiplegia might be helped to live independently by learning the skills of driving a car, or by using a car equipped with supports, such as hand controls). States typically cover skills training as Medicaid psychiatric rehabilitation services, including training regarding daily living/independent living skills, social skills, communication skills, self-care; such as personal grooming, household management, coping, and budgeting skills.

Consistent with Medicaid's criteria for rehabilitation, the psychiatric rehabilitation process helps people to preserve (retain) capacity for more independent functioning *but also* to reach or restore (attain) age appropriate functioning that either has been lost or never occurred because people's functional development was interrupted by severe mental illnesses.

In psychiatric rehabilitation, we typically use natural environments and meaningful tasks for the skill training component (much like in physical rehabilitation you learn a wheelchair to bed transfer at home, not just in the hospital). This is based on the evidence-based and common sense principle that states that skill acquisition and utilization occur best when tasks approximate the real environment in which they must be used (e.g., learning the skill of how to follow directions using a work task in a work environment). The Medicaid rehabilitation option facilitates this because, unlike some other Medicaid services, these services can be furnished in any location (such as home, school, community).

The process of psychiatric rehabilitation is "Medicaid friendly" because, as this primer shows, this evidence-based process may be easily tracked and recorded. Medicaid personnel can obtain information as to whether the psychiatric rehabilitation process has occurred and whether or not progress toward the person's goals is happening. It is important to remember, however, that Medicaid only pays for health care services. Specifically not covered are job training, academic teaching, and room and board in the community. As a result, practices such as supported employment, supported education, and supported housing can only be partially reimbursed by Medicaid.

Medicaid rules require that any service be "medically necessary" for the specific individual. The "medical necessity" for implementing the psychiatric rehabilitation process under Medicaid is based on two types of research that provide critical empirical support for the thread that links psychiatric symptoms and neurocognitive deficits to people's impaired functioning:

Implementing the psychiatric rehabilitation process allows one to diagnose, plan, and intervene with respect to a person's compromised functioning—a functioning that is linked to the symptoms and deficits of a severe mental illness.

1) The research which shows that symptoms (often negative symptoms) and neurocognitive deficits are a core feature of severe mental illnesses and that these symptoms and deficits routinely affect functioning. For example, neurocognitive deficits of severe mental illnesses, such as memory, concentration, and interpersonal skills deficit impair people's functioning; similarly, the negative symptoms of severe mental illnesses, such as flat affect,

inappropriate affect, alogia, avolition, asociality, and inattention also impair a person's functioning.

2) The research which shows that people's specific skill functioning correlates poorly with their specific symptoms.

Thus, while symptoms and deficits lead to functional impairments, merely knowing a person's particular symptoms or deficits provides little information about a person's unique functioning or specific goals. Implementing the psychiatric rehabilitation process allows one to diagnose, plan, and intervene with respect to a person's compromised functioning—a functioning that is linked to the symptoms and deficits of a severe mental illness.

Keeping Track of the Service Delivery Process

The major steps of any of the service delivery processes listed in TABLE 2, including the psychiatric rehabilitation process, can be tracked. The assumption underlying tracking is that the completion of various steps in the service delivery process brings the person closer to the preferred service outcome. Because one usually cannot wait for the outcome to be achieved in order to know if the consumer is being effectively served, or if changes to the service plan are needed, intermittent estimates of how the service process is unfolding must be used. Making sure the service delivery process is moving in a logical and expected manner is determined by keeping track of the processes' major steps as the service delivery process is being implemented.

Table 2—Essential Services in a Recovery-oriented System

Service Category	Description of the Content in the Process	Consumer Outcome
Treatment	Alleviating symptoms and distress	Symptom relief
Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
Case management	Obtaining the services consumer needs and wants	Services accessed
Rehabilitation	Developing consumers' skills and supports related to consumers' goals	Role functioning
Enrichment	Engaging consumers in fulfilling and satisfying activities	Self-development
Rights protection	Advocating to uphold one's rights	Equal opportunity
Basic support	Providing the people, places, and things consumer needs to survive (e.g., shelter, meals, health care)	Personal survival assured
Self-help	Exercising a voice and a choice in one's life	Empowerment
Wellness/Prevention	Promoting healthy lifestyles	Health status improved

Adapted from: Cohen, M., Cohen, B., Nemec, P., Farkas, M., & Forbess, R. (1988). *Psychiatric rehabilitation training technology: Case management.* Boston: Boston University, Center for Psychiatric Rehabilitation and Anthony, W.A., Cohen, M.R., & Farkas, M.D. (1990). *Psychiatric rehabilitation*. Boston: Boston University, Center for Psychiatric Rehabilitation.

Benefits in Tracking the Service Delivery Process

Documenting the service delivery process is important for a number of reasons. First of all, it lets a consumer answer the question, "how is it going?" The actual outcome may take so long to achieve that tracking the process lets the participant know more quickly that movement is happening. Knowing exactly where the consumer is in the process is important feedback for the practitioner as well, so that necessary changes to the implementation of the process can be made. Tracking the process lets supervisors determine what the focus of the supervisory session should be. Trainers can analyze what parts of the process require future training. Administrators can modify their program or system structures to reinforce and/or better implement certain parts of the process. Funders can be assured that the process they are

paying for actually is occurring. Researchers, who are studying a service intervention, can assess how faithfully the service intervention is being implemented. All of the many individuals concerned about the service delivery process benefit in different ways from tracking the service delivery process.

Understanding the Service Delivery Process

Like any of the various services used by people with severe mental illnesses (see TABLE 2, page 16), the psychiatric rehabilitation process can be understood best by segmenting the process into the three sequential phases of diagnosing (assessing), planning, and intervening (DPI). This sequencing is not to imply that the logical conceptual flow of the three phases describes how neatly the DPI process unfolds in practice. In practice, steps may be skipped or omitted, regression and plateauing may occur, etc. However, understanding the logic and flow of the process allows the process to be tracked, guided by the caveat that implementing service processes designed to help people with severe mental illnesses remains an art as well as a science.

The Diagnosis–Planning–Intervention (DPI) Process of Psychiatric Rehabilitation

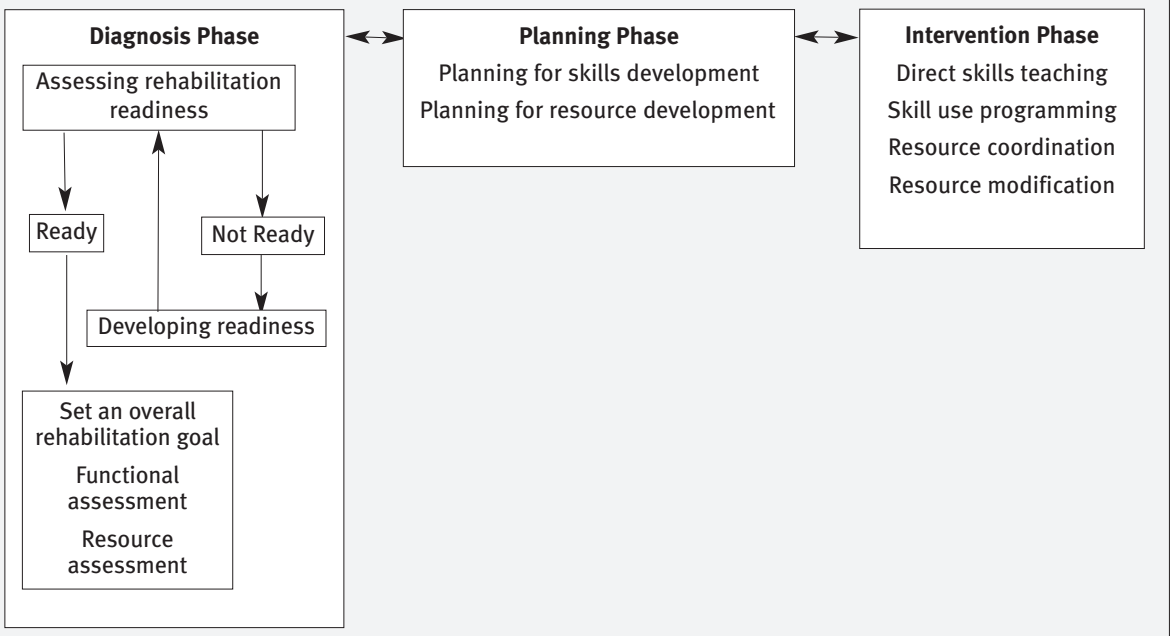
The *diagnostic phase* in the psychiatric rehabilitation process begins with the practitioner (or other helper) assisting the consumer to self-determine one's readiness for rehabilitation and to develop one's readiness, if needed. Then the practitioner assists the consumer to set the overall rehabilitation goal(s) and to evaluate his or her skill and support strengths and deficits in relation to the overall rehabilitation goal(s). In contrast to the traditional psychiatric diagnosis that describes symptomatology, the rehabilitation diagnosis yields a behavioral description of the person's self-determined readiness to proceed and to improve a person's readiness, if needed. The diagnostic phase also determines the person's current skills and supports (resources) needed to be successful and satisfied in the person's chosen residential, educational, social, and/or vocational environments.

