Advancing Rehabilitation and Recovery Practice in Massachusetts

MassPRA Workforce Development Recommendations

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Introduction

The Massachusetts Department of Mental Health has taken bold steps in recent years to move state-funded mental health services into the future. MassPRA applauds the leadership shown by the Department in reconceiving the service system so that the greatest value is placed upon recovery and resiliency and in recognizing the utility of psychiatric rehabilitation approach. However, significant barriers remain to full implementation of this vision in the Commonwealth, including the lack of staff competent in applying this approach in their daily practice.

Regardless of their academic preparation, most workers have not received the training needed to fully implement recovery-oriented psychiatric rehabilitation services. This is not strictly a local problem, as highlighted in a report issued by the Annapolis Coalition (2003) describing significant employer dissatisfaction with professionally trained graduates who are unprepared for practice in real-world settings. In-service trainings tend to be based on single-session lectures, widely recognized as ineffective in changing practice. The entrenched medical/clinical treatment model is too often focused on pharmaceutical interventions and risk management rather than rehabilitation and recovery. In addition, many service providers hold judgmental, pessimistic, and dismissive attitudes towards people with psychiatric disabilities and/or addictive disorders (Hansson et al., 2013; Thornicroft et al., 2007). Such negative beliefs, if reflected in service planning and rehabilitation interventions, may "induce pessimism and hopelessness in the individual" and "may also on a service level prevent the implementation of evidence-based interventions" (Hansson et al., 2013, p. 53).

Service system change, whether on a local or national level, requires changing day-to-day service provider practice, developing and applying new competencies, and using workforce development strategies that are both effective and sustainable. The paper outlines considerations and recommendations for workforce development in order to bring practice in line with the forward-thinking vision of the Massachusetts Department of Mental Health.

Overview of the problem

Based on the experience of individual and organizational members of MassPRA, this paper will focus primarily on the implementation of Community-Based Flexible Supports. It is likely that many of the comments and challenges summarized here apply to other sectors of state-funded mental health services as well. The need for a comprehensive state-wide workforce development plan arises from three primary areas: lack of qualified workers, inadequate training, and challenges for recruitment and retention.

Lack of qualified workers

Service provider agencies experience insufficient rehabilitation capacity in both credentialed and non-credentialed workers. MassPRA organizational members report that staff hired into direct service roles have less pre-service training than at any time in the past, although both the diversity and complexity of the needs of people served have dramatically increased. Many new staff arrive with minimal experience; some are newcomers to the United States, which can present language and cultural barriers to quality service provision.

People who work in publicly funded mental health services are diverse in their educational background—ranging from high school equivalency to post-doctoral educational achievement (Blankhertz, 1996), with about half of the workforce having little or no academic preparation (Leff et al., 2007). They share little common training background and, therefore, are diverse in their knowledge and skills. Advanced education often is not relevant to services being delivered in the field.

> In virtually every setting in which the Annapolis Coalition sought input… three interrelated themes emerged: (1) The content of current training and education frequently is not relevant to contemporary prevention and treatment practices, nor is it informed by empirical evidence; (2) teaching methods often are ineffective in changing the actual practice patterns of the people being trained; and (3) access to training and education is often quite limited, particularly in rural communities and for culturally diverse populations. These concerns were expressed about preservice professional training, the initial training offered to direct-care nondegreed or bachelor's-prepared staff, and the continuing education of all members of the workforce. The concerns were not specific to a particular sector of the field or discipline, but were described as generally applicable to the field as a whole. (Annapolis Coalition, 2003, p. 18 of Executive Summary)

Re-procurement for CBFS placed a greater emphasis on, and requirement for, licensed clinicians to provide oversight to the assessment and planning process. Unfortunately, clinical credentials by themselves have proved a poor match to the recovery-orientation and rehabilitation competencies needed to produce a person-centered planning process, guided by strengths and grounded in functional improvement in areas of housing, education, employment, and other citizenship roles.

