Training Mental Health Workers in Psychiatric Rehabilitation

by Erna S. Rogers, Barry F. Cohen, Karen S. Danley, Dorothy Hutchinson, and William A. Anthony

Abstract

Staff members from nine mental health agencies were trained in psychiatric rehabilitation technology. The trainers then received intensive followup to assist them in implementing the technology in their own agencies. Evaluation of the impact of the “training of trainers” strategy suggested that mental health workers were able to acquire and apply the skills of psychiatric rehabilitation. The training strategy also appeared to be effective in helping the agencies adopt the philosophy, principles, and skills of psychiatric rehabilitation.

Promoting the use of psychiatric rehabilitation technology is a challenge because it requires major changes in the structure of a mental health agency. Not only does the pattern of service delivery need modification, but changes are also required in the values, roles, and functions of the human service professional (Stern and Minkoff 1979). Psychiatric rehabilitation technology requires change at both the individual (Glaser and Backer 1979; Jansson 1980; Carolyn and Stoffelmayer 1981; Marlowe, Spector and Bedell 1983) and organizational levels (White 1974; Goldman 1976; Passmore and King 1978; Weinman et al. 1979; Astrachan and Tischler 1981; Boje, Fedor, and Rowland 1982; Glaser 1982).

An empirically based set of principles and practitioner skills, and a number of model service programs have been identified for the field of psychiatric rehabilitation (Anthony 1980; Bachrach 1980; Liberman et al. 1984). Training manuals also have been developed to improve the expertise of rehabilitation professionals (see Liberman et al. 1975, 1984; Anthony, Cohen, and Pierce 1980; Anthony, Pierce, and Cohen 1980a, 1980b; Cohen et al. 1980a, 1980b; Pierce et al. 1980a, 1980b; Cohen and Nemec 1985). However, innovation in psychiatric rehabilitation has been limited by the recency of constituent knowledge and skills, and the complexity of the task of dissemination (Zand and Sorenson 1975; Haveliwala 1979; Liberman et al. 1982; Wolkon, Peterson, and Gougla 1982; Marlowe, Spector, and Bedell 1983). Backer, Liberman, and Kuehnelt (1986) analyzed three examples of effective innovation in psychosocial rehabilitation and concluded that the following factors were critical: interpersonal contact with credible professional peers; outside consultation for the adoption process; organizational support for the innovation; persistent championship of the innovation; adaptability of the innovation; and credible evidence of success for the innovative program.

Use of the methods of psychiatric rehabilitation may become increasingly feasible because of advances in the specificity and hence teachability of this technology. Methods inherent in the psychiatric rehabilitation approach have been refined, and components of assessment, treatment, and staff functions are now well defined (Beard, Probst, and Malamud 1982; Anthony, Cohen, and Cohen 1983).

The focus of this study is the psychiatric rehabilitation approach, which has been described by Anthony, Cohen, and Cohen (1983). Using this approach, a practitioner guides the client through a three-phase rehabilitation process of...
diagnosis, planning, and intervention. In the diagnostic phase, functional and resource assessments are made of the particular environments in which the client is to live, learn, and work. In the next phase, a plan is developed which prioritizes skills to teach clients the resource goals, the interventions for achieving these goals, and the time frames and personnel responsible for implementing the interventions. In the final phase, interventions for building skills and developing resources are implemented.

This study was designed to promote the use of psychiatric rehabilitation technology, emphasizing what practitioners do rather than simply what they know. A method of “training trainers” was used because it was hoped that training existing agency staff to become “in-house” trainers would increase the chances of rehabilitation methods becoming established in the organization, instead of disappearing when the outside consultants leave (Glaser 1981). The agency trainers also became intimately involved in the change process and have an ongoing capability to adopt the innovation. Table 1 delineates the principles of dissemination and utilization of innovations upon which this study was based.

Methods

Agency Recruitment and Selection. This project began with a letter sent by the Center for Psychiatric Rehabilitation to 132 mental health agencies that had previous contact with the Center. Of the 132 letters sent, 85 agencies called the Center to indicate interest. After learning the goals of the project, 23 decided they were not able to participate or were not interested. The remaining 62 were sent application packets to facilitate the next level of screening. Forty sites returned completed applications.

