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Transforming Group Treatment in Acute Psychiatry: The CPA Model

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Abstract
In acute psychiatry, regulatory guidelines require a shorter length of stay which demands greater organization of group treatment that serves a patient's individual treatment goals. Kings County Hospital, in response to a federal mandate, developed the Central Program Area ("CPA") group program to provide categorized interdisciplinary group treatment that delivers a skill building approach to help patients in their recovery process. Through a commitment to person-centered care, the CPA, a person-centered group programming model was developed. Within the CPA model, group therapy approaches to curriculum such as the Road to Home, which provides group treatment for patients with substance abuse issues, are discussed. Efficacy measures on program implementation indicate that providing CPA group programming increased patient engagement in prescribed group treatment from 47% to 69%, and through the review of the Group Notes weekly group programming summary in treatment team meetings, staff report that patients practiced and reinforced new recovery skills.

Key words: inpatient psychiatric rehabilitation; person-centered care; CPA Model; Road to Home; group treatment efficacy

Introduction:
This paper reports the development of an innovative approach to provide group programming treatment in an effort to engage patients with a serious mental illness in their recovery process in Behavioral Health at Kings County Hospital Center ("KCHC"). KCHC is located in Central Brooklyn and is a member hospital of New York City Health and Hospitals ("NYC H+H"), the largest provider of public health services in the United States. As a re-

sponse to the tragic death of Esmin Green in the psychiatric emergency room in 2008, reform was mandated through terms of a consent judgment and upheld by the Department of Justice ("DOJ") to provide oversight in the transformation of Kings County Behavioral Health from an antiquated 20th century provider to a modern facility able to deliver state of the art care to persons with serious mental illness.

During the DOJ's 8 ½ year visit, state measures for reimbursement changed given the advent of Medicaid redesign, managed care requirements, and the state's Delivery System Reform Incentive Payment Program ("DSRIP"). As systems reimbursement changed to support maintenance of patients in the community, the decreasing length of hospital stay emerged as a continual challenge in the delivery of short-term acute care, thus clinical treatment had to evolve throughout the extensive DOJ survey and in conjunction with regulatory changes.

There were systemic issues within Kings County Hospital based on the lack of an operational philosophy promoting wellness that affected all aspects of Behavioral Health service. Challenges identified in the provision of psychiatric rehabilitation were: a lack of individualized group treatment, patient engagement, lack of integrated group documentation, use of space, policy and standard of work procedures, safety concerns, interdisciplinary involvement in group treatment, and group programming efficacy. The Central Program Area ("CPA") group programming model was developed to address many of these issues, and importantly, to provide a skill building approach integrated into the individualized recovery plan to assist patients with treatment goals. Essential social skills to assist patients with treatment goals were envisioned for long-term outpatient treatment (Bellack, Mueser, Gingerich, & Agresta, 1997) and long-term state rehabilitation treatment (Dhillon, & Dollieslager, 2000) and efficacy were assessed in social and instrumental skills training (Wallace, Liberman, MacKain, Blackwell, & Eckman, 1992). The question remained: how do we deliver meaningful treatment to patients within the regulatory constraints of acute care, engage patients in their treatment, help them learn new skills to support behavioral change as their recovery in the hospital was in increasingly shorter periods of time, and prepare them for maintenance in the community?

The recovery model in psychiatric rehabilitation in mental health was established in the early 1990's (Anthony, 1993), however practical challenges to treatment such as education, training, and implementation of person-centered treatment planning remain in mental health and addiction settings (Adams & Grieder, 2005). The term 'person-centered' in Behavioral Health was instituted in 2009 to support the patients' engagement in their own treatment and to engage in and develop best practices in order to improve treatment outcomes. The partnership between the clinician and patient central to this process is conveyed through empathic concern (Rogers, 2007), considering cultural identity, personal strengths, and demonstrated hope and belief in the patient's ability to meet treatment goals.

KCHC Behavioral Health implemented training to support the culture shift from a traditional medical model, a paternalistic approach that focuses on symptoms of disease, to a wellness approach guided by self-determination (Swarbrick, 2006) and shared decision making (Hamann, Cohen, Leucht, Busch & Kissling, 2005) with a focus on wellness and recovery in acute psychiatry. Wellness is discussed by Swarbrick (2009; 2012), as the multi-faceted approach to create healing on the physical, spiritual, mental, and emotional dimensions for persons with mental illness with consideration of the economic, vocational, social, and political impediments that provide an additional burden to treatment (pp. 343-344; p. 30).

The evolution of mental health toward individualized targeted treatment was the new goal, and one different from our DOJ expert's initial observation of a "one size fits all" group program that was not able to meet the complex needs of the patient population. The development of the CPA model was considered a method to provide every patient equal treatment, to offer flexibility within the daily tracks, to offer an opportunity for skill building to support treatment objectives, and to maximize staff potential through an interdisciplinary focus in the delivery of group programming and through the mechanics of implementation that required interdisciplinary teamwork. Similarities were explored between a treatment program and education curriculum to consider sequential learning and specific treatment based on patient needs, given the transient nature of inpatient treatment.

The work reported here reflects the development of group programming in Behavioral Health's journey to transform the delivery of psychiatric rehabilitation treatment in acute psychiatry to include the concept of group prescription, the integration of group programming into the individual recovery plan, program development, group documentation, and group program efficacy. Person-centered care was the foundation of the person-centered treatment plan model which is the central focus of this journey in Behavioral Health (Adams & Grieder, 2005, 2013) and the framework for the development of person-centered group programming in which the delivery of group treatment is prescribed and integrated into the individualized recovery plan, specifically as interventions to address patient treatment objectives.

