2017

Behavioral Interventions that Treat Aggression: Employees Implementation Experiences within Adult Psychiatric Settings

Alyse Catherine Donovan
Antioch University, New England

Behavioral Interventions that Treat Aggression:

Employees' Implementation Experiences within Adult Psychiatric Settings

by

Alyse C. Donovan

B.A., Loyola University Maryland, 2009
M.S., Antioch University New England, 2015

DISSERTATION

Submitted in partial fulfillment for the degree of
Psychology in the Department of Clinical Psychology
at Antioch University New England, 2017

Keene, New Hampshire

ANTIOCH UNIVERSITY
NEW ENGLAND

Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

BEHAVIORAL INTERVENTIONS THAT TREAT AGGRESSION: EMPLOYEES' IMPLEMENTATION EXPERIENCES WITHIN ADULT PSYCHIATRIC SETTINGS

presented on June 23, 2017

by

Alyse C. Donovan

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Martha Straus, Ph.D.

Dissertation Committee members:
David Hamolsky, Psy.D.
Daniel Lambert, Ph.D.

Accepted by the

Department of Clinical Psychology Chairperson

George Trembly, Ph.D.

on **June 23, 2017**

***** Signatures are on file with the Registrar's Office at Antioch University New England

Acknowledgments

A special thank you to all of the talented individuals who choose to work within adult inpatient psychiatric settings. Without your daily hard work and dedication to improving patient care this project would not have been possible.

To my dissertation committee: Thank you, Dr. Hamolsky, for sparking my interest in systems interventions. Thank you, Dr. Lambert, for your supervision and guidance on my first behavioral plan I wrote for an inpatient setting. Thank you, Dr. Straus, for your words of encouragement, humor, and continual support throughout this project, and my five-year graduate school journey.

Table of Contents

List of Tables

Abstract

When adults hospitalized within inpatient psychiatric settings engage in aggressive behavior, it can have detrimental psychological and physical effects on not only other patients, but on hospital employees. Several adult psychiatric inpatient facilities have successfully reduced rates of patient aggression through the implementation of behavioral interventions. While there is much research on factors that lead to successful implementation of evidence based interventions, the literature had not yet explored the subjective experience of employees who are asked to implement behavioral plans in adult psychiatric settings. This study utilized Interpretive Phenomenological Analysis to gain an understanding of employees' perceptions of barriers and facilitators to implementation of behavioral plans that target patient aggression. Participants were employees within maximum and intermediate security units within a forensic state psychiatric hospital. The results express the behavioral plan implementation needs for the studied treatment program. These needs include: (a) an increase in communication between all disciplines involved with behavioral plan implementation; (b) an increase in the number of floor staff members and consistent unit assignments; (c) more direct involvement from behavioral technicians; (d) more nurses trained on behavioral interventions, (e) an increase in direct involvement of authors of behavioral plans and behavioral technicians with floor staff members and patients; (f) designated time for staff to complete various implementation tasks; (g) required behavioral theory competency standards for case managers before behavioral plan authorship is allowed; (h) continued trainings on behavioral theory and practice for all staff; (i) a formal data collections system to measure patient behaviors over time; and (j) a formal data collection system to determine staff fidelity to behavioral plan implementation.

Keywords: adult psychiatric inpatient, aggression, behavior plans, behavioral interventions

Behavioral Interventions That Treat Aggressive Behavior:
Employees' Implementation Experiences within Adult Psychiatric Settings

Risk of physical injury from patient aggression is a significant problem for individuals who work within psychiatric inpatient settings. While there are evidence-based behavioral treatments for aggressive behavior, these treatments are not always implemented as intended. This dissertation is a qualitative study that sought to understand the successes and struggles psychiatric hospital employees have when implementing behavioral plans with patients who have aggressive behavior.

Physical Aggression is a Problem in Psychiatric Inpatient Settings

A meta analysis of adult inpatient aggression research published between 1960 and 2009 found that 16.92% of United States psychiatric patients engaged in some form of aggressive act within one month of admittance to a psychiatric hospital (Bowers et al., 2011). Physical aggression is defined as any act that is intended to cause another person physical pain (Anderson & Bushman, 2002). The most common types of physical aggression reported in psychiatric inpatient settings include: "biting, kicking, hitting, scratching, grabbing, pinching, spitting, or pulling hair" (Jansen, Dassen, & Groot Jebbink, 2005). Aggression can be further classified as hostile or instrumental. Hostile aggression is "impulsive, thoughtless (i.e., unplanned), driven by anger, having the ultimate motive of harming the target, and occur[s] as a reaction to some perceived provocation" (Anderson & Bushman, 2002, p. 29). Conversely, instrumental aggression is proactive and premeditative, with the perpetrator hoping to accomplish a goal other than harming the victim through their aggressive action (Anderson & Bushman, 2002).

Aggression in Inpatient Psychiatric Settings Leads to Injury of Staff Members

The job-related violent crime rate for psychiatrists and mental health professionals is

more than five times the rate for all other occupations, with 68.2 incidents reported per 1000 workers per year (Friedman, 2006). For mental health custodial workers, the incident rate is even higher, with 69.0 per 1000 workers experiencing a job-related violent crime per year (Friedman, 2006). Of those employees that required time away from work in 2014 due to an occupational injury or illness, 52% of psychiatric aids, 46% of psychiatric technicians, and 75% psychiatrists cited being physically injured by mental health care patient as the source of their injury (U.S. Department of Labor, 2015).

In a similar vein, Privitera, Weisman, Cerulli, Tu, and Groman (2005) surveyed employees of a psychiatric hospital and found that 34% of clinicians and 8% of non-clinicians had experienced assaults from patients. Staff that had close and frequent contact with patients, including nurses, physicians, and advanced practice nurses, were the staff members most likely to be assaulted by patients (Privitera et al., 2005), with one in four psychiatric nurses being injured by assaultive patients each year (Quanbeck, 2006). This research also highlighted the concern that surveyed employees greatly under-reported aggressive incidents to hospital administration; in fact, employees only filed incident reports for 50% of aggressive incidents experienced. Therefore, it is likely psychiatric hospitals may have inaccurate records of how many assaults by patients actually occur on a daily basis (Privitera et al., 2005). Possible reasons for nursing staff underreporting assaultive patient behaviors included: expectations that experiencing patient aggression was part of the job; the employee did not sustain a serious injury; beliefs that patients did not intend to cause harm; belief that filing a report is too hard or time consuming; belief that administration would not take action based upon a filed report; and lack of procedures requiring reporting of aggressive incidents (Snyder & Chen, 2007).

Instances of Patient Aggression Predict Negative Staff Work Performance

Assaults from patients can lead to not only physical injury, but can create psychological problems for victimized workers. Dean, Gibbon, McDermott, Davidson, and Scott (2010) examined the effects aggression had on staff members who worked with children and adolescents in an inpatient setting. They found those staff members who experienced aggression from patients were more likely to have a difficult time attending work, to consider resigning, and were less likely to engage therapeutically with the client after the occurrence of aggression. Staff members also reported feelings of anger, fear, anxiety, low job satisfaction, increased use of sick leave, increased substance use, and experienced trauma symptoms following physical assault by a patient (Dean et al., 2010). Changes in social relationships with co-workers, headaches, and body tension were also reported following experiences of physical assaults by patients (Jansen et al., 2005).

Patient Demographics and Diagnosis Predict Aggressive Behavior

Sex, age, and psychiatric diagnosis predict aggressive acting out among adult psychiatric inpatients. For example, a literature review completed by Jansen et al. (2005) found males between the ages of 20 to 39 were more likely than psychiatric patients of different age groups and genders to engage in aggressive behavior in inpatient settings. Similarly, Faulkner, Grimm, McFarland, and Bloom (1990) found that inpatients 30 years old and younger committed 68% of reported assaults. James, Fineberg, Shah, and Priest (1990) further found that patients ages 25 years and younger were more likely to act aggressively than older patients. Independent of age, diagnoses associated with higher prevalence of aggressive behavior include dementia, Alzheimer's disease, organic brain syndromes (Jansen et al., 2005), and schizophrenia (Dack,

Ross, Papadopoulos, Stewart, & Bowers, 2013; Flannery, Farley, Tierney, & Walker, 2011), specifically schizophrenia paranoid type (Jansen et al., 2005).

Interviews with patients revealed that internal symptoms (including those psychotic in nature) were antecedents to aggressive behavior (Dickens, Piccirillo, & Alderman, 2012), although psychotic symptoms were found to be the least frequent immediate precursor to aggression (Quanbeck, 2006). Aggressive acts carried out by people with the aforementioned diagnoses may be conceptualized as hostile aggression. For example, a person experiencing delusional thoughts may perceive something in their environment as dangerous and impulsively act aggressively to extinguish the threat, instead of taking a few moments to consider alternative explanations for what had just occurred in their environment.

Hospital Environment and Treatment Factors Predict Aggressive Acts

While patient characteristics are linked with aggressive behavior, so too are factors more within the control of psychiatric facilities. Researchers examined patterns of aggression within psychiatric hospitals and found several antecedents that included environmental factors, treatment factors, and interactions between patients and staff. *Environmental factors* that are antecedents to patient aggression include inadequate staffing, vague unit policy, lack of organization, and turmoil on the unit (Jansen et al., 2005). The most commonly reported environmental antecedent to violent patient behavior is overcrowding on the unit (Daffern & Howells, 2002; Dickens et al., 2012; Papadopoulos et al., 2012). Issues related to overcrowding, including limited privacy and intrusions on personal space, sensory overstimulation, and noisy wards were found to precede aggressive incidents (Daffern & Howells, 2002; Dickens et al., 2012; Papadopoulos et al., 2012). Nurses and patients both agreed that confined environments and restriction of patients' access to other areas of the hospital were also related to outbursts of

patient aggression (Dickens et al., 2012; Papadopoulos et al., 2012). Finally, access to weapons within the hospital was found, perhaps unsurprisingly, to precede aggressive actions (Daffern & Howells, 2002; Papadopoulos et al., 2012).

Treatment factors that were antecedents to aggression included use of restraint, seclusion, and changes in medication; unwanted help with activities of daily living; and staff denial of patient requests (Jansen et al., 2005). Jansen et al. found that patients perceived limit setting and closed units within psychiatric hospitals as controlling behavior by staff that disregarded patients' freedom and privacy. Patients' perceptions of lack of freedom and privacy were found to precede aggression (Jansen et al., 2005). Medication management was also associated with aggressive behavior, specifically when staff members strongly encouraged reluctant patients to take medication (Papadopoulos et al., 2012).

Particular types of *interactions with staff* are also associated with increased aggression. For example, Papadopoulos et al. (2012) completed a meta analysis of 51 studies that examined patient aggression and found interpersonal interactions between staff members and patients were the most frequent antecedents to patients' physical aggression. Thematic analysis revealed the following types of staff to patient interactions to be the most common antecedents to aggressive patient behaviors: limitation of patient freedoms, physical restriction of the patient by staff (including restraints and seclusion), staff attempts to de-escalate the patient, conversations about medications, staff ordering patients to do something, staff intervention of a fight or argument, staff caring physically for the patient, staff searching the patient, negative staff attitudes during interactions with patients, staff having casual physical contact with patient, staff interrupting a patient's activity, miscommunication between staff and patient, and staff error during interaction with patient (Papadopoulos et al., 2012). Staff-to-patient interaction was found to precede 39%

of aggressive incidents, with 25% of these interactions involving staff denial of a patient's request (Papadopoulos et al., 2012). Similarly, other researchers specified staff members' verbal requests to the patient to alter their behavior (Quanbeck, 2006), staff unavailability during staff turn over or meal times, staff inability to meet a patient's request, and patients feeling unheard by staff members (Dickens et al., 2012; Quanbeck, 2006) as antecedents to patients' aggressive behavior toward staff.

The recurrence of aggressive behavior has also been studied. Researchers conclude that failure to debrief both patients and staff involved in aggressive incidents were most commonly related to recurrences of aggressive behavior (Secker, Benson, Lipsedge, Robinson, & Walker, 2004). In a related earlier exploration, Maier, Stava, Morrow, Van Rybroek, and Bauman (1987) examined staff responses to aggressive behavior that were observed during a four-year period at a maximum-security forensic psychiatric hospital. The researchers found that staff experienced feelings of fear, distrust, and anger toward the patients who had acted aggressively. Unresolved staff countertransference following an aggressive act led to fewer patient-staff interactions, resulting in patients feeling isolated on the unit (Maier et al., 1987). Patients' perception of unresolved staff countertransference following verbal or physical aggressive outbursts was also found to lead to patient mistrust, social isolation, and continued aggression toward staff (Maier et al., 1987).

As the aforementioned research stated, deficits in patient's communication skills and misunderstandings between patients and staff can be the catalyst to aggressive behavior. Therefore, teaching patients more effective communication skills can improve the quality of communication between patients and staff, which may lead to less frequent patient aggressive behavior. Interventions that help to clarify unit rules and bring predictability to patient and staff

interactions may also help reduce aggressive patient behavior (Corrigan & Liberman, 1994). Interventions that have clear protocols for staff also create cohesion among the unit employees. Staff members that consistently follow behavioral intervention protocols are less likely to inappropriately use physical restraint or medication as a way to manage patients' behavioral outbursts (Donat, 1998). Finally, interventions that teach patients coping skills can also help to reduce aggressive outbursts (Corrigan & Liberman, 1994). Behavioral interventions can effectively create predictability, while helping patients gain interpersonal and daily living skills which may help reduce the need to use aggressive behavior to meet one's needs (Corrigan & Liberman, 1994; Menditto, 2002; Quanbeck, 2006).

Behavioral Theory Conceptualizes the Function of Aggression

In the behavioral frame, aggressive behaviors can be considered learned behavior, just like any other habit or skill that one acquires (Hanley, 2012). Therefore, the goal of behavioral intervention is to reduce undesired behavior by teaching and reinforcing a more adaptive and desired behavior (Dean et al., 2007; Donat & McKeegan, 2003). Behavioral theory attends to a person's current behaviors and looks at how these behaviors elicit reactions from the person's environment. When creating a behavioral plan to target aggressive behavior, the clinician seeks to understand the function of the aggression and how it helps patients meet their needs. Once the patient's need is understood, the behavioral plan functions in two ways. First, it orients those staff members who work with the patient to how they should react if the patient engages in aggressive behavior. But more importantly, the behavioral plan describes how staff members can teach the patient specific more adaptive skills so the patient may learn safe ways to meet his or her needs (Corrigan & Liberman, 1994).

Behavioral Interventions are Effective at Reducing Aggression in Inpatient Settings

Behavioral interventions are effective at reducing aggression in psychiatric inpatient settings (e.g., Beck, Menditto, Baldwin, Angelone, & Maddox, 1991; Bellus et al., 2003; Bisconer, Green, Mallon-Czajka, & Johnson, 2006; Daffern & Howells, 2002; Dean, Duke, George, & Scott, 2007; Longo & Bisconer, 2003; Menditto, 2002). One model program, The Clinical Research Unit at Camarillo Hospital (CRU), served as an example of this intervention strategy. The CRU treated the most severely impaired and symptomatic patients, most of whom were diagnosed with schizophrenia and exhibited "severe psychosis, impaired judgment, and extremely bizarre behavior," despite some benefit from antipsychotic medication (Glynn et al., 1994, pp. 39–40). Within the CRU, patients received behaviorally oriented treatment that focused on "reduct[ion] of aggression, psychotic speech, and bizarre behaviors," while patients were helped to improve social skills, gain independence with activities of daily living, and improve relationships with their family members (p. 40). Behavioral interventions specific to treatment of aggressive behaviors included: brief time-outs immediately following aggressive acts; token fines for violation of unit rules and enactment of a treatment targeted behavior; and staff members ignored verbally aggressive or teasing behavior as to put verbal aggression on extinction (pp. 45–46). Time-outs occurred in "quiet areas" on the unit and were designated by a line of demarcation on the floor. A three-month study of all patients' acts of aggression within the CRU revealed that 74% of assaults and property destruction were immediately stopped when staff directed patients to designated quiet areas to calm down for a minimum of five minutes (p. 45). A 20-year study of frequency of patient aggression within the CRU revealed a 50-75% reduction in the frequency of aggressive acts within the patients' last three weeks at the CRU compared to their rates of aggression at admission (Glynn et al., 1994).

For another model example, The Social Learning Program within the forensic psychiatric service at Fulton State Hospital was designed to treat the hospital's lowest functioning patients who have experienced prolonged or repeated psychiatric hospitalizations, most of whom are diagnosed with schizophrenia or schizoaffective disorder and are aquitees found not guilty by reason of insanity (Menditto, Valdes, & Beck, 1994). The Social Learning Program uses a token economy and rewards patients for behaviors ranging from increases in personal hygiene and reductions of bizarre behavior and aggression, to increases in social and vocational skills—ultimately rewarding patients for efforts toward community reintegration (Menditto et al., 1994). Data collected on 19 male patients, who had an average 10-year length of hospitalization within the maximum-security unit, revealed a 92% decrease in aggressive behavior 21 months after implementation of the Social Learning Program (Beck et al., 1991). It is important to consider that after the implementation of the Social Learning Program, staff to patient interactions actually increased in frequency by more than 200%, which makes such a stark reduction in patients' aggressive behaviors more impressive (Jones, Menditto, Geeson, Larson, & Sadewite, 2001).

Multiple case studies have also demonstrated that a combination of skill acquisition, reinforcement of desired behaviors, and changes in the way staff react can modify inpatient psychiatric patients' aggressive behavior (Bisconer et al., 2006; Dean et al., 2007; Longo & Bisconer, 2003). For instance, Longo and Bisconer successfully implemented a behavioral treatment for an adult male diagnosed with schizophrenia with a longstanding pattern of aggressive behavior in an inpatient setting. The researchers found that a 27-month behavioral intervention focused on rewarding pro-social behavior while teaching social skills training, combined with modifications in the way staff and other patients approached the client, was

successful in eliminating aggressive behavior at 33-months inpatient and the patient remained non-assaultive for another year while he continued to be hospitalized. In contrast with programs that combine rewards, negative reinforcement, and punishments, the authors noted that only positive reinforcement was utilized during this intervention; therefore, no losses of privileges, restrictions, seclusions, restraints, or PRN medications were implemented (Longo & Bisconer, 2003).

Bisconer et al. (2006) also report success with another 40 year old male patient who had been diagnosed with schizoaffective disorder bipolar type, mild mental retardation, and seizure disorder who showed reduction in aggressive behavior toward himself and others after a 39-month inpatient behavioral plan implementation. Interventions included: (a) creation of a calming environment in the patient's room; (b) verbal encouragement to the patient to use his room when the ward became noisy and over stimulating; (c) individual social skills training and practice with positive social and communication skills three times a week; and (d) tangible reinforcement delivered throughout the day when prosocial behaviors occurred. Researchers found that these interventions led to a decrease in staff injury resulting from this patient's behavior, and the client learned appropriate behavior skills to express his needs.

Behavioral Plans Only Work When Implemented Correctly

Proper implementation of behavioral interventions is essential to ensure that patients get the highest quality and most appropriate care. Behavioral theory assumes that an individual's behavior is maintained by external gains from the individual's environment. Therefore, if a behavior elicits a desired reaction from the environment, the person is more likely to repeat that behavior to get what they seek (Antony & Roemer, 2011). In order for behavioral treatments to be effective, those delivering the interventions need to provide the individual with consistent

reactions to the patient's behavior. Behavioral interventions are therefore considered environmental interventions, as the patient needs opportunities to learn through repeated social interactions in order to gain new skills to change their behavior (Corrigan & Liberman, 1994). It is this predictability and consistent reaction from others that teaches patients new ways of interacting with their environment, and new ways to get what they seek (Antony & Roemer, 2011).

To achieve such uniformity of response, Bisconer et al. (2006) stressed the importance of multidisciplinary communication and consistent implementation of behavioral interventions by all staff members as instrumental in achievement of reduction in assaultive behaviors by patients. Behavioral support plans provide staff members with clearly defined guidelines for staff-to-patient interaction so those individuals who interact with the patient respond in a therapeutic way to specific targeted patient behaviors. A behavioral support plan that is consistently implemented as intended (Sanetti, Kratochwill, Collier-Meek, & Long, 2014) by all staff will be most likely to help a patient change his or her behavior. But getting all hospital employees including milieu staff, nurses, doctors, psychologists, and administrators to operate as a cohesive team is no easy task. A growing body of research on implementation provides guidelines on how to turn recommendations of an evidence-based treatment into a successful multi-system treatment program within an organization.

Components of Implementation for Evidence-Based Practices

Fixen, Naoom, Blase, Friedman, and Wallace (2005) completed a literature review that sought to determine the necessary components for implementation of evidence-based practices into successful human service programs. The researchers also reviewed program implementation successes across a variety of disciplines including agriculture, business, engineering, medicine,

manufacturing, and marketing. Fixen et al. found that successful programs have the following core implementation components: (a) facilitative administrative supports; (b) systems interventions; (c) selection; (d) preservice and inservice training; (e) consultation and coaching; and (f) staff and program evaluations. These implementation components were found essential to successful evidence-based programs across all disciplines including mental health, juvenile justice, education, and child welfare systems.

An organization has *facilitative administrative supports* when there are clear leaders who oversee and support the program's implementation. Administrative supports utilize data collected during staff and program evaluations to focus implementation efforts, keep staff motivated, and track clinical outcomes (Fixen et al., 2005). Closely connected to facilitative administration supports are *systems interventions*. Systems interventions include methods used to secure "financial, organizational and human resources" (Fixen et al., 2005, p. 29) so that staff members who implement the intervention have the resources necessary for successful application of the evidence-based practice.

Fixen et al. (2005) use the term *selection* to refer to standards that define who is qualified to deliver the different interventions within an evidence-based practice. Factors that are considered during selection include skill level needed to perform various tasks of the intervention, time that is required for the selected staff member to perform the intervention, and if the organization can financially afford to hire people with the necessary qualification to implement the interventions. McGuire (2001) emphasized the importance of staff selection with the statement: "There are no known treatment or training materials that will achieve their goals in the absence of trained and committed staff with adequate resources and managerial support" (p. 34).