The application packet requested detailed information from each agency about the following: clients served; staffing (numbers and type of education/experience); type of training and supervision methods used; previous research and program evaluation; and administrative information. The application process was guided by the literature on adoption of innovations which suggests that the readiness and ability of an agency to adopt an innovation can and should be assessed before embarking on such a complex process. The selection process provided information about how compatible the philosophy and structure of each agency was with the proposed training; how motivated each agency was to implement the innovation; and whether each agency had the resources to support the innovation. (Anthony et al. 1985).

The final selection of training sites was made from scores based on the following:

- Assessment of written applications provided by the recruited sites using a standardized assessment format.
- Elimination of sites that did not meet minimal criteria for successful innovation (e.g., client/staff ratio adequate to implement the approach; agency control over the treatment process).
- Assessment of State support for the psychiatric rehabilitation training technology on a 5-point scale.
- Assessment of the level of interest and motivation of site personnel and validation of application data through site visits.

The intensive nature of the project allowed the Center to choose only three sites for the first year and seven for the second year. One site dropped out of the project during the second year because of manpower shortages.

Training. Each site selected at least two “trainer-apprentices” for the training. Several sites designated more than two. A total of 30 trainer-apprentices began the training and, of those, 29 completed the training.

Training focused on teaching the core skills of psychiatric rehabilitation: rehabilitation diagnosis, planning, and intervention. The trainer-apprentices were also taught how to train and supervise practitioners (i.e., their trainees) in the use of these skills at their own sites. The training process consisted of five steps.

Step 1: Training in psychiatric rehabilitation practice at the Center. The trainer-apprentices from all selected sites came to the Center for Psychiatric Rehabilitation at Boston University for 5 days of training in the skills of psychiatric rehabilitation (see table 2). The following training methods were used: didactic presentation, videotaped demonstrations, live demonstrations, discussions, case presentations, role-playing exercises, paper-and-pencil exercises, keeping a personal learning journal, and homework assignments. The objectives of the first 5 days of training were to increase the readiness, awareness, and ability to perform the skills of psychiatric rehabilitation of the trainer-apprentices. The training also provided an opportunity to exchange ideas and develop networks with
Table 1. Principles of utilization

**Product principle**

1. Utilization is enhanced when the product is characterized by credibility, observability, relevance, relative advantage, ease in understanding and installation, compatibility, and ability to experiment.

**Process principles**

2. Utilization involves an ongoing process which includes: (1) the identification of a relevant need, (2) the development or adoption of an innovation, (3) the development of an implementation strategy, and (4) the stabilization of innovation. The need identification process must include a feasibility assessment related to personal and organizational readiness for adoption.

3. Utilization is enhanced by an action orientation by disseminators. An action orientation assumes a mutual sharing of responsibility for implementation by the disseminator and the user.

4. Successful utilization depends on the early and active support of potential users. Potential users need to be involved in the process of planning, implementing, and evaluating an innovation. This is especially true when the innovation involves behavioral changes on the part of the user.

5. Utilization is enhanced through the establishment of a “linking role” by the disseminator. This linking role would include (1) establishing effective communication, (2) direct teaching, (3) problem solving, and (4) support and encouragement of users.

6. The point of implementation is especially crucial in the utilization process. Local change agents and users need continuing support and encouragement from the disseminator to ensure adoption will be consistent with the spirit and intent of the innovation, and to overcome the resistances inherent in any change situation. This is especially true when the innovation requires skill/behavioral changes on the part of the user.

7. Utilization is enhanced when the adequacy and effectiveness of the innovation are actively monitored and evaluated.

**Context principles**

8. Successful utilization depends on the active support of the host agency. Critical factors include readiness for change, capacity for change, and the availability of resources to support change.

9. Utilization is enhanced when individuals are motivated to learn, open to change, flexible, and possess an adequate level of self-integration.

10. Utilization is enhanced when a “felt need” exists for the innovation. Potential users must recognize the relevance and benefit of the innovation to their concerns.

11. Utilization is enhanced through the establishment of a “linker role” within the utilization site. This “linking person” would (1) coordinate the site effort, (2) maintain communications, (3) teach, (4) solve problems, and (5) provide local support and encouragement.

12. Utilization is enhanced by an interpersonal environment within the host agency characterized by trust, clarity of communication, willingness to entertain challenge, and effective problem solving.

