Psychological Services

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Introduction

The practice of psychology in an inpatient psychiatric hospital is well suited to the recovery model. The recovery model's emphasis on viewing the person holistically, not as defined by his/her diagnoses, person-centered treatment, hope, wellness, respect, and striving to live a satisfying and meaningful life, are all consistent with the training and practice of psychology. Nevertheless, the inpatient psychiatric hospital presents challenges not so often found in the outpatient setting where psychologists have received much of their training and commonly practice. This chapter describes how the recovery model can be incorporated into the delivery of psychological services in inpatient psychiatric hospitals and some of the dilemmas psychologists encounter.

My reference for the inpatient setting is a state behavioral health hospital in which individuals are typically committed involuntarily on a civil or forensic status with lengths of stay ranging from weeks to months to years. This contrasts with psychiatric units in general hospitals where individuals are hospitalized for a relatively short time and often on a voluntary status. Not only is this the setting I am most familiar with, but it likely presents distinctive challenges and opportunities

for psychologists to provide recovery-oriented treatment. There is a dearth of empirical studies on psychological services in inpatient psychiatric hospitals. Nevertheless, I hope that this chapter conveys some of the recovery-oriented services psychologists can offer to individuals with serious mental disorders in public behavioral health facilities.

To provide context for subsequent sections, this chapter begins with a brief description of the patient population and the public mental health hospital. This is not a common site for psychologists in their training or practice (Duffy et al. 2002; Michalski et al. 2011; Norcross et al. 2005). To those with limited experience in public inpatient psychiatric facilities, this description will provide an overview of the patient population and the hospital in which such individuals receive services. To those who already work in such facilities, this description should sound familiar. Following this overview, this chapter describes some of the services psychologists provide. Many of these are traditional services provided by psychologists in other clinical settings, but often need adaptation to the public mental health hospital. Finally, I discuss some of the challenges posed by the recovery model for psychologists working in inpatient psychiatric facilities.

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Individuals Served and Clinical Setting

The state mental health hospital serves individuals with serious mental illnesses, often with co-occurring conditions, complex psychosocial needs, and limited resources. "Serious mental illness (SMI) is a diagnosable mental, behavioral, or emotional disorder … that results in serious functional impairment. These difficulties substantially interfere with a person's ability to carry out major life activities at home, at work, or in the community" (SAMHSA 2012, p. 10). Although a number of diagnoses fit this definition, common ones include schizophrenia spectrum disorders (notably Schizophrenia and Schizoaffective Disorder), severe mood disorders (such as Bipolar Disorder and Major Depressive Disorder, often with psychotic features), and personality disorders (in particular Borderline Personality Disorder and Antisocial Personality Disorder) (SAMHSA 2012). Substance use disorders commonly co-occur with these severe mental disorders (Bahorik et al. 2013; Fowler et al. 1998; Swartz et al. 2006) and an individual may experience more than one mental disorder. Intellectual Disabilities and Borderline Intellectual Functioning may be present along with a history of traumatic brain injury, all of which compromise cognitive abilities. Individuals with SMI commonly have a history of trauma (Grubaugh et al. 2011) and a high incidence of medical conditions (Parks et al. 2006; Saha et al. 2007). A large percentage of patients are hospitalized on a forensic status, and must concurrently address legal issues. Because many of these disorders have an onset in late adolescence or early adulthood, education, employment, social relationships, and family life are often disrupted. Thus, this population has serious mental disorders, often co-occurring mental or substance use disorders, medical conditions, legal problems, and limited resources, presenting many challenges to care.

Most individuals with SMI reside in the community, not inpatient facilities. For example, in 2009 just under 5% of U.S. adults aged 18 or older had a SMI in the past year representing approximately 11.0 million adults, and of these, 6.8 % received inpatient mental health services in the prior year (SAMSHA 2012). Thus, the individuals served in the public inpatient facility represent a small fraction of individuals with SMI, but they are often those with the most debilitating, treatment refractory, and complex issues.

Individuals admitted to an inpatient facility on a civil status (whether voluntary or involuntary), may have been treated first at a community hospital for several days or weeks, and then transferred because they were not sufficiently well to return to the community. Thus, the state hospital is often the last treatment alternative in the continuum of care. While commitment criteria vary from state to state, they commonly include dangerousness to self or others or an inability to care for oneself or protect oneself from harm. Individuals on a forensic status may be admitted directly to the state facility from a correctional center after having been charged with a criminal offense. They may be admitted for emergency treatment due to dangerousness to self or others, an evaluation of their competency to stand trial, restoration of their trial competency, or an evaluation of their mental state at the time of the alleged offense. Still others may be hospitalized after being adjudicated not guilty by reason of insanity.

Targets of treatment during hospitalization include symptoms associated with these serious mental disorders such as delusions, hallucinations, thought disorganization, negative symptoms, depression, mania, and anxiety; and the reasons leading to hospitalization such as dangerousness to self and others or an inability to care for oneself. While these are traditional areas to address during a hospitalization, and continue to be important, the recovery model considerably broadens the focus of care to include helping individuals assess their own recovery goals and to progress toward building or rebuilding personally satisfying and meaningful lives.

Length of stay in the hospital may range from weeks to years. Even with lengthy hospitalizations the goal is to help individuals return to the community in as independent a setting as is safely possible. Because of the long standing nature of many of these disorders, relapse and

rehospitalization are common. Thus, with read-missions and sometimes lengthy hospitalizations, a psychologist may work with an individual over a significant portion of the person's lifetime.

The complexity facing individuals with SMI in an inpatient setting necessitates a multidisciplinary approach including staff members from psychology, psychiatry, nursing, social work, occupational therapy, primary care, and other disciplines. As such, psychologists work as members of a treatment team which may differ from their training and previous experience (Geczy and Cote 2002; Reddy et al. 2010). Psychologists need to be aware of the services provided by other disciplines, the perspectives those disciplines hold, and the responsibilities and authorities of each, all within a system of care with many interested parties within and outside the hospital (Wood et al. 1994).

The Role of Psychologists in the Treatment of Individuals with Severe Mental Illness in Public Psychiatric Inpatient Hospitals

Despite important contributions by psychologists over the years, and a history of training and employment in settings serving individuals with SMI, currently psychologists are underrepresented in public psychiatry hospitals. In a survey of members of the American Psychological Association (Norcross et al. 2005), in 1960 45 % worked in settings that would likely treat individuals with SMI (psychiatric hospitals, general hospitals, and outpatient clinics). By 2003 the percentage had decreased to 13 %. The percentage working in psychiatric hospitals declined from 15 % in 1960 to 4 % in 2003. Some of this decline in employment in psychiatric hospitals may be attributable to the large reduction in psychiatric beds over this time; nevertheless, this low percentage contrasts considerably with other disciplines. For example, according to data from Duffy et al. (2002), 41.9 % of psychiatrists, 30.9 % of social workers, and 50.8 % of psychiatric nurses were primarily employed in hospitals and clinics compared to 15 % of psychologists. Comparable figures for mental health hospitals were 21 % for psychiatrists, 3.9 % for social workers, 9.9 % for psychiatric nurses, and 3.0 % for psychologists. As Levant et al. (2001) lamented, "Psychology does not currently play a major role in the treatment of persons with serious mental illnesses such as schizophrenia and other psychotic disorders, and is not an important presence in the public sector systems that provide most of their care. Although clinical psychology once specifically defined its purview as serious psychopathology, this area has largely been abandoned to psychiatrists and sub-doctoral personnel. This has been short-sighted for the profession and has not been in the best interest of persons with serious mental illnesses" (p. 81).

A number of reasons may account for this underrepresentation by psychologists in inpatient psychiatric hospitals. In their graduate training, students may have limited coursework and practica relevant to SMI or exposure to faculty for whom this is a primary interest (Hoge et al. 2000; Mueser et al. 2013; Reddy et al. 2010). Psychologists may adhere to outdated models of SMI, especially ones that overly emphasize a medical model, leading to the belief that psychological services are of little value (Roe et al. 2006; Smith et al. 1993). They may be unaware of the many contributions psychologists have made to the field, other models of SMI (including the recovery model), and evidence-based and best practices for SMI (e.g., American Psychological Association and Jansen 2014; APA/CAPP Task Force on Serious Mental Illness and Severe Emotional Disturbance 2007; Dixon et al. 2009; Mueser et al. 2003b; Silverstein et al. 2006b). Finally, psychologists may have a preference for working with individuals who have good insight, motivation, cognitive abilities, and verbal skills, and thus steer away from those with SMI (Roe et al. 2006).

With specific reference to public inpatient psychiatric facilities, psychologists may be discouraged by the problems they encounter (Geczy et al. 1990; Wood et al. 1994). Other disciplines, and even psychologists themselves, may question their level of clinical authority and effectiveness, and whether they have the requisite knowledge, skills,

and abilities to practice independently, especially if the facility relies heavily on a medical or disease model. Limited resources, competition for scarce resources, and scrutiny and mandates by outside agencies (e.g., the Centers for Medicare and Medicaid Services, the Joint Commission, and the U.S. Department of Justice) can put considerable pressure on psychologists (and even more so on members of other disciplines) to justify their work and follow certain procedures. Psychologists may then find themselves doing a considerable amount of documentation rather than more satisfying tasks. For example, in one survey, psychologists working in state hospitals in the Midwest reported spending over 27 % of their time doing paperwork (Corrigan et al. 1998). The contributions of psychologists may be undervalued leading to difficulties effecting change within a facility such as implementing or maintaining innovative programs. For example, in Nebraska a long standing state of the art psychosocial rehabilitation program in a state hospital was closed despite good outcomes (e.g., reductions in aggression, discharge of individuals with long stays in the hospital) and being cost-effective (Spaulding et al. 2010; Tarasenko et al. 2013). In light of these trends and obstacles, some have called for revisions to the training of psychologists so that they are well prepared to work with persons with SMI (e.g., Mueser et al. 2013; Wood et al. 1994).