Preservice and *inservice* training are terms used to describe training that is given to selected employees before and during implementation of evidence-based practices (Fixen et al., 2005). The purpose of preservice training is to orient employees to the purpose, theory, rationale, and key values of the evidence-based practice. Inservice training gives employees a chance to try implementation of the evidence-based program and receive feedback before attempting to deliver the intervention to clients (Fixen et al., 2005). *Consultation* and *coaching* are used to encourage behavioral change within multiple levels of an organization throughout all stages of implementation. Consultants and coaches model successful implementation of the interventions and provide on-the-job help to employees while they deliver interventions to clients. Consultants and coaches can be individuals employed outside of the organization who have expertise with the evidence-based practice, or they can be employees within the organization who are selected based upon their education, training, or skillset (Fixen et al., 2005).

Finally, Fixen et al. (2005) state that organizations need to collect data on their implementation efforts to discover which aspects of implementation are successful and identify drivers that require improvement. These researchers recommended that organizations evaluate both staff members and programs. *Staff evaluations* inform administrators which components of the evidence-based intervention have been put into practice, the integrity of such interventions, and how useful the preservice, inservice, and consultation or coaching were in aiding intervention integrity during implementation. *Program evaluation* looks at how different systems within the organization are handling implementation efforts and examines the organization's adherence to the evidence-based practice mission (Fixen et al., 2005). Feedback determined from both staff and program evaluation can pinpoint which components of implementation need to be adjusted to promote treatment integrity, and which components are successfully aiding treatment

integrity and may be replicated.

The Transition from Evidence-Based Practice to Treatment Program is Complex

While there are ample studies that state the effectiveness of behavioral interventions for the treatment of aggressive behavior in adult inpatient settings, and clear descriptions of optimal strategies for implementation, hospitals still struggle to successfully carry out behavioral interventions. Program evaluation can determine which components of behavioral interventions exist procedurally within the hospital's particular organizational structure, but do not fully assess staff members' day-to-day experiences with the application of behavioral plans. Inpatient settings like the above mentioned CRU and Social Learning Program at Fulton State Hospital are designed to function as behaviorally oriented facilities. Therefore, resources are focused on ensuring all components of behavioral practices are implemented in a systematic way. But, not every adult psychiatric inpatient setting is grounded in behavioral theory. While the research states the necessary steps for implementing behavioral plans, and how they are effective once all of the components fall into place, there is a gap in the literature explaining how non-behaviorally oriented sites manage to implement behavioral interventions effectively.

Research highlights the distinction in success of implementation by setting. For example Paul and Lentz (1977) found distinctions between the attitudes of employees that worked on behaviorally oriented inpatient units versus those who worked in more traditional psychiatric wards (as cited in Corrigan & Liberman, 1994). Findings included (a) differing views on how mental illness should be managed, (b) the nature of relationships staff should form with patients, and (c) the focus of interventions for patient behavior. Those employees working within behavioral units believed a patient's interactions with others on the unit could improve (a) mental illness symptoms; (b) current behavior should be the focus of treatment; and (c) proactive

interventions aimed to increase prosocial behavior and life skills should be the focus of treatment. These views directly clashed with more traditional medical models of severe mental illness treatment that recommended the use of restrictive treatments and environments, formal relationships with patients, and reactive interventions focused on reduction of aggression after the behavioral outburst.

Further, Corrigan, McCracken, Kommana, Edwards, and Simpatico (1996) studied the relationship between nursing and clinical staff attitudes and their beliefs about implementation of behavioral interventions. They interviewed nursing and clinical staff that worked on five acute care units in a state psychiatric hospital. Corrigan et al. found emotional exhaustion and depersonalization at work were related to perceptions that institutional barriers and lack of cohesive treatment teams would negatively impact implementation of behavioral interventions. More specifically, those staff members that experienced "burn-out" were likely to believe lack of support from their colleagues, issues with funding, and administrative practices would impede their implementation of behavioral interventions. In contrast, those employees who had received prior training with behavioral interventions were optimistic about implementation on the acute care units (Corrigan et al., 1996). Corrigan et al. recommend further research to confirm providing nursing and clinical staff members with training in behavioral treatments, coping skills, cognitive reframing, and helping staff to achieve greater treatment team cohesion will together improve optimism and fidelity to implementation of behavioral interventions within psychiatric hospital settings.

By taking into account the research on necessary components of implementation and the impact that staff attitudes can have on optimism about their ability to execute behavioral interventions, this dissertation sought to understand through qualitative research how non

behaviorally oriented psychiatric hospital employees cope with the daily process of behavioral intervention delivery. It was assumed staff from various disciplines would have differing thoughts on their own ability and their colleagues' abilities to successfully implement behavioral interventions. Therefore, for this study, I was interested in hearing from staff at all levels of engagement in patient care, including nursing, milieu, psychology, psychiatry, and administrative staff.

Statement of Purpose

The purpose of this dissertation was to gain understanding of employees' beliefs and experiences with implementation of evidence-based behavioral therapy interventions within an adult psychiatric inpatient facility that utilizes specific behavioral interventions with patients, but does not have behavioral theory as the prominent theoretical orientation for its program.

Research Questions

The following questions were addressed by this research project:

1. What components of behavioral plan implementation have employees been involved in within the hospital?
2. What do employees believe are current facilitators of behavioral plan implementation?
3. What do employees believe are current barriers to behavioral plan implementation?

Method

Study Design

This dissertation utilized an exploratory program evaluation design informed by the postpositivist paradigm of research. The W. K. Kellogg Foundation (2007) describes exploratory evaluation as the first step in program evaluation. Exploratory evaluation can be used to uncover information about what is working and can be encouraged in program implementation, as well as

what is not working and areas to focus further program evaluation and/or implementation improvement efforts (W. K. Kellogg Foundation, 2007). The postpositivist paradigm defines the role of the evaluator as the investigative scholar that brings insights from extant literature and applies this knowledge to the program that is being evaluated. In this way the researcher uses existing scientific theory to inform the further improvement and continued development of the program that is investigated (Mertens, 2010, p. 57).

The purpose of combining exploratory program evaluation and the postpositivist paradigm to evaluate behavioral plan implementation within psychiatric inpatient settings is to inquire about the well-researched aspects of multidisciplinary intervention implementation, while remaining open to discovering facilitators and barriers to implementation that are specific to the particular hospital and staff configuration tasked with implementing behavioral interventions that target aggressive behavior.

Methodology: Interpretive Phenomenological Analysis

Interpretive phenomenological analysis (IPA) seeks to understand a particular group of individuals' experience of some phenomenon. Rooted in social constructionism, IPA theorists believe that various cultural aspects of the individual's day-to-day life determine one's interpretation of an event. Just as participants' views are shaped by their cultural identity and experiences, the researcher's cultural identity also influences the way participant's narratives are interpreted and understood. IPA refers to this phenomenon as a double hermeneutic (Smith, 2008).

The IPA method utilizes semi-structured individual interviews to gather information about the participant's experience. This type of data collection provides opportunity to establish rapport with employees while inquiring about details of their experience. As previous studies

have found, employees' experiences within an organization shape their beliefs about their efficacy and the organization's ability to implement behavioral plans. IPA seeks to understand specific experiences of individuals, leading to idiographic analysis of data (Smith, 2008). IPA methods utilize conversational analysis to deepen understanding of multi-disciplinary employees' experiences with implementation of various behavioral plan tasks.

Sampling and Recruitment

To qualify as an appropriate site for this study, hospitals needed at least one adult psychiatric unit, to have used behavioral plans as an intervention for at least one patient's aggressive behavior, and had multidisciplinary staff members engaged in the implementation of the behavioral plan(s). A behavioral plan is a document that clearly describes the following: the behavior being targeted by the intervention; contexts in which the behavior has occurred; directions for how staff are to act when the behavior occurs; specific desired behaviors that staff are to teach and/or attend; and how staff are to teach and/or attend to these desired behaviors. Behavioral plans are determined to be ethical and culturally sensitive to the person and the environment in which the person resides (Haring & De Vault, 1996). They may be created by the patient's treatment team, with or without the help of the patient, and are often approved as both ethical and appropriate treatment by a hospital's patients rights committee or the patient's doctor before implementation can begin.

Participants were sought from multiple disciplines working within the hospital that met the inclusion criteria and included psychology, psychiatry, nursing, social work, and milieu workers. Stratified purposeful sampling was utilized to select participants as it allowed the researcher to limit participant selection by sampling from any one demographic group (Mertens, 2010). Employees who wished to participate were selected as participants only if they had some

direct involvement with behavioral plan implementation. The desired sample size for this project was a minimum of six with a maximum of 15 participants as recommended for IPA (Mertens, 2010).

Measures

Demographic information. Basic demographic information about the participant was collected which included age, sex, and ethnicity. Information about the participant's employment history was collected including (a) current job title, (d) duration at current job, (c) number of years of experience working with adults in a psychiatric inpatient setting, (d) number of patients the participant directly works with that have current behavior plans, and (e) any previous training or work experience with behavioral interventions. The purpose of gaining this information was to determine the participant's role within the hospital, what experience they have currently in the hospital with behavioral plan implementation and training, and what training or work experience they had before being asked to deliver behavioral interventions within this specific inpatient setting. See Appendix A for the demographic questionnaire.

Research questions. 1. Which components of behavioral plan implementation have employees been involved in within the hospital? 2. What do employees believe are current facilitators of behavioral plan implementation? 3. What do employees believe are current barriers to behavioral plan implementation?

Interview questions. Interview questions were developed based upon the necessary components of implementation described by Fixen et al. (2005), as well as criteria for successful behavioral treatment programs described by Corrigan and Liberman (1994). The interview questions were designed to expand upon the research of Corrigan et al. (1996), and gain insight into what psychiatric inpatient staff members believe they need to feel confident with behavioral

plan application.

1. What is your role in the implementation of behavioral plans?
2. How were you selected to do behavioral plans? How much of your time at work is spent working with behavioral interventions versus other tasks you are required to complete?
3. What types of training did you receive before you were asked to implement a behavioral plan? How did this training address the purpose, theory, rationale, and key-values of behavioral plans?
4. Can you tell me about the role that feedback plays during and after your training? How does this feedback affect your motivation to continue following the behavior plan? How do you stay motivated to continue implementing a behavior plan?
5. What is the referral process for a client that needs a behavior plan?
6. Who do you turn to when you have questions about delivering behavioral plan interventions? Is there someone who can provide in the moment training if you need it?
7. How are your skills with behavioral plan implementation monitored? How is your personal experience with behavioral plan implementation shared with your colleagues? How are issues that arise discussed and resolved?
8. Does your organization have the materials you need to conduct this behavioral intervention? Are there enough staff members available to carry out behavioral plans?
9. What is working in regards to behavioral plan implementation?
10. What is not working in regards to behavioral plan implementation?
11. What do you think you could do to improve implementation?
12. What do you think others could do to improve implementation?

Procedures

A 399-bed state-funded adult inpatient psychiatric hospital was chosen as the data collection site. The hospital includes maximum, intermediate, and minimum security settings, and serves individuals with a variety of commitment statuses, including civil commitments and patients with forensic commitment statuses such as incompetent to proceed or not guilty by reason of mental illness or mental defect. Patients are assigned to one of four treatment programs that specialize in evidence-based treatments that treat specific diagnoses and/or symptoms. One of these treatment programs was chosen for this study, as the program was being reworked and conceptualized to include more opportunities for patients to earn privileges through individualized behavioral incentives.

The studied treatment program is located within the hospital's maximum and intermediate security settings. The program is designed for patients who have primary diagnoses of psychotic disorders and/or major mood disorders with secondary diagnoses of personality disorders. The most common comorbid personality disorder within the studied program is Antisocial Personality Disorder.

The studied treatment program has a diverse, multidisciplinary workforce that includes psychiatrists, nurses, psychologists, social workers, music therapists, art therapists, occupational therapists, forensic rehab specialists (floor staff members), and behavior analysts. An application to conduct research within the treatment program was submitted to the hospital's research committee. Consent to interview employees was granted by the research committee and a permission letter was signed by the Director of Treatment Services. A copy of the permission letter can be found in Appendix E. This letter was included in the Antioch University New England Institutional Review Board (IRB) approval application.

Once IRB approval was obtained from Antioch University New England, recruitment flyers and informed consent forms were distributed via email to employees working within the chosen treatment program. A copy of the recruitment flyer is located in Appendix B. The recruitment letter instructed any employee interest in becoming a participant to return the completed informed consent form via email or in person to the primary investigator. A copy of the informed consent form can be found in Appendix D.

All signed informed consent forms were printed and stored in a locked cabinet at the primary investigator's residence. Electronic copies of the informed consent form were deleted once the forms were printed. Signed consent forms will be shredded seven years after the completion of the study.

Interviews were conducted via telephone. Telephone interviews allowed the employee to participate in the interview at a location of their choosing. For example, participants could speak about their experiences at work or in a location other than the hospital in which they were employed. Each interview lasted between 20 to 45 minutes. Before the interview began, the researcher again reviewed the information listed in the informed consent form. Specifically, participants were reminded that their participation was voluntary, and they could choose to stop participation during the interview and up to one month after the interview. Participants were reminded their interviews were to be audio recorded, and this audio file would be destroyed once it was transcribed. Participants were given the opportunity to ask any questions before being asked for verbal consent to start the interview process.

All employees who consented to proceed with the interview were assigned an identification number during the telephone interview, which was used to protect their anonymity to those who read the results of this dissertation project. This identification number was used to

match demographic information to the participants' transcribed interviews and used in place of the employees' names. The interview began with a demographic questionnaire that was read aloud to the participant, and the primary investigator transcribed the participants' answers. Collected demographic information included age, sex, ethnicity, job title, years of experience working in an inpatient facility, years of experience working at their current job, and previous experience with behavioral plans. A copy of the demographic questionnaire can be found in Appendix A. The demographic questionnaire was then followed with the semi-structured interview protocol. An example of the interview protocol can be located in Appendix C.

Once the interview was completed, the primary investigator transcribed the entire interview. Audio files used for data analysis were stored in encrypted files until the interview was transcribed. Once transcription was completed, the audio files were destroyed to protect the participants' confidentiality. All identifying information in the transcribed interview was replaced with the participant's identification number so that the participant remained anonymous to those who review the results of this study. The participant's identification number was indicated on their informed consent form. This was done to identify the demographic questionnaire and interview that the participant completed, in the event that a participant wanted to withdraw from the study and that participant's data was to be destroyed. Informed consent forms were kept in a locked cabinet, separate from the data collected during the interview, to ensure participant confidentiality.

Ethical principles addressed. This project strove to uphold the strictest standards of ethical guidelines presented by the American Psychological Association (2017). The following is a list of guidelines followed by the researcher: 8.01 Institutional Approval; 8.02 Informed Consent to Research; 8.03 Informed Consent for Recording Voices and Images in Research; 8.04

Client/patient, student, and subordinate research participants; 8.05 Dispensing with Informed Consent for Research; 8.08 Debriefing; 8.10 Reporting Research Results; 8.11 Plagiarism; 8.12 Publication Credit; and 8.14 Sharing Research Data for Verification.

Ethical recruiting procedures and documents. The researcher sought written permission to contact hospital employees from the hospital's research committee. Once obtained, Institutional Review Board (IRB) approval was sought from Antioch University New England before any emails were sent to recruit participants for this project. An example of the recruitment flyer can be found in Appendix B. If an employee chose to participate in the study, they contacted the primary investigator directly via email or in person of their interest in participation.

Participants provided written informed consent prior to the interview. A copy of the informed consent form can be found in Appendix D. Participants were reminded before the start of the interview that their participation was voluntary and they may choose to terminate the interview at any time at no penalty. Participants were informed of the process for securing and destroying the audio files from their interviews after the interviews were transcribed. Participants were reminded that their participation in the research was strictly voluntary and their employer was not informed about their choice to participate in this research study. Participants were given the option to opt out of the research study at any time. After the interviews were complete, the participants were debriefed, and again, the use of their transcribed interviews was described.

Issues of Trustworthiness

Credibility and validity. Bloomberg and Volpe (2012) state several recommendations to promote credibility of qualitative research. These include upfront statements of researcher bias, thorough analysis of data, and member checks to ensure credibility of research findings.

As the primary investigator, I brought my bias of having implemented behavioral plans with multiple clients in both inpatient and outpatient settings. I have seen how effective behavioral interventions can be at reducing aggressive behavior and teaching more adaptive social skills for both children and adults. I have also been frustrated by well-intentioned family members, teachers, and other staff who do not follow the behavioral plans as intended, an action that created inconsistency in the clients' environments and confusion about behavioral expectations. I have also had the opportunity to work with parents, teachers, and staff to explain the importance of consistency when implementing behavioral interventions, listened to their concerns, and helped them to practice behavioral interventions so that they felt more comfortable performing the intervention on their own.

Having had these experiences personally, I took action to not interject my bias when interviewing individuals about their own experiences with behavioral plan implementation. A colleague not directly involved in my research reviewed the semi-structured interview question protocol to reduce bias in the wording of interview questions. I drew from my clinical skillset when speaking with the participants to be sure that I did not indicate judgment about how the participants answered any of the interview questions through my vocal tone or follow up questions. I expected that each of the participants' experiences were unique, and that these personal accounts would be invaluable to learning more about the behavioral intervention implementation process.

Thorough analysis of the data is necessary to determine if the conclusions drawn are valid. These include using multiple sources of data, examining the data in a variety of ways, and presenting findings that conflict with conclusions (Bloomberg & Volpe, 2012). IPA methodology demands rigorous review of the data that required me to check previous records as

new themes emerged. This checking and rechecking of ideas helped to ensure that the final concluded themes held credibility. By following an idiographic approach to analysis, the IPA researcher first identifies participant specific themes before making any broad statements about the population as a whole. This allowed for discrepant findings to emerge and be searched for in other participant transcribed interviews (Smith, 2008).

Finally, Bloomberg and Volpe (2012) recommend the use of "peer debriefing" to ensure credibility of the research findings. IPA theory assumes that the researcher will create their own meaning from participants' constructed meaning of the phenomenon at study (Smith, 2008). Therefore, one of the disadvantages of IPA is that participants' "true" meaning cannot be established, as the theory states that true meaning does not exist. Peer debriefing, or peer examination, attempts to correct for researcher bias by having a colleague of the researcher read through the data and themes constructed by the researcher to determine appropriate research conclusions (Krefting, 1991). By utilizing peer debriefing, I was able to organize and understand my construction of the participants' narratives in a more complete way. By having my data reviewed by a peer, I gauged my understanding and promoted validity in my own narrative of the participants' accounts (Mertens, 2010).

Data Analysis

Overview. IPA theory states an individual's personal meaning is the central focus of research. Therefore, the purpose of data analysis is to gain insight into each individual participant's personal interpretation of behavioral plan implementation (Smith, 2008). An idiographic approach to data analysis is used to uncover the specifics of each participant's experience. Researchers who use the IPA technique believe that the entire interview is valuable as themes could emerge from any point of the transcript. The researchers do not try to create

themes, they are allowed to develop and emerge from the text (Smith, 2008). Researchers are encouraged to discuss their findings with colleagues, being sure to distinguish between interpretations of the participant's experience and direct quotes from participants (Smith, 2008).

Analytic approach. The first step of IPA data analysis was to transcribe the interviews. The transcript was divided into three columns—the main text positioned in the middle column with the right and left columns designated for notes. I read the first transcript numerous times to familiarize myself with the participant's experiences. The left column was then used to list various notes including associations, paraphrase, interpretations, note language usage, and notes about the participant's presence (Smith, 2008). Once notes were completed for the whole text, the right column was used to fill in more abstract, psychologically oriented themes that emerged from prior analysis (Smith, 2008). This process was repeated with each additional participant transcript.

Themes were then listed chronologically in a separate document. Themes were positioned together and formed overarching and subordinate themes (Smith, 2008). Phrases in the text that supported themes were located and direct quotes from the transcript were placed into the thematic document. From this document, a table of themes was created. Each theme was assigned a descriptive term and identifiers were assigned to indicate where each quote is located within the transcripts. The data table used to organize and define themes is Table 1 located in Appendix F.

Once the above steps were completed for the first transcript, the remaining transcripts were analyzed. The themes from the first transcript were used to inform the analysis of the other transcripts. As new themes emerged, previous transcripts were reviewed to determine the existence of new themes. This process continued until all data was investigated. The finalized

themes were then converted into a cohesive narrative of the participants' experiences (Smith, 2008). The interpretations, constructed themes, and direct quotes from participants were included in the narrative within the results section (Smith, 2008).

Determining data analysis credibility. As the interviews were audio recorded, I was able to transcribe verbatim what was said in each interview, thus ensuring a high level of data credibility during transcription of data.

Results

Demographic Data

Six participants who work within the treatment program were interviewed and described the current practices of the treatment program in regards to behavioral plan implementation. These participants represented the psychiatry, psychology, social work, activity aide, and floor staff disciplines. Participants ranged in age from 25 to 54 years old (M = 36.7 years old). Three males and three females participated in this study. Five participants identified as White/Caucasian and one participant identified as Jamaican. Time in current job role varied greatly from three months to 19 years (M = 4.6 years). The participants' years of work experience within an adult inpatient psychiatric setting varied between three and 25 years (M = 15 years).

Employees' Roles in Implementation of Behavioral Interventions

Within the treatment program staff members assume varying roles with implementation of behavioral treatments. A psychiatrist explained his role as minimal, stating,

> I'd say it's mainly supervisory, uh the system at [hospital] uses, the psychiatrist is sort of an indirect supervisor, [mm hmm] …and I guess ah, this sounds terrible but the best way that I could explain it is sort of like Queen of England, a fancy title but very little power.