13. Utilization is enhanced when the social/cultural environment is actively considered. This may take the form of establishing open communications and being sensitive to expressed needs and concerns.

14. The linking person in an agency needs to provide continuing support during the implementation process to ensure adoption will be consistent with the spirit and intent of the innovation, and, to overcome the resistances inherent in any change situation. This is especially true when the innovation requires skill/behavioral changes on the part of the adopter.

15. Utilization is enhanced when the philosophy and values of the site are consistent with the spirit and intent of the innovation.
Table 2. Skills of psychiatric rehabilitation taught to trainer-apprentices and trainees

<table>
<thead>
<tr>
<th>Skill domain</th>
<th>Specific components</th>
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| Rehabilitation diagnosis | Defining an overall rehabilitation goal  
                      | Defining rehabilitation problems  
                      | Defining goals in relation to specific environmental situations  
                      | Identifying skill strengths and deficits in relation to the rehabilitation goal  
                      | Defining skill strengths and deficits in observable, measurable terms  
                      | Identifying present and needed levels of functioning  
                      | Involving the client in the process of rehabilitation  
                      | Responding to the client’s feelings and problems  
                      | Sharing one’s own perspective  
                      | Assigning priorities to client’s problems and goals  
                      | Translating skill strengths and deficits into goal statements  
                      | Identifying time lines for goals  
                      | Developing goals for learning and applying skills  
                      | Linking goals to the overall rehabilitation goal  
                      | Identifying client steps that will lead to achievement of skill goals  
                      | Behaviorally stating, measuring, and sequencing skill steps  
                      | Developing teaching plans to teach skills to clients  
                      | Explaining and demonstrating skill steps to clients  
                      | Providing opportunities for clients to practice and receive feedback on skills  
                      | Providing followup to ensure skill use |

Other professionals working in the field of psychiatric rehabilitation.

Step 2: Practice at their sites.
Trainer-apprentices returned to their agencies to practice the skills of psychiatric rehabilitation as a means of increasing mastery. They conducted a minimum of four client interviews in which they practiced their skills. The interviews were audiotaped and mailed to project mentors at the Center. The Center mentors used telephone contact to provide feedback and remediation based upon their evaluation of the four taped sessions. Telephone contact throughout the training period was extensive, averaging a minimum of two 30-minute calls per month to each site. Sites were encouraged to contact the Center mentors whenever necessary for support, remediation, and advice.

Step 3: Training in “how to teach psychiatric rehabilitation” at the Center. The second week of training, approximately 7 weeks after the first week at Boston University, focused on teaching techniques (table 3). Twenty-four staff members from Massachusetts mental health agencies volunteered to act as “trainees” to be taught by the trainer-apprentices. Thus, apprentices had the opportunity to teach a group of professionals similar to their own staff while being observed, taped, and critiqued by Center mentors.

Step 4: Practice at sites.
Apprentice trainers were required to practice their training skills by developing curricula and conducting “practice” sessions with their fellow trainer-apprentices and/or colleagues outside their agencies. Practice was conducted in small groups and in 1:1 sessions with trainees. The taped training sessions were reviewed by Center mentors and feedback was provided.

Step 5: Develop training programs used at sites. The trainer-apprentices developed plans to conduct on-site training of their staff in the skills of psychiatric rehabilitation. A total of 168 trainees (i.e., practitioners trained on-site by the trainer-apprentices) participated in some portion of the study. The training of staff at the sites involved a series of
Table 3. Teaching skills and techniques

<table>
<thead>
<tr>
<th>Skill domain</th>
<th>Specific components</th>
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<tbody>
<tr>
<td>Planning the training</td>
<td>Outlining the content</td>
</tr>
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<td></td>
<td>Developing the curriculum</td>
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<tr>
<td>Involving the trainees</td>
<td>Gathering information</td>
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<td></td>
<td>Encouraging participation</td>
</tr>
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<td></td>
<td>Modifying curricula</td>
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<tr>
<td>Following up the training</td>
<td>Developing study groups</td>
</tr>
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<td></td>
<td>Developing monitoring plans</td>
</tr>
<tr>
<td></td>
<td>Providing feedback</td>
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<tr>
<td></td>
<td>Revising the followup strategy</td>
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</table>

2-day workshops followed by weekly study groups where the staff reviewed their attempts to use their newly acquired skills with agency clients. The workshops were monitored by Center mentors during each of two planned visits to every site that were made in the 4 months following the Center training. These site visits gave the Center mentors an opportunity to observe the on-site training effort, to provide feedback and remedial training, and to plan needed changes. The study groups were taped to allow review by both the agency trainer-apprentices and Center mentors.