Methods

KCHC Behavioral Health's goal is to assist persons with a serious mental illness achieve recovery in order to live their fullest life possible. NYC H+H utilizes "Lean" management principles (Womack & Jones, 2005) as one tool to achieve the goal of their commitment to profession excellence. A "Lean" approach is a performance improvement methodology to help corporations deal with systemic challenges through an interdisciplinary problem-solving method designed to identify the value within the service, waste within the corporation, and address the root cause of impediments to promote the continuous enhancement of service (Womack & Jones, 2005). The Lean performance improvement process was well established at KCHC (Merlino, Omi, & Bowen, 2014). Therefore, the question of how to target psychiatric rehabilitation interventions to meet patient treatment goals was addressed through this process to provide a solution to challenges in the adult inpatient psychiatric service such as: non-engagement in group treatment, non-engagement in prescribed groups, and lack of efficacy measures to address clinical targets for patients. The importance of psychiatric rehabilitation treatment interventions in an inpatient setting has been reported as an essential step toward developing a mental health system which supports acute psychiatric services and pa- tient maintenance in a community mental health setting (Reinhart-Wood & Kinter, 2016).

Person-Centered Treatment Plan Template

Person-centered treatment planning (Adams & Grieder, 2005, 2013), requires an interdisciplinary team and an individualized recovery plan template to provide a strengths-based clinical formulation which addresses life and hospital goals, clinical objectives, and interventions to help patients meet their treatment goals. See the sample template in figure 1.

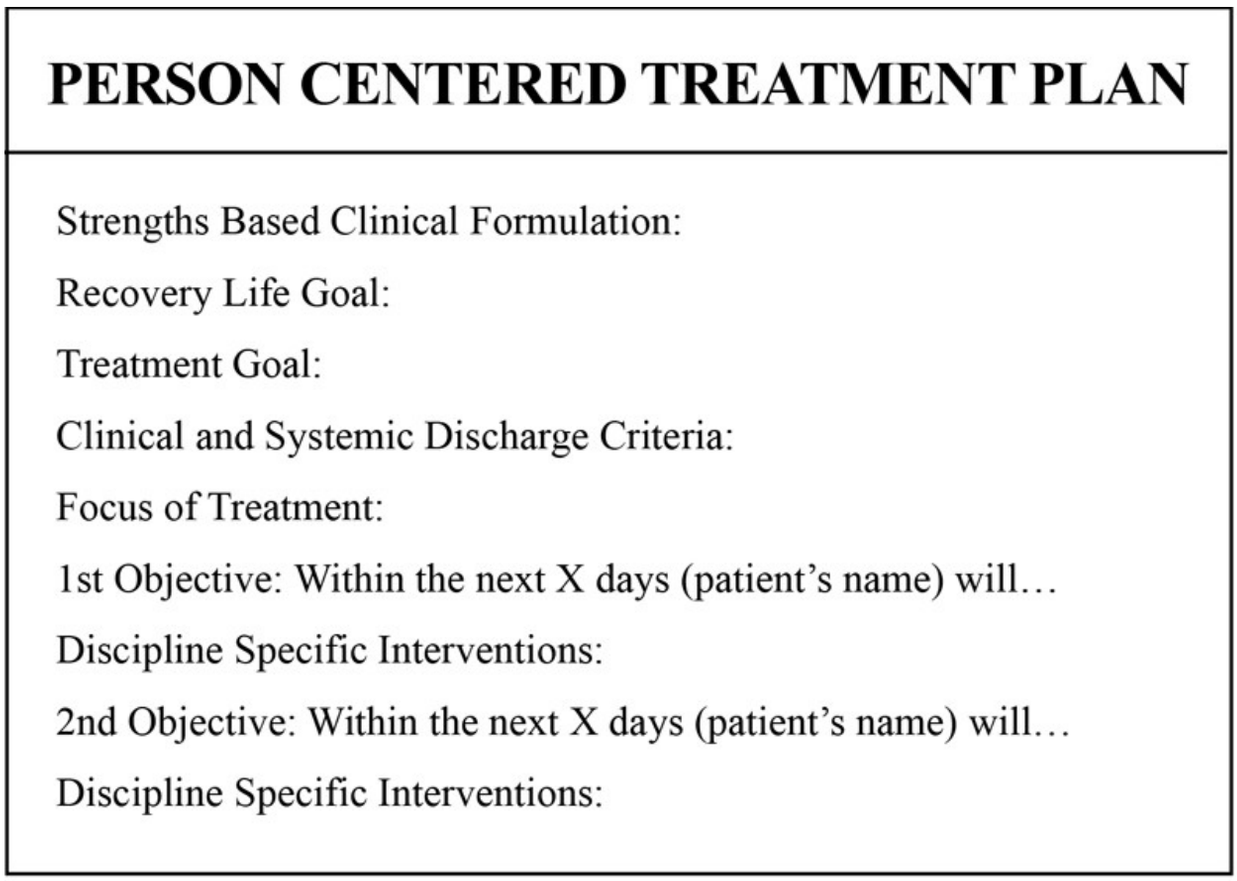

Figure 1

The intersection between person-centered treatment planning and person-centered group programming is the intervention of group prescription in the individual recovery plan. Group treatment which may include CPA treatment tracks and/or on-unit groups, is prescribed in the morning and/or afternoon to address these treatment goals. The integration of either prescribed or voluntary group programming into the treatment plan depends upon the focus of treatment and treatment objectives for the patient. Prescription is the clinical determination of specific groups or treatment tracks to address clinical goals by determining what skills will help a patient meet their treatment objectives. In addition to medication management, the interdisciplinary treatment team prescribes group treatment in the individualized recovery plan to target areas of personal growth.