Despite these challenges, psychologists practicing in the public inpatient setting reap many rewards (Geczy and Sultenfuss 1994; Geczy et al. 1990). Psychologists can make significant contributions to the recovery of individuals with severe and debilitating disorders. Psychologists work with individuals from other disciplines who bring their own perspectives and expertise to a common mission. This provides camaraderie and support while dealing with the difficulties faced in this setting. The inpatient setting offers opportunities to supervise and train students and interns which is intellectually stimulating. Finally, public psychiatric hospitals offer flexibility and freedom for psychologists to pursue a variety of tasks such as clinical care, supervision, research, program and policy development, and leadership. With this background, I now turn to specific areas of psychological services provided in public inpatient psychiatric hospitals, how they relate to recovery-oriented principles, and some of the challenges psychologists encounter.

Assessment

A good assessment is the foundation for treatment and clinical decision-making. Psychologists are well trained to perform assessments, and in a public psychiatric hospital psychologists assess many areas using a variety of methods. Many of these assessments predate the recovery movement; nonetheless, they can be performed in a recovery-oriented manner. For example, in order to provide good care, it is helpful to clarify diagnoses, symptoms, and personality characteristics that impact treatment. These are traditional areas of assessment for psychologists that might be accomplished using objective personality instruments such as the Personality Assessment Inventory (PAI; Morey 1997), the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher et al. 2001), and the Millon Clinical Multiaxial Inventory-IV (MCMI-IV; Millon et al. 2015). For the most part, these instruments assess symptoms and problem areas, and hence focus on deficits rather than strengths. While the assessment of symptoms and personality characteristics can be very useful, psychologists using such instruments need to bear in mind this narrow focus and that the results do not provide a full assessment of an individual. In contrast, neuropsychological assessments have long been used to identify both strengths and weakness, and to help individuals use their strengths to compensate for their weaknesses (Medalia and Belucci 2012).

Areas and Functions of Assessment

Psychological assessments help make differential diagnoses, describe current functioning, identify specific symptoms of mental disorders, assess personality characteristics, identify risk factors for harm to self and others, discern factors which mitigate risk, assess cognitive strengths and weaknesses, select therapeutic interventions, monitor change over time, and provide feedback as a therapeutic intervention (Meyer et al. 2001).

Psychological assessments help detect subtle thought disturbances, differentiate major mental disorders from personality disorders, and assess the manner in which personality characteristics impact treatment.

Given these long standing functions of psychological assessments, one may question the ways in which they are consistent with recovery-oriented principles. As noted by a number of writers, the concept of recovery includes the amelioration, if not elimination, of distressing symptoms that interfere with life goals, and having a meaningful life despite ongoing symptoms (e.g., Anthony 1993, Law and Morrison 2014). As such, accurate diagnoses and careful assessment of symptoms inform treatment. Furthermore, since recovery is expected to be nonlinear (Anthony 1993; Substance Abuse and Mental Health Services Administration 2006) and change is often slow, for a number of individuals in public psychiatric hospitals, psychological assessments can track subtle changes over time. Serial assessments document progress, and in doing so instill hope in individuals and their treatment teams. Finally, such assessments may be used therapeutically (Finn and Tonsager 1997; Poston and Hanson 2010). For example, while objective personality tests use fixed choices (e.g., true/false) for standardization, such a format does not allow individuals to qualify their answers. Discussing the overall test results and answers to specific questions can form the basis for therapeutic sessions. With self-report measures, this gives individuals the opportunity to disclose and learn more about themselves. Being better informed helps individuals be more involved in their treatment. For example, I worked with an adolescent woman who had been hospitalized for some time with Borderline Personality Disorder and frequently engaged in self-harm and aggression. In discussing Borderline Personality Disorder, not only did she find many of the characteristics descriptive of her, but she reported some reassurance in knowing that others have had similar experiences and were able to recover (Gunderson et al. 2011, Zanarini et al. 2012).

Because many traditional assessment instruments focus on symptoms and deficits, personal strengths can be overlooked when relying solely on these measures. Strengths should be incorporated into treatment plans and help the individual and treatment providers focus on behaviors to enhance, not just behaviors to suppress. A strengths based approach is especially well suited for positive behavior support plans which reinforce replacement behaviors. Identifying strengths can be done in an interview or with questionnaires, for example, by asking about goals that provide motivation for treatment, sources of support, interests, reasons for living, skills, religious beliefs, and so on.

Assessing the risk of self-harm and violence is especially germane in the public psychiatric facility because these risks are often the basis for persons being committed to the hospital. In terms of recovery, risk assessment is especially important as there can be tension between recovery-oriented principles such as autonomy, on the one hand, and the prevention of serious harm to self or others, on the other (Hillbrand et al. 2010; Pouncey and Lukens 2010). Many risk assessment instruments exist (e.g., the Broset Violence Checklist, Almvik and Woods 1998; the Classification of Violence Risk based on the MacArthur Violence Risk Assessment Study, Monahan et al. 2001; Fazel et al. 2012; the Historical, Clinical, Risk Management-20 version 3, Douglas et al. 2013; the Columbia-Suicide Severity Rating Scale, Posner et al. 2008). These instruments help determine a person's level of risk, factors that increase risk, protective or mitigating factors, and dynamic risk factors to focus on in treatment. Thus, these assessments aid in making decisions about precautions needed to protect the person or others from harm (e.g., one to one, constant, or direct observation), the selection of treatments to reduce risk (e.g., anger management or substance abuse treatment), and reassessing risk over time.

Assessment Methods

As in outpatient settings, psychologists in public inpatient psychiatric facilities have a wide array of methods available to assess the above areas. Objective personality tests, projective measures (e.g., Rorschach Inkblot Test), intelligence tests,

and neuropsychological tests are well known to psychologists in both inpatient and outpatient settings, and it is beyond the purview of this chapter to review these. However, I briefly comment below on a few assessment methods that are especially relevant to the inpatient psychiatric facility even though they are not unique to this setting.

Clinician administered rating scales and behavioral observations are especially helpful as supplements to or substitutes for self-report measures. They may be useful when working with individuals who have limited insight or who may have reasons for not being forthright, such as individuals with legal charges who wish to remain in a hospital rather than return to jail, or individuals with a high level of suspiciousness. Even though such individuals may decline most forms of assessment, clinicians still have an obligation to conduct assessments and provide treatment. Rating scales and observations can be useful in these situations. Examples of clinician administered rating scales include the Brief Psychiatric Rating Scale (BPRS; Lukoff et al. 1986) and the Positive and Negative Syndrome Scale (PANSS; Kay et al. 1987) for multidimensional symptoms, the PSYRATS (Haddock et al. 1999) for hallucinations and delusions, and the Young Mania Rating Scale (Young et al. 1978) for symptoms of mania.

Behavioral assessments, functional analyses, and functional assessments assist in describing challenging behaviors, specifying treatment goals, identifying hypothesized casual variables, selecting interventions, and monitoring treatment outcomes (Haynes et al. 1997; Iwata and Dozier 2008). Although functional analyses, in which hypothesized causal variables are experimentally manipulated, may be difficult to implement in inpatient psychiatric facilities, functional assessment methods can be useful. Interview based instruments, such as the Questions About Behavioral Function in Mental Illness (QABF-MI; Singh et al. 2006) and the Functional Assessment Interview (FAI; O'Neill et al. 1997), identify antecedents to and consequences of challenging behaviors and guide treatment. Similarly, using reinforcer checklists with patients or staff members who know the patient well can identify items or activities to use as reinforcers for replacement behaviors.

Because direct care staff members spend much time with patients in different settings within the hospital, they are important sources of behavioral observations. Behavioral observations can be complex as when an extensive array of behaviors are targeted (e.g., in some token economy systems; Paul and Lentz 1977; Silverstein et al. 2006a), or simple as when just a few behaviors are selected for observation (e.g., performance of activities of daily living, social skills, self-harm, and aggression). While some facilities have developed complex observational systems with good inter-rater reliability, often behavioral observations must be simplified due to minimal staffing, time pressures, and limited training opportunities. Behaviors need to be defined as clearly as possible and sampling intervals should fit the hospital routine. These observations often have high ecological validity in that behaviors that are the focus of treatment are directly observed (e.g., self-harm and aggression), and are especially useful for tracking change over time.

Self-monitoring is another assessment method that can be used in a public inpatient psychiatric facility. Examples include daily mood ratings (e.g., Miklowitz 2011), engagement in pleasant events (e.g., Addis and Martell 2004), and the use of skills learned in dialectical behavior therapy (DBT) via diary cards (Linehan 1993). Self-monitoring forms need to be simple given that many individuals with serious mental disorders in the hospital may be limited by cognitive impairments or the severity of their symptoms. The psychologist or other staff members should check self-monitoring forms frequently to promote completion of the forms. By its very nature self-monitoring provides immediate feedback to individuals, and allows them to see the progress they are making toward their goals. For this reason, as well as to be consistent with a strength-based approach to treatment, the valence of at least some of the target behaviors should be positive. Doing so capitalizes on the reactive effects and treatment functions of self-monitoring (Korotitsch and Nelson-Gray 1999).

Although not always thought of as an assessment method, per se, interviews are perhaps the most commonly used method of assessment in inpatient psychiatric facilities. Interviews may be structured (e.g., various diagnostic interview schedules) or unstructured, which is more common. Interviews are very flexible and serve many of the functions of other forms of assessment (e.g., diagnosis, identification of goals and strengths, development of a therapeutic alliance, assessment of change, formulation of factors contributing to problems impeding progress). Thought of in this way, interviews are subject to the same concerns about psychometrics (e.g., reliability, validity, positive and negative predictive power) as other forms of assessment. Structured interviews can be studied for their psychometric properties, but unstructured interviews cannot because of their lack of standardization. As such, psychologists need to be aware of the limitations of unstructured interviews. For example, individuals often provide different information, have different affective presentations, and may exhibit differences in thought organization and content during an interview with a treatment team than in an individual interview. Finally, collateral information from family members or previous treatment providers can be particularly helpful in corroborating interview and self-report information. In practice, assessments in public inpatient psychiatric hospitals rely on multiple methods rather than a single source, and are ongoing rather than static.

