Performance Standards

Psychiatric Rehabilitation Services

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, increase the consistency of service delivery, and improve outcomes for members.

Disclaimer: These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements, and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.
Table of Contents

Introduction ............................................................................................................................... 3
  Brief Description .................................................................................................................. 3
  Purpose of Performance Standards ....................................................................................... 3
  Philosophy and Principles ................................................................................................. 3
  Principles Specific to the Clubhouse Model ...................................................................... 4

Psyciatric Rehabilitation Approaches/Models ................................................................. 5
  Concurrent Use of Varying Models of PRS .................................................................... 5
  Use of Evidence-Based and Best Practices ..................................................................... 5

Program Specifications ........................................................................................................ 6
  Eligibility for Services .................................................................................................. 6
  Service Process ............................................................................................................. 7

Staff and Program Requirements ......................................................................................... 11
  Program Requirements ............................................................................................... 11
  Staff Requirements .................................................................................................. 11
  Record Keeping .......................................................................................................... 12

Quality Improvement ........................................................................................................ 13

Outcome Measurement ........................................................................................................ 13

References .......................................................................................................................... 15

Appendix A .......................................................................................................................... 17

Appendix B .......................................................................................................................... 25
Psychiatric Rehabilitation Services Performance Standards

Introduction

Brief Description

Psychiatric rehabilitation services (PRS) incorporate principles of recovery and wellness, community support, person-centered care, and active involvement of individuals and families in the behavioral health system and services. Based on the definition from the Psychiatric Rehabilitation Association (PRA, formerly USPRA), psychiatric rehabilitation:

“...promotes recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person-directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.” (PRA, 2011)

Purpose of Performance Standards

Because psychiatric rehabilitation is intended to be a person-directed and recovery-oriented service, the overall intent of this document is to establish broad parameters within which a variety of successful approaches can flourish. These performance standards are intended as a guide to best practice in psychiatric rehabilitation for site-based and mobile services, and Clubhouse Model programs.

Philosophy and Principles

PRS are recovery- and wellness-oriented, person-centered services offered individually or in groups. PRS is based on the principles, values, and practice standards of the Psychiatric Rehabilitation Association and Clubhouse International (CI, formerly International Center for Clubhouse Development).

A basic premise of PRS is that all individuals can recover. Recovery is defined as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, 2011). Recovery is not defined as a lack of symptoms, but the presence of meaning and purpose in life. In PRS, all individuals, regardless of the severity of the symptoms of their illness, are given the opportunity to learn, grow, and/or maintain skills in the life domains of their choice. Growth is accomplished by gathering information, sharing strategies and resources about recovery and wellness, and practicing self-care.

PRS must be designed to focus on each individual’s strengths and supports. The process involves helping people to identify what is needed to function in their chosen life roles, and learning the skills and using supports that they need to be successful. PRS require that an individual be actively involved in the design, development, and management of their recovery plan as well as in the overall PRS
Individuals are full partners in the planning of a program of services and activities designed to assist people in reaching their recovery goals, hopes, and dreams.

In addition to a focus on recovery, PRS programs are in a unique position to support health and wellness of individuals in recovery. Wellness is defined as the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness (Dunn, 1961; www.samhsa.gov/wellness). Making wellness a part of one’s daily life can improve mental and physical health for individuals recovering from mental health and substance use conditions (http://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness).

PRS must be sensitive to multicultural principles. PRA has endorsed 10 principles as the foundation for providing effective multicultural psychiatric rehabilitation services (http://www.psychrehabassociation.org/principles-multicultural-psychiatric-rehabilitation-services). One concept that psychiatric rehabilitation practitioners should embrace is that culture is central to recovery because culture shapes each person’s hopes and dreams. Each person’s thoughts and behaviors are influenced by their worldview, which is directly affected by their culture. In culturally sensitive PRS, each individual feels accepted and feels a part of the PRS community. Practitioners can foster this acceptance by showing respect towards others and accepting each person’s cultural values and beliefs as essential to that person.

Recovery, wellness, and multicultural principles are woven into every PRS service whether practitioners are working with groups or individuals. Services are provided at site-based facilities, in the community, and/or at the person’s home or place of their choosing. Programs must operate at hours convenient to individuals participating and should consider individuals’ needs outside of normal business hours. Programs operating in rural communities will need to be creative regarding the challenges associated with rural areas.

**Principles Specific to the Clubhouse Model**

The Clubhouse Model is a specific type of PRS and has specific standards of operation and guiding principles that any program that identifies itself as a Clubhouse must follow. A Clubhouse is organized to support people living with mental illness. During the course of their participation in a Clubhouse, members gain access to opportunities to rejoin the worlds of friendships, family, employment, and education, and to the services and support they may individually need to continue their recovery (Clubhouse International, http://www.iccd.org/whatis.html). Clubhouse programs should follow CI standards regarding hours of operation, including operating five days a week for the work-ordered day and being available for recreational and social programming evenings, weekends, and legal holidays.

CI has established 36 standards of operation and guiding principles to which all certified Clubhouses must adhere (most recently updated in February 2015, available at http://www.iccd.org/quality.html). These standards are specified under the following principles:

- **Membership**: participation is fully voluntary and members can access all the opportunities available to them through Clubhouses.
- **Relationships**: unique collegial relationship between Clubhouse staff and members.
- **Space**: the importance of creating an area for the Clubhouse that is distinct from other programming and that is a dignified, attractive environment where important work is carried
out.

- **Work-ordered day**: the structure of the day-to-day activity within a Clubhouse, organized to help members develop self-esteem, confidence, and friendships, which make up the foundation of the recovery process.
- **Employment**: members offered organized, effective strategies for employment, including transitional, supported, and independent employment opportunities.
- **Education**: members offered effective strategies to complete their education.
- **Functions of the house**: addresses basic requirements for meeting members’ needs, with an emphasis on social and health care services.
- **Funding, governance, and administration**: describes requirements for overseeing and managing Clubhouses.