Development of Group Programming

The Department of Therapeutic Rehabilitation ("TR") is responsible for hospital policies on group programming, which includes the policy for group protocols that detail the rationale and procedure of the group. TR group therapists provide the bulk of group treatment in Behavioral Health and utilize these protocols to provide standardized procedures. TR is comprised primarily of Licensed Creative Arts Therapists ("LCAT") who utilize art, music, dance, drama, and poetry as a form of psychotherapy, as well as Occupational Therapy, Rehabilitation and Child Counseling, and Activity Therapy. According to the National Coalition of Creative Arts Therapies Associations, Inc., "Creative Arts Therapists are human service professionals who use arts modalities and creative processes for the purpose of ameliorating disability and illness and optimizing health and wellness. Treatment outcomes include, for example, improving communication and expression, and increasing physical, emotional, cognitive and/or social functioning" (National Coalition of Creative Arts Therapies Associations, Inc., 2012). The history of the arts in

psychotherapy (McNiff, (1981) and development of creative arts therapies as a profession (Johnson, 1999) demonstrates the arts in therapy as a strength based approach to work with an inventory of the broad range of patient strengths, abilities, interests, talents, an involve their unique capacity to use symbolic representation (i.e., sound, image, metaphor, embodiment) to engage patients in their clinical recovery. Person-centered group programming encompasses these best practices through creating a culture shift in group programming to complement the Person-Centered Treatment Plan.

The first step in group programming development was to consider how to categorize group treatment into treatment "tracks" or treatment areas of focus. Six treatment tracks were identified, and groups were categorized under a treatment track with a corresponding list of skills to provide the foundation of design for the CPA program. The development of an interdisciplinary skills list helped facilitators be clear and concise in group facilitation to assist with acquisition and reinforcement of skills. Consideration was taken for the needs of our patient population located in the Flatbush/East Flatbush section of Central Brooklyn where patients' race is self-identified as 82% Black Non-Hispanic (African American and Caribbean), 8% Hispanic or Latino, 5% White Non-Hispanic, 3% Multi-Race/Other, and 2% declining identification. Additionally, socioeconomic factors that were considered included low income, Medicaid, uninsured, and underinsured patients (Kings County Community Health Needs Assessment, 2016). Consideration included primary diagnoses with co-morbid substance use. Response to the patient population demographics prompted development of the following critical areas for the CPA program: substance use, independent living, recovery, interpersonal communication, coping and social skills. The CPA model program was provided by an interdisciplinary team comprised of TR group therapists, peer counselors, psychologists, social workers, nursing staff, internists, psychiatrists, infectious disease counselors, dietary, and pastoral care.

The CPA Model

The CPA model was initiated by a team of administrative and clinical interdisciplinary professionals who used the "Lean" process to drill down on the engagement problems impacting patient treatment. The author, Ms. Bornmann, responsible for the delivery of group programming was asked to lead staff in creating this new model. The team worked together to develop a program to better utilize a central and under-utilized service area, and to deliver targeted group treatment to all units and floors in adult inpatient psychiatry. Staff resources and expertise were maximized in this model, as the interdisciplinary team of professionals provided integrated group programming to patients.

Structure of CPA Program

The CPA is located between an east and west unit on the 3rd, 4th, and 5th floors in a central area that includes 5 rooms. Three rooms were re-purposed to provide 75 groups per week in the following group treatment tracks: Substance Education & Recovery, Independent Living & Communication skills, Coping & Social skills. The Wednesday sample schedule displayed (figure 2) shows the group offerings in the CPA where patients from any unit/floor can be escorted to their prescribed treatment. The groups on each floor run concurrently during their timeframe and the patients move between groups on their prescribed treatment track. Categorized group treatment was organized to provide either 2 or 3 consecutive groups in the same treatment track to afford patients the opportunity to learn skills particular to that treatment track, benefit from different group facilitators, and increase the time of engagement in group treatment. Practice is important to engrain new behaviors through learning and development, thus patients were encouraged to practice skills in group and on the unit. The CPA model program provides an opportunity for patients to learn new skills through the reinforcement of skill building in three different consecutive groups in one treatment track. This structure helps with the acquisition of new skills through repetition and actualization of treatment objectives. CPA implementation provided group treatment to acute psychiatry that had 6 adult inpatient units, and first a break unit for patients 18-23 years old.

CPA WEDNESDAY SCHEDULE		
West Side Inpatient Units	CPA Treatment Tracks Centralized Program Area	East Side Inpatient Units
5W On-unit groups	5th Floor Tracks Coping & Social Skills 10 am Living Health Eating Well 10 am Spiritual Care 10 am Music and Mindfulness 1 pm Social Skills 1 pm Computer	5E On-unit groups
4W On-unit groups	4th Floor Tracks Independent Living & Communication 10 am Living Skills 10 am Get your Mind/Money Right 10 am Computer 1 pm Social Communication 1 pm Expressive Writing	4E On-unit groups
3W On-unit groups	3rd Floor Tracks Substance Education & Recovery 10 am Roadmap to Recovery 10 am Coping on the Unit 10 am Healthy Living 1 pm Peer Advocacy 1 pm Grooming	3E On-unit groups

Figure 2

Program Content

Admission to an inpatient unit can be a traumatic experience for patients. Coping with this transition and understanding how to get their needs fulfilled requires frustration tolerance, an important skill to be developed and practiced. Groups that address these immediate concerns were built in the Coping & Social skills track. The Creative Arts Therapy groups that focus on coping skills, (for example, distraction techniques, self-expression, anger management, and problem-solving) are the first groups that are recommended for patients upon admission, prior to their first treatment team meeting. Peer counselors, who are there to assist patients throughout their inpatient stay, provide a wellness recovery action plan ("WRAP"), a proven group process to help patients work towards recovery (Cook, et al. 2013). The social skills track was informed by the work of Dr. Allan Bellack (Bellack, Mueser, Gin- gerich, & Agresta, 1997), as the importance of recovery oriented therapy and social support are essential to suc- cessful treatment in the community (Chang, Heller, Pickett, & Chen, 2013). A social skills curriculum was de- veloped for the CPA to assist patients with receptive and expressive non-verbal, verbal, and interactive behavior, utilizing creative arts therapeutic interventions of music therapy for paralinguistic skills and drama therapy for role

play of relevant real life situations. Training in social skills requires encouragement and reinforcement to help patients generalize skills outside of the group setting, and, to settings outside of the hospital (Liberman & Fuller, 2000).

