Regular Articles

Effectiveness of Technical Assistance in the Development of Psychiatric Rehabilitation Programs

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Abstract

Most mental health programs need technical assistance to develop effective psychiatric rehabilitation programs. This article discusses how psychiatric rehabilitation was introduced into three community mental health programs and describes the elements of a psychiatric rehabilitation program and the phases of a technical assistance process. A case study illustrates how technical assistance consultants can be trained to develop psychiatric rehabilitation programs. Barriers and facilitators to the technical assistance are discussed in the context of several other technical assistance studies.

Introduction

New approaches to community support and rehabilitation services for persons with severe psychiatric disability are being developed and evaluated.[1-7] Descriptions of new and innovative programs in the literature are intriguing but often are insufficient for replication in new environments. Successful adaptation of model programs to new settings is facilitated by technical assistance. The term "technical assistance" has been used synonomously with staff training, on-site consultation, development of resource materials and the establishment of information clearinghouses.[8-15] Recent efforts to define technical assistance as it applies to community support and rehabilitation have narrowed its scope to a specific process of program development consultation.[16,17]

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The Center for Psychiatric Rehabilitation is based at the Sargent College of Allied Health Professions at Boston University and is funded, in part, by the National Institute of Disability and Rehabilitation Research and the National Institute of Mental Health. The Center conducts research, develops educational materials, disseminates new knowledge, and provides training and technical assistance in the area of psychiatric rehabilitation.

This article describes this newly defined technical assistance process by reporting on the development, implementation and evaluation of a technical assistance initiative. This project was unique in that mental health administrators were taught to be providers of technical assistance and not merely provided with technical assistance. This approach was expected to allow technical assistance to be available on a continual basis from within the mental health system. In this Introduction, an explanation of the principles of technical assistance is followed by a description of the application of the technical assistance process in psychiatric rehabilitation program development. A case study is presented describing a statewide technical assistance effort in which agencies were assessed, technical assistance was provided and the process was evaluated. The evaluation is discussed, and implications for administrators are identified.

Principles of Technical Assistance

Technical assistance involves a consultant helping a program adopt a new "technology."[18-20] The term technology implies defined and tested knowledge and methods which are applied to achieve a stated purpose, usually to increase or improve program outcomes.[8,10,16,17]

Objective assessment is crucial to technical assistance. Agency staff may perceive congruence with an "ideal" program, but this is not equivalent to congruence demonstrated through an objective assessment process. Perceived change following technical assistance may or may not be related to objectively measured change. Satisfaction with technical assistance may or may not be related to measured or perceived change. Each type of assessment is valuable.

As the technical assistance is provided, ongoing evaluation needs to occur to judge whether the strategies employed are on target and to identify and address unanticipated barriers. Once the technical assistance is completed, objective and subjective evaluations should be conducted to determine whether the desired goals and objectives have been achieved. The emphasis on ongoing evaluation and follow-up suggests a long-term technical assistance process, but a minimal amount of technical assistance consultation can produce change in an agency.[14,15,21] The "common sense" belief that more consultation is more effective is not supported in the literature. As little as one consultation visit can be sufficient to produce change.[15]

Support from the service system in which the program operates is critical to the success of technical assistance. Funding, staffing, commitment to training and stated service priorities are some of the most critical forms of support which can be offered by agency administration and the larger service system. Technical assistance to the service system can help put such support into place, thereby increasing the chances that technical assistance to agencies will be successful.

Requests for technical assistance should come from the agency and should emerge from an expressed need for the technology. Technical assistance provided solely as part of a mandate from a funding source can meet with resistance from agency staff. Staff attitudes need to reflect a sense of need. The role of the technical assistant should be clarified to distinguish it from the role of a state monitor or evaluator. Weaknesses in any of these areas will present significant barriers to the success of the technical assistance.

