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An Evidence-based Psychotherapy for Bipolar Disorder in Community Mental Health Settings: Facilitators and Barriers to IPSRT Implementation

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Abstract

Objective—Despite widespread use of individual outpatient psychotherapies in community mental health clinics (CMHCs), few studies have examined implementation of these psychotherapies. This exploratory qualitative study identified key themes associated with the implementation of an empirically supported psychotherapy in CMHCs.

Methods—We conducted semi-structured interviews with twelve key informants from four CMHCs trained in interpersonal and social rhythm therapy (IPSRT) and categorized recurring key themes.

Results—Five major themes were identified: pre- training familiarity with IPSRT, administrative and management support, IPSRT “fit” with usual practice and clinic culture, implementation team and plan, and supervision and consultation. Discussion of these themes varied between participants from clinics that had successfully implemented IPSRT and those that had not.

Conclusions—Interviewees identified both key themes and several strategies for facilitating implementation. Our findings suggest that when these key factors are present, outcome-enhancing treatments can be implemented and sustained, even in clinics with limited resources.

Bipolar disorder is a severe mental illness with high rates of impairment, suicide and comorbidities. Evidence-based psychosocial interventions can play an essential role in improving outcomes for individuals with bipolar disorder(1), but too few individuals receive these interventions(2).

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Effective implementation of evidence-based psychotherapies in community outpatient mental health settings is a long-recognized challenge(3). A range of organizational and environmental factors identified in other settings may impact the effective implementation of evidence-based practices in a community mental health clinic, as well as the clinical outcomes of those practices(4). These include the clinic's organization, approach to training and supervision, the psychotherapy's implementation process(5, 6), as well as the greater severity and clinical complexity of many publicly insured individuals served by these clinics. Better understanding the influence of these factors is critical to improving the quality and effectiveness of clinic care for individuals with serious mental disorders(7).

Unfortunately, studies of evidence-based mental health intervention implementation have seldom explored factors influencing the intervention implementation in outpatient clinics. A prior implementation study of interpersonal and social rhythm therapy (IPSRT), an evidence-based psychotherapy for bipolar disorder, examined the implementation process across multiple levels of care in one large academic medical center(8), and did not explore its implementation in community clinics.

To enhance our understanding of the organizational factors that influence such implementation, we conducted a qualitative study of IPSRT implementation in four community mental health center outpatient clinics.

Methods

IPSRT takes a two-pronged approach to ameliorating current mood symptoms and preventing manic and depressive relapse. First, IPSRT focuses on regularizing patients' social rhythms (i.e., daily routines) and titrating patients' level of activity, and second, IPSRT focuses on the resolution of current interpersonal and social role problems. Outpatients who receive IPSRT have better outcomes than individuals in comparison groups.(1, 9)

We recruited eight clinicians and four administrators/supervisors who had participated in IPSRT trainings between 2006 –2009 from four moderate to large non-profit community mental health center outpatient clinics located in urban or suburban communities in different parts of the country. Randomly selected individuals (from a list of IPSRT training participants provided by the clinic) who responded to an invitation completed a brief semi-structured phone interview. Following informed consent, interviews began with open-ended questions about IPSRT implementation, with subsequent follow-up probes and questions designed to explore IPSRT implementation facilitators and barriers. The interviewer took detailed field notes throughout the interview, and interviews were audio-recorded to facilitate clarification and verification of field notes. Study procedures were approved by the University of Pittsburgh IRB.

Analysis

Preliminary codes were developed (consistent with template coding) (10) based on common themes in the implementation literature), and reviewed and refined during coding by research team members. Recurring themes were identified and categorized by an initial coder, and independently reviewed and confirmed by a second coder. Themes were

aggregated into larger themes by the research team, and disagreements were resolved by consensus.

Results

The interviews revealed substantial differences in the extent to which the clinics successfully implemented IPSRT following the training. Interviewees from two clinics (hereafter referred to as successful implementers) described clinician's ongoing use of many IPSRT components, while interviewees from the other two clinics (hereafter referred to as unsuccessful implementers) reported very limited and quickly diminishing use of IPSRT subsequent to the training. Across both types of clinics, five major IPSRT implementation themes emerged. Below we provide exemplars and discuss these themes in greater detail, contrasting when appropriate successful vs. unsuccessful clinics.