Independent Living skills, a focus in the recovery process, are taught to provide practical skills essential to living in the community and maintenance in a community health setting. Vocational activities to assist patients to develop skills for voluntary work and employment are essential to be independently employed. An Independent Life Skills curriculum was developed to address these practical skills to support exploration of a patient's self-care, daily living, self-directed interests, and work readiness. This Independent Living skills track is paired with the Communication skills track to provide essential skills development to assist patients in communicating their needs to providers and family members, developing interpersonal relationships, and assisting with and reinforcing social development central to the recovery process as a preparation for discharge and maintenance in the community.

Substance education and recovery tracks provide interdisciplinary group treatment specific to those treatment modalities. In TR, the Road to Home model ("R2H") was developed by the author, George Jagatic with the help of Dana Trottier LCAT and Suzanne Garrison LCAT, as a way to provide a theoretical foundation to the groups within the substance education track. This sequence of groups was based on the Stages of Change model from the trans-theoretical model of behavior change which helps to increase motivation and decrease resistance to change (Prochaska & DiClemente, 1983). In the trans-theoretical model, each stage of change has unique interventions designed to meet the patients where they are at in order to obtain the greatest impact, as well as to build those patients' motivation to change.

Road to Home

The R2H model is a series of groups that are designed to match with the Stages of Change model in order to facilitate the patient's transition through those stages to obtain their desired goal relating to their substance use (see figure 3, for Road to Home / Stages of Change model). The interventions used by the therapist during their work with their patient are based on a theory and application called Motivational Interviewing ("MI") (Miller & Rollnick, 1991, 2002). MI's tenets are: collaboration, evocation, autonomy, and rolling with resistance, which match the tenets of person-centered care and the recovery model at KCHC. The collaborative approach of the Stages of Change model and Motivational Interviewing helps guide the therapist in a sequential process to help the patient consider the possibility of change, contemplate the risks and benefits of change, and prepare for moving forward with the identified change in his/her life.

The R2H model includes the following creative arts therapy groups and their intentional process in order of their stage of motivational efficacy.
-Pre-Contemplation: "I Don't Belong Here" is designed to allow patients the opportunity to express how they feel, and in return, have those feelings heard and validated. (Sample group protocol available in Appendix A.)

-Pre-Contemplation: "Coping on the Unit" provides non-judgmental discussion regarding challenges of living on an inpatient unit and identifies ways to deal with those challenges.

-Contemplation: "What is Treatment" explores the meaning of the word 'treatment' in order to gain a broader perspective of "Recovery" and healthy living.

-Contemplation: "My Treatment Team" helps the patient to concretely understand who their treatment team is and supports the communication with those individuals. It also helps to increase empowerment, ownership, and engagement in their recovery process.

-Preparation: "Symptom Awareness" helps the patient understand what a symptom is and how a number of symptoms create a diagnosis. This helps patients increase their awareness of the warning signs of de-compensation.