Social workers often develop and author the behavioral plans. The social worker said,

> We are working on a two-to-one one for [patient], um and my role was basically coming up with like the criteria for that, um, and honestly I used ones that were already in place, [Yeah!] …um, also finding where it needed to be specialized to meet his specific, um, issues.

Psychologists author, educate others about the behavioral plans, and initiate approval processes for the plans. The psychology resident explained,

> So, I would be the one to author the behavior plan. And I would also play a role in educating staff about why we are doing it. I would also play the role in explaining it to patients, and getting approval though the Treatment Counsel. So, in a lot of ways I would be the one implementing or initiating the intervention.

The Treatment Counsel is a group of administrators that review interventions for compliance with clients' rights and mental health regulations and laws. Members of the Treatment Counsel include the Director of Treatment Services, Director of Medical Services, Director of Psychology, Director of Social Work, and two individuals from Quality Management. Personnel in Quality Management monitor data on episodes of restraint and seclusion, worker injuries and workman's compensation, and incident and injury data.

Both floor staff and activity aides collect behavioral data through observation of patients and report this data to professional staff on the treatment team. The activity aide explained his duties to include "reporting back to the team leaders what behaviors we see occurring. What is a behavior that needs to be, um, changed, or what is a behavior that we need to praise." The floor staff member said, "We report stuff that we see and that goes into, well I would hope it goes into, making those plans." Floor staff members are the only members of the treatment team who

implement behavioral interventions on a regular basis. The interviewed floor staff member responded, “Well yeah, we are the ones that have to fa... I don’t know, facilitate it, would that be it? We actually have to do it.”

The majority of treatment team members interviewed believed that they were not specifically chosen to have their role with behavioral interventions. Rather, these employees explained that their role was simply part of their job description. The psychiatrist commented, “we have a bylaws for the medical staff uh where that’s outlined, and we also have policies and procedures at [hospital], and we also have procedures through CPS, which stands for uhh… something psychiatric services, uh centralized or something.” A social worker explained, “Primarily the license will get you into that role. Uh, in the interview process to put you into that decision making spot on the team,” while the other social worker said, “Um, I was his case manager, so I was it, yeah! [Laughs].” The activity aide described his role stating,

> I was interviewed and then I was granted the job. And then observative [sic] role comes along with the position. [Okay.] Because we are the Activity Aides, we create activities, we plan some of their daily movements, and as a result we have to observe their behavior, record, and chart whatever behavior that is shown.

The floor staff member said, “We’re just told to do it, they print it out and give it to us.”

Only the psychologist named her education and previous training as why she was selected to have her role in implementation. She elaborated,

> Um, as a psychology resident on the unit, uh, I’m the only with a psychology background. I am the one with the most amount of training. [Okay.] I don’t have a supervisor who works on the unit, or anyone who has more expertise in that area. Um, and sometimes there’s a behaviorist who works somewhere in the hospital who might be

> available, um, for consultation and sometimes he's not available and you are the best option.

Time spent on behavioral intervention tasks. Time spent on tasks of behavioral intervention implementation varied greatly among the professions. The psychology resident spent the least time working on behavioral interventions, as she explained,

> I've been so bombarded by case management responsibilities that I've devoted less time to the clinical interventions that take so much work to craft and to carry out. …Um, this year I've had good intentions of doing them with several clients, and I just never get around to it.

The psychiatrist estimated spending an hour a day or five hours a week on supervision of behavioral interventions. The time that social workers devoted to behavioral plans varied. One social worker reported spending a consistent 25 to 30 percent of his week on behavioral interventions, while another explained,

> Well it varies a lot depending on where he's at because he swings back and forth so much between good and re-really struggling. [Right.] When he's really struggling I probably spent like six hours a, a week. Right now, not really any, just waiting.

Activity aides and floor staff were the professions that spent the most time involved in tasks related to behavioral interventions. The activity aide explained, "right now we have 28 hours of full-on contact time," [Oh wow] "…with these clients. Um, in this 28 hours, in any given day or week it can change from 28 to 34 hours easy." The floor staff member explained she spent six hours of her 12-hour shift one-to-one with a patient on the day of her research interview. A protocol for one-to-one staffing is used with patients who display behavior that causes a danger to them self or others to such a degree that it requires 24-hour supervision to

prevent the behavior from happening. A one-to-one staff is only responsible for the patient they are assigned and is to remain within one arms length from that patient at all times. She elaborated, "Well if you are talking like one-to-ones I guess probably like 24 hours of the week or something like that probably."

Current Training Within the Treatment Program

Within the treatment program, trainings offered on behavioral plan implementation varied depending on profession. The hospital provided training on specific behavioral interventions to the professional staff (i.e., psychology and social work professions). Professional staff also received training specific to this program's Antisocial Personality Disorder population. Members of the floor staff and psychiatry professions said that they did not receive any training specific to behavioral interventions at this hospital.

When asked about training specific to behavioral theory and interventions, the psychiatrist and floor staff members said they had not been given formal training on this topic while employed at the hospital. One of the social workers stated, "Um, we are supposed to do like inservices whenever we implement one of those and make sure that all the staff are aware if there's a two-to-one protocol implemented or whatever." Two-to-One protocol is used with patients who display aggression that causes a serious danger to others. Two staff members provide 24-hour supervision to the patient to prevent the aggressive behavior from happening. Two-to-one staff members are only responsible for the patient they are assigned and are to remain within one arms' length from that patient at all times. The social worker spoke about the process of familiarizing floor staff with behavioral protocols, explaining,

> I don't know that it's an official one that you have to sign, but they will actually bring people, like pull FRS staff off the ward and have someone go into coverage for them so

that they can read it to them.

FRS stands for Forensic Rehabilitation Specialist and is the job title for floor staff or milieu workers at the hospital. The training for floor staff members described by the social worker conflicted with the floor staff member's report of how behavioral interventions are distributed to floor staff. The floor staff member explained, "The actual behavior plans we don't actually get trained on, they just make them up and they give it to us and they, if we have question they will answer our specific questions as we go along."

The social worker described a training that conceptualized Antisocial Personality Disorder and ways to work with that population. She stated, "Yeah, mostly just training about the different behaviors and then the interventions that are effective with different populations, like the Antisocial population. Um, and then the basic trainings that we go through here about, about different interventions." The activity aide referenced a training offered to new employees of the hospital that was specific to behavioral interventions. He described, "Those were mainly, um, carried out during um SMART training." [Okay.] "Um, we had one session on punishment versus um, rationalization, and that kind of stuff so…" [Yeah.] "…reinforcement, so, that was good towards that, so that was good."

Process for Development of Behavioral Interventions

Nurses, floor staff, and professional staff directly observe patient behaviors. One social worker commented, "Uh, um, pretty much we are looking for ongoing behaviors that are not going to be useful, either on the ward or in the community." When asked about the referral process, the activity aide explained,

> Now that mainly comes through FRS, communicated from the FRS to like a Case Manager or a Social Worker. Um, say for instance a client is exhibiting a certain

> behavior, over a period of time, and that gets communicated from the FRS that keep observing to the social worker, the Rec Therapists, or the Case Worker.

The floor staff member corroborated by commenting, "Yeah, I do all the time when I think that someone needs one. I bring it to the team." The information obtained when direct observations are reported contributes to the formulation of behavioral interventions by professional staff members. Once a behavioral plan is written, the intervention is sent to administrative staff members for approval. One social worker commented on this process,

> Usually it seems like the team will talk about it and say this is a good recommendation based upon the feedback from either what they've observed or what staff, like the frontline staff, has observed, the nurses. And um, afterword and all that they send it to the treatment counsel for approval for like the two-to-one protocols and stuff like that.

Process to Monitor Staff Members' Behavioral Plan Implementation Skill Level

Social workers and the psychology resident explained they are given verbal or written feedback on their written behavioral interventions. This feedback comes from treatment team leaders and the Treatment Counsel. The Treatment Counsel is a committee composed of administrators who approve interventions for patients based upon ethical guidelines. The psychology resident explained this process,

> So, it's monitored in a few different ways. Um, at this hospital we go through Treatment Counsel any time a behavior plan is implemented. And so, um, regardless of whether we are using punishments or rewards, um, we would need to get approval.

She then stated,

> So it would go before a committee with at least one psychologist and someone from administration so that you had some ethical checks. And hopefully it would go through a

peer who's knowledgeable in this area before you submitted to Treatment Counsel.

The frontline staff described getting little feedback on their progress regarding delivery of behavioral interventions directly to patients. The activity aide explained,

> There is not someone that is always present in the moment to give you your feedback so you have to sometimes just wing it and figure it out and hope that you are doing the best. And then there is other times that people are directly there and you can say how did I do with this, so that you can get feedback in the moment. But um, with the number of staff, and the staffing issue that we face, it is kind of hard to always have somebody around to give you the direct feedback there.

The floor staff member stated her supervisors review the notes she writes in the patients' charts. When asked if she received feedback concerning her delivery of interventions with clients, the floor staff member said, "I don't really, I don't think so. [Okay.] Unless something goes wrong [laughs] then we are told." The psychiatrist interviewed said that he receives no feedback concerning behavioral interventions with patients on his caseload.

Current Facilitators of Behavioral Plan Implementation

Employees believe good communication and consultation between treatment team members aids implementation. The treatment team has the intellectual and tangible resources necessary for follow through with behavioral interventions. Employees believe that floor staff members are highly valued, and consistency in staffing within the units of the treatment program aids implementation as staff form relationships with the patients. Treatment providers believe the current privilege system works.

Treatment team members have good communication and collaboration. Employees from multiple disciplines commented on the successful communication and collaboration

between treatment providers. The psychiatrist commented,

> Well, now, and this is one of the positive aspects, I found in 20 years, I would say almost virtually every team I've worked on has been very collegial, and we've gotten along, respected each other, uh, been able to talk in the team meetings. Of all the things that I do, I think that the time spent in the team meetings is probably the best use of my time and I think it's, it's where patients probably get the best care and formulations when everybody is kind of together.

The activity aide spoke about consultation with the team leaders, stating,

> Yeah, you can always ask one of the team leaders, they are pretty knowledgeable and if they are not able to answer you directly right there and then, they will tell you that they will get back to you and they will find an answer for you.

Behavioral interventions are documented in the electronic medical record and the paper chart located in the nurses' station on the units.

The treatment program has necessary tangible and intellectual resources. Staff members agreed the treatment program could provide the materials needed for patient incentives and had equipment to follow through with behavioral interventions. The psychology resident explained,

> Yes! And, um, each program in the hospital has budget resources, so if I wanted to come up with rewards like, say I wanted to take someone to the canteen once a week if they were engaging in safe behavior, I could get $3 a week approved by my treatment team leaders. So there's good resources in place, even outside of the program that is behaviorally based.

Floor staff members are highly valued. Several disciplines commented on the importance of the front line staff members in the delivery of behavioral interventions. Floor staff members spend the majority of their time with the patients, allowing them to get to know the patients and provide valuable information to the treatment team. A social worker commented, "The FRS are just wonderful they, they see these people 24/7. They, they a lot of times can just tap you on the shoulder and say, 'Check this out.'" The psychiatrist elaborated, "There's a push to make sure entry level staff and FRS that we listen to them they literally spend the bulk of the time with the patient." An activity aide further explained floor staff members keep the units safe by commenting,

> They are always very important. They are the safety line between administration and the staff, professional staff AND the clients. [Right.] A lot of clients perfectly interact with a FRS, even [more] than with a case worker or a psychiatrist.

Consistent staffing and working relationships with patients aid implementation. One of the social workers explained the importance of having consistent floor staff working on the unit who can form relationships with the patients. She stressed employees who know the patients can be role models to other employees and demonstrate how to effectively intervene proactively with patients before dangerous behavior occurs. She explained,

> Um… well when we have the regular staff there that are really educated on it, their consistency um is something that's really important to like be a role model to the other people. That, that's really helpful. Like when we have the good staff, good staff that's been there for a while. [That really know our patients.] That are comfortable, yeah. And can recognize maybe when they are amping up, so maybe they can intervene even before they have to implement two-to-one or something like that.

Privilege level system works well. One employee described the current privilege level system as an asset to treatment stating,

> Um, I think the privilege level is, is working. [Okay.] Being able to have a certain privilege because of having a certain behavior or lose his privilege because of a certain behavior can keep most of our clients on track. [Mhmm] There's clients that absolutely do not care, [mhmm] …or there's clients that do not understand. [Mhmm] But for the most part, um when a client has a certain privilege to lose or to work towards, [mhhmm] …they tend to shape the behavior that we want to see.

Current Barriers to Behavioral Plan Implementation

The interviewed treatment providers cited insufficient staffing as a major barrier to proper behavioral plan implementation. Those interviewed also commented on several issues with administrative supports including break down of communication between treatment providers and administration, lag in administrative approval for behavioral incentives, and administration being unfamiliar with daily activities of patients and staff members.

Insufficient staffing is a barrier. Every single participant commented that there are not enough staff members to follow through with behavioral interventions to treat aggressive behavior. The floor staff and activity aid—professions that spend the most direct time with patients—laughed when asked if there were enough staff to follow through with behavioral interventions. While the participants all commented the hospital is lacking enough floor staff members, the psychiatrist specifically named the nursing shortage as a barrier to behavioral plan implementation. He stated,

> And I would specifically point to nursing staff. Because, the, by design, in all hospitals especially mental health hospitals, the professionals that really deliver the services and

supervise non-professional staff are the nurses, and we, we just don't have them.

Barriers related to administrative supports. The treatment program psychiatrist described feeling frustrated with the hospital's strict adherence to policy guidelines he believed were not practical to daily practice at the hospital. He described interactions with the commission that oversees hospital policy, "They have no concept of the practicality and our organization never questions and never negotiates" and "But, but our approach to everything is *very* concrete. We are very unsophisticated in our psychological defenses as a hospital [laughs]."

The psychiatrist spoke to the discouragement patients have experienced due to slow administrative approval of patient incentives. He said,

> If we have a behavior plan and somebody does well, and we are at the reward stage, and we put in a packet for passes and it sits on someone's desk for two months, [Yup.] …the, the patient gets the message indirectly that their hard work and behavior didn't matter because it didn't result in a change. [Okay, so it seems like some of the administrative paperwork could be slowing down some of the reward.] It's painfully slow, and they will say it's a lack of personnel over there, but as far as I know they don't have any unfilled positions. [Okay.] So I, I don't understand how that's possible.

Finally, the psychiatrist commented on current processes for reporting treatment gains to administration as not detailed enough to show true patient progress. He stated,

> I do think there's a disconnect. And also, there's just a disconnect with day-to-day activities. They get a report as you probably, know, I don't know if you get it, about like seclusion and restraint and adverse events every day. [Mmhmm] Ah, they also get a report on a census that will tell them if somebody matriculated to a less secure facility, but small gains and stuff they are completely oblivious.

He added,

> One of my criticisms was, and one of the expectations at this meeting that I had with them this week, [Uh huh] …was that I thought we were actually going to see the patient. [Okay] Because I really thought that they needed to get a gestalt from the clinical presentation and they had no intention of doing so. And uh, apparently they never do. [Huh!] It's all chart or it's all from uh, the professionals who are getting the referral.

Employees' Motivations to Continue Behavioral Plan Implementation

Participants described patient progress, support from other staff, and the desire to perform duties of their job effectively as motivations to continue with implementation of behavioral interventions.

Patient progress is a motivating factor. Multidisciplinary staff described how they are motivated when patients show improvements in treatment. One participant elaborated,

> Well I tell the patients this all the time, I do believe this and I know it's kind of cliché to trite, but what I say is, "If I were a used car sales man and I had the same cars on the lot last year that I did this year, I'd be a pretty bad salesman." [Mmhmm] So I tell them, because the frequent resistance I get is, "You don't care that I'm here, you get paid more if I stay longer," and I say "Nope it is quite the opposite," I said, "The only job satisfaction I get is when you move on in treatment," [Right!] …and that is true, it's not just hyperbole for their benefit.

Participants explained treatment gains are often small and can be easily missed if not deliberately sought out. For example, one participant stated,

> Um, it's hard to stay motivated, but the small things sometimes, that's what keeps you going. Uh, for instance you are working with a certain client, and this client has been

> going down a path for the longest. And basically, the behavioral chain that you identify with them, you see that glimmer of hope… it keeps you going. You know that "Okay, at least I am getting somewhere."

Another participant explained,

> And I think we, we have to look at small elements of things that have changed, because um, these people come from a *very* bad background and they grew up with such non-useful tools… and uh, um, just the openness or, or, one, wanting to have an understanding and two, of what they have dealt with and how they have survived this long.

Treatment team member support is a motivating factor. Employees described the support of their team members as being helpful in finding the motivation to continue behavioral intervention follow through. One participant explained, "Yeah absolutely, because it takes a lot of work to write a behavior plan," [mhmm] "…um, and without staff buy-in, you are not going to see much of an impact." Another participant described utilizing peer support when patients on her caseload struggle. She commented,

> When he's struggling a lot, it is a lot harder to stay motivated because I just want to pretend that this isn't happening. [Right.] Um, so definitely just peer support, [Okay] …is pretty much the main thing, like knowing I'm not alone in working on this. Somebody else can help me with it.

Fulfillment of job requirements is a motivating factor. One floor staff member described fulfillment of her job requirements as the source of motivation to continue delivering behavioral interventions. She explained [sighs],

> Damn, I will, well I guess I just do it because it's what is expected of me. I'm not like

> excited about it but, um… yeah I think that's… there's definitely, like the, "Oh, you are doing a good job being one-to-one," we don't get that. But, I, that's my motivation, because it's my job. It's not the most fun part of this working here but…

Employees struggle with motivation to continue tasks of behavioral plan implementation. While employees were able to describe ways they stayed motivated, five out of six participants commented it was difficult to find motivation to continue with behavioral interventions. One social worker described feeling discouraged by a patient's continued aggressive behaviors. She explained, "When he's struggling a lot, it is a lot harder to stay motivated because I just want to pretend that this isn't happening." The psychology resident described a lack of support from the treatment team as detrimental to her willingness to create behavioral plans. She explained,

> For the few behavior plans I had in mind this year that I have not gotten around to, I talked to the team about it and they made it pretty clear that they wouldn't be willing to implement it. They were pretty convinced that it wouldn't work and I just wasn't able to get buy in to justify the time and the paper work that it would take.

Most strikingly, was the floor staff member's comment that front line staff members are never given praise for their involvement in behavioral interventions with the patients. She commented, "[So is there any positive feedback ever?] "Not really, no." [That's really sad!] "Yeah, that's one of the perks of working here." [Wow, only negative.] [She laughs].

Employees' Emotional Experiences During Behavioral Plan Implementation

Participants described a variety of emotional experiences during behavioral plan implementation that included experiencing the effects of power differentials between the professions, frustration, and fear of disciplinary action.

Power dynamic exist between the professional roles. All participants described the power dynamics among the treatment providers. In particular, employees who had the most direct contact with the patients described feeling like they had a minimal role in behavioral plan formulation and were unsure if professional staff used their input when creating behavioral interventions. Direct care employees commented, "Behavior plan, my role is mainly as an observer. Um, even as a part of the treatment team currently my role is still very minimal," and "I don't know we report stuff that we see and that goes into, well I would hope it goes into, making those plans."

Participants described being told to follow behavioral plans with little explanation or guidance. For example, one floor staff member commented, "We're just told to do it, they print it out and give it to us." The treatment program psychiatrist described the process with which administration delivered instructions for behavioral interventions as authoritarian. He explained,

> [I]t's sort of like, you know Moses comes down from the mountain, with this treatment plan, and, and I've got this on a tablet and if you all don't follow it exactly, you know, you are never going to see the Promised Land, and it's all you hear. So um it, uh, and frankly, some of the suggestions are completely ridiculous. And there's no give and take…

When asked to describe the power dynamics within the treatment team, the psychiatrist described treatment team members as having equal footing, stating, "So uh, I I think it's pretty, pretty democratic where everybody gets a say without fear of being shamed or put down because of the level of education so, I, I think it's a pretty good system."

Employees experience fear of disciplinary action for inconsistent implementation. Finally, one social worker spoke to the current employee culture that includes worry of

disciplinary action for not following interventions verbatim. She described an interaction with the unit nursing staff while writing the behavioral interventions for a patient. The social worker explained,

> Like when I said if he refuses to be searched, then we put him in a manual hold and search him anyway, just because of his history with weapons, and I think that they ended up scratching that part out because they wanted to leave it up to more of the nurses discretion. Which was fine with me, the nurses of course, with their different opinions, were a little [pause], they were afraid of getting in trouble. So when it was in writing that it was up to the nurses' discretion, they felt more comfortable with it.

Employee Recommendations to Improve Behavioral Plan Implementation

All employees who volunteered for this study had many suggestions for how to improve the care and safety of patients within the treatment program and the hospital as a whole. The suggestions are divided into the following categories: improvements for training; consistency in staff interactions with patients and unit assignments; ways to improve written behavioral interventions and delivery of those interventions; and suggestions for improving environmental factors within the hospital.

Improvements for staff training. The interviewed psychiatrist and psychology resident suggested all employees of the hospital who have direct contact with patients attend training in behavioral principles. The psychology resident elaborated,

> I think staff education is probably really big. Like today, we did a training where we talked about behaviorist principles and um, I saw a lot of direct care staff, it seem to really resonate with them and they seemed to get it and I think a lot of people are very teachable and they can learn these things. Um, they can see the value in it, they just need

> to sort of, they need more than a single conversation with the clinician… on the unit, they need real training.

Of those participants who suggested training for multidisciplinary staff, they were in agreement a yearly half-day training would be sufficient.

Participants want the training to address the theory and application of behavioral interventions. For example, the psychology resident commented,

> I think it would need to explain the theory behind why we do this, it would need to explain some of the research base, um, some of the evidence that this actually works. I think people would need to know in what cases is this the most helpful. And then I think people would need like the practical side of this, which is how do we, how to we implement this. Um, how do we utilize people on the team who can work on these behavioral plans and um, how can we support these types of interventions as a team.