**Psychiatric Rehabilitation Approaches/Models**

**Concurrent Use of Varying Models of PRS**

A provider may offer PRS at a program site (site-based services) or in the community (mobile services), individually or in groups. Both mobile and site-based PRS can be offered under one license if the approved program description submitted to the Office of Mental Health and Substance Abuse Services (OMHSAS) indicates that both types of services are offered. Each PRS program should choose a model or approach to psychiatric rehabilitation services (e.g., the Boston University Choose-Get-Keep approach, the Clubhouse Model). If there is more than one model in use, each must be able to function on a “stand alone” basis. The provider is expected to:

- Articulate the principles and elements of the model(s) used
- Demonstrate competency in using the model(s)
- Provide a service description that denotes ways in which the program is consistent with the model(s)
- Demonstrate that the model(s) chosen are appropriate for the population served

Any model of PRS can be used in conjunction with individualized service or small groups (five or less) in the community. This concurrent use is based on the member’s individual rehabilitation plan (IRP) and activities that are goal-directed and occur in the community must be documented in the IRP. Using more than one model or service requires that the individual and the providers coordinate very closely on the delivery of services. The goals of each service must be well defined and delineated, and seen as necessary to the overall specific goals of the individual. Both services must ensure attention to and support of the interventions of each distinct service model.

**Use of Evidence-Based and Best Practices**

There is no single program approach or model that is required; rather, PRS programs are expected to use evidence-based and best practices that are effective in responding to the needs of individuals participating in the program. Evidence-based and emerging best practices often utilized in PRS
programs are listed below (described briefly in Appendix A). The provider may employ any or all of the evidence-based/emerging practices identified in their service description to meet an individual’s preferences and needs:

- Boston University Choose-Get-Keep (BU CGK) approach
- Clubhouse approach
- Wellness Recovery Action Plan (WRAP)
- The CommonGround approach
- Motivational Interviewing (MI)
- Illness Management and Recovery (IMR)
- Supported Employment: Individual Placement and Support (IPS)
- Family Psychoeducation (FPE)
- Peer Support
- Wellness Coaching
- Cognitive Enhancement Therapy (CET)
- Social Skills Training

**Program Specifications**

**Eligibility for Services**

**Entering PRS.** Individuals participating in PRS must:

- Choose to participate in the program
- Be 18 years or older or meet the age criteria established by OMHSAS for youth and young adults
- Have a written recommendation by a licensed practitioner of the Healing Arts (physician, CRNP, physician assistant, or licensed psychologist)
- Have a history or presence of a serious mental illness as defined in the regulations
- Have difficulty functioning in at least one life domain (living, learning, working, socializing)

Exceptions are noted in the regulations (at 5230.31.(c)) and should be discussed with a care manager before entering the program.

**Continuing PRS.** A person’s eligibility for continued stay shall be determined by documentation of the following:

1. An individual chooses continued participation in the PRS
2. A continued need for service based upon one or both of the following:
   a. As a result of the mental health condition, there is a functional impairment or skill deficit that is addressed in the IRP.
b. The withdrawal of service could result in loss of rehabilitation gain or goal attained by an individual.

**Leaving PRS.** An individual may be deemed ready for discharge if he or she meets one of the following criteria:

1. The individual has achieved goals and sustained progress as designated in the IRP.
2. The individual has gained maximum rehabilitation benefit.
3. The individual will not lose rehabilitation gain or an attained goal as a result of withdrawal of service.
4. The individual has voluntarily terminated the service.

**Service Process**

Comparable to the regulations, the PRS process can be seen as composed of the following stages, not necessarily consecutive, that emphasize the active involvement and choice of the individual in all phases. The process is individualized to the needs of the person and starts where the person is most comfortable.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Assessment</td>
<td>Individual has not identified a focus for psychiatric rehabilitation services</td>
</tr>
<tr>
<td>Engagement and rehabilitation readiness</td>
<td>Individual would like to change living, learning, working and/or social role/ environment, but lacks confidence about selecting a specific goal or lacks awareness of the resources and personal skills needed for goal selection</td>
</tr>
<tr>
<td>Choosing a goal</td>
<td>Individual is in the process of building knowledge and experience to make informed choices regarding goals</td>
</tr>
<tr>
<td>Achieving a goal</td>
<td>Individual is developing the functional skills and using supports necessary to achieve goals</td>
</tr>
<tr>
<td>Maintaining a goal</td>
<td>Individual would like to continue or maintain goal</td>
</tr>
<tr>
<td>Graduating/Transition to the Community</td>
<td>Individual has achieved his/her goals, has determined that he/she is ready to transition to the community and/or he/she is no longer interested in participation</td>
</tr>
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</table>

Prior to the start of PRS, a provider should work with the member to fully inform the member of the PRS opportunities available and confirm the member’s willingness to participate. This can occur
through a conversation by phone or in person between the member and provider staff or other program participants.

**Initial Assessment**

At this stage, the individual has not identified a focus for psychiatric rehabilitation services. The assessment should include developing relationships and assessing strengths and needs in each of the domains of psychiatric rehabilitation.

The initial assessment period provides opportunities for individuals and service providers to identify strengths, needs, and preferences in the areas of living, learning, working, and socializing. A

*initial assessment period provides opportunities for individuals and service providers to identify strengths, needs, and preferences in the areas of living, learning, working, and socializing. An initial planning process must begin upon the first day of attendance and an individual rehabilitation plan based on the assessment must be completed by day 20 of attendance but no more than 60 calendar days after initial contact. PR staff and individuals collaborate on a rehabilitation assessment, which includes the strengths and needs, skills and competencies needed to function in identified domain areas, existing and needed natural and formal supports and other resources, cultural needs and preferences. The assessment is done in collaboration with the individual and any additional supports he/she chooses. The assessment is updated annually or when the individual requests an update, when a goal is completed, or when no progress is made on the stated goals.*

*Example: Using a strengths-based assessment, the individual has identified that he would like to live in a more independent setting but needs to learn how to budget, cook, and maintain the home.*

**Engagement and Rehabilitation Readiness**

At this stage, the individual would like to change living, learning, working, and/or social status but lacks confidence about selecting a specific goal or lacks awareness of the resources and personal choices regarding the goal.

