IMPLEMENTING and MAINTAINING BEHAVIOR THERAPY PROGRAMS

by
Robert Paul Liberman, M.D. & Patrick W. Corrigan, Psy.D.

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Two contradictory realities face the clinician or administrator who considers establishing a behavior therapy program in a psychiatric unit or hospital. First, there is the abundant clinical research literature, including reports in this book, that documents the efficacy and cost-effectiveness of behavior therapy and cognitive behavior therapy in the treatment of major mental disorders (Liberman & Bedell, 1989). Robust and consistently replicated findings show that behavioral programs, when implemented with fidelity to basic principles of human learning, decrease symptoms of mental illness; improve individuals' repertoires of coping, instrumental, and social skills; quicken the pace of discharge from hospital; lengthen the tenure of former patients' community adaptation; prevent or delay relapse and rehospitalization; and enhance individuals' quality of life. Findings like these would predict that behavior therapy is heartily embraced by most clinicians and administrators and readily incorporated into their daily practice and programs.

Yet, the second reality is that relatively few behavior therapy programs exist and endure in current private and public mental health

facilities. Despite the exemplars of behavior therapy programs described in the chapters of this book, there is a surprising dearth of such programs in psychiatric hospitals, inpatient units, and day treatment centers. Although discrete elements of behavior therapy programs or certain learning principles have been widely adopted by mental health practitioners, these have often been bastardized and used inconsistently. Rarely have they led to implementation of comprehensive and effective treatment programs. For example, a survey of practitioners working in psychiatric services at Department of Veterans Affairs Medical Centers across the US found that very few were using token economies, despite the well-documented efficacy of these methods (Boudewyns, Fry, & Nightingale, 1986). Only about a third of a large group of Texas clinicians considered a social learning approach to be relevant for treatment of the seriously mentally ill (Mirabi et al., 1985). One recent commentary on the sociopolitics of innovative services for the mentally ill and developmentally disabled noted that many behavioral programs disappeared even by the time publications describing their results were printed (Liberman, 1983).

In the next chapter, Moss compellingly highlights several reasons why behavior therapy programs have not "sold" well in the mental health marketplace. Among the reasons are marketplace contingencies of regulation and financing that have not favored behavioral programs and lack of penetration of behavioral technology and learning principles in the curricula of graduate and postgraduate training programs for psychiatrists, psychologists, social workers and nurses. Additional barriers to the widespread implementation and use of behavior therapy in psychiatric settings are created by the divide between researchers and clinicians; the failure of innovators to develop and use effective tools for technology transfer; and institutional, professional, and administrative constraints. This chapter catalogs these additional barriers with a view toward prescribing methods for more successful implementation and maintenance of behavior therapy programs within the psychiatric field. We are aiming this chapter at practitioners and administrators who can identify and remove obstacles to the successful introduction of behavior therapy in their work sites.

Bridging the Chasm Between Researchers and Clinicians

Divergences in values, professional rewards, and work environments between researchers—who design and validate treatment methods—and clinicians—who put them into practice can account for the regrettably slow and limited spread of therapeutic innovations from academia to clinics, consulting rooms, and hospitals (Barlow, 1981; Garfield & Kurtz, 1976). Because researchers and clinicians move in different professional circles, the important "word-of-mouth" interpersonal influences that are often the key mechanism in adoption of innovations do not operate.

Research findings that might improve clinical practice are virtually unknown to line level staff because these findings are written for academic audiences and require several years to reach the professional literature (Halpert, 1966). Moreover, published clinical research is rarely consumed by practitioners; it has been estimated that less than half of published journal articles are read by more than 200 persons (Garvey & Griffith, 1971). Furthermore, studies have shown that mental health professionals do not use journal-based literature to guide their practice (Cohen, 1979; Larsen, Norris, & Kroll, 1976).

To promote their treatment innovations, academic researchers will have to comprehend better the needs of practitioners who carry the responsibility for implementation. One avenue that has been fruitfully pursued lies in streamlining and packaging treatment programs so they become "user friendly" and utilitarian, making few demands on the practitioner's time and resources (Liberman et al., 1993). Clinicians are more likely to incorporate technologies that do not require excessive time or effort to carry out (Witt & Martens, 1983). Similarly, interventions that are perceived to be relevant to daily practice are more likely to be used by clinicians as are clinical innovations that do not require extensive training to master or large expense to use.