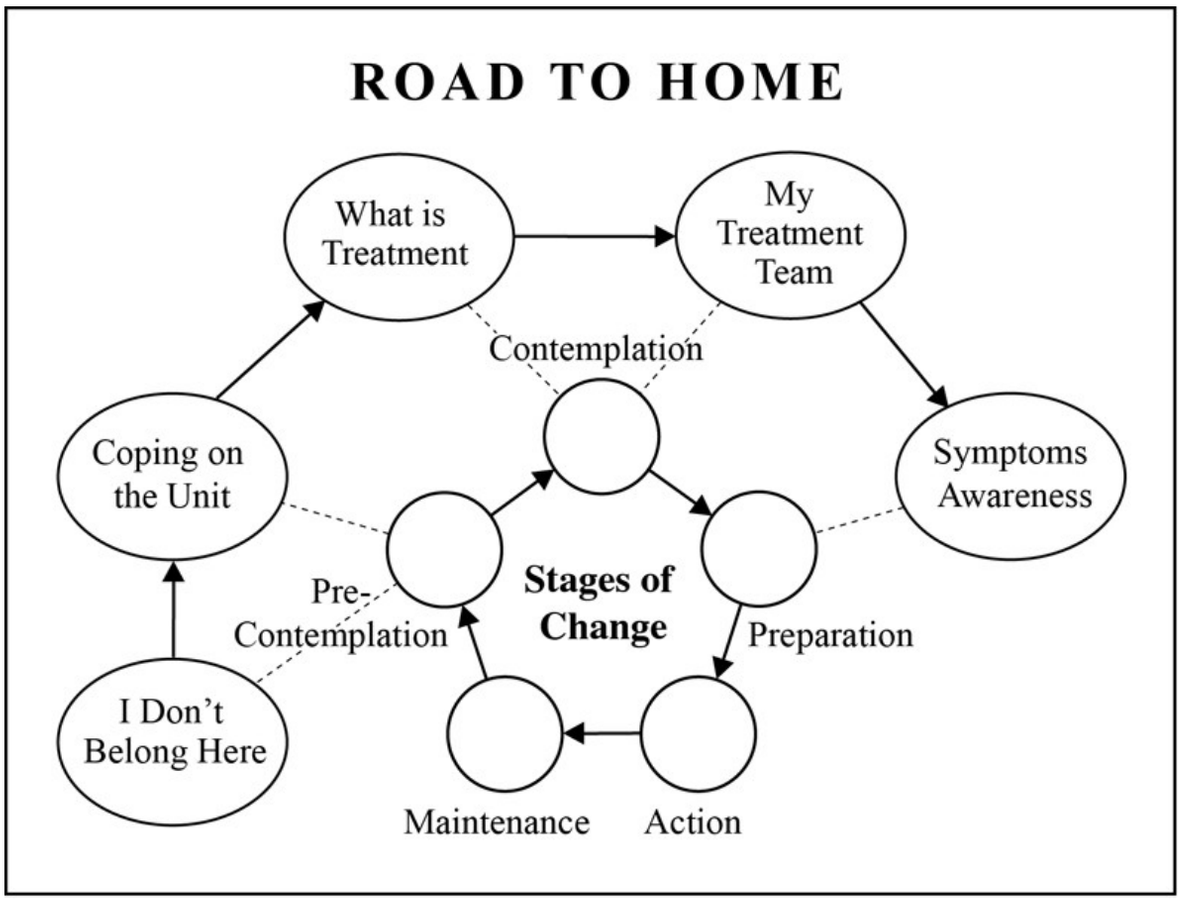

Figure 3

he groups in figure 3 were designed to assist patients through their inpatient process from admission through discharge, and to help patients deal with their resistance, a characteristic of their substance use recovery. These groups can be inserted into any standard inpatient schedule to help patients prepare for groups that are further along in their stage of change such as anger management, medication management, and aftercare planning.

The goal is that working in tandem, these groups help the recipient go from a 'pre-contemplative' stage of change ("I shouldn't be here!"), to one of consideration or the 'contemplative' stage ("OK, I'll consider your perspective"), followed by the 'preparation' stage ("I'll work with you in creating a prescribed group plan"), which in turn supports a more active role as they move closer to discharge. This not only helps the patient move towards discharge, it also helps the treatment team have more traction in the work that they are trying to accomplish. The R2H model utilizes psycho-education and transparency to facilitate a greater understanding of the inpatient system as well the therapeutic process itself. Utilizing a combination of motivational interviewing techniques and mul- tidisciplinary creative arts therapy approaches, the interventions employed in the R2H groups carry a track record of increased engagement in group therapy, as a sampling of questionnaires from two units provided promising res-
ults.

Barriers to CPA Implementation

Barriers such as space considerations, staff resistance to change, safety issues, and program complexity existed in re-purposing this central program area. The rooms that were identified for the CPA model were already in use by the staff and these meetings required relocation and adjustment by the staff. Considerations of the physical space were security between units affecting patient and staff safety and limited access to patient bathrooms that required

additional staff presence in the CPA area. Clinical staff were concerned about the delivery of treatment to patients they were unfamiliar with, and had safety concerns regarding patients who may be too acute to attend. All patients were evaluated by their treatment teams in morning report to attend the off-unit CPA program. Patients who demonstrated aggression or were on a 1:1 for clinical reasons would not be encouraged to attend until symptoms improved. Patients from each adult unit required escort from their units to their prescribed CPA track floor, and this required a prescription template for patients on the unit, daily maintenance of prescriptions, communication re- garding patient presentation in morning report, as well as staff volunteers to provide escort. The barriers were for- midable and demanded substantial supervision and constant reinforcement which in itself created additional stressors that staff had to contend with.

Results

Efficacy measures on the clinical focus of treatment are determined through documentation of patient engagement and skill building, specifically on attendance, duration, and measuring the skill building in group treatment, to determine if the group interventions satisfy the treatment objectives in the treatment plan. Participation outcomes are documented and consider the degree to which a patient was able to engage in the group, by practicing and demonstrating a skill as well as clinical recommendations of whether to continue, modify, or discontinue the skill / group, and to consider whether the skill building meets the treatment objectives.

Group Notes, a system in the electronic medical record ("EMR") was developed by the author, Ms. Bornmann and IT consultant, Christopher Kirton to order prescribed and voluntary groups and document on group treatment. The system addressed the need for an inter-disciplinary tracking system in the EMR that would capture group treatment, provide integration within the treatment plan, and provide accurate feedback to the patient and the treatment team regarding patient engagement in group treatment. Interdisciplinary staff contributed to the content of the system, including recommended patient groups and patient skills development per their discipline. Training on the system was provided by staff member Dana Trottier to all clinicians in Behavioral Health to prepare staff for the go-live and provide additional training, as needed.

The system supports the mechanics of group programming through generated information from the system, such as a sign-in sheet and prescription sheet for patients, and a group programming summary. The weekly group programming summary (figure 4) supports the treatment team meeting and reflects patient participation to the patient and treatment team members in an effort to engage the patient in their treatment objectives through reinforcement of learned skills. Additional reports provide QC data to monitor through supervision of the clinical provision of group treatment, and a group programming data download consisting of: quantity of patients served for CPA and on-unit programs, number of groups, number of group orders, and efficacy measures on skill building and clinical recommendations.

GROUP PROGRAMMING SUMMARY

Weekly total of voluntary groups: 1
Weekly total of prescribed groups: 4
% of prescribed group attendance: 75
% of voluntary group attendance: 100

PRESCRIBED GROUP TREATMENT

Date/Time	Group Note / Category	Sub Category	Skills	Type	Attend	Duration	Participation / Outcomes	Summary / Patient Note
30 Mar 15 1105	Creative Arts Therapy Group Note for Music Therapy		Learn self acceptance	Prescribe	Yes	15 min	Patient was partially able to practice the skill.	Patient asked to return to unit
3 Apr 15 1336	Physical Activity Group Note for Gym & Exercise		Physical activation	Prescribe	Yes	45 min	Patient was unable to practice the skill.	
2 Apr 15 1000	Sustance Use & Abuse Note for Healthy Living		Identify and understand physical disease	Prescribe	No	0 min	Patient did not attend	
1 Apr 15 1319	Coping Skills Group Note for Conflict Resolution		Demonstrate anger management	Voluntary	Yes	15 min	Patient was partially able to practice the skill. Continue, signs of progress needs more time to work	Test word document
3 Apr 15 1404	Coping Skills Group Note Creative Arts Therapy	Expressive Writing	Learn to reframe thoughts	Prescribe	Yes	30 min	Patient was partially able to practice the skill. Continue, signs of progress needs more time to work	

Figure 4

This example of the group programming summary from the training manual was produced during the training period on a test patient, therefore, this is an example of staff learning how to use the Group Notes system rather than an example of patient care. The group programming summary is brought into the treatment team meeting to provide real time feedback to the patient regarding engagement in group treatment. The specificity of this report allows clinicians to make detailed comparisons of prescribed interventions and skills versus actual skills practiced to measure progress towards treatment objectives. TR group therapists review the group programming summary to determine the degree to which a patient practiced skills to support treatment objectives and discuss with the team at the treatment team meeting.

