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EVIDENCE-BASED PRACTICES AND THE HOPE OF RECOVERY:

Knowing is Not Enough!

Sy Atezaz Saeed, M.D.

In more recent years, the field of mental health has seen an increasing amount of literature emerging on the evidence-based practice (EBP) model and the recovery model. The evidence-based practice is a scientifically grounded approach that emphasizes external scientific evidence. The recovery model emphasizes the importance of subjective experiences, right to self-determination, and autonomy of persons who are the recipient of mental health services.

The core concepts of evidence-based medicine have been around for many years. In the current era, these concepts were consolidated and named evidence-based medicine just over a decade ago by a group led by Gordon Guyatt at McMaster University in Canada. The field of mental health started to embrace concepts of evidence-based practice only in recent years bringing forth an increasing level of confidence in systemic use of empirically supported treatments. This adoption of scientifically grounded treatment approaches has been typically referred to as “evidence-based practices” (1-3).

At the same time that the evidence-based initiatives have been emerging in the mental health arena, a more personalized and subjective approach to caring for persons who have mental illness has also been growing—the recovery model. It appears that although there is an outpour of literature on the two concepts (EBPs and Recovery model) separately, the amount of literature that speaks to the relationship between EBPs and recovery is clearly not overwhelming. Its quite obvious that gaining consumer support for evidence-based practices requires recognition that consumers’ requests and needs for various types of treatments and services differ significantly. Some have suggested that the degree of support for evidence-based practices by consumers depends largely on the degree of their disability. They have suggested ways to integrate evidence-based practices with the recovery model in a way that maximizes the virtues and minimizes the weaknesses of each model. (4).

Although advocates of EBPs have emphasized significance of patients’ choices, it still appears that the two models can be at odds under many circumstances, e.g. when consumers make choices regarding treatment that are not evidence based. Clearly, there are areas where there is no conflict between the recovery model and EBPs. Hope, trust, autonomous decision making, and self-determination should be at the core of any treatment model. There are many other humanistic values, ethical principles, and legal standards that need to be incorporated when providing mental health services. For example, addressing patients as autonomous individuals, respecting privacy, interacting respectfully with families, and showing sensitivity with respect to age, sex, race, and cultural background are core values of the health care system. These are not just the tenets of recovery model but values that EBP model also embraces. Obviously, we do not need external evidence to support these standards.

It is becoming increasingly apparent that the probability of achieving recovery is greater when services provided are evidence-based. Treatments that work are also likely to get us closer to recovery sooner. With this realization comes the responsibility for those in positions of decision making for their respective systems to assure that the services provided in their systems are, first and foremost, empirically-supported. Unfortunately the gap between what we know today and what is being practiced in routine mental health settings remains wide. Services and programs based on scientific advances in treatment and services are not routinely available to individuals who have mental illness. The U.S. Surgeon General’s 1999 report on mental health (5) documented this disparity between the opportunities for improving treatment and services and the reality of everyday practice.

From a clinical-administrative perspective, implementing evidence-based practices can be seen as a quality-improvement process. This process can provide accountability through the monitoring of the fidelity of practices to models that have been shown to be effective by research (6). Programs that maintain fidelity to the evidence-based models are more likely to produce good outcomes. Although this may not be true for all individuals or for all circumstances, the quality of mental health services can still be continually improved by implementation of EBPs. Although fidelity should be a goal for the systems, it is also very important that fidelity to any model or practice is accommodative of patient choice, clinical judgment, and continuing change as new evidence emerges.

The most recent addition to the finding that routine mental health programs do not consistently provide evidence-based treatments to the patients and populations they serve comes from the *President’s New Freedom Commission on Mental Health*. This Commission was established by Executive Order on April 29, 2002. The President tasked the Commission to recommend improvements in the U.S. mental health service system for adults with serious mental illness and for children with serious emotional disturbances. This task included a review of both public and private sectors to identify policies that could be implemented by federal, state and local governments to maximize the utility of existing resources, to improve coordination of treatments and services, and to promote a full life in the community for people with mental illness. The Commission released an interim report to the President in November 2002 (7). The interim report has cited the need for dramatic reform at all levels of service delivery and has identified barriers to quality care and recovery. Overall, the report found that the system was not oriented to the single most important goal of the people it served - the hope of recovery. Many more individuals could recover - from even the most serious mental illnesses - if they had access to effective treatments tailored to their needs, to supports and to services in their communities. As with the Surgeon General's report, the Commission's interim report found that the state-of-the-art treatments, based on decades of scientific inquiry, were not being transferred from research to community settings while at the same time, many outdated and ineffective treatments were still being used (7).

The commission also solicited public comments from stakeholders in the mental health community on various topics related to the Commission's mission. The goal was to gain a better understanding of the public's experiences with, concerns about, and hopes for the mental health care system. More than twelve hundred individuals submitted comments to the Commission from all 50 states, the District of Columbia, and Guam, and from the full range of stakeholder groups, including mental health consumers, parents, family members, advocates, service providers, educators, researchers, and others. These comments were recently released by the Commission (8). Nearly all stakeholders described a system in which access to desired services was very problematic, resulting in over reliance on crisis management rather than effective illness management. The comments of these 1,205 stakeholders illustrate the very real challenges faced by mental health consumers and their families, and the service delivery system on which they rely.

As psychiatrist administrators we have a very important task in front of us. This is what we already know:

- Evidence-based practices exist for treatment of many psychiatric disorders.
- These state-of-the-art treatments, based on decades of scientific inquiry, are not being transferred from research to community settings while at the same time, many outdated and ineffective treatments were still being used.
- Evidence-based practices are more likely to produce favorable to optimal outcomes.
- EBPs are more likely to produce a favorable outcome sooner.
- There is a need to treat mental illness in a way similar to many other long-term medical illnesses. This requires that the goals of treatment should go beyond the traditional goals of symptom control, compliance, prevention of relapse, and reducing rehospitalizations. This new paradigm emphasizes achievement of outcomes such as employment, independent living, satisfying relationships, and good quality of life. EBPs help us with this paradigm shift.
- Use of EBPs is more likely to enhance the quality of our programs.
- There is a body of literature on the barriers to effective implementation of EBPs as well as on what is more likely to impact practice behavior.