Evaluation Design. The goal of this project was to promote the use of our psychiatric rehabilitation approach in the participating agencies. Evaluations of the project’s effectiveness were based on measures of:

- Acquisition of psychiatric rehabilitation skills.
- Application of psychiatric rehabilitation skills.
- Utilization of psychiatric rehabilitation skills.

Instruments. Skill acquisition was assessed with a paper-and-pencil instrument that was administered to all trainer-apprentices and trainees before and after training. Skill application (i.e., the extent to which a practitioner faithfully applied the acquired skills with a client) was assessed using audiotapes. Because of resistance on the part of the practitioners to providing audiotapes, a large amount of posttraining data were not collected. Even with these difficulties, however, the nine sites mailed in 375 pretraining audiotapes and 191 posttraining audiotapes.

Both the skill acquisition and skill application measures were developed by Center mentors who were experts in psychiatric rehabilitation. They were asked to generate, revise, and refine the content considered critical to all components of the skills being taught. This process of generation and refinement took place over a 4-month period during the first phase of the project. Both the skill acquisition and skill application measures were evaluated by raters trained at the Center to an acceptable level of interrater reliability.

Slight changes in the project between years 1 and 2 affected skill-acquisition comparisons. That is, changes in the instruments used to assess skill acquisition were made just before year 2. As a result, the trainer-apprentices from year 2 could not be compared to other trainer-apprentices and trainees. Comparisons were made, however, from pretraining to posttraining for year 2 trainer-apprentices.

Skill utilization, or the extent to which practitioners and agencies incorporated psychiatric rehabilitation into the ongoing treatment process, was measured three ways: (1) a self-report paper-and-pencil questionnaire at posttest only; (2) an analysis of clinical records before and after the training; (3) an assessment of the programs, staff, clients, and treatment methods before and after the training.

The self-report of skill utilization was made with a 50-item questionnaire administered at posttest only. The participants were asked to indicate the extent to which they needed to learn the 21 distinct psychiatric rehabilitation skills and the extent to which they were using these skills. They were also asked to describe the administrative support provided them to adopt and integrate the newly learned psychiatric rehabilitation skills, the extent to which they were using these skills. They were also asked to describe the administrative support provided them to adopt and integrate the newly learned psychiatric rehabilitation skills, a key variable in successful adoption of innovations (Backer, Liberman, and Kuehnel 1986).

The content analysis of clinical recordkeeping was performed by rating samples of records using a formalized scale, which was developed and refined by Center staff based upon psychiatric rehabilitation principles. It was assumed that an innovation that was “embedded” into an organization, and was not merely a superficial alteration, would be evident in the organization’s record-keeping system.

Trainer-apprentices from each site were asked to provide two to four random samples of records for themselves and for each trainee who participated in the project. If the job...
duties of the trainer-apprentices did not require them to keep clinical records (e.g., a supervisor with no client caseload), then no records were provided. Records were requested that would sample and reflect each major component of psychiatric rehabilitation skills (i.e., rehabilitation diagnosis, planning, and intervention). The review of clinical records was used to determine how congruent they were with the psychiatric rehabilitation approach taught in the project (see table 4 for criteria used).

The final measure of utilization was the same instrument that was previously administered for site

Table 4. Clinical record review criteria

I. Rehabilitation diagnosis
1. There is a statement of an Overall rehabilitation or treatment goal (i.e., a statement of the specific environment which the client is attempting to maintain or move)
2. Timelines for goal are given
3. The entire problems and goal section is written in language likely to be understood by the client
4. There is evidence of client involvement in the goal (e.g., client signature or place for signature)
5. There is evidence of a functional assessment, where client’s skill strengths and deficits are defined in relation to the rehabilitation goal
6. Skill strengths and deficits are listed in relation to specific environments in which client is attempting to maintain him/herself or move
7. Skill strengths and deficits are operationally defined (i.e., described in an observable, measurable manner)
8. Deficit behaviors are stated so that the present and needed levels of functioning are indicated
9. Skill strengths and deficits are stated in words likely to be understood by client
10. The entire assessment is written in language likely to be understood by the client

