Psychiatric Rehabilitation Curriculum Development from a Consumer Perspective

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ABSTRACT

This article is a retrospective of the author's work in the area of program development. In it, she describes her introduction to psychiatric rehabilitation, why she changed her research and teaching foci, and how she incrementally implemented the principles and practices of psychiatric rehabilitation within an existing MS in Rehabilitation Counseling Program. In addition to sharing the San Diego State University psychiatric rehabilitation curriculum, the author explains how her lived experience as a person with bipolar disorder influenced the delivery of the curriculum and, ultimately, student outcomes.

KEYWORDS

Psychiatric rehabilitation, professional education, peer perspective, lived experience

Psychiatric Rehabilitation Education from a Consumer Perspective

I arrived in San Diego in the summer of 2002, ready and eager to begin my new job with the Rehabilitation Counseling Program at San Diego State University (SDSU). What my colleagues and students did not know at that time was that I had recently been diagnosed with bipolar I disorder, a fact of my life that has greatly influenced my career over the past three decades.

Let me back up a few years. Beginning in the 1970s, I had a fulfilling career, first working with individuals with developmental disabilities and, second, assisting individuals with a variety of disabilities to obtain and maintain jobs. Over a decade of work in the field was followed by graduate study and a stint at the University of Illinois. In my research, I was studying people who had disabilities, specifically autism and cognitive disabilities, with a focus on communication and coping strategies (Olney, 2000, 2001; Olney & Brockelman, 2003; Olney & Kim, 2001).

In my experience, two mutually incompatible things were true by the end of the 1990s: First, several times, I had experienced symptoms of serious mental illness—weeks of mania followed by months of deep depression. Second, I had no particular interest in, or experience with, mental illness as a topic of study. At that time, I was just becoming aware that my own symptoms were, indeed, psychiatric symptoms. I had staunchly rejected the bipolar label until the facts became irrefutable. I finally "bought in" to my diagnosis in 1998.

During my early years at SDSU, I experienced a severe exacerbation of my psychiatric symptoms. Through the use of medications, weekly therapy, and a variety of lifestyle changes, I began to feel and function much better. Around the same time, I read about the discipline of psychiatric rehabilitation. Suddenly, personally and intellectually, mental illness and psychiatric rehabilitation both seemed more relevant to me. I began going to psychiatric rehabilitation conferences, reading the journals, and making the interpersonal connections that I ultimately used to develop a psychiatric rehabilitation track within the Rehabilitation Counseling Program at SDSU.

A critical element in both my personal development and that of the psychiatric rehabilitation track was my association with the Consortium of Psychiatric Rehabilitation Educators (CPRE). Annual meetings with this small, dedicated group of professors greatly added to both my knowledge about psychiatric rehabilitation and my ideas on how to convey key issues in the classroom. However, over my 10-year relationship with members of this group, I only shared my psychiatric diagnosis with one person. Skillful disclosure was not yet in my repertoire.

Based on my own experiences with therapy and medications, I thought I understood what traditional mental health care could accomplish. Learning about psychiatric rehabilitation opened a new universe of possibilities. With its emphasis on evidence-based practices, community-based interventions, services to those with significant disabilities, and just plain practicality, psychiatric rehabilitation resonated with me. I was invested in the ideas and had been reading all that I could on the topic. I even studied up, took the exam, and earned the Certified Psychiatric Rehabilitation Practitioner (CPRP) credential.

Sometimes by accident, sometimes purposefully, I let my colleagues within my department know that I had bipolar disorder. They were sur-

prisingly supportive and encouraging. More importantly, they were interested in my process. I was learning to take medication, manage my symptoms behaviorally, and recognize and address "trouble" before it went too far. Through my experience at SDSU, I learned the value of, and the necessity for, skillful disclosure, but that's a different essay.

