

Assessing and Developing Readiness for Psychiatric Rehabilitation

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Introduction by the column editors:

Clinicians face a difficult dilemma when they are asked to evaluate an individual's disability status. On one side they face the Scylla of the Social Security Administration and its demand that those with serious mental illness be "permanently disabled" to be eligible for benefits. These benefits may make the difference between consumers living independently in the community, living marginally on general relief, or being institutionalized. On the other side lurks the Charybdis of stigmatization and disincentives for rehabilitation. Once individuals receive SSI or SSDI benefits, they may identify themselves as "sick" and may become unwilling or unable to proceed to financial independence.

The challenge for rehabilitation practitioners is to use the outdated perspective of conventional psychiatric thinking—that those with serious mental illness are by definition permanently disabled—to obtain the necessary benefits for their clients while keeping their eyes and the eyes of the client on the prize of rehabilitation and recovery. These tasks require practitioners to be

willing to engage clients wherever they may be along the continuum of rehabilitation. Given the numerous barriers to rehabilitation (1), developing rehabilitation readiness is a necessary but frequently forgotten step between disability and rehabilitation. In this month's column, Mikal R. Cohen, Ph.D., and her colleagues emphasize the importance of engaging the active participation of the client in a motivational process leading toward "rehabilitation readiness."

One of the harshest pronouncements professionals make to people with severe psychiatric disabilities and their family members is some variation of the following phrase: "You are not ready for rehabilitation." With that shibboleth, people who want rehabilitation services can be rejected or banished from rehabilitation programs. The implicit directive to the potential client is to somehow "get ready." In the meantime, opportunities to participate in normal work, educational, residential, and social environments are restricted.

In contrast to this traditional dogma is the correct assumption that all people who show an interest in rehabilitation services are ready for rehabilitation. Unfortunately, it is the programs that are often not ready for the clients (2). People differ in their rehabilitation readiness just as they differ in their readiness for college, for a physical fitness program, or for a vacation. It is up to practitioners to help potential recipients of rehabilitation services determine their level of readiness so that when rehabilitation

interventions are made, they begin where the person is, rather than where the program is.

Survey after survey of consumer preferences has indicated that most people with psychiatric disabilities want to participate and feel included in natural community settings (3). The technology of rehabilitation readiness is designed to help consumers feel more confident, aware, and committed to their rehabilitation (4). The New York State Office of Mental Health has made the assessment and development of rehabilitation readiness an expected service provided by state hospitals and continuing day treatment centers and a Medicaid-reimbursable service in intensive psychiatric rehabilitation treatment programs (5).

Assessing readiness for rehabilitation

Readiness is a reflection of consumers' interest in rehabilitation and their self-confidence, not of their capacity to complete a rehabilitation program. Persons who are ready for rehabilitation are minimally ready on six dimensions. They perceive a need for rehabilitation to help them pursue their life goals, view change as desirable, and are open to establishing relationships. They also have sufficient understanding of themselves, can meaningfully interact with their environment, and have significant others who encourage their participation in rehabilitation services.

The purpose of assessing readiness for rehabilitation is to make clear the level of the consumer's commitment to participating in rehabilitation ac-

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tivities at a given point in time. The assessment is also used also to identify dimensions of readiness that need further development.

The skills the practitioner uses to involve consumers in assessing their own readiness include gathering relevant information, rating the consumer's readiness on each of the six dimensions, processing the results of the readiness assessment with the consumer, and choosing a direction for use of services (6). Readiness for rehabilitation is usually assessed before the consumer enters a rehabilitation program. However, readiness for rehabilitation is not a stable characteristic, and thus assessments should be repeated periodically.

Developing readiness for rehabilitation

The task of developing readiness for rehabilitation lies in creating learning experiences that, when they are understood by consumers, are likely to encourage their participation in rehabilitation services. Developing readiness activities begins only after consumers have processed the results of their readiness assessments, have understood their ambivalence toward rehabilitation, and have chosen to participate in activities designed to develop readiness. The practitioner and consumer jointly orchestrate a change process directed toward enhancing readiness on the dimensions that received low ratings.

To develop rehabilitation readiness, consumers and practitioners work together to organize motivational activities that produce incentives and new personal insights and that clarify the personal implications of those insights for decisions about whether to participate in a rehabilitation program. Also, the practitioner demonstrates to consumers that they will receive credible support from significant others if they participate in rehabilitation.

Developing readiness for rehabilitation is usually a cumulative process. Subtle changes in the consumer's commitment to rehabilitation occur only after the consumer has gained numerous insights both from planned motivational activities and from naturally occurring experi-

ences and has realized that significant others will provide reliable backing if the consumer participates in rehabilitation.

A case example

Maria was a 24-year-old, single woman living in a group home for persons with psychiatric disabilities. Maria had dropped out of college because of a series of psychiatric hospitalizations, the first of which occurred when she was 19. She was discharged to live in the group home after her last hospitalization. Her diagnosis was schizophrenia, paranoid type.

