Running head: IPRT Attendance

# Intensive Psychiatric Rehabilitation Treatment Attendance

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Table of Contents

## Abstract

An exploration of data gathered from the intake process at an Intensive Psychiatric Rehabilitation Treatment (IPRT) Program in New York State looked for possible relationships between consumer characteristics and attendance drop off during the second month of a two-month class cycle. A review of literature was followed by reporting the analysis of data collected. Several findings point to further exploration such as the impact of substance use disorders on attendance. Another area for future exploration is validation of the Rehabilitation Readiness Determination Scale used in the intake process. This scale was originally developed for people with schizophrenia and schizoaffective disorder and the population now being served at the Focus Program has a diagnosis of mood disorders.

# Intensive Psychiatric Rehabilitation Treatment Attendance

The focus of this study is on the exploration of possible causes or relationships for attendance drop off in one Intensive Psychiatric Treatment Program (IPRT) and Employment Services Program in Western New York State, hereafter referred to as Focus Program.. Attendance affects reimbursement for services, staff morale, consumer morale, and most importantly, can impede consumers in reaching their self-selected and defined goals toward a more meaningful life. IPRT serves people with severe and persistent mental illness (SPMI) diagnoses. Rather than exploring all aspects of the program from initial assessment and admission to planning and interventions, this research looked only at selected information gathered in the intake process to explore any possible factors contributing to attendance issues. Although the research itself was limited to information gathered in the admission process, the review of literature extends beyond a review of readiness assessment in admissions to include the role and experience of family, friends, and mental health professionals in psychiatric rehabilitation, policy issues, and interventions.

As defined by Anthony (1993, p.12), the vision of psychiatric rehabilitation in the 1990's emphasized treating the consequences of mental illness rather than just the illness itself. According to Anthony, recovery then evolved into "a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness". Anthony further explained that recovery can occur without complete relief from symptoms and is measured by the individual, not the mental health professional. Successful recovery is subjective and is based on self-esteem, empowerment, and self-determination (1993). Anthony is the director of the Psychiatric Rehabilitation Center at Boston University, where technology for psychiatric rehabilitation was developed and subsequently informed the creation of IPRT in New York State in 1992 (Lamberti, Melburg, Madi, 1998).

In 1987, New York had three times the number of inpatient psychiatric beds than any other state in the nation and also had the fastest rate of deinstitutionalization. With the influx of people with SPMI into communities, services needed to be developed to help them integrate back into society. The purpose of IPRT, was to "assist persons with serious and persistent mental illness in identifying and achieving personally meaningful goals within the community" (Lamberti, 1998, p.212). Consumers with a primary diagnosis of chemical dependency or developmental disability were excluded from admission. Twelve programs were initially launched in 1992, with a focus on vocational and educational goals and settings. The program today has expanded beyond vocational and educational goals to include goals in one's social and living spheres.

The Focus Program is one 58 IPRT programs statewide (Lamberti, 1998). The guiding principle from the inception of IPRT to present day is the central role of the client as choice and decision maker. Briefly, Lamberti (1998, p. 212)) described the process as "Diagnosis - Planning – Intervention" (p. 212). He explained that the diagnosis step included readiness assessment, goal setting, functional assessment, and resource assessment. In the planning step, skills were prioritized and responsibilities were assigned. The intervention step included skill teaching, skill programming, resource coordination, and resource modification (1998, p.213).

New York State IPRT programs, licensed by the Office of Mental Health, stand alone, but alongside continuing day treatment programs, partial hospitalization programs, and outpatient mental health clinics. The average length of stay in an IPRT program is 12 months with 24 months as the usual maximum (Lamberti, 1998; , "Medicaid Requirements for OMH-Licensed Outpatient Programs").

The admissions process begins with a referral from the consumer's therapist/counselor/psychologist in which the diagnoses and reason for the referral are noted.

Readiness to change is measured by the Rehabilitation Readiness Determination Scale (RRDS) that the practitioner uses to complete the Summary of Determination for Readiness from an interview between the practitioner and the consumer (Lamberti, 1998). (See Appendix A for RRDS and Appendix B for Summary of Determination for Readiness.) Lamberti described the RRDS as a tool to assess the need to make a change as determined by the extent to which the consumer feels successful and satisfied in his or her situation, and also, whether the consumer feels a need to make any changes. The second factor is assessing the consumer's commitment to change. Through discussion, it is determined to what extent the consumer is motivated to begin working on making changes and whether the consumer believes that change is possible, would be beneficial, and supported by important others in the consumer's life. Self awareness, the third area of assessment, looks at the consumer's level of self understanding by the degree to which the consumer can express his or her likes and dislikes, preferences, and values. The fourth area of assessment is environmental awareness that includes the consumer's level of knowledge about the community and options that are available. The fifth area assesses the consumer's personal closeness. The practitioner looks at the consumer's ability to engage with and work productively with the rehabilitation practitioner and other support persons. Each factor is scored on a scale of one to five, and overall readiness score is determined from the five areas. To be admitted, a consumer needs to have an overall score of "3" or higher (Lamberti, 1998).

Iowa is the only other state in the United States to offer IPRT Programs and bases their model on New York State's (Ellison, 2002). Iowa retained the basic principles of psychiatric rehabilitation, and in addition, they worked with managed care to develop measurements and accountability, as well as a six-month readiness program for those consumers who are not quite ready, as assessed by the Readiness Determination Scale to being ready to choose goals (Ellison, 2002). No published studies were found that measure readiness and attendance outcomes

specific to IPRT programs, only overviews of the New York State and Iowa programs. (Ellison, 2002; Lamberti, 1998). Demographics comparing consumers in Iowa to a selected sample from 14 programs in New York State and the Focus Program, as noted in Table 1. Of particular interest is the difference in the number of consumers diagnosed with schizophrenia or schizoaffective disorder. Iowa and the New York sample show similar percentage of consumers with schizophrenia or schizoaffective disorder at 44.3% and 46% respectively. The Focus Program shows just 11.5% with schizophrenia/schizoaffective disorder. In addition, The Focus Program shows more females than males in the program and an overall lower education attainment.

Table 1

*Demographic Comparison Between New York State, IOWA, and The Focus Program*

| | NY State N=114 | | Focus Program N=61 | Iowa N=364 | |
|---|---|---|---|---|---|
| Female | 54% | | 70.10% | 54.3% | |
| Age | Mean 38 SD=8.78 | | Mean 40.1 SD=10.5 | | |
| Diagnosis Axis I | | | | | |
| Schizophrenia | 46% | | 11.5% | 44.3% | |
| Major Depressive Disorder | 25% | 41% | 81.9% | 37.3% | |
| Bipolar Disorder | 16% | | | | |
| Anxiety Disorder | 8% | | 29.5% | | |
| Other | 5% | | | 37.4% | |
| Drug or Alcohol Abuse | 29% | | | 17.2% | Current abuse |
| Axis II | N/A | | 31.1% | | |
| SSI/SSDI | 83% | | 31.1% | | |
| Mental Retardation | N/A | | N/A | 13.80% | |
| Highest Grade Completed | | | Mean 13.6, SD=2.97 | Mean =21.4, SD=11.8 | |
| Age at first hospitalization | | | N/A | Mean=21.9, SD=8.8 | |
| Completed IPRT Program* | 27% | | N/A | | |

* IPRT Completion Rate statewide = 26%

Screening for readiness and attendance issues were addressed in a variety of programs and with various instruments. See Appendix C, Studies on Readiness Instruments, for an overview of these programs and instruments. Reviews covered programs for chemical dependency using the University of Rhode Island Change Assessment Scale, (Blanchard, 2003;

Heather, 1999; Miller, 1996); veterans with posttraumatic stress and substance use disorders (Rosen, 2001); consumers with dual diagnosis (Addington, 1999; Hilburger, 1999; Pantalon, 2003); consumers with eating disorders (Geller, 2001), and consumers with schizophrenia (Addington, 1999; Hilburger, 1999; Smith, 1998). Of those noted, only two studies used an interview to measure readiness (Geller, 2001; Smith, 1998). Geller (2001) was able to predict drop out and recovery problems for individuals with eating disorders by using the Readiness Motivation Interview (RMI). Although consistent with other study outcomes, this study was a first step in establishing validity and utility in using a comprehensive measure of readiness in assessing the need for change in individuals with eating disorders. An aspect of this study revealed that individuals were thought to be more forthcoming about their eating disorder with the interviewer than with their practitioner. The authors note that this may impact the interview's usefulness if the practitioners use it directly with their clients.

The second study utilizing an interview to determine readiness focused on 25 individuals with schizophrenia or schizoaffective disorder (Smith, 1998). The Rehabilitation Readiness Determination Profile (RRDP), described earlier, is currently mandated for use in New York State IPRT programs (Lamberti, 1998; , "Medicaid Requirements for OMH-Licensed Outpatient Programs"). Smith, et al (1998) described this interview as unique in that it captures the subjective experience of consumers across five scales. Also of note is that interviewers in this study underwent 24 hours of classroom instruction, performed discrimination exercises, and made audio and video tapes of clinical trials. To ensure consistency among interviewers, 13 interviews were videotaped and rated by a second interviewer. Interviews generally lasted from one hour to one and half hours.

*History and Stigma*

Historically, people with mental disorders were locked up, shunned, reviled, considered morally defective, and at times put to death (Simon, as cited in Corrigan, 2002; Garske & Stewart, 1999). Before the 18th century, people with mental illness usually received brutal and inhumane treatment. Starting in the 18th century, asylums with more humane conditions and treatment centers were established and physical explanations for mental illness were advanced ("History of Mental Illness"). Society continued to view people with mental illness as bizarre, scary, dangerous, irresponsible, and childlike (G. Garske, & Stewart, J., 1999). Myths about mental illness suggested a variety of causes: bad parenting, or early life trauma, weak character, punishment from God, or possession by the devil and that mental illness is lifelong (Garske, 1999). Similar attitudes can be found today in Hong Kong where families are blamed and shamed for having a family member who is mentally ill, but the effect is more exaggerated in a culture where the collective identity of families prevails. (Tsang, Tam, Chan, Cheung, 2003).

During institutionalization, patients often had little or no contact with their families. Many were thought to be successful when they could finally repeat after a hospital staff member "I am a schizophrenic", or "I am a bipolar". Patients were often heavily medicated rather than being helped to develop other coping mechanisms for stress (Deegan, 2005). Hospital staff discouraged patients from thinking they could have a normal life with a job and a place to live, believing they were doing the best thing for the patient to help them avoid another failure (Deegan, 1996). Hope was often extinguished by well-meaning staff (Deegan, 1996b). Decisions about patient's treatment were in the hands of professionals with little client involvement. Some patients learned a sense helplessness.

In one story of resilience, a former Marine Officer was hospitalized after the stress of providing security for atomic weapons. He subsequently went on to work for a Fortune 500

company, but was rehospitalized with delusions at which time a young psychologist told him he could become a professional someday if it weren't for his illness. He went on to earn his PhD in psychology and became licensed and director of psychology at Western Reserve Psychiatric Hospital for 15 years until retirement (Freese & David, 1997).

Deinstitutionalization in the United States began in the 1950's following World War II. Because of their success in treating war veterans, psychiatrists looked optimistically at treating mental disorders outside of hospitals (Grob, 1995). Additional contributing factors in deinstitutionalization include poor but costly conditions of institutionalized care, the long term effects of hospitalization and a growing awareness that civil rights of people with mental illness were being violated ("History of Treatment"). The development of chlorpromazine was introduced to treat people with schizophrenia in the early 1950's, and was the first medication to give hope in managing symptoms of schizophrenia ("History of Treatment"). Also in the 1950's the National Institute of Mental Health was founded ("Deinstitutionalization"; Gorb, 1995). Mass deinstitutionalization began in the 1970's, and Grob (1995), states that a network of community mental health centers was established, and legislation enacted provided services for substance abusers. Grob continued the historical view and described the advent of federal entitlement programs such as SSDI, SSI, Medicaid, and Medicare that served to assist those with mental illness. For a more detailed overview of political, policies, and demographic issues in mental health from post World War II, see Grob (1995).

An historical look at mental illness exposed the roots of current attitudes and barriers to people recovering from mental illness today. Stereotypes abound about mental illness which continue to cause fear, shame, and hopelessness (Corrigan, Watson, Barr, 2006). Internalized stigma changes a person's inner dialogue, altering their self perception to fit that of the stereotype (Caltaux, 2003). In conforming to the stereotype, the person with mental illness

changes how they think, feel, behave, and interact with others and thus contributing to diminished self-esteem (Caltaux, 2003; P. Corrigan, Watson, A., Barr, L., 2006; Link, 2001). In Fenton, Blyer, & Heinnssen (1997), when consumers internalize stigma, it affects their behavioral goals and they may not follow empirically validated interventions (P. Corrigan, Watson, A., Barr, L., 2006).

