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Implementing Evidenced-Based Practices in Public Mental Health Systems

During the past two decades enormous advances have been made in treatments available for persons with mental illness. New treatments have emerged. A substantial growth has occurred in the number of medication alternatives available. The available medication options have differing mechanisms of action, better tolerability, and enhanced safety. The diagnostic methods are more reliable and valid. We now have the tools to measure outcomes. Several psychosocial interventions, new services, and supports have proven effective. The US Surgeon General's Report on Mental Health provides an overview of these evidenced-based services that have resulted in favorable outcomes for patients in numerous controlled studies. Despite these scientific advances, unfortunately, there remains a huge gap between what is known through research and what is actually practiced in many public mental health systems across the country. These dissemination and implementation problems are neither new nor unique to the field of mental health. The literature from many disciplines is packed with examples of new research findings not being widely used in decision making, sometimes for decades or more. A critical challenge for the mental health field is to facilitate the widespread adoption of these empirically-supported practices in the routine mental health care settings and to seamlessly integrate them into existing systems of care so that persons with mental illnesses can benefit from the services that have been shown to work.

As the mental health field identifies the evidence-based practices, another challenge for public mental health systems is to assure that those services are the ones being purchased by state mental health agencies and utilized by providers. Although there is a growing body of research demonstrating that certain evidenced-based mental health interventions result in positive outcomes for consumers, there is less evidence about how to implement and integrate these practices into public mental health service systems. Implementation can be especially difficult when budgets are tight and there are competing priorities. Which services are to be displaced to allow for introduction of evidenced-based practices? The fact that other practices have not been deemed "evidenced-based" does not necessarily mean that they are ineffective. It may well be that the resources have not yet been available to conduct adequate controlled research on these practices. There are lessons to be learned from those who have attempted the implementation of evidenced-based mental health practices.

Several states are undertaking serious efforts to look at how they disseminate and implement evidenced-based practices for the public mental health system. Some of the states have now started to focus on identifying the most effective and feasible means by which the Offices of Mental Health can disseminate knowledge about evidence-based mental health services and to reasonably assure their adoption and use by providers of public mental health services, both in the community and in its hospitals. There are several major initiatives and projects currently in progress on the area of implementing evidenced-based practices. How do we address the major impediments to implementation? How do we address the important relevant areas such as staff turnover, training, ongoing funding, tracking clinical outcome, formulary, and information management? How do we align administrative rules and regulations to support the implementation of EBPs? These are some of the questions that psychiatric administrators are now beginning to see unfold. *Psychiatrist Administrator* would like to invite its readership to contribute articles addressing their experiences, opinions, as well as any data-driven pieces related to the implementation of evidence-based practices in mental health settings.

Sy Atezaz Saeed, M.D.
Editor

Surviving Organizational Change

Steven M. Mirin, M.D.

The Changing Healthcare Environment

The last two decades have been marked by enormous changes for both healthcare organizations and healthcare professionals. Numerous advances in basic and clinical research have been translated into advances in psychiatric diagnosis and clinical care, while the development of sophisticated imaging technology, along with new discoveries in neurobiology and molecular genetics, have enhanced our understanding of how the brain works in both health and disease. At the same time, the development of safer, more effective, biological therapies for the treatment of mental disorders has helped destigmatize mental illness and increased the demand for quality mental health care.

The excitement of our field has been tempered, however, by profound, and generally detrimental, changes in how mental health care is financed and delivered. In the late 80's and early 90's the availability, and subsequent use, of mental health services, led to rising costs for public and private payors, insurers, employers and patients. In the private sector, insurers and managed care organizations, spurred on by employers who saw their premium costs escalating, responded with vigorous efforts at cost containment in the form of discriminatory co-pays and deductibles and the imposition of managed care in its various forms. In the public sector, the dismantling of the hospital system and the privatization of care management, were among the steps taken to control costs.[1,2]

To address the realities of an increasingly difficult healthcare environment, hospitals, clinics and healthcare professionals have had to review their philosophies of care and reconfigure their expectations, and their budgets, to address current and future threats to their survival. Some healthcare organizations demonstrated courage and creativity in adapting to, or mitigating, the impact of cost containment measures on the quality of care they deliver. Other institutions were slow to initiate and/or implement the kind of organizational change needed to secure their place in the healthcare system of tomorrow, one in which concepts like cost effectiveness, quality and accountability will be continuously redefined and measured, not only by providers of care but by purchasers as well. This paper, grounded in the existing literature and the author's own experience, examines some of the factors that facilitate or impede organizational change in healthcare. It also suggests some strategies that healthcare leaders might use to make change and to survive the change process itself.

Why Do Healthcare Institutions Change?

Traditionally, organizational change in healthcare occurs in response to obvious, and powerful, external forces. The development of essential new technology, the emergence of new and compelling market forces and changes in the demographic and clinical characteristics of the population to be served are among the more potent initiators of such change. In the technology arena, the availability of new techniques for imaging the brain, gene mapping and eventually gene therapies, have been, or will be, embraced by institutions and individuals eager to apply these tools in the diagnosis and treatment of patients. Doing so, however, requires capital outlays, the recruitment and training of staff and other forms of investment currently beyond the reach of many institutions. In addition to having the necessary resources, those that have led the way in exploring the use of these, and other promising forms of technology, have benefited from a culture that supports innovation.

Market forces also help create institutional change. Beginning in the early 80's, the increased availability of insurance coverage for the treatment of mental disorders produced a rapid expansion in the availability of inpatient and other services in both general hospitals and freestanding private psychiatric facilities. Less than a decade later, pressure to reduce the costs of mental health care led to the introduction, and widespread use, of managed care procedures (e.g. pre-admission certification, concurrent and retrospective review) that resulted in a substantial contraction in the duration of hospital stays and in the number of inpatient psychiatric beds.

In this environment, successful adaptation, and at times institutional survival, required a willingness to reexamine philosophies of care and reconfigure clinical programs and facilities to respond to the new market imperatives.[3]

Healthcare institutions also change in an effort to meet the evolving needs of consumers. In the last decade, the changing clinical and demographic characteristics of neighborhoods, and the population as a whole, has caused healthcare organizations to rethink the kind of services they offer. Thus, in the 90's, many hospitals responded to the growing proportion of elderly in our country by developing services that address the mental health needs of this age group. Such services range from hospital-based inpatient units offering specialized care to geriatric patients, to offering psychiatric consultation in skilled nursing facilities, to community based support of caregivers. Similarly, the growing ethnic and cultural diversity of certain areas of our country have spurred the development of a range of mental health services that take into account the cultural and language differences of the population to be served.

Even in the absence of powerful external forces, most healthcare organizations are in a constant state of evolutionary change. Many are engaged, with variable degrees of commitment and efficiency, in processes designed to improve the quality of the services they deliver, increase the productivity and work satisfaction of their staff, keep operating costs in line with available revenue, and successfully compete within their market for the loyalty of patients and physicians.[4] In the same vein, healthcare institutions must recognize and respond, promptly and effectively, to emerging trends in healthcare delivery, invest in the training and education of their staff, and continuously upgrade their technology and physical plant. Those who neglect these imperatives eventually find themselves unable to deliver state-of-the-art care. The latter is often accompanied by a loss of reputation, referrals and revenue, from which it may be difficult to recover.

This discussion brings us to the most powerful motivator of institutional change, the will to survive. Hospitals with chronically empty inpatient beds have used their unproductive space to develop residential treatment programs, specialized outpatient clinics and wellness centers. Others have responded to the unforgiving, if not hostile, reimbursement environment by merging, to take advantage of economies of scale or the increased bargaining power of a hospital chain or an integrated delivery system. This, of course, often requires broadening ones perspective and reshaping ones relationship with former competitors. It may also require relinquishing the latitude for independent decision-making, a particularly difficult task for some clinicians, executives and boards of directors.

Impediments to Institutional Change

Regardless of the motivation, organizational change is hard. One of the hardest things about it is the difficulty in overcoming organizational complacency. There are many etiologic factors at work here. In organizations with a long history of relative stability and prosperity, there may be an absence of perceived threat, bordering on institutional denial. How could this be? Certainly, most organizational leaders and staff read newspapers, are aware of the economic trends affecting their niche in the marketplace and know (generally), how attractive their services are to their patients and the general public.

