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BEHAVIORAL HEALTHCARE

We proposed an exploratory study on the effects of participation in a treatment mall. We interviewed currently enrolled patients at the Recovery Mall at a state-operated behavioral healthcare hospital in Ohio. Treatment malls are an increasingly popular approach to rehabilitation of inpatient populations (Webster & Harmon, 2006). The popularity of the approach is based on the theory that empowerment of the consumer to participate in decision-making will aid in restoring functioning and return to community living (Rahe, 2001). Treatment malls offer multiple simultaneous therapeutic activities, allow the involvement of consumers in making choices about their treatment plans and their daily living activities, and provide a more normalized environment. Patients have to leave their home units to seek out opportunities to participate in community life activities such as going to the bank, hair salon or chapel; socializing; and making their own food choices.

Although there are sound reasons to believe that the treatment mall approach will provide patients with a basis for developing skills and knowledge they need for community living, to date there has been limited research on the effects of treatment mall approaches on psychosocial rehabilitation (Boppe, Ribble, Cassidy & Markoff, 1996; Tuit, 2005). Most early efforts have been qualitative studies that have examined staff and patient satisfaction with the approach (Tuit). More recently quantitative outcome data have begun to emerge. Dhillon and Dollieslager (2000) found that following implementation of a treatment mall model in a public psychiatric hospital in Virginia, staff reported better morale, improved individualization of treatment, and enhanced interdisciplinary collaboration. They also found that treatment consumers reported a better understanding of their illness, medication needs, and discharge plans.

The Wright State University research team sought to provide evidence of the effects of a treatment mall approach on recovery-related variables from the perspective of the patient. We developed a structured near-exit interview protocol and carried it out with 24 patients who were currently enrolled at the Recovery Mall at a state-operated behavioral healthcare hospital and who were identified as being close to discharge. We saw the research as an initial step in the development of a methodology for more comprehensive outcome research on the effectiveness of the treatment mall approach.

Our original research questions were:

1. What are the effects of participation in the Recovery Mall on patient perceptions of therapeutic alliance?

2. What are the effects of participation in the Recovery Mall on patient understanding about their illness, their knowledge about their prescribed medications, and their self-reported following of medication regimens?

3. What are consumer perceptions about participation in the treatment mall and its effects on their self-reported behavior changes?

4. Do these effects differ by frequency of attendance, length of stay, or by type of commitment (i.e., civil vs. criminal)?

5. How do self-reported behavior changes compare to Recovery Mall treatment records?

Acknowledgment

We would like to acknowledge the excellent cooperation we received from the Behavioral Healthcare Hospital in carrying out this project.

METHOD

Participants enrolled in this study were inpatients at a state-operated behavioral hospital. Because participants were inpatients, the study had numerous practical constraints for which the design had to accommodate. For example, very few civil-committed patients were referred to us for interviews. As a result, we could not conduct any analysis of effect differences by type of commitment. We also modified our intent to review treatment records. After consultation with staff, we realized that we could not compare self-reported behavior change to change reflected in treatment records effectively. Any inpatient who had been recently involved in major behavioral incidents would not have been referred to the study since such incidents would make them ineligible for discharge. We opted instead to have staff provide ratings and verbal commentary on progress for each interviewed participant. Also, we had intended to include the concept of therapeutic alliance, typically considered to be an agreement between the client and therapist on treatment goals and tasks to achieve goals as well as the personal bond between therapist and client. In discussions with hospital staff, it became clear that this measure was inappropriate for participants since an individual sees multiple therapists. Indeed, during the interviews, the majority of participants referred to therapists as "treatment team" or "hospital staff" rather than "my therapist". Finally, we had intended to interview 32 participants but could only complete 24. In the last few days on which we were scheduled to conduct interviews, it became increasingly difficult to find patients to interview. Hospital staff indicated that this difficulty was a result of interviewees having to be drawn primarily from two units. There were fewer and fewer participants who met the criteria for participation. We were also getting redundant information from the participants. With Ohio Department of Mental Health and Addiction Services (OhioMHAS) and the hospital approval, we stopped interviews at 24.

To construct the interview questions, we reviewed a variety of existing instruments, including, among others, the Illness Management Recovery Toolkit developed by Gingerich and Mueser (2003), the Personal Vision of Recovery Questionnaire created by Ensfeld (1998), the Working Alliance Inventory developed by Horvath and Greenberg (1989), and the Multnomah Community Ability Scale, a self-report treatment outcome assessment instrument for mental health service consumers developed by O'Malia, McFarland, and Barron (2002). From these instruments, we selected items relevant to our study, deleted redundant items, and constructed an initial set of questions.