II. Planning
1. There is written identification of interventions to modify client’s skills and environmental resources in order to achieve overall rehabilitation goal
2. There is a statement of the overall rehabilitation goal written on the plan
3. Skill and resource strengths and deficits are translated into goal statements
4. Goals are prioritized
5. Interventions for each of high priority goals are stated (e.g., skill programming, skill teaching, community resource coordination)
6. Times for interventions are stated (e.g., when intervention begins or ends)
7. A specific person is assigned responsibility for each high priority intervention
8. The entire plan is written in language likely to be understood by the client
9. There is evidence of client involvement in the planning (e.g., signature on plan or place for signature)

III. Interventions
1. There is evidence of rehabilitation programming (i.e., a step-by-step plan to achieve goals—client is the one taking active steps)
2. There is evidence of skill teaching (i.e., a step-by-step procedure that enables client to learn new skills)
selection purposes. This instrument was used to provide pre-post data about the effect of the training on the agency’s programs and structure. The following areas were surveyed:

- Client information.
- Staff information (e.g., client/staff ratio, staff turnover).
- Program information (e.g., assessment procedures, client participation in the assessment, and program goals).
- Training/supervision information.
- Administrative information (e.g., administrative support for the psychiatric rehabilitation approach).

A system was developed to rate the above information. Points were given depending on how closely the agency matched the characteristics of an ideal psychiatric rehabilitation setting. For example, a “positive” answer to the staff/client ratio was a ratio of less than 1:10, while a “neutral” answer was a ratio of 1:11 to 1:16, and a “negative” answer was a ratio of more than 1:16. This assessment was performed before the training and again approximately 2–3 months after the intervention was completed.

Training of Raters. Five individuals (Master’s students in the Boston University Psychiatric Rehabilitation Program) were trained to use specified criteria for the ratings of the trainer-apprentices and trainees. Each rater was knowledgeable in the principles and skills of psychiatric rehabilitation and received 20 hours of training specific to the criteria. Samples of mental health workers’ skill application, skill acquisition, and clinical records were rated by an expert trainer, and those ratings were used as criteria for the training of raters. Checks after each training session were performed to determine how close to criterion the raters were performing.

Interrater agreement was calculated on the measures of skill acquisition and application by determining the percentage of agreement of each rater with the “expert” rater. Agreements were calculated as follows: agreements/(agreements plus disagreements). Twelve comparisons were made on measures of skill acquisition; seven of these comparisons yielded agreements of 75 percent or more, and five yielded agreements between 64 and 74 percent. Sixteen comparisons were made of interrater agreement on skill application scores; eleven of these comparisons yielded percentages of greater than 75 percent, and five yielded agreements of between 50 and 65 percent.

The clinical review scoring was also examined for interrater agreement. Pearson correlation coefficients were computed using four samples of clinical records. The ratings of each of the three raters used for the records reviews were compared to the expert. Of the 12 correlation coefficients, seven ratings were between $r = .87$ and 1.00; two were between $r = .49$ and .62; and two were between $r = .30$ and .35.

The raters were unaware of the order of all assessments and the record reviews; i.e., they didn’t know whether the data derived from pretraining or posttraining periods.

Results

Acquisition of Psychiatric Rehabilitation Skills. For the trainer-apprentices of year 1 and trainees of year 2, significant improvement in skill acquisition was made from pretraining to posttraining. For the trainer-apprentices of year 2 made significant gains from pretraining to posttraining in all areas except planning. They improved in their ability to perform a rehabilitation diagnosis, and in two measures of intervention ($t = 5.07, df = 7, p < .001; t = 7.79, df = 5, p < .001; t = 3.61, df = 7, p < .009$, respectively). In planning, significant gains were not noted ($t = 0.74, df = 7, p < .48$). One additional measure was used for year 2 apprentice-trainers, that of their ability to formulate an overall rehabilitation goal. They improved significantly in that skill from pretraining to posttraining ($t = 4.21, df = 7, p < .004$).

Application of Psychiatric Rehabilitation Skills. As a total group, trainer-apprentices and their trainees demonstrated significant improvement from pretraining to posttraining for skill application in each of the three areas of rehabilitation diagnosis, planning, and intervention ($t = 7.98, df = 62, p < .0001; t = 10.71, df = 48, p < .0001; t = 7.38, df = 50, p < .0001$).