Interventions

This section describes a number of therapies and interventions psychologists can deliver in public inpatient behavioral health facilities including individual and group psychotherapy (e.g., supportive, brief, and extended therapies from various theoretical traditions), psychoeducation about mental disorders and treatment, and psychosocial or psychiatric rehabilitation (PSR). (The terms psychosocial rehabilitation and psychiatric rehabilitation are used interchangeably.) PSR refers to a set of interventions that focus "…

on the reduction of disability and the promotion of more effective adaptation in the individual's environment by using specific interventions to improve coping and behavioral abilities" (Silverstein et al. 2006b, p. 3). Psychologists developed many of these interventions, but they are not used solely by psychologists. Many are evidence-based practices while some are promising or emerging practices (APA/CAPP Task Force 2007; Dixon et al. 2010). The evidence for some of these interventions comes from studies conducted in outpatient settings or with study participants who differ in important respects from individuals in the public inpatient setting (e.g., symptom severity, cognitive impairment, length of stay, etc.). As such, it is often necessary to make adaptations to these interventions, knowing that this impacts the fidelity of their implementation. Many of these therapies can be delivered individually, in groups, or both.

The need for these therapies is well beyond the resources of hospital staff giving psychologists many opportunities to provide them. However, implementation depends on factors such as hospital resources and the willingness and readiness of individuals to avail themselves of these services. Despite its limitations, one advantage of the inpatient facility is that therapeutic interventions can be provided for differing lengths of time and frequencies. For example, for many individuals therapy works well when done in short informal sessions, e.g., 15 min in a consultation room or quiet area of the dayroom. At the other end of the spectrum, while unusual, sessions lasting an hour or longer several times a week can be conducted.

A comprehensive review of specific therapies is beyond the scope of this chapter, nor is this survey exhaustive. Furthermore, public psychiatric hospitals do not provide all the interventions describe here. Instead this section illustrates a range of interventions that psychologists can provide in inpatient facilities with comments on their relevance to recovery principles. For details about specific therapies, refer to the many available resources, especially those that describe interventions that have emerged over the past

20 years (e.g., APA and Jansen 2014; Dickerson and Lehman 2011; Dixon et al. 2010; Silverstein et al. 2006b; Wright et al. 2008).

Individual Psychotherapy

Lysaker et al. (2010) noted that individual psychotherapy, "an activity wherein a client and therapist develop an alliance and mutual goals, while using client's guided self-exploration in the service of improving functioning and reducing distress, is at present, notably absent from most discussions of recovery focused treatment…" (pp. 76–77). They speculate that the lack of individual psychotherapy may be due to limited resources or the perception that individuals with SMI do not benefit from therapy. For much of the twentieth century psychotherapy for schizophrenia used a psychodynamic paradigm. With the advent of psychotropic medication and studies in the 1980s showing a lack of efficacy for psychodynamic therapy, the study of psychotherapy for schizophrenia declined until the 1990s when cognitive behavior therapies began to appear (Dickerson and Lehman 2011). There are now a number of therapies for individuals with SMI with many outcome studies documenting their efficacy as described below.

Individual psychotherapy serves many functions: emotional support, skill building, illness education, symptom reduction, goal setting, improved self-control over impulses and behavior, and working toward a more meaningful life (Geczy and Cote 2002; Grant et al. 2014; Lysaker et al. 2010). In a study by Coursey et al. (1995), 72 % of individuals with SMI receiving services in psychiatric rehabilitation centers perceived individual psychotherapy as effective. The interventions rated as most useful were getting in touch with one's feelings and practical advice. On average, participants identified 28.5 therapeutic issues that were important to them, including illness-intensified life issues (e.g., independence, self-esteem, interpersonal relationships, feelings), adverse consequences of the illness (e.g., lack of work, stigma), self-management of the disorder, coming to terms with the disability, managing specific symptoms, and normal developmental issues (e.g., dealing with sexual issues and

family). Individuals with schizophrenia preferred shorter infrequent sessions while those with bipolar disorder and depression were evenly split between shorter infrequent sessions and longer frequent sessions.

In the inpatient setting, the mode and type of therapy depends on many factors such as the person's course of illness, progress in the hospital, severity of symptoms, past history with mental health services, and cultural issues. When individuals are first admitted to a public psychiatric hospital they may have many reactions. Some may be upset or angry at what they view as an illegal and unnecessary detention, frightened or confused not knowing what to expect, or discouraged by ending up in the hospital. Such reactions may be affected by prior experiences, fears of being harmed in the hospital fueled by paranoia or hallucinations, disorganized thinking making it difficult to understand events, communication difficulties (e.g., those with limited English proficiency, deaf), and cultural factors (e.g., the stigma of mental illness that exists in some cultures, men from some cultures being expected to follow directions from female staff members). On the other hand, some individuals may have positive reactions such as those with paranoia who see the hospital as a haven from those they think want to harm them, and people with suicidal ideation who feel relieved knowing that they will not likely hurt themselves in the hospital.

Given these reactions, in the early days of hospitalization the recovery principles of hope, safety, respect, and individualized person-centered care inform the therapeutic relationship. Developing a good therapeutic relationship has long been recognized as an important component in psychotherapy, in general, and specifically with individuals with SMI (Dickerson and Lehman 2011; Howgego et al. 2003; Kingdon and Turkington 2008; Taylor et al. 2009). For example, in an international Delphi study of service users, mental health professionals, caregivers, and advocates about what promotes recovery in people with long-term mental health problems in institutional settings, "staff attitudes," (e.g., the therapeutic alliance), were ranked second in importance among 11

domains (Turton et al. 2010). Therapeutic interventions, which included psychotropic medications and "talking therapies," were ranked the highest.

Developing a good therapeutic relationship early in the course of hospitalization can be challenging due to the factors noted above. Additionally, tension may exist with patients whose paramount goal is immediate release, but who have been committed involuntarily. In such instances, the psychologist can listen attentively to the person's account, provide information about what led to the admission, identify discharge criteria, and discuss what will help the person return to the community. At times, such discussions may provide some reassurance and shared understanding, but at other times the person may still not feel heard because the explanation did not result in release from the hospital.

In contrast to someone recently admitted to the hospital, for those whose hospitalization has been extended for a long period of time, discouragement, hopelessness, frustration, and resentment may set in, especially if they have limited insight into their illness. In such instances it may be beneficial to provide information about the reasons for continued hospitalization, discharge plans, and what they can do to facilitate discharge so as to instill a sense of agency. The psychologist may help the person identify goals to work on while in the hospital, and convey hope that discharge and other goals will indeed be reached.

Psychotherapy may be especially useful helping people put their illnesses and lives in a larger framework. Citing the literature indicating that many people with schizophrenia recover, Lysaker et al. (2010) speculated that psychotherapy might aid recovery by developing a personal narrative, i.e., a context for individuals' illnesses such that they have a richer understanding of themselves and the world. Such narratives might allow individuals to see themselves as resilient in the face of adversity, understand the illness as a biological disorder for which they are not to blame, reduce the stigma of having an illness, and instill a sense of personal agency.

While applicable throughout life, personal narratives become especially poignant at a couple of points in time. One point is early in the course of the illness. Since many serious mental disorders begin in late adolescence or early adulthood, they often disrupt critical developmental tasks such as completing an education, establishing a career, forming close interpersonal relationships, or creating families. Symptoms and behaviors associated with the illness may lead to withdraw from school, job loss, disrupted relationships, strain within the family of origin, lost social supports, hospitalizations, and legal charges. At such times, individuals may struggle with understanding their illness, the impact the illness is having on their lives, what the future holds for them, and how that future differs from what they had envisioned. The stigma associated with mental disorders adds to the burden. Psychotherapy may help individuals understand their illness and provide hope that by managing it there is much reason to expect that they will have meaningful and satisfying lives. The research on the long-term outcome for individuals with schizophrenia (Jaaskelainen et al. 2013; Lang et al. 2013; Warner 2010) and borderline personality disorder (Gunderson et al. 2011, Zanarini et al. 2012) can be illuminating, as can meeting with peers in recovery or reading books and articles by people with lived experiences (e.g., Jamison 1995; first person accounts in Schizophrenia Bulletin).

The other point where personal narratives can be especially poignant is much later in life when individuals look back on lives that had not turned out as they had hoped; lives that may have included many hospitalizations, little time spent in meaningful employment, limited social supports and satisfying relationships, few financial resources, and inadequate housing. Awareness of the illness, hopelessness, and feelings of inadequacy are risk factors for suicide in individuals with schizophrenia (Caldwell and Gottesman 1990; Drake et al. 1984; Siris 2001). At such times, psychotherapy can help individuals develop new goals for themselves and ways they can find meaning in their lives despite the effects the illness has had on them.

Group Psychotherapy

Group therapies have a number of advantages in public inpatient hospitals in much the same way as in outpatient settings. In public psychiatric facilities resources are limited, especially human resources, and psychologists find themselves spending a considerable amount of time in activities other than the direct delivery of patient care. For example, in a survey of psychologists in state hospitals, 40 % of their time was spent on paperwork and supervision (Corrigan et al. 1998). Thus, group therapies offer an economical and efficient way of delivering services. Beyond this practical advantage, group therapies have many other benefits especially relevant to recovery-oriented principles. Groups allow members to gain support from their peers, learn from the experience of others, and have models of individuals who are further along in their recovery. Other advantages are reality testing for psychotic symptoms, emotional support, and the opportunity to provide feedback and guidance in a nonthreatening setting (Geczy and Cote 2002).