The rehabilitation plan... differs from what sometimes is called an individualized service plan...[in that it identifies] high-priority skill and resource development objectives, and specific interventions for each objective, rather than simply identifying potential service providers or program activities.

The diagnostic information enables the person to develop a rehabilitation plan in the *planning phase*. A rehabilitation plan differs from most treatment planning in that the goal of a treatment plan is focused mostly on reducing symptoms. A rehabilitation plan specifies how to develop the person's skills and/or supports to achieve the person's overall rehabilitation goals. The rehabilitation plan also differs from what sometimes is called an individualized service plan. The major difference being its identification of high-priority skill and resource development objectives, and specific interventions for each objective, rather than simply identifying potential service providers or program activities.

In the *intervention phase,* the rehabilitation plan is implemented to achieve the overall rehabilitation goal(s) by changing the person and/or the person's environment, either through developing the person's skills and/or developing the person's environmental supports. FIGURE 1 (page 18) provides an overview of the DPI process of psychiatric rehabilitation.

Figure 1—An Overview of the Diagnosis–Planning–Intervention Process of Psychiatric Rehabilitation



An Example of Tracking the Psychiatric Rehabilitation Process

Boston University's Center for Psychiatric Rehabilitation has been involved in several demonstrations of tracking the psychiatric rehabilitation process. TABLE 3 (PAGE 19) is an example of the steps that were tracked in a demonstration carried out by the Center for Psychiatric Rehabilitation's Recovery Center. The process of psychiatric rehabilitation consists of many substeps related to each major step. APPENDIX A lists all of the major steps and a number of substeps for each major step. However, by keeping track of the implementation of just the major steps, the process of psychiatric rehabilitation can be documented for the benefit of all interested individuals. The Recovery Center developed a paper form as well as an electronic method to routinely collect this process information on the major steps depicted in TABLE 3.

How Detailed Must the Tracking Be?

Numerous benefits exist for tracking, as noted previously. Yet, tracking the service delivery process is not a task that comes easily or naturally to many individuals in the field of helping people with severe mental illnesses. The fundamental question for all who attempt tracking is—at what level of specificity should the process be documented? Based on years of experience, tracking the major steps in TABLE 3 seems to represent the minimum steps that should be tracked. Tracking all the major steps and substeps included in APPENDIX A, while possible, may represent overkill for most organizations. However, the listing of the major steps and substeps in APPENDIX A may be useful to supervisors and trainers in trouble shooting the process in order to specify the focus of needed supervision or training.

What about the Level of Specificity of the Intervention Itself?

The specificity of the tracking leads directly to questions about the level of specificity of the intervention process that is being tracked. The formality, specificity, and documentation of the psychiatric rehabilitation process vary significantly between practitioners, settings, and programs.

Table 3—A Form for Tracking the Psychiatric Rehabilitation Progress

Diagnosing Phase

Readiness assessment
☐ Begun ☐ Continuing ☐ Done

Readiness development
☐ Begun ☐ Continuing ☐ Done

Setting a self-determined goal
☐ Begun ☐ Continuing ☐ Done

Functional assessment
☐ Begun ☐ Continuing ☐ Done

Resource assessment
☐ Begun ☐ Continuing ☐ Done

Planning Phase

Developing a rehabilitation plan to improve skills
☐ Begun ☐ Continuing ☐ Done

Developing a rehabilitation plan to improve supports
☐ Begun ☐ Continuing ☐ Done

Intervening Phase

Direct skills teaching
☐ Begun ☐ Continuing ☐ Done

Programming skill use
☐ Begun ☐ Continuing ☐ Done

Resource coordination
☐ Begun ☐ Continuing ☐ Done

Resource modification
☐ Begun ☐ Continuing ☐ Done

Adapted from: Anthony, W.A., Cohen, M.R. & Farkas, M.D. (1990). *Psychiatric rehabilitation*. Boston: Boston University, Center for Psychiatric Rehabilitation.

At its most generic level of practice, the psychiatric rehabilitation process involves people figuring out the goals they want to achieve in their residential, educational, vocational and/or social roles and developing the skills and supports they need to reach their goals. In some practice settings and programs, this process unfolds in an environment that is structured to make the psychiatric rehabilitation process occur, but in an indirect, less formal, and less documented manner (e.g., clubhouses, drop in centers). In other psychiatric rehabilitation programs, this process is directly facilitated and documented by a practitioner (e.g., in settings and programs using the Choose-Get-Keep approach developed at the Center for Psychiatric Rehabilitation at Boston University).

Still other psychiatric rehabilitation settings are a combination of a structured psychiatric rehabilitation environment and the more structured practitioner approach developed at Boston University. Even with such differences in how the psychiatric rehabilitation process is structured in various rehabilitation settings and programs, at a minimum, process descriptions should be able to keep track of the major process dimensions listed in TABLE 3.

No matter how formal or informal the process, no matter how directly or indirectly the process is implemented, the basics of the process should be tracked...

TABLE 4 gives examples of questions that can assist in accurately categorizing the major psychiatric rehabilitation process steps that can be tracked in any psychiatric rehabilitation program, regardless of the program environments' specificity. No matter how formal or informal the process, no matter how directly or indirectly the process is implemented, the basics of the process should be tracked for all the reasons previously mentioned. One way or another, people being helped to attain a valued role do experience the psychiatric rehabilitation process in some shape or form.

Table 4—Questions to Ask to Help Categorize Activities Correctly

Diagnosing Phase

Is the person:

- Figuring out whether he or she is willing and prepared to begin a structured process of change? **(Readiness assessment)**
- Engaged in activities to improve readiness? **(Readiness development)**
- Engaged in figuring out his or her values, criteria for choosing a role, and environment to aim for in the next 6–24 months? **(Goal setting)**
- Evaluating what he or she can or cannot do competently in relation to this goal? **(Functional assessment)**
- Evaluating what he or she does or does not have to support success in relation to this goal? **(Resource assessment)**

Planning Phase

Is the person:

- Engaged in naming the most important skill deficits to formulate as objectives out of all the skills identified in functional assessment or resource assessment?
- Engaged in matching the skill objectives to direct skills teaching or programming skill use interventions? Is there an activity or agency named to provide this?
- Being given information about who will do it, where, when they will begin and end each intervention?
- Engaged in matching the resource objectives to resource coordination or resource modification interventions? Is there an activity or agency named to provide this?
- Being given information about who will do it, where, when they will begin and end each intervention?

Intervening Phase

Is the person:

- Learning new skills directly tied to success and satisfaction in the environment and/or role he or she wants? **(Direct skills teaching)**
- Overcoming barriers to using skills directly tied to success and satisfaction in the environment and/or role he or she wants? **(Programming skill use)**
- Being supported in linking to an existing resource directly tied to success and satisfaction in the environment and/or role he or she wants? **(Resource coordination)**
- Creating or modifying new resources that do not exist but are critical to success and satisfaction in the environment and/or role he or she wants? **(Resource modification)**

Tracking DPI Service Processes for Different Services

As noted previously, the content of the psychiatric rehabilitation DPI process is focused on goals, skills, and supports. In treatment services, the treatment process focus is on symptoms and distress. In case (or care) management services the process is focused on services the consumer wants and needs, and so on for the other services. To reiterate, what distinguishes the services one from the other is the content of the DPI process and its outcome. What remains common across services is the process of DPI.

What distinguishes the services one from the other is the content of the DPI process and its outcome. What remains common across services is the process of DPI.

TABLE 5 provides examples of how the Recovery Center at Boston University differentiates the psychiatric rehabilitation process from some of the other service processes offered to people with severe mental illnesses. Note that the differences in DPI service process for each service are in the specific content of what is being diagnosed, planned, and intervened in order to achieve a unique consumer outcome.