Psychiatric Rehabilitation Programs

Because the psychiatric rehabilitation approach is a clearly defined technology that includes specialized knowledge and methods[22-25] packaged in multimedia training materials,[26-29] it can be imparted by means of technical assistance. Use of the technology results in consistent and replicable psychiatric rehabilitation practice.[26-30] The technology was developed from a base of research,[1,23,31] and now a body of data is being developed to support its effectiveness.[32]

A psychiatric rehabilitation program has three major elements: the mission, the rehabilitation process and the environments in which programming occurs.[5,17,33] The mission provides overall direction for the program. Often, however, mission statements are developed simply to obtain funding and are considered by program personnel to be irrelevant to day-to-day program operation. In a psychiatric rehabilitation program, the mission does provide a foundation for program development and is used as a guide for program operation. The mission of psychiatric rehabilitation is to improve a client's functioning so that

the client is successful and satisfied in their environment of choice, with the least amount of ongoing professional intervention possible.[25] The values and principles of the psychiatric rehabilitation approach are incorporated in the mission statement,[5] which then becomes the basis for policy and funding, staff and client orientations, and program evaluations. Consultation and technical assistance can be helpful in defining organizational missions and long-term goals.[34]

The rehabilitation process is the most critical aspect of a rehabilitation program. The process includes the phases of diagnosis, planning and intervention. Psychiatric rehabilitation diagnosis helps clients choose a place to live, learn, socialize or work, and it involves clients in an assessment of the skills and supports they need to be successful and satisfied in their chosen environments. Developing a psychiatric rehabilitation plan organizes the client's priority goals and identifies interventions needed. Interventions help clients learn skills they do not possess, practice those skills they need to improve and link up with needed supports, and these interventions create supports that do not exist. The organizational structures needed to support this rehabilitation process include policies, procedures, activities and record keeping.[5,33]

Policies are guidelines for program practice and describe a general course of action. For example, a rehabilitation policy might include a statement such as, "All clients will be assisted to make a choice about where they would like to live, learn or work in the next six to24 months." Procedures describe the step-by-step methods for carrying out the program policy. For example, a procedural statement in relation to the policy example might be, "During the client's first week, the intake worker will assess the client's readiness to begin setting a goal." Program activities are interactions between clients and practitioners that translate the procedures into action. For example, a program activity might include organized visits to various residences to help clients gather information about places they would like to live. Systematic record keeping helps document the events and outcomes of program activities.

A program's environments are the residential, vocational or educational settings that are within the control of the program administration. A comprehensive network of environments will include an integrated range of settings in the living, learning and working areas that can accommodate clients of various levels of skill.

Technical Assistance in Psychiatric Rehabilitation

The technical assistance process involves four phases: assessment, cooperative planning, delivery of the technical assistance and evaluation. Technical assistance in psychiatric rehabilitation begins with an assessment of the program in terms of readiness and congruence. An assessment occurs of the readiness of a psychiatric rehabilitation program to receive consultation concerning implementation of psychiatric rehabilitation practices as well as an assessment of the congruence of the program's existing practices with "ideal" practices.[11,33,35]

Assessing readiness determines the extent to which a program's culture can facilitate or hinder the implementation of the psychiatric rehabilitation approach.[5,36] A critical element in readiness assessment is the value the agency staff places on the assistance.[16,37,38] Value relates to a perceived need for the technical assistance or consultation,[38] as well as a sense of fit,[39] between the recipient and the assistance offered. Also of importance in determining readiness is the issue of support from, for example, the political structure in which the program must function.[16,40-44] Resources must exist to allow the recipient to make use of the technical assistance, to implement the technology and to maintain its utilization.

Evaluating congruence enables the technical assistance consultant to identify strengths and weaknesses in the agency's delivery of psychiatric rehabilitation services.[45] The assessment results are specific to psychiatric rehabilitation. They do not evaluate the agency's overall effectiveness, nor do they reflect the efficiency of the management structure. Rather, the program assessment indicates the program's compatibility with the psychiatric rehabilitation approach and its readiness to receive technical assistance in psychiatric rehabilitation.

Following assessment, the cooperative planning process emphasizes the needs of the technical assistance recipient and involves third parties such as brokers or major funding sources who can help provide a broad perspective and lend support. The technical assistance consultant proposes target areas

for program change based on the assessment results. Agreement is reached about the goals and objectives, responsibilities, technical assistance strategies to be used, obstacles anticipated from the assessment results, and proposed methods to address those obstacles. The consultant's recommendations culminate in a mutually agreeable work plan for providing the technical assistance.