Groups can range from process-oriented groups with relatively little structure to highly structured groups with a clear curriculum and active direction from group leaders. Some structure is often beneficial for individuals with psychotic symptoms, cognitive disorganization, and/or negative symptoms. The effectiveness of inpatient group psychotherapy has empirical support. In one meta-analysis of group therapy, researchers found effect sizes of 0.31 in controlled studies and 0.59 in pre- post-studies, and 0.50 for individuals diagnosed with schizophrenia (Kösters et al. 2006). Many of the interventions described below can be delivered in group as well as individual formats.

Cognitive Behavior Therapy (CBT) for Psychosis and Mood Disorders

Many readers will be familiar with cognitive behavior therapy (CBT) (Beck et al. 1979) and behavior activation for depression (Addis and Martell 2004; Jacobson et al. 1996). Perhaps less well known are CBT for psychosis (CBTp) (Beck et al. 2008; Kingdon and Turkington 2008) and CBT for bipolar disorder (Basco and

Rush 2005; Miklowitz 2011). All of these therapies are useful in inpatient psychiatric hospitals.

Because of the frequency of psychosis in public behavioral health facilities, this section focuses on CBTp, which, like CBT for depression, links thoughts, emotions, and behaviors; and posits a central role for cognition (e.g., schemas, dysfunctional beliefs) and cognitive processes (e.g., overgeneralization, jumping to conclusions) in the presentation of symptoms and functioning. Therapy is individualized and multifaceted. It entails developing a shared understanding of symptoms and treatment goals; identifying the links between thoughts, emotions, and behaviors; collaboratively exploring the evidence for specific beliefs; devising means by which to test core beliefs; and problem solving. In published studies, CBTp has usually been provided in combination with pharmacotherapy.

CBTp has been subjected to much empirical testing and has been recommended in guidelines from the American Psychiatric Association (Dixon et al. 2009), the United Kingdom's National Institute for Health and Care Excellence (2014), and the Patient Outcome Research Team (PORT, Dixon et al. 2010). In a frequently cited meta-analysis of 34 studies, the overall effect sizes for CBTp were 0.37 for positive symptoms, 0.44 for negative symptoms, 0.38 for functioning, 0.36 for mood, −0.19 for hopelessness, and 0.35 for social anxiety (Wykes et al. 2008). In a more recent meta-analysis of 22 studies, smaller effect sizes were found. The effect size for positive symptoms was 0.16, which was still significant, but the effect size for negative symptoms was not significant (Turner et al. 2014). Differences in findings between the two meta-analyses may be due to insufficient power, heterogeneity of patients, differences in specific CBTp models, and the intensity of the therapy (Thase et al. 2014; Turner et al. 2014). In a recent effectiveness study of CBTp, moderate effect sizes were found for positive symptoms, general psychopathology, depression, and functional improvement in work and social relationships (Lincoln et al. 2012). Dropout rates were low, and participants' perceptions of treatment were highly positive (e.g., 98 % rated the therapy as

helpful or very helpful, 95 % would recommend it to a friend).

I offer two examples of CBTp from my hospital practice. One was with a middle-aged man with a college degree who had been married for many years and previously held professional jobs. For several years, he believed that there was a vast conspiracy against him such that people were watching him wherever he went. He believed that his family was behind this conspiracy and wanted him to kill himself. He was hospitalized after making threats to harm his family and kill himself. In the hospital he believed that his family continued to have him under surveillance by planting "fake patients" to watch him. As a result of his beliefs, his wife divorced him; he became estranged from his family of origin; and he had not been employed for several years. Early in his hospital stay he was convinced that if he told others his account of events, they too would conclude that he was the subject of a conspiracy. He rated the strength of his belief in the conspiracy at 99 %.

CBTp sessions were held two to three times a week for approximately 3 months. Therapy began by listening carefully and nonjudgmentally to his account of the conspiracy and learning about his life. He was then invited to consider the evidence for his beliefs, the plausibility of his conclusions, and alternative explanations for the events he had experienced. One by one he concluded that the evidence for his beliefs was weak, and by the end of therapy he no longer believed in the conspiracy. With this improvement the focus of therapy shifted to building a satisfying life for himself given what he had gone through over the past several years. As a result he restored relationships with his family of origin and planned to look for work again.

In another example of CBTp, a woman with a long history of psychiatric hospitalizations and several past suicide attempts had been hospitalized three times in just over a year. She was very upset by the thought that she could kill members of her family with her mind and had taken an overdose of her medication to avoid harming them. Therapy sessions took place almost daily for approximately 6 weeks. Treatment included several interventions: exposure to her repetitive thoughts that she could kill her family with her mind; coping skills training to manage stressors which exacerbated her delusions; and engagement in pleasant activities to improve her mood, social relationships, and quality of life. An important part of the CBTp treatment included behavioral experiments. We devised ways to test her belief that she could kill her family with her mind. For example, she thought that she could set her family on fire with her thoughts. She agreed that if she had this power she could easily light a match or raise the temperature of a thermometer using her mind. She also believed that her thoughts could cause her family to die in a car accident. Thus, in other experiments she tried to flatten car tires and burst street lamps at the hospital with the power of her thoughts. When she could not cause these things to happen, she questioned her mental powers such that by the end of therapy she no longer believed that she could kill her family with her mind. Greatly relieved by this new realization, she returned to the community.

As these two examples illustrate, CBTp is a highly collaborative partnership between the individual and the psychologist. Although not always highlighted in studies of CBTp, developing and maintaining a good working relationship is a significant component of therapy. Both individuals in the above examples had been upset that no one believed them, not treatment providers, not even family members; and they appreciated having someone listen to their accounts. CBTp brought relief from distressing and debilitating symptoms, taught coping skills, provided education, and promoted self-efficacy, all of which are consistent with recovery principles.

Dialectical Behavior Therapy (DBT)

Linehan (1993) developed DBT for the treatment of individuals with Borderline Personality Disorder (BPD). She designed it for outpatient treatment, but a high percentage of individuals with BPD are hospitalized at some time in their lives, and they occupy a high percentage of psychiatric beds (Bohus et al. 2000). Staff members often have strong negative reactions to

the volatile emotions and self-injurious and violent behaviors sometimes exhibited by individuals with BPD. Furthermore, some staff members believe that the course of BPD is chronic and unremitting with little likelihood of recovery. However, recent studies have shown high rates of symptom remission and functional improvement (Gunderson et al. 2011, Zanarini et al. 2012). For example, one 10-year follow-up study, found that 85 % of individuals with BPD met the definition of remission (two or fewer diagnostic criteria for BPD) for a 12-month period with a relapse rate of 12 % (Gunderson et al. 2011) although social functioning (e.g., full-time employment, marital or cohabitating relationships, Global Assessment of Functioning ratings) remained at low levels despite statistically significant improvements.

DBT is an evidence-based practice. In a 2-year follow-up study, compared to individuals who received therapy from community experts, those in the DBT group had half the rate of suicide attempts, fewer emergency department visits, and fewer hospitalizations (Linehan et al. 2006). In a more recent 2-year, naturalistic, outcome study, individuals in DBT showed improvement in self-injurious behaviors, symptom severity, utilization of health services, and quality of life at follow-up, but there were no significant differences from those receiving manualized general psychiatric management developed specifically for the study (McMain et al. 2012).

DBT has been adapted to inpatient settings. Swenson et al. (2001) described a program whose components included coming to agreement on treatment goals and plans, skill building, contingency management, behavioral analysis of self-injurious behaviors, staff support, and connections with outpatient therapists. Bohus et al. (2000) developed a 3-month DBT program with three stages: analysis of target behaviors, (especially those that led to hospitalization), education and skill building, and discharge planning. In a small pilot study, many symptoms and the frequency of self-harm improved significantly (Bohus et al. 2000). In another uncontrolled study, after 3 months of inpatient DBT, significant reductions in symptoms were found at

post-treatment and 15-month follow-up (Kroger et al. 2006). In a controlled trial in an inpatient facility, compared to a naturalistic wait list control group, those getting DBT showed a reduction in self-injurious behaviors and many symptoms (Bohus et al. 2004). DBT was introduced into the Pennsylvania state hospital system in 2003 in an effort to reduce seclusion and restraint (Smtih et al. 2015).

When DBT is implemented in a public inpatient facility, it may be necessary to make some modifications. Didactic information and skill building often need to be presented at a slower pace than in the outpatient setting. Similarly, abstract DBT concepts are difficult for some patients to comprehend (e.g., wise mind, emotional mind, and reasonable mind; some mindfulness strategies; radical acceptance). Such adjustments to teaching materials and strategies may be necessary because of the cognitive impairments, limited educational attainment, and/or symptom severity of individuals with BPD in public inpatient facilities. Nevertheless, many individuals enjoy learning about BPD and developing skills. For patients and staff alike, it is helpful to realize that they are "doing the best they can," which is quite a challenge during periods of extreme emotional and behavioral dyscontrol that can occur in the inpatient setting. To this end, the DBT core strategy of validation can be very useful. For example, "In cheerleading, the therapist is validating the inherent ability of the patient to overcome her difficulties and to build a life worth living … A key therapist attitude [that says] 'I believe in you'" (Linehan 1993, p. 243). Cheerleading can counter some of the person's self-loathing and negative reactions by staff. Coaching skills is another component of DBT which psychologists working in public psychiatric hospitals can employ frequently, often in vivo and at the time when the skills are needed. For example, an individual may get upset about a conflict with a peer on the unit. The psychologist may be on the unit when this occurs or shortly thereafter to coach DBT skills for that specific situation, and provide praise and encouragement. In these ways, DBT teaches individuals control over their lives and engenders autonomy consistent with a recovery orientation.

Token Economy and Contingency Management

Token economies and contingency management are based on operant and social learning principles. Their flexibility makes them particularly well suited for long-term inpatient care (Dixon et al. 2010). These programs can address a wide array of behaviors common to many individuals on a treatment unit and/or tailored to a small number of behaviors individualized for a particular person. Examples of target behaviors include activities of daily living, social skills, participation in treatment activities, and improved self-control of aggressive behaviors. Selection of reinforcers is also flexible, ranging from highly individualized ones to generalized reinforcers such as points or tokens that can be exchanged for back-up reinforcers. Reinforcers can be social (e.g., praise), tangible (e.g., snacks), or activity-based (e.g., extra time on a computer). Specific examples include playing basketball or football for half an hour with the unit psychiatrist or psychologist for controlling aggression, going to a restaurant with staff members for attending groups, and earning money for wearing a continuous positive airway pressure (CPAP) machine for sleep apnea.