Pre- training Familiarity with IPSRT

Awareness of IPSRT prior to training was a common theme. Participants at successful clinics frequently described some familiarity with IPSRT before the training, whether through workshops, readings, or conferences. One clinician *"had an 'informal training' with [her supervisor] 3 months before the formal training,"* while another *"had started doing readings and going to meetings about IPSRT in the 1990s and started using it in 2001."* In contrast, lack of familiarity with IPSRT was often mentioned at unsuccessful clinics. One administrator related, *"Other than the psychiatrists, few [clinicians] were (familiar) with IPSRT before the training, and there was resistance ... they did not want to incorporate the approach."* Another unsuccessful clinic administrator contrasted IPSRT to an intervention that had been successfully implemented, describing the successful implementation, *"There was prior familiarity with the (successfully implemented intervention). There was a foundation to build upon."*

Administrative Support for Implementation

Interviewees often stressed that administrative support was an integral component to successful implementation. Individuals from successful clinics commonly discussed the importance of a clinic champion—someone within the clinic who "represented" IPSRT and whom clinicians could approach with questions or concerns. A clinician related, *"I can't imagine (successfully implementing) without all of the administration on board,"* while an administrator observed, *"it helps to have someone in administrative power that is sold on the treatment and wants to make it happen."* A supervisor said her clinic's *"head doctor was very interested in IPSRT and ... pushed for it,"* while another supervisor noted, *"clinicians would stop her in the hallway to talk about (IPSRT) ... because they knew she was helping to facilitate the use of IPSRT."* Administrators at successful clinics also supported IPSRT when training disrupted clinicians' normal work schedule. One clinician recounted, *"(I) lost hours with patients, took days off for the training, and was not expected to make up days missed."* Such comments were lacking in interviews with individuals from unsuccessful clinics.

IPSRT Treatment Model “Fit” With Usual Practice and Clinic Culture

Another common theme in both successful and unsuccessful clinics was IPSRT’s fit with usual clinical practice. Many clinicians at all sites commented on the straightforwardness of IPSRT’s social rhythm component, as one clinician described *“it just made sense to me and I ran with it.”* However, interviewees also discussed how IPSRT’s interpersonal component was not as easily grasped or used. One clinician from a successfully implementing site described, *“glossing over the IPT part ... and using the social rhythm part more.”* Another clinician admitted *“the social rhythm part stood out for [her] more than the IPT part, and [she] remembered more of it”* from the training, and an administrator from a successful clinic noted, *“the IPT part of IPSRT did not take hold (among the clinicians), but people were using the social rhythm part.”*

Participants also discussed challenges implementing components that did not naturally fit with current activities. For example, many described how IPSRT’s physiological rationale (i.e. stabilizing circadian rhythms) was novel for both clinicians and patients, and therefore more difficult to teach patients. Interviewees were also concerned that some treatment activities could potentially overwhelm patients who—by the very nature of bipolar disorder—might be fragile. One clinician from a successfully clinic *“loved the SRM but found it a bit cumbersome...the grids and mood rankings can be a little intimidating to patients.”* Another clinician discussed difficulty in getting patients to understand and take steps to stabilize their circadian rhythms. *“(Patients) would hear it and seem to get it, but it’s hard to sustain ... there needs to be a better repertoire of materials to help patients understand the physiological aspect.”*

Many interviewees also discussed their clinic’s valuing the use of evidence-based interventions for mood disorders. One clinician at a successful clinic shared, *“[our clinic] was built around the goal of using EBPs like IPSRT,”* while another recalled when starting at her clinic, being *“presented IPSRT as an EBP for bipolar, and told to read [the treatment manual], learn it, and try it.”* An administrator at a successful clinic described the clinic as *“a mood disorders clinic that focused on using best practices for mood disorders.”*

Implementation Team and Plan

The importance of having a plan, and individuals to support implementation, was another common theme. Unsuccessful clinic participants described relying primarily on training, with less attention to a team and logistical foundation to support implementation. As an unsuccessful clinic administrator candidly stated, *“there was not enough ground work before, during, and after training on how IPSRT was going to be incorporated into standard practice”* while another unsuccessful clinic administrator lamented, *“no one was interested in [an implementation team] after [the training],”* and without such a team, *“there was no institutional togetherness ... clinicians did what they wanted to do.”*

In contrast, successful implementers commonly discussed an implementation team and/or implementation plan developed prior to training, involving motivated, interested clinicians. Some clinics hired only clinicians with prior experience in effective therapies, as did the clinic administrator who revealed *“we recruited clinicians specifically with training in EBPs”*

for mood disorder.” One supervisor commented, “clinicians came to us because they wanted to learn IPSRT and were excited about it.” Successful clinics also discussed the need for a clear implementation plan, with a clinician at a successful clinic relating “we had a plan going in [to the training], and knew how we’d be learning it [IPSRT] and using it with patients.”