In exploring empowerment in the face of stigma, stereotypes, and diminished self-esteem, the effects of language must be considered (W. Corrigan, 2002; G. Garske, 1999), as well as practitioners interactions with consumers (W. Corrigan, 2002; Linhorst, 2002), and external barriers (Corrigan, 2002) . When practitioners refer to clients as "schizophrenics" or "manics" rather than as people, a person is diminished (G. Garske, & Stewart, J., 1999), and when consumers who do not follow treatments are said to be "noncompliant", implicit in the statement is the role of practitioner as the decision maker, not the consumer (Corrigan, 2002). Staff do not always want to give up their perceived power and too many do not believe that recovery is possible (Linhorst, 2002). Labeling people with a mental illness in derogatory terms contributes to unemployment or unskilled or low paid jobs (Garske, 1999). In addition, negative advertising in all forms of media reinforce stereotypes with such statements as "You must be NUTS not to take advantage of this offer!" and Corrigan, (2002) further suggests economic boycotts to businesses with these negative practices and letter writing campaigns to end such representations.

Stereotypes, prejudices, and blame can extend to churches and further isolate not only the patient, but families. Families feel blamed based on heredity, and when consumers don't take medication, or become rehospitalized (P. Corrigan, & Miller, F., 2004; Riebschleger, 1991). Because the stigma of mental illness is experienced as such a strong force, psychiatric rehabilitation programs should address issues of sibling and other relative relationships (Hatfield,

2005). Once the parent of a consumer dies, siblings may feel conflicted to take on the role of the parent played and the consumer might very well be looking for friendship more than looking for a rescuer or a caretaker (Hatfield, 2005; Riebschleger, 1991).

*Barriers*

Beyond stigma, other societal barriers to recovery exist. Structures and systems contribute to higher incidences of mental illness in certain populations (Kelly, 2005). For example, people in the prison system, in lower socioeconomic classes, and those affected by migration were all represented in higher numbers of those with a mental illness (Kelly, 2005). Structural barriers to treatment and recovery include lack of access to treatment and inadequate funding for psychotropic medications (Braithwaite, 2006). New York State's IPRT programs were the first Medicaid funded programs in the United.States. They are now awaiting approval for Personalized Recovery Oriented Services (PROS) that will create a "customized package of rehabilitation and support services designed to assist an individual in attaining specific goals (eg. Employment, education, housing), and services used to provide targeted interventions to reduce the risk of hospitalization or involvement with the criminal justice system" ("Personalized Recovery Oriented Services (PROS) Background").

*Staff Training*

Inadequately trained staff may contribute to consumer attrition in rehabilitation programs (G. Garske, 1999) and some staff do not embrace the possibility of hope that people with SPMI can lead meaningful lives, including having careers and families (Brown, 1999; Deegan, 1996; Hensley, 2002; Spaniol, 2001). Besides conveying hope, Spaniol (2001) stated that students in Social Work and Mental Health track programs must be taught to look at structural barriers such as stigma and discrimination that isolate people and they need to be taught to work more collaboratively with people with psychiatric disabilities. The Recovery Knowledge Assessment

Tool can be useful in determining staff training needs (Bedregal, 2006). In a recent study assessing 122 mental health providers, staff had the least knowledge about the nature of the recovery process (Bedregal, 2006). This study revealed that staff did not understand that symptom management did not have to precede recovery, but can happen in conjunction with recovery; nor did they know about alternatives to traditional approaches that can aid recovery. In addition, staff competencies need to be developed in the context of managed care (Coursey, 2000). Coursey, et al, suggests that staff attitudes and the system itself need to be defined with measurable competencies to determine if staff are skilled enough to provide services. Coursey named competencies in the following arenas: Information on the recovery movement, cultural competencies, family interventions, accountability, empirically validated and cost effective innovations, ethics in complex environments. Programs may inadvertently contribute to attrition when they are not culturally responsive (Arthur, 2005; Braithwaite, 2006). When training is conducted, the Psychiatric Rehabilitation Belief, Goals, and Practices Scales (PRBGP) can be used as a pretest and posttest to measure staff sensitivity to change (Casper, 2003). This scale provided a reliable and valid means to assess curricula in psychiatric rehabilitation (Casper, 2003).

In the state of Maryland, a new managed care system was implemented which utilized a tool to measure perception of satisfaction of people from minority groups who received mental health services (Arthur, 2005). A 52 item assessment, with reliable validity and reliability was developed through collaborative efforts of consumers, clinicians and administrators. Arthur, et al (2005) described four key factors that evolved from their analysis: Cultural competency needs; the accessibility of services and the willingness to negotiate on priorities of care; efforts to reach out to racially diverse communities; and the willingness to listen to and attend to people from various cultures. Some themes that emerged in this process included consideration for alternative

healing practices, perception of feeling welcomed by staff and the agency, and communication issues related to language. Even with trained staff, in the Assertive Community Treatment Program (ACT), that provides home visits, staff need to be careful about not giving the difficult client as much time as is given to the client staff enjoy working with (G. Garske, 1999). Garske, (1999) suggested that mental health workers can unintentionally reinforce stigma when they avoid difficult clients and when they suggest unskilled jobs inappropriate for them.

*Interventions and Practices*

A variety of interventions aimed at increasing retention were reviewed from treatment with persons with traumatic brain injury (TBI) (J. Corrigan, & Bogner, J., 2007; J. Corrigan, Bogner, J., Lamb-Hart, G., Heinemann, A., & Moore, D., 2005), in testing a theoretical model and interventions such as reducing barriers to attendance, rewards for attendance, and attention to building a therapeutic alliance. In groups for people with cocaine and major depressive disorder, homework completion early in treatment predicted treatment completion (Gonzalez, 2006). The Narrative Evaluation of Intervention Interview (NEII), a 16 open ended questions assessment, used grounded theory to understand consumer's subjective experience of treatment, in order to determine characteristics of consumers with schizophrenia or schizoaffective disorder who drop out (Hasson-Ohayon, 2006). Veterans who were homeless showed higher drop out rates for those with an Axis II disorder or a history of psychiatric disorder and had substance use and mental illness (Justus, 2006). A study of African Americans with chronic mental illness in an outpatient setting showed that participants with a dual diagnosis were less likely to drop out at six months and those who did drop out had fewer social supports (Primm, 2000). Drop outs in a study of 393 dually diagnosed individuals in an intensive outpatient treatment program which utilized contingency management found that retention was similar across three groups for

standard treatment plus contingency management (Weinstock, 2006). For an overview of these studies see Appendix D, Intervention Studies.

Since the 1960's, substance use issues have increased in society and with the growing number of diagnoses and complexity of the DSM-IV, more people are diagnosed with multiple disorders. This fact impacts treatment and treatment planning (Angst, Sellarv, Merikangas, 2002). Multimorbidity studies explored overlap of clusters of psychiatric symptoms (Castel, 2006), gender differences and quality of life (Gamma, 2001), and changes in major diagnostic categories over a 15 year longitudinal study (Angst, 2002). Castle, et al (2006) states that research on multimorbidity is scarce and assumptions about paired morbidity should not be applied to a population with multimorbidity. In Castle, et al's study of 2,784 clients in outpatient addiction programs at a comprehensive addiction treatment facility, depression, anxiety, and a history of conduct disorder were the most frequent clusters found. The demographics for this study showed the higher the number of clusters of symptoms, the higher the proportion of women and increased unemployment rate. Clients with additional symptoms were less educated, had fewer legal problems and were younger than those with no psychiatric symptoms. As the level of support from family and friends decreased, the level of multimorbidity increased and treatment visits increased (Castel, 2006).

Gender differences in multimorbidity emerged in a community cohort study as the number of psychiatric diagnoses increased. (Gamma, & Angst, 2001). Women tended to rate their quality of life lower and their distress from symptoms significantly higher than men. Predictors of women's distress included alcohol dependence, bulimia, relationship difficulties with spouse or partner. Predictors for the well being of men were income and simple phobia (Gamma, 2001).

Another view on multimorbidity was found in a 15 year longitudinal study with 343 subjects (Angst, Sellarv, Merikangas, 2002). The most frequent finding showed that people with multiple psychiatric conditions may be more motivated for treatment, attend more visits, and had lower attrition rates. However, Angst, et al (2002), also suggested that with the increase of diagnostic categories in the DSM growing from 106 in the DSM I to almost 400 in the DSM IV results in multiple diagnoses contributed to an artificially induced increase of comormidity. In addition, some critics suggested that the increased number of categories decreases clinical utility from the lack of hierarchy in the DSM-IV (in Frances, et all. 1990, Angst, et al 2002). To remedy the lack of clinical utility, each syndrome could be ranked "according to the extent to which it induces impairment, subjective distress, or major life interference with others" (Angst et al, 2002). The specific results of the longitudinal study show that mood disorders and in particular, dysthymia, was the most common disorder involved with comorbidity, followed by panic disorder, agoraphobia, and drug abuse (Angst et al, 2002). In general, the results of this longitudinal study confirm the results of other studies that link multimorbidity to severity in adults and children.

*Spirituality*

Spirituality is not found in many first person recovery stories, but when viewing studies specifically there is much literature. The lack of attention to the potential positive role of spirituality in rehabilitation can be found in history, staff training, and changes in spirituality and religion in society (Longo & Peterson, 2002). Longo (2002), provided an historical view beginning at the turn of the century when views about mental illness adopted the medical model with its deep roots in science, deeming religious explanations invalid. Now in the 21st century, medical schools now offer a course in spirituality, and psychiatric training requires topics in spirituality. The Joint Commission on Accreditation of Health Care Organizations (as cited in

Blanch, 2007) now routinely includes spiritual assessment in a patients' overall assessment. Additionally, Longo (2002) stated that in psychology there is no movement to expand training to include topics in spirituality. The roots of professional avoidance began with Freud, who compared religion to neurosis. Other leaders in mental health like Skinner, Watson, and Ellis held negative views as well. These leaders believed that good mental health did not include interest in religion (Longo, 2002). Today, society has become pluralistic and multicultural through migration. Christianity is now joined by spiritual practices like Islam, Buddhism, Hinduism that challenge and expand our understanding of spirituality (Longo, 2002).

In a qualitative study, using an adapted version of the Religious Coping Index, 379 individuals with SPMI, 81% indicated that they use religious beliefs to cope and 65% stated that they perceived religion to be effective (Rogers, 2002). The more severe the symptomology, the more likely a person was engaged in religion to cope, and to find a sense of control and meaning. In another qualitative study, consumers who had experienced an existential crisis following a psychotic episode stated that their faith helped them to find answers (Murphy, 2000). Other participants in that study stated that their faith in God kept them from killing themselves. Rogers, et al (2002) concludes his study by recommending that religion and spirituality should be integrated into treatment since it can serve as such an important coping mechanism. For religion and spirituality to be integrated into treatment, mental health care workers will need to get more comfortable talking about spiritual matters with clients in order to understand the place of spirituality in their clients lives (Fallot, 2000). In a study to investigate the factors related to successful adjustment of current and former consumers of mental health services, Titone provides a definition of spirituality (as cited in Sullivan, 1993, p. 8).

"Spirituality may or may not include belief in God. It is one's personalized experiences and identity pertaining to a sense of self-worth, meaning, vitality, and connectedness to others

and the universe. It is incorporated faith – one's pattern of response to the uncertainty inherent in life where the limits of material and human effectiveness are exceeded. It pertains to one's relationship with ultimate sources of inspiration, energy, and motivation; it pertains to an object of worship and reverence; and it pertains to the natural human tendency toward healing and growth.".

A view of the effect of religion and spirituality on coping styles is found in Yangarber-Hick's (2004) empirical study using the Personal Vision of Recovery Questionnaire, a 24-item instrument used to measure individual's beliefs about what they can do to assist in their own recovery. She described four coping styles: The collaborative style shows that God and the individual jointly solve problems; in the self-directing style, the individual bears responsibility to solve problems at the exclusion of God; in the deferring style, the individual is passive and relies on God to solve problems, and in the Plead style, the individual petitions God for a miracle and sometimes bargains with God for desired outcomes. Of these four coping styles, collaboration with God was most consistent with actively engaging in recovery. Exclusive reliance on one's own coping may lead to lack of engagement in recovery and deferent and plead styles predicted fewer recovery-oriented efforts. For more reviews on incorporating spirituality into mental health treatment, see the Psychiatric Rehabilitation Journal issue 30 volume 4 in which the entire journal was devoted to this topic. Of note, this issue offered articles on integrating religion and spirituality in mental health (Blanch, 2007); another which anticipated arguments against including spirituality that drew parallels to staff resistance when they were required to learn about housing options for clients (Russinova & Blanch, 2007); and also, an overview of current issues (Fallot, 2007).

*Summary*

Exploring possible causes and relationships to poor attendance and program attrition in psychiatric rehabilitation crosses a vast landscape. Societal attitudes and perceptions of recovery for people with a mental illness evolve sometimes more slowly than policies and programs. Mental health workers themselves are sometimes rooted in historical attitudes of paternalistic caretaking and embrace an imbalance of power and control about treatment decisions and goal setting. Multiculturalism in the United States continues to grow with the influx of immigrants and refugees, and rather than collaboration with clients, staff needs to keep pace in their own understanding of people from other cultures, their experiences, and what those experiences mean in their clients' lives. Structural violence is evident in the disproportionate number of people with severe mental illness found in the lower socioeconomic classes, prisons, and refugees.

A number of studies assessed readiness to change, with hopes of finding predictors to successful change. Interventions to increase attendance and program completion with various populations and readiness assessment studies showed diversity and complexity in populations with mental illness. Perhaps most notably, the number of studies in which treatment for substance use and mental health were combined reflects the explosion of drug use since the 1960's intersecting with post World War II population growth.