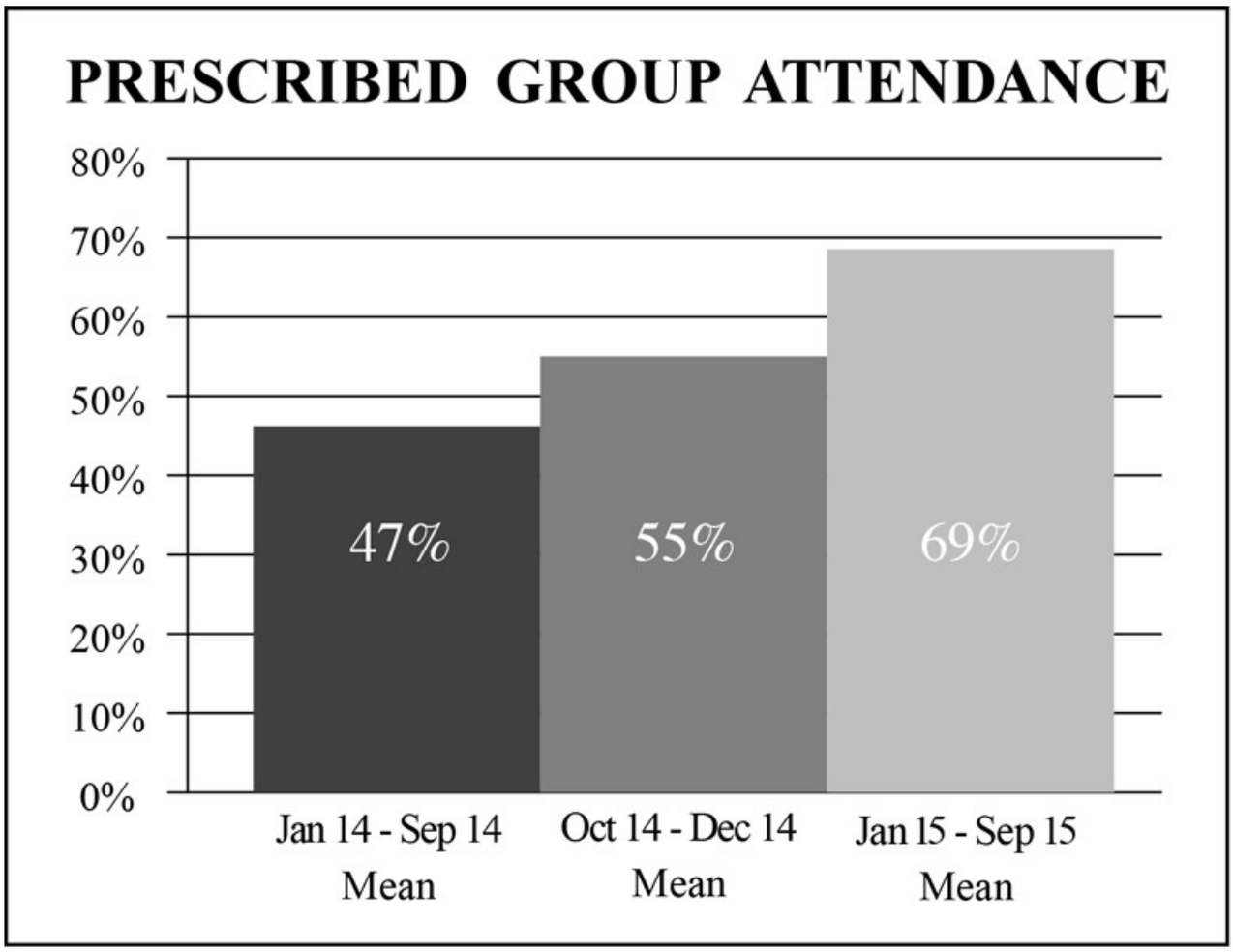

Figure 5

Figure 5 shows the increase in prescribed group attendance before, during, and after the implementation of the CPA. This graph shows prescribed group attendance from only on-unit group programming for a baseline period (Jan 14 – Sept 14) measured at 47%, to the first implementation phase of the CPA plus on-unit groups (Oct 14 – Dec 14) measured at 55%, and the second implementation phase of the CPA plus on-unit groups (Jan 15 – Sept 15) measured at 69%, which includes the go-live of the new electronic system (June 15) to document prescribed and voluntary treatment. The system required additional revision after go-live to generate requested data on all QC measures, specifically discreet data on CPA and on-unit group attendance.