Table 5—Recovery Center Example: Tracking Major Steps for Other Services Processes

CARE/CASE MANAGEMENT

Assist in monitoring, planning, or linking a participant to a service that he or she wants or needs

Diagnosing Phase	Planning Phase	Intervening Phase
Reviewing daily functioning	Formulating a service plan	Providing a care management service
Clarifying problems of participant	Supporting participant in the planning process	Linking to care services
Setting service goals		Monitoring care service use
Choosing strategies		

HEALTH AND WELLNESS

Assisting a person to improve or maintain his or her health or wellness

Diagnosing Phase	Planning Phase	Intervening Phase
Engaging participant in relationship	Formulating a health and wellness plan	Developing health behaviors
Assessing fitness status	Supporting participant in planning process	Developing resources to support health behaviors
Developing readiness for fitness		Supporting the use of health behaviors
Setting health and wellness goals		

ENRICHMENT SERVICES

Providing or engaging the participant in activities that enhance her or his lifestyle and quality of life

Diagnosing Phase	Planning Phase	Intervening Phase
Identifying enrichment needs and values	Scheduling enrichment activities	Delivering enrichment activity
Evaluating enrichment options	Supporting person's participation in planning activities	Accompanying to enrichment activity
Choosing enrichment activities		Supporting participation in enrichment activity

Common DPI Activities Across Service Processes

As can be seen in TABLE 5, the process of DPI occurs in all services. TABLE 6 is an example of how the Recovery Center tried to describe the common activities within the DPI phases for those services often implemented in conjunction with the psychiatric rehabilitation service. As mentioned previously, the DPI activities for any service can be conducted informally or formally, directed by a practitioner, and/or by arranging the program environment to indirectly facilitate these DPI process activities. But the bottom line is that the DPI activities that are occurring within a specific service delivery process can be tracked. While outside the focus of this primer, it certainly would be useful if all services were tracked using a common DPI process.

Table 6—Questions to Ask to Help Categorize Activities Correctly Within the DPI Service Phases

Diagnosing Phase	Planning Phase	Intervening Phase
Am I or the environment assessing, evaluating, monitoring, estimating, analyzing, judging, drawing conclusion, and/or assisting the participant to perform any of the above diagnostic tasks?	Am I or the environment preparing, setting up, scheduling, arranging, developing, getting ready, or assisting the participant to do any of the above planning tasks?	Am I or the environment implementing a plan or engaging in any goal-oriented activity with a participant?

The Importance of Record Keeping

It is a given that people record what is most important in their lives; such as money in their checkbook, food to be purchased (a grocery list), their monthly schedule, and the like. Furthermore, other people demand that certain records be kept; such as birth records, marriage certificates, income tax forms, passports, and the like. Similarly important to these other types of record keeping are the records of what is happening in the psychiatric rehabilitation process itself. Recording the psychiatric rehabilitation process literally can help change a person's life—and can be as valuable as a record of one's monthly schedule or a record of the balance in one's checkbook. There is no denying the importance of records in many walks of life, including psychiatric rehabilitation.

Recording the psychiatric rehabilitation process literally can help change a person's life—and can be as valuable as a record of one's monthly schedule or a record of the balance in one's checkbook.

Differences Between Tracking and Record Keeping

Tracking lets people know that the process is moving forward in a logical way; that the process is occurring. Record keeping lets people know exactly what progress is occurring in the process. Record keeping is more than knowing that something has been done (as in tracking), but knowing the results of that something having been done. As their names imply, tracking keeps the steps of a process on track; record keeping records the nature of the progress people are making in the process that is being tracked.

Tracking lets people know that the process is moving forward in a logical way; that the process is occurring. Record keeping lets people know exactly what progress is occurring in the process.

How Detailed Must the Record Keeping Be?

Just like in tracking the service delivery process, there are limits to how many different types of records can be kept and the detail within each record. The Center for Psychiatric Rehabilitation has devised records for each of the major steps and substeps listed in APPENDIX A. However, in the same way that tracking all of these steps may be overkill, for some organizations so would recording the consumer's progress for all of these steps. At a minimum, record keeping of how the participant is doing with respect to the major steps seems most efficient and effective. APPENDIX B describes a consumer and contains an example of only the major steps of the record forms filled out for that individual. The example in APPENDIX B is excerpted and adapted from the textbook entitled, *Psychiatric Rehabilitation* (Anthony Cohen, Farkas, & Gagne, 2002).

Recording the DPI Phases of the Psychiatric Rehabilitation Process

At a minimum, records should be completed for the major steps of:

1) Readiness assessment and development
2) Setting a goal
3) Functional assessment
4) Resource assessment
5) Planning and intervening

Records should exist to document that the participant's self-determined readiness has been assessed and that readiness development activities have been identified as needed; that a rehabilitation goal has been chosen; that the corresponding skill and support needs specified; and that the skill and support development interventions are progressing as planned.

Record Form for Assessing and Developing Readiness in the Psychiatric Rehabilitation Diagnostic Phase

Readiness assessment helps individuals "judge for themselves" whether or not it makes sense to them to engage in rehabilitation services within a particular living, learning, working, or social environment.

A readiness assessment helps people figure out their immediate willingness to participate in rehabilitation activities focused on impacting their role functioning. If individuals determine in the readiness assessment process that they do not feel ready, readiness development activities help them increase the knowledge and hopefulness about the possibilities psychiatric rehabilitation holds for them. Readiness assessment helps individuals "judge for themselves" whether or not it makes sense to them to engage in rehabilitation services within a particular living, learning, working, or social environment. Readiness for rehabilitation is an indication of people's self-determined commitment and interest in rehabilitation, and *not an assessment of their capacity to achieve rehabilitation success*. People differ in their rehabilitation readiness just as they vary in terms of their readiness for any possible change; such as college, marriage, a vacation, or a physical exercise program.

A record form for assessing and developing rehabilitation readiness shows people's self-determined readiness on five separate dimensions (see Table 7 on the following page). These dimensions are:

1) **Need for change**—evidenced by a lack of success or satisfaction in a particular living, learning, working, or social environment;
2) **Commitment to change**—evidenced by a belief that change is personally desirable and possible;
3) **Personal closeness**—evidenced by a personal relationship with someone who supports rehabilitation;
4) **Self awareness**—evidenced by an awareness of one's values and interests relevant to a particular environment; and
5) **Environmental awareness**—evidenced by an awareness of different characteristics and kinds of living, learning, working, and/or social environments in which the person may want to improve success and satisfaction.

The record form for assessing and developing rehabilitation readiness also has a place for describing readiness development activities, i.e., motivational or learning activities that may improve the person's self-determined readiness. Readiness development activities clarify whether or not to participate further in the rehabilitation process. These readiness development activities address any of the five readiness dimensions on which the readiness assessment indicated that the person thinks he or she is not ready. A blank form that can be used to record both rehabilitation readiness assessment and readiness development is included in APPENDIX C (page 40).

Table 7—Assessing and Developing Readiness Record

Consumer: Practitioner: Environmental Arena: Date:

	Need	Commitment to Change	Personal Closeness	Self-Awareness	Environmental Awareness
5 (High)	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐
1 (Low)	☐	☐	☐	☐	☐

Conclusions:

☐ Ready	☐ Ready	☐ Ready	☐ Ready	☐ Ready
☐ Unsure	☐ Unsure	☐ Unsure	☐ Unsure	☐ Unsure
☐ Not Ready	☐ Not Ready	☐ Not Ready	☐ Not Ready	☐ Not Ready

Developing Readiness Activities:

Adapted from: Farkas, M., Cohen, M., McNamara, S., Nemec, P., & Cohen, B. (2000). *Psychiatric rehabilitation training technology. Assessing readiness for rehabilitation.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Record Form for Setting an Overall Rehabilitation Goal in the Psychiatric Rehabilitation Diagnostic Phase

The overall rehabilitation goal identifies the particular environment in which the person chooses to live, learn, socialize, and/or work during the next 6 to 24 months. If more than one goal is set, then a functional and resource assessment is conducted and recorded for each separate goal. The particular environment in which the goal is set may be one in which the person currently lives, learns, socializes, or works and wants to stay; or the environment may be one in which the person desires to move to within the next year or two. The overall rehabilitation goal statement identifies the specific environment and a timeline.

Overall rehabilitation goals examples are:

- To live in the Oak Street supported apartments until September of next year;
- To enroll in a supported education program at Bunker Hill Community College for the next spring semester;
- To work in Genesis House's transitional employment program for 6 more months;
- To attend the Summit Street Drop-In Center on a weekly basis by next January.

Choosing an overall rehabilitation goal is essentially a systematic problem solving process, in which possible environmental goals are evaluated against the person's unique personal criteria and values in order to choose the goal which most satisfies the person's most important values. Effective goal setting is formally or informally done by most everyone when they select a particular goal from various alternative goals. The recording form for choosing a rehabilitation goal (TABLE 8), explicitly records the goal choosing process and ensures that the goal setting task occurs in a more understandable, systematic, observable way. A blank form that can be used for recording the process of Choosing a Goal is included in APPENDIX C (page 41). With or without a recording form, however, psychiatric rehabilitation helps people to choose their rehabilitation goals by engaging them in a problem solving process, by means of which they choose goals that they estimate will most effectively meet their most important personal criteria and values.

Possible environmental goals are evaluated against the person's unique personal criteria and values in order to choose the goal which most satisfies the person's most important values.

Table 8—Choosing a Goal Record

Consumer: Practitioner: Environmental Arena: Date:

		Alternative Goal Environments**			
Personal Criteria	**Weights***	**1.**	**2.**	**3.**	**Current**
1.					
2.					
3.					
4.					
5.					
6.					

Ideal Score = weights x 5

* The personal criteria are weighted on a 10-point scale with a weight of 10 being the highest.