The onset of deinstitutionalization of people with mental illness, beginning in 1970, brought with it freedom to make choices, and a lack of structure and supports that was a challenge for many to navigate. The demand for services, programs, and housing grew rapidly, and meeting the needs in a timely way became an ongoing challenge. (Grob, 1995)

Policies evolved to support recovery, as medications were developed that offered hope to manage symptoms, and supports evolved to integrate previously institutionalized people into living with family, friends, or independently, with new recognition that clients have feelings, hopes, and dreams to be respected and supported.

Early psychiatric rehabilitation focused on living and vocational issues. Today's IPRT programs includes living, learning, working, and social areas of ones life. Little is published about IPRT outcomes. New Federal Legislation, PROS, is designed to provide more integrated and comprehensive services. Perhaps the largest shift in psychiatric rehabilitation is found in a person centered approach. When people get to choose their own goals, they are more motivated to work toward them. When a person receives and an admissible score on the RRDS scale to be admitted to IPRT and subsequently does not attend, questions may focus on readiness, staff training, barriers, external factors, heightened symptoms, and in light of this research, internalized stigma that may hold people back even from the most empirically validated programs.

## Method

### *Setting*

*The setting was a medium sized city with a population of approximately 225,000. The Focus Program is one of four IPRT programs in the city and is one of many programs in a non-profit agency whose mission is to serve the poorest of the poor. The program is not connected to a hospital. The Focus Program is located in the heart of the downtown area and is easily accessible to major bus lines. The space was renovated in the last five years and includes a large dining area, one large classroom and five smaller classrooms. There is also a computer lab and restrooms are shared by staff and consumers. Each practitioner has a small office as does the office manager and director.*

### *Subjects*

Subjects included 61 of 71 consumers associated with the Focus Program for April and May 2007. Ten consumers were excluded from the data because they had either graduated, were

discharged, or were not admitted after screening. (Consumers can choose their graduation date based on their determination of reaching their goals.) Specific information was gathered from four forms in each consumer's file. The four forms were Summary of Rehabilitation Readiness Determination Scale (RRDS), (See Appendix B) Referral Form, which originated from the consumer's clinician or therapist, (See Appendix C); the Current Satisfaction Worksheet, (See Appendix F); and Quality of Life Rating Scale, (See Appendix G.). See Table 2 for an itemization of data collected from each form. The RRDS is the only instrument completed by the practitioner. The Current Satisfaction Worksheet and Quality of Life Scale were completed by the consumer at the intake stage.

A data base in Microsoft Access was created for data collection and analysis. Specific information collected included age, mental health diagnoses and any drug or alcohol issues, reason for referral, highest level of education achieved, source of income, whether or not the consumer had a phone, how many attempts were made to reach consumers for their intake appointment, the number of times a consumer did not keep their intake appointment, whether they receive a bus pass, whether they have children, and whether they have children but do not have custody of their children.

There were two places on the Referral Form to indicate drug and/or alcohol issues. The first was as an Axis I diagnosis and the second was a line further down on the form to indicate a problem with drugs and/or alcohol. It was not clear whether the line was for drugs or alcohol, or both. In some cases, the line was checked for an alcohol or drug issue, but it was not listed as an Axis I diagnosis. Only substance use diagnoses noted on Axis I on the Referral From were noted on Axis I in the database.

The database holding intake data was linked to the attendance database maintained by the Focus IPRT Program. The attendance database holds attendance data for each consumer and **Appendix A**

Table 2 *Summary of Data Collected from Intake Forms*

| **Referral Form** Completed by referring therapist | **Summary of Determination for Readiness** (Completed by IPRT Practitioner) | **Current Satisfaction Worksheet Readiness Determination: Assessing the Need for Change** (Completed by consumer) | **Quality of Life Survey** (Completed by consumer) 1=poor, 2=fair, 3=good, 4=excellent |
|---|---|---|---|
| Age<br>Diagnosis<br>Axis I – up to three diagnoses<br>Axis II<br>GAF<br>Drug Issue<br>Alcohol Issue<br>Drug/Alcohol Issue<br>Reason for referral<br>Attempts to reach consumer<br># of "No shows"<br># of cancellation for screening<br>Home phone yes/no<br><br>**Sources:**<br>Administrator:<br>Bus Passes<br><br>Director:<br>Consumers with minor children who have custody and those with minor children who do not have custody. | Summary of need to change score<br><br>Summary of Commitment to change score<br><br>Summary of Personal Closeness Score<br><br>Summary of Self-Awareness Score<br><br>Summary of Environmental Awareness Score<br><br>Overall readiness to set a rehabilitation goal<br>Admission Date | **Living Environment**<br>Overall, How satisfied are you with your current living environment?<br>___ very much ___ somewhat ____ not at all<br>Do you want to change your living environment?<br>___ yes __maybe __ no<br>If yes, do you need help to change your living environment?<br>___yes ___maybe ___ no<br>**Highest level of education**<br>**Member of a social club**<br>___yes __no<br>Overall, how satisfied are you with your current social club or group?<br>___very much ___somewhat ___not at all<br>**Work or Volunteer?** ___ yes ___no<br>**Income Source**<br>____DSS<br>____SSDI<br>____SSI<br>____Paid employment<br>____ Food stamps<br>____Other<br><br>Have you ever applied for SSI and/or SSDI? ___ yes ___no<br>If yes, what is the status of your application?<br>___ approved<br>___pending initial decision<br>___denied, never appealed<br>___pending appeal<br>___pending fair hearing<br>Do you receive Medicaid? __yes __no<br>If yes, ___Straight Medicaid ___Monroe Plan ___ Preferred Option<br>Do you have Medicaid Spend Down?<br>___yes ____ no<br>**In which environment do you feel the greatest need to make a change?**<br>___ Living<br>___Learning<br>___Working<br>___ Socializing | Quality of<br>1. The place where you live (your housing)<br>2. The amount of money you have to buy what you need?<br>3. Your involvement in work, employment?<br>4. Your level of education<br>5. Your access to transportation to get around<br>6. Your social life<br>7. Your participation in community activities (Leisure, sport, spiritual, volunteer work)<br>8. Your ability to have fun and relax<br>9. Your physical health<br>10. Your level of independence<br>11. Your ability to take care of yourself (staying healthy, eating right, avoiding danger)<br>12. Your self esteem (how you feel about yourself)<br>13. Your personal relationships<br>14. Overall, how are things going in your life<br>15. The effect of alcohol and other drugs in your life<br>16. Your mental health symptoms |

each class for which the consumer was enrolled in April and May 2007. Although April began a three month class cycle, by the end of April, the director decided that, following the current cycle, the program would revert back to a two-month class cycle. Therefore, data was collected only for April and May, the first two months of the class cycle, to assist in any future research comparing attendance in two month cycles. See Appendix H for the class schedule.

In developing the database, space for three diagnoses on Axis I was created, as well as space for one diagnosis on Axis II. Multiple diagnoses on Axis I were recorded in the order in which they were listed on the referral form. If more than three diagnoses on Axis I were listed in the referral form, only the first three were recorded. If more than one diagnosis on Axis II was listed only the first was recorded. If information was missing from forms completed by consumers, the field in the database was left blank. The names in research database did not always match the names in the attendance database. The research database excluded consumers who had graduated, were discharged, or were not admitted, and the attendance database included them throughout the class cycle.

Scores from the Rehabilitation Readiness Determination Scale (RRDS) were sometimes listed as a range, e.g. 3-4. When a range was listed, the lowest number of the two numbers was recorded. Scores ranged from one to five.

## Results

Demographic results are displayed in Table 3. For Axis I Diagnoses, there were 117 diagnoses for 61 consumers. Of the 61 consumers enrolled, 50 (82 %) had a primary diagnosis of Mood Disorder, 20 (32.8%) had a diagnosis of Anxiety Disorder, seven (11.5%) had a diagnosis of Schizophrenia or Schizoaffective Disorder, and eight (13.1 %) had a primary diagnosis of Disorder Diagnosed in Childhood. For a second diagnosis on Axis I, 15 had a diagnosis of Substance Use Disorder, 10 had a diagnosis of Anxiety Disorder, six had a diagnosis of Mood

Disorder, and one each were diagnosed with Somatoform Disorder, Eating Disorder, and Adjustment Disorder. Fourteen did not have a second diagnosis on Axis 1. A total of 17 consumers had a third diagnosis listed on Axis 1. Thirteen had a diagnosis of Substance Use Disorder and one each for Anxiety Disorder, Impulse Control Disorder, and Mood Disorder and Schizophrenia or Schizoaffective Disorder.

Table 3 *Focus Program Consumer Diagnoses*

| **Axis I** | **N** | **%** |
|---|---|---|
| Anxiety | 20 | 32.8% |
| Mood | 50 | 82.0% |
| Disorders diagnosed in childhood | 8 | 13.1% |
| Substance use disorders | 28 | 45.9% |
| Schizophrenia | 7 | 11.5% |
| Eating Disorder | 1 | 1.6% |
| Somatoform Disorder | 1 | 1.6% |
| Adjustment Disorder | 1 | 1.6% |
| Impulse Control Disorder | 1 | 1.6% |
| **Total Number of Consumers** | **61** | |
| **Total Diagnoses** | **117** | |

| **Axis II** | **N** | **%** |
|---|---|---|
| Borderline Personality Disorder | 8 | 42.1% |
| Dependent Personality Disorder | 1 | 5.3% |
| Personality Disorder NOS | 10 | 52.6% |
| **Total Number of Consumers** | **19** | |

Note: 61 consumers are represented
Consumers with only one Axis I diagnosis = 13
Consumers with two Axis I diagnosis = 16
Consumers with three Axis I diagnosis = 13
Consumers with one Axis I and one Axis II diagnosis = 8
Consumers with two Axis I diagnoses and one Axis II diagnosis = 7
Consumers with three Axis I diagnosis and one Axis II diagnosis = 4

The top four diagnoses on Axis 1 were: Mood Disorders at 51, Substance Use Disorder at 25, Anxiety Disorder at 20 and Schizophrenia or Schizoaffective Disorder at 7. Axis II diagnoses include: Borderline Personality Disorder, 10, Personality Disorder NOS, 10, and

Dependent and Histrionic Personality Disorder at one each. For a full explanation of multiimorbidity found in this study, see Table 4 for Multimorbidity.

Table 4 *Multimorbidity*

| | Axis I | | | Axis II | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | | |
| **Diagnostic Categories** | **N** | **N** | **N** | **N** | **Total** |
| Mood | 11 | 11 | 12 | 16 | 50 |
| Anxiety | 0 | 7 | 6 | 4 | 17 |
| Schizophrenia | 2 | 3 | 1 | 7 | 13 |
| Substance Use | 0 | 7 | 13 | 5 | 25 |
| Disorders Diagnosed in Childhood | 0 | 5 | 2 | 1 | 8 |
| Eating Disorders | 0 | 1 | 0 | 1 | 2 |
| Somatoform Disorders | 0 | 1 | 0 | 0 | 1 |
| Impulse Control Disorder | 0 | 0 | 3 | 0 | 3 |
| | **13** | **35** | **37** | **34** | **119** |

61 consumers have a total of 119 diagnoses
Column 1 indicates a single diagnosis. 13 individuals had only one Axis I diagnosis
Column 2 indicates one other Axis I diagnosis in addition to the diagnosis in column one.
Column 3 indicates the number of people who have a third diagnosis with the first diagnosis in column one.
Column 4 indicates a personality disorder in addition to the diagnosis listed in column one.

The mean for education level was 13.6 years with a standard deviation of 2.97. The mean age was 40.1 with a standard deviation of 10.5 and the mean Global Assessment Functioning (GAF) score was 54.1 with a standard deviation of 8.61. See Table 5 for further descriptive statistics.

Table 5 *Education, Age, GAF Data*

| Category | N | Mean | SD | Mode | Median | High | Low |
|---|---|---|---|---|---|---|---|
| Education | 57 | 13.6 | 2.97 | 13 | 13 | 22 | 8 |
| Age | 61 | 40.1 | 10.5 | 39 | 42 | 58 | 19 |
| GAF | 54 | 54.1 | 8.61 | 50 | 55 | 69 | 30 |

The overall attendance for 18 men was 66.3% compared to 55.15% for 43 women. However, women had more stable attendance over the two months than did men, 3.4% change for women compared to 10% change for men. Attendance by GAF score range showed that consumers with lower GAF scores, 30-39, had the highest class attendance with a 72.5% average, compared to the other three score groups that ranged from 53.54% to 54.51%. (See Table 6).

Table 6 *Attendance by GAF Score*

Attendance by GAF score range

| Range | April | May | Average | Number |
|---|---|---|---|---|
| 30-39 | 80.33 | 64.7 | 72.5 | 3 |
| 40-49 | 58.45 | 48.63 | 53.54 | 2 |
| 50-59 | 50.8 | 58.22 | 54.51 | 7 |
| 60-69 | 53.8 | 54.2 | 54 | 6 |

The highest attendance rate by age group was found in the 45-49 year old group with a two month average of 57.57%. This group showed a 6.5% drop in attendance from April to May, which was the lowest drop of any age group. (See Table 8).