Training on behavioral interventions can help facilitate staff buy-in, a factor employees believed to be necessary for implementation. The psychology resident offered,

> I think the major challenge on my unit is getting staff buy-in. Um, and not just from direct care staff, I think a lot of times they are more open to it, it's from other clinical staff, um nursing, social work, um, and a lot of times they are convinced that they've tried this in the past and that it was not easy to implement or that it didn't work. So trying to get them to consider doing it with a different client, um, and trying to encourage them to have the flexibility to stick with it.

Request to involve behavioral technicians and behaviorists in staff training. It was suggested the hospital's behaviorist and behavioral technicians could have a more direct role with the training of professional and floor staff members. The psychology resident suggested,

> I think we have such a great resource at this hospital because we have a behaviorist and a behavioral tech on site and I think they would be phenomenal trainers um, and they would be available for training. [Right.] And so I think, I think right now we under utilize them by only calling on them when we have a clinical request, and not utilizing them fully with training.

Increase consistency with staff to patient interactions and unit assignments. Employees expressed the importance of consistency in the way staff members respond to patients' requests, demands, or threats. The activity aide explained,

> Um we, we first have to be on the same page with answers for the clients. If the answer is "no" it needs to be "no" across the board. It's not "Okay, you might say no, but somebody else might say yes." [mhmm.] If the answer is "no," it's supposed to be "*No*." [Yep!] Straight across! So that it's not, they aren't able to move from one staff to another. Um, that would help with the reinforcement that this is what we are doing, and this is what needs to be done.

The social worker spoke to the importance of consistency in staff unit assignments, as it allows them to know the behavioral protocols of patients on that unit, which lends to correct implementation of the behavioral intervention. She commented,

> Yeah, um, and when there are staff that are pulled, which happens often especially when there is like a two-to-one or something, just that, then the consistency is a problem. Especially like, doing something that is detrimental to that whole plan of, like not talking to their two-to-one and instead making it like a fun thing.

Here the social worker referred to staff members who interacted in a friendly manner with the patient who they were assigned to for a two-to-one protocol. Typically, such protocols

require the staff members do not socially engage any patient on one-to-one or two-to-one protocol as a way to discourage patients from using aggression to gain social engagement.

Consistency in responding is especially important for safety and the population of this treatment program. The activity aide spoke about remaining mindful of the potential for dangerousness with the Antisocial Personality Disorder clinical population of this treatment program. He commented,

> One of the things that I would say is that we persons as staff members got to remember that even though these clients come to us with, um, an *illness,* we have to also be cognizant of the fact that they are with us *because* of either aggression, aggressive behavior or some um, criminal intent. [Right.] So we have to also be mindful of the fact that this is the population that we are dealing with. [mhmm.] Which, doesn't mean that you have to run around scared, but it means that you have to be aware. [mhmm] And be aware of your environment. [Right.] I think a lot of people becomes comfortable with them and forget that these are the clients that we are dealing with.

The activity aide stressed that due to the dangerousness of the clients, it was especially important that staff members remain consistent in the way they respond to patients who make verbal threats. He explained,

> Um, a lot of the clients make, and I want to say don't think I'm being naïve, but a lot of clients make threats, [mhmm] …while we know that the clients that we work with are very dangerous, giving into the threats and the demands of these clients, um puts the power in their hands. [mhmm.] And is that we are not realizing that they are here for the same purpose, so we can't just give in to them. [mhmm.] So I think that creates a large, barrier problem. [mhmm.] Because when you give into them, they've won. They won't

listen next time. So that's what's not working, not really.

Increase behavioral interventions and support to floor staff members. The floor staff member expressed her desire to have more specific behavioral plans written for the clients on the unit. She said, "Um, well, on this particular program it would be nice if we could get more target behaviors" [Okay!] "[laughs] When we, when the FRS is asking over and over and over for them, we could actually get them." This floor staff member also spoke to the importance of support from the professional staff who create the behavioral interventions. She expressed her frustration with inconsistent support from the treatment team, stating,

> When the staff is inconsistent or when we, the FRS, try to be consistent and then particular case managers don't back up the plans they've given us that they've made themselves. And then they don't back us up when we try to do them.

The psychology resident spoke to providing incentives for involvement in clinical interventions. She described the current culture within the hospital that rewards good bookkeeping, but lends to clinical staff spending more time off the unit away from patients and direct care staff. She explained,

> And I think part of that is at hospitals like this, um, staff are rewarded and they are incentivized for meeting paperwork deadlines. [mhmm] Um, for doing good documentation, but not for doing good clinical work. [Okay.] Like I don't think that there's a lot of positive reinforcement for that. [mhmm] Um, and so you see that at lot of times in people who assume leadership positions, um, they are the ones who are very diligent in spending time in their office and modifying treatment plans, but they are not necessarily the people on the unit who are investing a lot of time and energy into clinical work and who are really seeing results.

Improve written and verbal communication of behavioral plan specifics. Social work and floor staff spoke about the importance of seeking out better communication with all floor staff members. The social worker spoke about the daily separation of the floor staff from other professionals and how this can be detrimental to behavioral treatment integrity. She explained often floor staff are asked to work on units that are short staffed and are unfamiliar with the specifics of the patients' behavioral protocols. She commented,

> Well I guess making sure if it's someone that's like pulled or whatever, we aren't always up there to know that. So whoever is in charge, making sure that they get communicated that this is what the protocol is, that sort of thing.

While email can easily connect the professional staff within the treatment team, the social worker pointed out floor staff may not have access to email or be left off the email entirely.

The floor staff member spoke to how she and other floor staff supervisors could improve communication about the specifics of behavioral interventions, stating, "Maybe ask the FRS, try to talk to them more and see if they have any input, just ask them for it." She also suggested floor staff members document and report their experiences with patients more frequently. She explained,

> I think, um, if the other FRS, like that aren't FRS IIs if they would speak up more, write more notes, document more stuff, and come to the FRS II or the team about issues that they are having with particular clients, [mmhmm] …that would help, more communication.

An FRS II refers to a Forensic Rehabilitation Specialist Level II. FRS IIs supervise FRS members and are seen as leaders on their units.

The psychology resident spoke to the importance of allotting time for clinical staff to

formulate and write behavioral interventions. She stated,

> Uh, let's see. I think um, I think one of the greatest challenges probably for encouraging behavior plans at this hospital is that um, clinical staff often feel that they don't have um, enough time just to do the basics, just to meet their basic responsibilities. [mhmm] So I think when you are talking about behavior plans, you have to address like the amount of time that it takes to do that and there has to be team support um, if you are going to be working on something and you are going to set aside that much time. And so I think for the staff members who can do these behavior plans, that might mean like, that your co-facilitator takes care of the group for the week if you were, if you are using your knowledge and resources in this other area. So I think there's not a whole lot of team support for these things and so I think psychologists and any other staff who have knowledge to do behavior plans often don't develop them because there's just, there's not enough time to do things the way that they would ideally like to do it.

Finally, a social worker explained writing behavioral plans in clear, concise, non-clinical language may improve uniformity in behavioral intervention delivery. She suggested,

> I don't know if it's feasible, but if there was some way to make it, because it's like a two page thing for some people even longer, make it more concise so that people can very quickly read through it and remember it all, because I'm sure if I was in that position that I would not remember all that.

She spoke to the importance of language use when writing behavioral plans, elaborating, "Yeah so use words people understand so it's not something that's really clinical, or something not really, not very measurable and concrete," and,

> Yeah, and not the way that you and I would talk. Like, in a conversational way. Because

> not everyone has a social work degree or a psychology degree. Even though they might know what a certain word means and do it everyday, they might not know it when they see it on paper.

Suggestions for communication improvement between staff members, patients, and administration. The psychiatrist suggested a way to have administration more directly involved in behavioral interventions. He said,

> Well here's what I would do, and it could be a rotating position, or it could be a permanent position. I would have one member of the Treatment Counsel that is responsible for at least once a week checking on the progress for everybody that has a behavior plan. [mmhmm] There aren't that many in the hospital. As of Friday we had 408 patients, there's probably 10% that have this, [Okay.] …so it could easily be done. And then they could ask, "Is there anything you need?" "Is, is it a funding issue?" "Is Joe upset today because he didn't get the visit from his parents and he doesn't have shoes? Or he doesn't have a warm hat?" or whatever, and we could get the funds, get the hat, whatever.

Other participants spoke to improving communication between staff and administrators so administrators could be more aware of the impact their decisions have on the daily activities of patients and staff. The activity aide commented,

> I personally think that if we have more people um, are let's say that the persons that are in charge of making the major decisions are more aware of what FRS, Activity aides, the psychiatrists face on a daily basis when a rule is changed, or a rule does not seem to be working, then that information that is passed to them, would help them to make better decisions in terms of rules or whatever they are putting forth. [mhmm] So it makes our

job a little bit more, safer basically.

The social worker spoke about communicating the urgency of protocols with administration to speed up the approval process. She explained,

> Um, well, like when *patient* was struggling so much, we couldn't get an answer right then about the plan, and we really needed something immediate. [Okay] So, just kind of the process between [pause] sometimes it will go really quickly through Treatment Counsel, sometimes it will take a while.

She communicated a resolution to this issue, stating, "I guess communicating better with the Treatment Counsel, that would help. Because I don't know if we've ever said 'Hey! I need this quickly.'"

Suggestions for improving environmental factors within the hospital. One social worker raised the point that the physical environment may be leading to some of the outbursts of aggression. He commented, "I don't think, we just don't put that together too much to really stimulate their brains and then they get bored and they get in trouble and we have people that just keep" [Being in this cycle.] "Yeah." He suggested providing the patients more library time or creating classes that taught academic subjects. The social worker believes the new hospital being constructed will have spaces more conducive to therapeutic interventions and will improve patient privacy. He explained that currently, "Right now I'm doing like little things talking about someone's behavior and I'll have like 15 other people around listening to the conversation."

Discussion

This project invited several employees to vocalize their opinions about the strengths and weaknesses of their treatment program's delivery of behavioral interventions within an adult forensic psychiatric inpatient setting. This project was able to successfully recruit a psychiatrist,

two social workers, a psychologist, an activity aid, and one floor staff member. The participant group that volunteered was not as diverse as the overall workforce employed at the hospital. The sample was rather homogenous in education level as five out of six of the participants held graduate degrees. The sample was mostly White, with one participant who identified himself as Jamaican. Therefore, there may have been more variation in the participants' responses had a more educationally and ethnically diverse sample been questioned.

Dependability and Reliability

This project was successful in securing participants that had implemented behavioral plans for more than one patient. The participants had experience with behavioral interventions within the studied treatment program, as well as a variety of other settings. These settings included acute care settings for adults and children, group homes, residential programs for youth, and other state hospitals. This project was only successful in recruiting one floor staff member and was unsuccessful in the recruitment of nurses. I imagine nurses did not volunteer to participate in this study, as the nursing department is severely understaffed at the studied psychiatric hospital. Therefore, there were few nurses to recruit within the treatment program, and the nurses that do work within the treatment program may not have had any time or interest in volunteering.

There are a few possible explanations for my difficulties in recruitment beyond the nursing shortage. Most notably, it is possible some floor staff members felt ambivalent about participation. For example, although several floor staff members signed consent forms to participate in the study, only one completed an interview. Although outside of the focus of my inquiry, numerous staff members, from multiple disciplines, had spoken about the "old culture" of the hospital in which staff members consistently received disciplinary action for honest

mistakes and/or when they reported issues with implementation. One hypothesis is the disciplinary consequences may have created a culture of underreporting within cohorts that worked directly with the patients, as individuals did not want to get anyone in trouble.

While the hospital has attempted to change this culture over the last few years, some of the staff members who have worked at the hospital long-term may still be wary of voicing their opinions about what is working or not working at the hospital, as this type of behavior used to result in negative consequences. Therefore, the floor staff members who chose to not participate may have done so as a result of many factors including, for example: (a) the residual hospital culture, (b) issues related to understaffing, (c) disinterest, or even (d) a feeling their voice did not matter.

Transferability

The participants were all employees of the same treatment program who had worked in both maximum and intermediate security settings within the hospital. The hospital studied is unique in that each treatment program is designed to deliver an evidence-based treatment to a specific clinical population with homogeneous diagnoses.

The population of the studied treatment program is considered clinically challenging by many behavioral health providers. All of the patients had involvement with the legal system and the majority of patients are diagnosed with Antisocial Personality Disorder (ASPD). Symptoms of ASPD include three or more of the following behaviors:

1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.

3. Impulsivity or failure to plan ahead.
4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety of self and others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another. (American Psychiatric Association, 2013, p. 659).

Studies have determined callous-unemotional traits are related to severe aggressive behaviors (Frick, Stickle, Dandreaux, Farrell, & Kimonis, 2005; Salekin, 2008; Salekin, Rosenbaum, & Lee, 2008). These traits include absence of guilt, constricted emotions, failure to show empathy, and use of others for gain (Stickle, Kirkpatrick, & Brush, 2009). Additionally, under anxious temperament is associated with development of ASPD in adulthood. The under anxious temperament is described as "underreactiveity in the sympathetic nervous system" that manifests "behaviorally by low fearfulness to novel or threatening situations and poor responsiveness to cues of punishment" (Stickle et al., 2009, p. 517). Therefore, when an individual diagnosed with ASPD has his or her goal blocked, he or she is likely to try and find coercive ways around the blockage to get his or her need met.

Stickle et al. found callous-unemotional traits to be independently related to severe aggression. Additionally, antisocial youth who had intentions to problem solve or act pro-socially had lower levels of aggression than those who intended to act aggressively when provoked (Stickle et al., 2009). Based upon these findings, the recommended treatment for people with ASPD symptoms who display aggressive behavior includes individualized treatment plans (Stickle et al., 2009) that increase emphasis on empathy training and rewarding prosocial

behavior with decreased emphasis on punishment and negative consequences (Stickle & Frick, 2002; Wong & Hare, 2005).

The studied treatment program is being rewritten to include more individualized behavioral plan incentives for the patients, instead of using a universal privilege level system. The treatment program plans to take on a behavioral orientation when the new program manual is implemented in 2017. Until that transition occurs, the theoretical orientation of the program is eclectic and pulled from Illness Management and Recovery, Motivational Interviewing, and Stages of Change treatments. Therefore, due to the specifics of the delivered treatment, patient demographics and security level of the site, the needs of the studied treatment program may be unique and not easily transferred to other inpatient treatment programs.

Limitations

IPA research focuses on the specifics of an experienced phenomenon and less on the generalizability of findings. Therefore, this project was able to obtain a detailed account of the participants' experience within the studied treatment program within a maximum and intermediate security psychiatric state hospital. This research is not a critique of the appropriateness of particular behavioral interventions for a patient, but rather assesses the feasibility of carrying out behavior plans for patients within the treatment program.

It is possible the six employees interviewed have different experiences within the treatment program than those employees who did not volunteer for the study. Therefore, this research highlights specific needs of the employees who volunteered within the treatment program and it is possible other themes may have emerged if more employees, specifically nurses and additional floor staff members, had been interviewed. The results may not be able to be generalized to other treatment programs within this particular hospital, or to other adult

psychiatric inpatient settings.

Behavioral Plan Implementation Needs Assessment

Fixen and colleagues (2005) have listed the following as necessary components for evidence based practice implementation: facilitative administrative supports; systems interventions; selection; preservice and inservice training; consultation and coaching; and staff and program evaluations. After reviewing the data, the following program evaluation was formulated based upon employees' descriptions of the current treatment program. The treatment providers would like to incorporate individualized incentive plans into patient care starting in 2017. Therefore this desired change for treatment was kept in mind while the program evaluation was completed.

Facilitative administrative supports. The studied treatment program has the support for behavioral plan implementation from the hospital administration. Administrators attend treatment program meetings and safety meetings that occur on a weekly basis. Administrators have been involved in the development of the treatment program that will begin implementation in 2017. The studied treatment program frequently submits behavioral protocols to the Treatment Counsel, a panel of administrators who review interventions for ethical and treatment concerns.

Moving forward, the studied treatment program will need support from administration to create a data collection system that will allow for routine staff and program evaluations. This data can help focus future implementation efforts, keep the program staff motivated, and track the clinical outcomes of the patients. Employees requested administrators have more interaction with both patients and floor staff who deliver behavioral interventions. The impact of this administrative involvement can serve multiple purposes. Direct administration involvement may communicate to floor staff members that their input and work with clients is valuable. Research

has shown that when employees from all levels of a system are involved in treatment planning, implementation of that intervention is more likely to be successful as employees feel a sense of ownership for the treatment conceptualization (Katzenbach, Steffen, & Kronley, 2012). Direct administrative involvement with floor staff and patients will also allow for first hand accounts of client behavior when formulating conceptualizations and troubleshooting issues with behavioral plans. Therefore valuable time may be saved during treatment formulation for some of the hospital's most dangerous behaviors.

Systems interventions. Staff members who work within the studied treatment program agreed the program has the intellectual and tangible resources to implement various behavioral interventions. All staff was also in agreement that there are currently not enough staff members employed within the treatment program. The program specifically needs nurses and floor staff members. Additional floor staff members would be especially helpful for the program when patient behavior requires one-to-one or two-to-one safety protocols to be put into practice. These protocols are especially labor intensive. Constant vigilance of the patient is required of staff assigned to implement safety protocols. The assigned floor staff members may also be required to engage in physical interaction with the patient including manual holds, blocking physical aggression with pads, physically transporting a client, and application of mechanical restraints. Additional floor staff members assigned to the program will allow more floor staff to be trained on the specific safety protocols. It will also allow floor staff members to spend less time assigned as a one-to-one or two-to-one staff, which may result in less fatigue, stress, and physical injury.

Selection. The participants believed the studied treatment program has been able to employ individuals who have the necessary training and skillset to implement various tasks involved in behavioral interventions. The program does not allot enough time for these qualified

individuals to focus their efforts on time consuming behavioral plan writing, coaching, and intervention delivery. Employees suggested the behavioral technicians employed by the hospital could be great resources and be able to help complete some of the tasks that other qualified program employees do not have time to complete. This project was unable to determine if the hospital has the financial resources to hire individuals with the necessary qualification for behavioral plan implementation.

Preservice and inservice training. Currently, professional staff (psychologists, social workers, and activity aides) within the studied treatment program receive yearly training about treatment for Antisocial Personality Disorder. About one year ago, the hospital began offering a full-day preservice training in new employee orientation on Positive Behavioral Supports (PBS). The PBS training addresses the purpose, theory, rationale, and key values of behaviorism in a user friendly way. The training also includes role-plays so the staff in training can practice the behavioral interventions for a variety of situations from non-aggressive (for example, a patient picks their nose in front of you) to emergency situations (for example, a patient becomes aggressive with another patient).

While staff members alluded to an inservice training in which floor staff are given a chance to review and practice behavioral plans before delivering the intervention to the patient, the floor staff member did not say this training had ever occurred. It is not clear that this training has taken place— such training is one more responsibility for the understaffed and overstretched nursing staff on the unit. Until the hospital is able to recruit more nurses, it may be beneficial for staff that author behavioral interventions to take on the task of leading these inservice trainings.

Staff members within the studied treatment program had become discouraged when formulating behavioral interventions. The staff members had negative experiences that included,

for example, implementation of an intervention that did not work with a client, or trying to manage an intervention that was determined to be too time consuming for the treatment team to effectively develop. Therefore, it may be helpful for the program staff to receive training and support that specifically focuses on troubleshooting issues with implementation and intervention appropriateness. It may be helpful to develop clinical case studies in this training. These case examples might describe the process from intervention development to behavioral change, realistically describing typical difficulties staff members and patients are likely to encounter throughout the change process.

Consultation and coaching. The members of the treatment team currently receive consultation during weekly treatment program meetings and biweekly safety planning meetings. Disciplines present at these meeting include psychiatry, psychology, social work, rehabilitation specialists, and activity aides. The floor staff members typically do not attend the program meetings, although floor staff supervisors are present at the safety planning meetings. Administrators attend the safety planning meetings and occasionally the behaviorists or behavioral technicians will attend as well.

There is not a formal system in place within the studied treatment program to allow consistent coaching to occur during behavioral plan implementation. It may be beneficial to the program to enlist the help of the behaviorist and behavioral technicians as they have extensive training in PBS interventions. It may also be beneficial for psychology staff to be allotted time to spend with other professions on the floor as to provide in the moment modeling, coaching, and guidance in interactions with patients.

Staff and program evaluations. The studied program's treatment team members receive updates on patients' progress during daily shift reports. These meetings are attended by every

discipline. The program's treatment team also holds treatment review meetings for each patient once every three months. Patients are present at treatment review meetings and are able to report on their own progress and goals for their future treatment. Each discipline is in attendance for treatment review meetings and data for these meetings comes from personal experiences with the patient and review of the patients' files. While this type of evaluation helps to identify the individual patient's progress, the treatment program may benefit from a formal program review that uses measurable patient outcomes to determine which aspects of the evidence based intervention have been put into practice. A formal program review can inform training as the review may identify the aspects of behavioral interventions with which the treatment program excels and the components need more training, coaching, and consultation. This program evaluation can include a formal behavioral data collection system that can highlight small treatment gains for patients that may be lost in a file review or more general discussion.

Staff members reported receiving feedback on written behavioral interventions and improper implementation of behavioral plans. The studied treatment program may benefit from a formal process that reviews employees' clinical skills in regard to behavioral plan implementation. This may include direct observations of the staff members as they deliver the interventions. As staff members' abilities to implement behavioral interventions are evaluated, supervisors and administrators may be able to identify employees who would make good coaches and trainers for their peers. Staff evaluation may also identify areas for growth and guide training for staff members.

