

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

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*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, Zippel & 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 discus-

sions 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 be-

come 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 com-

mitment 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.

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