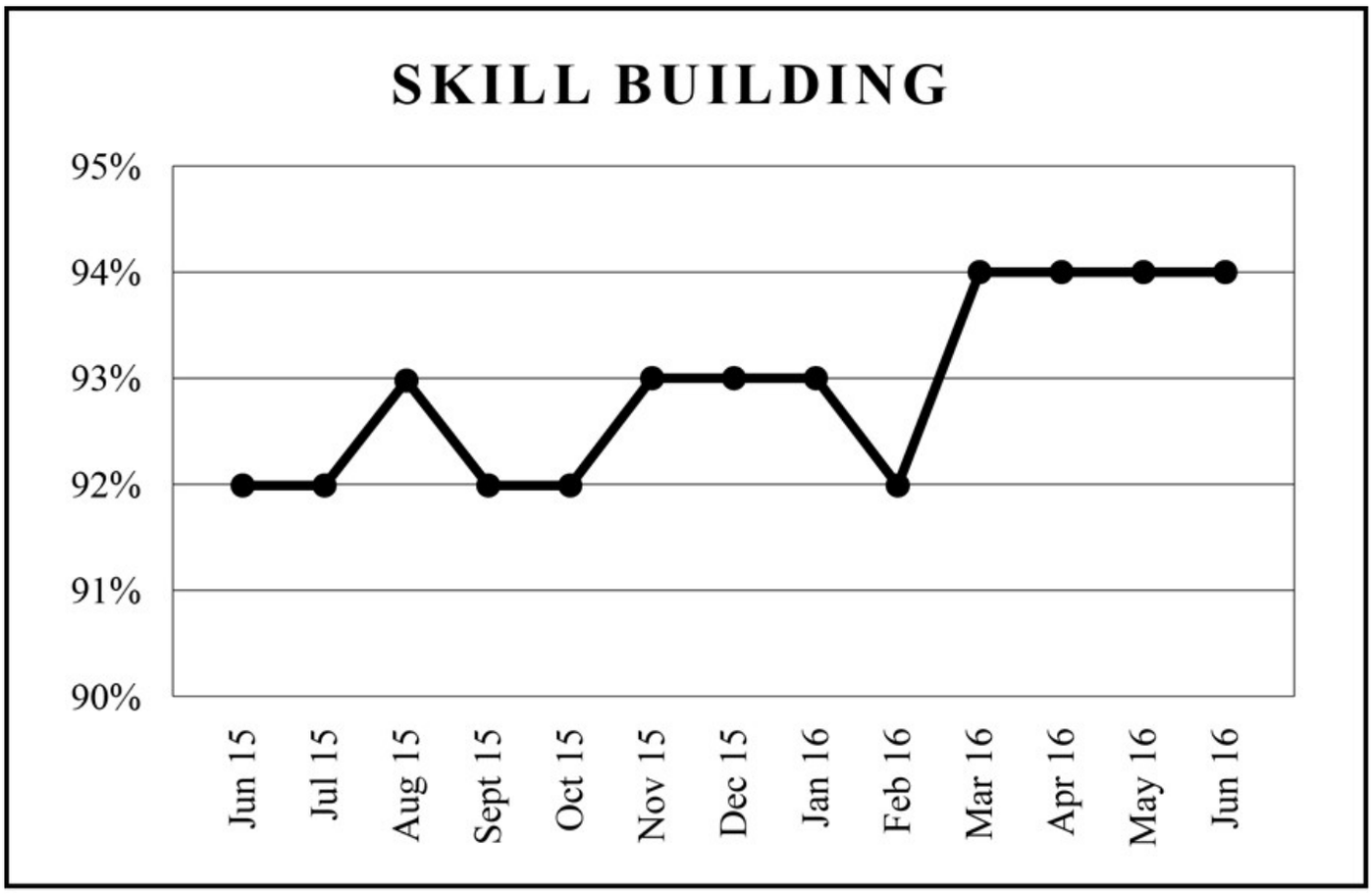

Figure 6

This graph in figure 6 reflects the first year of electronic data on skill building for both CPA and on-unit group programming. Inclusion criteria: 1) partially able, or 2) able to practice a skill, is measured by a Likert scale of 5 criteria to determine patient engagement in group treatment. Within this first year of the Group Notes program, staff worked with the electronic system to assess patient engagement through skill building. Continued supervision was provided, and advancements in a skill building approach, such as standardization of criteria for assessment, are ongoing. In addition to staff documentation on skill building, CPA groups were randomly selected to submit patient self-report questionnaires specific to each treatment track to provide feedback data on skills focus within each group, helpfulness of the group, and provide comments on group process.

Discussion

KCHC's Behavioral Health Service developed the CPA group program model, a person-centered approach to interdisciplinary group treatment that provides 75 categorized group offerings to address skills needed for successful living in the community. Through the application of Lean thinking, problems with the content and delivery of group treatment were identified, and the central program area was targeted to deliver group treatment. The Director of the Therapeutic Rehabilitation Department was responsible for the leadership in the creation and development of this model including program conception, developing an interdisciplinary approach to group treatment, and logistics.

Featured also is the Road to Home model which demonstrates creative arts therapy approaches developed to improve the delivery and efficacy of the substance education group treatment. The CPA model produced significant improvements in engagement in prescribed group treatment from 47% - 69%, as well as the attainment of clinical

treatment goals. The Group Notes system provided feedback to enhance patient treatment through the group programming summary and documentation and data on a skill-building approach, as well as QC efficacy measures to assist with program maintenance and continuous improvement. Thus, this progressive CPA group programming model helped to further patient recovery and move treatment into the future.

Limitations of the CPA model include primarily that it is complicated and staff intensive, required prescription templates, daily maintenance of templates, interdisciplinary communication, an escort twice daily. Escorting patients to their recommended treatment became too difficult with staff attrition. Timing issues include facilitators being present prior to the start of the group and escorting issues resulting in patients' arrival after the group had begun. The model is complex and has to work well from prescription, morning report discussions, escort, and, importantly, patient willingness to engage in group treatment. To address these challenges, we adjusted the CPA model from a 3-floor model described in figure 2, to a floor based model with targeted treatment track offerings on each floor, thereby moving the interdisciplinary staff from floor to floor and eliminating the escorting of patients to and from their prescribed treatment.

