

Training Teams to Deliver Better Psychiatric Rehabilitation Programs

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Introduction by the column editors: Most rehabilitation programs for persons with severe mental illness are provided by interdisciplinary teams whose members include professionals, paraprofessionals, and, sometimes, "prosumers"—individuals who both provide and consume mental health services. Despite the ubiquity with which psychiatric rehabilitation techniques such as social skills training, vocational rehabilitation, and family psychoeducation are used within a team approach, with few exceptions practitioners are taught these techniques without reference to how they may fit in with a team that delivers the mental health services.

One exception is the approach of the Program for Assertive Community Treatment (PACT), which emphasizes adequate preparation of practitioners for working together as a team. Staff members who work on PACT teams have clearly specified roles and frequent face-to-face meetings and use methods of group problem solving that have been operationalized for day-to-day practice.

Without recognition of the importance of the team context in which rehabilitation modalities are delivered, rehabilitation practitioners may compromise clinical goals and lose a valuable source of social support and encourage-

ment—namely, positive feedback and reciprocal reinforcement from their teammates. In this month's Rehab Rounds column, Patrick W. Corrigan, Psy.D., and Stanley G. McCracken, Ph.D., describe their method of combining educational and organizational strategies for teaching teams to deliver better psychiatric rehabilitation programs. They show how combinations of strategies offer the greatest promise for assisting rehabilitation teams in developing programs that meet clients' needs effectively.

Use of psychiatric rehabilitation techniques within the context of a team of practitioners is almost axiomatic. The multiple and concurrent interventions required by persons with pervasive disabilities would be too demanding for a solo clinician. Thus it is not surprising that clinicians who provide services to individuals with psychiatric disabilities through a team approach experience less burn-out, have more optimistic attitudes about rehabilitation, and provide better services (1,2).

However, teaching practitioners to work effectively as a team requires the use of both educational and organizational strategies (3,4). Educational strategies are designed to increase the knowledge and skills of team members, while organizational strategies foster administrative support, group cohesion, and leadership. Training efforts that combine both sets of strategies are required to address the individual and systemic issues that influence the implementation of effective psychiatric rehabilitation programs. This column reviews educational approaches to staff training and

describes phases in a training approach that combines educational and organizational strategies.

Educational approaches

The training of line-level clinicians who are currently providing rehabilitation services is usually accomplished with inservice training using social learning strategies. For example, staff members who are learning how to conduct social skills training are shown how to guide program participants through relevant exercises. Role-play opportunities are provided for staff trainees to practice these skills. Trainees who participate in these programs show marked increases in skills and use these skills regularly with appropriate supervision (5-7).

Researchers have extended the impact of educational programs by developing user-friendly rehabilitation modules that can be easily learned and implemented by staff (8,9). Wallace and colleagues (10) demonstrated that non-professional staff at a residential program learned and subsequently used a prepackaged skills training module after a relatively brief training course.

Although educational strategies improve staff knowledge and skills, they are not sufficient to ensure that a cohesive team provides rehabilitation competently. For example, staff members who should participate in training may choose not to or may drop out before the course is complete. Also, graduates of training programs frequently do not develop enduring rehabilitation programs (11). Organizational factors such as collegial support, staff ideology, and strong leadership must be addressed so that the increases in staff knowledge and skills can create and maintain the most effective programs (12).

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Interactive staff training

Interactive staff training combines a quality management approach with more traditional educational strategies used in team development to help staff create the most effective rehabilitation programs for their clients (1,3). Interactive staff training differs from many traditional training efforts in two important ways.

First, training focuses on the treatment team in situ, whereas traditional training frequently requires staff members to travel to conferences or seminars where they learn innovative practices from the experts who developed them. Often staff members are not able to implement these innovations at their home programs because fellow team members do not share the same ideology, enthusiasm, knowledge, or skills about the newly learned practice. Even when team members are enthusiastic about a new practice, implementation often requires changes in schedules and staffing patterns that are difficult to achieve without an administrative mandate. Consultants who provide interactive staff training overcome these pitfalls by meeting with all team members and their administrative leaders at the focal agency, institution, or facility so that these basic issues can be addressed directly.

Second, interactive staff training encourages the development of user-friendly programs. For example, by creating teams that can translate the results of academically generated, highly controlled efficacy studies into the real world of clinical practice, rehabilitation practitioners may be able to overcome the obstacles that frequently undermine provision of state-of-the-art services. These obstacles include staffing limitations, heterogeneous patient populations, and third-party-payer considerations. The fundamental task of consultants who provide interactive staff training is to teach line-level clinicians how to adapt research findings and practice guidelines to meet the challenges of ordinary clinical programs without sacrificing the essential elements of the novel treatment program.

Interactive staff training aims to induce specific practices with teams through four stages. Typically, month-

ly meetings over a year or more are required to progress through these stages.