Table 7 *Attendance by Age Range*

| | N | April | May | % Change | Average |
|---|---|---|---|---|---|
| 19-24 | 10 | 52.9 | 47.1 | 11.0% | 49.8 |
| 30-34 | 5 | 46.6 | 38 | 18.5% | 42.3 |
| 35-39 | 12 | 46.4 | 50.5 | -8.8% | 48.5 |
| 40-44 | 8 | 54.6 | 59.5 | -9.0% | 57 |
| 45-49 | 16 | 59.5 | 55.6 | 6.6% | 57.5 |
| 50-54 | 6 | 34.3 | 58.8 | -71.4% | 45 |
| 55-60 | 4 | 38.5 | 48.7 | -26.5% | 43.5 |

Attendance for consumers with an alcohol only diagnosis and those with alcohol and drugs had the lowest average attendance rate at 48.8% compared to those who had just a drug diagnosis. (See Table 8).

Table 8 *Attendance by Substance Use Disorder*

| Substance Use | N | April | May | % Change | Average |
|---|---|---|---|---|---|
| Drug Issue | 23 | 56.1 | 52.8 | 5.9% | 54.0 |
| No Drug | 38 | 61.2 | 57.3 | 6.4% | 59.2 |
| Alcohol Issue | 17 | 48.8 | 56.4 | -15.6% | 52.6 |
| No Alcohol | 44 | 63.8 | 55.2 | 13.5% | 59.5 |
| Drug and Alcohol | 11 | 48.8 | 56.1 | -15.0% | 52.4 |
| No Drug or Alcohol | 50 | 61.4 | 57 | 7.2% | 59.2 |

Other variables that can negatively impact attendance include transportation issues and children and custody. Attendance increased for those who have custody of their children from April to May from 46.5% to 57.9%. Attendance for consumers who had children but did not have custody of them, showed a decline from 66.6% in April to 48.5% in May. Also compared in this group were consumers for whom April and May were their first class cycle in IPRT. They had an increase from 47.1% in April to 55.3% in May. The lowest attendance for May was found for consumers who had been enrolled at IPRT at least one class cycle before April. Their attendance went from 60.3% in April to 42.4% in May.

Attendance for consumers who were a member of a social club had an attendance rate of 61.2% compared to 54.9% for those who were not members of social clubs. Attendance for consumers who worked or did volunteer work had an average attendance rate of 52.25% compared to 58.95% for those who do not. (See Tables 9 and 10).

Table 9 *Additional Variables Which May Influence Attendance*

| Attendance Variables | N | April | May | % Change | Average |
|---|---|---|---|---|---|
| Bus Pass | 27 | 57.6 | 54.4 | 5.6% | 56.0 |
| No Bus Pass | 34 | 61.6 | 57.1 | 7.3% | 59.3 |
| First Time in IPRT | 10 | 47.1 | 55.3 | -17.4% | 51.2 |
| Not First Time | 50 | 60.3 | 42.4 | 29.7% | 51.3 |
| Children and custody | 9 | 46.5 | 57.9 | -24.5% | 52.2 |
| Children and no custody | 7 | 66.6 | 48.5 | 27.2% | 57.6 |

Table 10 *Additional Attendance Variables*

| Social Club and Work | N | April | May | Average |
|---|---|---|---|---|
| Member of Social Club | 24 | 62.7 | 59.7 | 61.2 |
| Non Member | 37 | 57.1 | 52.7 | 54.9 |
| Volunteer/Work | 15 | 57.5 | 47 | 52.25 |
| No Volunteer/Work | 46 | 59.7 | 58.2 | 58.95 |

Attendance for those who did not attend or call to cancel their intake appointment was lower in April but improved in May, going from 23.5% to 52.1% attendance. The attendance rate and rate of change from April to May was very similar for those who cancelled or did not cancel their first appointment. Attendance outcomes for consumers who had a phone or did not have a phone were also similar to attendance in the cancel/no cancel group. (See Table 11).

Table 11 *Attendance Comparison for Three Factors in the Intake Process*

| | N | April | May | % Change | Average |
|---|---|---|---|---|---|
| No Show | 4 | 23.5 | 52.1 | -121.7% | 37.8 |
| Show | 5 | 75.7 | 70.3 | 7.1% | 73 |
| Cancel | 7 | 58.1 | 53.89 | 7.2% | 55.9 |
| No Cancel | 54 | 59.5 | 55.9 | 6.1% | 57.7 |
| No Phone | 56 | 57.1 | 53.6 | 6.1% | 56.5 |
| Phone | 57 | 60 | 55.6 | 7.3% | 58.5 |

In the education category, attendance for consumers who were college graduates was the highest, with an overall attendance rate of 73.75% , with attendance for April at 66% and May at 81.5%. The lowest attendance rate was found for those with a ninth grade level of education at 49% for April, 45.7% for May and an overall average of 47.3%. The highest number in a category was found in high school graduates and their attendance rate for April was 71.3% with April at 61.2%. (See Table 12).

Table 12 *Attendance by Education Level*

| Educational Level | N | April | May | Average |
|---|---|---|---|---|
| <9th | 1 | 50 | 66.6 | 58 |
| 9th | 3 | 49 | 45.7 | 47.3 |
| 10th | 3 | 50 | 62.7 | 56.3 |
| 11th | 4 | 50 | 63.1 | 56.5 |
| 12th | 4 | 50 | 45.2 | 48.5 |
| HS grad | 12 | 71.3 | 61.2 | 66 |
| GED | 6 | 59.1 | 67.8 | 63.7 |
| <1 yr college | 6 | 58.9 | 50.6 | 54.7 |
| 1-2 yr. college | 7 | 43.1 | 39.5 | 41.2 |
| 2-3 yr college | 0 | 0 | 0 | 0 |
| 3-4 yr college | 3 | 59 | 67.5 | 63 |
| college graduate | 5 | 66 | 81.5 | 73.75 |
| <l yr graduate work | 0 | 0 | 0 | 0 |
| 1-2yrs grad study | 0 | 0 | 0 | 0 |
| 2-3 yrs grad study | 0 | 0 | 0 | 0 |
| graduate degree | 1 | 81.8 | 58.8 | 70.3 |
| associates degree | 2 | 50 | 51.4 | 50.7 |

Consumers who had a fair hearing pending for their SSI or SSDI application had the highest overall attendance at 72.4% followed by those whose applications were pending, 68.4%, and those who had already been approved, 67%. (See Table 13).

Table 13 *Status of SSI/SSDI*

| Status | N | April | May | % Change | Average |
|---|---|---|---|---|---|
| Approved | 19 | 70 | 64 | 8.6% | 67 |
| Denied | 3 | 66.6 | 41.8 | 37.2% | 54.2 |
| Pending | 3 | 64 | 72.9 | -13.9% | 68.4 |
| Pending Appeal | 4 | 52.8 | 63.1 | -19.5% | 57.95 |
| Pending Fair Hearing | 3 | 68.5 | 76.4 | -11.5% | 72.45 |

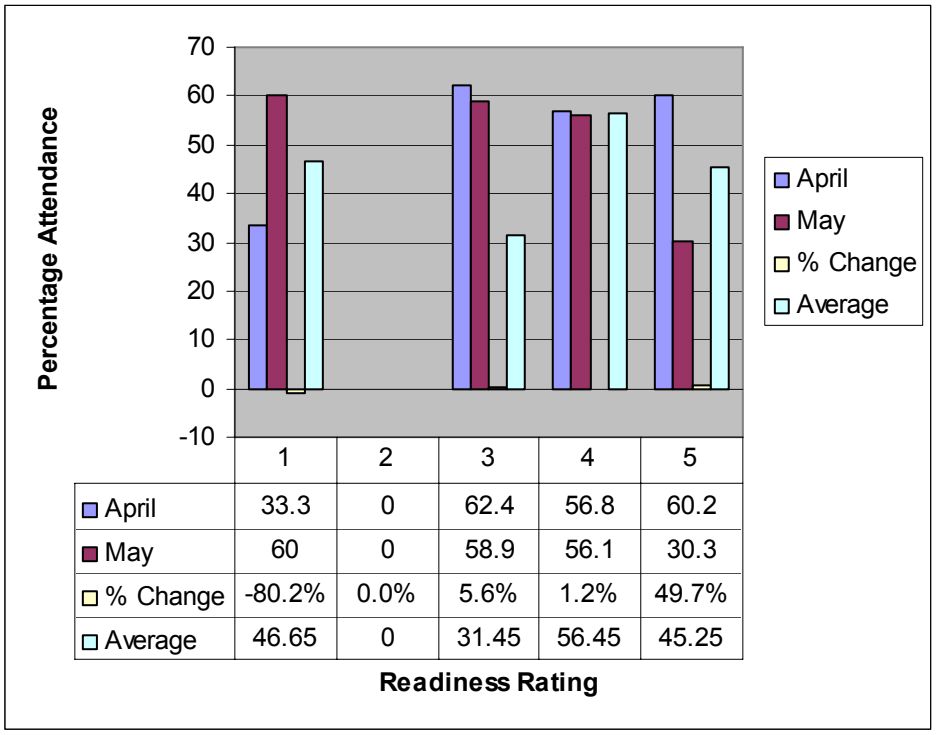
The Readiness Rating Determination Scale, (RRDS) administered by the practitioner includes five subscales and an overall readiness score. Subscales include Commitment to Change, Need for Change, Environmental Awareness, Self Awareness, and Personal Closeness, as well as an Overall Readiness assessment.

Readiness Rating, Commitment to Change, indicated the most stable attendance between April and May from those with a score of 14, at 1.2% change. Those with a score of 5 indicated the greatest decline in attendance between April and May, from 45% to25%. (See Figure 1).

Those needing to set an overall goal, represented on the Need to Change figure, (See Figure 2), showed the most consistent attendance between April and May for those who were rated a '3' with a 3.3% change. Consumers with a rating of '3' also had the highest average attendance of 59.4%. Consumers with a score of '4' on the Environmental Awareness scale showed the most consistent attendance between April and May with a 4.3% difference compared to those with a score of '3' who showed an 8.8% rate of change. (See Figure 3).

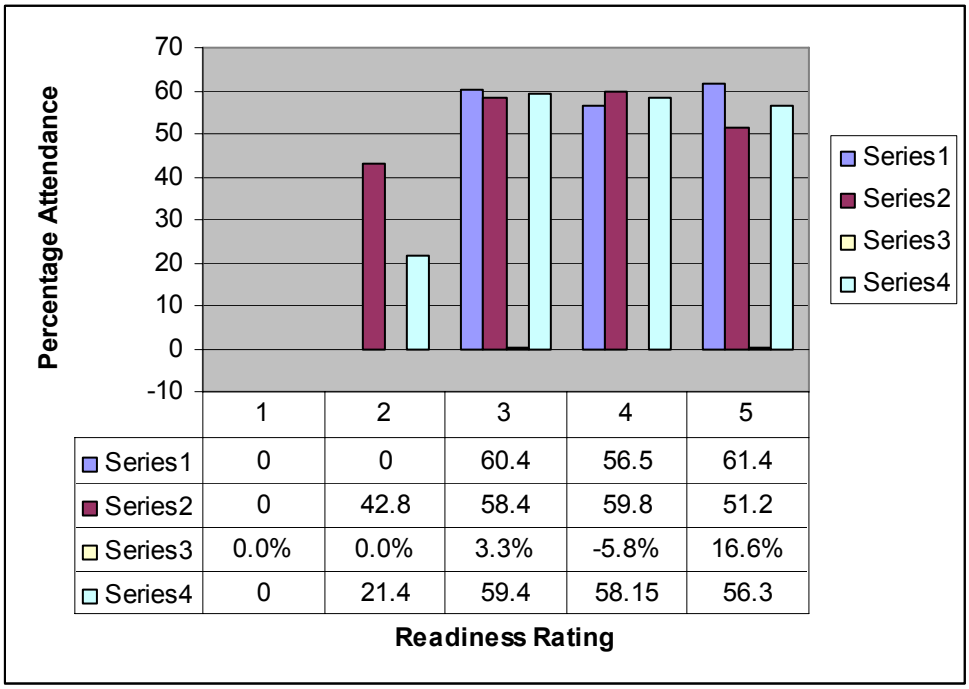
Consumers with a score of '3' on the self awareness scale showed the most consistent attendance between April and May with a 3.6% difference compared to a 10.7% difference for those who scored a '2'. However, those who scored a '5' showed the highest average attendance at 66%. (See Figure 4). Consumers with a score of '3'on the rating for closeness scale had the least percent of change in attendance between April and May at 4.9% and had an average attendance for the two months of 58.8%. Score of '4' had an average attendance of 59.8% and '5' had an average attendance of 60.95. (See Figure 5). Attendance on the overall readiness scale showed the most consistent attendance between April and May for those who were rated with a '4' at 3.4% and an average attendance of 60%. The percent of change for those with a score of '3' was 8.4% with the average overall attendance at 57%. (See Figure 6).