One explanation is that, in the face of external threat, denial is not confined solely to individuals. Some institutions seem unable to process threatening information, particularly when it comes from outside their own culture. Alternately, a threat may be perceived but then dismissed as having little relevance. For example, in the 80's and 90's, some very prestigious psychiatric hospitals believed that the spread of managed care would not affect their referral or revenue streams because patients and families would need/demand their high quality services, even if they had to pay some or all of the cost themselves. Unfortunately, many such institutions discovered that while, to some extent, this was true, there were not enough such patients to sustain their large and expensive physical plants, their high staff to patient ratios and their commitment to support teaching and research. Moreover, a stellar

reputation and a tradition of clinical excellence were insufficient to assure a continued flow of referrals from health maintenance organizations and managed care networks focused on driving down the costs of mental health and substance abuse treatment. As a result, some hospitals lost lots of money and others lost their place in the nation's mental health service system.

Even in the face of unequivocal signs that an organization is in trouble, leaders and followers alike may still refuse to believe there is a problem, or insist that it will pass without their having to do anything about it. This type of faulty corporate reality testing is sometimes supported by a long history of success, coupled with the need to defend long held traditions and ways of doing things. This is may be a particular problem in organizations in which long-term employees, loyal to the institution, are promoted to positions of authority with the understanding that they will maintain the tradition and culture, even in the face of compelling reasons to change. Clearly, while the value of doing some important things well is undeniable, this type of organizational rigidity can, at times, lead to stagnation and/or erosion of performance standards, as in "we do it this way, so this must be the way to do it." The price of this resistance to innovation is paid first by patients but eventually by the institution itself.

Finally, for some healthcare organizations, the pressure exerted by new and unwelcome challenges (e.g. aggressive managed care) can be overwhelming, and paralyze key decision-makers. Yet the fact that the leadership has "given up" is not always easy to recognize. Managers are still walking, talking and making promises, but internally a switch has been turned off. As administrators, we need to learn how to recognize this in others, and in ourselves.

Implementing Organization Change

A. Role of the leadership group

Kotter[5] and others[6,7] have described the key elements of organizational change. One of the first tasks is to try to overcome institutional inertia and resistance by establishing a sense of urgency. This entails getting key audiences (e.g., trustees, managers, staff) to understand the competitive realities and identify the actual or potential strengths and weaknesses that could be important in developing and implementing an organizational response.

For the organization's leaders, this is a task that cannot be faced alone.[8] Leading change is a group effort. But who are the right people? They are people with leadership and/or management skills, (the two are often mutually exclusive) who can participate in a collaborative planning and decision making process. Some people are terrific leaders but can't manage anything.[9] Others are excellent managers and implementers but are simply not leaders. You need a mix of skills and expertise and varied points of view, but not so varied that the group becomes a " Tower of Babel," with everybody clinging inflexibly to their point of view. These change agents are not necessarily the people at the top of the organizational hierarchy, but they must be respected within their peer group. In hospitals, this means not only physicians and administrators, but nurses, social workers, and non-clinical staff.

Eventually, planning needs to give way to action. The leadership group needs to be given authority not only to express opinions but to make decisions and take responsibility for implementing them. Within limits, organizational change in the form of creating new initiatives, changing (or closing) existing programs or experimenting with staffing patterns, should, ideally, be the result of "bottom up" decision making, lest they be viewed as part of a predetermined plan developed by a select group of powerful, but misguided, insiders.

B. Role of the leader

Let me now turn to the role of the leader in the organizational change process. Leadership matters. Though the effectiveness of a leader is not always immediately apparent, ineffectiveness is felt immediately and at all levels.[10,11] Similarly, though meaningful change is not often attributable to the will of a single individual, failure to accomplish needed change is often due to the failure of a leader to lead.

So what does the leader do? One key task is to personify the values of the organization, what it is the organization stands for, what makes people proud

to work there. The leader needs to not only be identified with those values but to continually restate them and model behaviors consistent with the shared values as often as possible.

The leader also needs to know how to scan the environment, accurately assess the situation, and create a process that leads to an institutional consensus about what to do. He/she also needs to know how to both stimulate and manage change, marshal the necessary resources to sustain the change process and drive the process to completion. With regard to the latter, "the perfect is the enemy of the good". No change process has a perfect outcome and no change process is ever complete. New data and changing circumstances all require a flexible, evolutionary and adaptive organizational response. Thus, another task of the leader is to help create an environment where this can occur, where it is the way we "do business".

Leadership is a lonely task. Authority and responsibility are both a privilege and a drain on your time, on your emotional stability and on your family. There are social relationships that you might like to develop but can't because one day you may have to make decisions that may be biased by, or jeopardize, that relationship. Extramural peer support is helpful, from both a personal perspective and to realize that others share similar burdens.

At times, it helps to be a psychiatrist. The leader must be aware that, in every work environment, group dynamics and transference are always operative. Sibling rivalry, resentment of authority and aggression bordering on sadism, are commonplace in institutional settings. Understanding individual and group behavior, being able to identify what's emotionally important to an institution and to the people who work there, understanding the corporate culture, and being able to tolerate peoples' grief over what is lost when an institution changes, are part of the job description.

Finally, as the song says, 'don't go looking for love in all the wrong places". Leaders must resist the temptation to be the "good guy/gal" at the expense of those working on your behalf. They must also realize that, regardless of the number of facts you marshal or the logic of your arguments, you cannot convince everyone of the need for change, and even if you could, change itself arouses fear, anxiety and resentment toward change agents. It is also important to remember that personal popularity does not always equate with success. The real task is to help define and fulfill the organization's mission and then make the changes necessary to assure its survival, while preserving its core values.

Dr. Mirin is the Medical Director of American Psychiatric Association

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"Surviving Organizational Change"

by Sidney Weissman, MD

Perhaps a more appropriate title for this paper might be "How to Implement Organizational Change." Healthcare delivery organizations or professional associations must either change or face extinction in our forever rapidly evolving medical world. Mirin proposes healthcare organizations must be cost effective, demand quality, be accountable and continuously redefine themselves.

Forces compelling change, Mirin states, relate to new knowledge, market forces, new consumer (in the case of the American Psychiatric Association, member) needs, quality assurance, and a will to survive. Mirin presents the existence of powerful forces that impede change. They include individual or group denial. The latter concept implies a shared belief of the invincibility and essential permanent societal need for either the healthcare provider or professional association as it currently exists. The denial by a leader of need to change at times is maintained in spite of overwhelming evidence to the contrary.

The APA is one example of this process. In spite of significant membership loss indicative of membership disaffection some leaders insist there is not a major problem for the association in its relationship with its members. Another example of disregarding critical information is our profession's response to the major reduction of resources for the treatment of individuals with serious and chronic mental illness. We are experiencing a three pronged attack on their needs. First is a reduction of funding for state operated mental health facilities with a reduction of beds. Second is a reduction of Medicaid funding which had lead to the closure of general hospital psychiatric beds and the third is the underfunding of community based ambulatory programs. In any other area actions of this magnitude would be experienced as devastating and generate a powerful response. In mental health we seem to respond as if they are a matter of course. For some there may be an assumption that we and our patients will be rescued and we should not rock the boat by complaining. Our failure to act for whatever reason may mean these funds are permanently lost.

In addition to denial interfering with change Mirin addresses another impediment. Members of the organization who are in leadership positions who feel a "special" responsibility to protect the organization by maintaining the status quo. Here Mirin does not address the intrapsychic meaning of change to individuals and how this meaning may impede the process of change. Many individuals become defined by their position in organization not by their unique talents or abilities. When this occurs change is unconsciously experienced as an attack on self. These individuals not only do not support change but actively oppose change in spite of all external evidence that it is essential for the organization's survival. Change in either individual psychotherapy or in an organization will only occur if the individual or organization experiences pain. Denial, one of the most primitive of defenses exists to obscure pain. The charge to a leader is to understand the needs of the organization and to address those forces that maintain and use denial to support the status quo to prevent change. To be an effective leader one needs courage and vision.

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The Impact of An Electronic Linkage Form on Readmission to a State-Operated Psychiatric Hospital

Matthew F. Shaw, M.Div., John S. Lyons, Ph.D., Kathy Nee, Tom Simpatico, M.D.