Prior to the development of an IRP, individuals in service may participate in activities within the program to assist in identifying areas for goal development and developing rehabilitation readiness. Activities may include, but are not limited to:

- Groups both onsite and in the community
- Peer support from other members
- Individual skill building and supports with peers or staff

*Example: The individual has identified that the living domain needs development but is not sure where to begin with skill building. To engage and build readiness, he may attend a cooking skills group and also participate in a community activity at the grocery store to purchase items for meals that remain within his budget. These activities will help him to learn further skills he needs to develop for his goal.*

Program staff must collaborate with individuals and other stakeholders in identifying potential obstacles to participation and design strategies to overcome those obstacles. Examples of such obstacles might include (but are not limited to) hours of operation, transportation, issues of stigma and social exclusion, lack of cultural awareness, sensitivity, or competence.

It is understood that some individuals will have difficulty participating in psychiatric rehabilitation
services because of limitations related to disability, the effect of co-existing health conditions, lifestyle preferences, or other factors. In these situations, PRS services should provide resource and skill development to assist the person to participate in the service before considering discharge options. Others may reach a point where it is mutually agreed that the service is not meeting the individual’s needs at that time. In such situations, the provider is expected to fully explore other service options with the individual, including the possibility of interventions to foster a readiness for psychiatric rehabilitation.

Choosing a Goal

At this stage, the individual is in the process of building knowledge and experience to make informed choices regarding goals. This stage should incorporate planning and prioritizing needs and preferred skills and supports as well as planning for skill and resource development.

Staff and the individual use the assessment to identify goal areas and develop an IRP. The IRP must be developed early in order to guide the PR process, so that the member has a direction and purpose for being involved in PRS. The IRP must be comprehensive and should include means of integrating the psychiatric rehabilitation goals with the goals of other services with a focus on community integration. The member will co-sign all assessments, plans, and updates signifying informed participation and agreement with the goals and objectives. The initial IRP must be completed within 20 days of attendance, but no later than 60 calendar days after initial contact.

While the IRP incorporates the interventions that the individual selects, there may be times that these interventions are not adequate to facilitate goal achievement. PRS staff will assist individuals to explore wellness and supports needed and desired by PRS as the individual pursues psychiatric rehabilitation goals. Additional interventions such as wellness coaching or developing a WRAP, crisis plan, or advance directive may also be useful.

The IRP shall be reviewed and updated collaboratively with the individual at least every 90 calendar days, as well as when a goal is completed, no significant progress is made, or if an individual requests a change. The IRP and the summary of progress and any changes to the plan should include the signature of the individual. The review will be a comprehensive summary that includes the following:

1. A description of the service provided in the context of the goal identified in the IRP
2. Documentation of individual participation and response to the service
3. A summary of progress or lack of progress toward the individual’s goal
4. A summary of changes made to the IRP

Example: After participating in the cooking and grocery shopping group, the individual identifies that budgeting and purchasing healthy food items within that budget need further development. He chooses a goal for his IRP in the living domain to learn how to create a weekly food budget. This goal may include steps such as creating a weekly menu, searching store fliers for sales, and using coupons to help remain within his budget.

Achieving a Goal

At this stage, the individual is developing and using the skills and supports necessary to achieve desired goals.
In order to achieve identified goals from the IRP, the individual may participate in activities that will teach specific skills and provide opportunities for practicing those skills either onsite or in the community. This stage includes the use of direct and indirect skill development, education, and building natural, community, and professional supports.

Example: After attending groups to plan healthy meals for the PRS program and purchase items for meals, the individual is ready to practice these skills in his own environment. He may work with peers and/or staff to create his own weekly menu and practice the skills he learned in the grocery shopping group with his sister. He can then work further with the staff to identify additional skills that may be needed to become more independent.

Maintaining a Goal
At this stage, the individual would like to continue or maintain the goal.

In order to maintain a goal, individuals may continue participating in PRS to assure that discontinuing participation will not result in a loss of skills learned. Individuals may continue to participate in groups related to their goals and perhaps co-facilitate groups or work individually with peers who are working on similar goals.

Example: The individual has successfully met his goal of being able to create a weekly food budget both with the group and with his sister. In order to maintain the skills learned, he continues to participate in the menu planning and grocery group and begins assisting with the facilitation of the group. He also works with a peer who has a similar goal so the two can practice the skills together.

Graduating/Transition to Community
Over the course of services, the individual and provider collaboratively determine the need for ongoing services. An individual may choose to leave psychiatric rehabilitation services when he/she has determined that he/she: 1) has achieved his/her goals, 2) is ready to transition to the community, and/or 3) no longer wants to participate in PRS.

In addition to following the Pennsylvania OMHSAS regulations regarding discharge from services, Community Care’s expectations include:

- Confirmation that the individual has made an active decision about leaving services
- Identification of interests and needs regarding other services and supports
- Coordination of care among all current and needed services and natural supports
- Sharing information about options for returning to PRS and/or to other available resources and supports
- Submission of Community Care’s Psychiatric Rehabilitation Discharge Form within 30 days (http://www.ccbh.com/providers/phealthchoices/forms/index.php)

Modification Specific to the Clubhouse Model
In addition to the above, under Clubhouse International standards, membership as part of the Clubhouse is voluntary and not time-limited. Participation in PRS, including the stages above, can be time limited. Individuals may choose to participate in ongoing social activities at the Clubhouse after
graduation from the work-ordered day. This standard requires that regardless of current level of functioning, a person may remain an active member of the Clubhouse community for as long as he/she wishes. Clubhouse programs should have a policy in place for doing outreach to members who are not actively participating, whether in PRS or social activities. Members have a right to immediate re-entry into the Clubhouse community after any length of absence, unless their return poses a threat to the Clubhouse community. Upon discharge for this reason, the person is informed of his/her rights and the process for appeal.

