Staff Training to Improve Implementation and Impact of Behavioral Rehabilitation Programs

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Staff who provide services for persons with severe mental illness often have pessimistic attitudes about adopting behavioral innovations for their programs. Thirty-five staff members in psychiatric residential programs participated in eight months of interactive staff training, an organizational development strategy that helps the rehabilitation team develop behavioral approaches to changing clients' behavior. After the training, staff members reported significant improvement in their attitudes about behavioral interventions and increased perceptions of collegial support. Direct care staff reported significantly less emotional exhaustion. Interactive staff training may facilitate implementation of behavioral strategies by improving attitudes toward these interventions. (*Psychiatric Services* 48:1336–1338, 1997)

Rehabilitation programs that incorporate behavioral strategies like social skills training, token economy, or behavior family management have been shown to significantly improve some of the psychotic symptoms and social dysfunctions of participants with severe mental illness (1–3). Despite the impact of behavioral approaches, staff members' attitudes about these strategies may impede their adoption and use by real-world practitioners (4). Negative expectations about the benefits of behavioral strategies are likely to undermine their use (5). Thus improving attitudes about behavioral innovations may remove a significant impediment to their implementation.

Research has suggested that staff members who report burnout or little collegial support are likely to report pessimistic attitudes about innovative behavioral programs (6). Interactive staff training, which combines concepts and skills from educational and organizational psychology, facilitates program development by improving staff attitudes, increasing collegial support, and diminishing burnout (7). Three steps are involved. First, staff are surveyed about their perceptions of clients' treatment-related needs, and findings from the assessment are used to identify relevant behavioral strategies for development. Second, a program development committee is selected from the ranks of line-level staff to guide colleagues through development of the selected behavioral strategy. Third, the program committee interacts with a training consultant to make decisions about the selected rehabilitation strategy. For example, results of the needs assessment may suggest that staff want to develop an incentive program to augment skills training classes. The next step is to identify client behaviors that the team wants to target with reinforcement.

The purpose of the study reported here was to determine the effects of interactive staff training on burnout, collegial support, and attitudes about behavioral innovations. We expected improvements in these areas after an eight-month course of interactive staff training. A second goal of the study was to determine whether the beneficial effects of interactive staff training vary by job category. Staff attitudes about behavioral innovations, burnout, and support have been found to differ by job category (8). Direct care staff such as psychiatric technicians and nurses report different stressors and collegial relationships than clinical staff such as psychiatrists, psychologists, and activity therapists.

Methods

All direct care and clinical staff from three residential programs serving persons with severe mental illness were instructed by the agency's director to participate in interactive staff training. The sample consisted of the 35 staff members from the programs who completed measures that

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Table 1

Changes in mean scores measuring attitudes about behavior therapy, collegial support, and burnout among 13 direct care staff and 22 clinical staff before and after eight months of interactive staff training

Scale and attitude	Before training		After training	
	Mean	SD	Mean	SD
Barriers to the Implementation of Behavior Therapy[1]				
Institutional constraints				
Clinical staff	9.5	5.1	13.0	5.4
Direct care staff	12.9	4.9	13.8	5.7
No collegial support				
Clinical staff	10.2	5.1	12.8	4.3
Direct care staff	15.0	5.0	16.4	4.6
Philosophical opposition				
Clinical staff	14.0	3.5	15.5	3.6
Direct care staff	14.5	2.7	15.5	2.1
Social Support Questionnaire				
N members in support network				
Clinical staff	20.1	15.6	19.3	10.6
Direct care staff	25.0	17.4	19.4	11.7
Satisfaction with support[2]				
Clinical staff	25.5	12.5	30.9	7.9
Direct care staff	31.3	7.2	33.2	6.9
Maslach Burnout Inventory[3]				
Emotional exhaustion				
Clinical staff	24.7	10.9	25.2	9.5
Direct care staff	18.4	11.6	12.3	9.4
Depersonalization				
Clinical staff	4.9	3.9	5.0	4.2
Direct care staff	4.1	5.3	3.2	2.7
Personal accomplishment				
Clinical staff	40.1	7.2	39.5	7.0
Direct care staff	35.8	6.3	36.5	8.4

[1] Lower scores indicate improved attitudes.
[2] Higher scores indicate greater satisfaction.
[3] Lower scores indicate less burnout.

assessed the impact of interactive staff training on burnout, perceptions of collegial support, and attitudes about behavioral rehabilitation. These measures were administered before staff participated in the training and eight months after the program began. The study was conducted in 1994 and 1995

Training included monthly 90-minute meetings in which staff members identified program needs, selected behavioral rehabilitation strategies to meet these needs, decided how to implement these strategies, and considered the risks and benefits of specific plans. The facilitator educated staff members about specific rehabilitation strategies as needed.