The third phase of the technical assistance process is the actual delivery of technical assistance. Technical assistance strategies used to create psychiatric rehabilitation programs use an "intense" approach[10,43] involving in-depth consultation and training. Techniques used include consultation to specify operating guidelines (mission, policy and procedures), organizing the psychiatric rehabilitation process, constructing record-keeping systems and designing rehabilitation environments. Training practitioners in the skills of psychiatric rehabilitation can be part of an overall technical assistance plan and has been found to be effective in improving client outcomes.[46] Program administrators who have received training as psychiatric rehabilitation practitioners then have gone on to implement changes in their rehabilitation programs.

Whatever the specific technical assistance strategy used, consultation must enable the program administrators to anticipate both the consequences of implementation of the technology and the difficulties associated with the change process itself. In one evaluation study of a technical assistance project,[16] the stress of change was a recurring theme among the agencies receiving technical assistance. Agency administrators reported staff turnover as both a result of and a contribution to the change process. Cultural issues, political structure and attitudes of the personnel involved were also cited as stressors during the change process. Introduction of new technologies often creates anxiety and conflict among service providers.[47] Lack of orientation to the process of change can have a negative effect on the technical assistance. Therefore, it is important to provide program administrators with knowledge and skills in the area of managing change as well as in the technology itself. The need for a thorough orientation to the change process is supported by the literature.[21,48]

Ongoing evaluation occurs for the purpose of judging whether the technical assistance strategies are on target and to anticipate any possible changes in the plan. Once the technical assistance is completed, a follow-up evaluation is conducted to determine whether the desired goals and objectives have been achieved. The program assessment process is repeated to determine whether the degree of congruence between the program's delivery of psychiatric rehabilitation and an "ideal" psychiatric rehabilitation program has increased.[42]

Purpose of the Study

The purpose of this study was to use a case study approach to examine the efficacy of training technical assistance consultants to help develop psychiatric rehabilitation programs in community mental health centers. The case study described below was undertaken jointly by the West Virginia Office of Behavioral Health Services and the Center for Psychiatric Rehabilitation at Boston University.

Methods

As part of its long-range planning methods for the Community Support System, the Office of Behavioral Health Services (OBHS) in West Virginia developed a goal to implement the psychiatric rehabilitation approach in the state's 14 mental health agencies, known as community behavioral health centers, and in two state-operated psychiatric hospitals. Commitment to implementing psychiatric rehabilitation has been demonstrated by the OBHS and its Division of Mental Health and Community Rehabilitation Services in many concrete ways over a consistent period of time, including the allocation of funds for training.

As the first step in the project, 10 people were originally selected, based on their expressed interest and availability, to receive training in technical assistance from the Center for Psychiatric Rehabilitation. The trainees included four state personnel from OBHS, one state hospital administrator, one state hospital

program supervisor, two administrators from community behavioral health centers, one faculty person from a West Virginia university and one administrator from a hospital inpatient service.

Training occurred in two phases. First, the trainees received 10 days of training in the psychiatric rehabilitation skills used by practitioners and the implications for changes needed in a program structure to support use of those skills. During the second phase of training, six sessions in technical assistance consultation were conducted between July and December 1986. The purpose of the second phase of training was to teach the trainees how to become effective providers of technical assistance. The topics included program assessment (readiness and congruence assessment), proposing program change (cooperative planning) and creating a psychiatric rehabilitation program (specifying operating guidelines, organizing the rehabilitation process, constructing record-keeping systems and designing rehabilitation environments). Only four of the original 10 trainees were interested in committing the time needed on the technical assistance phase of the project. Those trainees included two state administrators from OBHS and two administrators from community behavioral health centers.

Four community mental health agencies were selected to be the target of technical assistance. The agencies were selected by OBHS, and final selection was made based on their commitment and readiness to implement the psychiatric rehabilitation approach. Organization, staffing, budget and demography differ among the agencies, but data were not collected to determine the impact of these factors on the technical assistance process.