Token economies have been used for many decades and are supported by research, but they have not been widely implemented in hospitals (Dickerson et al. 2005; Dixon et al. 2010; Paul and Lentz 1977; Silverstein et al. 2006a). Dickerson et al. (2005) pointed out that much of the research on token economies is more than 20-years old and was conducted before the adoption of more objective diagnostic criteria and the introduction of atypical antipsychotic medications. Some of the institutions in which the research was conducted would not have met the basic needs of individuals according to today's standards, and therefore some of the reinforcers used in the studies would not be appropriate today. Finally, by current standards for admission, some of the individuals would probably not have been hospitalized, limiting the external validity of the research (Dickerson et al. 2005).

While seemingly simple, the development, implementation, maintenance, and evaluation of token economies and contingency management programs require considerable care and expertise which psychologists can provide. It is important to insure that deprivation of basic needs is not a part of the program and that patients' rights are upheld. Preferably, the program is overwhelmingly positive; that is, positive reinforcement is provided for adaptive behaviors. Much care must be exercised in the use of restrictive measures such as response cost. Not only are positive programs more likely to be effective, but they encourage patients and staff to work toward desired goals and utilize persons' strengths to build new skills.

Token economies have been criticized for the degree of control exerted by staff. However, as pointed out by Dickerson et al. (2005), hospital staff already exercises a high level of control without the use of token economies, and contingencies are ubiquitous for all individuals whether mentally ill or not. The issue then is how best to structure these contingencies. One way to address this criticism is to make participation in the program voluntary as in the Second Chance program described by Silverstein et al. (2006a). During the first 5 years of the program only one person requested to return to the referring state hospital from which he/she had come, reflecting the participants' favorable impressions of the program.

Social Skills Training

Social skills training utilizes behavioral principles to teach a broad array of skills necessary for effective functioning in interpersonal situations (Bellack et al. 2004; Kopelowicz et al. 2006; Liberman 2007). Topics include basic communication skills, assertiveness, conflict resolution, problem solving, developing supportive relationships, job interviewing, refusing illicit drugs, and collaborating with mental health care providers. Training is often done in groups and includes goal setting, didactic instruction, modeling, behavioral rehearsal, coaching, feedback, positive reinforcement, and homework assignments. The content is flexible enough so that group members can raise specific situations to address in training.

Social skills training is an evidence-based practice recommended in the PORT guidelines

for individuals who have skills deficits in everyday activities (Dixon et al. 2010). A meta-analysis of 22 randomly controlled trials found moderate effect sizes on performance-based measure of social and daily living skills, community functioning, and negative symptoms; a small and significant effect size for relapse; and a small and nonsignificant effect sizes for other symptoms (Kurtz and Mueser 2008). Training needs to incorporate maintenance of skills over time and generalization to everyday settings (American Psychological Association and Jansen 2014; Dixon et al. 2010; Kern et al. 2009).

Integrated Treatment for Co-occurring Disorders

Individuals with SMI have high rates of alcohol and drug use. Estimates of the co-occurrence of SMI and substance use vary depending on the study sample and methods. In the National Institute of Mental Health Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) project, 60.3 % of individuals with schizophrenia had at least some substance use including 37 % classified as having a current substance use disorder (Swartz et al. 2006). Rates of current substance use disorders for men and unmarried individuals were over 80 %. In an outpatient sample, almost 60 % of individuals with a diagnosis of schizophrenia currently used alcohol or drugs (Fowler et al. 1998). Over 26 % had a current diagnosis of substance abuse or dependence, and almost 60 % had a lifetime diagnosis of substance abuse or dependence. In the McArthur Violence Risk Assessment Study, 67 % of those with SMI used alcohol within 30 days of hospital admission, and 30 % used marijuana (Bahorik et al. 2013). Substance use in individuals with SMI has been associated with symptoms, recent exacerbations of illness, violence, suicide, hospitalization, poor functioning, criminal charges, and a persistent and severe course (Bahorik et al. 2013; Fowler et al. 1998; Kessler 2004; Roncero et al. 2011; Swartz et al. 2006).

With these rates of substance use and associated risks in individuals with SMI, the PORT guidelines recommend substance abuse treatment for individuals with co-occurring conditions (Dixon et al. 2010). There are three treatment models for individuals with co-occurring disorders (Roncero et al. 2011). In sequential or serial treatment individuals are first provided treatment for either their mental illness or substance use. Once treatment is completed for one disorder, treatment is provided for the other. In parallel treatment both disorders are treated concurrently, but by different treatment teams. In integrated treatment the same team treats both disorders concurrently. The PORT guidelines recommend the integrated treatment model.

Mueser et al. (2003a) and SAMSHA's Center for Substance Abuse Treatment (2005) developed models for integrated treatment for co-occurring disorders. These and other such programs are multifaceted and individualized. Motivational interviewing (Miller and Rollnick 2013) and the transtheoretical model of stages of change (Prochaska et al. 1992) are used to increase motivation and tailor interventions to the individual. Treatment strategies include psychoeducation; training in social skills, coping skills, and relaxation skills; contingency management; family involvement; and relapse prevention.

The inpatient setting lends itself well to integrated treatment because one treatment team is responsible for all aspects of a person's care. However, for hospitalized individuals, especially those involuntarily committed, it is their serious mental illness that led to their hospitalization and commitment, and is often seen as the primary focus of treatment. Nevertheless, inpatient psychiatric facilities provide substance abuse programming, and many of the skills taught to help individuals with their mental disorder can be adapted to problems with substance use (e.g., social skills).

Cognitive Remediation (CR)/Cognitive Enhancement

Interest in cognitive remediation (also referred to as cognitive enhancement) stems from the finding that individuals with schizophrenia often have impairments in attention, working memory,

processing speed, executive functioning, and social cognition (e.g., processing facial expressions, interpreting and responding to social cues, theory of mind, and attributional styles) (Kurtz and Marcopulos 2012). Cognitive skills predict everyday functioning and the ability to benefit from psychosocial rehabilitation (Kurtz 2012).

Cognitive remediation can take the form of restoration or compensation (Medalia and Belucci 2012). Restorative approaches aim to directly improve basic cognitive abilities, such as attention and working memory, without emphasizing how such remediation generalizes to everyday functioning. This approach assumes that generalization will occur. Restorative procedures often use massed drill and practice exercises of specific skills. Many of these systems use computer-based programs, but paper and pencil versions are also available. The frequency of sessions ranges from as little as once a week to daily with the duration of training ranging from several weeks to over a year. McGurk et al. (2013) recommended at least 20 h of training over the course of 10 weeks with multiple sessions per week. Task difficulty can vary, depending on the skills of the individual, so as to be challenging but not too difficult.

Compensatory strategies strive to compensate for deficits by improving functioning without directly targeting basic underlying cognitive skills although change in these skills may be an indirect benefit. They include environmental modifications and training that enlists a person's strengths to overcome or compensate for cognitive deficits. Examples include the use of daily calendars to keep track of appointments, checklists of tasks that need to be completed, alarms as reminders for appointments, and hygiene items placed in convenient locations. As with restorative approaches, compensatory strategies can be highly individualized to meet a person's needs while taking into account cognitive strengths and weaknesses.

Two recent meta-analyses of CR, one including 26 randomized controlled trials and the other covering 40 trials, found moderate effect sizes for global cognitive functioning (mean effects sizes of 0.41 and 0.45) and psychosocial functioning (mean effect sizes of 0.35 and 0.42), with small effect sizes for symptoms (mean effect sizes of 0.28 and 0.17) (McGurk et al. 2007; Wykes et al. 2011). Gains were durable: at follow-up the mean effect size was 0.43 for global cognition, 0.37 for functioning, and 0.17 for symptoms (Wykes et al. 2011). Adding CR to PSR, or integrating the two approaches, results in greater improvements in psychosocial functioning when compared to PSR without CR or CR combined with treatment as usual (McGurk et al. 2013). Especially noteworthy is that almost half of the more than 2000 study participants in the Wykes et al. (2011) meta-analysis were inpatients.

Illness Management and Recovery (IMR)

Illness Management and Recovery (IMR) was developed as an evidence-based practice "… to help clients with schizophrenia or major mood disorders learn how to manage their illnesses more effectively in the context of pursuing their personal goal" (Mueser et al. 2006, p. S33). The goals of the program are to "learn about mental illnesses and strategies for treatment; decrease symptoms; reduce relapses and rehospitalizations; and make progress toward goals and toward recovery" (SAMSHA 2009, p. 6). IMR incorporates empirically supported strategies identified in a review of the literature: psychoeducation about mental disorders and their treatment, cognitive behavioral strategies for improving adherence to medication, relapse prevention, social skills training, and coping skills training (Mueser et al. 2002a, 2006). Theoretically, IMR is based on the stress-vulnerability model of illness, the trans-theoretical model of change, and motivational interviewing (Mueser et al. 2006). It consists of 10 modules beginning with a discussion of the meaning of recovery, identifying personal recovery goals, and developing a plan for achieving those goals. Practical facts about mental illnesses are then discussed followed by modules on the stress-vulnerability model, building social supports, using medications effectively, limiting alcohol and drug use, reducing relapse (e.g., identifying triggers and warning signs), coping with stress and persistent symptoms, and utilizing the mental health system (SAMSHA 2009).

