

Record: 1

Title: Building recovery-oriented services: Lessons from implementing individual placement and...

Authors: Becker, Deborah R.
Torrey, William C.
Toscano, Richard
Wyzik, Phillip F.
Fox, Thomas S.

Source: Psychiatric Rehabilitation Journal; Summer98, Vol. 22 Issue 1, p51, 4p

Document Type: Article

Subject Terms: *COMMUNITY mental health services
*MENTALLY ill -- Employment
NAICS/Industry Codes621420 Outpatient Mental Health and Substance Abuse Centers
623220 Residential Mental Health and Substance Abuse Facilities
624190 Other Individual and Family Services

Abstract: Focuses on the attempts made by community mental health centers in implementing recovery-oriented services, including supported employment, in connection with the experiences of assisting mental health centers in several states. Circumstances surrounding the implementation of the individual placement and support (IPS) programs; Importance of recovery; Information on IPS.

Full Text Word Count: 2600

ISSN: 1095-158X

Accession Number: 922739

Database: Academic Search Elite

BUILDING RECOVERY-ORIENTED SERVICES: LESSONS FROM IMPLEMENTING INDIVIDUAL PLACEMENT AND SUPPORT (IPS) IN COMMUNITY MENTAL HEALTH CENTERS

Many community mental health centers are attempting to implement recovery-oriented services such as supported employment. Based on their experiences helping mental health centers in several states to implement Individual Placement and Support (IPS) programs, the authors identify five areas that are critical for successful implementation: leadership, organizational structure, training, finances, and time frames.

INTRODUCTION

Recovery has become an important ideology in the field of mental health services (Anthony, 1993; Carling, 1995; Mowbray, 1997; Torrey, Ross & Mead, 1998). People with severe psychiatric disorders want to lead normal, healthy lives as regular members of the community (Rogers, 1995). Recovery offers the promise of managing one's illness and moving ahead with one's life. For most consumers, moving ahead includes employment.

Individual Placement and Support (IPS) is a community-based approach to supported employment that encourages illness self-management and normal, adult roles through its focus on competitive employment and individual choice. IPS assists consumers in their efforts to seek competitive employment rapidly in jobs of their choice (Bond, 1998; Becker & Drake, 1994; Drake & Becker, 1996).

Community mental health centers (CMHCs) experience a number of difficulties in implementing

recovery-oriented services such as IPS, yet quality of implementation is often related to outcomes (Blakely et al., 1987). Several factors that influence the implementation of new programs and innovations, such as IPS, have been identified. Change occurs most readily if at least one front line person champions the process (Backer, Liberman & Kuehnel, 1986; Corrigan, 1995; Liberman & Eckman, 1989; Spaniol, Zippie & Cohen, 1991). This change agent helps to coordinate the efforts in planning and implementing the innovation. Outside consultation and interpersonal contact between the adopters of the new program and those knowledgeable of the innovation enhance implementation (Backer et al., 1989; Liberman & Eckman, 1989; Spaniol et al., 1991). Training must include not only didactic instruction but also experiential learning and supervised practice (Backer et al., 1989; Liberman & Eckman, 1989). Program readiness may also be a factor (Anthony & Farkas, 1989; Spaniol et al., 1991). Implementation occurs more easily in programs that have a mission, structure, and environment that are consistent with the values inherent in the new program and approach. Anthony and Farkas (1989) suggest time frames for the different stages of the change process: 6 months to introduce the idea, 6 months to prepare for the change, and another year for the change to actually occur.

The purpose of this article is to discuss common themes that the authors have encountered while helping CMHCs to implement IPS. The themes involve leadership, organizational structure, training, finances, and time frames. Describing the lessons learned from these experiences will hopefully provide guidelines for other CMHCs making similar changes.

METHOD

Over the past 10 years, the authors have helped more than a dozen CMHCs in six states to implement IPS programs. In each case at least one of us participated as a consultant, trainer, or supervisor in developing the program for more than one year. In some cases, IPS replaced rehabilitative day treatment, and in others it was implemented as an additional service. In each situation, we have had extensive, longitudinal discussions with program administrators, staff members, and clients about the implementation experience.

RESULTS

Leadership

Executive director. The executive director must communicate a vision of the recovery ideology and how the IPS program actualizes the vision. This person charges the middle managers and other management personnel, such as the medical director and the finance director, to guide the staff and overcome barriers to change.