Preconsultation agency assessments were conducted at the conclusion of the technical assistance training program. The assessments were performed over a two-day period by a team of evaluators. The teams included both trained evaluators from the Center for Psychiatric Rehabilitation and the newly trained technical assistance consultants. Information was collected through staff interviews, written questionnaires, a review of agency documents, client interviews and observations of program activities. The information collected was rated and summarized by a trained rater at the Center for Psychiatric Rehabilitation, and the ratings were used as a pretest against which to determine the effectiveness of the technical assistance consultation. After completing the initial agency assessments, two of the four remaining technical assistance consultant trainees changed jobs and were unable to continue participation in the study, leaving only two of the original trainees on the project.

Two of the four agencies targeted received formal technical assistance, one received informal assistance and one agency received assistance which was limited to cooperative planning and training program staff in psychiatric rehabilitation. The two agencies that received formal technical assistance had equal amounts of contact with one of the trained technical assistance consultants (a total of 64 hours over a 10-month period, with consultation occurring monthly). The agency receiving informal consultation had less contact with the consultant, about 40 hours over the 10 months. In all four agencies, the consultants worked with the agencies through an implementation committee. Psychiatric rehabilitation practitioners on the agency staff who were trained in psychiatric rehabilitation in a separate project were involved in the committees, which focused on program development and implementation. The technical assistance consultation assisted the committees with setting goals for the agency, revising the program mission statement and modifying the program process. One of the agencies experienced a change in leadership shortly after the initial assessment was conducted. Although technical assistance proceeded, there was a decrease in the level of support for the eventual implementation and maintenance of the psychiatric rehabilitation approach.

Following the consultation period, a second assessment was conducted by evaluators at three of the original four sites. The fourth site, which set goals but did not receive consultation, did not agree to the second assessment because the program administrators believed the program had not changed markedly. In addition, information about the impact of the consultation from the trainees, agencies and a state administrator was gathered. Finally, an evaluation of the technical assistance training was conducted to measure the satisfaction of the trainees/consultants. Those ratings were made immediately following the completion of the training and one year after the training was completed.

Table I. Agency Change Ratings[a]

Assessment Items	Measured Change	Perceived Change		
	Evaluator	Consultant	Agency	State
agency 1				
mission	0	++	+	0
diagnosis	+	0	+	0
planning	0	+	+	++
intervention	+	+	+	+
agency 2				
mission	0	++	+	+
diagnosis	+	++	+	+
planning	0	++	0	+
intervention	0	++	0	+
agency 3				
mission	0	+	+	+
diagnosis	+	+	++	+
planning	++	+	++	++
intervention	0	+	++	++

[a]Ratings: ++, great change; +, some change; 0, little or no change. Measured change was obtained by Center for Psychiatric Rehabilitation consultants using formal assessments. Ratings of perceived change were obtained by asking the technical assistance consultants, the agencies and state administrator about their perceptions of change in each of the componenets of psychiatric rehabilitation.

Results

Seven of the original 10 technical assistance consultant trainees responded to the one-year follow-up evaluation and satisfaction questionnaire. Five of these seven rated the training program as good or very good. The other two rated it as excellent. Of the three who did not respond to the follow-up questionnaire, one training participant had reported on the initial questionnaire feeling "very disappointed in the training;" the other two trainees also did not complete the questionnaire at the conclusion of the training. All of the four participants who became the technical assistance consultants reported that, one year following the conclusion of training, they were still using the knowledge and materials received during the training program.

Satisfaction with the technical assistance consultation was rated by administrators at the four agencies using a five point scale (excellent to poor). Their level of satisfaction with the overall consultation process ranged from fair (two agencies) to very good (two agencies). All of the agencies were satisfied with the goals of the consultation. One agency indicated that the goal of consultation was achieved and that the amount of consultation received was "just right." The other three agencies believed more consultation was needed. The ratings of satisfaction with amount of consultation were not related to the amount of consultation actually received.

Agency administrators, the technical assistance consultants and one state administrator from OBHS were asked to rate the amount of change they perceived as resulting from the technical assistance consultation. Their perceptions of agency change varied. Table I summarizes those perceptions. Change was also evaluated based on the assessment data collected by trained evaluators from the Center for Psychiatric Rehabilitation. Interestingly, when the objective, or measured assessment of change, was

compared to each of the three sources of perceived change, there was no agreement about the amount of change. By use of the κ statistic for agreement between raters, the agreement was non-significant ($\kappa = 0.09, Z = 0.92$).