Two additional implementation activities commonly discussed by successful clinics were: 1) marketing the treatment model to everyone in the clinic, and 2) having a referral plan in place before IPSRT training. For example, one clinician said IPSRT was “*marketed (in the clinic) as a new hope.*” With respect to referrals, interviewees described a shared awareness and responsibility for case referrals among all clinicians— regardless of discipline— for maintaining referral flow. As one clinician discussed, “*others not treating bipolar or using IPSRT were very good about ... bipolar referrals that could be passed along,*” while another related, “*cases came to her through internal referrals from the psychiatrist, and patients knew they were coming to her for IPSRT.*” One administrator provided an overview, describing how “*(his clinic) had a steady stream of referrals, and there was collaboration among social workers, psychologists, and psychiatrists, who would talk and hand off cases.*”

Supervision and Consultation

All interviewees discussed the importance of adequate consultation after training. Individuals receiving it found it extremely useful while those not receiving it wish it would have been available. One clinician at a successful clinic related “*it (consultation) got us to stay true to the model and bring us back if we were going astray.*” A supervisor asserted, “*(the trainers) should follow up with [the trainees] and do consultation or some sort of follow-up.*” An unsuccessful clinic administrator admitted, “*the consultation piece wasn’t there, and that is where the initiative was lost.*” Common in successful clinics were built-in support mechanisms and routine supervision and meetings. In contrast, an unsuccessful clinic clinician discussed wanting an “*in-house, forum-style*” venue focused on “*checking in on how things are going, seeing if there are any challenges, and troubleshooting [the challenges].*”

Discussion

In this study of IPSRT implementation in outpatient clinics, we identified five major themes related to effective implementation, with interviewees providing concrete descriptions of strategies facilitating successful IPSRT implementation. Ours is one of the first studies examining the implementation of an evidence based psychotherapy in community mental health outpatient clinics, and many themes identified are consistent with those identified in studies of other interventions and settings(5, 11–13), and the description of specific strategies are an important contribution for those seeking to turn the concepts into concrete activities to support implementation.

The importance of a good “fit” between the intervention and the culture of a clinical setting for successful implementation has been reported for other interventions(6, 14), as has the need for ongoing supervision and consultation as recent trainees begin using and seeking to master the intervention(15). Our interviewees’ comments were consistent with these

findings, and also provided some concrete examples of successful and unsuccessful approaches. A number of comments, however, were also made about the importance of pre-training familiarity with the intervention. Many felt this was important for later successful implementation, a factor not as commonly identified. While we are unable to examine to what extent such pre-training familiarity is causal or reflects unobserved clinic characteristics associated with more successful implementation, attention to pre-training familiarity may be useful for future implementation efforts.

Our interviewees discussed the importance of both management support for implementation and the importance of the intervention's fit with the clinical setting, themes commonly mentioned in the implementation literature(6, 11). Interestingly, however, the discussion of fit focused on intervention components, with the more concrete and behavioral social rhythm components being implemented more commonly than the interpersonal therapy component. Other studies also suggest that there are some components of effective interventions that are more likely to be implemented than others(14). The social rhythm handouts and other documents available for clinician use may have facilitated its use, as well as the social rhythm component being less complex and more easily triable (6) compared to the interpersonal therapy component. As we seek ways to better implement effective psychotherapies in outpatient clinics, this finding suggests the need to consider differential levels of implementation support for therapy components if all components must be implemented, and/or greater attention to identifying the effective components of existing evidence-based psychotherapies.