Staff and Program Requirements

Program Requirements

Providers must be licensed by the PA OMHSAS to be qualified to render psychiatric rehabilitation services. For clubhouses, providers are also expected to have certification through the Clubhouse International. Please refer to reference list for OMHSAS regulations (Pennsylvania Code, Chapter 5320, 2013) and Clubhouse International standards (2015) for details on provider qualifications.

Staff Requirements

Psychiatric rehabilitation programs must comply with licensure regulations developed by OMHSAS for requisite staff credentials and competencies to work in psychiatric rehabilitation programs. These regulations specify the education, experience, certification, and ongoing training requirements for all positions, with a focus on credentials related to psychiatric rehabilitation. In addition, Community Care expects that:

- All staff exhibit competencies and expertise related to the seven domains of practice specified for the Certified Psychiatric Rehabilitation Practitioner (CPRP) credential:
  1. Interpersonal Competencies
  2. Professional Role Competencies
  3. Community Integration
  4. Strategies for Facilitating Recovery
  5. Assessment, Planning, and Outcomes
  6. Systems Competencies
  7. Supporting Health and Wellness

- Each PRS program will develop a process for assessing and documenting staff competencies and expertise as noted above.

- Peer staff with lived experience in recovery from mental health and/or substance use issues are well represented on the individual’s care team.

- Staff reflect the cultural diversity of the community and participants.
Record Keeping

Member Records

Psychiatric rehabilitation programs must maintain records on each member receiving service. In addition to referrals and member identifying information, individual records must include the referral source, reason for referral, and a written recommendation by a Licensed Practitioner of the Healing Arts (LPHA). Verification that the individual received and had an opportunity to discuss the oral and written versions of the PRS statement of rights should also be present. An individualized rehabilitation assessment and individual rehabilitation plan signed by the participant must also be included, as well as documentation that the participant meets the admission and continued stay eligibility criteria, documentation of coordination of care with health care providers and other social service agencies, and any required consent forms. Daily entries should be reflective of the goals established on the individual rehabilitation plan and should reflect daily progress and response to services. Lastly, a discharge summary must also be in the member record for persons transitioning out of the service.

Daily entries must be completed for the day the PRS was provided and for each individual receiving service. Daily entries must be legible and signed and dated by the person providing the service and the individual participant. The daily entry should include the date, time, duration, location, and type of intervention provided. The service provided should be described in the context of the individual’s goal and should include the individual’s response to the service. Notes should be specific in terms of the measurable objectives identified in the plan.

Whenever feasible, the individual using PRS should participate in the regular evaluation of progress, including participation in the active writing of daily progress notes as described above. The individual will co-sign each progress note, indicating his/her agreement with the content thereof. If the individual is unable or unwilling to co-sign, the provider must document the reason for not signing, and the note must include documentation of the provider’s efforts to re-engage the individual in a collaborative documentation effort.

Record keeping must also be consistent with the requirements of Chapter 1101 of the Pennsylvania Code for Medical Assistance regulations and policies.

Using Collaborative Documentation

An OMHSAS workgroup on collaborative documentation (CD) convened under the OMHSAS Policy Bureau has suggested a definition of collaborative documentation as:

- A person-driven therapeutic approach and an interactive process that supports recovery-oriented services in which documentation of the assessment, goal setting, and progress notes is integrated into the delivery of services. The individual is face-to-face with the provider and engaged in the documentation process by providing input and perspective on their services and progress.

As of publication of these performance standards, final OMHSAS guidance for implementation of CD is in process. Providers should consult OMHSAS policies on CD once finalized and issued in the OMHSAS bulletin. In practice, collaboration on documentation is consistent with psychiatric rehabilitation approaches of actively involving the individuals as full partners in the planning and operation of PRS. Each PRS program should develop policies and procedures consistent with OMHSAS regulations that
include how staff will collaborate with individuals on documentation, staff training, and supervision requirements.

Quality Improvement

Individual satisfaction and progress are key elements of the quality improvement (QI) programs for PRS. Each PRS agency shall establish and implement a written QI plan that meets the following requirements:

1. Provides for an annual review of the quality, timeliness, and appropriateness of services, including the following:
   a. Individual record reviews
   b. Individual satisfaction
   c. Use of exceptions to admission and continued stay requirements
   d. Evaluation of compliance with the agency service description

2. Includes, in the annual review, a report of outcomes for PRS (see below). Some of this outcome information might be obtained for the annual review through aggregating the results of regularly completed Psychiatric Rehabilitation Outcomes Measures.

3. Identifies reviewers, frequency, and types of reviews and methodology for establishing sample size.

Each PRS agency shall document that individuals served participate in QI plan development and follow-up.

Each PRS agency shall prepare an annual report that:

1. Documents analysis of the findings of the annual review described above.
2. Identifies actions to address annual review findings.

Each PRS agency shall make the report available to the public.