Endorsing change may require executive directors to take financial and clinical risks, as in the case of replacing rehabilitative day treatment with IPS. Switching from a revenue-lucrative program such as rehabilitative day treatment to IPS requires establishing different reimbursement mechanisms. There are clinical implications when the program transfers from a group modality in a segregated environment (day program) to individualized services in the community (IPS). In the past, one way CMHCs have accounted for the welfare of consumers has been through the efficiency of seeing people on a regular, group basis in a day program. Eliminating the convention of gathering consumers in a day program results in a greater need for staff outreach and creativity in developing options for integrating consumers into community life. The executive director should emphasize outcomes (i.e., jobs) rather than service units (i.e., number of people in day treatment).

Middle managers. Middle managers must understand the model and provide the direction to execute the change process. They educate the front line staff about the clinical benefits of IPS and seek out clinician-leaders to become allies in coordinating the implementation process. Middle managers provide forums for all stakeholders (consumers, families, providers) to participate early in the planning process, which improves the quality of the plans and helps stakeholders to influence and endorse the change. Middle managers watch the system for necessary adjustments since a change in one part (i.e., the vocational unit) may bring about change in another. For example, greater flexibility is needed for scheduling clinical appointments as consumers go to work. Middle managers may be in the best position to remove obstacles and solve problems. They ensure that training is

provided to teach staff members the skills to implement IPS. This is an ongoing process because of staff turnover.

Change agent. To successfully implement IPS, an internal front line person assumes the role of change agent to organize and lead the effort. The change agent helps to keep the staff focused on implementing the new program and generates momentum for positive change.

The most common problem that leaders encounter when implementing IPS is stress among the staff associated with the uncertainty of change and learning new job skills. Leaders can promote a culture of change that eases the process of implementing new programs and different patterns of service delivery. A culture of change develops in an environment where leaders encourage good communication and feedback, in which many views are respected, including critical ones. Leaders function as role models. They must be seen as sincere and positive about implementing change and must demonstrate commitment to it. Leaders should attend key meetings and demonstrate involvement in the process. For example, one executive director demonstrated commitment by periodically attending the IPS group supervision meetings.

Organizational Structure

Agency restructuring. The essence of a recovery orientation is the integration of clinical and rehabilitation services. In IPS, rehabilitation and mental health treatment are linked through a multidisciplinary team approach. Some CMHCs that were organized around independent service departments (e.g., case management, psychiatric services, rehabilitation, and residential services) reorganized services into multidisciplinary treatment teams. Communication is a key ingredient when implementing a team approach. In most of the CMHCs, the integrated teams meet at least weekly. The employment specialists also meet separately as a unit for group vocational supervision on at least a weekly basis.

Staff roles. In the programs that eliminated rehabilitative day treatment, staff positions were converted to IPS employment specialist positions. Staff members who are unable to learn the new skills or to make the change to working out in the community need help in transitioning to other jobs. Case managers, residential workers, and other staff members must learn how to support clients in their efforts to work.

Resources. The need for overall office space was reduced in several CMHCs since services were mostly provided in the community and center-based day activities were eliminated. Staff offices are rearranged by teams to facilitate informal communication and the timely exchange of critical information. On the other hand, transportation needs may increase if staff members who provide services in the community are required to drive agency cars.

Documentation. Requirements for documentation and record keeping are not always congruent with the program goals of IPS. Recovery-oriented services like IPS focus on personal goals more than on problems and deficits, yet eligibility determinations and reimbursement patterns often emphasize symptoms and problems. Staff members were confronted with the dilemma of how to document strengths-oriented goals in deficit-oriented language. In recovery-oriented programs, treatment plans focus on helping clients attain regular homes, jobs, and relationships. Assessments and plans need to incorporate information from people who have known the client well in the community, not just from professional staff members, which helps in planning for regular jobs and meaningful community life.

Training

Initial training. CMHC staff members were trained to implement IPS, usually by an outside trainer who was knowledgeable about IPS. All staff members need a clear understanding of the IPS model, including principles, goals, and implementation criteria. Employment specialists must learn the specific skills of engagement, continuous vocational assessment, individualized job seeking, and follow-along supports. Psychiatrists, nurses, case managers and clinicians must learn to use their

clinical skills to help clients in planning for and obtaining competitive employment (Torrey et al., 1998). Residential staff members need to understand their role in supporting consumers' work efforts.