ABSTRACT

We studied the impact of an inter-agency, electronic linkage form on 30-day readmission rates and average monthly lengths of stay at a state psychiatric hospital. We reviewed 3,164 consecutive admissions spanning the year preceding and year following the implementation of the form. Using results from a previous study examining the impact of comorbid substance abuse on readmission rates, we calculated the expected increase in readmission rates and decrease in average lengths of stay attributable merely to case shifting. We then calculated pre and post-intervention readmission rates adjusted to variability in the total monthly censuses and total monthly admissions. Forty seven percent (n=1494) of admissions occurred before implementation while fifty three percent (n=1670) occurred after implementation. Ten percent (n=322) of the sample were readmissions while 90% (n=2842) were first time admissions. Using a Pearson chi square test of association, we found no significant differences in the readmission rates or average lengths of stay attributable to the intervention. We conclude that although increased communication between state hospital and community agency personnel may provide numerous benefits, it does not seem to reduce readmission rates or lengths of stay.

INTRODUCTION

Nearly forty years ago, President Kennedy called for a "bold new approach" to the delivery of mental health services (1). Since then, a variety of political, economic and social factors have de-centralized and de-institutionalized the mental health system (2). The widespread use of psychotropic medications, growing demand for outcomes assessment, and rise of the consumer movement have promoted community based mental health care (3). Numerous regions have closed their large state facilities and shifted care toward general hospitals and community agencies (4). Given the potential fragmentation of services within a de-centralized system, the importance of linking service providers has become a largely unquestioned assumption (5).

Though many researchers assume that fragmented systems lead to the inefficient use of resources, drop out of vulnerable clients and readmission of discharged clients, these assumptions have rarely been tested empirically (5). Client characteristics that influence readmission rates have been identified (6-8); however, the corresponding systemic variables have not been comprehensively studied. The pattern of multiple admissions among a group of clients called "revolving door" clients has been considered a qualitative failure of the mental health system (8). Bachrach (1996) claims these clients are not merely a subgroup but rather the majority of clients within the state mental health system.

Haywood et al (1995) compared 135 inpatients at four State of Illinois Department of Mental Health hospital facilities. They found that medication noncompliance and substance abuse after discharge were the best predictors of rehospitalization. Sanguineti et al (1996) found demographic factors (e.g. young, male, African-American) to be better predictors of readmission than substance abuse, medication compliance or severity of symptoms. Husted (1999) suggests that population density is a reliable and often neglected predictor (9). He claims that crowded, urban centers produce higher readmission rates.

Despite lacking empirical justification, various researchers and policy makers propose using readmission rates as quality indicators for mental health hospitals (10). Lyons et al (1997) challenge these proposals by examining a variety of predictors of psychiatric rehospitalization within a private managed care company. They use the Severity of Psychiatric Illness scale (a case-mix utilization review tool) and the Acuity of Psychiatric Illness scale (an outcome assessment relevant to acute psychiatric services) to study the impact of clinical variables and outcome factors on rehospitalization. These data indicate that greater impairment in self-care, more severe symptoms, and more persistent illness were the best predictors of readmission. Poor hospital outcome and premature discharge were not correlated strongly with rehospitalization. Given their findings, they suggest that readmission rates not serve as quality indicators but rather a combination of the following three functions.

First, differences in readmission rates may result from the varying courses of mental illnesses. In other words, illness specific factors rather than institutional factors may influence rehospitalization. Second, readmission rates may reflect general admission policies. High hospital readmission rates have been associated with high frequencies of inappropriate admissions (11). Therefore, high readmission rates may not reflect the quality of inpatient care but rather the

quality of inpatient admission screening. Last, high readmission rates may reflect the poor quality of community services. Lyons and colleagues (1997) claim that the community care provider may have more influence than the inpatient provider in preventing rehospitalization.

An additional possibility is closely associated with Lyons' third suggestion. High readmission rates may not be primarily the result of either the hospital or community agency but rather the linkage between the two. A variety of interventions have been used to link services. Improved outpatient compliance has resulted from referring patients to previously known clinicians (12), reducing the time period between discharge and initial appointments (13), providing transportation to outpatient appointments (14), and scheduling appointments before discharge (15). However, these researchers did not assess the impact of their interventions on readmission rates.

Nelson et al (2000) studied 3,113 psychiatric admissions within United Behavioral Health of Georgia in 1998 (16). They found that clients who attended their first outpatient appointment after discharge were two times more likely to remain in the community than clients who missed their initial appointment. They suggest that recidivism is neither due to premature discharge nor poor initial care, but rather inadequate discharge planning and service linkage.

Contradicting Nelson's findings, Olfson and colleagues (1998) found that increased outpatient compliance did not affect readmission rates (17). Clients who contacted their future outpatient providers before discharge had significantly better outpatient compliance but comparable readmission rates than those without pre-discharge linkage.

The present study adds unique data to the debate. Rather than studying the impact of linking hospitalized clients to their outpatient providers, we studied the impact of linking inpatient personnel with outpatient personnel. In other words, if inpatient and outpatient personnel communicate during discharge, will readmission rates at the hospital decline?

In February of 1999, Chicago Read State Mental Hospital began using an electronic discharge linkage form. The form is filled out at the state hospital when a client is discharged. It then is sent electronically to the referral agency within the community. Personnel at the referral agency fill in the second half of the form upon making contact and meeting the discharged client. The form serves to hold the referral agency accountable and track the progress of the clients. We retrospectively studied whether this intervention reduced readmission rates and lengths of stay for readmissions at the state hospital.

SUBJECTS AND METHOD

We reviewed 3,164 consecutive admissions to Chicago Read State Mental Hospital. The admissions occurred between February 1998 and February 2000, omitting February 1999 as the month of implementation. We utilized five sources of data already contained within the hospital's database: the monthly number of readmissions; the monthly number of total admissions (including readmissions); the cumulative number of dual diagnosis discharges; the average monthly lengths of stay; and the total monthly censuses. A readmission was defined as the admission of a client who had been discharged within the past thirty days.

Using the results from Leon and colleagues' study (18), we calculated the expected increase in readmissions and decrease in average lengths of stay attributable to dual diagnosis case shifts within the subject pool. We then compared the expected results to our actual results. We also calculated two proportions to describe the monthly readmission rates. First, we calculated the proportion of monthly readmissions relative to the total monthly census. Second, we calculated the proportion of monthly readmissions relative to the total monthly admissions. We then separated the pre-intervention data from the post-intervention data. We compared the mean proportions for both adjusted rates between the pre and post-intervention datasets to determine whether there were significant changes.

RESULTS

Forty seven percent (n=1494) of admissions occurred before the implementation of the linkage form. Fifty three percent (1670) occurred after implementation. Ten percent (n=322) of the sample was readmissions while 90% (n=2842) was first time admissions. There were no significant differences between the adjusted admission rates before and after implementation.

We first assessed whether the forms actually linked the state hospital with community providers. Graph 1 depicts the percentage of forms returned to the state hospital after discharge during three-month intervals. During the first quarter, 40% of the forms were returned while during the third and fourth quarters 51% of forms were returned.

Given the increasing number of patients with comorbid substance abuse diagnoses, we calculated the expected increase in readmission rates and decrease in average lengths of stay attributable solely to case shifting. Table 1 compares the expected and obtained results using Pearson's chi square tests of association. There were no significant differences between these results.

Table 2 compares the pre and post-intervention readmission rates when adjusted to census data. The proportions of monthly readmissions relative to monthly census figures were compared between the two groups. The mean proportion for the pre-intervention group (mean 0.0677 + 0.0241) was not significantly different than the post-intervention group (mean 0.0792 + 0.0185). Graph 2 depicts the variability of the monthly proportions for both groups throughout their respective years.

Table 2 also compares the pre and post-intervention readmission rates when adjusted to monthly admission rates. The proportions of monthly readmissions relative to total monthly admissions were compared. The mean proportion for the pre-intervention group (mean 0.0956 + 0.0792) was not significantly different than the post-intervention group (mean 0.1089 + 0.0279). Graph 3 depicts the variability of the monthly proportions for both groups throughout their respective years.

DISCUSSION

Discontinuity in the treatment of persons with serious mental illness has often been identified as a barrier to high quality and effective care. One strategy to reduce this fragmentation is to improve communication between the discharging hospital and the referral agency. Unfortunately, merely improving and formalizing communication does not appear to prevent the rapid re-hospitalization of a subset of these individuals. The present data indicate that readmission rates and average lengths of stay of future readmissions are not significantly reduced by the implementation of the linkage form. Perhaps it is not surprising that efforts to reduce rapid readmissions involve more than coordination and communication between the hospital and community agency.