In the spirit of community participatory research, we also did three group interviews with hospital staff (one with Occupational Therapists, one with Psychology staff, and one with SAMI and Social Work staff) to elicit input as to what questions staff would like to include in the interview instrument. Staff also provided information that assisted us in modifying the original research design. Staff suggestions for questions were combined with items identified through the literature review to create a draft instrument for inpatients. We then circulated the complete set of questions to hospital staff and the research team and asked them to rate each question as High, Medium, or Low Priority. For the final step, we selected questions rated by most respondents as High Priority and worked with a staff psychologist on question wording to ensure that patients would be able to understand and respond to the questions.

Hospital and OhioMHAS staffs reviewed the research protocol, including human subjects' protection. Wright State University IRB approved the research design.

We familiarized hospital staff with the project through group informational sessions. We also distributed to them a one page project summary that included inclusionary and exclusionary criteria for the inpatients to be interviewed. Our inclusionary criteria included: anticipated release within 2-3 months of interview; stable enough to participate in an interview; and cognitively capable of answering simple questions. Exclusionary criteria included inpatients who were actively psychotic, violent, or mentally retarded with a low level of functioning.

Hospital treatment team staff identified potential participants and provided them with information about the project. If the inpatient agreed to be interviewed, staff obtained informed consent and completed a demographic information sheet on the inpatient that included a therapist rating of progress on a 5-point scale.

An interview process was developed. A hospital liaison was assigned to assist with arranging the interviews and with carrying out the logistics of interviewing the inpatient. As part of the process, interviews were scheduled to be completed on Wednesday mornings. On the day of the interviews, hospital staff provided us with a list of interviewees, their demographic information and rating sheet, and the signed informed consent form. A monitor brought the interviewee to a private room where the interview was conducted. Two members of the

research team participated in each interview, one conducting the interview and one taking notes. We began each interview by introducing ourselves, discussing why we were there, reminding them of the purpose of the interviews, and verifying that they had signed an informed consent form. In addition to the PI and Co-PIs, a Graduate Research Assistant (a doctoral student from the School of Professional Psychology) participated in the interviews. No interview lasted more than an hour, and we typically completed two to four interviews per visit.

RESULTS

Demographics

Twenty-four people participated in the interviews. There were 19 males and five females, ranging in age from 23 to 68 with an average age of approximately 41. Fourteen interviewees were African American, and 10 were European American. Twenty-two were criminal commitments, and two were civil commitments. The participants had an average of three prior commitments (range 0-20+). The length of time of the participant's current admission ranged from less than one month to over three years. Ten had been hospitalized for more than a year.

Functionality

A therapist measured each patient's functionality prior to the interview. The scale ranged from "1" to "5" with "1" meaning no behavior change since admission and "5" meaning significant behavior change since admission. No inpatient with a score of less than "2" was referred for an interview. The average functionality score was 3.68, with 91% of the interviewees scoring "3" or above. Although these scores did provide some screening, we found that inpatients were not always at a high level of functionality. Whether it was a result of medications or anxiety about the interview or a change in circumstances, many interviewees seemed to have difficulty focusing and answering the questions. Because of this, when we analyzed the interview results, we took the entire interview into account, not just the immediate response to a specific question. For example, we asked whether the opportunity to socialize was helpful. While many interviewees addressed that issue, they did not always address the issue as a response to the specific question regarding the opportunity to socialize. Rather, we read the entire interview to determine if the interviewee said that the opportunity to socialize was helpful.

Interview Question Responses

We summarized responses by question, and results are presented in the following paragraphs. Percentages were calculated using the number of people who responded to the question as the denominator. The total number of responses frequently exceeds the number of interviewees because all relevant responses were included even when they came from the same respondent.

Question 1: Please think back to the time when you first came to the [hospital]. Have you changed since then?

Seventeen of twenty-four respondents (70.8%) indicated that they had changed. Two indicated that they did not feel they were better, and five did not answer the question. Several people gave "before and after" profiles of themselves (e.g, "I heard voices before I got here but not now").