** How well a particular alternative environment satisfies the personal criteria is rated on a 5-point scale with 5 being the highest level of satisfaction.

Comments:

Cohen, M., Farkas, M., Cohen, B., & Unger, K. (1991, 2007). *Psychiatric rehabilitation training technology: Setting an overall rehabilitation goal.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Record Forms for Functional and Resource Assessments in the Psychiatric Rehabilitation Diagnostic Phase

The overall rehabilitation goal is recorded at the top of both the functional assessment form and the resource assessment form. The overall rehabilitation goal focuses the functional and resource assessment on those skills and supports that are relevant to a person's success and satisfaction in the goal environment. A functional assessment records the evaluation of the participant's present and needed functioning on those critical skills necessary to achieve the rehabilitation goal, while a resource assessment records the evaluation of the present and needed supports necessary to achieve this same goal. The skills and supports are written in a way that is as observable, measureable, and objective as possible. Skill and support examples are:

- The number of times per week the consumer converses with family at the dinner table;
- Percentage of times per week the consumer speaks in a calm manner when he is upset;
- The number of days per week a relative can drive consumer to the college campus;
- The number of job leads per month that someone can provide the consumer.

TABLES 9 and 10 (page 28) are blank forms that can be used to record the overall rehabilitation goal and the subsequent functional and resource assessment. Note that the functional assessment form names the critical skills, while the resource assessment form identifies the critical supports (resources). Examples for the previously noted skills and resources are: Conversing; expressing emotions; driver; job developer. Additional blank forms for functional and resource assessment are included in APPENDIX C (pages 42 & 43).

Table 9—Functional Assessment Record

Consumer: Practitioner: Environmental Arena: Date:

Overall Rehabilitation Goal:

Strengths/Deficits	Critical Skills	Skill Use Descriptions	Skill Evaluation	
			Present	Needed

Cohen, M., Farkas, M., & Cohen, B. (1986, 2007). *Psychiatric rehabilitation training technology: Functional assessment.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Table 10—Resource Assessment Record

Consumer: Practitioner: Environmental Arena: Date:

Overall Rehabilitation Goal:

Strengths/Deficits	Critical Resources	Resource Use Descriptions	Resource Evaluation	
			Present	Needed

Cohen, M., Farkas, M., & Cohen, B. (1986, 2007). *Psychiatric rehabilitation training technology: Functional assessment.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Record Form for Planning and Intervening in the Psychiatric Rehabilitation Planning and Intervention Phases

The record form for planning and intervening flows directly from the diagnostic record keeping form. Recording the rehabilitation plan identifies who is responsible for doing what, by when, for how long and where. The previously completed rehabilitation diagnostic record provides the answer to the question: "why?" Recording the rehabilitation intervention (and any changes to it) addresses the issue: "how well are we doing?" The specific intervention for each diagnosed skill and resource objective is documented, along with each person responsible for providing and monitoring the intervention. The starting and completion dates are listed. As the interventions are implemented, the same form is used to record changes based on the progress of each skill or resource intervention. The form for the Rehabilitation Plan and Intervention Schedule (see TABLE 11, page 29) also includes a space at the top for the overall rehabilitation goal statement and a line at the bottom for the consumer to sign that indicates the consumer's agreement with the plan and intervention schedule, as well as the consumer's participation in developing the plan and intervention schedule.

Note that the skill and resource development objectives, as well as the overall rehabilitation goal, are simply copied from the functional and resource assessment records. And remember that APPENDIX B provides an example of a consumer for whom all the record forms (TABLES 7, 8, 9, 10, and 11) are filled out and APPENDIX C includes additional blank recording forms.

Table 11—Rehabilitation Plan and Intervention Schedule

Consumer: Practitioner: Environmental Arena: Date:

Overall Rehabilitation Goal:

Priority Skill/Resource Development Objectives	Interventions	Person(s) Responsible	Starting Dates Projected/Actual	Completion Dates
		Developer: Provider: Monitor:		
		Developer: Provider: Monitor:		
		Developer: Provider: Monitor:		
		Developer: Provider: Monitor:		

I participated in developing this plan and the plan reflects my objectives.

Signature: _____

Adapted from: Anthony, W.A., Cohen, M.R., Farkas, M.D., & Gagne, C. (2002). *Psychiatric rehabilitation, Second edition.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Summary

Documents that track and record the diagnostic, planning, and intervention process are becoming increasingly necessary in the mental health field. Better understanding of what constitutes the different service processes leads to the possibility of improved tracking and recording of the different service processes, including the process of psychiatric rehabilitation. No doubt a strong incentive for accurate tracking and record keeping is the economic pressure on the entire health care system and the need to document that what is being funded, actually is occurring. Fewer financial resources usually translate into a demand for more accountability, and that is what is happening again. This time, however, the psychiatric rehabilitation field is primed to meet that obligation. As this psychiatric rehabilitation primer clearly demonstrates, the psychiatric rehabilitation process has a significant empirical base; is an understandable process that can be implemented by different types of people in a variety of settings and programs; and is a process that has the capacity to be tracked and recorded.

The psychiatric rehabilitation process has a significant empirical base; is an understandable process that can be implemented by different types of people in a variety of settings and programs; and is a process that has the capacity to be tracked and recorded.

And remember, the process of psychiatric rehabilitation can be implemented through a structured environment as well as the purposeful activities of the practitioner. The key is that the psychiatric rehabilitation process occurs—that is, the service recipient feels ready or gets ready; a rehabilitation goal(s) is set; the things the person needs to do and have to reach the goal are identified; and the needed skills and supports (resources) are developed.

The key is that…the service recipient feels ready or gets ready; a rehabilitation goal is set; the things the person needs to do and have to reach the goal are identified; and the needed skills and supports (resources) are developed.

Also remember that with respect to the helping environment, any environment can be purposefully structured to directly facilitate the psychiatric rehabilitation process. The environment of a community mental health center, a clubhouse, a day program, a psychosocial rehabilitation center, a recovery program, etc., can help the psychiatric rehabilitation process happen. Since 1982, the Center for Psychiatric Rehabilitation has been identifying and refining setting ingredients that are helpful in supporting the implementation of the psychiatric rehabilitation DPI process within any setting. The latest iteration of these standards can be found in TABLE 12 (page 32). Settings or environments, which are attempting to move toward at least some of these ingredients, demonstrate a willingness and a capacity to implement the psychiatric rehabilitation process.

Any environment can be purposefully structured to directly facilitate the psychiatric rehabilitation process. The environment of a community mental health center, a clubhouse, a day program, a psychosocial rehabilitation center, a recovery program, etc., can help the psychiatric rehabilitation process happen.

Lastly, it is worth noting that within any of these environments, tracking and recording the process can be complex because individuals involved in any environment may partake of the same activities in order to accomplish different parts of the rehabilitation process. For example, taking a healthy eating (nutrition) course may be useful in helping one person *become ready* to try other educational activities; for another person, this same course may be a *skill teaching intervention* that is relevant to their long-term goal of living independently; for yet another person, it is a *skill teaching intervention* for a different long-term

goal, e.g, to help that person achieve a parenting goal; for still another person, the course may help provide a *functional assessment* of the person's dietary skills; and so forth. *It is important for psychiatric rehabilitation program staff to assist people in knowing what parts of the process are being achieved by certain DPI activities*. These people include, first and foremost, the service recipient; but also, family, other providers, supervisors, and funding sources. The psychiatric rehabilitation practitioner and the environment in which the practitioner practices do not exist to provide activities simply to keep the person busy, but rather to advance the process of psychiatric rehabilitation in a way that can be understood, tracked, and recorded as the person progresses toward improved functioning and a valued role.

It is important for psychiatric rehabilitation program staff to assist people in knowing what parts of the process are being achieved by certain DPI activities.

