Compendium of Activities for

Assessing & Developing Readiness for Rehabilitation Services

Edited by
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In consultation with
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## Contents

*Compendium of Activities for Assessing and Developing Readiness for Rehabilitation Services*

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Overview of Assessing and Developing Readiness</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td><strong>Section 1</strong> Activities for Orienting a Person to Psychiatric Rehabilitation Services</td>
<td>9</td>
</tr>
<tr>
<td>17</td>
<td><strong>Section 2</strong> Activities for Assessing Readiness for Rehabilitation Services</td>
<td>17</td>
</tr>
<tr>
<td>41</td>
<td><strong>Section 3</strong> Activities for Developing Self-Awareness</td>
<td>41</td>
</tr>
<tr>
<td>59</td>
<td><strong>Section 4</strong> Activities for Developing Awareness of Alternative Environments</td>
<td>59</td>
</tr>
<tr>
<td>73</td>
<td><strong>Section 5</strong> Activities for Mobilizing Support for Participation in Rehabilitation Services</td>
<td>73</td>
</tr>
<tr>
<td>79</td>
<td><strong>Section 6</strong> Activities for Personalizing Accomplishments</td>
<td>79</td>
</tr>
<tr>
<td>83</td>
<td><strong>Appendix</strong> Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s—William A. Anthony</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>Recovery: The Lived Experience—Patricia E. Deegan</td>
<td></td>
</tr>
<tr>
<td>103</td>
<td><strong>References</strong></td>
<td>103</td>
</tr>
</tbody>
</table>
Introduction

Purpose of the Compendium
This compendium is designed as a collection of activities that can be utilized with persons with long-term psychiatric disabilities in psychiatric centers or in outpatient settings (e.g., continuing day treatment and intensive psychiatric rehabilitation treatment programs). Each activity is outlined in a step-by-step fashion. This is not intended as a training manual on how to design or conduct readiness activities. Rather it is a tool to be used by practitioners who have received training in how to assess and/or develop rehabilitation readiness and are skilled in conducting group activities. Untrained practitioners should receive training in the assessing and developing readiness technology developed by the Center for Psychiatric Rehabilitation before attempting to lead the activities contained in this compendium.

How the Compendium was Developed
This compendium of activities for assessing and developing a person’s desire to participate in rehabilitation services was developed from activities designed by the psychiatric rehabilitation teams in the New York State psychiatric centers. Each team spent considerable time developing the activities for the production of this compendium. The format of the activities submitted by the teams varied in style. Therefore, it was necessary to format and edit all the activities before including them in this compendium. The following is a list of the psychiatric centers that contributed activities for this compendium and the project directors at the centers:

- Binghamton Psychiatric Center
  425 Robinson Street
  Binghamton, New York 13901
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- Bronx Psychiatric Center
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Elmira, New York 14902
Project Director: Barbara Nikolovska

Harlem Valley Psychiatric Center
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Wingdale, New York 12594
Project Director: Paul Margolies, Ph.D.

Hudson River Psychiatric Center
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Poughkeepsie, New York 12601–1197
Project Director: Paul Margolies, Ph.D.

Hutchings Psychiatric Center
Box 27, College Station
Syracuse, New York 13210–0027
Project Director: Jomel Lawless

Kingsboro Psychiatric Center
861 Clarkson Avenue
Brooklyn, New York 11203–2199
Project Director: Cheryl Doby-Copeland

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Kings Park, New York 11754–9000
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Kirby Forensic Psychiatric Center  
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Ward’s Island, New York 10035  
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New Hampton, New York 10948–0158  
*Project Director: Ahmed L. Sawi, M.D.*

Mohawk Valley Psychiatric Center  
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*Project Director: Edward Narenkivicius*

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*Project Director: Verna Belotti*

Rochester Psychiatric Center  
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Rochester, New York 14620  
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Rockland Psychiatric Center  
Orangeburg, New York 10962  
*Project Director: Anthony Salerno*

South Beach Psychiatric Center  
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Staten Island, New York 10305  
*Project Directors: Harvey Lieberman, Ph.D. and Fran Goldberg*