Table 1 summarizes the emerging themes for Question 1. The primary theme was **medication**, named by 12 of 17 inpatients (70.5%). The majority of comments were about positive effects of the medication, with six comments specifying that the medication calmed or stabilized the participants. Two said more generically that the medication made them "feel better." Four patients mentioned their increased knowledge about their medications, their increased understanding of the need to stay on the medications prescribed, or their newly gained understanding of the need not to mix these drugs with alcohol. Two patients complained about the medication's side effects. One said that the medications made his/her energy level low. Another indicated that the medication gave him/her hand and body tremors (borne out by observation of him/her during the interview).

A secondary theme, mentioned by six of 17 (35.2%) respondents was **better social relationships**. These patients indicated having a greater comfort level in talking to other people, more acceptance of differences in others in their peer group, and pleasure in socializing. For instance, one respondent noted: "I am more accepting of others that are different."

Question 2: Has participating in the Recovery Mall helped you to understand what causes the symptoms of your mental illness and how to deal with the symptoms?

Thirteen respondents indicated that the Recovery Mall helped them cope with their symptoms. Only one participant definitively answered no to this question. The participant commented, "It has not helped me under-

stand my illness. It is more a measure of responsibility and maturity. It helps to show if you are responsible enough to handle it, you earn responsibility based on behavior and only make it to the treatment mall if you behave and are stable. It is a measure of progress and behavior, not of illness."

Three subjects indicated that they did not believe they have a mental illness, and two of these three respondents blamed other causes for their hospital commitment. One indicated that he/she had had a substance-abuse related incident and that he/she has been an alcoholic for a long time. Another said, "I don't have a mental illness. I've just got a bad family."

Seven respondents did not directly answer this question. While most of these respondents made comments relevant to their experiences at the hospital, they were unresponsive to the question of whether or not their hospitalization had helped them understand the symptoms of their mental illness. One respondent noted: "Yes. I understand that I like to watch others. It gave me a goal, to get the green badge. Mealtime is fun. The birds are nice to watch."

Question 3: What things at the Recovery Mall have helped you get better?

According to 13 (54%) of the 24 participants, **participation in therapy groups** was the most helpful contributor to getting better. Several patients identified specific benefits to group therapy participation, including contributing to motivation, help in being less withdrawn, learning things about their illness, and understanding coping mechanisms. Two participants gave particularly powerful statements about participation in group therapy:

Table 1. Question 1 Responses: Please think back to the time when you first came to [hospital] . Have you changed since then?

Issue	# of Respondents
Medication	17
Better social relationships	6
Learned about myself/figured out my life	3
Developed trust with staff	3
Learned to communicate better	2
Learned patience	2
Became calmer	2

Table 2. Question 3 Responses: What things at the Recovery Mall have helped you get better

Facilitator	# of Respondents
Participation in Therapy Groups	13
Socializing with a Peer	7
Freedom of Choice	5
Stabilized on Medications	4

"Groups have been a life saver."

"Groups give me something to live for."

Question 4: Do the groups offered at the recovery mall help you get better?

Sixteen respondents (66.7%) indicated that groups helped them get better. Two (8.3%) indicated that groups did not help them get better. Two others (8.3%) seemed to indicate that groups helped them get better, although they did not directly answer the question. The other respondents either gave no clear answer, or they just listed groups in which they participated.

Several themes were mentioned in response to this question. One theme related to how the groups helped the respondents **understand issues related to their legal cases**. One respondent noted: "Groups give information on my legal status and what you need to know relative to NGRI". Another theme dealt with how t**he groups help the respondent learn**. According to one respondent, "[g]roups are great as you learn something." A third theme pertained to the **social aspects of the group**. For instance, one respondent commented that "[g]roups help you interact[,]" while another mentioned that"[y]ou are able to discuss things with other patients."

Question 5: What groups do you find most helpful?

The group with the highest number of responses was SAMI with seven participants mentioning this group. Two respondents each mentioned the following groups: Restoration to

Competency, AA/NA, Voices/Schizophrenia, Responsible Adult Development, and Computer Class. The groups mentioned by one respondent are as follows: Religion and Spirituality, Mind Over Mood, Weighing the Cost, Boys to Men, What Can I Do?, Living Skills, Anger Management, Tai Chi, Meditation, Recovering from Trauma, Music, Community Reintegration, Sewing, Occupational Therapy, Behaviors of Use, Relationships, Metaphors for Recovery, Recovery Check-in, and Rights, Rules, and Responsibilities. Participants also specified enjoying fitness classes and activities and visits to the library.