The measured evaluation of change by the Center for Psychiatric Rehabilitation indicated some positive change in each of the three agencies receiving consultation. Overall ratings of the program missions changed very little. Mission ratings were determined from a variety of sources including documents and interviews with executive directors and program staff. When individual sources were compared, some changes could be seen, but consistency among sources was poor. The mission statements given by executives following the consultation were much closer to an ideal psychiatric rehabilitation mission statement than the statements given prior to consultation. However, these changes were not always evident in program documents, and statements by program staff did not reflect parallel changes.

Some changes in the psychiatric rehabilitation process were found. The most consistent impact was in the area of rehabilitation diagnosis — a process used to help clients choose a setting in which to live, learn or work and to assess the skills and resources the client needs to be successful and satisfied in that setting.[30] Rehabilitation interventions were the weakest aspect, and rehabilitation planning was the strongest aspect of the psychiatric rehabilitation process in the three agencies.

Discussion

Results of this project are similar to those of several other technical assistance studies, suggesting that the process of providing technical assistance to psychiatric rehabilitation programs is predictable and supporting the technical assistance principles identified earlier.

In this evaluation, the positive program changes, both measured and perceived, demonstrated that even minimal technical assistance can have an impact. The total contact time of the technical assistant was no more than eight days with any agency; the program assessment provided another two days of assistance. Contact during the eight days included goal setting based on the program assessment results. This indicates that at least 25% of the total technical assistance contact time related directly to conducting and discussing the program assessment. While it is not possible to separate the impact of the program assessment from other factors promoting change, simply presenting an agency with this type of assessment information can produce change.[49]

The rehabilitation process demonstrated in the agencies in this study showed patterns of assessment and change results similar to the results in other studies of agency change in psychiatric rehabilitation.[33,35] In each study, planning was initially the strongest phase of the rehabilitation process, intervention was initially the weakest, and diagnosis was the phase showing the greatest change following technical assistance consultation.

Rehabilitation planning may be consistently strong for several reasons. State funding and insurance reimbursement regulations require clear objectives and specific review dates and often insist on individualized plans that indicate client agreement with the plan. These characteristics are all seen as desirable in a model psychiatric rehabilitation plan.[33]

In contrast to rehabilitation planning, the diagnosis and interventions in many programs are most influenced by a traditional psychotherapeutic orientation. Diagnostic process often draws from the DSM III-R,[50] a system largely irrelevant to psychiatric rehabilitation.[25] Interventions based on the clinical therapeutic techniques still taught in most professional mental health disciplines might be described as "round holes" into which people with severe psychiatric disabilities (the "square pegs") are expected to fit, with little or no success.[42] Changes in intervention methods may also be difficult due to negative staff attitudes toward working with this population.[42,51] A technical assistance case study in Michigan[42] identified an additional area of difficulty in changing interventions: staff tended to deliver services in a way that met their own professional needs and desires but not necessarily those of the clients. Finally, interventions may be difficult to alter because they are not monitored closely or documented in the records. Individuals and organizations tend to direct their energies toward areas where information is

collected, as opposed to areas where there is no data collection.[49] Practitioners often are not required to document and justify their interventions. In contrast, in psychiatric rehabilitation, both diagnosis and interventions result in a written product that guides and documents the practitioner's performance.

The greater change in diagnostic procedures following technical assistance may be due to factors related to the process of gathering information from clients. Differences in traditional diagnostic interviews and the interviews conducted during a rehabilitation diagnosis relate partly to the type of information collected. Additionally, in psychiatric rehabilitation, the client is actively involved in guiding the diagnostic process and is thoroughly oriented to the process and its outcome.