Academic training typically offers little or no information about recent recovery research and psychiatric rehabilitation services, neither for practitioners with professional degrees, including the "core disciplines" formally recognized in the past by NIMH (psychiatry, psychology, social work, and nursing; Robiner, 2006), nor for providers who have degrees in counseling, mental health counseling, occupational therapy, rehabilitation counseling, and substance abuse (addictions) counseling. (**See Appendix**: **Core Educational Requirements**)

In addition to the absence of a focus on psychiatric rehabilitation in most mental health related degree programs, such programs also tend to lack competency-based training and evaluation (Stuart, Hoge, & Tondora, 2004). Instruction and evaluation more often focus on knowledge rather than skill. For example, counseling theories tend to occupy a more prominent place in the curriculum than practice-based training in interpersonal skills and in such evidence-based relationship-building skills as developing goal consensus (Norcross, 2002). Internship experiences, where they exist, tend to provide "exposure" or "experience" rather than the development of "expertise" (Farkas & Anthony, 1993). Courses presenting research on psychiatric rehabilitation programs and recovery-oriented service systems tend to take a back seat to courses focused on DSM diagnoses and psychopharmacology.

Rehabilitation-specific competencies, such as how to help people with psychiatric disabilities develop skills and access resources, are also missing from most academic curricula. A curriculum providing competency-based training at an <u>expertise</u> level (Farkas & Anthony, 2001) requires that students or trainees master both knowledge and skill, and emphasizes integration into actual practice in the field, the approach recommended by the Annapolis Coalition on Behavioral Health Workforce Education (2003).

In addition to the lack of focus on rehabilitation and recovery, graduates of academic programs in mental health tend to lack training in supervision or leadership, and are unprepared for working on an interdisciplinary team. Given that services are often delivered in a team model (e.g., CBFS, PACT), communication and coordination of services within and across teams is an important competency area for service providers (Robiner, 2006). Teamwork competencies will likely increase in importance as mental health services move more towards a model of integrated healthcare (Horevitz & Manoleas, 2013).

Challenges for recruitment and retention

Generally, rates for DMH-contracted services have not seen structural increases in many years. While Chapter 257 rate-setting may soon make a significant difference in the resources available, agencies struggle to find and retain sufficient licensed staff for meeting safety and Medicaid documentation requirements, leaving little in the budget to hire and train qualified and non-licensed rehabilitation practitioners. Compensation to staff has lost significant ground in the last 20 years. In 1988, direct service salaries were at 88% of the median for salaries within the Commonwealth; in 2005 they were at 44% of the median (Massachusetts Council of Human Service Providers, 2007).

Low wages, heavy workloads, high paperwork demands, and the ongoing stressors of the work result in employee turnover. The costs of turnover range from 30-150% of an employee's annual salary:

> Recent studies have shown that turnover is a particular concern in the mental health arena. Some human service organizations report direct care staff turnover at over 60% per year (Massachusetts Council of Human Service Providers, 2007). Surveys specific to mental health organizations show consistently high turnover rates, ranging from an average of 23-30% for mental health case managers in Washington State to 27-54% for community-based mental health agencies in New York State (Kadis, 2003). In comparison, across all business sectors, the average employee turnover rate is closer to 15% annually (Ramlall, 2003). (Selden, 2010, p. 71)

With high turnover contributing to high costs and ongoing training needs, service provider agency budgets experience significant drains.

Additional dollars for CBFS were allocated through "Clinical Enhancement" monies following the Moulton tragedy. The greater number of licensed clinicians working in the community resulting from this investment has been welcome, increasing consultative support to keep all people in the community safe; however, this funding carries an implied message that clinical authority and expertise must drive services in order to mitigate risk. This increased focus on risk reduction has not been balanced by increased partnership with service users. Without a focus on shared responsibility, this emphasis on risk neglects critical elements for supporting the CBFS goals of helping people to live satisfying lives in their communities. The presence of additional clinical staff will not, by itself, increase the ability of CBFS teams to foster success in competitive employment, education, community integration, and development of supportive social networks.