*Figure 1* Commitment to change



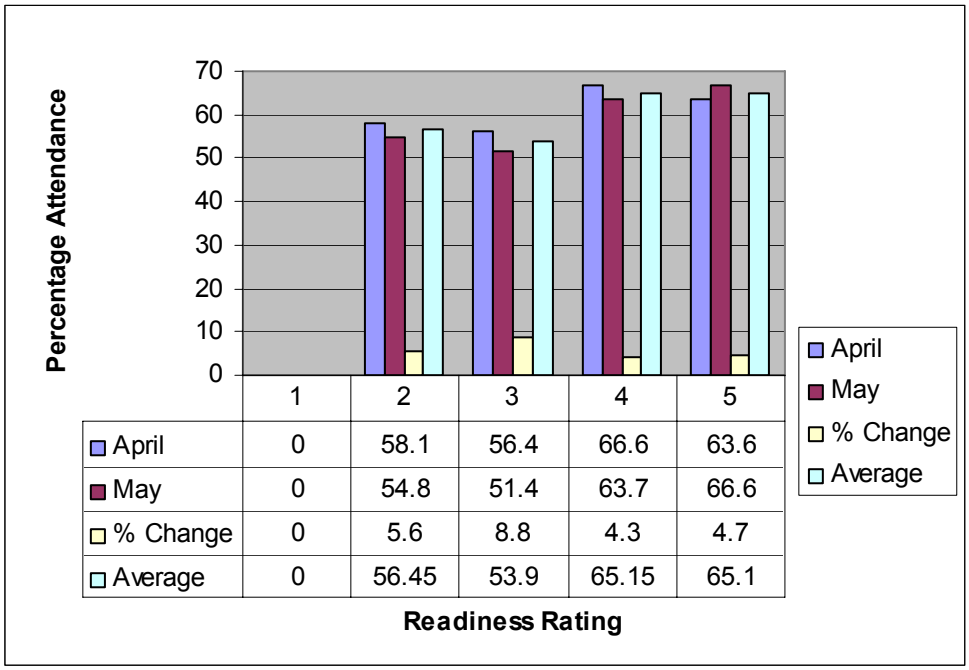

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| April | 33.3 | 0 | 62.4 | 56.8 | 60.2 |
| May | 60 | 0 | 58.9 | 56.1 | 30.3 |
| % Change | -80.2% | 0.0% | 5.6% | 1.2% | 49.7% |
| Average | 46.65 | 0 | 31.45 | 56.45 | 45.25 |

*Figure 2* Need for change



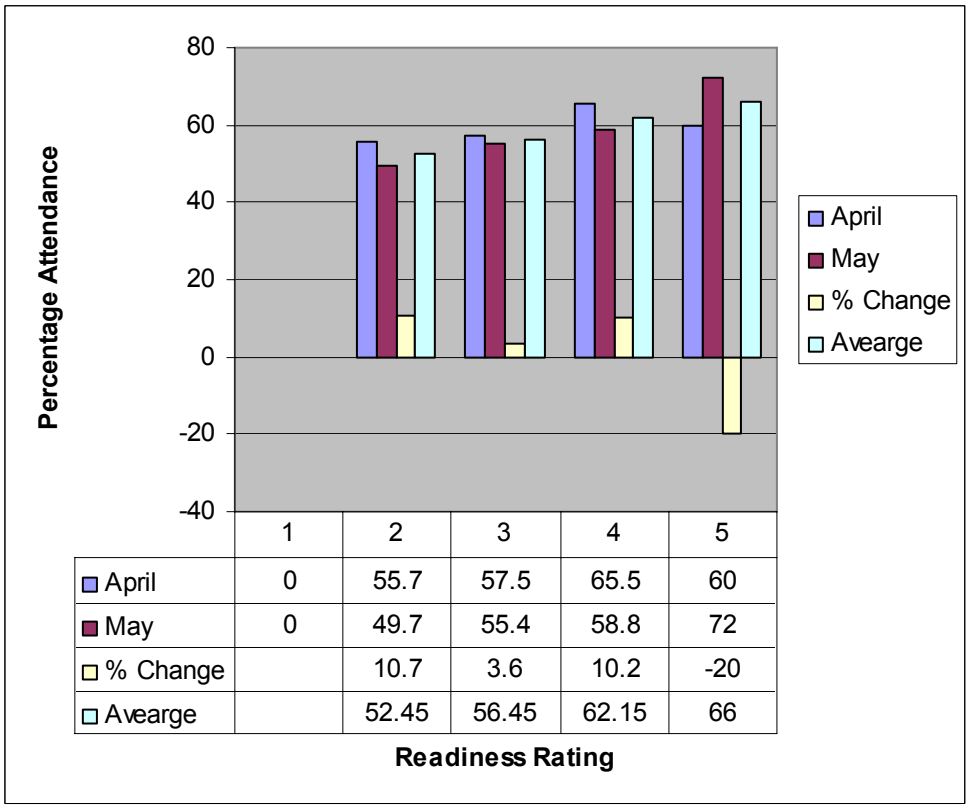

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Series1 | 0 | 0 | 60.4 | 56.5 | 61.4 |
| Series2 | 0 | 42.8 | 58.4 | 59.8 | 51.2 |
| Series3 | 0.0% | 0.0% | 3.3% | -5.8% | 16.6% |
| Series4 | 0 | 21.4 | 59.4 | 58.15 | 56.3 |

*Figure 3* Environmental Awareness



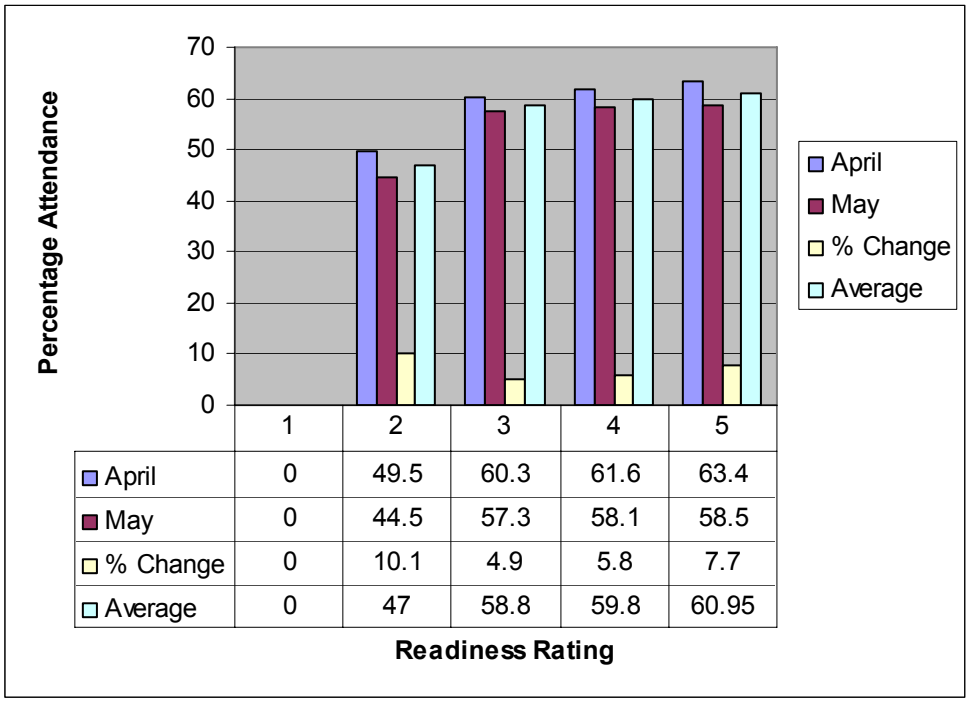

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| April | 0 | 58.1 | 56.4 | 66.6 | 63.6 |
| May | 0 | 54.8 | 51.4 | 63.7 | 66.6 |
| % Change | 0 | 5.6 | 8.8 | 4.3 | 4.7 |
| Average | 0 | 56.45 | 53.9 | 65.15 | 65.1 |

*Figure 4* Self Awareness



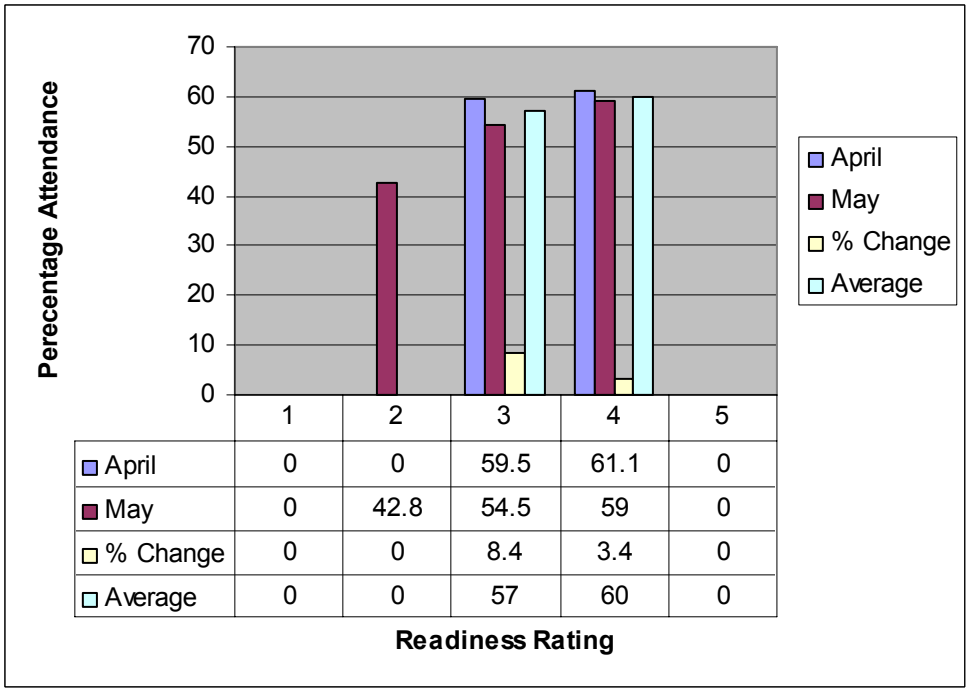

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| April | 0 | 55.7 | 57.5 | 65.5 | 60 |
| May | 0 | 49.7 | 55.4 | 58.8 | 72 |
| % Change | | 10.7 | 3.6 | 10.2 | -20 |
| Avearge | | 52.45 | 56.45 | 62.15 | 66 |

*Figure 5* Personal Closeness




| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| April | 0 | 49.5 | 60.3 | 61.6 | 63.4 |
| May | 0 | 44.5 | 57.3 | 58.1 | 58.5 |
| % Change | 0 | 10.1 | 4.9 | 5.8 | 7.7 |
| Average | 0 | 47 | 58.8 | 59.8 | 60.95 |

*Figure 6* Overall Readiness




| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| April | 0 | 0 | 59.5 | 61.1 | 0 |
| May | 0 | 42.8 | 54.5 | 59 | 0 |
| % Change | 0 | 0 | 8.4 | 3.4 | 0 |
| Average | 0 | 0 | 57 | 60 | 0 |

*Class Attendance*

Results for class attendance focused on four areas: classes with highest attendance increase between April and May, found in Table 14; Classes with the highest average class attendance for both April and May, found in Table 15; and most frequently chosen classes, found in Table 16.

Of note in classes with the highest increase in attendance is the variety in size from large to small class and the number of consumers for whom there was no data or '0' listed for their attendance. The type of classes also included mental health, job readiness, social, and the arts.

Table 14 *Classes With the Highest Attendance Increases*

| Class | # Enrolled | # No Data or 0 | % April | % May | % Average | % Change |
|---|---|---|---|---|---|---|
| Taking Charge | 19 | 9 | 37 | 59 | 46 | 62 |
| Weekend Plans | 7 | 4 | 40 | 59 | 50 | 47 |
| Dual Recovery | 13 | 5 | 32 | 44 | 39 | 38 |
| Job Search Skills | 9 | 1 | 65 | 73 | 67 | 13 |
| Creative Writing | 7 | 0 | 80 | 85 | 82 | 6 |

Classes with the highest average attendance also spanned mental health, job readiness, the arts and varied in size from large of 34 to small of 7. More than half of the Building Self Esteem class had no data or a '0' listed for attendance.

Table 15 *Five Highest Average Class Attendance*

| Classes | # Enrolled | # No Data or 0 | % April | % May | % Average | % Change |
|---|---|---|---|---|---|---|
| Creative Writing | 7 | 0 | 80 | 85 | 82 | 6 |
| Job Search Skills | 9 | 1 | 65 | 73 | 67 | 13 |
| Building Self Esteem | 34 | 18 | 67 | 60 | 63 | -11 |
| Newsletter Team | 7 | 1 | 67 | 67 | 67 | 0 |
| Computer Lab | 6 | 3 | 69 | 57 | 62 | -17 |

The most frequently chosen classes are almost all mental health classes with the exception of Assertiveness Skills, which is a Healthy Relationships class and Creative Expression with Arts and Fibers. These classes all began with over ten consumers and two began with over 20 consumers. The larger classes also had the highest number of consumers for whom no data was available or for whom a '0' was entered for attendance.

Table 16 *The Most Frequently Chosen Classes*

| | # Enrolled | # No Data or 0 | % April | % May | % Average | % Change |
|---|---|---|---|---|---|---|
| Building Self Esteem | 34 | 18 | 67 | 60 | 63 | -11 |
| One Crisis Too Many, pt 1 | 26 | 19 | 51 | 52 | 52 | 1 |
| Taking Charge | 19 | 9 | 37 | 59 | 46 | 62 |
| Creative Expression with Arts and Fibers | 17 | 3 | 65 | 44 | 55 | -32 |
| One Crisis Too Many, pt. 2 | 17 | 5 | 58 | 57 | 58 | -1 |
| Assertive Skills | 16 | 5 | 58 | 57 | 57 | -1 |
| Managing Depression | 15 | 5 | 54 | 51 | 52 | -6 |
| Anger Management | 14 | 8 | 48 | 48 | 48 | 0 |
| Dual Recovery | 13 | 5 | 32 | 44 | 39 | 38 |

## Discussion

Selected data collected through the intake process was explored to look for possible relationships contributing to attendance drop off in the second month of a two-month class cycle in the Focus IPRT Program. Determining possible causes for attendance drop off is important to consumers being able to reach their goals, staff morale, and program reimbursement. Decisions about specific data to collect were a collaboration of the program director, the Focus Program Practitioners, and the researcher.