Maria worked for a while in the clerical unit at a psychosocial clubhouse but was bored and dropped out. Although she continued to participate in the social aspects of the clubhouse, she felt aimless and restless. She worked as a volunteer for a few hours every week in the neighborhood library and spent the rest of her time browsing in bookstores. Maria felt hopeless and felt that something had to change. She was sure that if she could pinpoint a direction for either getting a job or going back to school, her life would improve.

She was unclear about different types of academic programs that might be options for her because she had chosen the college she attended based on her parents' recommendation. She knew she liked her science courses but did not know why. She had no idea about job possibilities available without a college degree. She was depressed about the loss of her friends and her identity as a student—in short, about the loss of the last five years of her life while she had been in and out of hospitals. Her parents were worried that Maria would get lost in the mental health system and not fulfill her potential. Maria believed that her parents wanted to help her. She was beginning to receive services at a continuing day treatment program.

Overall, Maria was moderately ready to make a commitment to participate in a vocational rehabilitation program. She had perceived the need for rehabilitation. She was dissatisfied with her lack of a full-time voca-

tionary or educational program. Her parents also wanted to see Maria develop a career. Maria had some resolve to change but strongly lacked the belief that change was possible. She had a strong positive orientation toward relationships and participated in the social aspects of the clubhouse. Her sadness at the loss of her old friends indicated that she, in fact, preferred being connected to others over being isolated.

Maria's self-awareness was minimal, and she could only vaguely describe her experiences at school and at work. Similarly, Maria's environmental awareness was limited to her knowledge about the school program she had attended and the few jobs she had held. However, Maria did have the strong support of her parents for rehabilitation.

After completing a readiness assessment and processing the results, Maria and her practitioner agreed that they would pursue two tracks. During the next three months the practitioner would help Maria further develop her readiness for rehabilitation, especially her resolve to change, her self-awareness, and her environmental awareness. Simultaneously, they would start exploring different vocational rehabilitation services that Maria could begin to use in three months.

Maria and her practitioner agreed to focus first on enhancing Maria's resolve to change. They began by defining her need to understand that change could be both positive and possible. Together they chose a task whose completion would signify to Maria that she had made a meaningful personal change—working part-time in her parents' store for two weeks without having an emotional blow-up with them.

Maria and the practitioner developed a detailed plan to ensure that the action would occur. The practitioner elicited specific commitments from Maria's parents to enable Maria to complete the task: they agreed to give her daily positive feedback on her work behavior. Frequently during Maria's work toward this personal accomplishment, the practitioner met with her to summarize her experience, help her to conceptualize the

insights and awareness she gained from the experience, and help her to state the implications of her insights for her decision about whether to enter a vocational rehabilitation program. With support Maria completed the task. Afterward she acknowledged learning that she could restrain the expression of her angry feelings and that other changes in her life were possible.

Research

The concept of readiness has been studied in several projects at the Center for Psychiatric Rehabilitation. One is an experimental study designed to assess the effectiveness of a highly individualized, rehabilitation-oriented, supported housing approach (Felton C, unpublished data, 1996). Clients were randomly assigned to a treatment or a control condition. Ninety-one people who were severely mentally ill and lived on the streets were assigned to the rehabilitation condition (7). As part of the intervention, rehabilitation readiness was assessed regularly.

Each subject in the experimental condition whose overall rehabilitation readiness was assessed at least once (76 of 91 subjects) received an overall readiness score, calculated as the average of all individual overall readiness ratings. Overall readiness was significantly related to two housing outcomes—time spent on the streets and time in community housing. Individuals with higher readiness scores spent less time on the streets ($r = -.318$, $p < .01$) and more time in community housing ($r = .413$, $p < .01$).

A second investigation was an experimental study of two types of vocational interventions (Rogers S, Martin R, Danley K, unpublished data, 1996). Before random assignment, all potential subjects participated in groups designed to help them make an informed decision about their readiness to participate in the rehabilitation interventions. Results indicated that subjects who discontinued participation on their own before random assignment to study groups scored at a lower level of readiness to change than those who decided to enter the study.

Afterword by the column editors: Incorporating their many years of experience in psychiatric rehabilitation, the authors have developed a rehabilitation readiness technology (6) and a compendium of readiness development activities (4) to help mental health settings of all types overcome the barriers encountered by individuals attempting to benefit from rehabilitation services. As the authors note, the purpose of a readiness assessment is not to label or exclude people from participation in rehabilitation services, but rather to help the person decide whether to actively participate in rehabilitation activities at this time and if needed to engage in activities to become ready to participate.

Future work in this field may include expanding the definition of rehabilitation readiness from "desire to work" to include the idea of "capacity for work" as well as exploring the relationship between these two concepts and variables such as psychopathology, social functioning, work history, and disability status. A possible direction is to examine whether receiving Supplemental Security Income or Social Security Disability Insurance serves as a disincentive for rehabilitation readiness. For example, a growing body of evidence suggests that cognitive dysfunctions—such as negative symptoms and problems with sustained attention and verbal learning—may be important in predicting social and vocational functioning (8). If these

findings can be confirmed, new technologies such as cognitive remediation, focused behavior therapy and atypical antipsychotic agents which target some of the putative causes of poor rehabilitation readiness, may enhance rehabilitation outcomes. ♦

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