Working It Out: Lessons to Help People with Mental Illness and Other Disabilities Find Employment and Empowerment (Olney, 2022) describes what I have learned about psychiatric rehabilitation. The book is the result of many years of journaling as I learned about my own mental illness and began making sense of this new knowledge considering my job. It covers a range of psychiatric rehabilitation issues and is intended to be useful to individuals with psychiatric disabilities, family members, counselors-in-training, and professionals.

The Importance of a "Consumer Perspective"

I came into the world of psychiatric rehabilitation as a "consumer" rather than a "provider" of services. Having received traditional mental health services for a number of years, I had a pretty good idea of what treatments were efficacious and which ones were a waste of my time. More importantly, I quickly sensed the gaps in clinicians' knowledge. For example, in the years that I had been on mood-managing medications and engaging in therapy, not one clinician ever mentioned that, not only could I manage my own symptoms, but that I would need to learn how to do this if I ever wanted to "get off the rollercoaster" of bipolar symptoms. It was through the psychiatric rehabilitation literature, not in therapy or in consultation with my psychiatrist, that I learned how to monitor my sleep, my interactions, and my moods. Through my self-education in psychiatric rehabilitation, I also learned about shared decision-making; peer support; effective ways to deal with my own family, friends, and career; and, most importantly, the positive aspects of living life with a psychiatric disability (Olney, 2022).

Something I learned from my students, again not my therapists, is that clinicians (and clinicians-in-training) often have a strong, negative bias toward their clients. This bias may be the greatest barrier to good services that people with mental illness face. Teaching and mentoring students from a consumer perspective helped me to both see and address this unconscious bias, providing more constructive perspectives for students to

consider. For example, my students frequently discussed the low activity level of people with schizophrenia or clinical depression as a problem of motivation. They often talked about substance use disorders as if individuals affected by them were engaging in willful misbehavior. Not only was I able to bring students back to the literature on these matters, but I could also gently address their underlying biases.

Having bipolar disorder has been a gift, especially for teaching and specifically for teaching counselors-in-training. I believe that I read and process literature on psychiatric rehabilitation differently from professors who teach from the "provider" perspective—it's very personal to me. One frustration I have had over the years is that, despite my best efforts, I'm not equally successful at influencing every student. I have graduates who leave the program with attitudes that are not helpful. However, I am confident that seeing the world as I do and sharing my perspective with counselors-in-training has made a positive difference in the lives and careers of most graduates I have taught over the years. For example, many of my graduates take positions in psychiatric rehabilitation within California. A large number have gone on to become psychiatric rehabilitation educators. I receive frequent feedback from former students, updating me on their work in our field. I have no doubts that my "consumer" perspective has had a positive influence on most of my students over the years.

Evolution of the Psychiatric Rehabilitation Track

In 2004, with the encouragement of my department chair, I developed a course in psychiatric rehabilitation, titling it "Best Practices in Psychiatric Rehabilitation." Because I was new to the field, I consulted with advisors from San Diego County Behavioral Health and Community Research Foundation, a psychiatric rehabilitation provider agency in San Diego, to assure that the topics I addressed were fully relevant to the field. That first course was offered as an elective and covered some of the big topics in psychiatric rehabilitation: supported employment, co-occurring disorders, symptom management, ethics, and motivational interviewing. I frequently invited guest speakers who were experts in mental health or had experienced mental illness. I assigned *Psychiatric Rehabilitation—Second Edition* (Pratt et al., 2006) along with then-current journal articles to supplement the lectures. My intention in offering this course was to give future rehabil-

itation counselors some of the tools they would require to meet the needs of their clients with mental illness. The training was fully relevant because one-third of the clients most rehabilitation counselors encounter have a diagnosis of mental illness or substance use disorder (Peterson & Olney, 2021).