The present data are limited in three ways, however. First, only those readmissions that occurred within thirty days of discharge were documented. It is possible that increased continuity of care impacts the readmission rates of clients who remain in the community for more than a month. Second, we only collected data for the year preceding and year following the implementation of the linkage form. The intervention may take longer to improve the functioning of the system. Graph 1 demonstrated that it took nearly one year for the majority of agencies to utilize the linkage form. Data from the second year after the intervention may demonstrate a reduction in the readmission rates as 70 to 80% of the agencies utilize the intervention.

Third, we did not track specific clients but rather monitored systemic admission patterns. Therefore, we did not study variables, such as case-mix and client functioning while in the community. If the intervention had the effect of altering the case-mix of state-hospital admissions, then readmission might be affected as well. Further research that focuses on individual-level data may demonstrate greater utility of the linkage form.

Despite these limitations and assuming they would not have significantly changed the results, the present data highlight two primary issues. First, interventions affecting other aspects of communication, coordination, and planning within the mental health system may have greater impact on reducing readmission rates than the one studied here. Perhaps, connecting hospital and community personnel during other stages of treatment may be more effective.

GRAPH 1

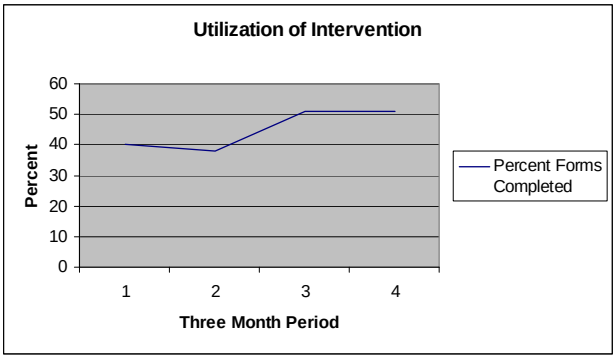

TABLE 1

Actual Results vs. Results Predicted According to Case Shifts within the Subject Pool

	Readmitted	Not Readmitted
Obtained	180	1438
Expected	196	1422

($\chi 2 = 1.49$, $v = 1$, $\alpha = 0.05$)

GRAPH 2

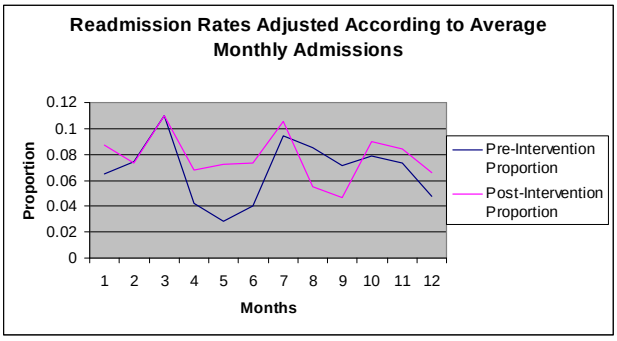

TABLE 2

Readmission Rates Adjusted According to Census and Admission Rates

	Date	Census	Admissions	Readmissions	Readmissions/Census	Readmissions/Admissions
	Feb-98	184	104	12	0.0652	0.1153
	Mar-98	175	113	13	0.0742	0.1151
	Apr-98	164	119	18	0.1098	0.1513
	May-98	166	101	7	0.0422	0.0693
P	**Jun-98**	177	129	5	0.0285	0.0388
R	**Jul-98**	172	126	7	0.0407	0.0556
E	**Aug-98**	180	128	17	0.0944	0.1328
	Sep-98	176	142	15	0.0852	0.1056
	Oct-98	167	128	12	0.0719	0.0938
	Nov-98	178	121	14	0.0787	0.1157
	Dec-98	177	150	13	0.0734	0.0867
	Jan-99	188	133	9	0.0479	0.0677
sum		2104	1494	142	**0.8121**	**1.1477**
mean		175.3333	124.5000	11.8333	**0.0677**	**0.0956**
	Mar-99	183	153	16	0.0874	0.1046
	Apr-99	191	145	14	0.0732	0.0966
	May-99	191	138	21	0.1101	0.1522
P	**Jun-99**	176	125	12	0.0682	0.0961
O	**Jul-99**	180	140	13	0.0722	0.0929
S	**Aug-99**	192	147	14	0.0729	0.0952
T	**Sep-99**	197	152	20	0.1051	0.1316
	Oct-99	199	130	11	0.0553	0.0846
	Nov-99	194	149	9	0.0464	0.0604
	Dec-99	190	131	17	0.0895	0.1298
	Jan-00	202	156	17	0.0842	0.1091
	Feb-00	196	140	13	0.0663	0.0923
sum		2291	1706	177	**0.9308**	**1.2454**
mean		190.9167	142.1667	14.7500	**0.0776**	**0.1038**

For example, personnel may need to communicate when clients are having difficulty staying within the community. If both sets of providers work together, clients may experience a unified effort to keep them within the community as opposed to experiencing the state hospital as not only an escape from community stressors but also an escape from community mental health care. Seeking a return to the hospital may be a way of expressing dissatisfaction with community care for some individuals.

Second, the largely unquestioned target of reducing readmission rates may be overemphasized. Elsewhere it has been shown that rapid readmission was more of a function of patient characteristics than hospital outcomes or length of stay (19). Obviously, a central goal of the mental health system is to serve clients in the least restrictive environment possible. However, envisioning readmissions as systemic failures may be misguided. Perhaps, we will find that periodic readmissions allow some clients released into the community to function at levels not otherwise possible. Clients, who are not readmitted but are seriously impaired, may function at more stable but lower levels than clients who are periodically readmitted. Hospital readmissions may reinforce or enhance community care rather than indicate qualitative deficiencies.

Of course, to say that the discharge linkage form has not reduced readmission rates is not to say that it is useless. It may affect variables other than those studied presently. Perhaps, the discharge linkage form alters the ways in which clients are readmitted into state hospitals. Clients may be less likely to experience volatile readmissions (e.g. through the police or the court system) when outpatient and inpatient personnel are in conversation. Perhaps, by holding community agencies accountable, the form will encourage community personnel to develop more efficient

outreach strategies. These hypotheses and others demand empirical study in order to understand the full impact of linking services.

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A Primer on Management and the Management Environment

William H. Reid, M.D., M.P.H. and Daniel J. Reid, D.P.P., M.B.A.

EDITOR'S NOTE: *This is the first of two articles designed for clinicians who are new to health care administration, or merely confused by it. Some may be enthusiastic about moving from a primarily clinical base to a management career. Some may be stuck in a frustrating environment and want to do something about it. The articles are purposely informal and practical, even simplistic, compared to most books and papers on the topic. They are a guide, not a scholarly reference. The articles are taken from similar chapters by the authors in the forthcoming Handbook of Mental Health Management, edited by William H. Reid and Stuart B. Silver (New York: Brunner-Routledge, 2002).*

Over 2000 years ago, a Chinese general named Sun Tzu[1] wrote *The Art of War*. Since then, every study of strategy, including those in the vast array of "power books" in bookstores and airport book stalls, has begun with the same idea: Understand where you are and where you want to be.

Understand where you are and where you want to be.

One must also know the "enemy." History is full of generals who won battles by knowing both their own armies and the enemy's strategy and capabilities. Custer knew the former, but had a serious problem with the latter. The process of moving you into the management arena begins with understanding that arena and its functions.

Sounds like we're talking about a war, doesn't it? With some important exceptions, pursuing what is best for you or your organization is often a highly aggressive activity. We strongly suggest that you accept and practice a certain amount of aggression in your pursuit of the management ranks.[2]

Finally, we want you to *identify* with the people whose positions you would like to attain. If you want to be taken seriously — by yourself as well as by senior management — start thinking of yourself as something more than a clinical professional. Show others that you think and feel like a manager, even an executive. Learn and *use* the vocabulary and principles you'll find in this book; don't keep them to yourself like some bit of scholarly knowledge or cocktail-party information.

Dress the part. Identify with that which you want to become, not just with your professional peers. We're sorry to have to break this to you, but most of your peers aren't good managers or leaders. We'll have lots of suggestions about this later.

Identify with that which you want to become.

Please note that we did not say your peers are bad or unimportant people. We're not asking you to be mean or unethical, or to shun your friends and patients. We just want you to see some things that other clinicians don't see. We want you to be ambitious, not "cutthroat." Believe it or not, business and management have some pretty strong ethics, to which the book from which this article comes devotes considerable space.