Use of Psychiatric Rehabilitation Skills. For the self-report of utilization, trainer-apprentices and trainees were asked to indicate the extent to which they felt they needed to learn each of 21 psychiatric rehabilitation skills. One hundred utilization questionnaires were completed. Level of need was rated on a 5-point scale ranging from no need (1.0) to great need (5.0). The
individual skills (and their mean level of need) viewed as most "needed" were:

- Identifying skill strengths and deficits in relation to a rehabilitation goal (M = 4.0).
- Defining goals in relation to specific environmental situations (M = 3.91).
- Defining skill strengths and deficits in observable, measurable terms (M = 3.91).
- Developing teaching plans (M = 3.88).
- Defining an overall rehabilitation goal (M = 3.87).

In response to the question about the extent to which the trainees were using psychiatric rehabilitation skills, the following skills had the highest mean score:

- Involving the client in the process of rehabilitation (M = 4.61).
- Responding to the client’s feeling and problems (M = 4.52).
- Identifying skill strengths and deficits in relation to a rehabilitation goal (M = 4.31).
- Defining goals in relation to specific environmental situations (M = 4.30).
- Providing feedback opportunities (M = 4.25).

There was some convergence in the skills perceived as needed and as being used. Two of the five skills perceived as most needed were also rated as being used to the greatest extent. Curiously, the skill of "developing teaching plans" ranked high in perceived need but was not perceived as being greatly used.

To the remaining questions on use of skills, the trainees and trainers-apprentices were asked to indicate to what extent they perceived readiness, support, and a strategy to adopt the psychiatric rehabilitation approach in their agency. Mean scores to these nine items fell into the "some extent" to "moderate extent" categories. The lowest mean responses were to questions of whether it was "manageable to adopt the new skills" and "the extent to which the agency had adopted the principles and practices of psychiatric rehabilitation."

In the second measure of utilization, a total of 307 samples of clinical records were received by the Center and were sufficiently complete for rating. The samples of records were obtained before the training and again 1-1½ years after the training ended. The Center allowed 1½ years to elapse after the training for the posttraining record samples because clinical records were expected to be the last medium to reflect the adoption of an innovation. Due to the large amount of staff turnover between the pretraining and posttraining record reviews, however, statistical analysis comparing the two sets of ratings could not be undertaken. Therefore, a percentage of gain score for each component of the record review was computed using the following formula:

\[
\text{Gain Score} = \frac{\text{Post Mean Rating} - \text{Pre Mean Rating}}{\text{Pre Mean Rating}} \times 100
\]

The rehabilitation diagnosis record review had a mean of .58 on pretraining (n = 85) and a mean of 1.19 (n = 43) at posttraining (range = 0.0-2.4) for a gain score of 105 percent. The planning record review had a mean of .69 before (n = 127) and a mean of 1.60 after training (range = 0.0-2.2) for a gain score of 132 percent. Finally, the intervention portion of the record review had a mean on pretraining of 1.95 (n = 10) and a mean of 2.54 (n = 19) on posttraining (range = 0.0-3.0) for a gain score of 30 percent. For the record samples of trainer-apprentices and trainees who remained in the agency, paired t tests were conducted on rehabilitation diagnosis and planning samples. Significant improvements were noted in both record reviews (t = 2.72, df = 12, p < .02; t = 8.55, df = 32, p < .001). No pretraining-posttraining samples of the intervention samples were available for analysis.

Impact of Training on Program Structure. Comparing the sites to an "ideal" program structure yielded a mean of 16.75 at pretraining and a mean at posttest of 22.75, out of a possible 40 points. A paired t test suggested that significant changes occurred in agency structure (t = 1.97, df = 7, p < .05).