Outcome Measurement

Psychiatric rehabilitation programs have been noted to be of significant value to individuals living with serious mental health conditions. All PRS programs should design and document a process to gather and analyze outcomes of participation in PRS. Outcomes documented in research studies of psychiatric rehabilitation services include:

1. Increased community tenure
2. Increased social connectedness
3. Reduced psychiatric hospitalization
4. Reduced involvement with criminal justice
5. Decreased use of illicit drugs and/or decreased misuse of prescription drugs
6. Improved member satisfaction with:
   a. Behavioral health services received
   b. Quality of life
7. Increased active participation in treatment and service planning
8. Improved adherence to agreed-upon services
9. Active self-notation of progress
11. Improved vocational functioning
12. Improved educational status
13. Improved stability of housing status
14. Improved self-perception of overall wellness

Community Care’s “Progress Measure” (see Appendix B) was designed as an interview tool that a member can complete collaboratively with psychiatric rehabilitation staff, and can also be used to document psychiatric rehabilitation program outcomes. Individual data is summarized for individuals and rehabilitation staff to review. The measure was created with input from providers and members participating in psychiatric rehabilitation services. Completed on Community Care’s ePortal at regular intervals (every three months), Community Care recommends collecting and sharing results from the Progress Measure every three months with the individual, incorporating it into the rehabilitation planning process, and six-month reviews, which may coincide with IRP updates and continued stay reviews. The Progress Measure can be used to empower individuals in service in their care and improve communication between providers and individuals around domains important to psychiatric rehabilitation service delivery.
References


Appendix A

Evidence-Based and Best Practices in Psychiatric Rehabilitation

There is a growing body of evidence showing that the following are effective recovery-based tools, approaches, and practices that empower individuals to reach their goals. These best and evidence-based practices are examples of approaches that can be used within psychiatric rehabilitation programs. This listing is intended as a guide, not as an all-inclusive list.

Boston University’s Choose-Get-Keep Process

Boston University’s Center for Psychiatric Rehabilitation has explained the psychiatric rehabilitation process from the service recipient’s perspective as a Choose-Get-Keep (CGK) process. In other words, *from the perspective of the people being served*, the psychiatric rehabilitation process helps people choose their goals, get or achieve their goals, and/or keep their goals, depending on their needs and wants (Anthony & Farkas, 2009). The psychiatric rehabilitation process can be implemented within any program model or setting, as long as the outcome is to help people become more successful and satisfied in the living, learning, working, or social environments or roles of their choice.

The Boston University PR process involves three phases:

1. *Diagnosis* – Determining rehabilitation readiness, setting overall rehabilitation goals, assessing strengths and needs
2. *Planning* – Prioritizing needed and preferred skills and supports, planning for skill and resource development
3. *Intervening* – Developing and/or supporting the use of skills and supports needed to achieve desired goals

The diagnostic phase in the psychiatric rehabilitation process begins with the practitioner (or other helper) assisting the person to self-determine one’s readiness for rehabilitation and to develop readiness, if needed. Then the practitioner assists the person to set the overall rehabilitation goal(s) and to evaluate his or her skill and support strengths and needs in relation to the overall rehabilitation goal(s). The goal specifically identifies the environment and/or the role chosen by the individual within a short-term time frame (e.g., I want to work part-time in an office support position within six months, I want to live in my own apartment for the next year). The diagnostic phase also determines the person’s current skills and supports (resources) needed to be successful and satisfied in the chosen living, learning, working, or social environments or roles.

In the planning phase, the diagnostic information is used by the person to develop a rehabilitation plan. A rehabilitation plan specifies how to develop the person’s skills and/or supports to achieve the person’s overall rehabilitation goals. The rehabilitation plan differs from treatment plans or individualized service plans in the identification of high-priority skill and resource development objectives, and specific interventions for each objective, rather than identifying symptoms to reduce, treatments prescribed, or other services or program activities.

In the intervention phase, the rehabilitation plan is implemented to achieve the overall rehabilitation goal(s) by developing the person’s skills and/or developing the person’s environmental supports. Skill
development interventions focus on teaching new skills and assisting the person to apply and use those skills in their preferred environments and roles. For example, a person who wants to successfully parent their elementary school aged children may need to learn how to set limits with a child who has temper tantrums and will require support in using the skill of setting limits at home with that child. Support or resource development focuses on creating, modifying, or linking the person to the people, place, thing, or activity resources that help the individual accomplish their goal. Resources such as peer support, an affordable gym to exercise, or an agenda to record course requirement due dates will need to be accessed or adjusted to meet the support needs of the person.

**Clubhouse Approach**

PRS programs may also opt to use a Clubhouse approach to providing services. A Clubhouse is defined as “a community of people who are working together to achieve a common goal.” Individuals participating in the Clubhouse are referred to as members. Clubhouse programs provide the space and programming for members and staff to share in the operations and activities of the club as a community that supports one another.

The organization that certifies and sets standards for Clubhouse programs is Clubhouse International (CI), formerly known as the International Center for Clubhouse Development. The standards provide a basis for assessing Clubhouse quality through the Clubhouse International accreditation process (Clubhouse International, [http://www.iccd.org/whatis.html](http://www.iccd.org/whatis.html)). A few standards related to the setting of Clubhouses include a dignified, attractive space where important work is carried out, and the work-ordered day, a structure of activity within a clubhouse. In addition to the work-ordered day, another key feature of the Clubhouse is the availability of recreational and social programming in evenings and on weekends, including holiday celebrations on the actual day they are observed. Refer to the “Program Specifications” section for detail on the Clubhouse standards.

**Wellness Recovery Action Plan (WRAP)**

WRAP is an approach developed by Mary Ellen Copeland, PhD, who is also a person in recovery. WRAP is a person-centered, individualized written plan that people in recovery develop understanding and using personal wellness resources for dealing with troubling symptoms and managing their health condition (Copeland, 1997). WRAP has the following goals:

- Teach participants how to implement the key concepts of recovery (hope, personal responsibility, education, self-advocacy, and support) in their day-to-day lives
- Help participants organize a list of their wellness tools — activities they can use to help themselves feel better when they are experiencing mental health difficulties and to prevent these difficulties from arising
- Assist each participant in creating an advance directive that guides the involvement of family members or supporters when he or she can no longer take appropriate actions on his or her own behalf
- Help each participant develop an individualized post-crisis plan for use as the mental health difficulty subsides, to promote a return to wellness

Certified WRAP trainers can teach individuals to develop a personal WRAP, often in a group setting. Included in this training are the key concepts, values, and components of how to write a WRAP. The key elements of a WRAP include:
• Wellness toolbox
• Daily maintenance plan
• Identifying triggers and an action plan
• Identifying early warning signs and an action plan
• Identifying when things are breaking down and an action plan
• Crisis planning
• Post-crisis planning

The CommonGround Approach

CommonGround is an approach developed by Pat Deegan, PhD & Associates for empowering individuals in their recovery. The CommonGround approach brings the voice of individuals to the center of care teams and helps people become experts in their own self-care. CommonGround is also a web-based application that helps people prepare to meet with their psychiatrists or treatment teams and arrive at the best decisions for treatment and recovery. The CommonGround approach and web application are developed for persons in recovery by persons in recovery. CommonGround promotes shared decision making and self-management of psychiatric, substance use, and co-occurring health conditions through four cornerstone methods. Together, these methods help teams consistently deliver person-centered care.