We need to integrate this knowledge base that has evolved through various lines of investigation and put it to good use. The time has now come for us to take what is now known and to work hard and seriously toward overcoming the barriers in the way that keep people with mental illness from getting to the desired goal- recovery! Evidence-based practices increase, and expedite, the probability of this happening.

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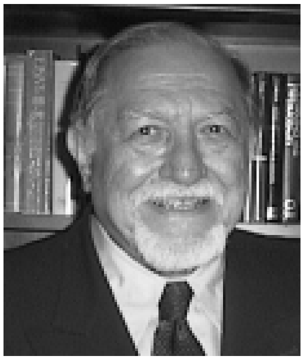
Boris M. Astrachan, M.D. 1931-2002

Joseph A. Flaherty, M.D., and Kathleen M. Kim, M.D.



Boris Astrachan died in Chicago on September 21, 2002, of pancreatic cancer at the age of 70. Most of his distinguished career concerned administrative psychiatry and he served as president of the AAPA in 1994. During his final weeks, Dr. Astrachan remained active in an area of special interest over the last decade: child welfare system reform.

Days before his death Boris composed a detailed letter to his friend, Jess McDonald, Director of the Illinois Department of Children and Family Services, and ACLU attorney Ben Wolf, who was appointed by the courts nearly ten years ago to monitor the child welfare system. The letter brimmed with specific ideas, work that needed to be done, advice, and hope for the future. Similarly, days before he died, Boris asked about issues raised in the newspaper concerning residential care for DCFS wards. This was quintessential Boris Astrachan – ever helpful, ever vigilant.

It was both appropriate and ironic that on the night he died, surrounded by his wife, Batja, their children, and his brother and sister in-law, Boris listened to Puccini's *Nessun Dorma* ("No One Sleeps"). It was more than an opera aficionado's favorite aria, it was a constant theme in Boris' life.

Dr. Astrachan was born in New York City on December 1, 1931 to Russian immigrant parents, Dr. Isaac and Ethel Astrachan. He delighted in telling stories of his father's poor but committed life as a general practitioner in New York and also of this mother's family who had been prominent furriers and shipping magnates. Dr. Astrachan graduated from Bronx Science in NYC; received his cum laude undergraduate degree from Alfred University, and earned his Doctor of Medicine from Albany Medical School. After serving two years as a lieutenant commander in the U.S. Navy, Dr. Astrachan joined the Yale Department of Psychiatry. During his early Yale years, he served as director of the acute inpatient unit, chief of the day hospital and outpatient program, and director of the clinical division of Connecticut Mental Health Center (CMHC). In 1971 he was appointed Director of the CMHC, a position he held until 1987. From 1987-89 he served as director of mental health policy and service center at CMHC.

Dr. Astrachan benefited from the leadership and mentoring of many friends, including Dr. Tom Detre, Dr. Stephan Fleck and Dr. Daniel Freedman. In turn, Dr. Astrachan mentored many psychiatrists including a large number who chose careers in public and administrative psychiatry. Some continue at Yale: Drs. Ezra Griffith, Selby Jacobs, Will Sledge, Howard Zonana, and some have moved to other institutions: Dave Johnson (Nevada), Kathleen Kim (UIC), Ken Marcus (CT Dept. of Mental Health), Walter Reich (George Washington U), Rich Mollica (Harvard), Mary Swigar (Rutgers), Gary Tischler (Cornell), Gary Tucker (Univ. of Washington), Don Williams (Michigan State). Many of his mentees are leaders in psychiatry today and importantly, many chose public and administrative psychiatry as a career. Dr. Astrachan also mentored and befriended scholars and administrators in other fields: Drs. Philip Leaf (Hopkins), Dan Levinson (deceased), Susan Essock (NYU), Myrna Weissman (Columbia), and Sheila Wellington, to name a few.

In his administrative positions, Boris always sought to link university programs to state and community needs. His research focused on depression, schizophrenia, group process, systems theory, and administrative psychiatry. He was a strong voice in American psychiatry serving in key national positions including the board of ADAMHA (Alcohol, Drug Addiction, Mental Health Administration), chair of the National Institutes of Mental Health Study Section on Mental Health Services Research, and President of the American Association of Psychiatric Administrators.

As a visionary leader always on the forefront of psychiatry, Dr. Astrachan helped usher the change from psychoanalytic dominance to social and community psychiatry in the late '50s and early '60s. In the late '70s and early '80s he helped lead the charge to shift psychiatry from a therapeutic discipline to a reliance on neuropharmacology. In Illinois and Connecticut, he played a strong role in working with the legislature, the courts, and the state to improve child welfare and mental health policy.

Principles and Interest

Boris' principles and personal interests came through loud and clear in his many publications, lectures and discussions. Several are relevant to psychiatric administration:

1. To improve, advocating the status quo is insufficient; one must lead change. His longtime friend and colleague, Dr. Gary Tischler, former Study Director of the President's Commission on Mental Health during the Carter Administration, commented, "We have all been enriched by Boris' wisdom, warmed by his humor and astounded by his organizational abilities. His gift was to make us believe that it is not enough to make a record of the world, it is necessary to change it."

2. Psychiatry must define itself by the needs of the patient first, and from the patient, move to the community to help develop systems of care and caring. Dr. Astrachan frequently challenged psychiatric audiences by pointing out how the practice of psychiatry was designed to be convenient and comfortable for its practitioners, rather than the patients.

3. Dr. Astrachan always believed that practice should be based in science; it should be evidenced-based. He continually asked what the data supported as the best course of action. He was exceptionally skillful in designing complex new systems of care like Assertive Community Training or Multiple Systems Therapy if supported by data.

4. Dr. Astrachan genuinely believed in diversity at all levels of mental health care and administration, not for its political correctness, but for what minorities bring to the profession, design of services, role modeling for students, and respect for patients from various cultural backgrounds. He believed that the essence of care is collaborative and that through diversity we learn to work with others.

5. Effort, hard work, and contributions to others were watchwords for Boris Astrachan. He relentlessly asked about the nature of tasks, how work benefited others, and set up lists of things to do, people to call, and programs to consider. No task was too small or too great. He reviewed medical records with the same exuberance and talent he used in designing mental health systems.