St. Lawrence Psychiatric Center  
Station A  
Ogdensburg, New York 13669  
*Project Director: Harry Clarke*

Willard Psychiatric Center  
Willard, New York 14588  
*Project Director: Carmen Goddard*
How the Compendium is Organized
The compendium of activities is organized into six sections:
• Activities for orienting a person to psychiatric rehabilitation services,
• Activities for assessing readiness for rehabilitation services,
• Activities for developing self-awareness,
• Activities for developing awareness of alternative environments,
• Activities for mobilizing support for participation in rehabilitation services; and
• Activities for personalizing accomplishments.
Each section begins with an orientation that describes the activities in the section, the purpose of the activities and the persons who can best benefit from participation in the activities.

Format of the Activities
Each activity is presented in a format detailing what, why, when, where, and how the activity is to be conducted. The what is a definition of the activity. The why is an explanation of the benefits of participating in the activity and the anticipated outcomes of the activity. The when describes the frequency and duration of the activities, and the where describes the preferred physical setting for the activity. Each activity is intended to occur in one or more sessions. The how presents a series of steps to be performed by the activity leaders when conducting the activity. For some of the activities a description of the who is also included, specifying the preferred characteristics and number of participants. Many of the activities include handouts to be given to the participants or information to be written on a flipchart or blackboard. The handouts can be reproduced from masters provided in this book. Master handouts for an activity are included after the how section of the activity presentation.

Use of the Activities
Although the activities were originally developed and conducted in psychiatric centers, they have been revised to be able to be conducted in community settings (e.g., outpatient services) as well in inpatient settings. The original focus of the activities was on preparing patients for their discharge from the psychiatric centers to community residential environments. Therefore, some of the activities have a strong residential focus. Where possible, the environmental focus has been expanded through the use of language that refers to educational, vocational, and social environments as well as residential environments. The activities which still focus only on residential environments (e.g., Increasing Awareness about Residential Values), can be adapted by the activity leader for use with participants who are focusing on other types of environments.
Overview of Assessing and Developing Readiness

The key factor in the successful participation of a person in psychiatric rehabilitation services is the person’s desire for rehabilitation. Rehabilitation has been described as a service that must be done with a person never to a person. Therefore, it is essential to determine a person’s desire for rehabilitation before providing rehabilitation services, and if necessary engage the person in activities to develop their readiness.

A readiness assessment determines a person’s current level of interest in setting and achieving self-determined rehabilitation goals. The purpose of assessing readiness is to determine whether an individual is prepared to participate in psychiatric rehabilitation services. It is also used to identify those areas of readiness that need further development. Based on the results of this assessment, an individual could either begin using psychiatric rehabilitation services, choose to use alternative mental health services, or decide to participate in activities that develop his or her readiness for rehabilitation. Personal and environmental factors can influence a person’s readiness for rehabilitation. Individuals cannot benefit from rehabilitation services if they do not feel a need for rehabilitation, if they do not perceive change as desirable or possible, or if their awareness of themselves and the community is too limited to make informed decisions. These individuals may choose to participate in developing readiness activities, engage in self-help or peer-support activities, use other mental health services, or choose to be left alone for awhile.

Cohen, Farkas, and Cohen (1992) describe a series of activities for assessing a person’s readiness for rehabilitation services. The following description of the five dimensions of

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rehabilitation readiness is excerpted from the training technology developed by Cohen, Farkas, and Cohen (1992):

**Need for Change**

Need for change may be internally or externally motivated. An example of external motivation would be a patient who is being discharged from a psychiatric hospital because his or her treatment team feels the individual doesn’t need inpatient treatment services. An example of internal motivation would be an individual who is dissatisfied with his or her current housing and wants to move to an independent apartment. A high rating for need results from a person being very dissatisfied with his or her current environment(s) and/or others in the person’s environment expressing an urgent need for the person to either change or leave because she or her is perceived as unsuccessful in the environment.

**Commitment to Change**

Commitment to change is the person’s belief that change is necessary, change is positive, change is possible, and change will be supported. A high rating for commitment to change results from the person possessing all four beliefs about change.