Stage 1: introduction to the system

Consultants who provide interactive staff training usually come from outside the treatment team. Hence they need to gain the trust of team members before significant training and program development can occur. To help develop this trust, the consultants usually begin the training with a needs assessment. The assessment conveys the message that the team knows its training needs best. Team members are asked to report their perceptions of the strengths and limitations of the current rehabilitation program. The consultants then present the team with a menu of rehabilitation interventions, such as skills training, supported employment, programs for persons with mental illness and substance abuse habits, cognitive rehabilitation, and family education and support programs, and ask the team members to choose one intervention in which the limitations identified in the survey will be addressed.

Individuals from within the existing team are then assembled as a program committee charged with making preliminary decisions about how to implement the selected intervention package. One person from the committee is chosen as a "champion" to promote the training and development effort (13). Usually, the champion is an energetic and optimistic individual who wants responsibility for convening the program committee and for keeping the group on task.

Stage 2: program development

The consultants next work with the program champion and committee to make decisions about the selected intervention package. Teams that decide to implement incentive programs need to select specific targets and contingencies for the program. Teams that wish to augment their skills training program need to decide which skills will be taught to clients.

The interactive staff training consultant provides committee members with the principles that define the selected intervention. The consultant

then engages the program committee in making decisions about how the ideal program will be adapted to meet the needs of clients and staff members. The consultant guides the committee through this process by asking questions that committee members answer as homework to frame specific decisions. For example, a committee that was making preliminary decisions about supported employment was asked to list vocational counseling strategies that would prepare clients for job placement.

Consultants then use their expertise to help the committee evaluate initial decisions. Socratic questioning is a useful means for accomplishing this goal. Rather than stating a weakness or limitation of a program, the Socratic method helps the program committee evaluate the costs and benefits of specific program choices. For example, the interactive staff training consultant may ask, "What do you think are the advantages and disadvantages of assigning all clients in your supported employment program to a janitorial service?"

The Socratic method may help the committee realize that they do not have enough information about a component of the rehabilitation package. The consultant takes advantage of these learning opportunities by teaching curious team members about the identified intervention. Although traditional education strategies are used for this purpose, classroom-based training has a different quality in this context because team members study rehabilitation strategies that they have identified as important and relevant to their plan of care.

Stage 3: program implementation

The program committee pilot-tests the program to uncover weaknesses before a full-fledged trial occurs. Pilot tests are conducted by a subgroup of team members with a subset of clients. The program committee is advised not to attempt to implement a new program with all staff and clients until some of the more obvious pitfalls have been worked out.

The program committee uses a problem-solving approach to resolve difficulties discovered in the pilot run. Through this process, program

committees and treatment teams are taught the value of an empirical approach to program evaluation. They also learn that limitations in a rehabilitation program are problems that can be fixed, rather than overwhelming difficulties that indicate the program should be abandoned. For example, a trial of a new supported employment program suggested client dissatisfaction with the narrow range of job options. The team decided to hire a part-time job developer to find employers who would consider clients for a broader array of jobs.

Stage 4: program maintenance

In this stage, the team sets up structures that help maintain the newly developed intervention over the long term. Staff members are encouraged to ask questions about the efficacy of the program. Answers to these questions, in turn, suggest plans for correction. For example, the team might question whether their new skills training program actually leads to clients' learning more social and coping skills. The program committee would collect data to determine program efficacy in terms of the specific questions and the data to adjust the program as needed.

Research on interactive staff training

Three studies have examined the effects of interactive staff training. The first examined the impact of nine months of interactive staff training on attitudes and burnout of 35 staff members in a behavioral rehabilitation program (14). Results showed significant reductions in burnout and improvements in collegial support and attitudes about program development. These effects interacted with staff roles; nursing staff charged with more face-to-face interactions with clients showed greater reduction in burnout than clinical staff such as psychiatrists, psychologists, and social workers whose activities were restricted to infrequent therapy sessions.

A second study used a team level of analysis to examine whether interactive staff training led to actual change in the behavior of staff conducting a rehabilitation program in a residential setting (15). Staff participation in the

program increased from none to more than 75 percent of the team. Moreover, clients increased their participation in rehabilitation activities from less than 10 percent to more than 85 percent of the population attending that center. Finally, clients showed a 40 percent reduction in aggression following the implementation of the rehabilitation program.

A third study had similar results using a time-series design that measured changes in staff behavior related to the rehabilitation program and examined clients' response to that program (16). Staff burnout diminished across the team. Staff attitudes about rehabilitation innovations, and the actual implementation of these innovations, improved significantly. Client satisfaction with the rehabilitation program significantly improved, as did clinical outcome as measured by the Global Assessment of Functioning scale.

Afterword by the column editors:

For readers interested in a more thorough explanation of the interactive staff training model, the authors' recently published book on the subject is available (1). Like most interventions, interactive staff training is a work in progress. As a package for program development, interactive staff training is generating a base of empirical support. However, much more work must be done before it can be prescribed widely. For example, the interactive staff training model must demonstrate not only that user-friendly clinical procedures can be implemented and maintained, but also that these real-world adaptations faithfully represent the original science-based, state-of-the-art technologies (17).

Most important, although administrative and training efforts to promote team building represent important structural and process variables in improving the quality of care, the bottom-line utility of these methods must be gauged by program outcomes in the areas of the symptoms, functioning, and quality of life of individuals with mental disorders and their families. ♦

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