Discussion

The major conclusion from this study is that psychiatric rehabilitation skills can be effectively transferred via a "training of trainers" approach. That is, staff from carefully selected agencies can learn psychiatric rehabilitation skills and then learn how to teach them to their own staff. Our experience indicates, however, that intensive consultation is required to help agencies adopt this innovation. The amount and duration of followup assistance required to implement psychiatric rehabilitation in these nine sites was more extensive than originally expected. Analysis of the utilization questionnaire suggested that the trainer-apprentices and trainees also perceived the process of innovation as a difficult one.
Our experience corroborated what was suggested by the utilization literature—namely, that innovations such as this are complex and can change the very fabric of an organization. Change must occur at all levels of an organization if an innovation is to be permanent and not just superficial. The principles of utilization listed in the following table provide an accurate and comprehensive picture of what an agency and a change agent face during the planning and implementation of any meaningful innovation. All of the variables outlined by Backer, Liberman, and Kuehnel (1986) were critical to the innovation process, especially the need for organizational support and persistent championship of the innovation.

Additional findings which emerged from this 3-year project can be summarized as follows:

1. The number of inquiries and applications to the project indicated a growing interest in psychiatric rehabilitation as a treatment modality for individuals who are severely psychiatrically disabled (Mosher 1986).


3. The rigorous site selection process contributed to the Center's understanding of the sites' readiness for use of psychiatric rehabilitation skills. The philosophy of an agency, its rate of staff turnover, its programmatic sophistication, and the value it places on staff development are critical to implementing psychiatric rehabilitation approaches. A selection process must take these factors into account.

4. Accurate selection of agencies for "training the trainers" is not possible without a site visit where one can observe and assess the organization, and potential trainers and trainees (Farkas, Cohen, and Nemec 1986). While the written site selection application provided helpful information, it was not sufficient to judge the motivation and capacity of the personnel.

5. The initial 5 days of training in psychiatric rehabilitation skills at Boston University served a readiness function, but failed to make the trainers-apprentices totally proficient in the skills. Most trainer-apprentices did become sufficiently motivated to acquire the skills by practice at their agency with feedback from the Center's trainers.

6. Learning how to teach the psychiatric rehabilitation skills allowed the trainer-apprentices to gain substantially in their understanding of psychiatric rehabilitation. It seems as if the adage is true: "The best way to learn is by teaching."

7. Training by the trainer-apprentices at their sites proved to be the most difficult task. The Center assumed that knowing the psychiatric rehabilitation skills and knowing how to teach them would be sufficient. However, because of resistance to innovation, the trainer-apprentices also had to learn how to mobilize the political system in their agency.

8. The most effective part of the training at the sites was the weekly "study group" concept carried out at each site. The most difficult part of the training appeared to be the intervention skills. The agencies seemed to adopt the rehabilitation diagnosis and planning phases of the approach more readily than the intervention of teaching skills directly to clients. This intervention may be particularly difficult because it requires the greatest shift by practitioners from their typical roles and practices.

9. Without question, the training at the sites raised the energy level of the agencies but also produced many crises in the staff (e.g., "What if I don't want to do rehabilitation?").

10. Staff turnover and resistance to research projects greatly affect the data collection process (Marlowe, Spector, and Bedell 1983). It is unclear whether staff turnover rates changed because of the project, but the literature suggests that major innovations often provoke staff turnover early in the implementation phase.

11. Audiotapes appear to be more useful in determining if skills can be applied than paper-and-pencil questionnaires; that is, trainees may demonstrate acquisition of the skills on paper and still not be able to apply them.

By conducting this utilization project with its comprehensive evaluation, the Center gained insight into how to implement a psychiatric rehabilitation approach and how to refine the psychiatric rehabilitation skills curricula. This project stimulated the production of a series of multimedia training packages designed to teach practitioner skills (Cohen, Farkas, and Cohen 1985).

In addition, the extensive development and testing of personnel and program instruments has made it possible to evaluate the use of training interventions and program consultation. Course work, workshops, and technical assistance in psychiatric rehabilitation can now be assessed by whether people are doing things differently as a result of the intervention.

Using audiotapes for feedback and as measures of outcome has become an integral part of the Center's training technology. Individuals who wish to be certified trainers or practitioners in psychiatric rehabilitation must submit audiotapes as evidence of their ability to apply skills. An off-campus Master's degree program...
in psychiatric rehabilitation at Boston University relies extensively on audiocassettes of client-practitioner sessions as data for feedback and evaluation. The use of audiocassettes in psychotherapy outcome research also has received wider recognition (Cooke and Kipnis 1986). In conclusion, this project demonstrated the effectiveness of a "training of trainers" strategy for promoting the use of psychiatric rehabilitation skills in nine different mental health agencies.

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