One example of making a clinical innovation user friendly are *modules* for training social and independent living skills (Corrigan, MacKain, & Liberman, 1994; Liberman & Bryan, 1977; Liberman, King, & DeRisi, 1976; Liberman et al., 1993). Although skills training modules may incorporate highly technical findings from state-of-the-art research, they are nevertheless planned and designed to

be easily conducted by most practitioners. Trainer skills necessary to conduct modules are easy to learn and do not require an extensive education to learn. Any motivated and experienced professional or paraprofessional can follow the step-by-step procedures faithfully and with predictable effects. Therapists demonstrate the training skills competently after a relatively short course of training and practice.

Skills training modules comprise both a curriculum of discrete interpersonal, cognitive, self-care, and coping skills that are taught to the patients as well as a series of learning activities that are led by the staff member to facilitate patients' skill acquisition. Most modules require one or two trainers to provide services for 5 to 10 participants. Each module is divided into several skill areas and includes a Trainer's Manual, Demonstration Videotape, and Patient Workbook to conduct training. Skills training is discussed more fully in chapter 1.

Several modules have been developed for use with chronic mentally ill adults; these include Medication Management, Symptom Management, Self-Care and Grooming, Job Finding, Social Problem Solving, Basic Conversational Skills, Street Smarts, and Recreation for Leisure (Liberman & Corrigan, 1993; Liberman et al., 1986; Wallace et al., 1992; Wallace et al., 1985). Research has shown that clinicians are able to learn and regularly use these modules after a 2-day orientation and subsequent consultation (Eckman, Liberman, Phipps, & Blair, 1990; Wallace et al., 1992). Moreover, these modules remain important ingredients in the treatment approach of trained clinicians years after training has ceased (Eckman et al., 1992). Patients who completed these modules demonstrated significantly increased knowledge and skills in the content areas, better social adjustment, and improved quality of life (Liberman et al., 1993).

By breaking down comprehensive treatment programs into their constituent elements of service, and then packaging the elements as treatment "modules," innovators can increase the likelihood that their therapeutic advances will be successfully "exported" to other sites. Several of the behavior therapy programs described in this book have modularized elements of service. For example, Levendusky and his colleagues in chapter 8 described therapeutic contracting in modular format with the components of the contract serving as skill areas. Patients are taught how to identify the

life problems that led to hospitalization, restate these problems in terms of long-term goals, specify behaviors that will lead to attainment of these goals, and provide contingent reinforcement to motivate patients to attempt these behaviors.

Psychoeducational modules were evident in other programs reviewed in this book. Hierholzer and Thornbrough (chapter 4) designed an entire curriculum that included the modules developed by Liberman and his colleagues plus innovative programs that address anger management skills, self-esteem development, and successful living. Mohr and his colleagues (chapter 5) adopted Brenner's cognitive rehabilitation program into a module that teaches patients skills to manage their cognitive deficits.

Tools for Technology Transfer

Designing treatment techniques as "modules" for convenient insertion into existing psychiatric programs is certainly one tool for facilitating the adoption of innovations, such as those crafted by cognitive behavior therapists. Another tool is the creative use of interpersonal influence for persuading clinicians to adopt an empirically validated behavior therapy method. Although practitioners don't learn from journals or textbooks, they do learn from peer models—especially when the individuals doing the modeling have demonstrated competence and can show how the innovative technique is effectively applied to the kinds of patients seen in everyday clinical practice. The key role of personal influence was proved in a landmark study conducted by Fairweather and his colleagues more than 20 years ago in disseminating a lodge program for social and vocational rehabilitation of chronic mental patients. They found that in-person visits to applicant hospitals and agencies, during which clinical demonstrations of the lodge program were provided led to much greater adoption of the lodge program than when the program was introduced without face-to-face workshops.

In more than 20 years of active dissemination of social skills training and other behavior therapy techniques, Liberman and his associates at the UCLA Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation have effectively "sold" innovative methods to clinicians through experiential workshops. At these workshops, interdisciplinary staff members from the host organization

get "hands on" experience in trying the new technique—first in role-playing exercises and later in demonstrations with real patients from their own clinical program. The most persuasive event in this process occurs when a difficult and treatment refractory patient is presented to workshop leaders, and they demonstrate how to mobilize the patient's active participation in social skills training effectively.

Once an organization decides to introduce an innovation, the same effective use of personal influence continues to facilitate successful adoption and to counter resistance; however, at this stage the influence is usually provided by the program director and the organization's cadre of trainers or educators. Often, the in-house training staff are supplemented by the strategic use of expert consultants who help in the design of staff training, and for the subsequent maintenance of the program's fidelity to the methods via clinical supervision and quality assurance.