Table 12—Description of Program or Setting Standards which Support the Implementation of the Process of Psychiatric Rehabilitation *(page 1 of 2)*

Element	Evaluated Ingredient	Description
Rehabilitation Mission	Mission Statement/Description	Evidence that the agency's mission includes concepts of: Increasing people's functioning in their environment of choice with the least amount of professional intervention.
Rehabilitation Environments	**Network**	
	Network Array	There is an array of settings either under the program's control (or available to it), in or (closely resembling) naturally occurring settings.
	Network Relevance	Settings reflect evidence that all program activities are designed around the needs and preferences of participants.
	Culture	
	Partnership	Evidence that all program activities involve participants as partners.
	Compatible with Values	Evidence that all program activities and structures are congruent with rehabilitation values, e.g., program hours; methods of supervision; official acknowledgment of staff and participants (personal events, accomplishments, etc.).
Rehabilitation Process: Diagnosis	Readiness Assessment	Evidence that all persons are helped to assess themselves in terms of their need for rehabilitation, commitment to change personal closeness, awareness of self and environments.
	Readiness Development	Evidence that there is a structured process to help people choose whether to continue rehabilitation and a series of activities that focus on helping interested participants become ready for rehabilitation.
	Overall Rehabilitation Goal	Evidence that all rehabilitation assessments begin with an environmentally specific goal within 6 to 24 months, e.g., "John intends to live at Sunrise House by January." "Sarah intends to work part time as a chef at Martin's until July."
	Skills Assessment	Evidence that assessment focuses on skills; not symptoms, traits, or global needs; and they are derived from an overall rehabilitation goal, e.g., "asking for staff assistance."
	Behaviorally Defined	Evidence that skills are observable, measurable actions, e.g., "Percentage of times/week Sarah calls staff when she begins to talk to her voices at the restaurant."
	Comprehensive by Skill Type	Evidence that skills are assessed holistically, i.e., physical, emotional, and intellectual skill strengths/deficits, e.g., "washing dishes," "expressing feelings," "planning leisure time."
	Comprehensive by Environments	Evidence that skills in each of the living, learning, working, and social environments that may impact success and satisfaction in the specific goal environment is considered in the assessments.
	Resources Assessment	Evidence that resource strengths and deficits are listed, e.g., "responsive family," "nearby grocery," "rent money."
	Resources Defined	Evidence that resources define what is provided, e.g., "number of $/month SSI pays Sarah before her rent is due."
	Comprehensive by Type of Resource	Evidence that resources listed include supportive people, places, things, and activities.
	Involvement	Evidence that the person participated in: the readiness activities; setting rehabilitation goals; assessing skills/resources.

Table 12—Description of Program or Setting Standards which Support the Implementation of the Process of Psychiatric Rehabilitation *(page 2 of 2)*

Element	Evaluated Ingredient	Description
Rehabilitation Process: Planning	Skill or Resource Objectives	Evidence that the plan includes defined skill or resource objectives, e.g., "40% of times/week Sarah calls staff when she begins to talk to her voices at the restaurant."
	Integrated with Diagnosis and Subsequent Interventions	Evidence that the skill or resource objectives used in the plan come from the diagnosis; and that the interventions described in the plan are implemented based on the plan.
	Priorities Assigned	Evidence that there is a system for selecting skill or resource goals, which are of high priority in the achievement of the overall rehabilitation goal.
	Specific Interventions Selected	Evidence that each objective has a specific skill development or resource development intervention assigned to it.
	Timelines Included	Evidence that each intervention described in plan has a projected starting and completion dates.
	Responsibilities Identified	Evidence that someone is named as responsible for developing, implementing, and monitoring the interventions described in the plan.
	Involvement	Evidence that the person participated in developing the plan selected high priority goals, timelines, etc.
Rehabilitation Process: Intervention	**Skill Development**	
	Skill Teaching Focus	Evidence that agency values skill teaching as an intervention.
	Lessons Prepared	Evidence that each skill taught has a description of its behaviors and a lesson plan for each of the behaviors.
	Skill Learning Monitored	Evidence that a system exists to provide feedback of skill performance during the learning process.
	Skill Use Program Defined	Evidence that skill performance in the environment of need is increased through the use of sequenced and behaviorally defined steps.
	Timelines Included	Evidence that each step in the skill use program has projected timelines assigned to it.
	Reinforcers	Evidence that reinforcers are developed from the person's perspective and applied to the major steps of the skill use program.
	Resource Coordination	
	Service Coordination	Evidence that agencies value and believe they use referral or linking techniques as an intervention.
	Goal Defined	Evidence that agencies make referrals based on the participant's overall rehab goal, and skill and resource assessments.
	Alternative Resources Listed	Evidence that alternative resources have been considered in making the referral.
	Plan for Linking	Evidence that a plan to implement referral has been made; including: a person to refer, date for referral, and arrangement for the link to occur.
	Plan for Utilization	Evidence that a plan to help the participant and the resource maintain the link, once the referral is made.
	Resource Modification	
	Resource Appraisal	Evidence that a method for collecting information about inadequate existing resources has been developed.
	Resource Improved	Evidence that a structure exists for the development of plans and implementation to improve resource deficits.

Adapted from: Anthony, W.A., Cohen, M.R., Farkas, M.D., & Gagne, C. (2002). *Psychiatric rehabilitation, Second edition*. Boston: Boston University, Center for Psychiatric Rehabilitation.

Appendix A—Major Steps and Substeps of the Psychiatric Rehabilitation Process

Phase	Major Steps (Activities)	Substeps
Diagnosing	Assessing Rehabilitation Readiness	Inferring need Validating commitment to change Estimating awareness Discriminating personal closeness Choosing a direction
	Developing Rehabilitation Readiness	Organizing motivational activities Clarifying personal implications Demostrating credible support
	Setting an Overall Rehabilitation Goal	Connecting Identifying personal criteria Describing alternative environments Choosing the goal
	Functional Assessment	Listing critical skills Describing skill use Evaluating skill functioning Coaching
	Resource Assessment	Listing critical resources Describing resource use Evaluating resource use Coaching
Planning	Planning for Skills Development	Setting priorities Defining objectives Choosing interventions Formulating the plan
	Planning for Resource Development	Setting priorities Defining objectives Choosing interventions Formulating the plan
Intervening	Direct Skills Teaching	Outlining skill content Planning the lesson Coaching
	Skills Use Programming	Identifying barriers Developing the program Supporting consumer action
	Resource Coordination	Marketing consumers to resources Problem solving Programming resource use
	Resource Modification	Assessing readiness for change Proposing change Consulting to resources Training resources

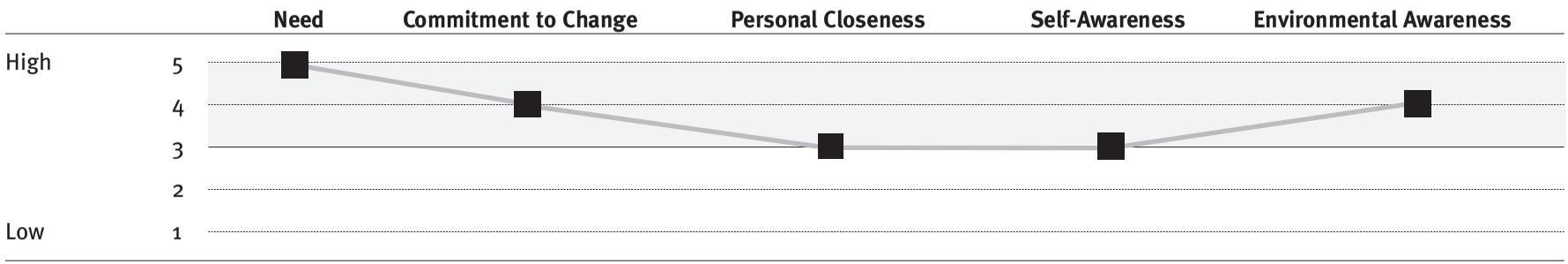
Adapted from: Anthony, W.A., Cohen, M.R., Farkas, M.D., & Gagne, C. (2002). *Psychiatric rehabilitation, Second edition.* Boston: Boston University, Center for Psychiatric Rehabilitation.

An Example of a Person Experiencing the Psychiatric Rehabilitation Process and Record Keeping Forms for the Major Steps and Substeps

After discussing his dissatisfaction with his life with his psychiatrist, Robert was referred to a rehabilitation program offered at the clinic. Robert stated that he felt dissatisfied in all areas of his life—his living, learning, working, and social environments. He was most dissatisfied with his living situation and felt he wanted to begin working on improving his living situation first. Robert and his psychiatric rehabilitation practitioner, Jim, met to assess Robert's readiness to set and achieve an overall rehabilitation goal. After developing Robert's readiness to set an overall rehabilitation goal, he and Jim began working on Setting the Overall Rehabilitation Goal. They proceeded to work through the psychiatric rehabilitation process as recorded on the record forms which follow in Appendix B.

Table 7 Example: Assessing and Developing Readiness Record

Consumer: *Robert* Practitioner: *Jim* Environmental Arena: *Living* Date: *February 26th*



Conclusions:	Need	Commitment to Change	Personal Closeness	Self-Awareness	Environmental Awareness
	_✗_ Ready	_✗_ Ready	__ Ready	__ Ready	_✗_ Ready
	__ Unsure	__ Unsure	_✗_ Unsure	_✗_ Unsure	__ Unsure
	__ Not Ready	__ Not Ready	__ Not Ready	__ Not Ready	__ Not Ready

Developing Readiness Activities:

Overall, Robert is ready to set an overall rehabilitation goal. He and Jim will work on some connecting activities to improve his personal closeness with Jim. They also will build in some additional values clarification activities to improve Robert's self-awareness.