Training

Most training offered by service provider agencies is not effective. Trainers rarely have been trained themselves in evidence-based instruction. Single lecture-based training sessions do not change practice. "Old habits die hard. Even with simple and useful suggestions built into the training session, and trainees who want to try to change their behavior, trainees may never really attempt to use the new techniques or worksheets. They may try to incorporate a few new things into their old way of doing things, but, when the hybrid approach doesn't work, or when the practitioner finds the new techniques or worksheets hard to use, then discouragement results in abandoning the new in favor of the old" (Nemec, 2006, p. 152).

Academic detailing is considered the most effective method for changing service provider practice (Leff et al., 2007). This approach requires easy access to training. "Detailing" recommends that training content be designed to have the maximal effect with a limited message, using specially designed concise one-page handouts that are text-rich, rather than sketchy PowerPoint® slides or lengthy readings that may not be directly applicable to the work. Significant practice opportunities are needed, followed by access to supervision and consultation related to implementing the new practice or intervention on the job. Offering "booster shot" training sessions from time to time can help prevent practitioners drifting away from desired practice. This labor intensive approach, though effective, is likely to be costly.

Given the high rates of turnover in the field, as well as the rapid development of knowledge, ongoing training efforts will be necessary. Financially stretched service providers struggle to find an affordable and sustainable model for workforce development, yet rarely, if ever, join forces to minimize costs. Scheduling training sessions is a challenge, given coverage issues, yet few behavioral health agencies make effective use of asynchronous web-based training as a supplement to their face-to-face sessions. The national Psychiatric Rehabilitation Association offers online learning, as do other organizations (e.g., Relias Learning), yet these offerings do not capture the local context and, for some service provider agencies, may be cost prohibitive.

Need for local competency-based training

A competency is "the capability of applying or using knowledge, skills, abilities, behaviors, and personal characteristics to successfully perform critical work tasks, specific functions, or operate in a given role or position" (Ennis, 2008, pp. 4-5). Competencies often are described as knowledge, skills, and attitudes (KSA).

- **<u>Knowledge</u>** refers to "awareness, information, or understanding about facts, rules, principles, guidelines, concepts, theories, or processes needed to successfully perform a task" (Marrelli, Tondora, & Hoge, 2005, p. 534).

- A **<u>skill</u>** is an action performed to some identified standard to achieve a specified outcome. Marelli, Tondora, and Hoge (2005) point out that skills and abilities "are often time-consuming and difficult to develop, and usually have a strong component of innate capacity. For example, the ability of analytical thinking comes more naturally to some than to others, and can be quite challenging for many individuals to develop" (p. 537). This suggests implications for hiring as well as training.

- **<u>Attitudes</u>** and other personal qualities or characteristics are sometimes cited as competencies, including "work habits, ways of interacting with others, or manners of conducting oneself that contribute to effective work performance. Examples are managing work priorities and assignments to meet schedule commitments, developing rapport with others, and treating others with respect" (Marrelli, Tondora, & Hoge, 2005, p. 537).

For psychiatric rehabilitation practitioners, a list of competencies has developed based on a series of role delineation studies to identify key competencies on which to base the certification examination for the Certified Psychiatric Rehabilitation Practitioner credential (Gill, 2005; http://www.psychrehabassociation.org). A role delineation study, or job analysis, involves achieving some form of consensus about the requirements of the job role (Knapp & Knapp, 1995). Training, whether, pre-service, in-service, or continuing education, needs to focus on the development and maintenance of those competencies.

Evidence-based instructional approaches

Although research evidence is lacking, consensus is developing on best practices in psychiatric rehabilitation education. Based on the work of the Annapolis Coalition for Behavioral Healthcare Workforce Development, Human Services Research Institute (2007), the Consortium of Psychiatric Rehabilitation Educators, and the Massachusetts Psychiatric Rehabilitation Association (MassPRA, 2009), the following principles for effective training emerge:

- Training is relevant to practice and is based on practice guidelines, fidelity scales, and manuals, where these exist.
- Training is focused on competencies, using frequent practice with feedback, and activities requiring application of knowledge. A focus on values, attitudes, beliefs, and feelings (the "affective domain") is included, along with practice competencies.
- Training encourages life-long learning, and is integrated with follow-up supervision and performance expectations.
- Instructors model psychiatric rehabilitation practice by showing respect to the learners and to people with psychiatric disabilities, by connecting with the learners and eliciting/reflecting their ideas and experiences, by collaborative and inclusive methods of instructional design and delivery, and by demonstrating hope and optimism for recovery for all people with psychiatric disabilities.
- Training programs involve people with psychiatric disabilities in curriculum design, delivery, and evaluation, and as instructors.