In a review of the literature, individuals in IMR programs, compared to treatment as usual, showed improvement in their knowledge about mental illness, progress toward recovery goals, relapse prevention plans, substance use, and ratings of symptoms by observers (but not by consumers) (McGuire et al. 2014). Evidence was lacking or mixed for long-term effects, such as quality of life, role functioning, community integration, social support, hospitalizations, emergency room visits, medication dosages, incarcerations, or hopelessness, although conclusions about some of these outcomes were limited by the number and quality of studies. In a recent randomized control trial comparing IMR with an active control group, no significant differences were found on any outcome measures, but the participation rates in both groups were low (Salyers et al. 2014).

Most studies of IMR have been in community settings, but IMR has been implemented in state hospital units with diverse populations (e.g., acute admissions, long stay patients with persistent symptoms, individuals with co-occurring substance use disorders, and individuals with cognitive impairment) as a means of operationalizing a recovery philosophy (Bartholomew and Kensler 2010; Bartholomew and Zechner 2014). According to these authors, recovery is enhanced when individuals learn to collaborate with treatment providers, manage their illness, and prevent relapse and rehospitalization. In one study in a New Jersey state psychiatric hospital, for each hour an individual participated in IMR the risk of returning to the hospital over the 5-year study period decreased by 1.1 % (Bartholomew and Zechner 2014).

Trauma Informed Care and Trauma Specific Treatment

Rates of trauma exposure in individuals with SMI are higher than in the general population, ranging from 49 to 100 % in study samples (Grubaugh et al. 2011). Traumatic events include childhood and adult sexual and physical assault, crime victimization, etc. Similarly, rates for Posttraumatic Stress Disorder (PTSD) in individuals with SMI are higher than in the general population with prevalence rates ranging from 13 to 53 % in the former compared to 7–12 % in the latter (Grubaugh et al. 2011). Despite these rates of trauma exposure, in the public sector individuals with SMI are under-diagnosed with PTSD and trauma related problems (Mueser et al. 1998; Salyers et al. 2004). In addition to their direct effects, the experience of traumatic events and PTSD contribute to the symptoms and course of SMI (Gracie et al. 2007; Mueser et al. 2002b; Scott et al. 2007).

The prevalence of trauma in persons with SMI has led recently to the development of trauma related services. Trauma informed care is a broad-based approach that recognizes the impact of trauma and incorporates that understanding across many aspects of service delivery. It includes support from an organization's leadership, policies and procedures, staff training, attention to the physical environment, assessment of trauma, specific trauma services, providing safety, minimizing retraumatization, and so on (SAMSHA 2014a). In trauma informed care screening for trauma is universal. Strengths are incorporated into treatment, and recovery and resilience are expected (SAMSHA 2014b). Examples of trauma informed care include being aware of triggers based on a person's trauma history (e.g., loud noises, isolation, people arguing, physical characteristics of staff members), and asking individuals what may be helpful if they are distressed (e.g., talking with staff, having a safe and quiet place in which to be alone, listening to music).

While trauma informed care is a broad-based approach, trauma specific treatment directly addresses trauma and its sequelae. Few such treatments for individuals with SMI who also have PTSD have been studied or implemented in the public sector (Frueh et al. 2009a). One such therapy is cognitive restructuring which borrows from cognitive behavior therapy for PTSD (Mueser et al. 2009). The core modules include developing a crisis plan, psychoeducation, breathing retraining, and cognitive restructuring. Most sessions focus on cognitive restructuring, a "… strategy for identifying, evaluating, and changing inaccurate thoughts and beliefs that lead to negative feelings" (Mueser et al. 2009,

p. 57). Similar to cognitive therapy for depression, cognitive restructuring for PTSD makes a connection between thoughts, feelings, and behaviors. Individuals are taught the five steps of cognitive restructuring: describe the situation, identify the strongest negative feeling, identify the thought most closely related to that feeling, evaluate the evidence for and against that thought, and take action either by changing the thought to a more accurate one if it is not supported by the evidence or changing the situation. Unlike some treatments for PTSD in the general population, prolonged exposure to the traumatic stimuli, either in vivo or imaginal, is not done. The developers of the therapy reasoned that exposure procedures might be too stressful for individuals with SMI and might lead to a high dropout rate.

Research studies on cognitive restructuring for PTSD in persons with SMI have found some promising results. In a preliminary study, 59 % of the participants completed the treatment (Mueser et al. 2007). Those who completed treatment had significant reductions in PTSD symptoms and depression from baseline to post-treatment, while those who dropped out did not. In a randomized controlled trial comparing cognitive restructuring to treatment as usual, 81 % assigned to cognitive restructuring completed the program (Mueser et al. 2008). Compared to treatment as usual, those in the cognitive restructuring group improved significantly on PTSD symptoms, depression, anxiety, other symptoms, physical health concerns, and working alliance with their case managers. There was no significant difference in whether individuals retained a PTSD diagnosis.

Unlike the above studies, a small pilot study included exposure therapy along with education, anxiety management, trauma illness management, social skills training, and anger management training for individuals with PTSD and schizophrenia or schizoaffective disorder (Frueh et al. 2009b). Significant improvements were noted in PTSD symptoms and anger, but not depression, anxiety, social activities, or physical health. Many of the gains were maintained at 3-month follow-up. Ten of the 13 individuals

who completed treatment no longer met criteria for PTSD. These studies of trauma specific treatment for individuals with SMI are promising, but additional research is needed.

Positive Psychology Interventions (PPI)

Positive psychology has grown rapidly over the past two decades. Seligman and Csikszentmihalyi (2000) noted, "Psychology has, since World War II, become a science largely about healing. It concentrates on repairing damage within a disease model of human functioning. This almost exclusive attention to pathology neglects the fulfilled individual and the thriving community" (p. 5). Seligman (2011) has called positive psychology a "tectonic upheaval" in psychology with the goal of "… exploring what makes life worth living and building the enabling conditions of a life worth living… [which] is by no means identical with the goal of understanding misery and undoing the disabling conditions of life" (p. 1–2). Although there have been few empirical studies of Positive Psychology Interventions (PPI) with individuals with SMI, PPI is included here because of its congruence with the principles of the recovery model (Resnick and Rosenheck 2006; Schrank et al. 2014a).

Interventions derived from positive psychology are "… primarily aimed at increasing positive feelings, positive behaviors, or positive cognitions, as opposed to ameliorating pathology or fixing negative thoughts or maladaptive behavior patterns" (Sin and Lyubomirsky 2009, p. 469). Most studies using PPI have been conducted with the general public, but a few have included people with specific psychological problems. In one meta-analysis of studies with depressed individuals, the mean effect sizes for PPI on well-being and depression were 0.33 and 0.32, respectively (Sin and Lyubomirsky 2009). In another meta-analysis of 39 studies, the 7 studies that targeted individuals with anxiety or depression found effect sizes of 0.31, 0.59, and 0.78 on measures of subjective well-being, psychological well-being, and depression, respectively (Bolier et al. 2013).

Positive psychotherapy (PPT; Seligman et al. 2006) is a PPI designed specifically for depression.

A group of researchers in the United Kingdom adapted it for individuals with psychosis (Schrank et al. 2014b). Called WELLFOCUS PPT, the primary goal of this intervention is to improve subjective well-being with secondary goals of increasing positive feelings, hope, connectedness, self-worth, empowerment, and meaning; and reducing symptoms. Over the course of 11 group sessions, 10 exercises adapted from PPT target positive experiences, strengths, relationships, and development of a meaningful life narrative. Examples include savoring good things, forgiveness, identifying personal strengths, gratitude, and positive responding. Results from a pilot study with individuals with primary diagnoses of psychosis using specialized mental health services found significant improvement in the WELLFOCUS PPT group, compared to a treatment as usual group, on measures of well-being, symptoms, and depression (Schrank et al. 2015). Clearly more research is needed on the use of PPI with individuals with SMI, but "positive psychology provides a useful framework for professionals seeking to provide services that support the recovery orientation" (Resnick and Rosenheck 2006, p. 120).

Common Factors

Common factors found in most psychotherapies, such as the therapeutic alliance, empathy, instilling hope, acceptance, understanding, and education (Davidson and Chan 2014), cut across many of the psychological services provided in public inpatient psychiatric facilities. Common factors are consistent with recovery-oriented practice and can form the foundation for many psychological services. Individuals with SMI have identified many of these factors as important to their recovery. In one study, of the top 10 competencies consumers rated as important for providers to have, 8 reflected common factors: show respect, see the person holistically apart from his/her diagnosis and symptoms, listen without judgment, believe in the person's potential to recover, trust the person, care about the person, understand the person, and be accessible (Russinova et al. 2011). As the authors noted, these factors represent the traditional

concept of a therapeutic alliance and forming a strong bond with the person. It can be easy to overlook the importance of such factors when individuals have severe symptoms and in-service settings that emphasize a medical model. Nevertheless, there are many opportunities to use them in public inpatient facilities.

Treatment Planning

In the inpatient psychiatric hospital psychologists collaborate with patients and treatment team members to develop and implement treatment plans. Psychologists are involved in all aspects of treatment plan development including identifying problem areas, goals, objectives, discharge criteria, and strengths. They bring a psychological formulation to the multidisciplinary treatment planning process. Psychologists attend to developing objectives which are clear, specific, and individualized. They help plan and implement interventions to achieve goals and objectives. Psychologists are especially instrumental in overseeing the behavioral and interactional elements of treatment plans such as identifying antecedents to behaviors, ways in which staff should respond to antecedents, and reinforcement strategies.

Consistent with recovery-oriented principles, psychologists, along with other members of the treatment team, seek to involve patients in the development of treatment plans as much as possible. In the public inpatient facility this is an area in which patient involvement varies on a continuum consistent with Smith and Bartholomew's (2006) description of a *hospital* model and a *recovery* model. Both of these models apply to the state hospital setting and depend on a person's "phase of illness." The hospital model plays a central role when an individual with a mental disorder is a clear and imminent danger to self or others, and interventions such as involuntary hospitalization and "caretaking and prescriptive treatments" may be needed. Hospitals also need to promote an individual's recovery, and Smith and Bartholomew advocated progressive empowerment toward a recovery model

when restrictive measures recede and autonomy increases.