When he moved to Chicago in 1990 as Professor and Head of Psychiatry at the University of Illinois College of Medicine in Chicago, Dr. Astrachan continued to refer fondly to Yale as the "Y place." He joined UIC at a tumultuous time for the campus, immediately after a failed attempt by the University to close its university hospital and move its teaching service to Michael Reese Hospital. The ordeal amounted to civil war among the faculty, and left bruised feelings and shaken confidence in the college and the Department. Working with its newly appointed dean, Dr. Gerald Moss, Dr. Astrachan gained the confidence of the department's faculty, restored solidarity, and brought enormous benefit to the college overall. As testimony to his larger than life reputation, even before Dr. Astrachan officially joined the department, the residents included him in their holiday skit in a program titled, "Astraclaus is coming to town." They had already recognized his warmth and generosity.

Their perception was prescient. Dr. Astrachan dramatically improved UIC's Department of Psychiatry and raised it into the top tier of medical school departments, using his values, his political savvy and nearly 30 years experience at Yale. It's worth noting the significance that Boris' personal values played in these endeavors. He made it clear he did not condone rumors and gossip, particularly of the kind that encouraged animosity between people. Though not a religious man, this set of values is often linked to the Jewish admonition against the practice of *lashon hara* (the shameful tongue). He also gave his word, which he kept, that he would not lie to the Department, though he would reserve telling everything he knew. He also made clear from the beginning that we must set a mission for the department larger than any individual because, in his words, "it was the right thing to do." Boris' honor and honesty was uplifting and healing, and enabled the many changes that were to come in his tenure as department head.

Institute for Juvenile Research

One of the first administrative actions Dr. Astrachan took was ensuring the transfer of the state's Institute of Juvenile Research directly into the Psychiatry Department. IJR was one of the first child guidance clinics in the country, established in 1909, and was a potentially strong resource to begin building the department. Dr. Astrachan recruited a strong research faculty whose interests centered on the prevention of injurious behaviors in poor, urban children at high risk for HIV, violence, incarceration, suicide, and homicide. He inherited a child fellowship program on probation with the RRC, but he worked with one of the child faculty to transform the program. Within two years, the clinical operation of the child division grew significantly, as did NIH and private grants awarded to the institution.

Dr. Astrachan put to good use his experience as chair of the NIMH review section on mental health services research with the design of research projects and recruitment of outstanding investigators whose interests were in public-community mental health. Within eight years of the transfer, the IJR had leveraged its initial state support three fold and regained much of the fame it established nearly a century before. In Dr. Astrachan's tenure, IJR returned to its roots — serving the social welfare and juvenile court systems, and had been established by the same individuals and out of the same zeitgeist of Jane Addam's Hull House.

In 1993, Chicago was horrified by accounts of a mother allegedly hanging her three-year-old son, Joseph Wallace. The child and mother were on file in the state's Department of Children and Family Services, which was attacked following the incident. The state appointed Dr. Astrachan to chair a blue ribbon panel to investigate this tragedy and seek ways to avoid such calamities. Working with newly appointed DCFS director Jess McDonald and key child welfare advocates, Dr. Astrachan and his committee were central to the reforms of child welfare in Illinois that received national attention as a model. Their accomplishments included:

- From 1995 to 2001, the number of children brought into state care dropped 62 percent; reports of neglect or abuse fell by 47 percent.

- DCFS' child abuse and neglect investigation process strengthened; an effective risk-assessment protocol was established to evaluate family problems, gauge potential harm of leaving children with their families and identify supportive services that might be needed to allow youth to remain safely at home.

- DCFS succeeded in resolving the national scandal of exporting its most seriously disturbed children, returning nearly 800 youth to Illinois—and saving taxpayers $65 million a year.

- DCFS' internal reform efforts and increasing success rate in moving children to permanent settings produced a 54 percent reduction in substitute care caseloads over the past five years, and the number of children in state custody in 2002 was less than half of what it had been in 1997.

- A parent assessment team at UIC was developed by Dr. Laura Miller to assist the courts in making critical decisions about the parenting skills of mentally ill parents, and this led to establishing one of the first women's mental health programs with a fellowship program recognized in 1996 with a Gold Achievement Award for innovative mental health services by the American Psychiatric Association.

Dr. Astrachan also developed a relationship with the court system working and fostering several noteworthy projects including a racial, ethnic, gender and sexual orientation diversity and tolerance program for all new judges and officers of the court that is ongoing. UIC and the court also opened a child assessment and intervention program for children whose parents were arguing custody in domestic court.

Dr. Astrachan's longtime commitment to community mental health served him and the state well in working with the Office of Mental Health. Following considerable public debate and with the strong support of former mental health commissioner Dr. Ivan Pavkovic, Dr. Astrachan engineered the transfer of the state's research institute, the Illinois State Psychiatric Institute (ISPI) to UIC. Once the transfer was complete, Dr. Astrachan recruited National Academy of Science member, Dr. Erminio Costa to lead the neuroscience programs and the university renovated the wet laboratories for this purpose. Within six years of this transfer, state dollars for research had been leveraged threefold.

Dr. Astrachan had an equally expansive and successful plan for the ISPI education mission. The ISPI training program had been outstanding but was then in difficult times. Dr. Astrachan had the vision to merge the ISPI program with the newly affiliated Michael Reese training program. The programs were combined into a single multi-track residency with rotations at all three sites. Importantly for Dr. Astrachan, a public track was part of the program and included rotations at state facilities and community mental health centers. Residency candidates interested in public sector work were encouraged by this track, which aided in recruiting outstanding minority and other candidates. Dr. Carl Bell, CEO of Community Mental Health Council, was also recruited in to the department to strengthen this part of the program. Dr. Astrachan's interest in child community mental health was instrumental in merging and augmenting efforts of the Department and the Illinois Office of Mental Health to establish a curriculum in child mental health through lectures, readings, and web-based learning for mental health workers in nearly 100 state agencies. An additional outgrowth of this project was the establishment of a telepsychiatry network within the state to provide service in areas without child psychiatrists.