Overcoming Institutional, Professional, and Administrative Constraints

Even after the proverbial "foot is in the door" and behavior therapy techniques are being introduced into an agency or hospital, many barriers can interfere with the full development and prosperity of a behavioral program. Staff resources can be cut and the behavior therapy unit ordered to open even though too few staff are available to deliver consistent contingencies of reinforcement, and planned and scheduled treatment sessions (Emerson & Emerson, 1987). Philosophical opposition to behavioral principles can be mounted; funds for programmatic needs (e.g., rewards to back up a ward's token economy) can disappear; the purchase of necessary video equipment for social skills training may come a cropper; incompetent staff members who are *persona non grata* may be transferred to work on the behavior therapy unit; and the hospital's full complement of violent patients could be placed on the waiting list of the behavior therapy unit.

Resources supporting development of treatment innovations in model programs tend to be far greater than resources available to customary facilities, thereby preventing facile transposition of these innovations into customary settings (Corrigan, MacKain, & Liberman, 1994). Research programs are frequently conducted

using funds generated by grants; from these monies the size of treatment and support staff can be greatly increased. Large research budgets also facilitate the purchase of bountiful reinforcers that support token economies and of learning materials necessary for skills training. In addition, research protocols attract highly motivated students and postdoctoral fellows who are willing to provide services in exchange for training and research experience.

Limited resources not only impede the introduction of new programs, they can halt successful ongoing programs as well. For example, observation of paraprofessionals conducting skills training groups in a California-based treatment program showed these interventions were affecting patients' behavior significantly (MacKain & Wallace, 1989). Attendance at the groups was high, patients were learning new skills, and the quality of behavioral exchanges in the residential setting was improving. However, administrative personnel believed the skills training modules were an inefficient use of staff time and physical space. Administrative disapproval slowly trickled down to staff perceptions and performance. The trainers felt isolated from and unappreciated by management. Eventually, the administrator decided that funds were better allocated to another task and the successful groups were stopped altogether.

Administrative directives created to manage institutional resources may impede the practice of behavior therapy as well. Although the goal of administrative decision making is to streamline functioning, red tape and layers of bureaucracy that accompany these decisions may hamper creative treatment planning and innovations (Tharp & Wetzel, 1969). Repucci and Saunders (1974) provide an example in which layers of administrative bureaucracy prevented channeling available resources for proper use. Clinicians at a training school for delinquent boys tried to integrate a patient payment system used at the institution into a token economy. Unfortunately, the commissioner of the state department in charge of the school said any changes in allocation of money would require approval of the state legislature, an almost impossible task. The head of the school's business office refused to link the boys' money with a behavioral plan. Supervisors responsible for monitoring the boy's work said their job description did not include teaching skills or giving points. Three different administrative levels

prevented implementation of a plan that front line staff were ready to use.

Centralization of administrative and personnel sharply limit the efficacy of behavioral treatment units (Merkel & Pollard, 1987). In most settings, psychiatrists report to the medical director, psychologists to the psychology service, and nurses to a central nursing office. Instead of allegiance to the practice and principles of the behavioral treatment unit, staff members are tied up reporting to administrators not involved with day-to-day implementation of the program. As a result, treatment plans are undermined, and the growth of behavioral programs is stunted. Successful behavior therapy programs require consistency, coordination, and systematic contingencies of reinforcement by all levels of staff working conjointly; this flies in the face of rigid, vertical, disciplinary hierarchies (Liberman, King, & DeRisi, 1976).

Rigidity in the professional hierarchy may affect staff communication as well. Instead of a cohesive professional body working together, roadblocks can develop in the communication network preventing colleagues from being fully informed regarding treatment. For example, Tharp and Wetzel (1969) tried to set up a simple incentive program for an underachieving boy that would have allowed him to play football as a reinforcer for completing academic work each day. Everyone thought it was a good idea: the school principal, the parents, the teachers, and the football coach. However, there was no way for the information about the boy's academic accomplishment to go from the teacher to the football coach. Both the teacher and the coach considered it a violation of their job descriptions to seek out their colleague and share this information. Because no communication channel existed, the school pronounced the plan impossible.