In ideal circumstances individuals are motivated to make changes in the problem areas that led to their hospitalization and that will lead to a return to the community as soon as is safely possible. This might include a reduction in distressing symptoms and improved self-management of aggressive and self-injurious behaviors. In these instances all aspect of treatment planning can be very collaborative. At the other end of the continuum are situations in which individuals have very limited understanding of their mental disorder or the problems that led to their hospitalization. Unfortunately, this is the more typical case in the state psychiatric hospital. Such individuals may have little interest in developing treatment plans since they may view their hospitalization or legal charges (for those on a forensic status) as unjustified, and their only goal is immediate release from the hospital. However, the treatment team still has the responsibility to develop treatment plans consistent with hospital, legal, and regulatory requirements. Even in circumstances in which individuals are unwilling or unable to provide much input into their treatment, it might be possible to elicit their involvement in certain aspects of the plan such as suggestions for activities or items that may be used as reinforcers.

Once treatment plans have been developed, psychologists implement the plan themselves, or, more commonly, monitor and troubleshoot implementation of the plan by other staff members. This involves staff training and clarifying questions about the plan during the course of implementation. Psychologists evaluate the effectiveness of the plan, collect data, and suggest modifications based on the data and feedback from the patient and staff.

Forensic Services

In public inpatient psychiatric hospitals, psychologists conduct evaluations of trial competency and mental state at the time of alleged offenses when questions about legal insanity are raised. For individuals who have been adjudicated incompetent to stand trial, psychologists provide restoration services. For individuals adjudicated not guilty by reason of insanity, psychologists conduct assessments to help review panels and courts make decisions about a person's disposition (e.g., continued hospitalization, release to the community), and when hospitalized, provide a range of assessment and therapeutic services. As experts recognized by courts and in statutes, psychologists have the opportunity to educate individuals in the criminal justice system who lack expertise about serious mental disorders.

The provision of psychological services to individuals on a forensic status is complicated by the increased oversight, accountability, security concerns, and stigma associated with the forensic system. These factors create tension with recovery-oriented principles (Pouncey and Lukens 2010; Simpson and Penney 2011). As noted by an expert panel convened by the National Association of State Mental Health Program Directors, "… there is a need for additional detailed guidance on how best to treat and manage persons in state psychiatric hospitals who continue to present a significant risk of violence due to a serious mental illness, substance use disorder, and/or criminal behavior in a manner that is consistent with recovery principles and practices" (Parks et al. 2014, p. 52).

Despite these added complications, individuals with SMI involved in the criminal justice system have many of the same needs as those without such involvement. As such, recovery encompasses many of the same elements including ameliorating symptoms, improving functional capabilities, developing supports, working toward desired goals, and building a satisfying life (Simpson and Penney 2011). Thus, many of the psychological services described in this chapter apply to the forensic population (Osher and Steadman 2007). For example, in forensic inpatient units at Missouri's Fulton State Hospital, a social learning program facilitated an increase in adaptive behaviors from baseline to follow-up (Newbill et al. 2011). Another proposed program for psychological services adapted the risk-needs-responsivity and the "good lives" models of treatment used with offender

populations to individuals in forensic mental health settings (Gudjonsson and Young (2007).

Training Students and Staff

The inpatient psychiatric facility provides an excellent opportunity for psychologists to train students, interns, and post-doctoral fellows in psychology; students from other disciplines; and hospital staff. In noting that the workforce "… has historically been woefully unprepared in terms of the requisite knowledge, values, and skills for working with this population…" Mueser et al. (2013, p. 54) asserted that there is a "moral imperative" to mandate training in the treatment of individuals with serious mental disorders in clinical psychology graduate programs, and that competence in working with this population should be a requirement of graduation from programs approved by the American Psychological Association (APA). In a survey of APA accredited graduate clinical psychology program training directors, 39 % of the programs did not have any faculty who identified SMI as their primary area of research, clinical practice, and/or academic interest (Reddy et al. 2010). When asked about factors that encourage or discourage students' training and education in SMI, 51 % of the respondents cited a preference by psychologists to work with clients who have "insight" and are "motivated for treatment" as factors that discouraged students. Only 41 % thought that psychologists had the relevant skills for working with individuals with SMI. More encouraging was the finding that students in 70 % of the programs had an opportunity to take a practicum that allowed at least an exposure level of supervised experience in settings that serve individuals with SMI (these settings were not only inpatient facilities, but included outpatient, residential, emergency, day treatment, rehabilitation, and crisis settings).

For students, interns, and fellows the training experience may range from exposure to serious mental disorders in the inpatient setting to assuming considerable responsibilities. At the introductory level, training may consist of observing and "shadowing" a psychologist in the hospital. At a more advanced level, students and trainees may conduct many of the psychological services described in this chapter under the supervision of a psychologist. Geczy and Cote (2002) and Hoge et al. (2000) described some of the features to incorporate in training: learning to develop a therapeutic alliance, overcoming anxiety, developing confidence, learning to provide individual and group psychotherapy, developing behavioral treatment plans, working with multidisciplinary treatment teams, learning about psychosocial rehabilitation services, working within systems of care with their bureaucracies, and learning the role of psychologists in this setting.

Many trainees may be under the impression that individuals with SMI experience a deteriorating course of illness with little hope of recovery. Furthermore, they may believe that medications are the only treatment for such disorders, and that psychologists contribute little to recovery. Psychologists in public inpatient psychiatric hospitals are in an excellent position to address the stereotypes and myths that trainees hold. They can promote clinical skills needed to work with individuals with SMI, model psychological services, and expose trainees to the range of services available to individuals with SMI.

As professionals with considerable training and experience, psychologists are called upon to provide training to students from other disciplines and hospital staff (Roe et al. 2006). Examples include basic information about mental disorders to front line staff, behavioral methods and effective ways to interact with patients (Donat et al. 1991), and in-service presentations on specialty topics. Not only do these training activities benefit students, staff, and indirectly, patients, but they can be a source of considerable professional satisfaction and enrichment for psychologists in public inpatient facilities.

Consultation, Program Development and Leadership

In the public inpatient psychiatric hospital, psychologists serve as consultants, develop programs,

and provide leadership, and in doing so can help incorporate a recovery model of care. Consultations may include in-depth assessments and treatment recommendations for exceptionally challenging cases that have confounded the efforts of treatment teams, second opinions regarding risks, and the creation of specialty treatment protocols (e.g., violence prevention, and swallowing foreign objects). Examples of program development include designing, implementing, coordinating, and evaluating the effectiveness of unit token economies, unit rules, and PSR services. In these roles psychologists collaborate with members of other disciplines, bringing their training and perspective. Psychologists serve on committees within the facility or across a state (e.g., forensic issues, seclusion/restraint reduction efforts, preparing for reviews by regulatory agencies). Leadership positions for psychologists range from being an influential and prominent member of the treatment team to the director of the facility.

Challenges

Many of the services provided by psychologists in the inpatient psychiatric hospital as described in this chapter are consistent with recovery principles. Even more broadly, the training and professional experiences most psychologists bring to their inpatient practice are consistent with recovery principles. However, there are some tensions between recovery principles and psychological services in the inpatient psychiatric setting. Many of these are not unique to psychologists; indeed, they may be felt more keenly by members of other disciplines. In this section I discuss some of the challenges that are particularly relevant to psychologists.

Autonomy, Choice, and Coercion
Perhaps one of the thorniest tensions in the public inpatient psychiatric hospital is balancing the autonomy of individuals with the use of coercive, restrictive, and paternalistic measures. Autonomy, self-determination, and choice are central recovery principles. However, in public psychiatric hospitals most individuals are committed

involuntarily on a civil or forensic status, which is already a restriction of their freedom. This issue is further complicated by the limited insight many individuals have. As Bellack (2006) noted, "… the balance of power may need to shift toward the professional when the consumer is highly impaired and has diminished decisional capacity" (p. 441). Much of this debate is framed around the risk of harm to self and others, that is, more restrictive measure are justifiable when such risks are high (Davidson et al. 2006).

This issue is probably less pertinent to psychologists than practitioners from other disciplines because many of the services psychologists provide rely on the willing participation of the individuals they serve. For example, most formal psychological assessments (e.g., personality testing, intelligence testing) cannot be done without the person's active engagement. However, even in conducting assessments there are exceptions such as the use of clinician administered rating scales and behavioral observations, many forensic evaluations, and risk assessments. Likewise, psychotherapy, psychoeducation, and skills training require at least some engagement by patients.

Autonomy becomes more relevant for psychologists in clinical decision-making. One such area is working toward patient identified goals, another central concept of the recovery model. Examples of conflicts over goals include a person who wants immediate discharge even though he/she has been committed and is not ready for discharge (e.g., engages in and threatens aggression), and a person who wants to smoke in a tobacco-free facility. In the first example, discharge may be the ultimate goal, but often the individual views it as the immediate goal. In this situation there is agreement on the goal, but not when it will be accomplished. Another example is when an individual is unwilling to leave the hospital even though the treatment team believes the person is clinically ready, and housing, financial supports, and outpatient services are available. As an example, a middle-aged woman I worked with refused discharge until her husband, a medical doctor, came to pick her up and take her to the new home he was building for them. In reality, she had no husband, and she

extended her stay in the hospital by refusing to accept available community housing. Much later, she became attracted to a male patient quite younger than herself who she regarded as her husband even though they were not married. When he was preparing for discharge, she agreed to live in the residential placement he chose. In another case, a man believed that a local government had cheated him out of a multi-million dollar service contract he bid on. As a result he thought that the government owed him a huge sum of money as compensation, and he refused discharge unless he was guaranteed a yearly income of over $100,000 and a large house.

At times, even if one wants to fulfill a person's goals, it can be difficult to know what those are. For example, a young man I worked with requested discharge from the hospital frequently, often several times a day. However, his choice of where he wanted to live often changed over the course of just a few hours. This vacillation began early in his hospitalization and went on for months before he was discharged.