Practitioners wondered whether consumers with children would have poorer attendance, which did not occur. Two categories for consumers with children included those who had custody and those who did not. Attendance was 5 percentage points higher for those without children. Practitioners also wondered whether a consumer had no phone, or cancelled, or didn't

show for their first appointment indicated behavior that would lead to poor attendance. Significantly, consumers who did not call to cancel their initial appointment had an attendance rate of 20%, whereas those who did call to cancel had an attendance rate of 72.5%. There was very little difference in attendance between those who had a phone and those who did not. However, it was not clear on several intake forms whether the phone listed for contacting the consumer was the consumer's phone or someone else's phone, through which the consumer could be reached. There is no place specifically on the intake form to indicate whether the phone listed belongs to the consumer.

Men had higher attendance rate than women, 66.3% compared to 55.17%, but attendance for women was more consistent over the two month class cycle. Consumers with the lowest GAF scores had the highest attendance, 72.5%, of any other GAF score group. It would be interesting to know how long these consumers have attended IPRT and what their current GAF scores are. Consumers aged 45-49 had the highest overall attendance, but also showed the lowest drop off in attendance, at 6.5%, than any other age group. It may be useful to know what other characteristics are attributed to this group.

One area of particular interest from the literature reviewed is the readiness score for personal closeness. The level of isolation was shown to impact attendance in other studies. Corrigan (2005) stated that people with substance use issues typically find comfort in the substance of choice, and the intervention used in his study was to build the therapeutic alliance between consumer and practitioner. Drop outs from Primm's (2000) study showed that dropouts had lower baseline support from friends and family.

Several studies in the literature showed favorable outcomes for contingency management by providing various prizes or rewards that improved retention. The Focus Program has given, grocery store gift cards for good attendance for a period of time now. One gift card is given and

staff do not seem to believe that the gift card improves attendance. Perhaps the gift card could be given for the most improved attendance.

With a growing body of literature about integrating spirituality into psychiatric rehabilitation and the effect of stigma as a barrier to consumers reaching their goals, class curriculum may be reviewed to insure that sufficient attention is paid to these concerns.

Attendance by classes showed that some of the most frequently selected classes tended to have the highest initial enrollment, but also had greatest attrition. Mueser (2005) suggested using short term interventions at specific stages of recovery and the high attendance for one month classes could confirm Mueser's findings. Capping class size may help to improve retention. Classes in creative arts and vocational readiness were well attended and classes offered for just one month had the highest attendance overall of any other classes. The Focus Program may want to consider a stronger mix of one month classes to boost attendance if appropriate need and curriculum exist.

To further address the lack of closeness of so many consumers, a class could be created to focus on family expectations, roles, responsibility, and mutuality. The literature clearly shows that some consumers lack insight into what their families want from them and also lack skills to interact in mutually satisfying ways (Corrigan, 2004). Since personal closeness is such a strong indicator for retention, this may be an avenue to improve closeness and attendance. There is already a place on the Summary for Rehabilitation Readiness that asks for names of family and/or friends to include in planning goals.

The focus program offers a class called "Life 101" where values and meaning are explored and discussed. This class often includes a sense of spirituality. In light of the current trend to integrate spirituality further into the program, they may to explore other opportunities to do so.

## Conclusion

Recovery from drugs and alcohol combined with mental illness continue to influence psychiatric rehabilitation, as evidenced by the large number of studies investigating engagement and retention issues. No other program in the review of literature for this study used the RRDS that the Focus program used as a screening tool. Originally, this tool was tested on 25 people who had a diagnosis of schizophrenia or schizoaffective disorder. No one in the 25 subjects had an Axis II diagnosis or a primary substance use disorder. However, this instrument is now being used with a population with a primary diagnosis of mood disorders, and many with substance use disorders. Data from a study of 14 IPRT programs in New York State and all IPRT programs in Iowa showed an average population of 45% consumers with schizophrenia or schizoaffective disorder. The percent of consumers with schizophrenia or schizoaffective at the Focus program is only 11.5%. There was no published outcome research that examines screening and retention for IPRT programs. The RRDS is one of many tools and technology developed at Boston University's Center for Psychiatric Rehabilitation.

Some programs in the literature reviewed suggested that staff and consumers share common eating space and share the same restrooms to help break down any perceived hierarchal barriers. The Focus Program has bright and cheery space with a shared dining room that serves as a gathering place during the day for both consumers and practitioners. All restrooms are shared. Mental fitness tool signs hang as mobiles from classroom ceilings, camaraderie among practitioners is evident as is the hopefulness they engender in consumers.

### *Limitations*

The small number in the population explored was a limitation in this study, especially when computing attendance averages. In addition, the diagnosis for mood disorder included major depression and bipolar disorder; it would have been more useful for future program

planning to have those broken out separately. This was a very elementary exploration of the data available. Consumer characteristics could be combined for a deeper look into possible relationships. Data collection concerns included incomplete or ambiguous information provided on the referral form. For example, it was not always clear, nor always stated, why the referral was being made. The referral form also does not make clear whether someone has a drug or alcohol problem or both, other than the Axis I diagnosis. The Consumer Satisfaction Survey asks whether someone works or volunteers but does not specify which. Again, these things may not be important outside the data collection issues for this project. Perhaps the strongest concern is about the lack of continuity in counting consumers for attendance purposed between the two databases. The attendance database included all consumers who started the class cycle even if they had been discharged or graduated whereas the research database omitted consumers who graduated or were discharged.

# Appendix A

## Rehabilitation Readiness Determination Scale

Reference 18

Scale for Rating Need to Set an Overall Rehabilitation Goal

| LEVEL | | DEFINITION |
|---|---|---|
| Level 5: | Urgent Need | The client and/or environment are very unhappy with each other. Or environment is thinking of asking client to leave very soon, or client may be thinking of "getting out." |
| Level 4: | Strong Need | Client is mixed/moderately dissatisfied. May have identified specific areas of dissatisfaction. Or environment perceives that his/her success is in jeopardy or that he/she is currently very unsuccessful, and if it continues may ask client to leave in near future. |
| Level 3: | Moderate Need | Client feels somewhat satisfied but has specific areas of strong dissatisfaction, or environment sees client as either unsuccessful to mildly or minimally unsuccessful, and /or thinks the client should leave at some point. |
| Level 2: | Minimal Need | Client is mostly satisfied. Or environment sees client as mildly or minimally unsuccessful and/or has few opinions about whether client should stay or go. |
| Level 1: | No Need | Client is satisfied. And environment perceives client as successful and/or doesn't care if client stays or goes. |

When need is not there, Assessing Readiness would terminate.

Appendix A, continued

Reference 26

Scale for Rating Commitment to Change

| Level | | Definition |
|---|---|---|
| Level 5: | Very Committed | "Felt" need believes that change will be positive; believes s/he can make change; "felt" need sees support for change |
| Level 4: | Committed | "Felt" need; believes change will be positive; not sure can make change OR unsure about support. |
| Level 3: | Moderately Committed | "Felt" need; believes change may be positive; not sure can make change or believes it may be possible; not sure of support/may have support. |
| Level 2: | Minimally Committee | "Felt" need, but unsure about positiveness of change, self-efficacy and support (some willingness). |
| Level 1: | Uncommitted | Really doubtful about need and positiveness, or self-efficacy or support. |

## Appendix A, continued

Reference 45

Personal Closeness Rating Scale

| Level | | Definition |
|---|---|---|
| Level 5 | Very High | Client is not isolated at all, likes closeness a great deal and feels very positively about the practitioner or other helpers. |
| Level 4 | High | Client is not isolated, likes closeness and feels positively towards the practitioner or other helpers. |
| Level 3 | Moderate | Client is somewhat/sporadically isolated; somewhat likes closeness, and feels neutral to positively towards the practitioner or other helpers. |
| Level 2 | Minimal | Client is guarded, does not like closeness, and feels ambivalent or tenuous about the practitioner or other helpers. |
| Level 1 | Very Low | Client is very isolated, strongly dislikes closeness and dislikes/has no rapport with practitioner or others. |

Adapted from: Cohen, et al., 1989. Case Management

Appendix A, continued

Reference 37

Scale for Rating Self-Awareness

| Level | | Definition |
|---|---|---|
| Level 5: | Expert | • Describes interests, values, and own general system of choosing without prompting.<br>• May have had many past experiences with selecting a place to LLWS. |
| Level 4: | Aware | • Describes interests, values, and past methods for making the choices that are being discussed.<br>• May have had some experience with selecting from among alternative places to LLWS. |
| Level 3: | Moderate Awareness | • Can answer questions about interests, values, and past selection methods.<br>• May or may not have had experience in selecting a place to LLWS.<br>• Probably a number of experiences making other important choices. |
| Level 2: | Minimal Awareness | • Can answer questions about general interests and values.<br>• Has only vague notions about how s/he makes choices.<br>• Probably has had no experiences selecting a place to LLWS.<br>• May have had few experiences making other important choices. |
| Level 1: | No Awareness | • Cannot discuss interests, values, or any methods of choosing regardless of who initiates.<br>• Has had no experience making choices that can be recalled. |

## Appendix A, continued

Reference 32

Scale for Rating Environmental Awareness

| Level | | Definition |
|---|---|---|
| Level 5: | Expert | • Can talk about alternative types of future environments with descriptive detail about the characteristics of physical setting, requirements and responsibilities; is very knowledgeable about past environments. |
| Level 4: | Aware | • Can talk about alternative type of future environments with minimal descriptive detail about the characteristics of physical setting, requirements and responsibilities; is knowledgeable about past environments. |
| Level 3: | Moderate Awareness | • Can name some alternative types of environments (present, past or future possibilities).<br>• May describe some physical characteristics but does not know requirements or responsibilities. |
| Level 2: | Minimal Awareness | • Can name more than one present environment and perhaps describe something about one past environment (e.g., hospital). |
| Level 1: | No Awareness | • Can name only present environment.<br>• Can only vaguely talk with limited awareness of characteristics. OR<br>• Cannot talk about any environments. |

Appendix A, continued

Reference 50

Overall Readiness Scale

| Level | Definition |
|---|---|
| Level 5: Definitely ready to set an Overall Rehabilitation Goal: | All factors are rated 4 or above |
| Level 4: Probably ready to set an Overall Rehabilitation Goal: | Need = 4 – 5<br>Commitment = 3 or more<br>Closeness = 4 or more<br>Self-Awareness = 3 or more<br>Environmental Awareness = 3 |
| Level 3: May be ready to begin Setting an Overall Rehabilitation Goal may develop readiness: | Need = 4 – 5<br>Commitment = 3 or more<br>Closeness = 3 or more<br>Self-Awareness = 2<br>Environmental Awareness = 2 or more |
| Level 2: Needs greater awareness to set an Overall Rehabilitation Goal: | Need = 3 or more<br>Commitment = 3 or more<br>Closeness = 3 or more<br>Self-Awareness = 2<br>Environmental Awareness = 2 or less |
| Level 1: Needs developmental activities to become ready to set an Overall Rehabilitation Goal: | Need = 2 - 3<br>Commitment = 2<br>Closeness = 2 or less<br>Self-Awareness = 2 or less<br>Environmental Awareness = 1 |

Appendix B

SUMMARY OF DETERMINATION OF READINESS
**FOR ADMISSION TO**
**INTENSIVE PSYCHIATRIC REHABILITATION TREATMENT**

**Participant Name:** _____

Dates of Determinations: Sessions #1_____ #2 _____ #3 _____

Designated Environment for Change:_____

**1. Summary of Need for Change** Rating_____

____in jeopardy ____possibly be asked to leave ____lack of environment
Overall satisfaction in current role: High ____ Medium _____ Low _____
Intent to leave role in next 6 months: ____

**2. Summary of Commitment to Change:** Rating _____

Change is ___positive ___possible ____supported _____self-efficacy

**3. Summary of Personal Closeness:** Rating _____

___keeps appointments ____comfortable talking with practitioner ____comfort in group setting

**4. Summary of Self-Awareness:** Rating _____

___values:_____
___interests: _____
___method of choosing: _____
___strengths: _____
___weaknesses: _____
___likes: _____
___dislikes: _____

Appendix B, continued



**5.** **Summary of Environmental Awareness:** Rating: _____

____aware of available opportunities in specified environments
____ previous experience in different environments
____ can describe relevant characteristics in detail

**6.** **Overall readiness to set a rehabilitation goal:** **Overall Rating _____**
(Priority weight to need and commitment rating)

Profile of Readiness:

High 5

4

3 _____

2

Low 1 _____

| | Need | Commitment To Change | Personal Closeness | Self Awareness | Environmental Awareness |
|---|---|---|---|---|---|
| Ratings | | | | | |

**Summary of Readiness:**

Appendix B, continued



**Recommendations:** (Include focus of services to enhance readiness to set an ORG and the Initial IPRT classes and interventions recommended. )

_____

_____

_____

_____

_____

_____

_____

☐ Admission: Date: _____

Based upon this determination of readiness, this individual is recommended for admission to IPRT, an Intensive Psychiatric Rehabilitation Treatment Program.