Dr. Astrachan clearly served psychiatry beyond the parochial. He served on numerous significant national committees, authored or co-authored nearly 200 publications and was on the editorial boards of major psychiatric and behavioral science journals, including the Archives of General Psychiatry, The Journal of Applied Behavioral Science, Cultural Diversity and Mental Health Journal, and Administration in Mental Health. According to current head of the UIC Department of Psychiatry, Dr. Joe Flaherty, "Boris is regarded both nationally and internationally as a consultant who could transform anachronistic systems of health care into modern, functional, patient and provider-friendly systems."

Dr. Astrachan earned many awards and recognitions, including several from classes of residents, the Administrative Psychiatry Award from the American Psychiatric Association, Lifeline 2002 Award from the Community Mental Health Council, The Distinguished Faculty Award from the University of Illinois at Chicago College of Medicine, the Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill, and the Distinguished Alumnus Award from Albany Medical College. Dr. Astrachan was a fellow of several associations including the American Psychiatric Association and the American College of Psychiatrists. He was a board member of many academic and other organizations including the IBM Mental Health Advisory Board, the National Clinical Advisory Board for Psychiatric Service for Healthcare Services of America, and the John Paul II Newman Center.

While these accomplishments provide a record of the man, they do not do justice to the fullness of Dr. Astrachan's character. Boris once mentioned he had always been a grandfather, a modest allusion to the fact that he had been such an important mentor to so many and did so without expectation of personal return, but with the expectation that those he helped would help others. He had an incredible capacity to bring people together, discuss differences, and to move forward productively, or as Jess McDonald, DCFS director said, "Few people had the capacity to bring grown men into a room filled with testosterone and get them to sit down and actually talk about substance and co-operation." One of Dr. Astrachan's greatest enjoyments in the work arena was hosting dinner meetings that brought together a variety of administrators in the public sector with visiting professors and faculty for the purpose of discussion and friendship. After a year or two of experimenting with Chicago restaurants, he settled on an Italian restaurant off Michigan Avenue, Avanzare's. Here he held court, introduced topics, brought people together and more than anything showed that the world of psychiatric administration is more than one of statistics and finances, it is about people, collaboration, and mutual respect. He demonstrated that administrators are not important in their own right, but only to the extent they make the world better for the patients and workers they serve.

Dr. Astrachan had great humanity and that was evidenced in his family and their work. He cared for family around the world and what little vacation time he took was always in the service of others. Those who worked with him knew well his caring for his family. In his final year he spent time with his wife and children, discussing with them the lessons of his life and helping to strengthen their unity and love for one another. The values that underlie this behavior were evident in how he approached medicine.

Dr. Astrachan is survived by his wife, Batja; their sons, David (Orange, CT), Joseph (Atlanta, GA), and Michael (West Hartford, CT); his daughter Ellen Astrachan-Fletcher (Oak Park, IL); his brother Samuel Astrachan (Provence, France), and ten grandchildren.

Dr. Flaherty, is Professor and Head and Dr. Kim is the Deputy Head, Department of Psychiatry at the University of Illinois College of Medicine at Chicago.

THE RECOVERY VISION AND EVIDENCE-BASED PRACTICES:

More Than Just a Song and Dance!

Nanette V. Larson, B.A., and Robert W. Vyverberg, Ed.D.

Abstract*: Although literature about and understanding of the concepts and operations of both the recovery vision/principles and evidence-based practices have become widespread and popular, much less has been written about the interface of the two concepts and operations, and very little at all about the interdependence of the two, and the resulting potential impact of this interdependence on the mental health service delivery system. This article examines the two concepts, makes a case for the operational interdependence of the two, and offers a specific Performance Indicator that might be utilized by mental health agencies/hospitals to assess the Evidence of Recovery-Based Services within organizations. The conclusion of the authors is that with the recovery vision at the foundation, and evidence-based practices provided within a recovery-oriented service system, treatment outcomes may be maximized.*

Vision: Expanding Horizons

We begin with some observations of friend and educator, Karl Moehling, who wrote in his 'Parting Thoughts' communication, delivered upon his retirement from an Illinois State Hospital, that "illness, whether it is mental or physical, limits and is reductive. It reduces a person's world to its own pernicious margins. The loss of health estranges and alienates a person from the world, from others, and from self, whereas health is unlimited, expansive and opens a person's world to a vast horizon."(1) Dr. Moehling's foundational contention propels us quickly to our belief, that before evidence-based treatment, or continuity of care, or continuous quality improvement, or any kind of mental health service delivery, for that matter, is to maximize the positive outcomes of mental health services/treatment, and ultimately to enhance and facilitate an individual's discovery of the potential of Moehling's vast horizon, there must be, first and foremost, a fundamental vision of recovery. Our point here is that putting the recovery vision at the base of evidence-based service delivery, foundationally allows for positive service delivery outcomes to be maximized. Further, if those recovery/evidence-based *services* are offered as part of a recovery-based *system*, there is even greater potential for maximized, positive individual and systemic outcomes.

All of this leads us to transformation, defined in Webster's terms as "the operation of changing one configuration into another, in accordance with an ordered set of rules (often mathematical)."(2) We hold, as preached by psychiatric rehabilitation visionary William Anthony(3), that the bedrock for this transformation must be a recovery-oriented system, within which the actualization of the recovery vision may be facilitated. For this actualization to be facilitated, the system must first believe and embrace that vision, must teach that vision, and must assure that the recovery/evidence-based services provided within that system, are delivered within a context of that vision.

Part of the complication in bringing about this transformation, may well be that service providers, at least up until a few years ago, had forgotten/not known/not believed, that persons with mental illness can, and do, get better. We've been reminded/shown/taught that fact in recent years. We've recovered a bit from some past notions, if you will, from believing that maintenance and day treatment and analysis forever, is the way it has to be. Not so, say those who are recovering, or who have recovered. Whether bipolar illness or breast cancer is the challenge, persons can do more than just survive — they can RECOVER!