While efficacy measures indicate improved engagement in group treatment during admission, effects on length of stay have not been established, nor post-discharge effects on successful maintenance in the community verses recidivism (Anthony, Buell, Sharratt, & Althoff, 1972). Importantly, Behavioral Health embraced the realization that a psychiatric rehabilitation model offering a skill building approach was necessary in addition to medication management in order to provide the best service to our patients (Liberman, 2007). The CPA model was dependent on the physical plant of acute psychiatry at Kings County Hospital, however, the concepts of person-centered group treatment that offers an individualized approach to group treatment and well-defined treatment tracks specific to the patient population that offer a skill building approach can be developed on any inpatient service. A specialized, targeted group program in addition to medication management and milieu treatment, may help patients in their recovery process adjust to a shorter hospitalization and prepare them for maintenance in a community mental health setting.

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Appendix A

GROUP PROTOCOL: I DON'T BELONG HERE

Description/Rationale:
I Don't Belong Here is a group designed to focus on the pre-contemplation stage within the "Stages of Change" model through the use of motivational interviewing interventions. This group will enhance the recipient of care's intrinsic motivation to change by exploring and resolving resistance. Motivational interviewing acknowledges and emphasizes the notion that, the person who is resistant to treatment needs to begin by expressing their perspective, both the positive and negative aspects, in order to develop discrepancy as a way to support change. Hence, this group will recognize the uniqueness of each recipient of care by acknowledging their feelings and experiences related to their current hospitalization. The group should build on the four principles of MI: Express Empathy, Support Self-Efficacy, Develop Discrepancy and Roll with Resistance within a conversational model. The collaborative approach of motivational interviewing (MI) and Stages of Change Module (SCM) will guide the Therapist, to help the recipients' of care ("ROC") to consider the possibility of change, contemplate the risks and benefits of change, and prepare for moving forward with the identified change in their life. The therapist is cautioned to remain aware of how avoidance can derail this process.

Goals:
-To provide a "safe" environment
-To establish and continue to build therapeutic rapport
-To have the ROC express their feelings (both negative & positive) about being in a psychiatric setting.
-To develop discrepancy between current behavior and healthy alternatives

Objectives:
-The recipient of care will express their thoughts and feelings related to their hospitalization within a psychiatric setting.
-The recipient of care will acknowledge that their opinions have been heard as reported by facilitator.
-The recipient of care will be able to verbalize the pros and cons of the behavior that preceded their hospitalization and consider the elements of each.
-The recipient will be more receptive to the possibility of change.

Criteria:
-The recipient of care should be identified by the treatment team as in the pre-contemplative stage of change, in denial, or resistant to recovery based treatment.

-The recipient of care should be organized enough to sit through the duration of the group even if they chose not to speak.
-The recipient of care should be alert to time, person and place.

Referral:
The recipient of care will be selected by their treatment team, given their assessment of being in the pre-contemplative stage of change and referred to the group, "I Don't Belong Here."
Group Process/Content:

Introduction
-When the members have arrived, the group leader begins with introductory interventions that get the group members to make small talk and share their names. Ice breaker exercises that allow the recipients to get to know each other should be incorporated at this point.
-During this portion of the group the leader should ask the group members how long they have been in the hospital. Take note of those recipients with a longer length of stay, as their experiences can be utilized later in the group.

Week 1 - Development
-Facilitation of a go round share should explore why the group members feel that they should not be here (in the hospital) with further exploration about the situation that occurred prior to their hospitalization.
-An exploration should follow to identify some of the ways that a hospital can help a person.
-Once all members have shared, the group leader should ask for one volunteer to share their story the following week in order to further explore their experience.

Closure
-The take away worksheet should then be given out to each member with instructions to complete it and bring it to their next treatment team meeting.
-A brief review of the worksheet should tie in what the members talked about during the group. Ask each member to identify and write down 3 reasons that they shouldn't be in the hospital and 3 things that might be helpful about their hospitalization.
-The leader should then ask the members to share something that they felt was valuable from the group.

Week 2 - Development
-The leader should then reflect back on the beliefs and perspectives that were expressed in the previous group. New members should be allowed to express their own feelings and the circumstances that led to their hospitalization. Normalization and universality are the goals for the facilitator without moving to discussing coping skills.
-Utilizing a white board, the facilitator should get the previous weeks member to complete a "pros and cons" list of things related to their experience. Additional items should be pulled from the other members of the group to enhance the list.
-Processing afterwards should developing discrepancy between the cons and the pros.

Closure
-Repeat closure above

Week 3 - Development
-The leader should then reflect back on the beliefs and perspectives that were expressed in the previous 2 groups. New members should be allowed to express their own feelings and the circumstances that led to their hospitalization. Reflection and empathy should be the goals of the facilitator.
-The original example should be utilized in a role play. If the recipient who gave the example is not present, another example should be pulled from the group. The leader should facilitate a role play where the ROC plays both him/herself and the other people in their experience. Utilizing other members of the group to play additional roles

in the experience is encouraged.
-The processing continues to build on the discrepancy between what happened and a more therapeutic approach to what could happen.

Closure
-The facilitator should ask the members to discuss the worksheets that have been given out and their experience of bringing them to their treatment teams. Their responses should be processed in a way that encourages continued communication with their teams.

Evaluation:
Effectiveness of group interventions will be evaluated and subsequent recommendations/modifications determined on the basis of multiple factors, including:
1) Consumers' self-report during the discussion phase of the group, during treatment team meetings, and in individual discussions (i.e., change in reported attitudes).
2) Therapist's observation of the consumers' level of functioning during and outside of groups (i.e.: changes in observed behaviors).
3) Any changes in engagement or perspective connected with group participation and engagement in their recovery reported to or observed by other staff.

I Don't Belong Here worksheet

3 Reasons why you should not be in the hospital:
1. _____
2. _____
3. _____

3 Things that are helpful while in the hospital:
1. _____
2. _____
3. _____

Bring this to your next Treatment Team and share with them your thoughts.