Previous Training and Attitudes Toward Behavioral Plan Implementation

Corrigan et al. (1996) recommended training in behavioral treatments and treatment team cohesion will together improve optimism and fidelity of behavioral interventions within

psychiatric hospital settings. Four out of six participants indicated they had received behavioral intervention training prior to their employment with the studied hospital. The other two participants endorsed they received training while employed within the studied treatment program. The participants' training was obtained from a variety of treatment settings with varying target populations. While the participants may already possess valuable knowledge regarding behavioral interventions, the need exists for training to focus the participant's clinical skills on the treatment program's population of adult inpatient forensic patients with diagnoses of ASPD.

The participants have varying opinions about the cohesion of the treatment team. While four out of six participants felt the treatment team members communicated well, two members pointed out areas for improvement in communication. Specifically, employees believed more communication about the behavioral protocols and issues with implementation are needed. Participants indicated their desire for more team cohesion through requests for more consistent unit assignments for employees within the treatment program. While those staff with professional degrees expressed appreciation of the floor staff members, the floor staff member interviewed requested more support from the professional staff. This support could help to unify the treatment team and address the power differentials that exist within the current treatment team structure. A unified team may provide consistent moral support to each other, better vocalize challenges and problem solve, and ultimately be more consistent with delivery of behavioral protocols.

Areas for Further Investigation

This project was able to determine the process of behavioral plan implementation within a treatment program designed for individuals who have diagnoses of mood disorders, psychotic

disorders, and personality disorders, excluding borderline personality disorder. This treatment program exists within a psychiatric state hospital with maximum and intermediate security levels and serves an adult forensic population. The patients within the studied program are considered to be "high functioning" with many patients having average or higher intelligence. Future research may examine the implementation practices for employees who work with a variety of diagnoses and settings.

This project was not able to measure the level of burnout experienced by the employees working within the studied treatment program. It is possible burn out could be associated with quality of behavioral plan implementation as behavioral interventions are time consuming and require constant evaluation and data collection. Future research may consider the relationship between employee burn out and fidelity of behavioral interventions.

Researcher Biases Emerged During Data Collection

I had the interesting experience of working within the studied treatment program in maximum and intermediate security for six months during my internship year. This experience offered me insight into the behavioral plan implementation practices and allowed discussions with staff members and patients outside of this project. Along with experience writing and analyzing data from behavioral interventions within the treatment program, I also have had related experience implementing behavioral interventions in a variety of settings including a child inpatient neurobehavioral unit, an applied behavioral analysis program for children diagnosed with Autism Spectrum Disorders, and adult inpatient psychiatric hospitals. Therefore, my closing remarks are informed not only by the interviews with research participants, but by the whole of my professional experience.

As I interviewed the floor staff member, I experienced guilt when this participant spoke about feeling unappreciated and not validated for the good work that the floor staff members do. I had directly worked with this staff member, and this staff member had followed the one-to-one protocol I wrote for a patient on her caseload. While I recall explaining to the patient why staff members were following the protocol, I had not done as thorough a job with my explanation to the staff members. I also realized I had never thanked the staff members for collecting behavioral data and following through with the behavioral plan. The staff members involved in this protocol had done an excellent job with this patient, and while this was highlighted in the treatment review meeting, only one floor staff member was present to hear these praises. The floor staff member expressed emotional responses to her job including frustration, exhaustion, and self-doubt, and uncertainty about how she was viewed by the rest of the treatment team. This interview resonated with me and reminded me to point out treatment successes, even small ones, to those who are directly involved in the day-to-day interventions with patients.

A comment from one of the social workers also resonated with me about how critical the need is for the studied treatment program to invest in behavioral theory training for *all* staff members. The social worker had described an instance in which the nurses on her unit recommended that she make the behavioral intervention protocol for her patient intentionally vague. The social worker had felt that by leaving the outcome of the intervention "up to the nurses' discretion," that she was helping nurses avoid feeling uncomfortable for choosing to follow through (or not) with her patient's weapons protocol. I found the vagueness of this intervention to not only weaken the behavioral intervention, but possibly to also create an unsafe environment for staff members within the treatment program.

From a behavioral perspective, allowing staff members to use discretion to follow through with a behavioral intervention designed to decrease aggressive behavior puts all staff members at risk. Patients diagnosed with ASPD have a tendency to view aggression as socially acceptable and effective at meeting their needs. Patients with ASPD are also less likely to experience emotional dysregulation in dangerous situations. Therefore, these patients are likely to use aggression as they have learned it to be an effective behavior that brings little to no distress to the patient. Staff members who inconsistently follow a behavioral protocol designed to decrease aggression provides *variable reinforcement* for the aggressive behavior, as they allow the patient to continue to use aggression to have his or her needs met. Allowing staff members to choose if they would like to follow through with a behavioral intervention that is meant to reduce aggression creates an environment where those staff members who follow through with the intervention become a target for aggression, as patients learn that if the staff member is injured others will not continue the intervention. Patients then learn that if they intimidate staff long enough or injure enough staff they will be able to obtain their goals through aggressive means, just as they had been able to in the community.

Based on the conceptualized treatment for ASPD from the literature (Stickle & Frick, 2002; Stickle et al., 2009; Wong & Hare, 2005), it is recommended the studied treatment program take a realistic appraisal of the treatment providers' abilities and willingness to consistently implement any behavioral interventions to treat aggression. Only those interventions that all staff members are willing and able to implement should be put into practice. If the studied treatment program continues to write behavioral interventions to treat aggression that are intentionally vague, there will continue to be risk for unintentional reinforcement of patient aggressive behaviors.

Conclusion

The treatment providers who volunteered for this study represented a cohort of individuals who are dedicated to providing treatment to a clinically challenging population. While the participants discussed their struggles with treatment delivery, they appeared optimistic about the future of behavioral plan implementation and named many suggestions for how to improve behavioral plan delivery within the treatment program. A unified commitment to behavioral treatment by all treatment program employees is necessary for the program to move forward with plans to implement an increased number of individualized behavioral incentives in 2017. The following recommendations may help to increase employee commitment to the use of behavioral interventions within the studied treatment program:

- More frequent communication between administration, professional staff, and floor staff may reduce time when formulating treatment and allow for troubleshooting during implementation. Involvement of at least one floor staff member and one behavioral technician at weekly treatment team meetings could enhance treatment planning as individuals who conceptualize treatment and those who implement treatment protocols may discuss intervention feasibility and concerns before the protocol is finalized and distributed.
- An increase in the number of floor staff may reduce fatigue and stress for frontline staff members. Consistent unit assignments for floor staff members will increase fidelity of the treatment and may result in less physical injury of frontline staff members.
- Behavioral technicians are not currently assigned to any treatment program; rather they have consultant roles with treatment programs that would like their assistance. It may be beneficial to hire additional behavioral technicians so each treatment program has at least

one behavioral technician as a treatment team member. This would allow the treatment programs continuous access to someone who specializes in behavioral intervention to assist with various tasks of behavioral plan implementation.

- Until more nurses are employed and trained on behavioral interventions, those individuals who author the behavioral plans should be more directly involved in floor staff training on the behavioral incentive plans. If available, behavioral technicians may also assist with training.
- Designation of time for staff members to complete duties related to behavioral plan implementation including writing, coaching, and intervention delivery. Behavioral technicians may be especially helpful with all stages of intervention implementation.
- Psychologists, Social Workers, and Recreational Therapists (music and art therapists) all currently hold similar case management roles within the treatment team. In the current system, each profession will be responsible for authoring behavioral incentives for their assigned case management clients. While this model allows more staff members to be available to create behavioral interventions, it does not take into account the case manager's skillset or ability to create behavioral protocols. The treatment program may benefit from a system that measures an individual's current behavioral therapy skillset and requires a certain competency level before a case manager is asked to produce behavioral interventions for their caseload. Education and training can be provided to those staff members who do not meet the required competency level so that they may author behavioral protocols once they obtain the required skillset.
- Continued regular trainings for all staff members on conceptualization of behavioral interventions for adult forensic patients diagnosed with ASPD are recommended.

Information from the Positive Behavioral Support training currently being given to new employees can be used to create a yearly refresher course for all employees.

- A formal data collection system that measures frequency of patient behaviors over time is needed to accurately measure progress with behavioral treatment. The behavioral technicians or quality management personnel may be helpful with this task.
- A formal data collection to determine staff fidelity with implementation can be used to provide encouragement to continue with the intervention and coaching and training if necessary. The behavioral technicians or quality management personnel may be helpful with this task.

While the above recommendations are specific to the studied treatment program, the struggles of this particular treatment program are not entirely unique. In fact, many organizations from all areas of industry struggle with implementation (Fixen et al., 2005). While extant literature does not specifically detail the struggles of eclectic psychiatric settings who chose to implement behavioral programs, numerous researchers have wrestled with implementation of evidence-based practice within psychiatric settings. Researchers have identified factors that impede implementation. Drake et al. (2001) determined multiple factors that impede implementation of evidence-based practice to fall under the following categories: policy; program; clinical; and consumer and family barriers. Policy barriers included state, county, and city funding; regulations; credential criteria; and legislation. Program barriers included (a) difficulty with recruitment of workers with the necessary skillset; lack of training materials/resources for current employees; administrative guidelines; unavailable or under utilized outcome measures; and varied service models. Variety and lack of standardization in clinician training created a workforce with varied experience in any number of interventions and

was viewed as a clinical barrier. Finally, consumers and their supporting families had various degrees of knowledge about effective treatment options and therefore each have different levels of commitment to offered evidence-based treatment.

Although implementation of an evidence-based practice may be difficult, it is possible to be successful. Titler (2008) provided guidelines for introduction and implementation of patient safety standards within clinical settings. First, the treatment providers need to be educated about the effectiveness of the intervention and context in which the intervention had improved treatment outcomes. Second, those leading implementation efforts are to provide clinical staff with information about how the intervention can address a treatment need within their organization. For example, evidence to support the need for safety interventions may include monthly totals of staff or patient injuries within the treatment program. Third, training should be an ongoing process where employees can ask questions and materials needed to follow through with interventions are readily available. Fourth, efforts to implement the new intervention need to be monitored so difficulties are addressed quickly and modified to promote success. Lastly, employees need to be shown evidence of their hard work. Treatment outcomes should be monitored so employees can clearly see the impact of the new intervention on patient outcomes (Titler, 2008)

An example of successful program implementation is the work of Espinosa et al. (2015). Within a medical center that served 350 psychiatric inpatients across 15 different treatment units, the researchers successfully implemented a program to improve the therapeutic climate of the inpatient unit milieu. The implementation efforts successfully reduced seclusion and restraint and increased staff job satisfaction. Implementation efforts focused on the following areas: agreement that current treatment needed to change; literature review to determine best practices

for the population and aid treatment selection; training and supervision of all staff at all levels to ensure fidelity to evidence based treatment; and multiple data collection systems to measure implementation successes. The researchers used program evaluation to determine which parts of the intervention were working and continuously adjusted aspects that were unsuccessful until the desired outcome was achieved.

Continued program evaluation may help the studied treatment program successfully transition to treatment that consists of increased individualized behavioral incentives. This project sought to determine individual employees' experiences with delivery of behavioral interventions. In doing so, the project examined the participants' personal experiences with what research determined to be necessary components for intervention implementation in clinical settings. The use of open-ended questions allowed this project to uncover various issues that the studied treatment program can continue to monitor throughout program development. Similar to the methodology of this study, Masterson-Algar, Burton, Rycroft-Malone, Sackley, and Walker (2014) used telephone interviews to determine key areas that impact intervention fidelity. The researchers recommended using information from the interviews to form hypotheses to be tested throughout the clinical trial of an evidence-based intervention and to frame the eventual clinical trial findings.

IPA methodology was beneficial for the beginning stage of program evaluation, as it reduced researcher bias and uncovered issues relevant to the context of this particular organization. Although helpful, IPA methodology required employees to take valuable time away from daily tasks to complete interviews. Further, data analysis was intensive and time consuming, as it required hours of interview transcription and analysis to formulate conclusions.

Moving forward, the treatment program may benefit from a simplified, more focused method to measure progress with behavioral plan implementation.

For the second stage of program evaluation, the studied treatment program may benefit from methodology similar to that used by Verloo, Desment, and Morin (2017). The researchers sought to determine hospital wide fidelity with an evidenced-based treatment through distribution of two Likert scale measures to a multidisciplinary workforce. These measures determined employees' beliefs about the value of the evidence-based practice, beliefs about employees' ability to implement the practice, and how often employees had performed specific processes of the practice over an eight week period. The studied treatment program may benefit from utilization of similar measures to track the progression of employees' fidelity, knowledge, and confidence with behavioral interventions. Survey measures may assist with further program evaluation of the studied treatment program as the survey can quickly provide information as it does not take much time to administer and score, be repeated to obtain information about continued fidelity to behavioral interventions over time, provide information about implementation progression after delivery of didactic training on behavioral intervention, and inform trainers of knowledge deficits to be targeted in future training sessions. The ease of administration, scoring, and analysis of a survey may especially benefit this training program, as understaffing already puts additional pressure on existing staff to complete tasks. With continued monitoring of implementation efforts, the studied treatment program can move closer to the goal of integrating more behavioral based treatment into everyday practice.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C.: American Psychiatric Association.

American Psychological Association (2017). Ethical principles of psychologists and code of conduct. Retrieved from: http://www.apa.org/ethics/code/ethics-code-2017.pdf

Anderson, C. A., & Bushman, B. J. (2002). Human aggression. *Annual Review of Psychology, 53*, 27–51. doi:10.1146/annurev.psych.53.100901.135231

Antony, M. M., & Roemer, L. (2011). Behavioral therapy: Traditional approaches. In S. B. Messer & A. S. Gurman (Eds.), *Essential psychotherapies: Theory and practice* (3rd ed., pp. 107–142). New York, NY: The Guilford Press.

Beck, N. C., Menditto, A. A., Baldwin, L., Angelone, E., & Maddox, M. (1991). Reduced frequency of aggressive behavior in forensic patients in a social learning program. *Hospital & Community Psychiatry: A Journal of the American Psychological Association, 42*(7), 750–752.

Bellus, S. B., Donovan, S. M., Kost, P. P., Vergo, J. G., Gramse, R. A., Bross, A., & Tervit, S. L. (2003). Behavior change and achieving hospital discharge in persons with severe, chronic psychiatric disabilities. *Psychiatric Quarterly, 74*(1), 31–42.

Bisconer, S. W., Green, M., Mallon-Czajka, J., & Johnson, J. S. (2006). Managing aggression in a psychiatric hospital using a behavior plan: A case study. *Journal of Psychiatric and Mental Health Nursing, 13*, 515–521.

Bloomberg, L. D., & Volpe, M. (2012). *Completing your qualitative dissertation: A road map from beginning to end* (2nd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Bowers, L., Stewart, D., Papadopoulos, C., Dack, C., Ross, J., Khanom, H., & Jeffery, D. (2011). Inpatient violence and aggression: A literature review. *Journal of Psychiatric and Mental Health Nursing, 14*(7), 652–660.

Corrigan, P. W., & Liberman, R. P. (1994). Overview of behavioral therapy in psychiatric hospitals. In P. W. Corrigan & R. P. Liberman (Eds.), *Behavior therapy in psychiatric hospitals* (pp. 1–38). New York, NY: Springer Publishing Company.

Corrigan, P. W., McCracken, S. G., Kommana, S., Edwards, M., & Simpatico, T. (1996). Staff perceptions about barriers to innovative behavioral rehabilitation programs. *Cognitive Therapy and Research, 20*(5), 541–551.

Dack, C., Ross, J., Papadopoulos, C., Stewart, D., & Bowers, L. (2013). A review and meta-analysis of the patient factors associated with psychiatric in-patient aggression. *Acta Psychiatricia Scandinavica, 127*, 255–268. doi:10.1111/acps.12053

Daffern, M., & Howells, K. (2002). Psychiatric inpatient aggression: A review of structural and functional assessment approaches. *Aggression and Violent Behavior, 7*, 477–497.

Dean, A. J., Duke, S. G., George, M., & Scott, J. (2007). Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *American Academy of Child and Adolescent Psychiatry, 46*(6), 711–720. doi:10.1097/chi.0b013e3180465a1a

Dean, A. J., Gibbon, P., McDermott, B. M., Davidson, T., & Scott, J. (2010). Exposure to aggression and the impact on staff in a child and adolescent inpatient unit. *Archives of Psychiatric Nursing, 24*(1), 15–26. doi:10.1016/j.apnu.2009.01.002

Dickens, G., Piccirillo, M., & Alderman, N. (2012). Causes and management of aggression and violence in a forensic mental health service: Perspectives of nurses and patients. *International Journal of Mental Health Nursing, 22*, 532–544. doi:10.1111/j.1447-0349.2012.00888.x

Donat, D. C., & McKeegan, G. F. (2003). Employing behavioral methods to improve the context of care in a public psychiatric hospital: Realizing improvements in the interpersonal behavior of direct-care providers. *Cognitive and Behavioral Practice, 10*, 178–187.

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52*(4), 469–476.

Espinosa, L., Harris, B., Frank, J., Armstrong-Muth, J., Brous, E., Moran, J., & Giorgi-Cipriano, J. (2015). Milieu improvement in psychiatry using evidence-based practices: The long and winding road to culture change. *Archives of Psychiatric Nursing, 29,* 202–207.

Faulkner, L. R., Grimm, N. R., McFarland, B.H., & Bloom, J. D. (1990). Threats and assaults against psychiatrists. *The Bulletin of the American Academy of Psychiatry and the Law, 18*, 37–46.

Fixen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature.* Tampa, Florida: Louis de la Parte Florida Mental Health Institute Publication.

Flannery, R. B., Farley, E., Tierney, T., & Walker, A. P. (2011). Characteristics of assaultive psychiatric patients: 20-Year analysis of the assaultive staff action program (ASAP). *Psychiatric Quarterly, 82*, 1–10.

Frick, P. J., Stickle, T. R., Dandreaux, D. M., Farrell, J. M., & Kimonis, E. R. (2005). Callous-unemotional traits in predicting severity and stability of conduct problems and delinquency. *Journal of Abnormal Child Psychology, 33*, 471–487. doi:10.1007/s10648-005-5728-9

Friedman, R. A. (2006). Violence and mental illness: How strong is the link? *The New England Journal of Medicine, 355*(20), 2064–2066.

Glynn, S. M., Liberman, R. P., Bowen, L., Kuehnel, T., Marshall, B. D., Gnanamuthu, S. (1994). The clinical research unit at Camarillo State Hospital. In P. W. Corrigan & R. P. Liberman (Eds.), *Behavior therapy in psychiatric hospitals* (39–59). New York, NY: Springer Publishing Company.

Hanley, G. P. (2012). Functional assessment of problem behavior: Dispelling myths, overcoming implementation obstacles, and developing new lore. *Behavior Analysis in Practice, 5*(1), 54–72.

Haring, N. G., & De Vault, G. (1996). Family issues and family support: Discussion. In L. K. Koegel, R. L. Koegel, & G. Dunlap (Eds.), *Positive behavioral support: Including people with difficult behavior in the community* (pp. 116–120). Baltimore: Brookes.

James, D., Fineberg, N., Shah, A., & Priest, R. (1990). An increase in violence on an acute psychiatric ward: A study of associated factors. *The British Journal of Psychiatry, 156*, 846–852.

Jansen, G. J., Dassen, T. W. N., & Groot Jebbink, G. (2005). Staff attitudes toward aggression in health care: A review of the literature. *Journal of Psychiatric and Mental Health Nursing, 12*, 3–13.

Jones, N. T., Menditto, A. A., Geeson, L. R., Larson, E., & Sadewite, L. (2001). Teaching social-learning procedures to paraprofessionals working with individuals with severe mental illness in a maximum-security forensic hospital. *Behavioral Interventions*, 16, 167–179. doi:10.1002/bin.090

Katzenbach, J. R., Steffen, I., & Kronley, C. (2012). Cultural change that sticks. *Harvard Business Review.* Retrieved from https://hbr.org/2012/07/cultural-change-that-sticks#

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy, 45*(3), 214–222.

Longo, D. A., & Bisconer, S. W. (2003). Treatment of aggression for an adult diagnosed with schizophrenia at a public psychiatric hospital. *Professional Psychology: Research and Practice, 34*(2), 177–179. doi:10.1037/0735-7028.34.2.177

Maier, G. J., Stava, L. J., Morrow, B. R., Van Rybroek, G. J., & Bauman, K. G. (1987). A model for understanding and managing cycles of aggression among psychiatric inpatients. *Psychiatric Services, 38*(5), 520–524. doi:10.1176/ps.38.5.520

Masterson-Algar, P., Burton, C. R., Rycroft-Malone, J., Sackley, C. M., & Walker, M. F. (2014). Towards a programme theory for fidelity in the evaluation of complex interventions. *Journal of Evaluation in Clinical Practice, 20*, 445–452. doi:10.1111/jep.12174

McGuire, J. (2001). What works in correctional intervention? Evidence and practical implications. In G. A. Bernfeld, D. P. Farrington, & A. W. Leschied (Eds.), *Offender rehabilitation in practice: Implementing and evaluating effective programs* (pp. 25–43). London: Wiley.

Menditto, A. A. (2002). A social-learning approach to the rehabilitation of individuals with severe mental disorders who reside in forensic facilities. *Psychiatric Rehabilitation Skills, 6*(1), 73–93. doi:10.1080/10973430208408423

Menditto, A. A., Valdes, L. A., & Beck, N. C. (1994). Implementing a comprehensive social-learning program within the forensic psychiatric service of Fulton State Hospital. In P. W. Corrigan & R. P. Liberman (Eds.), *Behavior therapy in psychiatric hospitals* (pp. 61–78). New York, NY: Springer Publishing Company.