Championing Behavior Therapy from the Inside

Introduction and consistent use of behavioral programs in traditional treatment settings are greatly facilitated by staff "champions." Champions are typically practitioners who assume responsibility for faithfully learning a behavioral innovation and for subsequently introducing the innovation into their treatment setting. Hence, champions train their colleagues on the new intervention, making

sure that each clinician has accurately learned the procedure. After peers have mastered the intervention, the champion becomes a resource, offering ongoing consultation regarding the innovation and problems that may occur when conducting it with specific patients. Lastly, the champion provides motivation and clinical supervision to peers, thereby maintaining and assuring quality of the techniques after initial excitement wanes.

Typically, the program champion is a professional with administrative or clinical duties who has formal or informal status and authority to introduce new interventions into the treatment milieu and who can motivate staff to support program development. Qualities of champions coincide less with their administrative titles and more with their interpersonal skills; characteristics of champions are listed in Table 11.1. Champions are able to grasp quickly the significance of new techniques for their treatment population and learn the steps that comprise the intervention. Champions have a certain charismatic and infectious air of excitement about them as well. Colleagues soon become interested in the new intervention and wish to learn it.

The power of the champion is dramatically demonstrated when such a person leaves a clinical setting. Treatment strategies they were supporting soon fall into disuse (Corrigan, MacKain, & Liberman, 1994). Similarly, inpatient programs without champions of innovation remain static, rarely incorporating new treatment strategies for their patients. Settings without spontaneous champions may overcome this shortfall by drafting responsible practitioners to assume this role. Some staff members who do not initiate

Table 11.1. Characteristics of a Champion for Innovation

Enthusiastic in therapeutic work with patients in their treatment setting
Realistic in understanding treatment needs of patient population
Intellectually stimulated by therapeutic work, frequently seeking alternative treatment strategies
Comfortable with change and flexible in meeting treatment goals
Capable of getting things done and efficient in organization of work
Interpersonally skilled and able to
Excite others about treatment innovations
Teach and model for peers novel treatment techniques
Work well in interdisciplinary groups
Does not burn out easily

innovations or motivate peers may be able to champion new approaches when guided through the role's responsibilities. For example, when disseminating several skills training modules to community mental health centers (CMHC) across the United States, Liberman and his colleagues (1982) instructed administrators to identify peer tutors in each setting to conduct extended training. The extended training was outlined in detailed training guides provided by treatment innovators and mailed to each CMHC over the subsequent 6 weeks. On-site peer tutors were not required to be experts in their content areas, but rather served to keep the training sessions on task and to facilitate behavioral rehearsal and role playing during the sessions. Peer tutors were also responsible for distributing and collecting data and training materials for each of the modules. As a result of these peer tutors, therapists at participating CMHCs quickly learned and incorporated these interventions into their clinical armamentarium.

Examples of the value and impact of champions can be found in the accounts of behavior therapy programs in psychiatric hospitals reported in the chapters of this book. At the Camarillo-UCLA Clinical Research Unit, for instance, two champions emerged to provide leadership during the unit's infancy. One was the unit psychologist—a behaviorally trained and research-minded young postdoctoral professional—and the other was the unit's head nurse. She was an outspoken advocate for improving patient care and had accumulated a great deal of informal status because of her 25 years of state hospital experience. When an experiment was done to determine which "leader" of the unit had the greatest influence as a model for promoting staff-patient interaction, the head nurse easily outperformed the unit psychologist, psychiatrist, and program director (Wallace, Davis, Liberman, & Baker, 1973).

Strengthening Rapport and Credibility with Administrators

The professionals who are invested in establishing and maintaining a high-quality behavior therapy program in a psychiatric hospital must realize that busy administrators, who have the power and authority to allocate resources, are largely unaware of the special value of behavior therapy and may not be sympathetic to the resource requisitions made by the behavior therapy staff. If favor-

able attitudes toward behavior therapy of the executive, medical, and clinical directors of a hospital are to be achieved, then the behaviorally oriented professionals have the responsibility for communicating and relating with top management. Reciprocity should be the norm governing this relationship; thus, every request for resources should be balanced by a report of success in the clinical program and its varied spinoffs.

Several strategies can facilitate the communication and rapport between behavioral clinicians and their administrators (Liberman, 1979; Slama & Bannerman, 1983) including (a) regular but informal luncheons at which the clinician-leader or champion gives current examples of progress and achievement by the behavior therapy unit; (b) poster displays in the hospital lobby that depict successful research or case studies; (c) capsule reports of program progress and case studies in the hospital or agency newsletter; (d) open-house receptions and tours that educate administrators and other clinicians from the hospital about behavior therapy; (e) positive publicity for the hospital through articles in the local press; (f) credit to administrators for their programmatic support by inviting their coauthorship on publications and their participation in professional and scientific presentations; (g) professionals who lead the behavior therapy unit of a hospital and are accessible when licensing and accreditation teams and other site visitors come to survey the quality of the hospital; (h) acceptance of responsibility for dealing with special problem cases that are burdens to the administrators.