Adapted from: Farkas, M., Cohen, M., McNamara, S., Nemec, P., & Cohen, B. (2000). *Psychiatric rehabilitation training technology. Assessing readiness for rehabilitation*. Boston: Boston University, Center for Psychiatric Rehabilitation and Anthony, W.A., Cohen, M.R., Farkas, M.D., & Gagne, C. (2002). *Psychiatric rehabilitation, Second edition*. Boston: Boston University, Center for Psychiatric Rehabilitation.

Table 8 Example: Choosing a Goal Record

Consumer: *Robert* Practitioner: *Jim* Environmental Arena: *Living* Date: *March 15th*

Personal Criteria	**Weights***	**Alternative Goal Environments****							
		1. Woodland Apts. with roommate		2. Bay State Apts. with roommate		3. Main St. Group Home with 5 residents		Current: Home with Mother & Sister	
1. Affordable rent	10	$500/mo	(4)	$500/mo	(4)	$400/mo	(5)	$250/mo	(5)
2. Accessible transportation	5	2 blocks to bus	(4)	On busline	(5)	On busline	(5)	Rides from Mom	(1)
3. Private room	8	Own room	(5)	Own room	(5)	One roommate	(3)	Own room	(5)
4. Safe neighborhood	4	Good report	(3)	Very Good	(4)	Very Good	(4)	Excellent	(5)
5. Minimal rules	7	Apt. rules	(5)	Apt. rules	(5)	Staff rules	(3)	Mother's rules	(1)
6. Shared chores	1	50% share	(3)	50% share	(3)	20% share	(5)	33% share	(4)
Ideal Score = weights x 5	175		150		**159**		141		126

* The personal criteria are weighted on a 10-point scale with a weight of 10 being the highest.

** How well a particular alternative environment satisfies the personal criteria is rated on a 5-point scale with 5 being the highest level of satisfaction.

Comments:

Robert selected the Bay State Apartments as his preferred environmental goal because it had most of the characteristics he wanted in his living environment. He and Jim then assessed the skills and resources he would need to succeed (Example: Tables 9 & 10).

Adapted from: Cohen, M., Farkas, M., Cohen, B., & Unger, K. (1991, 2007). *Psychiatric rehabilitation training technology: Setting an overall rehabilitation goal.* Boston: Boston University, Center for Psychiatric Rehabilitation and Anthony, W.A., Cohen, M.R., Farkas, M.D., & Gagne, C. (2002). *Psychiatric rehabilitation, Second edition.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Table 9 Example: Functional Assessment Record

Consumer: *Robert* Practitioner: *Jim* Environmental Arena: *Living* Date: *June 1st*

Overall Rehabilitation Goal: I intend to live in the Bay State Apartment Complex with one roommate by next September.

Strengths/Deficits	Critical Skills	Skill Use Descriptions	Skill Evaluation**	
			Present	Needed
–	Planning activities	Number of days per week Robert schedules activities for the next day before going to bed at night.	0	5
–	Identifying shopping needs	Number of days per month Robert lists missing household groceries and supplies before going to the store.	0	4
+	Preparing meals	Number of days per week Robert makes food for supper for himself at home in the evening.	7	7
–	Expressing opinions	Percentage of times per week Robert states his thoughts and beliefs when in a discussion with others.	25%	75%

Adapted from: Cohen, M., Farkas, M., & Cohen, B. (1986, 2007). *Psychiatric rehabilitation training technology: Functional assessment.* Boston: Boston University, Center for Psychiatric Rehabilitation and Anthony, W.A., Cohen, M.R., Farkas, M.D., & Gagne, C. (2002). *Psychiatric rehabilitation, Second edition.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Table 10 Example: Resource Assessment Record

Consumer: *Robert* Practitioner: *Jim* Environmental Arena: *Living* Date: *June 5th*

Overall Rehabilitation Goal: I intend to live in the Bay State Apartment Complex with one roommate by next September.

Strengths/Deficits	Critical Resources	Resource Use Descriptions	Resource Evaluation	
			Present	Needed
–	Health club partner	Number of days per week someone accompanies Robert to the gym before going to work.	0	3
+	Transportation	Number of times per month someone drives Robert to his medical appointments.	4	4

Adapted from: Cohen, M., Farkas, M., & Cohen, B. (1986, 2007). *Psychiatric rehabilitation training technology: Functional assessment.* Boston: Boston University, Center for Psychiatric Rehabilitation and Anthony, W.A., Cohen, M.R., Farkas, M.D., & Gagne, C. (2002). *Psychiatric rehabilitation, Second edition.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Table 11 Example: Rehabilitation Plan and Intervention Schedule

Consumer: *Robert* Practitioner: *Jim* Environmental Arena: *Living* Date: *June 7th*

Overall Rehabilitation Goal: I intend to live in the Bay State Apartment Complex with one roommate by next September.

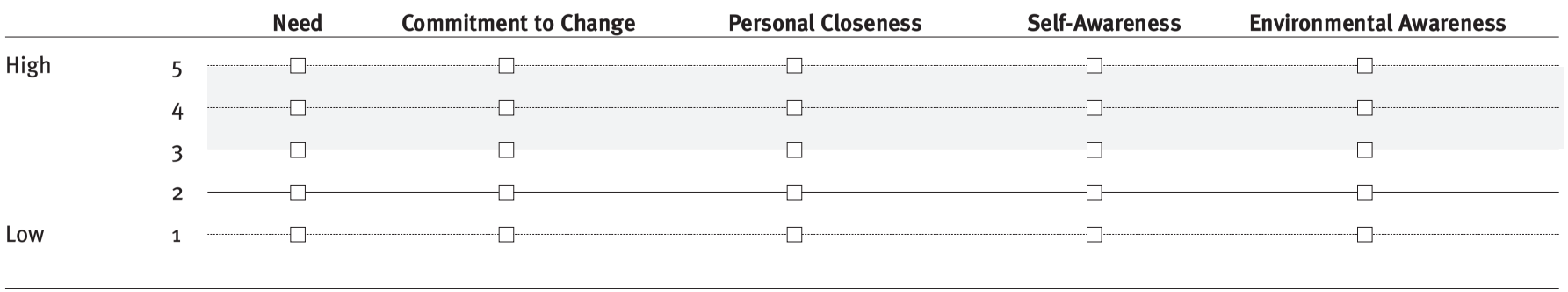
Priority Skill/Resource Development Objectives	Interventions	Person(s) Responsible	Starting Dates Projected/Actual	Completion Dates
Skill—Planning activities: 5 days per week Robert schedules activities for the next day before going to bed at night.	Direct Skills Teaching	Developer: Maria, teacher Provider: Maria Monitor: Jim	June 15th	August 15th
Skill—Identifying shopping needs: 4 days per month Robert lists missing household groceries and supplies before going to store.	Direct Skills Teaching	Developer: Maria, teacher Provider: Maria Monitor: Jim	June 30th	August 30th
Skill—Expressing opinions: 75% of times per week Robert states his thoughts and beliefs when in a discussion with others.	Programming Skill Use	Developer: Jim Provider: Robert Monitor: Robert & Jim	September 5th	October 5th
Resource—Health club partner: 3 days per week someone accompanies Robert to the gym before going to work.	Resource Coordination	Developer: Jim Provider: José, partner Monitor: Robert & Jim	June 10th	August 10th

I participated in developing this plan and the plan reflects my objectives. Signature: *Robert*

Adapted from: Anthony, W.A., Cohen, M.R., Farkas, M.D., & Gagne, C. (2002). *Psychiatric rehabilitation, Second edition.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Assessing and Developing Readiness Record

Consumer: Practitioner: Environmental Arena: Date:



Conclusions:

Need	Commitment to Change	Personal Closeness	Self-Awareness	Environmental Awareness
__Ready	__Ready	__Ready	__Ready	__Ready
__Unsure	__Unsure	__Unsure	__Unsure	__Unsure
__Not Ready	__Not Ready	__Not Ready	__Not Ready	__Not Ready

Developing Readiness Activities:

Adapted from: Farkas, M., Cohen, M., McNamara, S., Nemec, P., & Cohen, B. (2000). *Psychiatric rehabilitation training technology. Assessing readiness for rehabilitation*. Boston: Boston University, Center for Psychiatric Rehabilitation.

Choosing a Goal Record

Consumer: Practitioner: Environmental Arena: Date:

Personal Criteria **Weights*** **Alternative Goal Environments****

		1.	2.	3.	Current:
1.					
2.					
3.					
4.					
5.					
6.					
Ideal Score = weights x 5					

* The personal criteria are weighted on a 10-point scale with a weight of 10 being the highest.

** How well a particular alternative environment satisfies the personal criteria is rated on a 5-point scale with 5 being the highest level of satisfaction.