Mertens, D. M. (2010). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (3rd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Papadopoulos, C., Ross, J., Stewart, D., Dack, C., James, K., & Bowers, L. (2012). Meta-analysis: The antecedents of violence and aggression within psychiatric in-patient settings. *Acta Psychiatrica Scandinavica, 125*, 425–439. doi:10.1111/j.1600-0447.2012.01827.x

Privitera, M., Weisman, R., Cerulli, C., Tu, X., & Groman, A. (2005). Violence toward mental health staff and safety in the work environment. *Occupational Medicine, 55*, 480–486. doi:10.1093/occmed/kqi110

Quanbeck, C. (2006). Forensic psychiatric aspects of inpatient violence. *Psychiatric Clinics of North America, 29*, 743–760.

Salekin, R. T. (2008). Psychopathy and recidivism from mid-adolescence to young adulthood: Cumulating legal problems and limiting life opportunities. *Journal of Abnormal Psychology, 117*, 386–395. doi:10.1037/0021-843X.117.2.386

Salekin, R. T., Rosenbaum, J., & Lee, Z. (2008). Child and adolescent psychopathology: Stability and change. *Psychiatry, Psychology and Law, 15*, 224–236. doi:10.1080/13218710802014519

Sanetti, L. M., Kratochwill, T. R., Collier-Meek, M. A., & Long, A. C. J. (2014). PRIME: Planning realistic implementation and maintenance by educators. Retrieved from: http://implementationscience.uconn.edu/wp-content/uploads/sites/1115/2014/12/PRIME_guide1.pdf

Secker, J., Benson, A., Lipsedge, M., Robinson, S., & Walker, J. (2004). Understanding the social context of violent and aggressive incidents on an inpatient unit. *Journal of Psychiatric and Mental Health Nursing, 11*(2), 172–178. doi:10.1111/j.1365-2850.2003.00703.x

Smith, J. A. (2008). Qualitative psychology: A practical guide to research methods (2nd ed.). Thousand Oaks: SAGE Publications, Inc.

Snyder, L. A., & Chen, P. Y. (2007). The underreporting gap in aggressive incidents from geriatric patients against certified nursing assistants. *Violence and Victims, 22*(3), 367–379.

Stickle, T. R., & Frick, P. J. (2002). Developmental pathways to severe antisocial behavior: Interventions for youth with callous-unemotional traits. *Expert Review of Neurotherapeutics, 2*, 511–522. doi:10.1586/14737175.2.4.511

Stickle, T. R., Kirkpatrick, N. M., & Brush, L. N. (2009). Callous-unemotional traits and social information processing: Multiple risk-factor models for understanding aggressive behavior in antisocial youth. *Law and Human Behavior, 33,* 515–529. doi:10.1007/s10979-008-9171-7

Titler, M. G. (2008). The evidence for evidence-based practice implementation. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses* (p. 7). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK2659/?report=reader

United States Department of Labor. (2015). Bureau of labor statistics: Occupational injuries/illnesses and fatal injuries profiles [Data file]. Retrieved from http://data.bls.gov/gqt/ProfileCharacteristics

Verloo, H., Desment, M., & Morin, D. (2017). Beliefs and implementation of evidence-based practice among nurses and allied healthcare providers in the Valais hospital, Switzerland. *Journal of Evaluation in Clinical Practice, 23*, 139–148. doi:10.1111/jep.12653

W. K. Kellogg Foundation. (2007). *Designing initiative evaluation: A systems-oriented framework for evaluating social change efforts.* Retrieved from http://www.wkkf.org/resource-directory/resource/2008/04/designing-initiative-evaluation-a-systems-orientated-framework-for-evaluating-social-change-efforts

Wong, S., & Hare, R. D. (2005). *Guidelines for psychopathy treatment program.* Toronto, ON: Multi-Health Systems.

Appendix A

Demographic Form

Participant Identification number: _____

Date: _____

Demographic information:

Age (in years): _____

Sex: _____

Ethnicity, Race, Immigrant or Refugee status: _____

Employment History:

Current Job Title: _____

Number of years at current job:_____

Number of years working within adult inpatient psychiatric hospital:_____

Please list any previous training or work experience with behavioral plans:

Population:_____ Training/work:_____

_____

Population:_____ Training/work:_____

_____

Population:_____ Training/work:_____

_____

Please list number of patients you currently work with that have behavioral plans:

_____

Appendix B

Recruitment Letter

To Whom It May Concern:

My name is Alyse Donovan, MS. I am a doctoral student in the Clinical Psychology Department at Antioch University New England. I am writing to ask you to join in my dissertation research. Do you work with adults in an inpatient psychiatric setting? Do you work with adult patients who have a behavioral plan because of aggressive behavior? If you answered yes to both of these questions, I'd like to hear from you! By talking to you I hope to learn what it is like for employees to actually use a behavioral plan. I hope to learn what is helpful, or not helpful, when trying to follow behavior plans in inpatient settings.

You may participate if you currently work in an adult inpatient psychiatric setting. You must also have worked with at least one adult patient who has a behavioral plan for aggressive behavior.

Your participation is voluntary. You may choose to leave the study at any time.

If you would like to be a participant, please review the attached information and contact me at Email@domain.edu.

If you do not want to be a participant you do not need to respond. If you know someone who may want to be a participant, you may pass this information along. You do not have to share this information.

Thank you for your time. I look forward to hearing from you.

Sincerely,
Alyse Donovan, MS

Appendix C

Semi-structured Interview Outline

1. What is your role in the implementation of behavioral plans?
2. How were you selected to do behavioral plans? How much of your time at work is spent working with behavioral interventions versus other tasks you are required to complete?
3. What types of training did you receive before you were asked to implement a behavioral plan? How did this training address the purpose, theory, rationale, and key-values of behavioral plans?
4. Can you tell me about the role that feedback plays during and after your training? How does this feedback effect your motivation to continue following the behavior plan? How do you stay motivated to continue implementing a behavior plan?
5. What is the referral process for a client that needs a behavior plan?
6. Who do you turn to when you have questions about delivering behavioral plan interventions? Is there someone who can provide in the moment training if you need it?
7. How are your skills with behavioral plan implementation monitored? How is your personal experience with behavioral plan implementation shared with your colleagues? How are issues that arise discussed and resolved?
8. Does your organization have the materials you need to conduct this behavioral intervention? Are there enough staff members available to carry out behavioral plans?
9. What is working in regards to behavioral plan implementation?
10. What is not working in regards to behavioral plan implementation?
11. What do you think you could do to improve implementation?
12. What do you think others could do to improve implementation?

Appendix D

Informed Consent Document

Study Title
Behavioral Interventions That Treat Aggression: Employees' Implementation Experiences within Adult Psychiatric Settings

Principal Investigator
Alyse C. Donovan, MS, ###-###-####, Email@domain.edu
Antioch University New England

To Whom It May Concern:

My name is Alyse Donovan, MS, and I am a doctoral student in clinical psychology at Antioch University New England. You are asked to join this study, as you are a member of the adult psychiatric inpatient work force. I am interested in learning what helps, or does not help, you follow a behavioral plan for your patients. I am also interested in learning what you believe could better the process of using a behavioral plan with patients.

If you would like to be in my study, you will speak with me for an interview lasting 45 minutes to one hour. During this interview you may be asked for your opinion about behavioral plan procedures at your workplace. I will also ask you to provide some information about yourself (for example: age, sex, job title). Any personal information that you share will be kept strictly confidential according to HIPAA laws. For example, your name will not be known by anyone except me. I will replace your name with an identification number on all data and files to protect your anonymity. Interviews will be audio recorded so that everything said is accurately documented. All audio files will be encrypted to secure confidentiality. After I type the interviews, the audio files will be destroyed. All files associated with this project will be encrypted and kept on a password-protected computer. Signed consent forms and demographic forms will be kept in a locked cabinet for up to seven years after this study is completed. After seven years all paper documents will be shredded.

Participation in this study will consist of one telephone interview. You may make this call during work hours if you get permission from your supervisor to do so. A risk in calling while at work is that your employer will know you chose to be a participant. You may also make this phone call outside of work hours. This option lets you make the call at a place and time that is convenient to you, and you do not have to ask permission or even tell your supervisor you made the phone call. If at any time during and for one month after your interview you want to exit the study, contact Alyse via email at Email@domain.edu or by telephone at ###-###-####. There is no penalty for ending the study early.

All personal information will be kept anonymous in the data files and final dissertation document. Your employer will not be notified of your choice to participate or not to participate. Your employer will have access to the finished dissertation document. There are several benefits for this study. These benefits include increased knowledge about which resources employees think they need, how to improve safety for employees, and how to support employees who participate in behavioral interventions. A potential risk to you as a participant is the re-occurrence of negative feelings or memories about a time when a patient became aggressive with

you or a co-worker. Another potential risk is that other employees will be able to read the final dissertation document, and may be able to guess who answered interview questions; especially if he or she were also involved in an incident you talk about.

If you have any questions about this study, you may contact the primary investigator Alyse Donovan, MS via email at Email@domain.edu or by telephone ###-###-####. If you have any questions about your rights as a research participant, you may contact Kevin Lyness, Chair of the Antioch University New England Institutional Review Board (IRB), at telephone ###-###-#### or Melinda Treadwell, AUNE Provost, at ###-###-####.

Consent Statement:

I have read and understood the information above. I consent to take part in the research described above.

Participant's Full Name

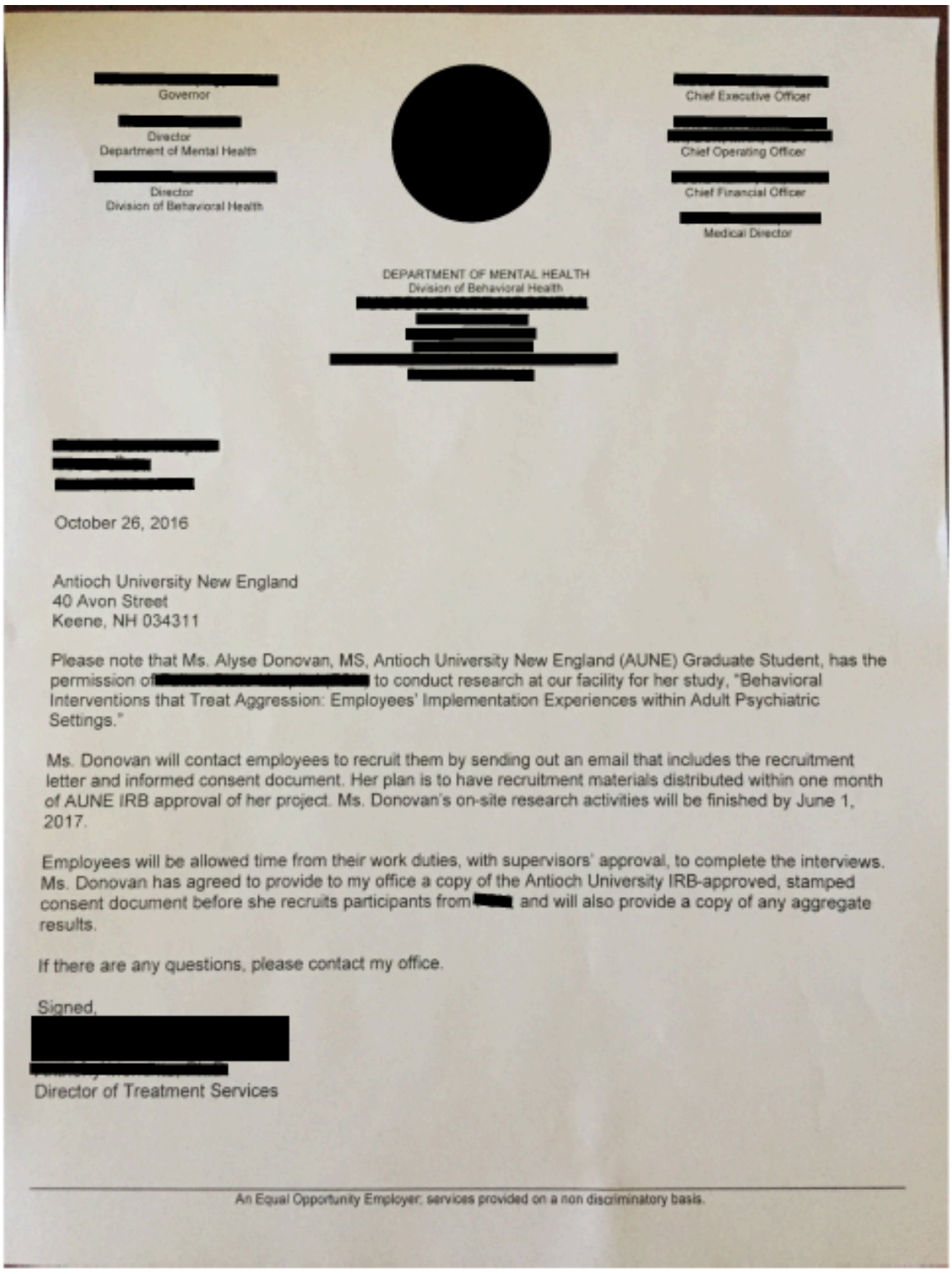
Participant's Signature

Participant's Phone Number and Email Address

Primary Investigator's Signature

Appendix E

Data Collection Permission Letter



[redacted]
Governor

[redacted]
Director
Department of Mental Health

[redacted]
Director
Division of Behavioral Health

[redacted]

[redacted]
Chief Executive Officer

[redacted]
Chief Operating Officer

[redacted]
Chief Financial Officer

[redacted]
Medical Director

DEPARTMENT OF MENTAL HEALTH
Division of Behavioral Health
[redacted]

[redacted]

October 26, 2016

Antioch University New England
40 Avon Street
Keene, NH 034311

Please note that Ms. Alyse Donovan, MS, Antioch University New England (AUNE) Graduate Student, has the permission of [redacted] to conduct research at our facility for her study, "Behavioral Interventions that Treat Aggression: Employees' Implementation Experiences within Adult Psychiatric Settings."

Ms. Donovan will contact employees to recruit them by sending out an email that includes the recruitment letter and informed consent document. Her plan is to have recruitment materials distributed within one month of AUNE IRB approval of her project. Ms. Donovan's on-site research activities will be finished by June 1, 2017.

Employees will be allowed time from their work duties, with supervisors' approval, to complete the interviews. Ms. Donovan has agreed to provide to my office a copy of the Antioch University IRB-approved, stamped consent document before she recruits participants from [redacted] and will also provide a copy of any aggregate results.

If there are any questions, please contact my office.

Signed,

[redacted]
Director of Treatment Services

An Equal Opportunity Employer; services provided on a non discriminatory basis.

Appendix F

Table 1

Conversational Analysis Interpretation

Identifier	List of Themes and Text to Support Themes	Reference to Interview Transcription
1. Employees' Roles in Implementation	Psychiatry has a minimal, supervisory role with behavioral plan implementation. • Umm… I'd say it's mainly supervisory, uh the system at (hospital) uses the psychiatrist is sort of an indirect supervisor," [mm hmm] "…and I guess ah, this sounds terrible but the best way that I could explain it is sort of like Queen of England, a fancy title but very little power." [Okay.] "(Laughs) Uh, but I'm required to participate in state occasions like um... treatment plan reviews," [mm hmm] "…things like that. Um, I'm free to give my input, I would say that our FRS, our aid staff, have uh, do the majority of the heavy lifting regarding implementation."	P1, p. 1, lines 2-13
	Social Workers are responsible for formulating the behavioral plan. • "Yeah, so we are working on a two-to-one one for (patient), um and my role was basically coming up with like the criteria for that, um, and honestly I used ones that were already in place," [Yeah!] "…um, also finding where it needed to be specialized to meet his specific, um, issues, as far as claiming he has a shank, that sort of thing." [Okay.] "More the low level behaviors that then escalate to aggression, like the horse playing with staff and stuff."	P2, p. 1, lines 3-11
	• "Uh, as a team member I try to make an analysis about what the person's motivations are and how they would work best. Um, and and I'd like to try and see if I could put some positives in there." [Mhmm] "I like it to be more positive," [mhmm] "…then find, and tweak it whenever that doesn't work, find something new, sometimes even be flexible enough to change people that aren't working well with me or someone else and whatever's needed."	P4, p. 1, lines 2-10
	Psychologists author, educate staff, collaborate with patients, and initiate implementation of the behavior plan. • "So, I would be the one to author the behavior plan.	P3, p. 1, line

	And I would also play a role in educating staff about why we are doing it. I would also play the role in explaining it to patients, and getting approval though the treatment counsel. So, in a lot of ways I would be the one implementing or initiating the intervention."	2-6
	• "Um, because I think some of that responsibility as a clinician to, to get buy in for an intervention, it falls on us. Like, we have to learn how to sell this and explain the rationale for it in a way that's more effective for our direct care staff."	P3, p. 4, line 99-102
	Activity aides collect behavioral data and report observations of patients to the Treatment Team.	
	• "Behavior plan, my role is mainly as an observer. Um, even as a part of the treatment team currently my role is still very minimal." [Okay] "So it's more, reporting back to the team leaders what behaviors we see occurring. What is a behavior that needs to be, um, changed, or what is a behavior that we need to praise. Praise is good." [Okay] "So it's more of observing what the clients are doing and what role they are taking towards improving."	P5, p. 1, line 6-14
	Floor Staff collect behavioral data, report observations to Treatment Team, and implement behavioral interventions with patients.	
	• Well... umm… I don't know we report stuff that we see and that goes into, well I would hope it goes into, making those plans." [Yeah. And when it comes, when there is a behavior plan on the floor, are you involved in that at all, like um, like out on the unit?] "Well yeah, we are the ones that have to fa... I don't know; facilitate it, would that be it? We actually have to do it."	P6, p. 1, line 2-7
2. Selection of Employees for Implementation	Employees believe their role in implementation of behavior plans was part of their job description.	P1, p. 1, line 16-23
	○ "Yeah, we have a bylaws for the medical staff uh where that's outlined, and we also have policies and procedures at (hospital), and we also have procedures through CPS, which stands for uhh… something psychiatric services, uh centralized or something." [Okay] "That's what runs the whole department," [Okay] "…and this is all formulated and written down."	
	○ "Um, I was his case manager, so I was it, yeah!	P2, p. 1, line

	[Laughs]" o "Um, well, uh, primarily the license will get you into that role. Uh, in the interview process to put you into that decision making spot on the team." o "Well as a FRS, actually I am still in that role currently, I am in that position as PRN, um, after finishing college I decided that I wanted to do something different before I move on. So I applied for the Activity aide job, I was interviewed and then I was granted the job. And then observative role comes along with the position." [Okay.] "Because we are the Activity aides, we create activities, we plan some of their daily movements, and as a result we have to observe their behavior, record, and chart whatever behavior that is shown." o "We're just told to do it, they print it out and give it to us." Psychologist selected for role in implementation based upon education and previous training. o "Um, as a psychology resident on the unit, uh, I'm the only with a psychology background. I am the one with the most amount of training." [Okay.] "I don't have a supervisor who works on the unit, or anyone who has more expertise in that area. Um, and sometimes there's a behaviorist who works somewhere in the hospital who might be available, um, for consultation and sometimes he's not available and you are the best option."	17 P4, p. 1, line 20-21 P5, p. 1, 18-26 P6, p. 1, line 11 P3, p. 1, line 10-17
4. Behavioral Intervention Referral Process for Patients	Direct observations by nurses, floor staff, professional staff contributed to formations of behavioral plans. o "But as a psychologist, I'm always kind of looking out for people that would be good candidates for that." o "Uh, um, pretty much we are looking for ongoing behaviors that are not going to be useful, either on the ward or in the community." o "Now that mainly comes through FRS, communicated from the FRS to like a Case Manager or a Social Worker. Um, say for instance a client is exhibiting a certain behavior, over a period of time, and that gets communicated from the FRS that keep observing to the social worker, the Rec Therapists or the Case Worker. And that information is brought back into one of our team meetings."	P3, p. 4, line 110-111 P4, p. 6, line 175-176 P5, p. 5, line 148-153