• Personal Medicine: Uncovers what individuals can do to get active in their recovery and wellness
• Power Statements: Prompts individuals to advocate for themselves so that services and treatment support their personal recovery goals
• Decision Support: Increases individual involvement in decision making and the skills needed to get well and stay well
• Shared Decision Making: Promotes collaboration among individuals and care teams on decisions related to the individual’s recovery, health, and wellness

CommonGround is an emerging best practice that supports individuals in becoming more active in their recovery. These methods can be used in psychiatric rehabilitation programs to assist individuals in developing skills and accessing resources to make decisions and self-manage their behavioral health conditions. Power Statements focus on the goals or roles that are important to the person, similar to overall rehabilitation goals. The strategies and resources involved in decision support and shared decision making emphasize the person gathering the information needed to make informed and personal decisions about treatment, rehabilitation, and recovery.

Motivational Interviewing (MI)

Motivational interviewing is an evidenced-based, counseling practice that helps people change by assisting individuals to explore and resolve ambivalence (Miller & Rollnick, 2013). MI is person-centered and is designed to reduce ambivalence and increase motivation to change. It involves a collaborative approach that respects an individual’s autonomy. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. There are four guiding principles of motivational
interviewing: express empathy, develop discrepancy, roll with resistance, and support self-efficacy. The following is a list of some of the strategies used in MI:

- Establishing rapport and listening reflectively
- Asking open-ended questions to explore the person’s own motivations for change
- Affirming the person’s change-related statements and efforts
- Eliciting recognition of the gap between current behavior and desired life goals
- Asking permission before providing information or advice
- Responding to resistance without direct confrontation (resistance is used as a feedback signal to adjust the approach)
- Encouraging the person’s self-efficacy for change
- Developing an action plan to which the person is willing to commit

MI is consistent with the principles and practices of psychiatric rehabilitation, especially in determining readiness for change. MI strategies can be used to help an individual in setting goals and preparing for action.

**Illness Management and Recovery (IMR)**

IMR is an evidence-based psychiatric rehabilitation practice whose primary aim is to empower individuals to manage their illnesses, find their own goals for recovery, and make informed decisions about their treatment by teaching them the necessary knowledge and skills (SAMHSA, 2009; Mueser et al., 2002). IMR provides education about mental illnesses and strategies that help individuals manage their illnesses and pursue personal recovery goals. People are empowered by knowledge. The more individuals understand the basic facts about their mental illnesses, the better equipped they are to speak for themselves and take an active role in their recovery.

IMR sessions are conducted by trained practitioners and occur on a weekly basis. Sessions may occur individually or in small groups over a period of 3 to 10 months. The curriculum covers ten recovery strategies based on the core components of psycho-education, behavioral tailoring, relapse prevention, and coping skills training.

The principles of psychiatric rehabilitation align closely with the components of IMR. Use of the IMR curriculum can effectively assist individuals in meeting their recovery goals and becoming empowered and activated in their treatment. IMR can be set up as a scheduled program within the psychiatric rehabilitation services to assist those individuals with goals related to learning about and managing their mental health diagnosis and symptoms. As individuals often attend site-based programs or receive mobile services on a regular schedule, IMR could effectively be implemented into those schedules to meet the needs of the individuals receiving services. SAMHSA Toolkit materials are available at [http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463](http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463).

**Supported Employment: Individual Placement and Support (IPS)**

Supported employment is a well-researched evidence-based practice (Bond, et al. 2001; Cook, et al., 2005). It is a well-defined approach to assist people with disabilities to obtain and retain competitive
employment in integrated work settings consistent with the strengths, preferences, and capabilities of people who have mental health conditions that have interfered with vocational success. The IPS approach developed by Robert Drake and Deborah Becker (Becker & Drake, 1993; Drake & Becker, 1996) is the supported employment model with the most evidence. Essentially, supported employment involves identifying a preferred job goal, providing job placement services to help the person get the job, and providing training and support on and off the job site for as long as needed. This might include on site job coaching as well as behind the scenes support. The principles of IPS for people who have a diagnosed mental health condition include:

1. Every person who wants to work is eligible for IPS supported employment.
2. Employment services are integrated with mental health treatment services.
3. Competitive employment is the goal.
4. Personalized benefits counseling is provided.
5. The job search starts soon after a person expresses interest in working
6. Employment specialists systematically develop relationships with employers based upon the individual’s work preferences.
7. Job supports are continuous.
8. Individual preferences are honored.

Supported employment services may be included in psychiatric rehabilitation programs and are an important path to recovery for many. SAMHSA Toolkit materials on this practice are available at http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365.

Family Psychoeducation (FPE)

FPE is a structured approach for partnering with consumers and families to support recovery. Consumers and families receive information about mental illnesses and learn problem-solving, communication, and coping skills. Research shows that individual outcomes improve if families receive information and support (Dixon, et al., 2001). Family Psychoeducation is an evidence-based practice, with a toolkit available by SAMHSA. For this reason, a number of family psycho-education programs have been developed over the past two decades. Models differ in their format (whether they use a multifamily or single-family format); duration of treatment; participation of the person in recovery; and location. The critical ingredients of effective FPE include the following (Dixon, et al., 2001):

- Education about serious mental illnesses;
- Information resources, especially during periods of crises;
- Skills training and ongoing guidance about managing mental illnesses;
- Problem solving; and
- Social and emotional support.