In that same year, I responded to a request for proposals from the federal Rehabilitation Services Administration (RSA). I wrote a training grant to fund 10 students each year to study psychiatric rehabilitation, making a compelling case in the proposal for the need for rehabilitation counselors to work more effectively with this diverse and complex population. I won the five-year grant, making psychiatric rehabilitation an area of study in my department, not just an elective. Interestingly, the RSA has funded the psychiatric rehabilitation program continuously from 2005 to 2024, the final year for the current five-year grant. I have no doubts that, due to its efficacy and practicality, the RSA will continue to value and support psychiatric rehabilitation.

The RSA grant funding required me to develop a second course, this one titled "Principles of Psychiatric Rehabilitation." As I developed the course, I had in mind the 12 principles that were imparted on the Psychiatric Rehabilitation Association (PRA; https://www.psychrehabassociation.org/) website (Table 1).

Again, I consulted with experts in the field, selecting content about serious mental illnesses as the centerpiece of the course. Additional topics were psychopharmacology, criminal justice, and working with families. However, I surely did not want to teach a traditional mental health course, so I depended on guest speakers, firsthand video accounts, autobiographies, articles by authors with mental illness, and videos to bring a first-person perspective to students' learning. The course covered depression, bipolar disorder, schizophrenia, posttraumatic stress disorder, substance use disorder, and anxiety, not solely through the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition—Text Revision* (*DSM-IV-TR* 2000, American Psychiatric Association), but considering the experiences of people with the various mental illnesses. Along with autobiographies and journal articles, I assigned reading from the Pratt et al. (2006, 2014) text. See Table 2 for a list of autobiographies by individuals with mental illness that I have assigned to my students over the years.

Table 1: Psychiatric Rehabilitation Association's 12 Principles

Principle 1:	Psychiatric rehabilitation practitioners convey hope and respect and believe that all individuals have the capacity for learning and growth.
Principle 2:	Psychiatric rehabilitation practitioners recognize that culture is central to recovery and strive to ensure that all services are culturally relevant to individuals receiving services.
Principle 3:	Psychiatric rehabilitation practitioners engage in the processes of informed and shared decision-making and facilitate partnerships with other persons identified by the individual receiving services.
Principle 4:	Psychiatric rehabilitation practices build on the strengths and capabilities of individuals.
Principle 5:	Psychiatric rehabilitation practices are person-centered; they are designed to address the unique needs of individuals, consistent with their values, hopes and aspirations.
Principle 6:	Psychiatric rehabilitation practices support full integration of people in recovery into their communities where they can exercise their rights of citizenship, as well as to accept the responsibilities and explore the opportunities that come with being a member of a community and a larger society.
Principle 7:	Psychiatric rehabilitation practices promote self-determination and empowerment. All individuals have the right to make their own decisions, including decisions about the types of services and supports they receive.
Principle 8:	Psychiatric rehabilitation practices facilitate the development of personal support networks by utilizing natural supports within communities, peer support initiatives, and self- and mutual-help groups.
Principle 9:	Psychiatric rehabilitation practices strive to help individuals improve the quality of all aspects of their lives, including social, occupational, educational, residential, intellectual, spiritual, and financial.
Principle 10:	Psychiatric rehabilitation practices promote health and wellness, encouraging individuals to develop, and use individualized wellness plans.
Principle 11:	Psychiatric rehabilitation services emphasize evidence-based, promising, and emerging best practices that produce outcomes congruent with personal recovery. Programs include structured program evaluation and quality improvement mechanisms that actively involve persons receiving services.
Principle 12:	Psychiatric rehabilitation services must be readily accessible to all individuals whenever they need them. These services also should be well coordinated and integrated with other psychiatric, medical, and holistic treatments and practices.