"Train and pray" has long been recognized as an approach unlikely to result in effective implementation(12, 13), and a common theme was the importance of clinics having a planned implementation approach and an identified team to carry-out the implementation plan. Interestingly, several recommendations were related to having sufficient awareness of and referrals for the intervention, illuminating the importance of providing sufficient patient flow for clinicians providing the intervention, especially immediately post-training when clinicians are working to master new techniques.

This study must be considered within the context of its limitations. We focus on a relatively small number of community mental health outpatient clinics and a single therapy. Interviewing several individuals from each clinic allows us to identify general issues within the clinics, but we are unable to assess to what extent there was, within clinics, variation in implementation plan or experience, nor do we know how involving more clinics would change our findings. All participating clinics sought IPSRT training, suggesting substantial interest in IPSRT, and we do not know to what extent our findings would generalize to other psychotherapies, to other outpatient settings providing psychotherapy, or to clinics in states where the use of evidence-based practices is now mandated.

Conclusion

Despite these limitations, our study suggests a roadmap for community mental health outpatient clinics seeking to successfully implement an effective psychotherapy such as IPSRT. Our findings are also positive for those seeking to implement such interventions,

clearly suggesting that when key factors are present, these outcome-enhancing treatments can be both implemented and sustained, even in community mental health clinics with relatively limited resources.

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References

1. Frank E, Kupfer DJ, Thase ME, et al. Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. *Archives of General Psychiatry*. 2005; 62:996–1004. [PubMed: 16143731]
2. Corrigan PW, Steiner L, McCracken SG, et al. Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. *Psychiatric Services*. 2001; 52:1598–1606. [PubMed: 11726749]
3. Backer TE, Liberman RP, Kuehnlel TG. Dissemination and adoption of innovative psychosocial interventions. *Journal of Consulting and Clinical Psychology*. 1986; 54:111–118. [PubMed: 3958295]
4. Glisson C, Hemmelgarn A. The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse & Neglect*. 1998; 22:401–421. [PubMed: 9631252]
5. Gotham HJ. Advancing the Implementation of Evidence-Based Practices Into Clinical Practice: How Do We Get There From Here? *Professional Psychology: Research & Practice*. 2006; 37:606–613.
6. Damschroder LJ, Aron DC, Keith RE, et al. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science*. 2009; 4:50. [PubMed: 19664226]
7. McHugh RK, Barlow DH. The dissemination and implementation of evidence-based psychological treatments. A review of current efforts. *American Psychologist*. 2010; 65:73–84. [PubMed: 20141263]
8. Swartz HA, Frank E, O'Toole K, et al. Implementing interpersonal and social rhythm therapy for mood disorders across a continuum of care. *Psychiatric Services*. 2011; 62:1377–1380. [PubMed: 22211221]
9. Frank E, Soreca I, Swartz HA, et al. The role of interpersonal and social rhythm therapy in improving occupational functioning in patients with bipolar I disorder. *American Journal of Psychiatry*. 2008; 165:1559–1565. [PubMed: 18829872]
10. Miller, W.; Crabtree, B. Primary care research: a multi typology and qualitative road map. In: Crabtree, B.; Miller, W., editors. *Doing Qualitative Research*. London: Sage; 1992. p. 23-28.
11. Fixsen, DL.; Naoom, SF.; Blase, KA., et al. *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, the National Implementation Research Network; 2005. FMHI Publication #231
12. Beidas RS, Kendall PC. Training Therapists in Evidence-Based Practice: A Critical Review of Studies From a Systems-Contextual Perspective. *Clinical Psychology*. 2010; 17:1–30. [PubMed: 20877441]
13. Herschell AD, Kolko DJ, Baumann BL, et al. The role of therapist training in the implementation of psychosocial treatments: a review and critique with recommendations. *Clinical Psychology Review*. 2010; 30:448–466. [PubMed: 20304542]
14. Zazzali JL, Sherbourne C, Hoagwood KE, et al. The adoption and implementation of an evidence based practice in child and family mental health services organizations: a pilot study of functional

family therapy in New York State. *Administration and Policy in Mental Health*. 2008; 35:38–49. [PubMed: 17985232]

15. Schoenwald SK, Sheidow AJ, Letourneau EJ. Toward effective quality assurance in evidence-based practice: links between expert consultation, therapist fidelity, and child outcomes. *Journal of Clinical Child and Adolescent Psychology*. 2004; 33:94–104. [PubMed: 15028545]