Question 6: If you had a positive experience participating in a particular group in the recovery mall, was it due to what you did in the group, or was it due to the person who was leading the group?

Five respondents (20.8%) stated that their positive experience was due to the leader. Three respondents (12.5%) indicated that it was due to what they did in the group. Nine respondents (37.5%) stated that it was due to both the leader and what they did in the group. Two respondents (8.3%) indicated that their positive experience was due to the inpatients themselves. Five respondents (20.8%) did not give a clear answer.

Respondents made several comments on the qualities of a group leader that contribute to making a group good or bad. According to one respondent, "[t]he key to a good leader is to direct the class. Do not depend on the participants." Another commented that "[i]t is not good if the leader talks all the time. The group can make up for a bad leader."

Some participants believed that the group members made an equal or superior contribution to the group. According to one respondent:

> "If you have the right make-up, you will have a good group. If you have the right messages but the wrong people, it is not so good. In good groups, you hear other people's problems. This makes me thankful. I try to help with words/experiences. A good leader equals a good group. A bad leader and good people are not so good. Is laid back, not focused, and people can get away with a lot. A group can compensate for a bad leader."

Question 7: Are the opportunities to talk to other patients or the opportunity to do things like go to the barber or beauty shop helpful for you to get better?

Socializing was a strong theme that was frequently discussed during the interviews and discussed in response to many of the questions. Of the 21 participants who mentioned socializing, 17 or 81% indicated that the treatment mall provided interaction opportunities that the patients did not seek out prior to hospitalization and/or allowed them to work on their socialization skills. One interviewee said: "Yes, in certain ways but you can't just talk to anybody. You have to have friends and feel open with our friends. You get support and it is more personal."

Also, inpatients indicated that interacting with patients who they perceived to be worse than them provided a cautionary tale and this was also helpful. For example, one stated, "Yes, I learn from their experience. I can give them advice or support."

According to four participants (19%), socializing had a negative effect on them. One patient indicated that he/she gets to the point where he/she shuts down and can't handle being around people who curse and are disrespectful. Another inpatient indicated that he/she was not at the hospital to make friends.

Seven participants directly answered that they found opportunities to do other things, and these opportunities were helpful in their recovery. These opportunities included going to the beauty shop or barber, the commissary, the exercise facility, and the bank. One woman said getting her hair cut makes her feel better as a woman.

Question 8. Have you been in other facilities not like the recovery mall? If so, how is the recovery mall different?

Sixteen interviewees indicated that they had been in other facilities. The most common response was jail (seven participants) followed by the Veteran's Administration (VA) Hospital (four participants). Most interviewees were vague about whether the Recovery Mall was better than the other facilities. They were clearer on how aspects of other facilities compared to the Recovery Mall. The most frequently mentioned comparison related to activities offered (seven participants). For instance, "a[t] [Recovery Mall], I can read, walk, exercise. There are more options, more responsibilities, you can get a job at [Recovery Mall]."

Six people talked about freedom or flexibility at the Recovery Mall as compared to other facilities. One respondent stated that: "[a]t [RecoveryMall] there is a schedule...you get ready for the day, groups, read, return to unit, read, dinner, community meetings, current events, read, snack, read, talk to parents, bed. [Other] hospital did not have groups, exercise, less flexible. Same people all day."

Another respondent noted that there was more freedom at VA than at the Recovery Mall and commented that: "[t]he VA had more freedom. You could smoke and there was better food. VA had groups all day. Kept busy from breakfast to 3:30. I was outpatient but did not learn as much about myself as I did here....[Recovery Mall] is great compared to jail but still less freedom than VA."

Four people discussed comparisons in how the staff treated them at different facilities. These comparisons mainly focused on being treated with respect. For example, one respondent noted: "[y]ou get more respect from the staff here. Facility requires this. Interaction with staff is respectful and there are repercussions if not."

There were other comments about the safety at the Recovery Mall, privacy, the ambiance and the rules, but there was no emerging theme associated with safety. One participant commented on the separate facilities for men and women. The participant said: "[the other facility] was paradise compared to here because it was coed so it was more of a natural environment. I can't stand being around all men. There is more fighting and aggression."

DISCUSSION

Overall clear themes emerged that cut across the responses to all the questions. The first theme related to medications. Repeatedly, interviewees discussed how they had learned how medications help them to remain stable.