Managers and Executives —

The management environment has a hierarchy of people whose function is to design and execute the goals of the organization. If this sounds simple, that's because it is. Let's start with **managers.**

[1]No one is completely sure who Sun Tzu was. Some scholars think the real general was his grandfather, or even his grandson. A minority are convinced "Sun Tzu" actually referred to a popular pre-Confucian beer.

[2]Dan calls it our "balls to the wall" approach to management, a reference not to things sexist or genital, but to WW II fighter pilots who got maximum power by pushing their throttle controls (often levers with spheres at the top) all the way forward, toward the firewall.

Managers manage, right? Well, yes and no. Most people believe that the function of a manager (aside from getting in your hair) is simply to insure that certain goals and/or tasks are completed. While this is generally true as far as it goes, only the lowest level managers have so simple a job description.

Herein lies a fundamental flaw in many clinicians' perception of management. It goes like this: "I'm a professional. I know my job and do it well. Why do I need a manager, so long as I complete my tasks on my own?"

First of all, if you perform a professional function with little or no direct supervision, then you are by definition already a manager of sorts. Add a few more tasks and a few more people and you are still a manager, but now you have a few more tasks and a few more people. Add some time constraints, quality constraints, and budgetary constraints, and you have become a middle manager with more people and tasks, working within a lot of constraints. While an important step, this isn't where you ultimately want to be, managing ever-larger tasks and more people, under ever-more-complex constraints. Does this sound like the freedom and control you seek?

Whether they manage a little or a lot, managers carry out assignments. They are measured and compensated on the basis of how well they perform a directed function, whether that function is greater output, reduced cost, or higher quality. The key is that, as a rule, managers do not make major policy; they carry it out.

Managers don't make major policy; they carry it out.

Here's the catch, and the reason you should want to be a manager, at least for a while: Managers, as contrasted with many other employees, have added *flexibility* in how they accomplish their assignments; the more senior the manager, the more flexibility. In a progressive organization, they are allowed — and encouraged — to be very creative. Since most management centers on people, this means choosing from a variety of *management tools* for motivating, rewarding, guiding and controlling others. You already know that you do your best work when your boss recognizes your abilities and lets you use them. Successful managers know lots of ways to do that.

Policy refers to decisions about how and why things are done in the organization. Some policy affects the entire organization, but some is as simple as adhering to a particular job procedure. If you have influence over such procedures, that's a start. We don't want you to use your professional training and experience just to carry out others' directives, however. We want you to be able to influence major policy decisions.

The logical hierarchy of management levels is where most of us "pay our dues" and learn about the organization, its various functions, and its culture. Clinicians, by virtue of their college degrees, skills, and special importance to the organization's mission, often enter that hierarchy at a level which is beyond their management skills, or are promoted into professional management positions early in their careers. This is especially common in rural areas, professional shortage specialties, and organizations in which the pay for senior clinician-manager positions is so low that it doesn't attract highly experienced candidates (cf., some public sector mental health facilities and agencies).

That sounds good for your career, but it's actually bad. Think about it. Should a recently-graduated psychologist be expected to manage a treatment program? Does nursing school alone prepare one to be a hospital unit chief or director of nursing? Do psychiatrists have any business being state mental hospital superintendents?

Not without management skills and attitudes, they don't.

The newly-anointed clinician-manager often does a mediocre job, and sometimes fails completely. "Mediocre" and "fail" are not in the lexicon of most physicians and other clinicians. They don't feel good. They can crush your self-image, sour you on management in general, contribute to early burn-out, and, of course, destroy any hope of your being recognized and promoted for your management success.

The new clinician manager, the person who has just been promoted to section chief or program director (or who wants to be), is thus at a critical crossroads in his or her career. The crucial question is: "Are you sure you want to be one of Them?"

If you just answered, "yes," you must address a second question: *"Do you understand that your potential for success does not rest with your professional skills and experience?"*

Your potential for management success does not rely on your professional skills and experience.

We believe that, in the long run, the skills required of policy makers and senior management staff need not require years in the trenches of the organization. It is the skills and attitudes of management, not the types[3] nor durations of management jobs, that are important.

Executive and senior management qualities are not the result of time spent in the trenches.

Your management skills and attitudes are more important than where you have worked.

We want you to think of "middle" managerial positions as *steps*, important but interim in nature. Think of management positions as a training ground. In general, the better you do and the more you learn, the better are your chances of becoming a senior manager or executive. Management positions are your first steps toward influencing policy and weaning yourself from being solely a clinician.

Executives are an interesting breed. They come in all flavors, from Lee Iacocca, to RJR Nabisco's flamboyant Ross Johnson, to the back-room types who move and shake from obscurity. Some are the true leaders, while some are more like senior managers than archetypal executives. The line is fuzzy at times. The important point, and one we stress, is that executives in large organizations spend most of their time developing and fostering major policy, not implementing it. It is here that your biggest great ideas can see some action.

That's the good news.

The bad news is that with the executive's power to create comes the responsibility for his or her creations. A failed managerial *task* affects your job and a small part of the organization's mission. Failed major *policy* can affect everyone's job, and the entire system. That's why organizations are so particular about who becomes a senior manager or executive. Even in small organizations, the executive/senior management arena is no place for amateurs. Organizations simply can't afford to put much power in the hands of clinicians (even highly-competent ones) who don't deeply understand broad management, executive, and leadership issues.

Organizations can't afford to give power to people who don't understand broad management, executive, and leadership issues.

This also applies to small groups such as mental health practice partnerships. Although management problems may be hidden for awhile by the ability of the clinicians to make money, office and business management — by a real manager — can make the difference between failure and success of the group enterprise.

Again, there is no magic to all of this. Whether you work for a large mental health agency or a small clinical practice; whether you have a Harvard MBA or can't spell bizniss, executives and senior managers must succeed at three functions: Defining the goals of the organization, developing strategies for reaching those goals, and implementing the strategies. They devote most or all of their working hours to these three functions. Everything else is detail.

Executives and senior managers do only three things:

Define organization goals, develop goal-oriented strategies, and implement those strategies.

Organization Structure

Managing well is essential, but let's broaden our scope for a moment. The more you understand about the overall structure of the organization, its culture, and what it needs, the more you will succeed and the more you will be rewarded.

Clinicians work in far more organizations than we can specifically describe. Mental health organizations can be public or private, for-profit or non-profit. They can be as large as a huge government agency with many sub-divisions or as small as a private office or rural outreach center. You may work in a mental health clinic, a hospital, a managed care organization, or a public agency.

In every case, your organization has a *structure* which both supports and is a result of its *function*. Understanding the structure tells you more about where you are (remember Sun Tzu). It also provides valuable information about goals, strategies, and organization culture. In ailing or struggling organizations, the structure is a good place to look for areas of mismatch between what is there and what is needed for success (managerial "diagnostic and treatment" suggestions).

Knowledge of *goals* and *strategies* is another key to understanding any organization. All the reasoning behind the organization's structure is related to these two concepts. Change either and the structure should change as well. If it doesn't, the organization will begin to fail.

For example, the motto, or "mission statement," of a once very successful company was "We Make the Finest Available Carriages and Related Equestrian Tack." Then along came Henry Ford and his Model 'T.' Horses stayed in style, but carriages were out. The mission statement had to become "We Make the Finest Equestrian Tack."

That organization had to change a peripheral portion of the business into the core of the business. It then had to create demand, expand the line, change the sales emphasis, and deal with a lot of displaced workers. They no longer needed a carriage division, with its wheelwrights, upholsterers, salespeople, testing facility (with a wind tunnel for really fast carriages), or even the executives that planned new ways to increase carriage production. Had they been allowed to stay — had the old structure remained — the company's future would have been more like that of the Mortimer & Fitz Carriage Company (bet you've never heard of them).

We're sneaking in another concept here, so subtly that you probably haven't noticed it: The constancy, the inevitability of *change*.

Change

If you are a professor whose specialty is Cold War politics, you have two choices: You could (1) find a *niche* that lets you study and teach about a topic whose relevance is rapidly decreasing (a job strategy we might call "entrenchment"), or (2) find some way to turn the change in academic and political relevance to your advantage in your organization's environment. You might, for example, learn more about the goals and strategies of your department and college, then plan the next few years of your career accordingly.

Guess which we recommend.