FPE services include three phases:
- Joining sessions – introductory meetings to learn about family experiences, strengths and resources, and recovery goals;
• An educational workshop – one day session using standardized curriculum; and
• Ongoing FPE sessions – sessions which use a structured problem solving approach to address current issues that families and individuals face, single or multifamily groups.


Peer Support

Peer Support was first recognized as an Evidence Based Practice in The U.S. Surgeon General Report of 1999. In Pennsylvania, in 2007, the Center for Medicare and Medicaid Services approved Pennsylvania's request to include Peer Support in its Medicaid state plan amendment. Peer support services in Pennsylvania are a distinct and separately licensed service not to be co-located within Psychiatric Rehabilitation Services. However, because of the value of peer support as a practice, PRS programs may employ people in recovery as staff in the PRS program so that support of peers in recovery is integrated into the PRS program. In addition, PRS programs may support individuals in service to access peer support services in their communities.

In 2012, a national consensus among Peer Specialists from across the country was reached to establish core values:

1. Peer support is voluntary
2. Peer supporters are hopeful
3. Peer supports are open minded
4. Peer supporters are empathetic
5. Peer supports are respectful
6. Peer supporters facilitate change
7. Peer supporters are honest and direct
8. Peer support is mutual and reciprocal
9. Peer support is equally shared power
10. Peer support is strengths-focused
11. Peer support is transparent
12. Peer support is person-driven

Based upon the fundamental principles of recovery, peer support involves specialized interactions conducted by self-identified individuals currently receiving behavioral health services or those individuals who previously received behavioral health services, who are trained to offer support and assistance in helping others in their recovery and community-integration/re-integration process. Peer support is intended to inspire hope in individuals that recovery is not only possible, but also probable. Peer support is designed to promote empowerment, self-determination, understanding, coping and life skills, and resilience. This is achieved through mentoring, coaching, and service coordination supports that allow individuals with serious mental health conditions, substance use disorders, or co-occurring
disorders to achieve personal wellness and cope with the stressors and barriers encountered when recovering.

**Wellness Coaching**

Wellness Coaching is an emerging SAMHSA evidence-based practice that focuses on helping individuals make a lasting behavior change in one of the eight domains of wellness. Individuals are able to work on change in one of these various domains: emotional, financial, social, spiritual, occupational, physical, intellectual and environmental.

Wellness Coaching is intended to be peer-driven practice, but it can be used by other mental health professionals. The wellness coach’s role is to help an individual assess their wellness strengths and work towards a goal of the individual’s choosing in any wellness domain. The wellness coach will use a variety of communication and motivational techniques throughout the experience but does not set any rules or parameters. Wellness Coaching is an empowering practice for individuals in recovery and provides them with a sense of self-responsibility and the ability to be in control of their health and wellness lifestyle.

Similar to psychiatric rehabilitation, wellness coaching is a partnership that strives to make positive changes in an individual’s quality of life. Wellness coaching would be a fitting practice for those receiving Psychiatric Rehabilitation services in the community. It allows people to create measurable goals and monitor progress over time. Both psychiatric rehabilitation and wellness coaching allow people to work on their recovery with the overall goal to obtain the necessary skills so they can live and sustain a healthy and productive life.

**Cognitive Enhancement Therapy (CET)**

CET is a cognitive training program that helps individuals diagnosed with schizophrenia and other cognitive disorders to improve neurocognition (processing speed, attention, memory, and problem solving) cognitive style (including impoverished, disorganized, or rigid cognitive style), social cognition (including lack of perspective taking, foresight, and social context appraisal), and social adjustment (including social, vocational, and family functioning) (Hogarty & Flesher, 1999). This is done through structured activities that include computer-based exercises/interactive software, group-based interventions, and individual coaching sessions. Individuals must be willing to work within a group with peer partners. The groups run for approximately three hours a week for 48 weeks. Individuals also meet individually with their coach (staff) for up to an hour a week to work on personalized goals, receive support and/or guidance and prepare their homework assignment.

Participants of CET have identified the following outcomes (Flesher, Shumaker, Gonzalez, & Kubek, 2009):

1. Increased processing speed
2. Increased motivation, attention, concentration, memory, and problem solving
3. Perspective talking, gistful thinking, “thinking on your feet,” abstract vs. concrete thinking and increased sense of humor
4. Ability to identify and choose a life role meaningful to them such as spouse, parent, friend, student, employee
5. Increased ability to self-manage one’s physical and behavioral health
6. Increased ability to accept and adjust to a disability

Social Skills Training

Social Skills Training (SST) is an approach used to assist people with serious mental health conditions to develop social competence. Based on decades of research in interpersonal and cognitive skills training, SST teaches individuals “to express both positive and negative feelings in the interpersonal context without suffering the consequent of loss of social reinforcement...Such skill is demonstrated in a large variety of contexts and it involves the coordinated delivery of appropriate verbal and nonverbal responses.” (Hersen & Bellack, 1976, p. 562). There are various social skill sets that can be taught such as: basic social skills, conversation skills, assertiveness skills, conflict management skills, communal living skills, friendship and dating skills, health maintenance skills, vocational/work skills, and coping skills for drug/alcohol use (Bellack, Mueser, Gingerich, & Agresta, 2004).

All social skill sets consist of three types of skills, which are taught in each module:

1. Receiving skills - The ability to accurately perceive information in a social situation. Individuals are able to gain the ability to listen and pay attention to what another other person is saying. Individuals need to be able to accurately perceive environmental and interpersonal cues that will guide them to effective responses.

2. Processing skills - The ability to choose the most effective response for the social situation. Individuals are able to learn to process what their response or next step will be. Individuals need to learn to problem solve. To decide what our goal is (is it different from the other person’s goal) and how will we best achieve our goal.

3. Sending skills - The ability to respond effectively in social situations. Individuals learn about verbal, non-verbal, and paralingual skills.