During the evaluation of the technical assistance project, disappointments surfaced from all parties, even those perceiving much change. Even the most satisfied agency, which reported its goal had been met, described frustration that the changes needed to fully implement the technology of psychiatric rehabilitation happen slowly, and they had "to go much more incrementally than anticipated." Lack of time, difficulty contacting the consultant and lack of resources to support the technical assistance process all were mentioned as negatives. The inclusion of the OBHS administrators in the technical assistance consultation training caused some confusion for at least one agency. It was difficult for agency staff to distinguish the monitoring and funding roles of the OBHS administrator from the consultant role. The strongest complaint was about "the state Department of Health's 'great expectations' for implementation of psychiatric rehabilitation without the investment of requisite financial support." The theme of great expectations was echoed by one of the original trainees on the follow-up satisfaction questionnaire. Lack of financial support for implementing psychiatric rehabilitation and an experience of pressure from the mental health authority were cited as barriers in this study and have been cited as barriers in other evaluations of technical assistance projects.[16,42]

Some aspects of this case study were paralleled in a Michigan case study.[42] There, the state provided technical assistance and increased funding to a community mental health agency to implement the Program of Assertive Community Treatment Model (PACT).[52] Lack of motivation to change was a major barrier, and funding for program implementation did not seem to have an impact on practitioner attitudes. An additional difficulty was that the Michigan Department of Mental Health did not make clear who was responsible for the implementation of the program, and criteria were not specified for evaluating the adequacy of implementation.

The extent to which financial factors are barriers or incentives is difficult to determine, since they provide such a convenient target for blame. Many states are shifting funding priorities to services for persons with long-term and severe psychiatric disability[53,54] with a concurrent emphasis on developing community support and rehabilitation programs. For practitioners trained in and committed to providing outpatient services, this shift in funding priorities is seen as a funding cut when it is not accompanied by a similar shift in treatment priorities. Effective technical assistance in developing psychiatric rehabilitation programs must emphasize increasing practitioner motivation to serve the most severely disabled population and assisting administrators in identifying funding alternatives for services.

Implications for Administrators

Just as it is possible to train staff to teach psychiatric rehabilitation skills to practitioners, it is also possible to train technical assistants how to assist administrators in developing rehabilitative programs. Skilled practitioners must have state-of-the-art psychiatric rehabilitation programs in which to work, or attrition and burnout will result.[22] Training of psychiatric rehabilitation technical consultants should further the development of ideal psychiatric rehabilitation programs.

Administrators should assess the impact of the technical assistance process from a number of perspectives, including objective measures if possible. The differences between perceived change and measured change in the case study were not unexpected, but they do serve to highlight the value of different sources of information. Administrators can then determine which information sources have provided them with assessment information on which they wish to make decisions and take action. The evidence from this case study (that minimal consultation can produce change) supports the notion of

evaluating the impact of brief technical assistance interventions. The value of brief technical assistance in producing important program change has been confirmed once again by this case study.

The attrition of the trained technical assistance consultants in this study raises an important concern for administrators. Training technical assistance providers was emphasized in this study in the hope that local consultants would be more consistently available. This approach was used in other studies[46] because it has been demonstrated to be an effective method for imbedding an innovation into an organization. Without developing an agency's in-house capacity for change, and involving agency staff in the change process, the innovation is likely to fade when the outside consultants depart. Training to be a technical assistant consultant in psychiatric rehabilitation is demanding and time consuming. Practitioners who are already skilled in psychiatric rehabilitation practice may not wish to make the personal investment to be trained in psychiatric rehabilitation technical assistance. Furthermore, those who do become expert technical assistance consultants are uniquely qualified staff and attractive candidates for other job openings. Administrators must structure the jobs of these in-house consultants so that their expertise is used and valued.

With respect to researching technical assistance at their agencies, administrators should ensure that both the model for technical assistance provided and the technology being implemented are described in detail. Differences in the technical assistance process and/or the desired program outcomes may prevent comparisons among studies.[55]

While change in the agency's practices as a result of technical assistance consultation can be measured, changes in organizational culture are more difficult to assess.[56] The development of standardized tools to measure the culture of psychiatric rehabilitation programs will improve future efforts to assess changes and to identify the extent to which cultural barriers affect the change process. Finally, organization structure, staffing patterns, budget and demography of service area are ingredients that should be monitored in future studies to assess their effect on the technical assistance process.

As illustrated by the present case study, it is possible to train technical assistance consultants to assist administrators in developing psychiatric rehabilitation programs. Once trained, these consultants can have a positive impact on program development, thereby furthering the development of ideal psychiatric rehabilitation programs. In addition, incorporating research into ongoing technical assistance projects will facilitate identification of the principles and techniques of effective consultation. Reporting such research will increase the knowledge of both providers and recipients of technical assistance.

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