Instructional methods in a psychiatric rehabilitation training programs must promote competency development and facilitate problem-solving. To that end, content should be "nested" throughout the curriculum, with integrated courses that serve as building blocks for one another. Trainers should work collaboratively to share problem sets and clinical examples. Consistent standards and definitions should be employed for such foundation areas as writing skills required for documentation, interpersonal skills that facilitate relationship building and goal consensus, and how to write a "good" goal or service plan. Skills teaching methods used in psychiatric rehabilitation service delivery (e.g., as part of social skills instruction) are equally effective in teaching professional competencies, although the content focus is different. For example, concern about generalization of acquired skills is relevant to changing practitioner behavior in the field, not simply in the classroom. Performance will be enhanced by using a train-practice-train approach, where trainees learn a skill, apply it in a real-life practice setting, and then receive specific and rapid feedback, followed by further instruction. Admittedly, this is a labor-intensive approach, but anything less will fail to deliver the skilled practitioner in demand in the field.

Systems support for change[1]

Even if training does create change by building new competencies, applying and maintaining that change on the job requires significant organizational and systems support. Some recommendations for implementing and sustaining such changes are proposed by the Technical Assistance Collaborative (TAC; Hyde et al., 2003) in their monograph *Turning Knowledge into Practice*. Their recommendations address sustaining change when adopting evidence-based practices in behavioral health organizations, and include five areas for attention that are equally relevant for implementing any shift in clinical practice and service delivery.

- **Feedback**: Direct service providers, following training, should have follow-up with feedback on their on-the-job performance of the new skills. In addition to feedback on individual performance, Robert Rosenheck of the Veteran's Administration (2001) recommends team and organization evaluation, with feedback based on the results. Self-assessment forms can be developed for use by individual practitioners, teams, supervisors, and administrators.

- **Supervision** offers a means for providing feedback, but the TAC suggests that training in supervision is needed—both generic training on supervision and specific training on how to support the use of the new intervention or approach being adopted. Supervision or mentoring needs to include a structure for feedback, opportunities for re-training as needed, and (perhaps) building a community of practice (see below).

- The use of "**change champions**" is common in organizational development. Champions need to self-select and need training to ensure their expertise and consistency of message. Using champions and change-oriented groups helps create an organizational culture that supports and promotes learning and change.

- To create pressure for initiating and sustaining change, the TAC recommends **incentives** that are designed to "reward new behavior and to prevent old behavior that the program wants to see changed" (p. 96). These include no-cost incentives such as public recognition or additional training, as well as the obvious and costly rewards of bonuses, promotions, and "alleviation from other onerous duties" (p. 96). Clearly the idea of incentives is linked to evaluation and is actually another method of providing feedback on performance. In order to make an incentives program fair and practical, specific standards need to be set for expected, desirable, and unacceptable performance and practices.

- The TAC specifically recommends building new practices into **new employee training** and other on-the-job training. Rosenheck (2001) adds the need to link new practices to broad organizational goals and objectives, especially those that are already well accepted.

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[1] This section is excerpted and adapted from past and forthcoming Education and Training columns (Nemec), published in the *Psychiatric Rehabilitation Journal*.

Framework for Action

MassPRA proposes to transform the existing and future behavioral health workforce in Massachusetts through promoting the Certified Psychiatric Rehabilitation Practitioner credential, further defining the core knowledge and competencies needed provide high quality rehabilitation- and recovery-oriented services within Massachusetts, offering standardized and centralized training opportunities, and establishing a network of connected learning communities.

Promoting the CPRP

As a chapter of the national Psychiatric Rehabilitation Association, MassPRA has long championed the adoption of the Certified Psychiatric Rehabilitation Practitioner credential (CPRP), described as "a test-based certification that fosters the growth of a qualified, ethical, and culturally diverse psychiatric rehabilitation workforce through enforcement of a practitioner code of ethics" (http://www.psychrehabassociation.org/certification/cprp-certification).