Table 2: Narrative/Autobiographical Texts—Mental Health

Campbell, B. M. (2005). *72 Hour Hold*. Alfred A. Knopf.
Cheney, T. (2009). *Manic: A Memoir*. Harper Collins.
Close, J. (2015). *Resilience: Two Sisters and a Story of Mental Illness*. Grand Central.
Geller, J. L., & Harris, M. (1994). *Women of the Asylum*. Anchor Books.
Green, H. (1964). *I Never Promised You a Rose Garden*. Signet.
Jamison, K. R. (1996). *An Unquiet Mind*. Vintage Books.
Kaysen, S. (1994). *Girl, Interrupted*. Vintage Books.
LeMieux, R. (2015). *Breakfast at Sally's: One Homeless Man's Inspirational Journey*. Skyhorse.
Long, L. (2014). *The Price of Silence*. Random House.
Lopez, S. (2008). *The Soloist*. Berkeley Publishing Group.
Plath, S. (1971). *The Bell Jar*. Harper & Row.
Reiland, R. (2004). *Get Me Out of Here*. Hazeldon.
Saks, E. R. (2007). *The Center Cannot Hold*. Hyperion.
Schiller, L., & Bennett, A. (1996). *The Quiet Room*. Grand Central Publishing.
Simon, L. (2002). *Detour*. Washington Square Press.
Solomon, A. (2001). *The Noonday Demon*. Scribner.
Stossell, S. (2015). *My Age of Anxiety*. Random House.
Traig, J. (2004). *Devil in the Details*. Bayback Books.
Vonnegut, M. (2011). *Just Like Someone without Mental Illness only More So*. Bantam Books.
Wagner, P. S., & Spiro, C. S. (2005). *Divided Minds: Twin Sisters and Their Journey through Schizophrenia*. St. Martins Griffin.
Wang, E. W. (2019). *The Collected Schizophrenias: Essays*. Graywolf Press.

The Certificate in Psychiatric Rehabilitation

Academic certificates provide an avenue for students to develop expertise in an area, explore a discipline, and earn a credential. In 2008, the Certificate in Psychiatric Rehabilitation was added to the SDSU Graduate Bulletin. This 15-unit program included two psychiatric rehabilitation courses plus courses in counseling theories and group counseling (both required in the standard Rehabilitation Counseling Program), and a three-unit internship in a psychiatric rehabilitation setting. Nearly every MS in Rehabilitation Counseling student with an interest in mental health has also

signed up for the certificate over the past 14 years, thus earning a credential in psychiatric rehabilitation in addition to their master's degree.

One of the strongest features of the Certificate in Psychiatric Rehabilitation program is the student portfolio submitted and presented at the end of each student's program. The portfolio assignment encourages students to evaluate their body of work and assess their own values and principles. Each certificate student submits a paper that contains a number of specific elements related to psychiatric rehabilitation (Table 3).

Two faculty members are assigned to review the portfolio. The student meets individually with the examiners, presenting highlights of their portfolio in a PowerPoint presentation. The examiners ask the students questions based on the portfolio and oral defense. The examiners then ask the student to leave the room while they confer. They invite the student back into the room to announce their decision: pass, pass with revisions, or fail. The portfolio is a unique learning tool that helps students to consolidate their knowledge and values before they leave the program, an activity that I think is indispensable.

Creating a Licensure Option

The gold standard in rehabilitation counseling is the national Certified Rehabilitation Counselor (CRC) credential (Peterson & Olney, 2020). SDSU's Rehabilitation Counseling Program uses the CRC exam as our exit exam, so most of our graduates emerge from the program with the CRC under their belt. However, despite having a strong desire to make a difference in the lives of individuals with serious mental illness, a deep knowledge base in psychiatric rehabilitation, a master's degree, the CRC, and the Certificate in Psychiatric Rehabilitation, graduates of the Rehabilitation Counseling Program could not, as a rule, be promoted in mental health and substance use agencies without a license. To be sure, employers accepted our students as interns and were eager to hire our graduates. Nonetheless, to become a supervisor or program manager, a license was required.