Comments:

Adapted from: Cohen, M., Farkas, M., Cohen, B., & Unger, K. (1991, 2007). *Psychiatric rehabilitation training technology: Setting an overall rehabilitation goal.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Functional Assessment Record

Consumer: Practitioner: Environmental Arena: Date:

Overall Rehabilitation Goal:

Strengths/Deficits	Critical Skills	Skill Use Descriptions	Skill Evaluation	
			Present	Needed

Adapted from: Cohen, M., Farkas, M., & Cohen, B. (1986, 2007). *Psychiatric rehabilitation training technology: Functional assessment.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Resource Assessment Record

Consumer: Practitioner: Environmental Arena: Date:

Overall Rehabilitation Goal:

Strengths/Deficits	Critical Resources	Resource Use Descriptions	Resource Evaluation	
			Present	Needed

Adapted from: Cohen, M., Farkas, M., & Cohen, B. (1986, 2007). *Psychiatric rehabilitation training technology: Functional assessment.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Rehabilitation Plan and Intervention Schedule

Consumer: Practitioner: Environmental Arena: Date:

Overall Rehabilitation Goal:

Priority Skill/Resource Development Objectives	Interventions	Person(s) Responsible	Starting Dates Projected/Actual	Completion Dates
		Developer: Provider: Monitor:		
		Developer: Provider: Monitor:		
		Developer: Provider: Monitor:		
		Developer: Provider: Monitor:		

I participated in developing this plan and the plan reflects my objectives. Signature:

Adapted from: Anthony, W.A., Cohen, M.R., Farkas, M.D., & Gagne, C. (2002). *Psychiatric rehabilitation, Second edition.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Useful Resources for the Process of Psychiatric Rehabilitation

This section includes references noted in this text along with a bibliography of articles, books, training materials, and technical assistance resources that focus on any of the processes of psychiatric rehabilitation, and/or its implementation in whole, or in part, in various programs and systems.

Anthony, W. (2007). *Toward a vision of recovery.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Anthony, W.A. (1979). *The principles of psychiatric rehabilitation.* Baltimore: University Park Press.

Anthony, W. A., Buell, G. J., Sharratt, S., & Althoff, M. E. (1972). Efficacy of psychiatric rehabilitation. *Psychological Bulletin, 78,* 447–456.

Anthony, W. A., Cohen, M. R., & Cohen, B. F. (1983). Philosophy, treatment process, and principles of the psychiatric rehabilitation approach. In L. L. Bachrach (Ed.), *Deinstitutionalization (New Directions for Mental Health Services,* No. 17, pp. 67–69). San Francisco: Jossey-Bass.

Anthony, W. A., Cohen, M. R., & Farkas, M. D. (1982). A psychiatric rehabilitation treatment program: Can I recognize if I see one? *Community Mental Health Journal, 18,* 83–96.

Anthony, W. A., Cohen, M. R., Farkas, M. D., & Gagne, C. (2002). *Psychiatric Rehabilitation (2nd ed.).* Boston: Boston University, Center for Psychiatric Rehabilitation.

Anthony, W. A., Cohen, M. R., & Nemec, P. B. (1987). Assessment in psychiatric rehabilitation. In B. Bolton (Ed.), *Handbook of measurement and evaluation in rehabilitation* (pp. 299–312). Baltimore: Paul Brooks.

Anthony, W. A., Cohen, M. R., & Pierce, R. M. (1980). *Instructors' guide to the psychiatric rehabilitation practice series.* Baltimore: University Park Press.

Anthony, W.A., Cohen, M.R., Pierce, R.M. (1979) *The skills of psychiatric rehabilitation. Volumes 1–6.* Baltimore: University Park Press.

Anthony, W. A., Cohen, M. R., & Vitalo, R. L. (1978). The measurement of rehabilitation outcome. *Schizophrenia Bulletin, 4,* 365–383.

Anthony, W. A., Ellison, M., Rogers, E. S., & Lyass, A. (in preparation). The evaluation of consumer goal setting in a statewide, managed care psychiatric rehabilitation program.

Anthony, W. A., Forbess, R., & Cohen, M. R. (1993). Rehabilitation-oriented case management. In M. Harris & H. C. Bergman (Eds.), *Case management for mentally ill patients: Theory and practice. Chronic mental illness, Vol 1* (pp. 99–118). Langhorne, PA, USA: Harwood Academic Publishers/Gordon & Breach Science Publishers.

Anthony, W. A., & Huckshorn, K. (2008). *Principled leadership.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Anthony, W. A., & Liberman, R. P. (1986). The practice of psychiatric rehabilitation: Historical, conceptual, and research base. *Schizophrenia Bulletin, 12,* 542–544.

Anthony, W. A., & Margules, A. (1974). Toward improving the efficacy of psychiatric rehabilitation. A skills training approach. *Rehabilitation Psychology, 21,* 101–105.

Anthony, W.A., & Spaniol, L. (Eds). (1994). *Readings in psychiatric rehabilitation.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Cohen, B. F., & Anthony, W. A. (1984). Functional assessment in psychiatric rehabilitation. In. A. S. Halpern & M. J. Fuhrer (Eds.), *Functional assessment in rehabilitation* (pp. 79–100). Baltimore: Paul Brookes.

Cohen, B. F., Ridley, D. E., & Cohen, M. R. (1985). Teaching skills to severely psychiatrically disabled persons. In H. A. Marlowe & R. B. Weinberg (Eds.), *Competence development: Theory and practice in special populations* (pp.118–145). Springfield, IL: Charles C. Thomas.

Cohen, M. R., Anthony, W. A., & Farkas, M. D. (1997). Assessing and developing readiness for psychiatric rehabilitation. *Psychiatric Services, 48*(5), 644–646.

Cohen, M., Danley, K., & Nemec, P. (1985, 2007). *Psychiatric rehabilitation training technology: Direct skills teaching.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Cohen, M., Farkas, M., & Cohen, B. (1986, 2007). *Psychiatric rehabilitation training technology: Functional assessment.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Cohen, M., Farkas, M., Cohen, B., & Unger, K. (1991, 2007). *Psychiatric rehabilitation training technology: Setting an overall rehabilitation goal.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Cohen, M., Farkas, M., McNamara, S., Nemec, P., & Cohen, B. (2000). *Psychiatric rehabilitation training technology: Assessing readiness for rehabilitation.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Cohen, M., Forbess, R., & Farkas, M. (2000). *Psychiatric rehabilitation training technology: Developing readiness for rehabilitation.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Cohen, M., & Mynks, D. (Eds). (1993). *Compendium of activities for assessing and developing readiness for rehabilitation services.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Cohen, M., Nemec, P., & Farkas, M. (2000). *Psychiatric rehabilitation training technology: Connecting for rehabilitation readiness.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Danley, K., Hutchinson, D., & Restrepo-Toro, M. (1998). *Career planning curriculum: Instructor's guide.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Danley, K. S., Rogers, E. S., MacDonald Wilson, K., & Anthony, W. (1994). Supported employment for adults with psychiatric disability: Results of an innovative demonstration project. *Rehabilitation Psychology, 39*(4), 269–276.

Davidson, L, Harding, C., & Spaniol, L. (Eds). (2005). *Recovery from severe mental illnesses: Research evidence and implications for practice, Volume 1.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Davidson, L, Harding, C., & Spaniol, L. (Eds). (2006). *Recovery from severe mental illnesses: Research evidence and implications for practice, Volume 2.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Dunn, E., Rogers, E.S., Hutchinson, D. H., Lyass, A., MacDonald Wilson, K.L., Wallace, L. R., & Furlong-Norman, K. (2008). Results of an innovative university-based recovery education program for adults with psychiatric disabilities. *Administration and Policy in Mental Health, 35*: 357–369.

Ellison, M. L., Anthony, W. A., Sheets, J. L., Dodds, W., Barker, W. J., Massaro, J. M., et al. (2002). The integration of psychiatric rehabilitation services in behavioral health care structures: A state example. *Journal of Behavioral Health Services & Research, 29*(4), 381–393.

Ellison, M., Lyass, A., Rogers, E., Wewiorski, N., Massaro, J., & Anthony, W. (in preparation). Effectiveness of Intensive Psychiatric Rehabilitation: Results of a statewide initiative and evaluation.

Farkas, M. (2007). The vision of recovery today: What it is and what it means for services. *World Psychiatry, 6*(2), 1–7.

Farkas, M., & Anthony, W. A. (1989) *Psychiatric rehabilitation programs: Putting theory into practice.* Baltimore: Johns Hopkins University Press.

Farkas, M. D., Cohen, M. R., & Nemec, P. B. (1988). Psychiatric rehabilitation programs: Putting concepts into practice? *Community Mental Health Journal, 24*(1), 7–21.

Farkas, M., Gagne, C., & Anthony, W. A. (2001). Recovery and rehabilitation: A paradigm for the new millennium. *La rehabilitacio psicosical integral a la communitat I amb la communitat, 1*(1/8), 13–16.

Farkas, M. D., O'Brien, W. F., Cohen, M. R., & Anthony, W. A. (1994). Assessment and planning in psychiatric rehabilitation. In J. R. Bedell (Ed.). *Psychological assessment and treatment of persons with severe mental disorders* (pp. 3–30). Washington, DC: Taylor & Francis.