If academic credentials are not reliable indicators of competence in rehabilitation- and recovery-oriented services, then an alternative credential is needed. Fortunately, such as credential exists. MassPRA believes that the Certification for Psychiatric Rehabilitation Practitioners (CPRP) offers significant promise to developing our largely non-professionalized workforce, by defining the required knowledge and skills within seven domains necessary to foster recovery partnerships. Some benefits include:

1. Eligibility to sit for the exam requires relevant experience, and delivery of psychiatric rehabilitation services is required through employment verification prior to determining exam eligibility.

2. Training in Psychiatric Rehabilitation is required, specifically, a minimum of 45 hours within the three years prior to application, and ensures that exposure to relevant knowledge and skills has been attained.

3. The CPRP uses a valid and normed exam that ensures that applicants are tested on current practices. The exam is based on a role delineation study that is periodically updated to adjust to changes in the field over time.

4. Once certified, CPRPs must sign and adhere to a Practitioner Code of Ethics, which obligates ethical behavior and provides sanctions for substantiated complaints regarding deviations in practice.

5. Once certified, CPRPs are required to continue learning for life, as long as they hold the credential, since recertification at three-year intervals requires documentation of at least 45 hours of continuing education in psychiatric rehabilitation. The requirement to obtain these hours prompts practitioners to update their knowledge with the newest information regarding services that promote wellness, recovery, and meaningful social roles.

The practical implications of any certification or licensure process is that the competencies required for the discipline are developed over time, and practitioners form a community that helps to promote innovation and evolution of practices within the field. MassPRA has offered, and will continue to offer, educational opportunities to prepare for the CPRP exam as well as to obtain the continuing education credits needed for renewal.

Defining core competencies for local practice

Although several MassPRA organizational members have been working independently on training that is based on competencies for local practice, there is, as yet, no common list or definition of local competencies. However, the development of common standards for documentation within CBFS provides an opportunity for agency alignment of practice and related training, and offers a foundation for beginning the process of defining common local practice competencies that supplement or further specify the general CPRP competency list.

Offering standardized and centralized training opportunities

The MassPRA annual conference, sold out for several years running, has been a steady source of information on psychiatric rehabilitation practice. Plans to change venues for 2014 developed, in large part, to expand this opportunity to a wider audience. The full-day institute option offers a chance for more in-depth training than would be available in a brief workshop. Multiple meetings in a "conversation" format have allowed MassPRA to provide regional sessions for presenting and exchanging ideas. A 12-week training program has been offered as an overview of psychiatric rehabilitation and as an application of psychiatric rehabilitation to work with transition-age youth. These extended-format trainings provided in-depth competency development using a standardized curriculum based on sound instructional design, with in-class practice as well as practice assignments to be completed between sessions. MassPRA intends to continue and expand all of these efforts, based on identified training needs and local interest.

Centralized and standardized training programs can offer an affordable and sustainable supplement to agency-based training. There is great promise for cost-savings and potential for enhanced learning through online training offered in an asynchronous on-demand basis, provided in conjunction with agency-based face-to-face discussion and practice groups. MassPRA intends to explore all options for training formats in order to identify those that are most practical and most effective for the Massachusetts workforce.

Establishing a network of connected learning communities

A key component of the MassPRA mission and vision involves bolstering the capacity of the recovery workforce, enhancing the professional identities of workers providing psychiatric rehabilitation services, and linking continuing education opportunities to a "lifelong learning" approach to skill development within the core outcomes expectations of the Department of Mental Health and the increased uniformity of a common documentation protocol. These commonalities make it possible to share practice solutions both within and across organizational boundaries.

MassPRA envisions the development of key learning communities in which members enhance the greater overall capacity of the mental health system by sharing knowledge and expertise across organizational lines. An example of the power and potential of shared learning is found in the CBFS Rehab Option Workgroup, formed in the fall of 2009 to address adherence issues to a newly mandated form set within CBFS. By bringing together representatives from DMH with representatives from each CBFS provider, the group developed consensus and produced guidance to many commonly identified needs, including implementing person-centered planning, using shared approaches to managing safety and risk, and clarifying which activities are necessary to meet medical necessity guidelines for financing the services delivered. In addition to these outcomes, members have reported enhanced trust between service providers and DMH staff, greater clarity of expectations across multiple "areas" of DMH/provider operation, and high satisfaction with the interpersonal climate within the group.