So, if 'the genie is out of the bottle,' as Anthony(4) noted during an early '90s presentation on recovery, then isn't it time to take a closer look at the genie? And beyond just looking, isn't it indeed time to begin to understand this genie called 'recovery?' What is it that we're talking about here? Maybe, in the simplest terms, we're talking about getting better. Webster says that to recover is "to regain something lost or stolen."(5) Our Illinois Department of Human Services' Recovery Vision contends that recovery is about rising above the catastrophic consequences of the illness.(6) So, as we talk about recovery from mental illness, we come to understand that what was lost to the person, most centrally their sense of self or true identity, is regained, while at the same time, the person often discovers more and more of their own potential, more of what life has to offer.

It is convenient, therefore, to think of recovery as a process, a journey. And it's a journey built upon some very foundational principles, such as hope. Hope for the future. Hope to achieve one's goals. Hope for a rich, full, and meaningful life. And when that hope is nurtured by a system that fosters dignity and respect, then a person can be empowered to pursue healing. Further, when that system recognizes that recovery can come about only when the whole person, mind, body, and spirit, in the context of his community and culture, is receiving the very best evidence-based treatment available; ah, transformation in mental health service delivery can occur.(7)

Or as we like to say, recovery is the music that inspires this dance we call treatment. Evidence-based practices can become the dance steps. Without evidence-based practices, we are at a loss to know where to put our feet. Are we to waltz today, and jitterbug tomorrow? The absence of these steps has resulted in some of the mistakes of our past. Trends in mental health treatment have come and gone like new moves at a teen dance rave. Evidence-based practices can guide our steps. Through the use of clinical practice guidelines, developed as a result of a systematic review of all applicable research, a course of treatment can be selected of which we can be relatively certain regarding both the benefits and costs. Yet, devoid of recovery, we have no inspiration, we have no partner with whom to dance, and the dance never ends. Evidence-based practices are developed through rigorous scientific researches. Recovery is individually defined and is founded upon hope for getting better. Evidence-based practice recognizes the importance of expert opinion. Recovery recognizes the importance of consumer self-help, peer support, and self-responsibility. Recovery acknowledges a person's self-worth, self-esteem, and reason to keep on living. When we acknowledge recovery, we acknowledge the importance of the consumer's involvement in his own treatment planning, making his own life choices, and establishing successful coping strategies.(8) A *partnership* is developed between the person with mental illness and the provider; an interdependence, if you will, much like two persons on a dance floor, who from time to time, shift the 'lead.' Eventually, the music changes. And partners change. Yet having discovered so much in the process, and having uncovered so many of the rich resources within himself, the consumer will now be able to dance with another. Friends, family, and community, all will take prominence over this dance with 'the system.' A recovery-based system must be oriented toward this end, toward moving on, toward getting better.

A sidebar here is that we've found that providers sometimes have not allowed, or said less punitively, have not facilitated consumers getting better, moving on. We've seen it in our own, recent work as we've studied our Service Area's delivery of Case Management Services. We found uniformly, as we completed our analysis of these services, that we have treatment plans that are often missing a vision of recovery, a practice model, and an ongoing utilization review.(9) Or as we've come to say, as the Eagles sang — the 'Hotel California' syndrome – 'you can check out, but you can never leave'(10). And in the field, we're even beginning to see the questioning of such long standing evidence-based practices as PACT; and asking, what about consumer input? What about a vision of recovery? What about getting better? And even as Stein and Test recently all-but-acknowledged, practices could become even more effective when we are in partnership with consumers.(11)

Consumer Input: Transforming Systems

One of the ways our practices could become more effective would be to incorporate the principles of recovery as we design our mental health service delivery. The first Guiding Principle in Mental Health Recovery states quite simply that "the consumer directs the recovery process; therefore, consumer input is essential throughout the process."(12) So we must ask ourselves, as we begin to design a service delivery system that incorporates consumer involvement and resulting input at all levels, how exactly can this be done? We would offer that there are essentially four tiers to a service delivery system in which consumer involvement might be possible to facilitate the development of recovery-related processes and outcomes. These tiers include: administrative, middle management, direct care and consumer self -involvement.

Examples of consumer involvement at the administrative level might include consumers serving on the agency/hospital Board of Directors. Or having a consumer working in an executive level position. More and more, agencies in our Service Area are moving in this direction, recognizing that to influence the entire system, there is need for consumer presence, perspective and input at an executive level. The goal here is to have consumers involved and at the table from the beginning — from the beginning of any new policy discussion, of any program development, of any system design. When it affects consumers, consumers should be involved!

Examples of consumer involvement at a middle management level could include individuals serving as Consumer Services Specialists, acting as a liaison between consumers and management. These individuals may be responsible for coordinating and facilitating Consumer Councils or Advisory Boards, thereby providing consumer feedback to the agency, and resultingly, offering consumer perspective for, and influencing, policy decisions. Another example of involvement in this tier might be in the implementation of consumer surveys.

Then the third tier, which is direct care. At this level, consumers can be involved by providing direct services to other consumers through structured services such as peer mentoring, peer support groups, or consumer advocacy. Nationwide, for example, ACT Teams are beginning to adopt standards for including Peer Advocates on the Team; and consumers are serving as Wellness Recovery Action Plan (WRAP) Educators and group facilitators. (13) When consumers are part of the service delivery process, they can bring to the table their unique and valuable life experiences, and can utilize these experiences to help others in their journey toward recovery.

And finally, the fourth tier, which we term consumer self-involvement. At this level, we refer to consumers being directly involved in their own recovery planning, as contrasted to treatment planning, which is staff directed. It is at this level that the principles of empowerment and personal choice may be applied so critically, allowing an individual to learn and grow from their own choices, whether good, bad or indifferent. And by further focusing on a person's strengths, the individual is more engaged in their own treatment/recovery and is striving to achieve their own desired goals. Support for the powerful effect of consumer self-involvement in the recovery process has been provided through extensive research conducted by the developers of the Strengths-Base Case Management Model.(14)

So, let's say it again, from the beginning. We believe that health opens a person's world to discovery. And that health might best be achieved from an expectation of recovery, by both the person with mental illness, and the provider. And that, for the achievement to be maximized, that the recovery vision must be coupled with evidence-based practices. And, that our recovery/evidence-based services might have the most positive outcomes, in a recovery-based service system.