Knowing the "Big Picture." Knowledge of the current mission and goals of the mental health organization leads to an understanding of its structure (and *vice versa*). If you see that the structure is inefficient or doesn't fit the goals, *and* you have placed yourself in a position visible to upper management, your input (assuming you understand the mission and therefore the structure) is more likely to be heard. If you are heard, you are more likely to be heeded. If heeded, you are influencing policy. And that's where you want to be.

The same applies to strategy. You are more likely to be heard if your idea is clearly related to accomplishing *organization* goals than if your ideas seem limited to your profession. If you don't know the "big picture," you are less likely to be heard.

Smaller Parts of the Big Picture. This doesn't mean that suggestions about an individual job always fall on deaf ears. Progressive organizations pay attention to employee comments, suggestions, and feelings. After all, increasing the effectiveness of, say, a particular treatment procedure may save money and increase service quality.

Let's examine how such an idea might be

presented.

A state mental health center clinician tells his/her unit chief how to improve a particular procedure.

· The Unit Chief tells his/her Program Director how the department can do a better, more cost-effective job.

· The Program Director says "Let's do it," and puts the change in his/her next report to the CMHC Director. The report says something like "this process contributes to a 12% increase in our overall clinic productivity, with a 3% reduction in costs and a significant decrease in patient readmissions."

· The CMHC Director makes darn sure the appropriate senior manager in the state agency central office knows that his/her CMHC is supporting the agency's mission, which happens to be "Higher Quality and Greater Efficiency Working Hand-In-Hand For Patient Care."

Now, *who benefits from the treatment procedure suggestion?* (Keep an eye on how the local clinician makes out.)

· The statewide senior agency manager's position is strengthened because payer costs went down and quality went up.

· The CMHC Director (a local "CEO") gets recognized for contributing to the agency mission and to the strength of upper management. He/she wonders when the statewide senior manager is due to retire.

· The program director is recognized as a good local manager, one who supports organization goals and gets the job done.

· The Unit Chief (who may also be a direct-care clinician), gets a raise and recognition for his/her managerial success. If he/she is able to translate this talent to broader CMHC/Agency issues (broader than the local unit), and has the attitude and initiative necessary for broader responsibility, he/she may be ready to move out of this specific niche and into general management.

· The unit clinician gets a pat on the back and the satisfaction of seeing others take his/her idea and run with it.

If that's happened to you, keep reading.

Organizational Culture

It may seem strange to talk about "culture" in a mental health organization. It's a real thing, however, and a concept that can be of great use both to you and to the organization. It might be described as "personality," how things get done, the expected atmosphere and traditional *modus operandi*. It is important to realize the importance of culture to the organization and its people.

For example, many systems have very strict service and billing specifications. The specifications and their strictness are *policy*. The way clinical employees are motivated to meet those specifications is one (and only one) reflection of the organization's *culture*. One clinic or system may do it by punishing noncompliance. Another may accomplish the same goal by creating an atmosphere of dedication and teamwork.

Like "personality" in people, the organizational culture may not always seem logical. It may actually work against the corporate mission. In the carriage factory example mentioned earlier, even seemingly business-oriented executives may find it difficult to move from carriages to accessories. Why? Because "We've always made carriages" ... "I've devoted my career to carriages" ... "The equestrian tack division has always been second-class around here" ... "When people see our name, they think of carriages" ... "Everybody admires a fine carriage."

Never mind that no one *buys* them anymore.

As you study the culture of your organization, think about the following.

1. *Culture evolves from the needs and personalities of the people who shape (or shaped) the organization*. Study the personalities and look for the relationships.
2. *Culture can be healthy or unhealthy*. The sweatshop culture common to early industrialization was unhealthy. Companies that abolished the sweatshop mentality tended to prosper. The innovations and evolving ideas of Herman Miller, Inc., is one of the better examples of a healthy culture. CEO Max DePree summed it up as follows:
   "Corporations, like the people who compose them, are always in a state of becoming.

Covenants bind people together and enable them to meet their corporate needs by meeting the needs of one another."

3. *Mission, strategy, leadership, and structure should be in harmony*. Should a new CEO take the reins at Herman Miller, Inc. (above), there would be conflict until the new leadership conforms to the culture,[4] the culture changes, or the leadership changes again.
4. *Examine your compatibility with your organization's culture*. Do the mission and culture of your organization reflect ideals with which you can agree and identify? *This is one of the fundamental things you must know about yourself and your employer before you can set a course for the future*. One might think that few people would seek employment in a culture that is counter to their personalities or ideals. The fact is, they do it every day.

   A good example can be found in the conflict among environmentalists, the logging industry and the National Forest Service. Environmentalists want to protect virgin timer stands. Loggers want to make a living. The Forest Service has a duty to serve the needs of both. Many people join the Forest Service because of an interest in preserving forests, but soon come to believe that they cannot fairly serve both environmentalists and the logging industry. As the mission and policies of the Department of the Interior change, can the individuals change with it? If so, the culture will gradually shift. If not, either the workers will be replaced or a dysfunctional culture will evolve.

What happens if your beliefs are fundamentally different from those of your organization? Should you hang on, hoping for change? Quit and look for another job? Even if you quit, where can you find the compatibility you seek?

For some, there is little choice. You're dedicated to patient care and perfect jobs are pretty rare. Hanging on may be frustrating, but security and retirement vesting may be important to you. The best answer may be to hone your management skills, work with the organization, and prepare to become a shaper of your job and company policy rather than a victim of both.

[4]There is an historical adage that "the religion of the king is the religion of the people." This doesn't mean the people conform to the king, as most readers assume, but that the king — if he knows what's good for him — will conform to the needs of the people.

Is There An Ethical Way?

Column Editor: H. Steven Moffic, M.D., Chair, Ethics Committee

COLUMN INTRODUCTION:

The last column discussed what the ethical standards should be for standard evaluation time and medication visit times, and the role of the psychiatrist administrator in such ethical standards. For this column's ethical question, we are challenged by an interesting twist on the time question.

ETHICAL QUESTION:

Subject: Different Workloads For Locums and Salaried Physicians

I am a locum tenens. My last assignment at a CMHC with many clinics in a large midwest city was very interesting. As a locum, I saw three patients per hour. The salaried psychiatrists saw two patients per hour. I also assume that the salaried psychiatrists had a longer professional relationship with their patients.

Does this imply two different standards of care? Is this ethical? Comments are invited. Thank you,
Steve Able, M.D.

RESPONSE 1:

At our CMHC (40% of patients are insured; only 5-10% are "self" pay), all doctors, whether full or part time, or locum tenens, see two "old" patients (with established cases and stable) per hour; "new" patients are seen for one hour; kids for 1 ½ hours. The only time I, as medical director, see patients for less time, is when the patient is newly discharged from an area psychiatric hospital (for medical clinic I see them Q 15 minutes, and my RN follows for another 15 minutes) – reason being, on some days 40-50% of patients fail to show (no compensation to the agency for a no show), so when needed I can prolong this visit. There should be a single standard of care – established for all physicians at a specific agency or group.
Robert Karp, M.D.

RESPONSE 2:

I am the Medical Director at a CMHC in SC. We have used locum tenens coverage in the past when we were severely understaffed, and it was lifesaving! I did not expect the locum physicians to necessarily see more patients than our salaried/staff physicians, but by default their relationships with patients were short-lived and had a different clinical "feel" than their counterparts. Interestingly, they could sometimes focus more sharply on key issues than the physicians who had known the patients longer.
Greg Smith, M.D.

RESPONSE 3:

I agree that it is not tenable to have more than one standard. If you have two standards, then it is easy to call the lower one the standard and insist that everyone adhere to that. Before you know it you are seeing four or six an hour …..
Erik Roske, M.D.

RESPONSE 4:

As medical director of a large CMHC in SW Washington State, I have chosen not to dictate (or let anyone else in senior management dictate) how long psychiatrists and nurse practitioners can spend on new and follow-up visits, as long as their clients' needs generally seems to be getting met. Most see clients for follow-up visits every thirty minutes, but also provide a provision for seeing clients for unscheduled crisis visits, usually either by squeezing them into their regular schedule (so they may in fact have three 20 minutes visits in some hours) or by setting aside some walk-in times during which clients with urgent needs can be seen, usually briefly, but with some flexibility depending on needs. Some prescribers have walk-ins screened or triaged by a nurse, who can take care of some routine problems and identify those who need a different type of service altogether (e.g., a report to a PO, a referral to detox). In terms of fiscal impact, there seems to

be little difference between the different psychiatrists' practice styles in the long run. In our funding model we assume that psychiatric services will lose money under Medicaid no matter what – we just try to contain the losses so that the agency can break even by making a little bit of money elsewhere – therapy, case management, and (especially) dual diagnosis CD services. We have the most supportive and competent nurses (and other clinicians) you could find anywhere, but we have not found a way to make 15- minute med visits work. However, we have a practice management committee/task force of managers, doctors and nurses that have been piloting different models for doing this, and maybe one of them will eventually work.