The second theme pertained to the importance of socializing. Although there were a few exceptions, the majority of interviewees felt the opportunity to socialize was important to their recovery. Sometimes this theme involved learning how to socialize and have peer relations, but other times the theme pertained to lessons learned from socializing with patients less functional than themselves. Many interviewees expressed the concern that they did not want to end up like these less fortunate inpatients. Socializing was important to patients both in the formal context of therapy groups and in informal interactions on the unit and at mall venues. Informal interactions appeared to be especially important in the development of trust and as a source of personal support. In the formal settings of groups, many respondents felt that the comments participants made about their own experiences or their observations about issues brought up in the group helped to shape the group process either positively or negatively.

Closely related to the theme of socializing was the issue of credibility of the messenger when there was discussion of personal mental health concerns. Comments on socializing with other inpatients indicated that participants saw value in their peers' advice because the other person shared his/her symptoms or experiences. In a similar vein, participants in the SAMI groups especially valued group facilitators who had themselves had addiction experiences and thus spoke from personal knowledge. Some female participants also expressed the view that it was important to have a woman leading the Women's Issues group because a woman was perceived to have greater credibility to direct the discussion.

Many interviewees perceived therapy participation to be an important contributor to recovery. Even before specific questions were asked about groups at the hospital, more than half of those interviewed identified group participation as something that had helped them get better. For these participants, groups served as informational resources (e.g., helping them understand court processes, how much time and money is spent on alcohol or drugs, etc.); as a source of anticipatory guidance on handling life outside of the hospital setting (e.g., learning relapse triggers); as a source of learning life skills; and as a reliever of boredom (e.g. "gives me something to do").

Treatment malls represent a departure from traditional models of inpatient rehabilitation in their move from unit-based treatment to centralized programming that allows more choice in therapeutic and social activities and more normalized experiences for inpatients that are closer to community living. Professionals working in such facilities have identified the potential benefits of mall interventions for patients as including, among others:

- Opportunities for skills training and support relevant to community living
- Opportunity to experience socialization with a variety of peers resulting in increased ability to form friendships
- Opportunity to engage in many types of group activities that enrich daily life

- Opportunities to become part of a group of peers, resulting in enhanced feelings of acceptance
- Opportunities to function as one would in society, rising at a certain hour, getting dressed, participating in meaningful activities, and living on a schedule (Ballard, 2008).

The majority of participants in this treatment mall research saw themselves as having made progress since their admission to the hospital. Most could identify specific ways in which they had changed and specified the facilitators of change. Many of these identified facilitators mirrored the theoretical benefits acknowledged in professional literature. Socializing with peers was perceived as helping in recovery because of the personal support it offered and its function in peer-administered therapy. Inpatients also appreciated and saw value in the opportunity to participate in a wide variety of group therapeutic and recreational activities and that the treatment mall model broadens these choices from the two or three groups typically offered in unit-based treatment models to more than 20 group options scheduled in the treatment mall. Interviewees also specifically mentioned skills training that transfers to community living (e.g., sewing and cooking classes, learning relapse triggers) as helping prepare them for life after hospitalization. Inpatient perceptions identified in this research thus tend to validate the unique features of the treatment mall as helpful to recovery.

Limitations

Several limitations affected data collection and analysis. First, it was difficult to recruit the number participants needed to reach the target of 32 participants. If this study was a long-term project, taking place over several years, it may have been possible to obtain more and clearer data. This was a one-year study. During the first six months, we needed to create the research protocol and obtain IRB approval. We only had six months to collect data. Since inpatients are typically at the hospital for several months to several years, there simply were not enough inpatients close to discharge to be interviewed.

A second problem was that many of the inpatients simply were not at a level where they could track the questions and provide clear coherent answers. We went through many iterations of the questions to make them simple, clear, and concise. The problems in obtaining clear, coherent answers were not artifacts of the questions themselves. Rather, the problems stemmed from inpatient issues. The medication may have been at least partially responsible for the difficulties many inpatients experienced in providing clear, concise answers. Although all participants were able to complete the interview and for the most part responded appropriately to the questions, some interviews were very short because respondents had concentration and communication difficulties that appeared to be related to their medications.