The sample represented 56 percent of staff members working the day shift of the three residential programs. Participants did not differ from nonparticipants in gender, ethnicity, age, or tenure. Twenty-three of the sample members (66 percent) were women. The mean±SD age of the sample was 45.9±8.4 years. Fourteen (41 percent) were single or separated, and 21 (59 percent) were married. The sample was ethnically mixed, with 17 Caucasians (48 percent) and 18 from ethnic minority groups (52 percent). The sample was categorized by job title into direct care staff (13 persons, or 37 percent) and clinical staff (22 persons, or 63 percent).

An interactive staff training consultant (the third author) met with the program committee monthly to facilitate the process. At the time of data collection, the facilitator had met seven or eight times with the program committee at each site.

The 35 staff members completed three pencil-and-paper measures to assess their attitudes about behavior therapy, burnout, and collegial support. The Barriers to the Implementation of Behavior Therapy scale comprises 18 statements about barriers to behavioral innovations that are rated on a 6-point scale from 1, strongly agree, to 6, strongly disagree (4). A previous study of the instrument's psychometrics found three meaningful and reliable factors. The first barrier is institutional constraints, or administrative practices that are perceived to be inadequate to carry out behavioral innovations. The second is insufficient collegial support, or the perception that colleagues are not interested in behavioral innovations. The third barrier is philosophical opposition, or the participant's belief that behavioral innovations are ineffectual, irrelevant, or unethical. Lower factor scores indicate greater endorsement of each factor.

Maslach's Burnout Inventory (MBI) is a 22-item self-report measure that assesses burnout (9). The staff members rated the frequency with which they experienced job-related stressors on a 7-point Likert-type scale from 1, never, to 7, highly frequently. Factor analysis of the MBI has uncovered three reliable factors: emotional exhaustion, depersonalization, and personal accomplishment.

Sarason and colleagues (10) developed the Social Support Questionnaire (SSQ) to measure perceptions about the current size of a person's support network and his or her satisfaction with it. Respondents provide the initials of individuals who support them in coping with generic life problems. The SSQ was modified for this study in that staff were asked to list only colleagues in the program in which they worked.

The SSQ includes such questions as "Who can you really count on to be dependable when you need help?" Subjects also report satisfaction with their network in terms of each life problem on a 6-point Likert-type scale from 1, not satisfied, to 6, very satisfied. The SSQ yields two scores; one is the total number of different individuals listed, and the other is the sum of all satisfaction rat-

ings for the seven stimulus questions. Possible scores for the latter range from 6 to 42.

Results

Clinical staff and direct care staff varied significantly on several demographic variables. Clinical staff had a higher education level ($\chi^2=20.99$, df=1, $p<.001$), and a greater proportion were married ($\chi^2=5.78$, df=1, $p<.02$). A higher proportion of ethnic minorities were direct care staff ($\chi^2=8.19$, df=1, $p<.005$). Subsequent analyses showed that education, marital status, and race did not interact significantly with the dependent measures in the study.

Table 1 presents mean scores of clinical and direct care staff reflecting attitudes to behavior therapy, collegial support, and burnout before and after interactive staff training. Subsequent 2-by-2 analyses of variance (staff group by training trial) were conducted for each dependent measure. Staff perceptions about barriers to behavior therapy improved significantly after interactive staff training; they perceived fewer institutional constraints ($F=7.26$, df=1,33, $p<.01$), more collegial support ($F=9.31$, df=1,33, $p<.005$), and less philosophical opposition ($F=5.05$, df=1,33, $p<.05$). Changes in attitudes about behavior therapy did not differ by job category.

No significant change was reported in the size of the collegial support network after interactive staff training. However, satisfaction with the support network increased significantly ($F=4.69$, df=1,33, $p<.05$). Satisfaction did not differ significantly by job category. No significant changes were observed in depersonalization or personal accomplishment. However, significant main effects in emotional exhaustion were found for job category ($F=7.81$, df=1,33, $p<.01$), the training ($F=5.28$, df=1,33, $p<.05$), and the interaction ($F=7.32$, df=1,33, $p<.01$). Subsequent repeated-measures analyses of variance showed that direct care staff reported significant improvement in emotional exhaustion ($F=10.91$, df=1,12, $p<.01$), whereas no significant change was noticed for clinical staff.

Discussion and conclusions

Staff members who participated in interactive staff training perceived fewer institutional constraints to setting up behavioral innovations. They also perceived colleagues as more supportive of behavioral innovations, and they expressed less philosophical opposition to behavioral treatments. The changes in attitudes about behavioral innovations did not differ for clinical and direct care staff. These findings suggest that interactive staff training changes staff members' attitudes about behavioral innovations.

These beneficial effects may be due to changes in perceived collegial support. Staff members reported greater satisfaction with colleagues after training. Research is needed to determine the direction of this association. We expect to find that improvements in collegial support lead to fewer perceived barriers to behavioral interventions. Improvement in emotional exhaustion was found to vary by job category. Direct care staff reported significantly less emotional exhaustion after training.

We assumed that change in attitude is an essential first step in ensuring that interventions will succeed. Staff members are more likely to implement state-of-the-art interventions when they are more optimistic about their impact. Future studies must determine whether improved attitudes about behavioral programs are associated with more frequent and effective implementation of such programs. ♦

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