INTRODUCTION *to* REHABILITATION READINESS

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THE CENTER FOR PSYCHIATRIC REHABILITATION was established in 1979 in response to the recognition of the need for additional knowledge and skills to help to improve the lives of persons with severe psychiatric disabilities. The center is affiliated with Boston University's Sargent College of Health and Rehabilitation Sciences and is staffed by professionals from many disciplines who have national reputations in the fields of rehabilitation and mental health.

The mission of the center is the development, demonstration, dissemination, and utilization of the new knowledge and technology contributing to the recovery of people with severe mental illness.

The Center for Psychiatric Rehabilitation is supported in part by the National Institute on Disability and Rehabilitation Research and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

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INTRODUCTION

Determining which clients are committed to change and then promoting clients' willingness to engage in a change process is arguably one of the most difficult tasks facing clinicians. Investigators such as Prochaska (1991) and Tsang, Lam, Ng, and Leung (2000) have attempted to use variables such as socioeconomic status, age, gender, and problem characteristics, (e.g., duration, intensity, and type of symptoms) to predict those who will not commit to such a process or who will drop out from therapy. These variables have not proven useful in determining who is ready for therapy and who is not.

In the psychiatric rehabilitation field, the issue of rehabilitation readiness emerges frequently because active client involvement in the rehabilitation is central to the process. Psychiatric rehabilitation is designed to help people with a serious psychiatric disability choose, get, and keep a particular role in the setting that they prefer (Anthony, Cohen & Farkas, 1990). The client-practitioner partnership that is involved in supporting a person's determination of his or her own goal seems to imply that rehabilitation is only appropriate for those clients who function at the highest levels (Anthony, Cohen & Farkas, 1987; Anthony et al., 1990). In other words, many clinicians feel that only high functioning clients are ready to participate in rehabilitation. This perception persists despite solid evidence that psychiatric rehabilitation has been successfully used with individuals with even the most severe psychiatric disabilities (e.g., Shern, Tsemberis, Anthony et al., 2000; Shern, Tsemberis, Winarski et al., 1997). Mental

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health and rehabilitation practitioners routinely restrict opportunities to participate in normal work, educational, residential, and social environments based on the mistaken belief that rehabilitation is not appropriate for their particular client or that their clients are not ready to make use of rehabilitation activities (Cohen, Anthony & Farkas, 1997). Surveys of consumer preferences indicate, however, that most people with psychiatric disabilities do want to participate and feel included in natural community settings (Tanzman, 1993; Rogers, Danley, Anthony, Martin & Walsh, 1994). The process of Rehabilitation Readiness is designed to help consumers feel more confident, aware, and committed to their rehabilitation (Cohen et al., 1997).

Introduction to Rehabilitation Readiness discusses the process of helping an individual assess and develop his or her preparedness for the work involved in psychiatric rehabilitation. It also clarifies common terms used in the field and briefly describes the current state of the field of mental health and rehabilitation. Additionally, it outlines the process of psychiatric rehabilitation (Anthony, Cohen, Farkas & Gagne, 2001) and the concepts involved in the technology for assessing and developing readiness (Farkas, Cohen, McNamara, Nemec & Cohen, 2000; Cohen, Forbess & Farkas, 2000; Cohen, Nemec & Farkas, 2000).

Clarification of Terms

The field of mental health and psychiatric rehabilitation uses a plethora of terms to refer to the nature of the difficulty or problem being addressed by psychiatric rehabilitation, the individual with the difficulty, and the person working with that individual. The variety of terms used creates not only confusion but also polarizes the constituents of psychiatric rehabilitation because the terms often represent a particular philosophical point of view or opinion. For example, some people feel that people with schizophrenia are people who have a "mental illness." Others believe that it is more useful to refer to people as having a "psychiatric experience." Those who believe in using the term *mental illness* feel it is disingenuous and even harmful not to be direct and use the term. Those who believe in using the term *psychi-*

atric experience do not feel that the problems are, in fact, an illness and feel it is short sighted and stigmatizing to not to use the term. The following section clarifies the terms used in this text.

The Nature of the Difficulty Addressed by Psychiatric Rehabilitation

The first terms to be clarified are those that describe the type of difficulties for which psychiatric rehabilitation was designed. Various terms have been used both in mental health/rehabilitation literature and in practice: *psychiatric illness, impairment, psychiatric disability, emotional problems, psychiatric background,* and *psychiatric experience*. The variety of terms indicates varying points of view about the nature of the problem and the extent to which "mental illness" is an illness or a sociopolitical problem (Chamberlin, 1990). This text uses *psychiatric disability,* in preference to other terms when referring to the aspect of the problem which psychiatric rehabilitation addresses. The term *psychiatric disability* does not speak to the issue of the cause of mental illness nor does it imply that a particular psychiatric diagnosis is either correct or useful. In using the term *disability,* rather than *illness,* reference is made to the restriction in functioning experienced by some people with a psychiatric diagnosis of major mental illness or a long term psychiatric experience. The term *impairment* is used to refer to what is typically thought of as psychiatric symptoms or the personal distress related to the psychiatric difficulty or problem.

The Individual with the Psychiatric Disability

The individual with psychiatric "experience" or psychiatric disability is referred to in this text variously as: *consumer, consumer-survivor, client,* or *person*. The terms used reflect both the evolution of the field and the current debate within it. The debate centers on the question of what mode of identification most accurately portrays the individual's actual situation or enhances the individual's potential integration as a valued member of society (Caras, 1994; Fisher, 1994). *Consumer* or *consumer survivor* is a generic term used to refer to the relationship of the individual to the mental health system. The terminology of *con-*

sumer (i.e. one who "consumes" or actively uses services and/or a *survivor,* (i.e., one who has "survived" psychiatric or mental health treatment) invokes the personal experience of the individual. Many, but not all consumer organizations, use these terms. The term *client* is used to refer to someone's role in a specific helping relationship with a practitioner or helper. The term *person, people,* or *individual* is used most frequently in this text as an abbreviated form of the phrase: *person with a psychiatric disability*. It is used to underscore the fact that rehabilitation is interested in the human being across all of his or her roles (e.g., client, consumer, tenant, worker, parent, friend, student).

The Individual Providing Rehabilitation

Blankertz, Robinson, Baron, Hughes, and Rutman (1995) surveyed the psychosocial rehabilitation workforce. The survey showed that 40% of these workers were people who had trained in the "core disciplines" (e.g., psychology, social work, nursing, and psychiatry). The rest had a variety of backgrounds, including rehabilitation counselors, mental health counselors, and paraprofessionals. Increasingly, mental health consumers are being hired as providers of mental health services (Moxley & Mowbray, 1997). Consumer-oriented and consumer-provided services are seen as a fundamental aspect of a progressive mental health system (Anthony, 1994). The inclusion of consumers into the mental health and rehabilitation workforce has been occurring over the past 10 years at every level of service provision—direct service, administrative, and supervisory roles (Zipple, Drouin, Armstrong, Brooks, Flynn & Buckley, 1997).

Given the variety of backgrounds of people providing psychiatric rehabilitation services, generic terms best describe the broadest range of the formal and informal workforce. Most frequently the individual providing rehabilitation services is referred to as *practitioner* or *service provider.* Similar to the term *client,* the term *practitioner* describes a role. Some practitioners are consumer professionals and some are not. This text does not use different terms to refer to practitioners who have consumer experience from those who do not. At times, the term *helper* is used. *Helper* is a more generic term that refers to the fact that not all