Evidence: Assessing Progress

Now, let us take a final step. If indeed a service provider proclaims to have developed such a system, how might we assess such a developed 'recovery-oriented service delivery system?' Recovery is rich and attractive in philosophy, and hopefully we have shared enough of a flavor of that philosophy that you now have a vision. And we have offered strategies through which this vision, with one of its guiding principles, might be operationalized. How then, might an agency assess progress in implementing these principles?

In our Service Area in Illinois, we have developed a teaching/monitoring instrument to help guide such an assessment. The 'Performance Indicator.... Evidence of Recovery-Based Services' (Figure 1) addresses nine different areas, covering aspects of all four previously mentioned service system tiers, in which recovery can, and should be, reflected, to achieve a recovery-oriented service system.

- To begin, do the organization's mission and vision statements reflect a vision of recovery? Is an organization's mission 'to maintain persons in treatment' ('Hotel California') or 'to maximize persons' potential for productive living' (recovery!)? The word "recovery" does not necessarily have to appear in the statement, but the *spirit* of recovery must be reflected. We often ask organization consumers and staff if their vision inspires them.

- Secondly, how are staff trained? Has the organization worked to re-educate or un-educate persons whose formal training was in a system that said that persons with mental illness could not get better and would have to be cared for, for the rest of their lives? Do the staff understand the recovery vision and the core components of the consumer movement? Have consumers been included in providing training for staff: individuals who can speak from the perspective of one who has, as we say, had mental health system experience?

- Of equal importance, we ask if consumers and their family members, within an organization, have received education regarding the principles of recovery. For many organizations, this has been an equal or greater challenge than educating the staff. Particularly for individuals whose dependency on the system has been fostered for years, even decades, recovery can be a very new and challenging, even frightening, concept. Consumers, and staff, need to have the opportunity to meet other individuals who have recovered, as part of that educational experience.

- What is the composition of an organization's Board of Directors, or is there a Consumer Advisory Council, or other means by which consumers can influence policy within the organization? This is the life-source of the future for an organization. Here we often emphasize that organizations must keep in touch with their consumers, just as does any corporation that succeeds. Southwest Airlines, for example, does.

- And then, what type of recovery groups are offered to consumers of an organization? Examples of such groups may be those modeled after traditional 12-step programs (AA, NA, Codependents Anonymous, Double Trouble, etc.); peer support groups, such as those offered by local chapters of the Depression & Bipolar Support Alliance (DBSA); GROW groups; WRAP groups, designed to facilitate ongoing development of a Wellness Recovery Action Plan (15); or other peer-to-peer recovery groups. These groups should be for consumers, and led by consumers.

- Has an organization hired consumers to work on staff, in positions specifically designed to utilize their personal mental health experience? As mentioned earlier, there are many roles in which these individuals can function within the organization. How many have been hired? Is there only one person? Or several? And of course here, the organization must carefully evaluate that person's role, to assure that it is designed to have the desired level of influence, as opposed to mere tokenism.

- Does the organization have a written means, such as Satisfaction Surveys, by which consumers and family members can provide feedback to the organization? What is that survey measuring? How valid and reliable is the instrument used to collect it? And, how is that feedback utilized to assure it influences the system?

- In what ways has the organization strategically designed its system to involve consumers and family members in planning, developing, and evaluating services? Is there documentation of this, such as an organization's Strategic Plan, showing this intent?

- And finally, and most powerfully, we return again to 'Hotel California.' And we ask, does all of this translate into treatment planning that is individualized and recovery-oriented, reflecting consumer involvement and consumer choice, and provoking getting better rather than being maintained? Moving on, rather than staying around?

Something important to note here, is that the ultimate goal in all of this must not be the notion that hiring more and more consumers reflects positive outcomes. The goal here, our point, is people getting better. All of the examples we have given, from the hiring of consumers to involving consumers in all levels of service delivery, should be implemented with the explicit intent of constantly incorporating the presence, perspective and input of persons who have 'been there', into service delivery, while providing services that are solidly founded upon research-based evidence. By doing so, we move closer and closer to a system that reflects parity, openness, and the recognition of the worth and value of each person in their own personal journey toward recovery. The music of recovery, coupled with the dance steps of evidence-based practices, can indeed facilitate and enhance that personal journey, and when offered interdependently by consumer and provider, can be much, much more, than just a song and dance.

Ms. Larson is the Acting Director for statewide Consumer Services and Dr. Vyverberg is the Manager for the North Central Mental Health netWork within the Illinois Office of Mental Health.

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Figure 1

North Central Mental Health netWork
MONITORING ACTIVITIES

Performance Indicator for Community Agencies / Hospitals
EVIDENCE OF RECOVERY-BASED SERVICES

INDICATORS	THRESHOLD	INDICATOR REVIEW	FURTHER REVIEW
1) MISSION/VISION STATEMENTS	Schedule of core new staff Orientation/Ongoing Training Activities addresses the Family Partnerships/ Systems of Care and the Recovery Vision/Principles	Review both printed statements to note that the Family Partnerships/ Systems of Care and the Recovery Vision/Principles are included in system design and service delivery expectations	
2) STAFF ORIENTATION/ EDUCATION ACTIVITIES	Both Statements reflect the promulgation of the Family Partnerships/Systems of Care and the Recovery Vision/Principles	Review Annual Orientation/ In-Service/Training Schedule and activity description to note inclusion of training related to the Family Partnerships/ Systems of Care and the Recovery Vision/Principles, and consumer involvement in the training design, development and implementation	Interview Training Staff and consumers to discuss activities. If appropriate, observe partial orientation/training session
3) CONSUMER/ FAMILY EDUCATION ACTIVITIES	Schedule of Consumer/ Family Education Activities addresses the Family Partnerships/Systems of Care and the Recovery Vision/Principles	Review schedule and activity description of Consumer/Family Education Activities to note inclusion of activities related to the Family Partnerships/ Systems of Care and the Recovery Vision/Principles, and consumer leadership in the design and delivery of the activities	Interview consumers/ family members to discuss activities. If appropriate, observe partial education session
4) BOARD OF DIRECTORS/ GOVERNING BODY/ CONSUMER ADVISORY COUNCIL COMPOSITION	Listing/By-Laws description reflects Consumer/Family membership/ participation in Board of Directors/ Governing Body/Consumer Advisory Council	Review Board of Directors/ Governing Body/Advisory Council attendance listing and meeting minutes to note consumer/family attendance/ participation	Interview consumer/family members to discuss attendance/participation and support for that attendance/ participation
5) RECOVERY GROUPS	Schedule and description of Recovery Groups offered to Consumers, led by Consumers	Review schedule and written course description for Recovery Groups offered to consumers, led by consumers	Interview Recovery Group consumer leaders to discuss Group attendance and impact