Third, although therapists provided ratings indicating the level of the inpatient's functionality, it would have been helpful for us to have completed our own ratings at the time of the interviews. This rating would have provided us with a weighting in which to rank the interviews in terms of the responses' validity. Also, the screening question assessing functionality asked the therapist to rate the level of the inpatient's progress since coming to the hospital. A more targeted question would have addressed how the therapist assessed the inpatient's overall functionality. It certainly was possible for an inpatient to score a "5", which indicated s/he had progressed significantly since coming to the hospital but not be at a high functioning level. That said, all therapists who referred inpatients for interviews knew the purpose and likely sent only the most functional patients.

Future Directions

Studying inpatient perceptions of the effects of participating in a treatment mall has addressed gaps in the limited literature on treatment malls. To date, data on patient perceptions has examined little more than satisfaction with treatment services. Since the inpatient is the only source of information on the "felt experience" of the treatment mall, it is important to continue efforts to capture their perspectives. Future researchers might consider other methodology options for examining the inpatient's point of view. Since it was difficult in this study to get some inpatients to talk, a series of interviews might be considered rather than a one-time event. This format would allow for the development of trust, rapport, and comfort as well as the inclusion of other interview questions. In the present study, the number of questions was limited so that the interview could be completed within an hour. Additional interview time expanded over several sessions would allow for more in-depth exploration of topics.

This study's original purpose was to be able to provide some way for the hospital to obtain outcome data from inpatients related to the success of the treatment mall, perhaps through a written survey administered near the time of exit. It would have been very difficult to obtain valid survey data from many of the interviewees. Some had trouble tracking during a one-on-

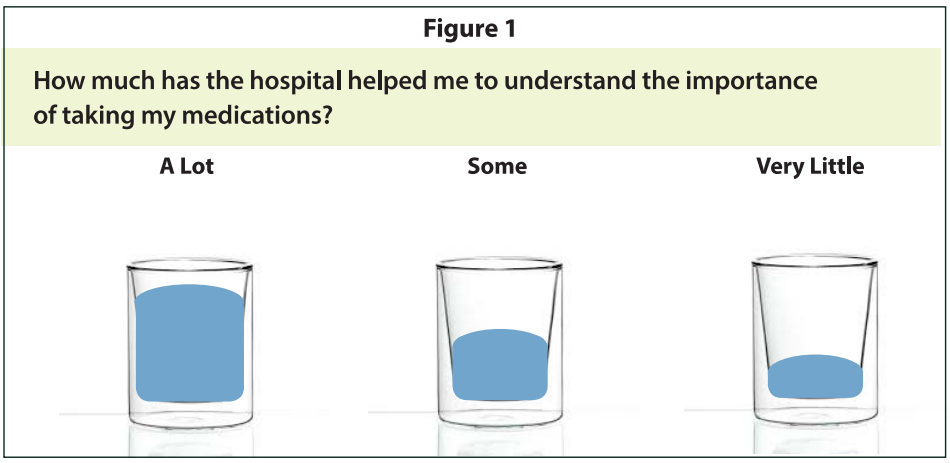
one interview and would likely have been unable to stay focused on a survey. However, if the survey were designed to be very simple, very concrete, and short (approximately 10 items) with easy to understand language, it might be possible to gather data from exiting inpatients. It would be advantageous not to offer too many response options, thus using a 3-point versus a 5-point scale and reading the questions to the inpatients. Response options could be augmented with a graphic to help represent the option. Consider the following example in Figure 1. Developing and using such a scale may allow hospital staff to measure the impact of its interventions using a more quantitative approach.

While the inpatient is an important source of information concerning treatment effects of the treatment mall approach, other perspectives should be included in future research. Interviews, focus groups, or surveys of professional groups providing treatment mall services should be undertaken to gather data on the therapeutic benefits of this approach for patients and whether it increases inpatient involvement in active treatment and advances progress toward goals. Studies might also include qualitative research with nonclinical staff and with inpatient families. In addition to clinical outcomes research, cost/benefit analysis is needed on the treatment mall model in light of the changes it entails in using staff and resources.

Finally, long-term follow-up studies on participation effects in treatment mall are needed for inpatients returning to community living. Studies should examine adherence to recommended medication regimens, quality of life indicators, and recidivism rates. A 2010 article on treatment malls identified nearly 40 hospital sites that have embraced this model in the past few years (McLoughlin, Webb, Myers, Skinners, & Adams, 2010). The growing acceptance of the treatment mall model needs to be accompanied by a rigorous program of research that both informs its direction and validates its outcomes.

Figure 1

How much has the hospital helped me to understand the importance of taking my medications?



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