We have more difficulty with privately insured clients, since the psychiatrists (or ARNPs) essentially have to pay their way in this arena. We do see some private clients for only 15-20 minutes when they have cheapo health plans that only pay $30-40 per visit. We haven't quite figured out how to deal with the ones that only pay $65 for the initial evaluation – we still usually feel obligated to see them for a full hour most of the time.

As for locums, when we have contracted with them, we have initially set up their schedule with "default" settings similar to what our staff typically does, i.e., 60-75-minute initial evaluations and 30-minute follow-ups. But, we tell them that once they have some comfort with the system they can change their schedule, if they think it will serve their clients.
Jonathan Day, M.D.

RESPONSE 5:

In the case of the locum tenens doctors, it seems a clinic, which was more genuinely concerned about its patients would not dump the higher caseload on the doctors least familiar with them. Maybe they should give some added incentives for the regular psychiatric staff to temporarily increase their caseloads and give the locum tenens doctors more time to familiarize themselves with the patients.
Bill Herz, M.D.

"The shortages will be divided among the peasants". – Pogo (Walt Kelly**)**

RESPONSE OF EDITOR:

The interesting scenario of different workloads for locums and salaried physicians asked whether this was ethical. Here's how I would currently answer that:

1) From a business ethical standpoint, if the different workloads helped the CMHC survive (and thrive), then it would be ethical.
2) From a psychiatrist as clinician ethical standpoint, per our AMA/APA Principles of Medical Ethics, both the workloads would be ethical, if the physician was able to provide "competent medical service". The obvious related issue is how "competent" is defined, documented, and verified. On a personal note, when I substitute for a regular psychiatrist, I generally spend less time, just doing what seems necessary to tide the patient over to the next visit with their regular psychiatrist.
3) From a psychiatrist administrator ethical standpoint, applying the new "Ethical Principles for Psychiatric Administrators", developed by the American Association of Psychiatric Administrators, should help to decide whether the workload differences were ethical. For the psychiatric administrator, while benefiting the patient should still be primary, the well-being of the institution and staff is also an appropriate ethical expectation. In addition, related to this specific example, the most relevant additional ethical principle would be "to deal honestly … with colleagues" (section 2 annotation 1), or in other words, to make it clear to the locum tenens why there is a different workload.

In conclusion, while this arrangement may be ethical by all perspectives, there is not enough information communicated so far to be more sure.
Steve Moffic, M.D.

RESPONSE OF DR. ABLE:

Steve,

Your comments and quotes were wonderful. I was told by the site manager that the "three patient per hour rule" was made by the medical director. He is a psychiatrist. I never talked about "the rule" with him.

Orientation was nil. It was a two-month assignment and I left three weeks early due to a family illness.

I still question the standard of care angle. Is this country in need for a Locum Law?
Stephen Able, M.D.

FURTHER RESPONSE OF EDITOR:

One key piece of new information indicated that the psychiatrist administrator, i.e. medical director, was likely unethical in part of his administration on this issue. By not providing information about the reasons for "the rule" of an increased workload to Dr. Able, he/she might be thought to have not dealt honestly with a colleague.

RESPONSE 6:

I got a kick out of the construction "might be thought to have not dealt honestly".

[A famous comedian] said that if you are going to tell people the truth you better make them laugh or they will kill you.

Now I am medical director and chief clinical officer (is there a difference?) of Portland Oregon's County public mental health "system".

If I don't tell lies, how long can I last?
Best wishes,
Peter Davidson, M.D.

NEXT ISSUE:

We, as usual, invite further responses to this month's ethical question and invite new questions, although it looks like Response 6 provides a question for the next issue. To repeat the question, as a psychiatrist administrator, "if I don't tell lies, how long can I last?" Your answer to that, along with the ethical considerations of your response, can be sent to:

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The AAPA on line . . .

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Send your comments to: **frda1@airmail.net**

Textbook of Administrative Psychiatry: New Concepts for a Changing Behavioral Health System (Second Edition)

John A. Talbott, M.D. and Robert E. Hales, M.D., M.B.A., Editors
Washington, DC: American Psychiatric Publishing, Inc., 2001, 420 pages

Throughout the 1990s, the American Psychiatric Press, Inc. (APPI) Textbook on Administrative Psychiatry (Talbott et al., 1992) has been the standard reference and introduction to the field for psychiatrists interested in furthering their understanding of issues and skills involved in leadership and management as practiced in the context of psychiatric administration. Those of us who have taken on such roles in various public and private systems have turned to this source to gain a theoretical orientation to our work, and to provide a starting point for development of a skill set and knowledge base inevitably entailing studies of material well beyond that which has been formalized as administrative education within professional psychiatry. Thus, the advent of the long-awaited second edition of the APPI Textbook (Talbott and Hales, 2001) is welcome, and represents an outstanding and definitive contribution to the literature in the field of administrative psychiatry. To call the volume a second edition understates the magnitude of the transformation that has taken place, not just to create an even better book, but to keep pace with the dramatic changes that have characterized the health care landscape in the past decade. Talbott and Hales' Textbook of Administrative Psychiatry is thus quite appropriately subtitled, "New Concepts for a Changing Behavioral Health System."

It is deceptive to compare the new volume with the old based on pagination, the two editions stacking up at 420 and 610 pages respectively, in that the new textbook is larger and contains many more words per page than the old. It is thus a somewhat longer read, is richer in detail, and covers a broader range of topics. Its 33 chapters plus introduction and conclusion represent an increase in topic headings of more than 50%, the first edition having 20 chapters plus introduction. In this new edition, each section includes an introduction by the section editor, which I found helpful in providing an overview and helping to frame the topics within the section. Divided into six sections, in contrast to the original five, the new book is organized in a manner entirely true to its subtitle, with pervasive themes of change and evolution. Four of six sections have titles that speak directly to, and all six have elements that address, processes of change. But then, in the current environment, how else could one organize thinking about health care administration?

In the book's introduction, Michael A. Freeman, M.D., D.M.H. explicitly frames the book within such a context, characterizing the first section as establishing the current situation in the field of administrative psychiatry and the remaining sections as structured around five central issues that "represent the framework of debate that will guide the evolution of our field and the uncharted territory on which new behavioral healthcare road maps will be drawn." (p. xvi) Similarly, senior editor John A. Talbott, M.D. concludes the volume with a look toward the future of a rapidly evolving field.

The first section, edited by Freeman, is divided into two chapters which provide a good overview of the history, current status, and evolving direction of private (Chapter 1) and public (Chapter 2) behavioral healthcare systems.

The second section, edited by Miles F. Shore, M.D., covers core concepts in administrative psychiatry. This section includes the majority of the basic concept headings covered in the first two sections of the first edition: Organizational Theory, Leadership, Planning, Implementation, and Training. Chapters from the first edition having to do with the nature of organized service systems, change strategies, and the mental healthcare marketplace have been developed in much more detail, completely updated, and transformed into more numerous and highly differentiated chapters appearing in later sections. Even the structuring of the traditional topics in the first section of the new

edition, however, reflects advances and changes in the field: "Planning," for example, is presented in the context of organizational response to uncertainty and environmental complexity, while "Implementation" is presented within a Continuous Quality Improvement framework. Appropriately, this "Core Concepts" section now includes a chapter on the medical director's role in organized care delivery systems and again, numerous aspects of the broader topic of professional roles in behavioral healthcare systems are drawn out in a series of additional chapters later in the book.

Under the heading of "New Concepts," the third section, edited by Robert E. Hales, M.D., M.B.A., begins the differentiation process referred to above. Six chapters address the topics of behavioral network development and maintenance, staffing, capitated financing and population-based care, behavioral health outcomes, and health information and confidentiality. The new concepts presented within this section are indeed the key elements of an evolving conceptual framework for defining, creating, and thinking about mental health systems. As Freeman states, it is a "framework of debate," and this section thoughtfully establishes it.