Continue... next page

INDICATORS	THRESHOLD	INDICATOR REVIEW	FURTHER REVIEW
6) CONSUMER SERVICES RECRUITMENT/ SELECTION PLAN AND EMPLOYMENT ROSTER	Listing of Consumer positions, established specifically to utilize Mental Health experience; description of Position Duties and Responsibilities (Employment of PT or FT Consumers depending on Agency/Hospital Size)	Review listing, duties and responsibilities and employment plan (larger, comprehensive agencies Guideline is to have 1.0 FT Consumer Services Specialist* on staff; for smaller specialty agencies, a PT Consumer Services Specialist)	Interview Consumer Services Specialists to discuss duties, responsibilities and employment plan (If Consumer Services Specialists are not on staff, interviews should be with appropriate leadership staff.)
7) CONSUMER/ FAMILY SATISFACTION SURVEYS	Summary Report of Consumer/ Family Satisfaction Survey findings, addresses the access, availability and quality of Consumer Services	Review of sampling of Consumer/ Family Satisfaction Surveys to note completion and findings	Interview consumers/ family members involved in Survey implementation and discuss findings and plans for responding to findings
8) CONSUMER/ FAMILY INVOLVEMENT	Description in Strategic Plan for Consumer/Family involvement in Service Planning, Development, Implementation and Evaluation	Review of documentation of consumer/family involvement in service planning, development, implementation and evaluation	Interview consumers/ family members involved in service planning, development, implementation and evaluation
9) RECOVERY-BASED INDIVIDUAL SERVICE PLANS	Reflection of Family Partnerships/ Systems of Care and the Recovery Vision/Principles in 50% of 10 reviewed Individual Service Plans (Treatment/ Discharge Plans)	Review of 10 Individual Services Plans for a reflection of Family Partnerships/Systems of Care and the Recovery Vision/Principles	Interview consumers/ family members and consumer leadership staff to discuss service planning

*** CONSUMER SERVICES SPECIALIST:**
This is a title intended to represent a variety of consumer-specific roles, responsibilities and functions, including Peer Mentor, Ombudsperson, Consumer Advocate and Consumer Case Aide, for which persons with mental health service experience, have been hired.

PROPOSED MONITORING PROCESS:
Performance Indicators 1), 2), 3), 4), 5) and 8) would be surveyed in FY-2003, and every two years thereafter. When deficits are found, either Plans For Action or Plans of Correction may be requested, when appropriate.

Performance Indicators 6), 7) and 9) would be surveyed in FY-2004, and annually thereafter. And again, Plans For Action or Plans of Correction may be requested, when appropriate.

NetWork staff, in consultation with agency/hospital Consumer Services Leadership Staff, shall make decisions concerning the Further Reviews. Resultingly, when consumer interviews are to be conducted, several consumers should be interviewed.

The Recovery Vision and Evidence-Based Practices
A Commentary on Larson and Vyverberg Paper

Beatrice Kovasznay, MD, MPH, PhD

When we hear stories about patients "recovering" from serious mental disorders such as schizophrenia, the skeptics among us might question the "true" diagnosis, while others might feel awed and inspired by them. In fact, we don't really know how many patients recover because if they are doing well they are often lost to follow-up. The Vermont Longitudinal Study (1) found that many individuals with chronic mental illness did better than expected thirty years after leaving a state hospital.

What are the factors that determine how well a patient can do in the community? Clearly we must offer the opportunity for a patient to do well. This means helping the individual plan what his/her life will be. For most individuals the goals will include independent living, gainful employment and a network of friends and family. These are common measures of success and productivity in our society.

Have we really prevented the achievement of these goals? Many clinicians would deny it, while the Psychiatric Survivor movement would give an emphatic "YES", and others might give an answer somewhere in between. How do we offer the opportunity? The Vermont study demonstrates that the type of services available does make a difference.

Clearly, we can learn from the consumer/survivor/recipient/patient what is important to him/her. Input at the various levels of organization can help assure that we address the needs of these individuals as they see them. We need true input, rather than just angry picketing from the sidelines. Larsen and Vyverberg (2) have provided us with a framework to evaluate the structure and process which can help this happen. The real outcome is measured by our patients' actual progress toward recovery.

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THE RECOVERY VISION AND EVIDENCE-BASED PRACTICES

A Commentary on Larson and Vyverberg Paper

Lawrence Goldberg, M.D.

The authors present an impassioned position statement of their values in the practice of psychosocial rehabilitation and recovery. Their list of nine key process outcome areas represents what they regard as the key practice elements for success. They provide a tool for assessment of programs, as well as for quality improvement activities. However, what they do not provide is a systematic review of the evidence, drawn from clinical research, of the effectiveness on actual outcomes for their clients. Because of this, the hopes raised by the title of the article, invoking the concept of evidence based practice, are ultimately not fulfilled.

The authors particularly stress the importance of including the client/consumer in the process of devising the rehabilitation plan. At first glance, this would seem in opposition to the concept of evidence based practice, as the guidelines for practice based on systematic reviews of the evidence are drawn of necessity from studies on large populations. But the true practice of evidence based mental health incorporates the assessment of the client's values, in considering how much the client stands to gain in quality of life in areas of social and occupational functioning most important to him/her, and at what risk or cost. What is also not mentioned is any assessment of risks and possible harms which may befall the client choosing to embark on a given rehabilitation program, such as the loss of entitlement benefits and even decompensation into overt mental illness in the face of the stress of heightened expectations.

In an era of diminishing funding both for public programs and in the private sector, mental health administrators are likely to be facing increasing pressure to cite the evidence for effectiveness for their programs. The ability to make an impassioned plea devoid of evidence will not be enough to carry the day. Indeed, it is our professional and ethical obligation to devote scant available resources to clients who both need them most, and are also most likely to measurably gain from the interventions. A thorough grounding in evidence based mental health principles will enable the administrator to both make and defend these hard choices.