	○ "Yeah, I do all the time when I think that someone needs one. I bring it to the team."	P6, p. 3, line 78-79
	Professional staff create behavioral interventions that are then approved by administration.	
	○ "Um, usually it seems like the team will talk about it and say this is a good recommendation based upon the feedback from either what they've observed or what staff, like the frontline staff, has observed, the nurses. And um, afterword and all that they send it to the treatment counsel for approval for like the two-to-one protocols and stuff like that."	P2, p. 4, line 113-117
	○ "And then the team comes up with a plan to move forward to help this person to get better. And then it's passed onto administration for approval."	P5, p. 5, line 155-157
Training on Behavioral Interventions at this Hospital	Floor Staff and Psychiatrist are not given training specific to behavioral plan implementation at this hospital.	
	• "Well, um there that's that's a great question because there was no formal training I don't believe I ever received," [Okay]. "…at (hospital), I do know that other professional staff have opportunities to be trained ah, in what they want in behavior plans, but I have never been asked or required to attend.	P1, p. 2, line 40-45
	• "…the time we spend on ridiculous stuff, uh, like it's bad to call your colleagues names, if you don't know that, you shouldn't have been hired," [Right. (Laughs)] "…uh, you know, I just get so frustrated with some of that stuff that, that just ought to be basic human understanding."	P1, p. 9, line 259-263
	• "Um… well we just got training in here about how to handle like certain, um, like disabilities or whatever. The actual behavior plans we don't actually get trained on, they just make them up and they give it to us and they, if we have question they will answer our specific questions as we go along."	P6, p. 2, line 34-38
	Professional Staff are given training specific to behavioral intervention implementation at this hospital.	
	• "It was… hmm… there was definitely some theoretical stuff that he covered as far as, um, how the anti-social individual and their personality and behaviors develop," [Okay] "…and what might contribute to that."	P2, p. 3, line 65-69
	• "So I have one supervisor who's a behaviorist. And	P3, p. 2, line

	she provided me with a plan that she's had approved by the treatment counsel. And, um, with her, she um, the plan was for someone who her team could not get to shower. And so they showed me how they handled that and the actual plan that was implemented."	39-43
	• "I think seeing the way that it was actually implemented by a supervisor was helpful," [Okay.] "…and probably the right amount of training, um, that I needed."	P3, p. 2, line 49-52
	• "Um, we are supposed to do like in-services whenever we implement one of those and make sure that all the staff are aware if there's a two-to-one protocol implemented or whatever. Um, and then, a lot of time there's lots of emails going out to the people who have email access (laughs)."	P2, p. 5, line 143-146
	• "Yeah, I don't know that it's an official one that you have to sign, but they will actually bring people, like pull FRS off the ward and have someone go into coverage for them so that they can read it to them."	P2, p. 5, line 149-151
	• "Yeah, they sure did. Those were mainly, um, carried out during um SMART training." [Okay.] "Um, we had one session on punishment versus um, rationalization, and that kind of stuff so…" [Yeah.] "…reinforcement, so, that was good towards that, so that was good."	P5, p. 3, line 86-92
	Professional Staff received training on interventions for the population specific to the treatment program.	
	• "Yeah, mostly just training about the different behaviors and then the interventions that are effective with different populations, like the anti-social population. Um, and then the basic trainings that we go through here about, about different interventions."	P2, p. 1-2, line 31-34
	• "Um… well.. would like the, like the one that's specific to the anti-social population I think that's just (treatment program) people." [Oh, okay! So I probably haven't gone through it yet.] "Well I'm thinking about the one, I don't think you were here yet, that the Neil Kirkpatrick guy did before. I don't know what it will look like this time, if it's similar or not."	P2, p. 2, line 52-57
	• "Um, well, up on (treatment program), the first training that I went to was the general SMART training." [Okay.] "Um, typically all staff goes through. Um, I did that at the beginning of my employment as a FRS. And I've been in SMART	P5, p. 3, line 71-80

	training and NEO since to do the refresher course. Um, upon selecting the position as an Activity Aid, I was in orientation for two, two and a half weeks, where I was mainly observing other Activity aides and um, Rec Therapists, and seeing how they carry out their duties on a daily basis, which gave me the tools to do my job"	
Feedback	Psychiatrists do not receive feedback specific to their performance with behavioral interventions. • "Not really, I can tell you that again, there is a formal mechanism for feedback in general…" • "…and that's done by the immediate supervisor at least once a year." • "It's it is a written, uhh, document that you get every year that you acknowledge with your signature." • "Again, I don't think there is a specific mechanism to monitor that aspect of my, uh, duties." Treatment Teams and Administration give authors of behavioral interventions feedback on the written intervention. • "I mean other than that, I, I've usually sent them to (Team Leader) first to review and then for the feedback and then to the Treatment Counsel and then unless they've said something I don't really get any other monitoring that I'm aware of. (Laughs)" • "Um, yeah, it was directed more at the actual plan it self, not what I could do differently, but like, um, like this part might be too strict. Like when I said if he refuses to be searched, then we put him in a manual hold and search him anyway, just because of his history with weapons, and I think that they ended up scratching that part out because they wanted to leave it up to more of the nurses discretion. Which was fine with me, the nurses of course, with their different opinions, were a little… they were afraid of getting in trouble. So when it was in writing that it was up to the nurses discretion, they felt more comfortable with it." • "So, it's monitored in a few different ways. Um, at this hospital we go through Treatment Counsel any time a behavior plan is implemented. And so, um, regardless of whether we are using punishments or rewards, um, we would need to get approval." • "So it would go before a committee with at least one psychologist and someone from administration so that you had some ethical checks. And hopefully it would	P1, p. 2, line 53-54 P1, p. 2, line 58 P1, p. 3, line 60-61 P1, p. 6, line 157-158 P2, p. 5, line 134-137 P2, p. 3, line 84-92 P3, p. 5, line 149-152 P3, p. 5, line 154-157

	go through a peer who's knowledgeable in this area before you submitted to Treatment Counsel."	
	• Yeah, especially if they go up to a target behavior, those go all the way to administration	P4, p. 9, line 257-258
	Frontline staff members receive limited feedback in regards to their delivery of behavioral interventions.	
	• "There is not someone that is always present in the moment to give you your feedback so you have to sometimes just wing it and figure it out and hope that you are doing the best. And then there is other times that people are directly there and you can say how did I do with this, so that you can get feedback in the moment. But um, with the number of staff, and the staffing issue that we face, it is kind of hard to always have somebody around to give you the direct feedback there," [Yeah.] "…right there."	P5, p. 6, 177-185
	• "Um, we have a, the supervisors there to go over our notes that we write, our chart, our… and give you also feedback on what's going on or what they think, or what needs improvement, and what not."	P6, p. 2, line 53-59
	• "(pauses, sighs) I don't really, I don't think so. [Okay.] Unless something goes wrong (laughs) then we are told. [(Laughs) So is there any positive feedback ever?] Not really, no. [That's really sad!] Yeah, that's one of the perks of working here."	P6, p. 2, line 53-59
	Staff members believe feedback is helpful to implementation of behavioral interventions.	
	• "Um, well, the client I find gives the best feedback." "And that they, they know how to live in their bodies or they can tell you how it is to live in their bodies."	P4, p. 3, line 86-89
	• "I think that's really important because I think sometimes as a clinical staff member um, I'm not that one who is primarily responsible for enforcing it, because I'm not on the unit all the time like FRS and so, um, the questions that come up, ah, the ideas that I had may not always be easily implemented, or we might be asking too much of a patient, and so I think the feedback that you get from supervision and then from your teammates and sometimes even from the client let's you know how you need to modify a plan. And I think sometimes staff are really quick to say that something is not working," [mhmm] "…but I think a lot of times you just have to think more flexibly about the plan and see what adjustments you	P3, p. 2-3, line 62-77

	can make." [Okay.] "So I think, you almost never get it right the first time," [mhmm] "…you have to be able to modify it until you get a better outcome." • "Um, I appreciated it to try and make it where it was more, um, reasonable for staff. I didn't want it to be something where they were going to get set up for getting written up if they didn't do something."	P2, p. 4, line 95-97
3. Time Each Disciple Spends on Behavioral Plan Implementation Tasks	Psychiatry • "I'd say prolly an hour a day, about 5 hours a week."	P1, p. 2, line 35-36
	Social Work • "Umm… well it varies a lot depending on where he's at because he swings back and forth so much between good and re-really struggling." [Right.] "When he's really struggling I probably spent like 6 hours a, a week. Right now, not really any, just waiting…"	P2, p.1, line 22-26
	• "I would say it could be like 25 to 35% of the time."	P4, p. 1, line 26
	Psychology • "Yeah. This year I really wanted to have more time to do that." [Mhmm] "And I've been so bombarded by case management responsibilities that I've devoted less time to the clinical interventions that take so much work to craft and to carry out. So I'd say in other settings, in other hospitals where um, I haven't had case management responsibilities, where I had a lot of freedom to do clinical work, I probably spent 10 to 20% of my time on behavior plans. Um, this year I've had good intentions of doing them with several clients, and I just never get around to it."	P3, p. 1, 21-29
	Activity aides • "So um, for us we, right now we have 28 hours of full on contact time," [Oh wow] "…with these clients. Um, in this 28 hours in any given day or week it can change from 28 to 34 hours easy," [Okay.] "…um, based on what we are doing."	P5, p. 2, line 46-51
	Floor Staff • "Um… (counting) well if you are talking like one-to-ones I guess probably like 24 hours of the week or	P6, p. 1, 23-26

	something like that probably." [That sounds like a lot of time to be one to one, it sounds like a lot!] "Well today I sat for 6 hours straight so…"	
Communication with Treatment Teams	1. Treatment Teams have good communication amongst team members. • "Well, now, and this is one of the positive aspects, I found in 20 years, I would say almost virtually every team I've worked on has been very collegial, and we've gotten along, respected each other, uh, been able to talk in the team meetings. Of all the things that I do, I think that the time spent in the team meetings is probably the best use of my time and I think it's, it's where patients probably get the best care and formulations when everybody is kind of together," [hmm] "…because somebody always knows something that somebody else doesn't know, "oh, the other night he did this," "O gosh! The other night his mother died!" There's always good information sharing," [mmhmm] "…and I think that leads to the best formulation of treatment plans, and I would carry that over to morning report. I think that the morning report and the team time, when the most people are together I think that we do the best."	P1, p. 6, line 161-176
	• "So uh, I I think it's pretty, pretty democratic where everybody gets a say without fear of being shamed or put down because of the level of education so, I, I think it's a pretty good system."	P1, p. 7, line 184-186
	• "What I think is working, and it's sort of redundant here, is the collaboration between professional disciplines and the collaboration between professional and non-professional staff. I think we do that pretty good."	P1, p. 7, line 204-207
	• "Um, the nurses have been helpful to things I didn't see or notice that they pointed out and said "Oh, we probably want to add that in there."	P2, p. 5, line130-131
	• "(Sigh) Uh…. I, I, yeah, yeah. I would send, I would send it out in emails and say, "what do you think?" Usually I send them out to the overall team and if I think it needs to be looked up a little higher, um, some, some of the clients are high profile so I always get administration's side."	P4, p. 8, line 247-250
	• "Yeah, you can always ask one of the team leaders, they are pretty knowledgeable and if they are not able to answer you directly right there and then, they will tell you that they will get back to you and they will	P5, p. 6, line 161-169

	find an answer for you." [Okay.] "So um, I think that the team we have in place is pretty good with um, passing along information and getting information."	
	• "Uh, we have um, team meeting once a week where you come and you discuss what happened. Discuss certain client behavior or anything like that, issues that need to be brought to the attention of everyone, and a decision is made within the team, if it's something simple, the decision can be made right there and then." [Okay.] "If it's not, then the team leaders arrange to speak with um, other administration level, and then it's related back to us," [Okay.] "…what the decision is."	P5, p. 7, line 207-216
	2. Treatment Teams document behavioral interventions in electronic medical record.	
	• "Usually they are posted, well the plan should be posted for the treatment plan if there is going to be a behavioral element that we are going to do it's going to be on the, the um, what is it, the electronic medical records. We try to put those into the um, uh, the overall plan but most of the time that will be, um, um, uh posted some place," [Okay] "…in, in the uh shift reports! Plus we also do, um, I've done this on a couple of people, um where we have like a, um, we don't put it in the chart, it's sort of like a check list when and most of the time it's just like when an avoidance or an extinction is the best way to do that."	P4, p. 10, line 281-290
	• "Um, that is in their chart. It's on, it's on um a list. It's a part of our access, you have access to the clients and their behavioral chart. What makes them go off, what's safe for them, what to look for," [Okay] "…in terms of agitation, and um, if they will become aggressive, that kind of stuff. Now, it's not 100% always accurate," [mmhmm] "…but it is very helpful."	P5, p. 4, line 118-125
	Communication amongst Treatment Team members needs improvement.	
	• "Um, we have morning meetings, which is like a 30 minute time period where the whole team's present um, and we talk about clients and various issues on the unit. And we also have a treatment team meeting but unfortunately direct care staff aren't involved in that. Um, and so there's not always a great time to come together as a team to navigate treatment issues	P3, p. 6, line 174-182

	because um, because of issues with staffing, it's hard to get everyone in the same place at the same time. And those 30 minute morning meetings aren't enough time to discuss 50 patients in any meaningful detail."	
	• "Well some of it is really good. Um, again, we don't live in a perfect world," [Yeah…] "…in a perfect world it would have been perfect." [Yeah.] "So then some is good and some is, there is some aspect of it that needs work."	P5, p. 7, line 196-201
	• "When we actually give a target behavior we document it and for the behavior plans I try to write in the, um, what's it called, the chart, what's it called? Oh! (Electronic medical record), that on the computer I make notes that, when I have time, that's directed toward their um plans if they're doing good things or bad things." [Okay] "Not just always bad." [Okay, and do, is that a job that mostly FRS IIs would be responsible for putting in…] "No we are all supposed to be."	P6, p. 3, line 86-95
3. This hospital has all of the tangible materials for the Behavioral Interventions	• "Well, I I would think so and I guess most of the resources would be intellectual resources. I don't, I don't know that there's any programs and, um, literature or material that we lack so…"	P1, p. 7, line 190-192
	• "Well when it comes to like the aggression one, yes, anything that's more complex than that, maybe, but we just don't do it enough for me to know for sure."	P2, p. 6, line 175-177
	• "Yes! And, um, each program in the hospital has budget resources, so if I wanted to come up with rewards like, say I wanted to take someone to the canteen once a week if they were engaging in safe behavior, I could get $3 a week approved by my treatment team leaders. So there's good resources in place, even outside of the program that is behaviorally based."	P3, p. 6, line 186-191
	• "Yeah. For example we have one client that is um, when he starts um, showing, uh, not so appropriate behavior," [mhmm] "…to intervene with his behavior it is simple. With him it's just more of a distraction in the moment and then after distracting, then you can create an environment where he feels a little bit more comfortable and he will eventually talk to you." [Mmhmm.] "But um, we have some very big, spongy dice," [mhmm] "…as soon as he starts acting up you present those dice to him and he's out there rolling	P5, p. 8, line 227-242

	them by himself." [Yep!] "It calms him down, then you can actually go in and talk to him." [I've seen him rolling those dice, yep.] "It's pretty neat! (Laughs)"	
There are NOT Enough Staff to Implement Behavioral Interventions	More nurses are needed for behavioral plan implementation. • "Uhh no. And I would specifically point to nursing staff. Because, the, by design, in all hospitals especially mental health hospitals, the professionals that really deliver the services and supervise non-professional staff are the nurses, and we, we just don't have them."	P1, p. 7, line 195-198
	More floor staff are needed for behavioral plan implementation. • "No. I don't think there's enough staff anywhere." [Period?] "Yeah, even when we are not implementing like a two-to-one or something like that."	P2, p. 6, line180-183
	• "Um… (paused). That's tough, I mean we are definitely under staffed, but in a way the more staff you have involved the harder it becomes because the more staff you have to educate," [mhmm] "…um, you know sometimes we're not, I think the one thing that we're not really good at that's often addressed in a behavior plan is when someone engages in unsafe behavior they are going to be place on one-to-one or two-to-one, but we often don't actually have the staffing to follow through with that. Um, and so I think that's a major issue where staffing comes up."	P3, p. 7, line 194-202
	• "But um, with the number of staff, and the staffing issue that we face, it is kind of hard to always have somebody around to give you the direct feedback there," [Yeah.] "…right there."	P5, p. 6, line 181-185
	• "Not even by a long shot! (Laughs) Not even close."	P5, p. 8, line 246
	• "(Laughing) Not even close." [(Laughs) Okay, what type of staff do you think we need more of?] "We definitely um, need more FRS. Um, believe it or not they are, while they do not present um, case managements per say for clients," [mmhmm] "…they are always very important. They are the safety line between administration and the staff, professional staff AND the clients." [Right.] "A lot of clients perfectly interact with a FRS, even than with a case worker or a psychiatrist."	P5, p. 8-9, line 248-257
	• [And do you think that there are enough staff members to carry out all of these behavioral plans…]	P6, p. 4-5, line 126-132

	"No." […and interventions?] "No, definitely not." [Everyone has answered no, every single person that I talked to] "(Laughs loudly)"	
Floor Staff are Highly Valued	4. The other hospital disciplines think floor staff are valuable to behavioral plan implementation. • "There's a push to make sure entry level staff and FRS that we listen to them they literally spend the bulk of the time with the patient." • "The FRS are just wonderful they, they see these people 24/7. They, they a lot of times can just tap you on the shoulder and say, 'Check this out.'" • "They are always very important. They are the safety line between administration and the staff, professional staff AND the clients." [Right.] "A lot of clients perfectly interact with a FRS, even than with a case worker or a psychiatrist." Floor Staff do not receive positive feedback about their role in behavioral plan implementation. • [So is there any positive feedback ever?] "Not really, no." [That's really sad!] "Yeah, that's one of the perks of working here." [Wow, only negative.] "(Laughs)"	P1, p. 7, line 180-182 P4, p. 8, line 237-239 P5, p. 8-9, line 253-257 P6, p. 2, line 56-61
Interactions between Administration and Treatment Team	The Treatment Counsel/members of administration are too far removed from daily activities of patients. • "Well, well I suppose in our institution we have a nebulous entity called, uh, what is it called, um, the um, and I just dealt with them this week, umm… ah, (laughs) can you help me?" [(Laughs) I can't remember either!] "Uh... what is it? Um, the Treatment Counsel! Yes!" [Ah yes! There we go (laughs)] "(laughs) The *Treatment Counsel* is supposed to be there to assist any team or team member in formulating a particularly difficult case." • "One of my criticisms was, and one of the expectations at this meeting that I had with them this week," [Uh huh] "…was that I thought we were actually going to see the patient." [Okay] "Because I really thought that they needed to get a gestalt from the clinical presentation and they had no intention of doing so. And uh, apparently they never do." [Huh!] "It's all chart or it's all from uh, the professionals who are getting the referral." • "Sure! I mean, I, it it, it's sort of like, you know Moses comes down from the mountain, with this	P1, p. 3-4, line 83-90 P1, p. 4, line 107-117 P1, p. 10, line 280-287

	treatment plan, and, and I've got this on a tablet and if you all don't follow it exactly, you know, you are never going to see the Promised Land, and it's all you hear. So um it, uh, and frankly, some of the suggestions are completely ridiculous. And there's no give and take, there's no body there to even say 'Oh! By the way we can't do that because Joe's in a wheelchair,' so we, whatever. It's, uh, it's completely inadequate…"	
	There is a breakdown in communication between the Treatment Team members and members of administration. • "Ah, I, again, and this is a major flaw of our program, I've been told in the past that even as a physician, I'm just not allowed to call anybody, on, on the, in the administration…"	P1. p. 5, line 125-127
	• "…and so, so because I'm so deferent to their wishes, I usually ask the Team Leader of that team," [mmhmm] "…if they will contact," [Okay.] "…and I'll say okay (name6), here's my question on what we need to do with (patient1)," [mmhmm] "…and please ask the Team Counsel this, [Okay.] "…and the Team Leader takes all of those questions I guess."	P1, p. 5, 133-142
	• "Um, but I, I do think there's a disconnect. And also, there's just a disconnect with day-to-day activities. They get a report as you probably, know, I don't know if you get it, about like seclusion and restraint and adverse events every day." [Mmhmm] "Ah, they also get a report on a census that will tell them if somebody matriculated to a less secure facility, but small gains and stuff they are completely oblivious."	P1, p.8, line 226-233
	Slow administrative decisions hurt the effectiveness of behavioral interventions. • "…if we have a behavior plan and somebody does well, and we are at the reward stage, and we put in a packet for passes and it sits on someone's desk for two months," [Yup.] "…the, the patient gets the message indirectly that their hard work and behavior didn't matter because it didn't result in a change." [Okay, so it seems like some of the administrative paperwork could be slowing down some of the reward.] "It's painfully slow, and they will say it's a lack of personnel over there, but as far as I know they don't have any unfilled positions." [Okay.] "So I, I don't understand how that's possible."	P1, p. 8, line 213-224

	• "Unfortunately for the people who are implementing it in there, a lot of times they defer until the treatment team comes back," [Okay] "…and then we discuss it, hash out the details. If it's something that's a major emergency, I think they call the AOD, so Administrator on call? I don't know, whatever those initials are." [Okay.] "So the administrator person that they can call after hours, or (Team Leader), I assume." [Okay, so yeah. So if something in the middle of the night happens and they realize this plan is totally wacky,] "Yeah." […they can either wait until we meet in the morning or they could call someone on call who can make the decision to change it.] "Ummhm"	P2, p. 6, line 157-171
Consultations	Multidisciplinary employees seek peer support with behavioral plan implementation.	
	• "I would probably go to a psychiatrist peer," [Okay] "…so I would probably as (psychiatrist1) or I would ask, uh, he'd probably be the first one I would go to or, perhaps (psychiatrist2) my immediate supervisor."	P1, p. 6, line 149-153
	• "Um, so definitely just peer support," [Okay] "…is pretty much the main thing, like knowing I'm not alone in working on this. Somebody else can help me with it."	P2, p. 4, line 105-108
	• "But then also um, I think having other people around me with similar open minds, because it, it, I'm not always right." [Okay.] "I think that it's okay if someone says '(Participant4) what about this?' and I say 'I hadn't thought about that, it's a good idea.' Also listening to your peer on what will work and what won't work," [Yeah.] "…all around working together. I can think of, there's several people on the staff that I'll like automatically go to and say 'What do you think?'"	P4, p. 3-4, line 94-102
	• "Um, or if it's not a client that I have a lot of direct experience with, I might find it beneficial to talk with the primary case manager or psychiatrist or clinician on the case, um, to get more information. And it may not be in the records."	P.3, p. 6, line 165-169
	• "Uh, we have um, team meeting once a week where you come and you discuss what happened. Discuss certain client behavior or anything like that, issues that need to be brought to the attention of everyone, and a decision is made within the team, if it's something simple, the decision can be made right there and then."	P5, p. 7, line 207-211