The differentiation process is continued in the fifth section, edited by Jose M. Santiago, M.D., with a series of chapters on how selected behavioral health systems are changing; the topic of organized psychiatric service systems has now evolved into nine different chapters looking at how specific organizations and sectors have responded and continue to adapt to the complex and changing healthcare environment. While any of the chapters could be singled out for further commentary, I found the chapter on "State and County Agencies" by Michael F. Hogan, Ph.D. to be simply the best thing I've read on the evolution of public mental health. Overall, the section takes a very comprehensive look at the assorted systems and fragments that make up American mental health care.

The fourth section, edited by Judith H. Browne, R.N., M.S.N. and presented under the heading of "New Concepts for a Changing Behavioral Health the present time; sober concern about the direction System," addresses changing roles for professionals and consumers in the new environment. Going well beyond the core topic of the medical director's role, this new section includes six chapters which speak to the evolving roles of a variety of stakeholders, mostly focused on changes experienced by mental health professionals working collaboratively within newly constructed systems. Much of this material could be organized under the important topic heading of career development, although the reality of increasingly collaborative roles for better informed patients and consumers is also addressed. Of special interest to physicians, a good overview on "Changing Roles for Psychiatrists," by Debra L. Klamen, M.D., Joseph A. Flaherty, M.D. and Boris M. Astrachan, M.D., is supplemented by a chapter addressing the issue of career changes for physicians. This latter chapter, by Arthur Lazarus, M.D., M.B.A., incorporates information and points to resources available through the American College of Physician Executives, a leading organization for physicians developing in the areas of management, leadership, and administration. Overall, the section might have been even more appropriately titled something like "Changing Roles and Relationships in Behavioral Health Systems."

The sixth section, edited by Donald H. Williams, M.D., covers law and ethics. The first edition's chapter on civil law has evolved into a chapter titled "Administrative Psychiatry: Practice and Legal Regulation." This is really one of the core chapters in addressing the important administrative law framework for behavioral health services. In addition to the chapters on criminal law and ethics, this new edition now has an informative and thoughtful chapter on American Prisons. This latter chapter was one of my favorites, partly because of its sophistication in the area of organizational dynamics but perhaps even more so because of the authors' willingness to face their difficult task of addressing issues in the management of scarce resources in a healthcare system. In the latter area, it adds thinking that may be generalizable and implicitly a component of much that is addressed elsewhere in the book.

As noted above, Talbott provides a conclusion

looking at future issues for administrative psychiatry. The spirit of this conclusion is several-fold: a little disconcerted by, but frankly quite interested in and curious about the pace of change in healthcare at the present time; sober concern about the direction of some of the changes, especially in the areas of funding for mental health services, ability to address complex psychosocial realities for more seriously ill patients, and the uses of data in addressing quality of care; pervasive awareness of opportunities for growth in midst of crisis, including the sense that administrative psychiatrists can be important players and problem-solvers in shaping the future of behavioral healthcare. Overall, the tone is hopeful and energetic; concerned but ready to meet challenge.

Overall, I found this new edition of the APPI Textbook of Psychiatry to be good reading – informative and enjoyable. Talbott and Hales have done an excellent job of compiling expertise in what has become an increasingly complex field. The most up-to-date statement of the field available, this book is now a "must read" for administrative psychiatrists.

By Christopher G. Fichtner, M.D.
Chicago, Illinois

Welcome! New Members

January 2002

Patricia Hogan, M.D.
Steven P. Kouris, M.D.

CALL FOR PAPERS

The ***Psychiatrist Administrator*** invites articles on all areas of psychiatric administration and management with a focus on the roles and perspectives of psychiatrists in leadership and management roles. Please make submissions and inquires to:

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INSTRUCTION FOR AUTHORS

The *Psychiatrist Administrator* is the official publication of the American Association of Psychiatric Administrators (AAPA). Established in 1961, AAPA is the premiere educational, networking, and support resource for psychiatrists interested in administration and management. The AAPA promotes medical leadership and medical excellence in behavioral healthcare systems, including services for mental illness, substance use disorders, and developmental disabilities.

The choice of "Psychiatrist Administrator" is intended to distinguish the NewsJournal from other publications in mental and behavioral health administration in terms of its focus on the roles and perspectives of psychiatrists in leadership and management within evolving systems of care.

The purpose of the NewsJournal is to provide up-to-date, accurate, and easily understandable information to our readership and to contribute to the body of scholarly work in the area of psychiatric administration and management. Your article should be written in a clear, straightforward style that is pleasant to read.

PREPARATION OF MANUSCRIPT

Manuscripts should be typewritten on standard (8 1/2" x 11") white paper with 1" margins on all sides. The entire manuscript, including references and figure legends, should be double-spaced. Each element of the manuscript should begin on a new page: title page, abstract, text, references, tables (typed 1 per page), figure legends. Number pages consecutively through the manuscript. Manuscripts should be no more than 3000 words of text (not including references or tables).

A separate page should be included giving the title of the paper, the names, titles, and affiliations of each author, and the mailing address, email address, and phone and fax numbers of the corresponding author. Any grant support requiring acknowledgment should be mentioned on this page. Acknowledgments other than those of grant support should be put at the end of the text.

An abstract should be provided, preferably no longer than 200 words.

Tables should be typed double-spaced one per page. Provide a clear, descriptive title for each table. Tables should be numbered consecutively as they appear in the text.

Figures should be numbered consecutively as they appear in the text. Illustrations - line drawings, graphs, or charts - should be of camera-ready quality.

References should be numbered consecutively as they are cited in the text, with reference numbers typed as superscripts. References should be typed double-spaced beginning on a separate page after the text and acknowledgments. The NewsJournal uses the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (Vancouver group) as its guide for reference style. Abbreviations of journal names must conform to Index Medicus style; journals not listed in Index Medicus should not be abbreviated. List all authors when there are no more than six; for more than six authors, list the first three, followed by et al.

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Manuscripts are reviewed by the editor, editorial board members, or other reviewers. Manuscripts may be edited for clarity, style, conciseness, and format. The edited manuscript will be sent to the corresponding author for approval. Authors may be asked to respond to editorial queries or make revisions.

Authors will receive page proofs before publication. The author should return corrected proofs to Frances Roton, Executive Director AAPA, within three days of receipt; delays in returning proofs may result in postponement of publication.

MANUSCRIPT SUBMISSION

Manuscript submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere.

Three copies of the manuscript should be sent to Sy Saeed, M.D., Editor, Psychiatrist Administrator, Department of Psychiatry & Behavioral Medicine, University of Illinois College of Medicine @ Peoria, 5407 North University Street, Suite "C", Peoria, Illinois 61614-4785. The manuscript should be accompanied by a transmittal letter giving the name, address, email address, and phone numbers of the corresponding author. The letter should indicate that all authors have seen and approved the manuscript and that the manuscript has not been published or is not under consideration for publication elsewhere. A disk copy of the complete manuscript, including tables and references, should also be submitted. Please label the disk with the name of the first author and title of the article and indicate what hardware and software were used. **You can also submit the manuscript electronically by sending it as an e-mail attachment to the editor at sasaeed@UIC.Edu.**

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CME Courses in *Administrative Psychiatry*

Two new CME courses in Administrative Psychiatry will be offered in May at the 2002 Annual Meeting of the American Psychiatric Association:

Course #6: Basic Concepts in Administrative Psychiatry: Theory, Human Resources, and Fiscal Management. Saturday, May 18, 2002, 9 am - 4 pm.

Co-Directors: Christopher G. Fichtner, M.D. and Thomas A. Simpatico, M.D.

Faculty: **L. Mark Russakoff, M.D., Stuart B. Silver, M.D., Sy Atezaz Saeed, M.D., Shivkumar Hatti, M.D., M.B.A.**

Course #23: Basic Concepts in Administrative Psychiatry: Care Management, Law, and Ethics. Sunday, May 19, 2002, 9 am - 4 pm.

Co-Directors: Christopher G. Fichtner, M.D. and Wesley Sowers, M.D.

Faculty: **Stephen H. Dinwiddie, M.D., William G. Wood, M.D., Ph.D., Steven Moffic, M.D., John A. Talbott, M.D.**

These courses are intended to complement one another, and may be helpful for psychiatrists contemplating certification in administrative psychiatry. For more information on these courses, please consult the APA 2002 Annual Meeting CME Course Brochure.

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