MassPRA is directed and supported by people in recovery, academics, policy-makers, and by the membership of provider agencies providing community-directed mental health services to people experiencing psychiatric disability. Given its breadth of members, MassPRA has the constituent makeup and workforce focus needed to offer a permanent contribution to developing the needed competencies required to redirect efforts toward successful and satisfying community participation of adults served in the community by the Department of Mental Health.

A **community of practice** builds a subculture or learning team within or across organizations that is focused on improving practice in some particular area (Wenger et al., 2003). A community of practice (CoP) is not just a team meeting, a network of connections, or a group supervision session. A CoP develops its group identity through a shared domain of interest or focus, such as serving transition-age youth, using motivational interviewing strategies, delivering recovery-oriented services, or implementing best practices in service planning. These CoPs might be time-limited or ongoing. By joining a community of practice, each member makes a commitment to increase his or her competence. Members need not be experts, but they do work together to gain and share knowledge and expertise. Critical success factors for a community of practice (McDermott, 2001; Nemec & LaMaster, 2014) can be summarized as follows:

- **<u>Focus:</u>** The selection of topic areas for the group, its values, and clear strategic goals provide both direction and boundaries to a CoP. Focus topics need to be important to the community members and relevant to the work itself (the "practice").

- **<u>Leadership</u>**: Most successful communities of practice have community coordination assigned to the leader as part of his/her regular work load (Wenger, McDermott, & Snyder, 2002). The leader's role is central to facilitating personal relationships among community members that build commitment, promote collaboration, and facilitate comfort with exchanging and debating ideas, including outright disagreeing—a sign of an effective team (Lencioni, 2002).

- **Input:** If the purpose of a CoP is to share and develop knowledge for quality improvements in an area of practice, fresh inputs are needed. Inviting external experts, whether as short-term guests or permanent members, can be an effective way to expand knowledge and stay abreast of new ideas.

- **Commitment:** An active and passionate core group helps sustain a CoP. Members need to have time, motivation, and encouragement to participate. The core members need to self-select, as assigning members to be the passionate core simply will not work (Senge, 2006). Ideally, a CoP includes opportunities to participate within regular work schedules and at a variety of levels (Wenger et al., 2003). A group of active members coexists with more peripheral members, often known as lurkers in a CoP. "Rather than force participation, successful communities 'build benches' for those on the sidelines" (Wenger et al., p. 57).

- **Open Forums:** To be meaningful, a CoP needs real dialogue about what McDermott (2001) calls cutting edge issues, recognizing that the community's purpose is to help their area of practice evolve and improve. The group needs to identify the issues that are at the cutting edge, whether there is a specific desired outcome for discussion. To promote exchange of ideas, a CoP needs a variety of modalities for collaboration. Members need to find it easy to contribute the community's knowledge and practices, in spite of their competing responsibilities and interests. Pre-existing demands on their time may make it difficult to check in regularly. Finding a "rhythm" for a CoP requires a balance between too fast, where "the community feels breathless," and too slow, where "the community feels sluggish" (Wenger et al., 2003, pp. 62-63).

Communities of practice can be initiated with more or less support, guidance, or instruction, or they can adapt, possibly starting out in a fairly structured and strongly moderated group with the leader/mentor fading over time.

Summary

MassPRA has, as one its strategic goals, the implementation of high quality training initiatives to improve the competence of the Massachusetts mental health workforce to deliver psychiatric rehabilitation and recovery-oriented services. Focusing on relevant practice competencies; effective, accessible, and affordable training; knowledge-sharing communities; and an expansion of CPRPs will achieve this goal.