IPRT Practitioner's Signature: _____

Program Director's Signature: _____

☐ No Admission

IPRT Practitioner's Signature: _____

Program Director's Signature: _____

Reason for no admission at this time: _____

_____

_____

_____

_____

Recommendations/Referrals: _____

_____

_____

_____

_____

_____

_____

☐ Notification to Referral Source: _____
Name Date

- ☐ telephoned
- ☐ letter sent

# Appendix C

## Readiness Studies

| Authors, Publication Date | Population | Type | Focus | Outcome |
|---|---|---|---|---|
| Addington 1999 | Outpatients with schizophrenia and substance use disorder N=39 | Positive and Negative Syndrome Scale (PANSS), used to determine symptoms were stable. Stages of Change and Readiness Treatment Scale (SOCRATES) version 6 drug and alcohol version Readiness to Change Questionnaire (RCQ) | Examined consistency of SOCRATES and the RCQ with Prochaska et al's algorithm for stages of change with individuals with schizophrenia, since evidence suggests they may have difficulty with self-report measures. | PANSS indicated symptoms were stable. Showed poor agreement between therapist rating and individual self-rating. Individuals tended to rate themselves more highly than therapist rating. No agreement between two self-report scales for drugs or alcohol. Problem agreement may lie in trying to look at stages of change as distinct categories rather than a continuous dimension. |
| Blanchard, Morganstern, Morgan, Labouvie, Bux, 2003 | Subjects in substance abuse study N=232 | University of Rhode Island Change Assessment Scale (URICA) Positive and Negative Syndrome Scale (PANSS) | Compared concurrent and predictive validity of motivational subtypes vs. a continuous measure of readiness for change in substance abuses. 1st study to do so. | Confirmed previous studies' results for both motivational subtypes and continuous readiness measure. Showed good concurrent validity. Neither readiness measures predicted attendance. Readiness to change did not differ between participants who were legally required to attend and those who were not. Showed difference between being motivated for treatment and being motivated to change substance use behavior. The gap between motivation and outcome are unclear. Not ready to recommend to treatment programs |
| Borkin 2000 | Respondents included family members, students, and consumers N=844 | Recovery Attitudes Questionnaire (RAQ) | Developed the RAQ collaboratively with consumers, family members, and professionals. Tested the 21-item instrument. Measured people's attitudes about recovery. | Internal consistency and test retest were acceptable. Professionals had most favorable attitudes toward recovery. Convenience sample, not random sample. Can be useful to assess feelings about recovery and for whom advocacy and self-help services may be appropriate over traditional mental health services. |

Appendix C, continued

Readiness Studies

| Authors, Publication Date | Population | Type | Focus | Outcome |
|---|---|---|---|---|
| Bracke 2001 | Participants in Belgium residential N=156 psychosocial rehabilitation N=85 residential | Life Satisfaction Survey (SCL-90-R) | Measured subjective well-being, feelings of empowerment, self-control, joys and enthusiasm, global self-esteem | People who dropped out showed higher sense of control and more outside emotional support. |
| Geller, Cockell, Drab 2001 | Eating Disorders N=99 | Readiness Motivational Interview (RMI) | Examined psychometric properties of RMI. Assesses the extent to which individuals are in precontemplation, contemplation, and action/maintenance and the extent to which change is made for internal or external reasons. | Good reliability and construct validity. Difference in readiness and motivation to change existed across symptoms. Predicted difficulty in completing recovery activities, completion of recovery activities, commitment to enroll in symptom reduction treatment, and dropout from day treatment programs. |
| Heather 1999 | Problem Drinkers N=263 | Readiness to Change Questionnaire (RCQ) | Report on development of a treatment version of the RCQ [TV] for excessive alcohol consumers. Tested three forms of intervention: skill based, action oriented, or motivational counseling. | Confined to precontemplation, contemplation, and action stages and can be useful at entry in treatment to determine which clients are ready to change their drinking behavior and be offered the appropriate intervention. |
| Hillberger & Lamb 1999 | Persons from multifaceted psychiatric rehabilitation programs with SPMI N=223 | Change Assessment Questionnaire (CAQ-SPMI) | Measured whether people with SPMI follow same continuum of stages of change as other groups. | Confirmed that people with SPMI do follow the same continuum of stages of change as other populations. Important to match treatment to stage of change. |

Appendix C, continued

Readiness Studies

| Authors, Publication Date | Population | Type | Focus | Outcome |
|---|---|---|---|---|
| Miller & Tonigan 1996 | Problem drinkers N=1672 In Project MATCH N=82 Test-retest | Stages of Change and Readiness and Treatment Scale (SOCRATES) | To provide support and validation for the reliability scales of SOCRATES. SOCRATES was originally developed as a parallel measure to URICA. | Outcomes provided support for the reliability of the SOCRATES scales. Ambivalence scale lagged behind other scales, signifying the difficulty in measuring ambivalence. SOCRATES does not measure self-efficacy, outcome expectancies, specific pros and cons of change and social support for drinking or abstinence. |
| Pantalone & Swanson 2003 | Dual diagnosis with substance use and mental illness N=120 | URICA | RCT compared standard treatment with standard treatment and motivational interview for inpatients. | First known study to validate URICA and explore the link between motivation and treatment adherence for psychiatric and dually diagnosed inpatients. People who showed low readiness remained engaged in the group at higher rates than those with a higher readiness score. Findings were inconsistent with previous studies. |
| Rosen, Murphy, Chow, Drescher, Ramirez, Ruddy, et al 2001 | Veterans with PTSD with alcohol and anger problems N=102 | URICA and process of change questionnaires based on Prochaska and DiClemente's transtheoretical model. (TTM). | Determine whether motivation was confined to a specific problem or was a reflection of overall readiness; people with more severe problems were more motivated to change; standard instruments to measure change proved consistent with clients' own identified anger and alcohol problems; the impact of motivation on individual process. | Results support use of TTM to anger management and PTSD management. Used to focus on goals clients most want to change. URICA is too long to use for more than one problem and scoring is too complex to use as a goal setting tool. |
| Smith, Rio, Hill, Hedayat-Harris, Goodman, Anthony 1998 | Individuals with schizophrenia and schizoaffective disorder N=25 | Rehabilitation Readiness Determination Profile (RRDP) | To measures consumers' point of view of their subjective satisfaction. Four scales and seven subscales for each. Vocational, living, learning and social environments. | Small sample size and people without comorbidity. No one in sample size had substance use issues or low mental functioning. Unique in that it measures subjective satisfaction. |

# Appendix D

## Intervention Studies

| Authors, Publication Date | Population | Type | Focus | Outcome |
|---|---|---|---|---|
| Corrigan, & Bogner, 2007 | Substance Abuse treatment for persons with traumatic brain injury (TBI) N = 74 | Randomized Controlled Trial (RCT) to test a theoretical model. Theorized that financial incentives, reduced barriers and attention control would improve attendance at 30 days, build a therapeutic alliance, reduce premature termination and increase successful treatment. | Rewarded with $20 gift certificate after signing treatment contract and 30 days perfect attendance, and paid for bus or parking, taxi, lunch and reminder calls. Someone verified information by phone, followed by a confirmation letter restating their appointment and barrier reduction methods. | Results showed uneven supports for the theoretical model. The financial incentive yielded the best result for improved attendance in first month. The interventions did not have a clear effect on therapeutic alliance. Clients who missed one or more appointments showed a higher therapeutic alliance than those with perfect attendance. Attention control had the least effect on retention. |
| Corrigan, Bogner, Lamb-Hart, Heineman, Moore, 2005 | Substance abuse treatment for people with traumatic brain injury (TBI) N=195 | Participants came from two treatment programs in Ohio. Participants were randomly assigned to 4 conditions: motivational interview, barrier reduction, financial incentive, attention control. | Similar to Corrigan & Bogner, but with an emphasis on therapeutic alliance, because people with addictions primarily get reinforcement from alcohol, not other people. | Those in the barrier reduction group had the highest percentage of participants retained in treatment, followed by those in the financial incentive group. |
| Gonzalez, Schmitz, DeLaune, 2006 | 1st group =Cocaine, alcohol, and major depressive order 2nd group = cocaine and major depressive disorder N=123 | Participants were drawn from two randomized clinical trials. Structured interview with URICA and readiness to change score from URCIA was determined by adding the mean contemplation, action, and precontemplation subscales. | The effect of homework compliance on treatment outcome in relapse prevention therapy | Homework completion early in treatment predicted treatment completion. Correlation between homework compliance and motivation was not significant; the interactive effect was. Therefore homework compliance should not be seen as motivation to change. |

Appendix D, continued

Intervention Studies

| Authors, Publication Date | Population | Type | Focus | Outcome |
|---|---|---|---|---|
| Justus, Burling, Weingardt, 2006 | Veterans who were homeless. N=596 (22 female) | Domiciliary Care for Homeless Veterans (DCHV) program established in 1987.<br><br>Used cognitive behavior therapy. | Six month residential program with 13 week aftercare program. Goals were abstinence from drugs and alcohol, complete social and vocational rehabilitation leading to stable employment, housing, financial stability, and ability to live independently. | Younger veterans showed higher retention after 90 days. Those with lower retention rates had an axis II diagnosis and had a history of psychiatric disorder. Residents with prior drug dependence more likely to complete. |
| Mueser, Drake, Sigmon, Brunetter, 2005 | Reviewed literature or psychosocial interventions in adults with severe mental illness and co-occurring substance use disorders | Outcomes from randomized control trials on the following interventions: individual, group, and family modalities; case management; contingency management; residential and vocational rehabilitation. | Reviewed literature on various psychosocial interventions. Methods in studies ranged from quasi-experimental to experimental with problems of attrition, assessment outcomes, fidelity, and treatment drift. | People in recovery need multiple interventions over the often lengthy recovery process. The authors suggested studying individual short term interventions for a particular stage of recovery when a particular outcome is important. Integrating mental health with substance use treatment improves outcomes. |
| Primm, Gomez, Tzolova-Iontchev, Perry, Vu, Drum, 2000 | Outpatients, primarily African American with chronic mental illness and/or substance use disorder. N=48 | Characteristics associated with attrition in dually diagnosed persons with substance use disorder and mental illness and mental illness alone group. | Information was gathered from medical records; authors administered the Brief Symptom Inventory (BSI), Perceived Social Support, Friends (PSS-Fr), and Perceived Social Support, Family (PSS-Fa), and the CSQ short form. | Those with a dual diagnosis were less likely to drop out at six months, although they expressed less satisfaction with treatment. Drop outs had more severe symptomatology, higher prevalence of affective disorder, lower baseline support from family and friends. No characteristics associated with the mental illness alone group.. |

Appendix D, continued

Intervention Studies

| Authors, Publication Date | Population | Type | Focus | Outcome |
|---|---|---|---|---|
| Weinstock, Alessi, Petry, 2006 | Dually diagnosed participants newly admitted to intensive outpatient treatment N=393 | Data from 3 separate randomized trials. Participants were randomly assigned to standard treatment or standard treatment with contingency management (CM). Measured weeks retained in treatment and longest duration of continuous abstinence. | CM participants received prizes or vouchers exchangeable for retail goods and services valued between $80 and $882. Rewards were for negative toxicology screens and for completion of targeted behaviors. | Participants in standard treatment dropped out of treatment earlier, as psychiatric severity increased. In the standard treatment group with CM, retention was similar across all groups. 35% in treatment plus CM achieved 8 wks of abstinence vs. less than 10% of participants in standard treatment achieved 8 wks of abstinence. |

# Appendix E

## Referral Form

**IPRT REFERRAL FORM DATA SHEET**

**NAME**_____**PHONE**_____
**ADDRESS** _____
**DATE OF BIRTH** _____ **Medicaid** ___Yes ___ No # _____
**SOCIAL SECURITY #** _____
Current Mental Health Service Providers:
Psychiatrist: Name:
Address:

Primary Therapist Name: _____Telephone _____
Agency: _____
Address: _____
Telephone: _____ Appointment Day:_____
Case
Manager: Name: _____ Telephone: _____
Agency: _____
Address: _____
VESID
Counselor: Name: _____ Telephone: _____
Other Treatment Programs (Name, Contact Person, Schedule): _____
_____
**DIAGNOSIS:** AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV _____
AXIS V GAF SCALE_____
Medications: _____
_____
Lethality Issues: No _____ Yes _____ Specify:
Drug/Alcohol Issues: No _____ Yes _____ Specify:
Any Physical Limitations: _____
_____
At this time, in which environment does the applicant what to make a change?
_____ Living _____ Learning _____Working _____ Social
REASON FOR REFERRAL _____
_____
_____
_____
_____
**PLEASE ATTACH MOST RECENT ASSESSMENT AND TREATMENT PLAN WITH COMPLETED CONSENT FOR RELEASE OF INFORMATION FOR PLANNING PURPOSES.**
***SIGNATURE OF REFERRNG LICENSED PRACTITIONER*:**