The Rehabilitation Counseling Program included nearly all the courses required for the Licensed Professional Clinical Counselor (LPCC) with a few exceptions. We did not have a course that specifically focused on the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition, Text Revision* (*DSM-4 TR*, 2000). I revised Principles of Psychiatric Rehabilita-

Table 3: Elements of the Psychiatric Rehabilitation Portfolio

Title Page
Table of Contents
Executive Learning Summary (5 pages) in which you specify and describe the items in the portfolio, addressing how this body of work demonstrates mastery in each of the following knowledge content areas: Understanding of psychiatric disability Multicultural knowledge and sensitivity Community integration and employment Counseling and communication with individuals who have psychiatric disabilities; and Implication for systems change
Your Mission, which encompasses how you see yourself and your future as a psychiatric rehabilitation practitioner. How are you going to make a difference in the lives of people with psychiatric disabilities? (1-page maximum)
Your Vision for the field of psychiatric rehabilitation and recovery. If you had the power to make changes to the existing mental health system, what would services look like? (1-page maximum)
Professional Growth and Development Plan. How will you use the learning obtained in the psychiatric rehabilitation curriculum to be a positive agent for change and how do you plan to continue your learning? (3–5 pages)
Four Examples of quality work you have produced in the program, with a 1–2-page summary for each example, which links your learning to one or more growth areas identified in item #3, Executive Summary. These papers will all be relevant to psychiatric rehabilitation and recovery and will be products from [specified courses] unless otherwise arranged with the program advisor.

tion to teach students to use the *DSM-4 TR* as they learned about serious mental illness. This way, I was able to keep the psychiatric rehabilitation focus intact while also exposing students to the diagnostic process. In addition to the coursework that was foundational to rehabilitation counseling, licensure required courses in psychopharmacology, substance use disorder, and trauma counseling. I collaborated with other programs in my college that were also pursuing licensure. Sharing courses was an excellent solution for several years until enrollments allowed each department to offer these courses individually.

California was the 50th state in the country to approve licensure under the LPCC credential. When the LPCC became available in California in

2011 and in 2012, I presented our curriculum to the California Board of Behavioral Sciences (California BBS; https://www.bbs.ca.gov/). Our curriculum was approved for the LPCC in 2012.

CACREP Accreditation

In 2016, the Concentration was accredited (under both the Clinical Mental Health Counseling and Clinical Rehabilitation Counseling specialty areas) by the Council for the Accreditation of Counseling and Related Education Programs (CACREP; https://www.cacrep.org/). Accreditation resulted in a larger number of applicants, helped to guide curriculum development, and provided structure for further program planning.

I found that CACREP accreditation was not in conflict with the principles and processes of psychiatric rehabilitation, and that I could incorporate both in my teaching practice. This was consistent with my earlier analysis of CORE standards (Olney & Gill, 2016). With CACREP's emphasis on mental health, accreditation resulted in a stronger emphasis on co-occurring disorders and trauma-informed care, areas of study and practice that are critical in all settings in which rehabilitation counselors work such as state/federal vocational rehabilitation, the Veteran's Administration, mental health and substance use programs, and for-profit and not-for-profit agencies.

Concentration in Clinical Rehabilitation Counseling

With the successful application to the California BBS to prepare students for state licensure under the LPCC credential and CACREP accreditation, creating a separate concentration was a logical next step in our program development. Over a period of two years, the Concentration in Clinical Mental Health Counseling and Clinical Rehabilitation Counseling was proposed, approved through multiple levels of review, and accepted by the university as a separate concentration within the Rehabilitation Counseling Program.

Courses were included in the concentration that met the requirements for both licensure and accreditation and included classes in psychiatric rehabilitation as well as clinical subjects such as substance use and psychopharmacology. The resulting 60-unit program prepares rehabilitation counseling students to work effectively with individuals who have a mental illness in traditional rehabilitation, psychiatric rehabilitation, and clinical settings. With a strong emphasis on motivational interviewing,

students develop the counseling skills they need for both vocational and personal counseling activities.