One example of outreach by the behavior therapy unit that gains credibility in the eyes of administration is the participation by behavior therapy professionals on "consultation teams" providing useful programmatic and case-by-case assessments and recommendations throughout the hospital. The behavior therapy consultation teams described by Glynn and her colleagues on the Camarillo-UCLA Clinical Research Unit (chapter 2) and by Levendusky et al. on the McLean Cognitive Behavior Therapy Unit (chapter 8) are excellent examples of this *quid pro quo* reciprocity that is much appreciated by top managers. Face-to-face contact and accessibility by the behavior therapist yields a mutually respectful and valued relationship that becomes a forum in which problems and joys may be discussed between the clinician and the administrator.

Establishing the Administrative Infrastructure

Hand in hand with the development of a positive and reciprocal working relationship with top management, the director or chief of a hospital's behavior therapy program or unit must seek alliances with coworkers and administrators to build an infrastructure that will support behavior therapy programming and motivate staff to use these more systematic techniques. The structural elements in this infrastructure include curricula for continuing education programs, criteria for clinical privileging of the various mental health professionals on the hospital staff, job descriptions (especially for those staff working on a behavior therapy unit), standards and criteria for annual performance evaluations, decentralization of clinical decision making, written and verbal mandates for behavior therapy in the hospital's "mission statement," and annual goals and objectives, and clearly stated priority for behavior therapy in program development and clinical services.

Space considerations preclude a full discussion of the preceding elements in the hospital's administrative infrastructure that can be critical in the survival and quality of a behavior therapy program; however, a few highlighted points can be made. At the time of initial establishment of a behavior therapy program or unit, the individual who will be designing and directing the program has maximal leverage with hospital administration to get commitments and action for building the infrastructure. This is the best time to negotiate such important matters as

- Control over the selection process for admission of patients and for staff assigned or recruited for the program or unit, which should reside with the program or unit director. An example of this agreement, establishing an important precedent that has weathered many storms over the 22 years of its functioning, was hammered out between Dr. Liberman (as the director of the Camarillo-UCLA Clinical Research Unit) and the superintendent of Camarillo State Hospital before Liberman agreed to open the unit in 1970 (discussed in chapter 2). In addition, the superintendent's reluctant commitment was obtained for a substantially richer staff:patient ratio for the unit.
- Delegation of clinical decision making to the staff of the

behavior therapy program or unit. The ability of behavior therapists to create and carry out behavioral interventions is greatly enhanced when the behavior treatment unit is an autonomous functioning body rather than embedded in the larger and more traditional hospital bureaucracy (Merkel & Pollard, 1987; Pollard, Merkel, & Obermeier, 1986). For example, when establishing the Behavioral Treatment Unit at Saint Louis University Hospital, the authors of chapter 7 believed that decisions regarding treatment plans and staffing needed to reside in the hands of the unit's staff, not the medical director, medical staff, or hospital administrator. Hence, an explicit agreement was signed establishing the respective authority of the unit's director, and the hospital administrators.

- Specific job descriptions and performance standards of staff, which should include the competencies in behavioral assessment and therapy required and expected of the interdisciplinary staff members. Long after the enthusiasm and good faith efforts of the first generation of staff members have waned, job descriptions and performance evaluations can continue to maintain the unique consistency in the staff's delivering carefully coordinated and contingent reinforcement and other techniques. In Table 11.2 are listed the competencies required of an effective social skills trainer—these can be used to craft the elements of a job description and associated performance standards.