_____
Signature Print Professional Credential Date
_____
*FOR OFFICE USE* – DISPOSITION
1) Referral Received Date: _____
2) Pre-Admission Assessment Scheduled: Date: _____ Time: _____ Staff: _____
3) Information Only: _____
_____
4) Other: _____
_____

Intake Completed by: _____

Appendix F

Current Satisfaction Worksheet

CURRENT SATISFACTION WORKSHEET
READINESS DETERMINATION: ASSESSING THE NEED FOR CHANGE

DATE: _____ NAME:_____

PRACTITIONER:_____

A. **LIVING ENVIRONMENT**:

1. What is your housing? I live in ☐ an apartment ☐ a rooming house
   I share an apartment /house with:_____
   I live in supported housing: specify; ☐ Independent Living Program
   ☐ Supported Apartment ☐ Group Home
   ☐ Supported Housing Program/Agency:_____
   I live in temporary housing: Specify_____
2. Overall, how satisfied are you with your current living environment?
   _____Very much _____ Somewhat _____Not at all
3. a. What do you **like** about your current living environment?_____
   _____
   _____
   b. What do you **dislike** about your current living environment? _____
   _____
   _____
4. Does anyone in your current living environment want you to leave?
   ____ Yes ____ Maybe ____No
5. Do you want to change your living environment?
   ____ Yes ____ Maybe ____No
6. If yes, do you need help to change your living environment?
   ____ Yes ____ Maybe ____No

**B. LEARNING ENVIRONMENT:**

1. What is the highest level of education your have completed?
   High School through grade: _____
   GED: Date received: _____
   GED class participation where: Where_____When_____
   College: Where: _____# credits/yrs._____
   Do you have outstanding student loans? ____ Yes ____ No
   If yes, is it in _____deferment or _____ default
   ☐ Training Programs: Where:_____
   What:_____ When:_____

Appendix F, continued

Current Satisfaction Worksheet

2. Are you currently enrolled in a learning environment? _____ Yes _____ No
If Yes: Describe: _____

_____

_____

What do you **like** about your current learning environment? _____

_____

_____

What do you **dislike** about your current learning environment? _____

_____

_____

Overall, how satisfied are you with this current learning environment?
_____ Very much ____ Somewhat ____Not at all
Are you at risk of having to drop out of this current learning environment?
_____ Yes ____ Maybe ____ No
If **NO**: Do you want to return to school? ____ Yes ____Maybe ____No
If **YES**: How much would you like to return to school?
____ Very much ____Somewhat ____ Not at all
Do you need help to return to school? ____ Yes ____Maybe ____No

**C. SOCIAL ENVIRONMENT:**

1. Are you currently a member of a social club or group? ____ Yes ____ No (go to part b).
   a. If **Yes**: Where and how often do you participate? _____

   _____

   _____

   What do you like about this club or group? _____

   _____

   _____

   What do you dislike about this club or group? _____

   _____

   _____

   Overall, how satisfied are you with your current social club or group?
   ____ Very much ____Somewhat ____ Not at all
   Are you in danger of losing your membership? ___Yes ____Maybe ___No
   b. If **NO**: Do you want to join some kind of club or social group?
   ___Yes ____Maybe ___No
   c. If **YES**, do you want join a club or group? How Much?
   ____ Very much ____Somewhat
   Do you need help to choose or join a social club?
   ___Yes ____Maybe ___No

Appendix F, continued

Current Satisfaction Worksheet

**D. WORK ENVIRONMENT:**

1. Are you currently working for pay or as a volunteer? ____ Yes ____No (go to b.)
   a. If Yes: Where do you work?_____
   What is your job title? _____
   What do you **like** about your job? _____
   _____
   _____
   What do you **dislike** about your job? _____
   _____
   _____
   Overall, how satisfied are you with your current job?
   ____ Very much ____Somewhat ____ Not at all
   Is there anyone at your workplace that is dissatisfied with your work?
   ___Yes ____Maybe ___No
   Do you need to change your current work environment?
   ___Yes ____Maybe ___No
   b. If NO: If not currently working, when did you last work? _____
   What was your job title? _____
   Where did you work? _____
   How long were you employed there? _____
   Overall, how much would you like to work? _____
   ____ Very much ____Somewhat ____ Not at all
   Do you currently **need** to get a job? ___Yes ____Maybe ___No
   Are you currently assigned to a DSS work unit? ____ Yes ____ No
   If yes, name of Work Unit caseworker _____
   What are your feelings about not having a job? _____
   _____

**E. BENEFITS INFORMATION:**

What is your gross monthly earned and unearned income $_____
Source of income $_____DSS (___Safety Net or ____TANF) $_____SSDI
$_____ SSI $_____Paid Employment $_____Food Stamps $_____Other
Have you ever applied for SSI and/or SSDI? _____ Yes _____No
If yes, what is the status of your application? ____Approved ____Pending
____Denied, never applied ____Pending appeal ____ Pending fair hearing
Do you receive your own benefits? ___ Yes ____ No
Or do you have a representative payee? ___Yes _____No
Do you receive Medicaid? ___Yes ___ No
If **Yes**: ____Straight Medicaid _____ Monroe Plan ____Preferred Option
Do you have Medicaid Spend Down? ___Yes ____ No If yes, $_____

Appendix F, continued

Current Satisfaction Worksheet

F. **IN WHICH ENVIRONMENT DO YOU FEEL THE GREATEST NEED TO MAKE CHANGE?**
____ Living ____ Learning _____ Working _____Socializing

**G. MY CURRENT OVERALL SATISFACTION IN THIS ENVIRONMENT IS?**
____ High ____ Medium ____ Low _____ Mixed

Summary of Success: _____
_____
_____
_____
Summary of Satisfaction: _____
_____
_____
_____

**H. WOULD IT BE HELPFUL TO EXPLORE SIGNIFICANT OTHER'S PERSPECTIVE OF YOUR SUCCESS IN THE FOUR ENVIRONMENTS?**
(Living, learning, working and social)
____ Yes ____ No Specify Whom _____

Appendix G

Quality of Life Assessment

# Quality of Life Self-Assessment

This self-assessment asks you to tell us how things are going for you these days. It should take you about five minutes to complete. When finished, please give the self-assessment to the staff member you are seeing today so that you can review the results together. This should be completed for the initial plan and at every plan review.

Please *pint* your name, the staff member's name, and today's date below.

1. Your Name (Please Print): _____
2. Staff Member's Name: _____
3. Today's Date: _____

In this section, we ask you to rate how things are going in different areas of your life. For each statement below, circle the answer that best matches your experience.

**Circle *ONE* choice for each statement below**

| **Overall, how would you rate. . . ?** | **1** | **2** | **3** | **4** | **Should this be in your service/recovery plan?** | |
|---|---|---|---|---|---|---|
| 1. The place where you live (your housing) | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 2. The amount of money you have to buy what you need? | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 3. Your involvement in work, employment? | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 4. Your level of education | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 5. Your access to transportation to get around | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 6. Your social life | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 7. Your participation in community activities (Leisure, sport, spiritual, volunteer work) | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 8. Your ability to have fun and relax | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 9. Your physical health | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 10. Your level of independence | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 11. Your ability to take care of yourself (staying healthy, eating right, avoiding danger) | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 12. Your self esteem (how you feel about yourself) | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 13. Your personal relationships | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |

Appendix G, continued

Quality of Life Assessment

| | | | | | | |
|---|---|---|---|---|---|---|
| 14. The effect of alcohol and other drugs in your life | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| 15. Your mental health symptoms | Poor | Fair | Good | Excellent | ☐ Yes | ☐ No |
| Is there anything else that you want in your service plan? | | | | | | |
| Comments (for example, what are your personal goals in this program?) | | | | | | |

(Rev 8/04/04)

# Appendix H

## Class Schedule

| | begin | end | | teacher | room | enroll |
|---|---|---|---|---|---|---|
| | 9:30 | 11:00 | Vocational Exploration M | | 4 | |
| M | 9:30 | 11:00 | Interpersonal Problem Solving Skills (HR) | | 3 | |
| 0 | 9:30 | 11:00 | Creative Writing ( C) | | i | |
| N | 11 :15 | 12:45 | Taking Charge (MH) | | 1 | |
| D | 11:15 | 12:45 | Job Search Skills M | | 4 | |
| A | 11:15 | 12:45 | Solution Circle (HR) · requires previous completion of Interpersonal Problem Solving | | 3 | |
| y | 12:45 | 1:30 | Lunch/Individual Appointments | | | |
| | 1:30 | 2:30 | Stop Sabotage and Self-Defeating Behaviors (MH) | | 1 | |
| | 1:30 | 2:30 | Looking For a Good Night's Sleep!!! (MH) - April | | 3 | |
| | 1:30 | 2:30 | Dream Journal and Exploration (MH)- May and June | | 3 | |
| | begin | end | | teacher | room | enroll |
| | 9:30 | 11:00 | Framework for Planning and Planning for Action (MH) | | 3 | |
| | !:J:30 | 11:00 | Framework for Planning and Planning for Action (MH) | | i | |
| T | 9:30 | 11:00 | Framework for Planning and Planning for Action (MH) | | 4 | |
| U | 9:30 | 11:00 | Computer lab (M | | lab | |
| E | 11:15 | 12:45 | One Crisis Too Many: Time To Change My Emotional Reaction (MH)-Part 1 | | i | |
| s | 11:15 | 12:45 | Common Sense Parenting (HR) | | 2 | |
| D | 11:15 | 12:45 | Assertive Skills (HR) | | 3 | |
| A | 12:45 | 1:30 | Lunch/Individual Appointments | | | |
| y | 1:30 | 2:30 | Intro to Computers M | | lab | |
| | 1:30 | 2:30 | Life 101 (MH) part I | | 1 | |
| | 1:30 | 2:30 | Driving Leamer's Permit Study Group (IW) -April and May | | 3 | |
| | 1:30 | 2:30 | Making Good Decisions (MH) - June | | 2 | |
| Begin | | end | | | | |
| | 9:30 | 11:00 | Framework for Planning and Planning for Action (MH) | | 3 | |
| W | 9:30 | 11:00 | Framework for Planning and Planning for Action (MH) | | 1 | |
| E | 9:30 | 11:00 | Keyboardina Skills and Confidence Builder M | | lab | |
| D | 11:15 | 12:45 | One Crisis Too Many: Time To Chanae My Emotional Reaction (MH)-Part 2 | | 3 | |
| N | 11:15 | 12:45 | Mindfulness and Meditation (MH) - May & June | | 1 | |
| E | 11:15 | 12:45 | Inspiration and Motivation Building Video-Discussion Series(MH).April | | 1 | |
| S | 12:45 | 1:30 | Lunch/Individual Appointments/ Eat & Meet Program Meeting-1 st of month | | 1 | |
| D | 1:30 | 2:30 | Speaker Series - April | | 3 | |
| A | 1:30 | 2:30 | Anger Management (MH) | | 4 | |
| y | 1:30 | 2:30 | Life 101 (MH) part II | | 1 | |
| | Begin | end | | | | |
| | 9:30 | 11:00 | Managina Depression (MH) - April and May | | 3 | |
| T | 9:30 | 11:00 | Taking Charge Refresher (MH) - June | | 3 | |
| H | 9:30 | 11:00 | Creative Expression with Fibers and Fabrics ( C) | | 1 | |
| U | 11:15 | 12:45 | Building Self Esteem (MH) | | 1 | |
| R | 11:15 | 12:45 | Newsletter Team M | | lab | |
| S | 11:15 | 12:45 | Building Work Readiness (V) · Current paid or volunteer role is expected | | 3 | |
| D | 12:45 | 1:30 | Lunch/Individual Appointments | | | |
| A | 1:30 | 2:30 | Finding Community Service Volunteer Roles M | | 4 | |
| y | 1:30 | 2:30 | Social Skills (HR) | | 3 | |
| | 1:30 | 2:30 | Expressing My Point of View/ Presentation Skills (HR) - April | | 1 | |
| | 9:30 | 11:00 | Leadership Class: Launch Wegman's "Eat Well, Live Well" Challenge at IPRT | | 2 | |
| F | 10:00 | 12:00 | Pathway to Recovery (MH) (began March 2nd - April 27th). | | | |
| R | 10:00 | 12:00 | W.RAP.- Wellness Recovery Action Planning (MH) - May and June | | 3 | |
| I | 9:30 | 12:45 | Data Entry Work Readiness Team M | | lab | |

Appendix H, continued

## Class Schedule

| | | | | | |
|---|---|---|---|---|---|
| D | 11:15 | 12:45 | Lunch Work Readiness Team M | kitchen | |
| A | 11:15 | 12:45 | Overcome Social Anxiety and Obsessive Thoughts (MH) | 3 | |
| y | 12:45 | 1:30 | Socialization and Lunch | 1 | |
| | 1:30 | 2:30 | Dual Recovery (MH) | 3 | |
| | 1:30 | 2:30 | Supportive GED Class (IW) | | |
| | 1:30 | 2:30 | Weekend Plans: Finding Affordable & Interesting Community Events (Il) | 1 | |
| Attendance Policy:Max of 2 absences/calendar for each weekly classes or 3 absences/calendar for 2x1week classes | | | | | |
| Job Retention Dinner Meeting -2nd Tuesday of Month, 5:30 p.m.:April1 Oth, May 8th, June 12th | | | I I | | |
| CLOSED: Friday, April 6th and Monday,May 28th | | | I T | | |

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