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Appendix A
Core Educational Requirements for LPHA-Eligible Credentials in MA

Masters' level mental health training programs in the Boston-area offer a wide variety of courses related to understanding and addressing needs of people diagnosed with mental illnesses; however, few of these programs specialize in Psychiatric Rehabilitation (PsyR). The majority of programs available serve disciplines of Social Work, Counseling Psychology and Mental Health Counseling, and Rehabilitation Counseling.

Social Work programs must conform to the standards set by the Council on Social Work Education (CSWE). These standards establish the areas of competency expected of the graduates of these programs. While some of these standards are consonant with the practices of Psychiatric Rehabilitation, for example, the emphasis on diversity and multicultural issues (SW standard 2.1.4) and the inclusion of strengths in any assessment (2.1.10b), none of them mandates knowledge of the techniques of PsyR. There are no references to teaching skills, supporting recovery, or employing natural supports[2].

The core standards are born out in the specific courses of study offered at local schools of Social Work. The Boston College Graduate School of Social Work offers courses on Contemporary Psychodynamic Theories[3], Family Therapy[4], and Psychosocial Pathology[5], but none on Psychiatric Rehabilitation and none on theories of recovery.

The course offerings at Simmons[6], Boston University[7], and Salem State University[8] are similar to those at Boston College. The Wheelock College's Social Work program only posts an overview of the curriculum[9], but it seems to follow the standards of the CSWE closely.

Lesley University and Cambridge College offer Masters' degrees in **Mental Health Counseling**, and Lesley additionally offers a Masters' in Counseling Psychology. Cambridge College offers specializations in Addictions, Addictions and Trauma, and Geriatric Mental Health, but none in Psychiatric Rehabilitation[10]. Lesley does not list courses online, but a list of the faculty and their specialties is available[11]. This list shows that none focuses on Psychiatric Rehabilitation.

There are three graduate programs in **rehabilitation counseling** in Massachusetts. Assumption College, in Worcester, requires one course in the principles of psychiatric rehabilitation, and does offer a specialization in this area. Springfield College, in Springfield, offers a course in psychiatric rehabilitation as an elective, and includes a specialization program in mental health, but may not fully embrace psychiatric rehabilitation, given its online description: "Emphasis is placed not solely on understanding and knowledge in ***psychopathology and psychotherapy*** but rather on concepts of growth and development, independent living, vocational rehabilitation, milieu and expressive therapies, and psychosocial support systems" (emphasis added). U Mass Boston does not list a course in psychiatric rehabilitation on their rehabilitation counseling program website.

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[2] http://www.cswe.org/File.aspx?id=41861
[3] http://www.bc.edu/content/dam/files/schools/gssw/pdf/03CoursesMSWSum13v2.pdf
[4] http://www.bc.edu/content/dam/files/schools/gssw/pdf/03CoursesMSWFall13v3.pdf
[5] http://www.bc.edu/content/dam/files/schools/gssw/pdf/03CoursesMSWSpr14.pdf
[6] http://www.simmons.edu/ssw/academics/msw/courses/index.php#content
[7] http://www.bu.edu/academics/ssw/courses/
[8] http://www.salemstate.edu/academics/schools/2194.php
[9] http://www.wheelock.edu/academics/graduate/social-work/msw-program-overview/msw-program-full-time-overview
[10] http://www.cambridgecollege.edu/download/CP-mentalhealth-091412.pdf
[11] http://www.lesley.edu/counseling-and-psychology/faculty/

In Massachusetts, licensure as a social worker, mental health counselor, or rehabilitation counselor does not require any knowledge, experience, or training in recovery-oriented services or psychiatric rehabilitation.

While there is a Psychiatric Rehabilitation Certificate Program at Bunker Hill Community College, the required courses are, for the most part, focused on generic human services content.

Recognizing the lack of attention in curricula for the professional disciplines, SAMHSA initiated a project funding six "national mental health professional organizations to develop and implement training curricula that promote greater awareness, acceptance, and adoption of mental health recovery principles and practices among mental health providers"[12]—rather brief curricula that are only recently being circulated.[13]

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[12] http://www.samhsa.gov/recoverytopractice/ProfnlDisciplineAwardees.aspx
[13] http://www.dsgonline.com/rtp/enews/2014/2014_01_30/enews_2014_01_30.html