Successful program implementation requires a clear description with guidelines. CMHCs use the IPS program manual, *A Working Life* (Becker & Drake, 1993). The IPS fidelity scale (Bond, Becker, Drake & Vogler, 1997) provides specific criteria and objective anchors for monitoring implementation on an ongoing basis.

Ongoing supervision. Concepts and skills taught in training are reinforced through regular supervision. New skills must be applied to relevant real-life situations, since clinicians learn by using techniques in the context of regular supervision. Supervisors critique and reinforce successes, highlight creative, recovery-oriented approaches, and generally help staff members apply training material to their everyday work. One of the benefits of having multidisciplinary teams is that there is an opportunity for cross-fertilization for learning and supervision. Group supervision with the treatment team occurs at least weekly and is most helpful when supervisors understand the model and have the basic values. The IPS vocational coordinator supervises the group of employment specialists at least weekly. When clients who were never considered good candidates for work get jobs, the process reinforces itself.

Resistance. Some staff members are unable to change and may deal with their discomfort in ways that are disruptive or harmful. Supervisors and administrators must confront these staff members straightforwardly and help them to move on if they are unable or unwilling to change.

Finances

Replacing day treatment revenue. Historically, day treatment has been a lucrative service for CMHCs. In order to survive the resulting loss of Medicaid revenue from closing day treatment, CMHCs need a financial plan. In one state, the Divisions of Mental Health and Vocational Rehabilitation established a strong partnership and worked out a plan in which both systems contributed to the financial support of IPS services (McCarthy, Thompson & Olson, 1998). CMHCs need to work closely with state mental health authorities and other funding sources in creating reimbursement mechanisms that help to finance IPS services.

Time Frames

Program implementation. Most of the CMHCs took at least one year to implement IPS. For another CMHC, it took 2-3 years from the time of initial discussions of change to a successful implementation of IPS. In another CMHC, it took 6 months from when they first started talking about the change to when they closed the day program, and another year before the program was running well. Several CMHC managers recommended a quicker timetable of 3-4 months for closing the day program because the anticipation of closing the day program was so stressful for staff members and consumers. In general, a minimum of one year is necessary for restructuring services, helping staff members build the necessary skills, removing the barriers to change, and becoming a mature program.

CONCLUSION

In this article, the authors describe their experiences with implementing IPS in more than 12 CMHC settings. There were a variety of barriers, cultures, and degrees of success encountered. For successful implementation, we recommend coordinated leadership led by an internal change agent, an organizational structure based on multidisciplinary treatment teams, ongoing training for all staff members, and reimbursement mechanisms that support IPS.

REFERENCES

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.

Anthony, W. A., & Farkas, M.D. (1989). The future of psychiatric rehabilitation. In M.D. Farkas & W.A. Anthony (Eds.), *Psychiatric rehabilitation programs: Putting theory into practice* (pp. 226-239). Baltimore: Johns Hopkins.

Backer, T. E., Liberman, R. P., & Kuehnel, T. G. (1986). Dissemination and adoption of innovative psychosocial interventions. *Journal of Consulting and Clinical Psychology*, 54, 111-118.

Becker, D. R., & Drake, R. E. (1993). *A working life: The Individual Placement and Support (IPS) Program*. Concord, NH: Hew Hampshire-Dartmouth Psychiatric Research Center.

Becker, D. R., & Drake, R. E. (1994). Individual Placement and Support: A community mental health center approach to vocational rehabilitation. *Community, Mental Health Journal*, 30, 193-206

Blakely, C. H, Mayer, J. P., Gottschalk, R. G., Schmitt, N., Davidson, W. S., Roitman, D. B., & Emshoff, J. G. (1987). The fidelity-adaption debate: Implications for the implementation of public sector social programs. *American Journal of Community Psychology*, 15, 253-268.

Bond, G. R. (1998). Principles of the Individual Placement and Support model: Empirical support. *Psychiatric Rehabilitation Journal*, this issue.

Bond, G. R., Becker, D. R, Drake, R. E., & Vogler, K. M. (1997). A fidelity scale for the Individual Placement and Support model of supported employment. *Rehabilitation Counseling Bulletin*, 40(4), 265-284.