As these examples show, there is a balance between autonomy and limiting choices as noted by Geller (2012) and in the following statement from SAMSHA (2011):

> Honoring self-determination, however, does not require, and is not equal to, doing whatever the person wants…. Mental health professionals are bound both by their professional ethics and by their societal obligation to act in the person's and community's best interests, even if that may be in conflict with the person's wishes at the time. When a person is incapacitated by an acute episode of psychosis, is unable to make his or her own decisions, and poses a serious and imminent risk, the recovery-oriented practitioner is equally obligated to intervene on the person's and the community's behalf.
>
> Recovery-oriented practice in this way is not contradictory to emergency intervention on the person's and community's behalf. What recovery-oriented practice requires is that such interventions be performed respectfully, in ways that ensure the dignity of the individual, with transparency, only for as long as is required by the emergent situation, and in ways that optimize the person's opportunities for exercising whatever degree of self-determination remains possible at the time. This typically requires the staff to offer the person choices, even though they may be

limited to a narrow range, and to be as clear and explicit as possible with the person throughout the process about what is happening, why it is happening, and what needs to happen for the person to regain control and autonomy' (pp. 25–26).

In response to this sentiment, Davidson (2012) placed a heavy burden of responsibility on treatment providers to show that acting in conflict with a person's wishes is necessary, especially in light of a history of abusing their power simply because a person had a mental illness (e.g., lobotomies, prolonged confinement without sufficient justification).

Diagnoses and Relief of Symptoms

To some extent advocates of recovery eschew the use of psychiatric diagnoses because it is stigmatizing, risks defining individuals as their diagnoses, and places undue emphasis on symptom relief as a treatment outcome rather than finding a meaningful life. While these are all valid concerns, accurate diagnoses and symptom relief are important in the public inpatient psychiatric facility. Accurate diagnoses can inform treatment, whether psychopharmacology or some of the psychological interventions described in this chapter, and can help the psychologist access the relevant scientific and professional literature. As an example of the importance of making accurate diagnoses, I worked with a young woman who had been committed to the hospital on a forensic status after incurring a felony charge for assaulting a police officer. She was estranged from her family, homeless, unemployed, and had no source of income. On the unit she frequently aggressed toward other patients and staff and was emotionally labile over the course of several weeks. Many members of the treatment team viewed her as having Antisocial Personality Disorder and advocated for her return to jail as soon as possible. I suggested that she had Bipolar Disorder, with or without Antisocial Personality Disorder, and recommended treatment for Bipolar Disorder. The attending psychiatrist agreed to offer a trial of a mood stabilizing medication to which she responded very well. Her aggression ceased and her mood improved dramatically. She was not prosecuted

for her legal charge, and instead, with the help of the treatment team and outpatient service providers, she was discharged to a residence in the community.

With regard to the relief of symptoms as a goal of treatment, individuals admitted to public behavioral health facilities commonly experience acute symptoms. In many instances individuals experience these symptoms as distressing. Examples include hallucinations of voices making derogatory comments about the person, fear that the person's life is in danger, depression, anxiety, anger, sleep disturbance, and so on. Even when symptoms are not reported as distressing, they may underlie the reasons individuals are admitted to the hospital, especially for those on an involuntary status. In both situations, symptom relief is an important goal. Indeed, studies have found a negative correlation between symptoms and ratings of recovery by individuals with SMI (Corrigan et al. 1999; Hackman et al. 2007). Furthermore, in a Delphi study that examined the meaning of recovery as defined by individuals with lived experience, over 80 % agreed that a characteristic of recovery is when symptoms interfere less and less with daily life or do not get in the way of doing things (Law and Morrison 2014). Thus, symptom relief can be one of several treatment goals, but complete remission is not a necessary criterion for discharge.

Hope and Discouragement

A cardinal feature of the recovery model is instilling and maintaining hope in individuals with SMI. The literature on the long-term outcome of individuals with SMI has shown that a high percentage of individuals recover, a finding that has contributed to the recovery movement. However, this same literature shows that a significant proportion of individuals do *not* recover very well. As described earlier in this chapter, the public inpatient behavioral health facility serves individuals with complex problems and needs. These individuals often have difficult to treat problems with long lengths of stay and/or repeat hospitalizations. Furthermore, psychologists and other treatment providers face criticisms of their

services from patients and family members, especially from those who are angry about having been hospitalized and how they have been treated, (even prior to admission). Such criticisms and oversight by regulatory agencies perform a valuable function, namely, to stimulate the reexamination and modification of practices, policies, and procedures. Nevertheless, the lack of progress by some patients, a barrage of criticisms, and unrealistic expectations to prevent all forms of harm can lead psychologists to become discouraged. Such discouragement, could, in turn, impede psychologists' ability to convey hope to patients and search for effective services. Indeed, in a couple of studies comparing outpatient and inpatient staff, the latter were less optimistic about consumers (e.g., their ability to live in their own residences and likelihood of remaining in the mental health system for the rest of their lives) (Salyers et al. 2007; Tsai and Salyers 2008).

To prevent discouragement and to stay hopeful about individuals' recovery, it is useful to be aware of the research literature on long-term outcomes for people with SMI, to keep in mind that recovery is "nonlinear," and to recall the many successes with individuals who had poor initial prognoses. It is important to rely on one's treatment team and colleagues as a source of support, seek consultation from within and outside the facility, include consumer peers as part of the hospital workforce, and have peers who have successfully transitioned to the community available as models.

Evidence-Based Practices (EBPs)

Many of the interventions described in this chapter are EBPs. Much has been written about EBPs in the field of psychology, and there is much debate about using them. These arguments are beyond the scope of this chapter. Instead, I focus here on their relationship to recovery-oriented practices.

As noted by Davidson et al. (2009), "… some mental health consumer advocates view the emphasis on evidence-based practices to place a further restriction on their ability to exercise choice in their care. They also are suspicious of scientific claims to offer a privileged access to

truth, arguing instead for relying on first-hand experiences as at least as equally valid sources of information about the utility of psychiatric interventions" (p. 323). Similarly, Anthony et al. (2003) highlighted several limitations of evidence-based practices as they apply to recovery. These include narrowly defined outcome measures such as symptoms and rates of hospitalization, rather than ones consumers value such as having meaningful roles in society. They asserted that evidence-based practices do not take into account subjective experiences or the understanding that there are many paths to recovery. Further, many evidence-based practices undervalue the "helper-helpee" relationship, something cited as critical to recovery by individuals with lived experiences. Finally, they noted that many recovery-oriented practices draw their importance from philosophical values, not just empirical evidence.

Such criticisms led Davidson et al. (2009) to ask rhetorically whether EBPs and recovery are like oil and water (i.e., fundamentally incompatible) or oil and vinegar (i.e., concepts that can be integrated). In arguing that EBPs and recovery are indeed compatible, Davidson et al. noted that just as in other fields of medicine, patients are partners in treatment and retain the right to make informed choices (as long as they have not been deemed incompetent to make such decisions) based on, or despite, the evidence. Individual preference is part of the definition of evidence-based practices in psychology (EBPP) adopted by the American Psychological Association. According to this definition "EBPP is the integration of the best available research with clinical expertise in the context of *patient characteristics, culture, and preferences*" (APA Presidential Task Force on Evidence-Based Practice 2006, p. 280, emphasis added). In support of the compatibility of EBPs and recovery principles, others have argued that many EBPs emphasize shared decision-making and education about available interventions so that individuals can make informed choices, and they provide individuals with tools to pursue their goals (Mueser 2012; Torrey et al. 2005). Mueser (2012) went even further by asking whether services can "… be

recovery oriented *without* helping individuals gain access to EBPs" (emphasis original, p. 288). He argued that "EBPs are a technology, not a value, and therefore, on their own (like computers or telephones) they are neither recovery-oriented nor antithetical to recovery" (p. 287). This is consistent with the view of SAMSHA (2011): "All of these practices [EBPs], when offered in a person-centered and empowering manner that focuses on inclusion in community life, can be viewed as recovery-oriented practices" (p. 9).

Personal Safety

Psychologists in public psychiatric hospitals work in settings that put them at some risk of harm to themselves, albeit to a lesser extent than front line, direct care staff members and clinicians from some other disciplines. This presents an intriguing challenge in that psychologists must be vigilant to indications of imminent violence and take steps to minimize the risk of violence, while at the same time provide services in a recovery-oriented manner. It is beyond the scope of this chapter to discuss the many ways in which risks can be minimized, but some examples include forming good working relationships with patients, providing encouragement and hope, and considering how and under which conditions to provide information or take necessary actions that a person might find upsetting. While personal safety is important, psychologists will not be effective if they are so wary of violence that they severely limit their interactions with the individuals they serve.

Conclusion

Psychologists in public inpatient psychiatric hospitals have many opportunities to provide much needed services to individuals with SMI. In this chapter, I have attempted to show how psychologists can incorporate recovery-oriented principles into their practice in these facilities, and discussed some of the challenges they face in doing so. As noted earlier, this survey of psychological services is not exhaustive, nor are all of the services described in this chapter available

at all facilities. Many of these practices are consistent with the training and experience that has been a part of psychology for many years, but because most of them have not been developed specifically for individuals in public inpatient psychiatric facilities, these practices often require some adaptation. Recovery principles are easier to implement in community settings than inpatient hospitals (Tsai and Salyers 2008), and a number of tensions exist between the recovery model and clinical practice in a state psychiatric hospital. Furthermore, the meaning of recovery and how to implement it often lack clarity, which complicates efforts to adhere to recovery-oriented principles. However, recovery, both as an achievable outcome and a set of principles, can serve as a guide to the practice of psychology in inpatient psychiatric hospitals by focusing attention on how a service helps a person recover and how it aligns with recovery principles. Psychological services will evolve with additional research, policies, and debate. The prospect of such change is not only expected and consistent with the long history of treatment for individuals with SMI, but invigorating to psychologists working in this clinical setting.

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