**Environmental Awareness**

Environmental awareness is the amount of knowledge a person has about actual residential, educational vocational and/or social environments, especially the specific characteristics of the place, people, and activities in the environment. A high rating for environmental awareness results from the person being able to talk about past environments and future alternative environments, describing in detail the people, the place, and the activities in a particular environment.

**Self-Awareness**

Self-awareness is the amount of knowledge a person has about the characteristics he or she liked and disliked in various environments in which he or she has been, and his or her personal values. A high rating for self-awareness results from a person describing his or her personal experiences and values without prompting, and having prior experiences choosing places to live, learn, work, and/or socialize.

**Closeness to Practitioner**

Closeness to the rehabilitation practitioner is the degree to which the person wants to engage in a long-term relationship with the practitioner. A high rating on closeness to the practitioner results from the person trusting the practitioner.
The main purpose of activities that develop a person’s readiness for rehabilitation services is to improve the person’s rating on the dimensions in which he or she scored low during the readiness assessment. Higher scores on these readiness dimensions reflect an increase in the person’s interest in engaging in a process of changing his- or herself and his or her environment. Many people with long-term psychiatric disabilities have given up hope. They have been expected to want little and have lost their dreams and sense of personal purpose. Developing readiness for rehabilitation is designed to empower a person to believe that he or she can improve his or her life.

In a training technology developed by Cohen and Forbess (1992), they describe five activities that facilitate the development of readiness for rehabilitation:

**Processing Readiness**
Processing readiness develops a person’s conscious awareness of his or her interest in participating in rehabilitation services. This activity focuses on reviewing the results of the readiness assessment. It is most often done right after completion of the readiness assessment. The activity results in an understanding of the person’s reactions to the readiness assessment and subsequent thoughts about the “next steps.”

**Choosing a Direction**
Choosing a direction involves the person deciding how to proceed with rehabilitation. The alternative directions explored are: participation in rehabilitation services; participation in activities which develop readiness for rehabilitation, participation in other mental health services; participation in self-help and peer support activities; continued connecting with the practitioner, or to be left alone for now.

**Developing Awareness**
Developing awareness expands the person’s understanding of his or her self, mental illness, potential for recovery, environments, and rehabilitation services. A variety of activities that increase the person’s exposure to particular subject areas are conducted. The desired outcomes are an increase in information and a change in attitude about the future.

**Mobilizing Environmental Supports**
Mobilizing environmental supports enlists the help of significant others in stimulating the person’s interest in rehabilitation. Significant people in the person’s life (e.g., spouse, friends, family members) are asked to encourage the person’s belief in rehabilitation. The desired outcome is
that the person is told that he or she will receive active support for participation in rehabilitation services.

**Personalizing Accomplishments**
Personalizing accomplishments develops the person’s recognition of the personal meaning of his or her recent achievements. Personalizing accomplishments focuses on creating experiences in which the person experiences a challenge doing something she or he did not think was possible. The practitioner assists the person in selecting, completing, and processing a personally meaningful action. The outcome is that the person feels increased self-confidence and self-efficacy.
SECTION ONE contains activities that are designed to explain psychiatric rehabilitation services to participants. Specifically, the personal benefit of participating in rehabilitation services, and the service activities, are described. The desired outcome of these activities is that the participants become interested in learning more about rehabilitation services.

The main focus of these activities is to increase participants’ understanding about how rehabilitation is different from other mental health services. It is important for participants to understand the difference between treatment and rehabilitation services. Using analogies of physical treatment and physical rehabilitation is useful. The facilitator must present rehabilitation services as based on both common sense and research literature.

It is recommended that an orientation activity (Activity 1.1 or 1.2) be conducted right after admission or intake, or frequently thereafter. The activities are designed to answer questions such as “How can you help me?” and “What goes on here?”
Activity 1.1

Group Orientation to Psychiatric Rehabilitation Services

▼ What?
Group activity designed to orient new consumers to psychiatric rehabilitation services as an essential provider of assistance.