Farkas, M. D, O'Brien, W. F., & Nemec, P. B. (1988). A graduate level curriculum in psychiatric rehabilitation: Filling a need. *Psychosocial Rehabilitation Journal, 12*(2), 53–66.

Farkas, M., Sullivan Soydan, A., & Gagne, C. (2000). *Introduction to rehabilitation readiness.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Goering, P. N., Wasylenki, D. A., Farkas, M. D., Lancee, W. J., & Ballantyne, R. (1988). What difference does case management make? *Hospital and Community Psychiatry, 39,* 272–276.

Hutchinson, D., Anthony, W., Massaro, J., & Rogers, E. S. (2007). Evaluation of a combined supported computer education and employment training program for persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 30*(3), 189–197.

Jacobs, J. (1997). *Major findings of the community support research demonstration projects (1989–1996).* Washington, DC: Community Support Program Branch, Substance Abuse and Mental Health Services Administration.

Kramer, P., Anthony, W. A., Rogers, E. S., & Kennard, W. A. (2003). Another way of avoiding the "single model trap." *Psychiatric Rehabilitation Journal, 26,* 413–415.

Lamberti, J. S., Melburg, V., & Madi, N. (1998). Intensive psychiatric rehabilitation treatment (IPRT): An overview of a new program. *Psychiatric Quarterly, 69*(3), 211–234.

Lovell, A. M., & Cohn, S. (1998). The elaboration of "choice" in a program for homeless persons labeled psychiatrically disabled. *Human Organization, 57*(1), 8–20.

McNamara, S. (Ed). (2009). *Voices of recovery.* Boston: Boston University, Center for Psychiatric Rehabilitation.

National Institute of Handicapped Research. (1980). A skills training approach in psychiatric rehabilitation. *Rehabilitation Research Brief, 4*(1). Washington, DC.

Nemec, P., Forbess, R., Farkas, M., Rogers, E. S., & Anthony, W. (1991). Effectiveness of technical assistance in the development of psychiatric rehabilitation programs. *Journal of Health Administration, 18*(1), 1–11.

Nemec, P. B., McNamara, S., & Walsh, D. (1992). Direct skills teaching. *Psychosocial Rehabilitation Journal, l6(1)*, 13–25.

Restrepo-Toro, M., Farkas, M., & Diaz, L (2005). *Abriendo caminos en tu vida: Guia de preparación para la rehabilitación psiquiátrica.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Rogers, E. S., Anthony, W. A., & Farkas, M. (2006). The Choose-Get-Keep model of psychiatric rehabilitation: A synopsis of recent studies. *Rehabilitation Psychology, 51*(3), 247–256.

Rogers, E. S., Anthony, W. A., & Jansen, M. A. (1988). Psychiatric rehabilitation as the preferred response to the needs of individuals with severe psychiatric disability. *Rehabilitation Psychology, 33,* 5–14.

Rogers, E. S., Anthony, W. A., & Lyass, A. (2006). A randomized clinical trial of psychiatric vocational rehabilitation. *Rehabilitation Counseling Bulletin, 49*(3), 143–156.

Rogers, E. S., Anthony, W. A., Toole, J., & Brown, M. A. (1991). Vocational outcomes following psychosocial rehabilitation: A longitudinal study of three programs. *Journal of Vocational Rehabilitation, 1*(3), 21–29.

Rogers, E. S., MacDonald Wilson, K., Danley, K., Martin, R., & Anthony, W. A. (1997). A process analysis of supported employment services for persons with serious psychiatric disability: Implications for program design. *Journal of Vocational Rehabilitation, 8*(3), 233–242.

Rogers, E., S., Martin, R., Anthony, W., Massaro, J., Danley, K., Crean, T., & Penk, W. (2001). Assessing readiness for change among persons with severe mental illness. *Community Mental Health Journal, 37,* 97–112.

Rogers, E. S., Sciarappa, K., MacDonald Wilson, K., & Danley, K. (1995). A benefit-cost analysis of a supported employment model for persons with psychiatric disabilities. *Evaluation and Program Planning, 18*(2), 105–115.

Russinova, Z., Rogers, E. S., Ellison, M. L., Cook, K., & Lyass, A. (2009, unpublished manuscript). *Conceptualization and measurement of mental health providers' recovery promoting competence.*

Russinova, Z., Rogers, E. S., & Ellison, M. L, (2006). *The Recovery Promoting Relationship Scale.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Shern, D. L., Trochim, W. M. K., & LaComb, C. A. (1995). The use of concept mapping for assessing fidelity of model transfer: An example from psychiatric rehabilitation. *Evaluation and Program Planning, 18*(2), 143–153.

Shern, D. L., Tsemberis, S., Anthony, W. A., Lovell, A. M., Richmond, L., Felton, V. J., Winarski, J., & Cohen, M. (2000). Serving street dwelling individuals with psychiatric disabilities: Outcomes of a psychiatric rehabilitation clinical trial. *American Journal of Public Health, 90,* 1873–1878.

Spaniol, L., Bellingham, R., Cohen, B., & Spaniol, S. (2003). *The recovery workbook 2: Connectedness.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Spaniol, L., & Koehler, M. (Eds). (1994). *The experience of recovery.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Spaniol, L., Koehler, M., & Gagne, C. (Eds). (1997). *Psychological and social aspects of psychiatric disability.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Spaniol, L., Koehler, M., & Hutchinson, D. (1994, 2009). *The recovery workbook: Practical coping and empowerment strategies for people with psychiatric disability, Revised edition.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Spaniol, L., Koehler, M., Hutchinson, D., & Restrepo-Toro, M. (1999). *Recuperando la esperanza—Libro práctico.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Spaniol, L., McNamara, S., Gagne, C., & Forbess, R. (2009). *Group process guidelines for leading groups and classes.* Boston: Boston University, Center for Psychiatric Rehabilitation.

Unger, K. V., Anthony, W. A., Sciarappa, K., & Rogers, E. S. (1991). Development and evaluation of a supported education program for young adults with long-term mental illness. *Hospital and Community Psychiatry, 42,* 838–842.

Training and Technical Assistance

The Boston University Center for Psychiatric Rehabilitation provides training and technical assistance in a variety of "How-To" topics designed to improve your work in psychiatric rehabilitation, as well as designing and implementing recovery-oriented systems and programs. The Center's 30 years of experience in training and technical assistance allows Center staff and associates to work together with you to tailor the "How–To's" to your unique situation.

Training and technical assistance topics include, how to:

Implement the psychiatric rehabilitation process in your program;

Train trainers and supervisors in psychiatric rehabilitation and recovery practices;

Become more expert in providing psychiatric vocational rehabilitation interventions;

Develop a recovery-oriented system;

Develop standards or metrics for a recovery-oriented system or program;

Help traditional mental health interventions become more recovery oriented;

Be a "principled leader" in mental health;

Implement value-based practices in your setting;

Set up a Recovery Education Center in your setting;

Provide supported education services at a university;

Train practitioners to help people:

- Become engaged in the helping process;
- Become inspired;
- Choose their own goals;
- Assess their self-determined readiness to change;
- Develop their self-determined readiness to change;

Teach skills in classes, groups and in individual interactions;

Do person directed planning;

Do case (care) management;

Do a functional and resource assessment;

Develop a pre-professional curriculum in rehabilitation and recovery;

Evaluate training project processes and outcomes;

Conduct a program evaluation;

Assess research papers for rigor;

Assess research papers for meaning;

Use the Empowerment scale in your setting;

Use the Recovery Promoting Relationship Scale in your setting;

Use a Participatory Action Research process to develop new instruments.

Visit **http://www.bu.edu/cpr/training/** for more information about consultation and in-service training available from the Center for Psychiatric Rehabilitation.

Products and Publications

For a more comprehensive, in-depth study of the psychiatric rehabilitation process described in this primer, the Boston University Center for Psychiatric Rehabilitation has published related books, training technology, and curricula, including:

Technology for Training Practitioners

Rehabilitation Readiness Training Technology
Setting an Overall Rehabilitation Goal Training Technology
Functional Assessment Training Technology
Direct Skills Teaching Training Technology
Case Management Training Technology

Workbooks for the Psychiatric Rehabilitation Process

Group Process Guidelines for Leading Groups and Classes
Activities for Assessing & Developing Readiness for Rehabilitation Services
Abriendo Caminos en Tu Vida
Career Planning Curriculum

Textbooks

Psychiatric Rehabilitation, Second Edition
Principled Leadership in Mental Health Systems and Programs
Recovery from Severe Mental Illnesses: Volume 1
Recovery from Severe Mental Illnesses: Volume 2
Psychological and Social Aspects of Psychiatric Disability

Visit **http://www.bu.edu/cpr/products/** for a complete listing and descriptions of products available from the Center for Psychiatric Rehabilitation.