Prior to the approval of the concentration, students could earn the Certificate in Psychiatric Rehabilitation, take the courses required for licensure, earn the CRC, and complete the assistantship and exam requirements to become an LPCC. Currently, the approval of the new concentration meant that students' diplomas reflected their training. The concentration is currently named the "Concentration in Clinical Mental Health Counseling and Clinical Rehabilitation Counseling" based on the two CACREP specialty areas under which the program was originally accredited. However, planning has begun to rename the program the "Concentration in Clinical Rehabilitation Counseling." An application is now being made to CACREP under that specialty area. Renaming the program will provide greater clarity to applicants, students, faculty members, and the community about the content and philosophy of the program.

Toward the Future

In 2019, I semi-retired from SDSU. Dr. Sonia Peterson was hired to take my place as the Director of the Clinical Rehabilitation Counseling program. In the past several years, the two of us have worked on a variety of projects, some together and some individually. A major initiative that Dr. Peterson and I completed jointly is the newly approved Advanced Certificate in Co-occurring Disorders. For this 21-unit credential, we were not required to add courses but did add content to our existing classes. We sought approval for our curriculum from the California Consortium of Addiction Programs and Professionals (CCAPP)—the body that grants substance abuse credentials in our state including the Licensed Advanced Alcohol and Drug Counselor (LAADC). The certificate is to be offered for the first time in the fall of 2022. As an online program, interested professionals throughout the state will be able to enroll in the program, completing the educational component for the LAADC. Training future substance abuse counselors through the psychiatric rehabilitation and recovery lens could have a profound impact on the way substance use interventions are experienced by both consumers and providers.

In Summary

Over two decades, I evolved from a new professor who had been recently diagnosed with bipolar I disorder and had a background in nearly every

disability except mental illness, to an expert in psychiatric rehabilitation. Looking back on my experiences, I see some intentionality but also a good dose of serendipity. My department chair and colleagues nurtured my development while my symptoms, and how I managed them, provided firsthand insights into what a life and a career with a mental illness could be. In addition, many students had an acute interest in mental illness and were eager to learn the principles and practices of psychiatric rehabilitation. It was clear to me that, although traditional approaches to mental illness can be particularly useful, the wide array of strategies associated with psychiatric rehabilitation had the versatility and flexibility to be helpful in new ways and with broader populations.

Over the years, I developed a strong interest in curriculum development and design, first out of necessity as the author of a new program, and second due to my curiosity about how students experience graduate school. I went to great lengths to assure that the programs I developed were fully relevant to the setting in which students would intern and eventually work. I consulted with local experts, attended Psychiatric Rehabilitation Association conferences, and benefitted from the knowledge of members of the Consortium of Psychiatric Rehabilitation Educators (CPRE, Psychiatric Rehabilitation Association).

The most important story I can tell concerning the development of the psychiatric rehabilitation program at San Diego State University is about the impact it has had on students. Our interns and graduates encounter counselors-in-training and professionals from a wide variety of counseling fields such as psychology, social work, and marriage and family therapy. Both interns and graduates constantly comment on the unique aspects of their psychiatric rehabilitation curriculum: a strong grounding in motivational interviewing, deep knowledge of employment and evidence-based practices that lead to lasting engagement in the workplace and community, psychiatric rehabilitation principles that are intended to fully humanize each client, and a first-person perspective that is reinforced through autobiographies, guest speakers, and interactions with faculty. We have not merely created a new licensure track so that students can become licensed professionals in the mental health and substance abuse fields, we have developed an entirely new kind of curriculum that is at once person-centered and evidence-based, a degree program that is appropriate to rehabilitation, mental health, and other community settings that serve individuals with serious mental illness.

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Pratt, C. W., Gill, K. J., Barrett, N. M., & Roberts, M. M. (2014). *Psychiatric rehabilitation* (3rd ed.). Academic Press.