▼ Why?
To increase participants’ awareness about alternative mental health services, rehabilitation services, and the difference between treatment and rehabilitation services.

▼ When?
Group meetings held weekly, for one hour. This is a recurring activity. Participants should be encouraged to attend the activity soon after intake.

▼ Where?
Large conference-style room with the chairs set up in a large circle. A blackboard or overhead projector may be used for presentations and demonstrations.

▼ How?
1. Orient the participants to the goal of the activity.

2. Ask the participants to introduce themselves and describe their experience with rehabilitation services.

3. Elicit from the participants their initial list of topics that they would like to know more about.

4. Introduce and define the basic services provided in mental health systems, i.e., basic support, treatment, rehabilitation, and enrichment using Handout 1.1.

5. Discuss the purpose of each service and give specific examples of how each service helps consumers using Handout 1.2.

6. Elaborate on the differences between treatment and rehabilitation using Handout 1.3.

7. Elaborate on examples of the rehabilitation activities currently being conducted in your setting to develop readiness, set self-determined goals, assess skills, and learn skills. (It is important here to have current consumers of rehabilitation services share their experiences of participation in rehabilitation).
8. Explain the benefits of participating in the activities in your setting and the steps for requesting participation in the activities. Give the participants literature that describes your rehabilitation program.

9. Summarize the session by requesting feedback from participants and answering their specific questions about rehabilitation services.
<table>
<thead>
<tr>
<th>Services</th>
<th>Basic Support</th>
<th>Treatment</th>
<th>Psychiatric Rehabilitation</th>
<th>Enrichment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission</td>
<td>Basic support maintains and/or gains for consumers the things required for survival.</td>
<td>Treatment decreases consumers’ emotional distress and symptoms of illness.</td>
<td>Psychiatric rehabilitation increases consumers’ success and satisfaction in environments of their choice with the least amount of professional help.</td>
<td>Enrichment maintains and increases a satisfactory quality of life for consumers.</td>
</tr>
<tr>
<td>Focus</td>
<td>Providing the things required for survival.</td>
<td>Reducing symptoms.</td>
<td>Developing skills and supports.</td>
<td>Enjoyment and self-development.</td>
</tr>
</tbody>
</table>
| Activities | • Financial support  
• Providing shelter  
• Meals  
• Health care  
• Protecting physical safety | • Psychiatric diagnosis  
• Treatment planning  
• Psychotherapy  
• Chemotherapy | • Setting an overall rehabilitation goal  
• Functional assessment  
• Resource assessment  
• Rehabilitation planning  
• Skills teaching  
• Skills programming  
• Resource coordination  
• Resource modification | • Socialization  
• Continuing education  
• Health promotion  
• Leisure-time activities |

### Handout 1.2

#### How Key Services Help Consumers: An Example

<table>
<thead>
<tr>
<th>Service</th>
<th>Example of How Service is Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>Reduces the discomfort of symptoms.</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Assists in choosing satisfying residential, educational, vocational, and social environments and developing the skills and supports needed for success and satisfaction.</td>
</tr>
<tr>
<td>Enrichment</td>
<td>Reduces stress of being a recipient of mental health services by improving the quality of life.</td>
</tr>
<tr>
<td>Basic Support</td>
<td>Provides comfortable housing, food, clothing, and medical services.</td>
</tr>
<tr>
<td>Traditionally Perceived Differences between Rehabilitation and Treatment</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Mission</strong></td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Improved functioning and satisfaction in specific environments</td>
</tr>
<tr>
<td><strong>Underlying causal theory</strong></td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>No causal theory</td>
</tr>
<tr>
<td><strong>Focus</strong></td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Present and future</td>
</tr>
<tr>
<td><strong>Diagnostic content</strong></td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Assess present and needed skills and supports</td>
</tr>
<tr>
<td><strong>Primary techniques</strong></td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Skills teaching, skills programming, resource coordination, resource modification</td>
</tr>
<tr>
<td><strong>Historical roots</strong></td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>Human resource development, vocational rehabilitation, physical rehabilitation, client-centered therapy, special education and learning approaches</td>
</tr>
</tbody>
</table>