Each skill is taught using behavioral principles such as modeling, reinforcement, shaping, overlearning, and generalization.

More information about evidence-based practices in mental health and substance use can be found at the National Registry of Evidence-based Programs and Practices (NREPP) at http://www.nrepp.samhsa.gov/.
Appendix B

Community Care Psychiatric Rehabilitation Progress Measure

*Please complete the Progress Measure every 3 months.*

Member’s 10-digit MA ID number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Member and Program Information:

Provider: __________________________________________________________

Provider staff: ___________________________________________________

(first and last name)

Discharge date ____/____/______ or: ○ not applicable

**Section 1. Goals:**

*Are goals in the following areas currently in the recovery/service plan? (fill in one response for each)*

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes</th>
<th>No</th>
<th>This goal has been completed</th>
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</thead>
<tbody>
<tr>
<td>1. Living?</td>
<td>○</td>
<td>○</td>
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<tr>
<td>2. Learning?</td>
<td>○</td>
<td>○</td>
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<tr>
<td>3. Working?</td>
<td>○</td>
<td>○</td>
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<tr>
<td>4. Social?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. Physical wellness?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. Spiritual?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. Emotional?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8. Financial?</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9. Substance use?</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tbody>
</table>
10. Please tell us about one current goal:  OR:  ○ I do not have a current goal (if no goal, please skip to Section 2, #13)

a. My goal is: ____________________________________________________________

b. This goal is important to me because: ______________________________________

c. The strengths that I have to help me reach this goal are:

   ____________________________________________________________

11. My current goal is in the following area: (please select one response):
   ○ Housing/living  ○ Education/learning  ○ Employment/working  ○ Social
   ○ Physical wellness  ○ Spiritual  ○ Emotional  ○ Financial
   ○ Substance use

12. Ask the member: In the past month, to what extent have you made progress on your current goal?
   ○ Not at all  ○ A little bit  ○ Some  ○ Quite a bit  ○ A lot

Section 2. Activities
Answer the following questions regardless of whether this item is currently in the recovery/service plan.
Fill in all responses that apply within the past month.

13. Living status:
   ○ CRR  ○ LTSR
   ○ D&A Community-based residential  ○ Nursing home
   ○ D&A non-hospital residential rehab  ○ Other community-based
   ○ Family setting  ○ PCH/enhanced PCH
   ○ Institutional setting  ○ Shelter/mission/homeless
   ○ Living independently  ○ Single room occupancy
   ○ Seeking independent housing  ○ Supported housing

14. Member lives with:
   ○ Spouse/partner  ○ Parents
   ○ Child(ren)  ○ Other family
   ○ Non-family person(s)  ○ Self/alone

15. Ask the member: In the past month, how stable has your housing been?
   ○ Not at all  ○ A little bit  ○ Some  ○ Quite a bit  ○ A lot

15 b). How long have you lived in your current housing? _____ years (use decimals for partial years, for example, 1.5 years)

16. Learning status:
   ○ Not in school/training  ○ Vocational/technical training program
   ○ Pursuing GED  ○ Trade school
   ○ Adult education/enrichment  ○ University
   ○ Community College  ○ Other: ____________________________________________
17). Working status:
   ○ No employment of any kind
   ○ Job specific training
   ○ Paid competitive/independent employment
   ○ Volunteer
   ○ Paid sheltered employment
   ○ Actively seeking job
   ○ Paid competitive/supported employment
   ○ Other: ___________________________

17b). If paid employment, number of hours in a typical week:
   ○ Less than 35 hours per week
   ○ 35 or more hours per week

18). Social goal status (fill in all responses that apply within the past month):
   ○ Not actively engaging in social activity
   ○ Worked on social development (eye contact, communication, phone skills, etc.)
   ○ Attended program sponsored social activities
   ○ Attended external sponsored social activities (church, community or drop-in center, etc.)
   ○ Attended non-sponsored social activities (outings with friends/co-workers/peers/family)

19). Physical wellness goal areas:
   ○ No physical wellness goals
   ○ Relaxation/stress management
   ○ Self-care/personal habits & routines
   ○ Sleep/rest
   ○ Diet and nutrition
   ○ Medical care/screening
   ○ Physical activity
   ○ Other: ___________________________

Section 3. Progress (this section is completed by the member; you may skip items not specified as goals)

Ask the member: In the past month, to what extent have you made progress in:

<table>
<thead>
<tr>
<th></th>
<th>Not at All</th>
<th>A Little Bit</th>
<th>Some</th>
<th>Quite a Bit</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>20). Your living situation?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>21). Your learning situation?</td>
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<tr>
<td>22). Your work situation?</td>
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<tr>
<td>23). Your social situation?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>24). Your physical wellness?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>25). Your substance use goals?</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

26). Overall, how much progress have you experienced while enrolled in the program?
   1   2   3   4   5   6   7   8   9   10
27). Overall, how hopeful do you feel about your life?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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</tr>
</tbody>
</table>

None/minimal hope | Some hope | Moderate hope | Filled with hope

Section 4. Demographics

Staff and member complete this section together (complete once):

28). Admission date into program ____/____/_______

29). Member’s ethnicity (fill in one response)

- Hispanic/Latino
- Non-Hispanic/Non-Latino
- Prefer not to answer

30). Member’s Race (fill in one response)

- Asian
- Black/African American
- White/Caucasian
- Self-identify (specify: ________________)
- Prefer not to answer
- More than one race (specify: ________________)

31). Member’s religion (fill in one response)

- Jewish
- Protestant
- Roman Catholic
- Muslim
- None/No religion/Not religious
- Other; specify: ________________
- Prefer not to answer

32). Member’s gender

- Male
- Female
- Transgender
- Self-identify: ________________

33). Highest level of education completed (fill in one response)

- Less than high school graduate
- High school graduate or GED
- Completed vocational/training program/certificate
- Completed some college
- Completed college
- Completed graduate school degree