Carling, P J. (1995). *Return to community*. New York: The Guilford Press.

Corrigan, P. W. (1995). Wanted: Champions of psychiatric rehabilitation. *American Psychologist*, 50, 514-521.

Drake, R. E., & Becker, D. R. (1996). The Individual Placement and Support (IPS) model of supported employment. *Psychiatric Services*, 47(5), 473-475.

Liberman, R. P., & Eckman, T. A. (1989). Dissemination of skills training modules to psychiatric facilities overcoming obstacles to the utilization of a rehabilitation innovation. *British Journal of Psychiatry*, 155 (suppl. 5), 117-122.

McCarthy, D., Thompson, D., & Olson, S. (1998). Planning a statewide project to convert day treatment to supported employment. *Psychiatric Rehabilitation Journal*, this issue.

Mowbray, C. T., Moxley, D. P., Jasper, C. A., & Howell, L. L. (Eds.) (1997). *Consumers as providers in psychiatric rehabilitation*. Columbia, MD: International Association of Psychosocial Rehabilitation Services.

Rogers, J. A. (1995). Work is a key to recovery. *Psychosocial Rehabilitation Journal* 18(4), 5-10.

Spaniol, L., Zippie, A., & Cohen, B. (1991). Managing innovation and change in psychosocial rehabilitation: Key principles and guidelines. *Psychosocial Rehabilitation Journal*, 14 (3), 27-38.

Torrey, W. C., Bebout, R. R., Kline, J., Becker, D. R., Alverson, M., & Drake, R. E. (1998). Practice guidelines for clinicians working in programs providing integrated vocational services for persons with severe mental disorders. *Psychiatric Rehabilitation Journal*, 21 (4), 288-293.

Torrey, W. C., Mead, S., & Ross, G. (1998). Addressing the social needs of mental health consumers when day treatment programs convert to supported employment. *Psychiatric Rehabilitation Journal*, this issue.

~~~~~

BY DEBORAH R. BECKER, WILLIAM C. TORREY, RICHARD TOSCANO, PHILIP F. WYZIK & THOMAS S. FOX

DEBORAH R. BECKER, MD, IS A RESEARCH ASSOCIATE IN THE DEPARTMENT OF COMMUNITY AND FAMILY MEDICINE AT DARTMOUTH MEDICAL SCHOOL, HANOVER, NEW HAMPSHIRE, AND IS SENIOR PROJECT DIRECTOR AT THE NEW HAMPSHIRE DARTMOUTH PSYCHIATRIC RESEARCH CENTER, LEBANON. NEW HAMPSHIRE.

WILLIAM C. TORREY, MD, IS AN ASSISTANT PROFESSOR OF PSYCHIATRY AT DARTMOUTH MEDICAL SCHOOL AND MEDICAL DIRECTOR, WEST CENTRAL SERVICES, LEBANON, NEW HAMPSHIRE.

RICHARD TOSCANO, MD, IS A PRIVATE MANAGEMENT CONSULTANT, RT MANAGEMENT CONSULTATION AND PERSONNEL DEVELOPMENT, NORTHAMPTON, MASSACHUSETTS.

PHILIP F. WYZIK, MA, IS VICE-PRESIDENT FOR COMMUNITY SUPPORT SERVICES, WEST CENTRAL SERVICES, LEBANON, NEW HAMPSHIRE.

THOMAS S. FOX, MD, IS AN ASSISTANT PROFESSOR OF PSYCHIATRY AT DARTMOUTH MEDICAL SCHOOL AND IS CHIEF MEDICAL OFFICER OF THE MENTAL HEALTH CENTER OF GREATER MANCHESTER, MANCHESTER, NEW HAMPSHIRE.

~~~~~

By DEBORAH R. BECKER; WILLIAM C. TORREY; RICHARD TOSCANO; PHILIP F. WYZIK & THOMAS S. FOX

Copyright of **Psychiatric Rehabilitation Journal** is the property of Center for Psychiatric Rehabilitation. The copyright in an individual article may be maintained by the author in certain cases. Content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.

Source: Psychiatric Rehabilitation Journal, Summer98, Vol. 22 Issue 1, p51, 4p

Item: 922739

◀Back