Staff Training and Consultation

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INTRODUCTION

The precise implementation of behavioral programs in the psychiatric setting is dependent primarily on the technical expertise of a variety of paraprofessionals and professionals, such as nursing assistants, mental health workers (usually B.A. level personnel), psychiatric nurses, and social workers. Irrespective of the particular setting in which a behavioral program is introduced (i.e., a state hospital, a mental health center, a university hospital, a Veterans Administration Hospital, or a general hospital), the aforementioned staff have literally "life-and-death" powers over its success or failure. Many a naive behavior therapist, although well trained and certainly well intentioned, has failed in his or her attempts either to implement a behavioral program from scratch or to replace an existing program with one behaviorally oriented. In both cases, failure can usually be traced to poor administrative support and staff resistance. Staff resistance is undoubtedly a result of inadequate preparation, the contrasting (and often covert) goals of the staff and the program initiator, incomplete training of the staff, and ineffective staff consultation once the program has been established.

In this chapter, we examine the issue of staff training and consultation from a number of different perspectives.

First, we will examine the psychiatric setting (e.g., the inpatient ward) from the "political" vantage point. (The political issues are less critical in the outpatient setting, primarily because of the smaller staff numbers typically found in this setting and the relative independence or isolation of outpatient workers.) Thus, we will see how the introduction of a behavioral program on the psychiatric ward may or may not fit in with the existing political scheme and hierarchical structure. Indeed, it will become apparent that a behavioral program may very well upset the balance of power in the typical psychiatric unit.

Second, we will contrast how traditionally trained staff and behaviorally trained staff interact with their patients. Evaluation of the empirical findings to date will support the superiority of behavioral training.
Third, we will attempt to share with the reader some of our own experiences in developing and maintaining programs in several different psychiatric settings.

Fourth, we will evaluate the current research literature documenting the most efficacious methods for training staff in behavioral methodology. Also, we will examine those behavioral strategies that appear most promising for maintaining staff behaviors once initial instruction has been concluded.

Fifth, we will comment on the distinction between staff training and staff consultation.

Sixth, we will attempt to summarize all the findings reviewed and to present an outline for effecting maximum behavioral change in staff in the psychiatric setting.

In considering the above topics, it should be noted that, largely as a function of the specificity of the behavioral approach (see Bellack & Hersen, 1977, Chapter 1), it is possible to evaluate staff functioning empirically. That is, because of the behavior therapist's penchant for precision and measurement, many of the staff's interchanges with patients can be quantified. Along with definition and precision, it then becomes possible to establish a system of staff accountability. It will also become apparent that the notion of staff accountability, although a distinct advantage to the empirically minded behavior therapist, may become a political liability unless handled with consummate skill by the program initiator.

**Hospital Politics**

In using the term *politics*, we are referring to the interpersonal forces, undercurrents, and informal networks that determine much of the day-to-day hospital operation, ranging from mores about the use of sick leave, to the degree of compliance required with directives, to which of two psychiatrists one approaches to get a medication change or pass for a patient. There can be no doubt that hospital politics are commonplace in the psychiatric setting, particularly with respect to the administration of inpatient units (see Hersen, 1976a,b; Kazdin, 1977; Patterson, 1975). In fact, we have often wondered whether the protagonists and antagonists on the "hospital battleground" frequently lose sight of their primary goal: patient care. (In our more facetious moments, we have argued that patient care is relegated to secondary or tertiary status and that politics assume primary status.) Therefore, when examined most dispassionately, such politics obviously are to be expected within the context of the hospital and ward hierarchy. The internal staff and administrative struggles found on the psychiatric unit long preceded the emergence of behavioral therapy. However, the introduction of a behavioral system (or, for that matter, any new system) on a given psychiatric ward can only intensify the struggles already found in the system. Consequently, the focus of the struggle will often shift, and the behavioral system will bear the brunt of existing conflicts.

Let us illustrate with the institution of a token economy ward in a psychiatric institution. In many instances, before the actual implementation of the behavioral program, the many virtues of token economics have been meticulously presented to the hospital administrator and to the staff of the designated unit. Frequently, the program has been portrayed with an overabundance of glowing terms and as a panacea for the many ills of the large psychiatric facility. Often, as a result of the young behavior therapist's (usually a psychologist) exposition of the program and accompanying enthusiasm, the hospital administrator will consent to implementing the program, promising administrative support. However, as previously articulated by Hersen (1976b):

What the unsuspecting administration and staff frequently do not realize is how much control over patients they will lose once the token system is fully implemented (i.e., decisions about patient care now follow programmatic lines rather than being made more subjectively). We can not understand better why administrators in key hospital positions sometimes are reluctant to support fully token economy programs following their initiation. (p. 207)