	• "Their case manager." [Okay.] "That's usually who I would go to."	P6, p.2, line 42-44
	• "Out of our case managers I would say it was (social worker)! (Laughs) She's probably the only one that like in the moment makes decisions that I can think of."	P6, p. 2, line 48-50
	Multidisciplinary staff members seek behavioral intervention consultation from those in leadership positions (i.e. Team Leaders, members of administration).	P4, p. 8, line 234-235
	• "But (Team leader) is a good resource, (Head of Social Work) is a good resource, and (Head of Psychology), she's very good.	
	• "Yeah, you can always ask one of the team leaders, they are pretty knowledgeable and if they are not able to answer you directly right there and then, they will tell you that they will get back to you and they will find an answer for you."	P5, p. 6, line 162-165
	• "If it's not, then the team leaders arrange to speak with um, other administration level, and then it's related back to us," [Okay.] "…what the decision is."	P5, p. 7, line 213-216
	• "Uh, we, I just document it on the computer and um, well we have our communication book where we ask questions, but yeah just bring it to the team." [Okay.] "Let them know."	P6, p. 4, line 107-111
	Psychologist seeks consultation with employees that have Behavioral Theory training and/or behavioral plan implementation experience.	P3, p. 4, line 120-122
	• "Um, and if I wasn't sure if it would be helpful, I would consult with the supervisor, or our behaviorist who works at the hospital and who's primary training is in creating these plans."	
	• "I definitely look to someone who has um, more of a pure behavioral approach, like my secondary supervisor this year, or the behaviorist who has specialized training. Because while I have the most training on my team in this area, I definitely don't have the most training in the hospital in this area, so I just look to someone who has more knowledge in implementing these plans and more experience."	P3, p. 5, line 128-133
	Floor Staff supervisor seeks consultation with other floor staff members.	P3, p. 6, line 164-165
	• "I may not know all the unit rules and it may be very helpful to go speak with a FRS about what the	

	restrictions are." Social Worker consults with the clients to formulate behavioral interventions. • "…a lot of the times the client's come up with the best way to change their behaviors," [mhmm]"…then, then I could ever come up with because they know their own motivations of what they want to do." • "If you don't talk to them," [yep] "…then you don't know the information, and it becomes a problem." [Mhmm] "You're addressing something that probably they didn't need the doctor about that."	P4, p. 2-3, line 60-65 P4, p. 7, line 200-205
Motivations to Continue with Implementation Tasks	1. Multidisciplinary staff member are motivated by patient progress in treatment. • "Well I tell the patients this all the time, I do believe this and I now its kind of cliché to trite, but what I say is 'If I were a used car sales man and I had the same cars on the lot last year that I did this year, I'd be a pretty bad salesman.'" [Mmhmm] "So I tell them, because the frequent resistance I get is, 'You don't care that I'm here, you get paid more if I stay longer,' and I say 'Nope it is quite the opposite,' I said, 'The only job satisfaction I get is when you move on in treatment,'" [Right!] "…and that is true, it's not just hyperbole for their benefit." • "And I think we, we have to look at small elements of things that have changed, because um, these people come from a *very* bad background and they grew up with such non-useful tools," [mhmm] "…and uh, um, just the openness or, or 1. wanting to have an understanding and 2. of what they have dealt with and how they have survived this long." [Mhmm] "And, and then try to teach them better ways, it's not always easy." [Mhmm] "It's um, they have, sometimes 50, 60 years of experience doing it their way." [Mhmm, Yeah, so like paying attention, and highlighting those small gains.] "Yes." • "Um, it's hard to stay motivated, but the small things sometimes, that's what keeps you going. Uh, for instance you are working with a certain client, and this client has been going down a path for the longest. And basically, the behavioral chain that you identify with them, you see that glimmer of hope," [mhmm] "…it keeps you going. You know that 'Okay, at least I am getting somewhere.'" [Mhmm] "So that's what,	P1, p. 3, line 70-80 P4, p. 4-5, line 112-135 P5, p. 5, 129-142

	that's what reinforce the motivation for you to keep going. So seeing those little glimmers of, 'O! We got a little bit," [yeah] "…better.'"	
	2. Peer and team member support motivates professional staff to continue with implementation of behavioral interventions. • "When he's doing, when he's struggling a lot, it is a lot harder to stay motivated because I just want to pretend that this isn't happening." [Right.] "Um, so definitely just peer support," [Okay] "…is pretty much the main thing, like knowing I'm not alone in working on this. Somebody else can help me with it." • "Yeah absolutely, because it takes a lot of work to write a behavior plan," [mhmm] "…um, and without staff buy-in, you are not going to see much of an impact." [Yeah] "And so for the few behavior plans I had in mind this year that I have not gotten around to, I talked to the team about it and they made it pretty clear that they wouldn't be willing to implement it." [Okay.] "They were pretty convinced that it wouldn't work and I just wasn't able to get buy in to justify the time and the paper work that it would take."	P2, p. 4, line 102-108 P3, p. 3, line 81-91
	3. Floor staff motivated by other's expectations of their job performance. • "(Sighs) Damn, I will, well I guess I just do it because it's what is expected of me. I'm not like excited about it but, um… yeah I think that's… there's definitely, like the, 'Oh, you are doing a good job being one-to-one,' we don't get that. But, I, that's my motivation, because it's my job. It's not the most fun part of this working here but…"	P6, p. 3, line 65-69
	Supervisor's support motivates Psychologist to continue with behavioral plan implementation. • "Yeah. I think for me, um, supervisors have been really helpful with troubleshooting the issues that come up when I am trying to do a behavior plan and I have invested enough time in it and have enough confidence in it that I could see results. Um, because I think some of that responsibility as a clinician to, to get buy in for an intervention, it falls on us. Like, we have to learn how to sell this and explain the rationale for it in a way that's more effective for our direct care staff."	P3, p. 4, line 96-102
Emotional	Fear of disciplinary action drives inconsistency in behavioral	P2, p. 3, line

Experiences While Implementing Behavioral Interventions	intervention implementation. • "Like when I said if he refuses to be searched, then we put him in a manual hold and search him anyway, just because of his history with weapons, and I think that they ended up scratching that part out because they wanted to leave it up to more of the nurses discretion. Which was fine with me, the nurses of course, with their different opinions, were a little (pause), they were afraid of getting in trouble. So when it was in writing that it was up to the nurses discretion, they felt more comfortable with it."	85-92
	4. Multiple professions find it hard to stay motivated to continue within their behavioral plan implementation role.	
	• Um, it's hard to stay motivated, but the small things sometimes, that's what keeps you going.	P5, p. 5, line 129-130
	• (sighs) Damn, I will, well I guess I just do it because it's what is expected of me. I'm not like excited about it but, um… yeah	P6, p. 3, line 65-66
	• When he's doing, when he's struggling a lot, it is a lot harder to stay motivated because I just want to pretend that this isn't happening.	P2, p. 4, line 102-103
	• "Um.. (pause) I think that once it's im-implemented the, the biggest problem or challenge that we have is keeping it going."	P4, p. 4, line 111-112
	• Yeah absolutely, because it takes a lot of work to write a behavior plan," [Mhmm] "…um, and without staff buy-in, you are not going to see much of an impact." [Yeah] "And so for the few behavior plans I had in mind this year that I have not gotten around to, I talked to the team about it and they made it pretty clear that they wouldn't be willing to implement it." [Okay.] "They were pretty convinced that it wouldn't work and I just wasn't able to get buy in to justify the time and the paper work that it would take."	P3, p. 3, line 81-91
	1. Multiple professions experience power differentials between the multidisciplinary roles.	
	• "Umm… I'd say it's mainly supervisory, uh the system at (Hospital) uses the psychiatrist is sort of an indirect supervisor," [mm hmm] "…and I guess ah, this sounds terrible but the best way that I could explain it is sort of like Queen of England, a fancy title but very little power." [Okay.] "[Laughs] Uh, but I'm required to participate in state occasions like	P1, p.1, lines 2-9

	um… treatment plan reviews."	
	• "I mean, I, it it, it's sort of like, you know Moses comes down from the mountain, with this treatment plan, and, and I've got this on a tablet and if you all don't follow it exactly, you know, you are never going to see the Promised Land, and it's all you hear. So um it, uh, and frankly, some of the suggestions are completely ridiculous. And there's no give and take…"	P1, p. 10, line 280-285
	• "Behavior plan, my role is mainly as an observer. Um, even as a part of the treatment team currently my role is still very minimal." [But it sounds like you guys have a lot of direct contact.] "Yes." [Yeah. Like a lot more than most,] "Yes." […other staff.] "Yes."	P5, p. 1, line 6-7; p. 2, line 59-64
	• [What is your role in the implementation of behavioral plans?] "Well... umm… I don't know we report stuff that we see and that goes into, well I would hope it goes into, making those plans."	P6, p. 1, line 1-3
	• [So how were you selected to do behavioral plans? Was there a formal process, were you just told to do it, what happens with that?] "We're just told to do it, they print it out and give it to us."	P6, p. 1, line 9-11
	• "For the most part with 99… well no, yeah, there's just one particular person that team decisions aren't made about him. But the other clients, usually it's team decisions, that's how they decide to make changes or (clears throat) do anything different." [Okay, so do you guys have to wait for the, like the team to meet to get things changed usually?] "We do yeah, the FRS don't."	P6, p. 4, line 114-120
	3. Psychiatrist believes that all Treatment Team members hold equal power in regards to making treatment decisions.	P1, p. 7, line 179-186
	• "Well again, I I think everybody is on a pretty even footing uh, there's even a push and I agree, there's a push to make sure entry level staff and FRS staff that we listen to them they literally spend the bulk of the time with the patient." [Right.] "So uh, I I think it's pretty, pretty democratic where everybody gets a say without fear of being shamed or put down because of the level of education so, I, I think it's a pretty good system."	
	2. Psychiatrist is frustrated by the hospital's concrete approach to policy guidelines.	
	• "Yeah, they have no concept of the practicality and	P1, p. 12, line

	our organization never questions and never negotiates. We, we take it at face value, um, and, and I have talked to the individual Joint Commissioner examiner nurse, Dr. Whatever, and they say, 'No, no, no! This is a give and take! This is, our recommendations are designed to be tailored to each organization.'" [Huh.] "But, but our approach to everything is *very* concrete. We are very unsophisticated in our psychological defenses as a hospital (laughs) and that has been, even something so simple as snow removal and parking spots, we don't have enough parking spots, that's not a difficult concept. Uh, it snowed, we need to call the people that remove the snow." [Mmhmm] "Uh, it, it's, just I'm so frustrated with that."	334-336
What this Hospital Does Well in Regards to Behavioral Plan Implementation	6. When staff members know the patients and are consistently present on the unit behavioral plan implementation goes well. • "Um… well when we have the regular staff there that are really educated on it, their consistency um is something that's really important to like be a role model to the other people. That, that's really helpful. Like when we have the good staff, good staff that's been there for a while." [That really know our patients.] "That are comfortable, yeah. And can recognize maybe when they are amping up, so maybe they can intervene even before they have to implement 2:1 or something like that." Professional and non-professional staff collaborate well with each other. • "What I think is working, and it's sort of redundant here, is the collaboration between professional disciplines and the collaboration between professional and non-professional staff. I think we do that pretty good." 7. Current Level System is working • "Um, I think the privilege level is, is working." [Okay.] "Being able to have a certain privilege because of having a certain behavior or lose his privilege because of a certain behavior can keep most of our clients on track." [Mhmm] "There's clients that absolutely do not care, [mhmm] "…or there's clients that do not understand." [Mhmm] "But for the most part, um when a client has a certain privilege to lose or to work towards," [mhhmm] "…they tend to shape the behavior that we want to see."	P2, p. 7, line 188-197 P1, p. 7, line 204-207 P5, p. 9, line 262-275

Ways to Improve Implementation of Behavioral Plans at This Hospital	1. Employees recommend formal training on behavioral interventions that is required for all hospital staff. • "That would be the big thing and I think we could, we could do, and again I think we are sort of the victims we train, because we are told that we need to train, I think this is something important enough that every couple of years, we, we could have a seminar and half the hospital could go in the morning and the other half could go in the afternoon and kind of brain storm about this. I'm not talking about a huge outlay of time, uh, but the time we spend on ridiculous stuff, uh, like it's bad to call your colleagues names, if you don't know that, you shouldn't have been hired."	P1, p. 9, line 253-260
	• [Okay, so the things, I'm just making sure that I'm understanding, the things that you are recommending would be um, like refresher courses for all staff on, um, what behavioral interventions could be, and how that could look, and how to do it.] "Right! And include staff at all levels! Include psychiatry! Include the FRS! You, you may not be able to this year to get all the FRS, but then next year get the ones that you didn't get."	P1, p. 10, line 266-272
	• "I think staff education is probably really big. Like today, we did a training where we talked about behaviorist principles and um, I saw a lot of direct care staff, it seem to really resonate with them and they seemed to get it and I think a lot of people are very teachable and they can learn these things. Um, they can see the value in it, they just need to sort of, they need more than a single conversation with the clinician," [mhmm] "…on the unit, they need real training."	P3, p. 8, line 241-248
	• "I mean I think a day and a half is a good amount of training, um, and I think it would need to explain the theory behind why we do this, it would need to explain some of the research base, um, some of the evidence that this actually works. I think people would need to know in what cases is this the most helpful. And then I think people would need like the practical side of this, which is how do we, how to we implement this." [mhmm] "Um, how do we utilize people on the team who can work on these behavioral plans and um, how can we support these types of interventions as a team."	P3, p. 8-9, line 253-262

	3. Employees recommend behaviorist and behavioral techs have more involvement with training and direct care staff.	
	• "I mean, I think we have such a great resource at this hospital because we have a behaviorist and a behavioral tech on site and I think they would be phenomenal trainers um, and they would be available for training." [Right.] "And so I think, I think right now we under utilize them by only calling on them when we have a clinical request, and not utilizing them fully with training."	P3, p. 9, line 269-275
	• "Yeah. And um, I think that they have more interaction with the treatment team and they have no interaction with FRS really."	P3, p. 9, line 279-280
	4. Employees recommend consistency with staff member unit assignments and interactions with patients.	P2, p. 7, line 211-215
	• "Yeah, um, and when there are staff that are pulled, which happens often especially when there is like a two-to-one or something, just that, then the consistency is a problem. Especially like, doing something that is detrimental to that whole plan of, like not talking to their two-to-one and instead making it like a fun thing."	
	• "Um we, we first have to be on the same page with answers for the clients. If the answer is 'no' it needs to be 'no' across the board. It's not 'Okay, you might say no, but somebody else might say yes.'" [mhmm.] "If the answer is 'no,' it's supposed to be '*No*.'" [Yep!] "Straight across! So that it's not, they aren't able to move from one staff to another. Um, that would help with the reinforcement that this is what we are doing, and this is what needs to be done."	P5, p. 10, line 304-312
	6. Employees recommend use of simplified, non-clinical language and brevity for written behavioral plans.	
	• "I, I don't know if it's feasible, but if there was someway to make it, because it's like a two page thing for some people even longer, make it more concise so that people can very quickly read through it and remember it all, because I'm sure if I was in that position that I would not remember all that." [Right.] "So some way to make it more concise and more easier to remember."	P2, p. 8, line 223-229
	• "Yeah so use words people understand so it's not something that's really clinical, or something not really, not very measurable and concrete."	P2, p. 11, line 317-318

	• "Yeah, and not the way that you and I would talk. Like, in a conversational way. Because not everyone has a social work degree or a psychology degree. Even though they might know what a certain word means and do it everyday, they might not know it when they see it on paper."	P2, p. 11, line 323-326
	5. Employees recommend increasing their communication about behavioral intervention specifics.	
	• "Well I guess making sure if it's someone that's like pulled or whatever, we aren't always up there to know that. So whoever is in charge, making sure that they get communicated that this is what the protocol is, that sort of thing"	P2, p. 8, line 244-247
	• "They (FRS) are kind of like their own island a lot of the time. And sometimes they are even forgotten on those emails that get sent out."	P2, p. 11, line 344-344
	• "I think, um, if the other FRS, like that aren't FRS IIs if they would speak up more, write more notes, document more stuff, and come to the FRS IIs or the team about issues that they are having with particular clients," [mmhmm] "…that would help, more communication."	P6, p. 5, line 147-152
	• "Same thing, I guess more communication. Maybe ask the FRS, try to talk to them more and see if they have any input, just ask them for it."	P6, p. 5, line 155-157
	6. Employees recommend members of administration have more direct involvement with patients and staff members.	
	• "Well here's what I would do, and it could be a rotating position, or it could be a permanent position. I would have one member of the Treatment Counsel that is responsible for at least once a week checking on the progress for everybody that has a behavior plan." [mmhmm] "There aren't that many in the hospital. As of Friday we had 408 patients, there's probably 10% that have this," [Okay.] "…so it could easily be done. And then they could ask, 'Is there anything you need?' 'Is, is it a funding issue?' 'Is Joe upset today because he didn't get the visit from his parents and he doesn't have shoes? Or he doesn't have a warm hat?' or whatever, and we could get the funds, get the hat, whatever."	P1, p. 9, line 237-249
	• "Very much so! I personally think that if we have more people um, are lets say that the persons that are in charge of making the major decisions are more	P5, p. 10-11, line 319-327

	aware of what FRS, Activity aides, the psychiatrists face on a daily basis when a rule is changed, or a rule does not seem to be working, then that information that is passed to them, would help them to make better decisions in terms of rules or whatever they are putting forth." [mhmm] "So it makes our job a little bit more, safer basically."	
	• "Um, well, like when (patient) was struggling so much, we couldn't get an answer right then about the plan, and we really needed something immediate." [Okay] "So, just kind of the process between (pause) sometimes it will go really quickly through Treatment Counsel, sometimes it will take a while. My guess is it was the holidays when, it didn't, I still haven't heard!" [Oh wow!] "And it probably got 'O he's doing okay, we are just going to wait.'"	P2, p. 7, line 200-208
	• "I guess communicating better with the Treatment Counsel, that would help. Because I don't know if we've ever said "Hey! I need this quickly!"	P2, p. 8, line 247-249
	7. Employees recommend an increase in mentally stimulating activities for patients and an environment that is more suited for therapeutic interventions.	
	• "It would be much better if we had the new place! (laughed) Some, some behavioral interventions we have are *caused* by the environment."	P4, p. 13, line 384-385
	• "Right now I'm doing like little things talking about someone's behavior and I'll have like 15 other people around listening to the conversation, so," [mhmm] "…so a quieter, um, more where you can get the point across and just really the environment has a lot to do with what you are able to do."	P4, p. 14, line 411-415
	• "…we just haven't had more staff or more things available to them to have, like more library time. There's some guys that would like to spend, and I can't think of anything more positive for them myself, to spend 5-6 hours in the library."	P4, p. 14, line 443-446
	• "I don't think, we just don't put that together too much to really stimulate their brains and then they get bored and they get in trouble and we have people that just keep," [Being in this cycle.] "Yeah."	P4, p. 15, line 460-456
	Employees recommend that all staff not give in to patients' threats or demands.	
	• "(pauses) Giving into the demands of our clients." [Okay.] "Um, a lot of the clients make, and I want to	P5, p. 9-10, line 280-295

	say don't think I'm being naïve, but a lot of clients make threats," [mhmm] "…while we know that the clients that we work with are very dangerous, giving into the threats and the demands of these clients, um puts the power in their hands." [mhmm.] "And is that we are not realizing that they are here for the same purpose, so we can't just give in to them." [mhmm.] "So I think that creates a large, barrier problem." [mhmm.] "Because when you give into them, they've won. They won't listen next time. So that's what's not working, not really."	
	Employees recommend that all staff remain mindful that they work with a dangerous population. • "Um… One of the things that I would say is that we persons as staff members got to remember that even though these clients come to us with, um, an *illness*, we have to also be cognizant of the fact that they are with us *because* of either aggression, aggressive behavior or some um, criminal intent." [Right.] "So we have to also be mindful of the fact that this is the population that we are dealing with." [mhmm.] "Which, doesn't mean that you have to run around scared, but it means that you have to be aware." [mhmm] "And be aware of your environment." [Right.] "I think a lot of people becomes comfortable with them and forget that these are the clients that we are dealing with."	P5, p. 11, line 336-351
	Employees recommend that job performance evaluation focus more on clinical intervention and less on completion of paper work. • "Uh, let's see. I think um, I think one of the greatest challenges probably for encouraging behavior plans at this hospital is that um, clinical staff often feel that they don't have um, enough time just to do the basics, just to meet their basic responsibilities." [mhmm] "So I think when you are talking about behavior plans, you have to address like the amount of time that it takes to do that and there has to be team support um, if you are going to be working on something and you are going to set aside that much time. And so I think for the staff members who can do these behavior plans, that might mean like, that your co-facilitator takes care of the group for the week if you were, if you are using your knowledge and resources in this	P3, p. 10, line 287-302

	other area. So I think there's not a whole lot of team support for these things and so I think psychologists and any other staff who have knowledge to do behavior plans often don't develop them because there's just, there's not enough time to do things the way that they would ideally like to do it." • "And I think part of that is at hospitals like this, um, staff are rewarded and they are incentivized for meeting paperwork deadlines." [mhmm] "Um, for doing good documentation, but not for doing good clinical work." [Okay.] "Like I don't think that there's a lot of positive reinforcement for that." [mhmm] "Um, and so you see that at lot of times in people who assume leadership positions, um, they are the ones who are very diligent in spending time in their office and modifying treatment plans, but they are not necessarily the people on the unit who are investing a lot of time and energy into clinical work and who are really seeing results."	P3, p. 10, line 306-317
	Floor staff members request an increase in specific behavioral interventions. • "I think the major challenge on my unit is getting staff buy-in. Um, and not just from direct care staff, I think a lot of times they are more open to it…" • "Um, well, on this particular program it would be nice if we could get more target behaviors" [Okay!] "(laughs) When we, when the FRS is asking over and over and over for them, we could actually get them."	P3, p. 7-8, line 222-224 P6, p. 6, line 161-165
	Floor staff members request more support from the professional staff members. • "When the staff is inconsistent or when we, the FRS try to be consistent and then particular case managers don't back up the plans they've given us that they've made themselves. And then they don't back us up when we try to do them."	P6, p. 5, line 141-144
	2. Employees believe that when more professional staff believe in the effectiveness of behavioral interventions implementation of such interventions will improve. • "I think the major challenge on my unit is getting staff buy-in. Um, and not just from direct care staff, I think a lot of times they are more open to it, it's from other clinical staff, um nursing, social work, um, and a lot of times they are convinced that they've tried this in	P3, p. 7-8, line 222-231

	the past and that it was not easy to implement or that it didn't work. So trying to get them to consider doing it with a different client, um, and trying to encourage them to have the flexibility to stick with it," [mhmm] "…for a little while until you can get a working plan, that's I think the hardest thing."	