Table 11.2. Competencies for a Social Skill Trainer

Actively helps patients elicit and set specific goals
Models skills for patients
Instructs patients how to promote favorable expectations about skill
Engages patient in role play to practice skills
Structures role plays for patient by setting the scene and assigning roles to all participants
Prompts and cues patient during role play
Provides positive and corrective feedback about role play
Ignores inappropriate behaviors during role play
Suggests alternative behaviors for problem situations which can be used during role playing
Gives homework assignments and in vivo exercises to promote transfer of learning to natural environments

Positive Reinforcements for the Staff

As a prospective director of behavior therapy in a hospital might ponder, how can the staff be motivated to perform in a consistent manner, deal with patients as individuals, and monitor individuals' behaviors through objective observation and record keeping? The job requirements for the nursing staff and other disciplines working on a behavior therapy unit are more demanding than the more spontaneous, ad hoc and anecdotal methods used by mental health professionals. To overcome philosophical opposition, uninformed stereotyping, and naïveté of staff members regarding behavior therapy and learning principles, as well as to provide motivation for the extra work expected of staff when they employ preplanned and systematic behavioral assessments and interventions, more than the usual reinforcers for staff must be mustered (Corrigan, Kwartarini, & Pramana, 1989; Hogg, Foxen, & McBrien, 1981; Milne, 1982, 1984; Watson & Uzell, 1980).

The most important and powerful source of motivating staff to new and higher levels of performance comes from the professional leaders of the behavior therapy program or unit themselves. The leader(s) must be visible and credible to line clinical staff by demonstrating to staff appropriate assessment and intervention techniques, serving in an ongoing way as a model clinician who manages by walking around, and giving positive feedback and encouragement to staff for their approximations to the desired performance. Social reinforcement can also be potent when genuinely and spontaneously given by the program leader and clinical director to interdisciplinary staff at coffee breaks, change-of-shift meetings, treatment planning sessions, clinical supervision, and staff parties. The effective use of social reinforcement, modeling, and teamwork has contributed to the cohesion and longevity of the Camarillo-UCLA Clinical Research Unit, described by Glynn and her colleagues in chapter 2. When positive reinforcement and constructive modeling is employed regularly and routinely by the director, chief, or champion of a unit as a means of improving staff performance, a positive emotional climate suffuses the entire clinical team and results in effective problem-solving and clinical outcomes (Marshall, Banzett, Kuehnel & Moore, 1983).

Conversely, Hierholzer and Thornbrough wrote in chapter 4 about institutional contingencies that may not reinforce participa-

tion in behavioral programs. For example, salary increases at the Albuquerque VA depended on the number of therapy groups conducted by individual clinicians. Behavioral "classes" were not considered therapeutic and therefore were not included in the count; as a result, staff members were not properly reinforced for their efforts in this regard. Similarly, performance appraisals at this VA were completed by discipline chiefs, not the head of the unit, and therefore reflected the agenda of the hospital wide discipline instead of the behavioral program on the unit.

Involving Consumers in the Behavior Therapy Program

The most powerful allies that can be joined in overcoming institutional and administrative constraints against behavior therapy are the consumers of services—both patients and family members. In the past 15 years, the National Alliance for the Mentally Ill (NAMI), the National Association for Depression and Manic-Depression, and self-help and advocacy organizations for clients or patients have mushroomed. For example, the NAMI grew from a few thousand supporters in a handful of local affiliates in 1980 to more than 180,000 members in more than 2,000 local and state affiliates throughout the US. These organizations, often in alliance with professional organizations like the American Psychiatric and American Psychological Associations, have taken the high road in advocating for improved clinical services and mental health research at the national, state, and local levels. The zeitgeist of the 1990s will be further involvement and partnerships between professionals and consumers in the clinical process of assessment, treatment planning, and rehabilitation. This unstoppable movement pervades all specialties of medicine and the helping professions, and is strongly validated by research that has shown the markedly superior clinical outcomes that accrue from involving patients and families more actively in treatment and rehabilitation (Falloon, 1985; Strachan, 1992; McFarlane, Stastny, & Deakins, 1992).

Examples of constructive collaboration between the leaders of behavior therapy units, and their patients and families abound in this book. For example, family members are active participants in the treatment program at the BTU of Haar Psychiatric Hospital described in chapter 5. Family and team members jointly identify behaviors and contingencies that the family might implement at home. The power

of family involvement was evident in the BTW described by Franco and Kelly in chapter 9. Patients' relatives spontaneously collected money to buy supplies for the activity therapy department when limitations in the ward's resources became apparent.

Summary

Creative juices must be squeezed from innovators and program directors that employ behavior therapy to overcome the host of barriers that can block the establishment and maintenance of high-quality cognitive behavior therapy services. A variety of strategies and tactics can be mustered to bridge the gap between researchers and practitioners effectively, streamline methods for enhancing technology transfer, and deflate the institutional and administrative constraints against behavior therapy programming. Innovators and administrators who decide to incorporate these strategies into their program development are more likely to produce a program that meets patients' needs, is faithfully implemented by the staff, and endures.

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