Dr. Goldberg is the Medical Director of New York Regional Service Center of Magellan Behavioral Healthcare.

Welcome! New Member

January 2003

David I. Greenspan, 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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From Soup To Nuts: Fables For Mental Health Administrators

Daniel Luchins, MD

Technological innovations allow many physical needs such as food, clothing, transportation, to be more readily met, often at less cost. This is the benefit of mass production and distribution systems. A similar economy is not possible with social needs such as child rearing, education, caregiving. Meeting these needs depends on human contact which cannot be mass produced or distributed. For these needs, there is no possibility of additional benefit from an economy of scales. These have already been more than maximized, witness the overcrowded state of our public child welfare, education and health care systems.

As a mental health administrator, I therefore am skeptical of innovations that promise more or better care with no additional resources. To illustrate the danger of these promises and to provide guidance on how to insure that innovations are coupled to the necessary resources, I would like to tell two stories, both of which involve soup.

Chicken Soup

The Rabbi's wife was justifiably proud that regardless of how many guests the Rabbi would bring home for Sabbath dinner, they could always be accommodated. One night, he brought more guests than ever before. She poured extra water in the chicken soup, but since the chicken only has so many thighs and wings, she told her children, "When the chicken is served, say no thank you I'm full." Everything was going as planned until she realized there wasn't enough dessert to go around. So she announced "Those children who have not eaten their chicken will get no dessert."

The Public Mental Health System is also expected to always accommodate. In response to legislative mandates usually without additional funds, or our own desire to expand services or serve new groups, we use the Rabbi's wife strategies.

1) Water down the soup:
Everyone can get crisis intervention, case management, counseling, psychotherapy, etc. Simply lower the qualifications necessary to be a provider and/or adjust the length, frequency and/or duration of the treatment.

To counter this tendency, as administrators we must avoid definitions of treatments that are malleable. Case Management must mean a certain type of professional spends a specific amount of time at a given frequency for a minimum period of the year.

2) No chicken for the children - just the guests:
When obligations are made for services that cannot be diluted down (e.g. housing or a job slot, those that have a well established definition and/or subject to regulation) the public mental health system accommodates by raising the criteria for eligibility. If supported housing was previously available to all persons discharged from State Hospitals with a serious and persistent mental illness, the criteria is raised to include only those with a dual diagnosis or a minimum of two hospitalizations.

To offset this stratagem, the need for resources should be defined on clinical grounds (specific diagnoses or level of disability) and not defined by working backwards from the availability of the resource. This may produce waiting lists or other unpleasantries, but raising criteria for eligibility just hides the problem, exchanging one needy group for another.

3) No chicken - no dessert:
This is similar to strategy #2, instead of raising eligibility criteria to serve the needier or more impaired, this strategy excludes those who are too needy or impaired. The very reason why someone might need a service becomes the reason why they cannot have it. Substance abusers who continue to abuse aren't suitable for housing. Persons who are not well organized or not motivated are not job ready.

Aside from the obvious perversity of this approach it actually runs contrary to empirical evidence. Denying treatment to the most impaired produces poor outcomes. However, that is only evident when follow-up is based on "intent to treat" and includes those who drop-out or who are denied treatment, not restricted only to those who remain in treatment. A follow-up of the Pathways to Housing Program, (Tsembaris and Asmusen, 1999) has shown a two-fold increase in stable housing outcomes when homeless

> mentally ill substance abusers are provided supported housing as a first step in their treatment, compared to conventional programs in which abstinence must be demonstrated before supported housing is provided. If these studies had simply compared outcome rates for those offered housing (all in Pathways to Housing and only the abstinent in other programs), the results would have favored conventional treatment.

Stone Soup

A troop of soldiers appear in a war torn village. The villagers hide their remaining provisions and lock their doors. In the village square, the soldiers announce a feast that night for all. They begin to boil a huge kettle of water and then add their magic stone. Stirring and sniffing, one declares "Delicious, but it would be better with a few carrots." A door opens and a villager volunteers some carrots. "Excellent, but how much better with some turnips." Turnips are added. The soup ready, the feast begins. The villagers, their hunger slated and now content, raise a cheer to the soldiers who promise them the magic stone. The next day their provisions now exhausted, the villagers have only hot, dirty water for supper.

Mental health is replete with innovations that succeed as pilots but are never expanded. They succeed because as pilots they can either draw additional resources into the system (Federal grants, university researchers) or cause a temporarily reallocation of internal resources. Once the one-time funding ends, the project is declared a success, but there are no resources for wider replication.

Administrators want innovation, academics want research, advocates want services, and legislators don't want to raise taxes. But they all love a success story. Under these circumstances the most expedient course of action is to fund pilot studies that cost a fraction of what the innovation would cost if made generally available. As a counter balance to these forces, I would offer a modest proposal. The true cost of any innovation including external resources and those diverted from internal sources needs to be determined before a project is undertaken. These costs should be multiplied by the potential need for the service and a high level decision must be made that if, a specified level of success is achieved, that there is the political will to move ahead system-wide within a specified time frame. Such decisions need to be memorialized and should be a pre-condition for Federal demonstration grants to State authorities**.**

These may seem like high standards. Administrators will say they stifle innovation, academics that they interfere with the search for truth, advocates will point out (justifiably) that they deny services to the pilot population, and legislators will insist they cannot commit tax funds that have not yet been raised. But I for one, have had my share of fine dining in Washington restaurants while doing research that once again shows that housing prevents homelessness. I feel the need to insist as my grandmother would say "Sometimes enough is enough." We need to forfeit the success stories that are hollow promises that raise expectation that cannot be fulfilled. The promise of a perpetual motion machines is an obvious hoax. Schemes to provide additional social services without a proportionate increase in resources are no different. Or, to mix culinary metaphors, in the future when such promises are made we need to ask, "Where's the beef?"

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Dr. Luchins is the Clinical Director at the Illinois Office of Mental Health, and an Associate Professor of Psychiatry at the University of Chicago.

APA Certification Exam in Administrative Psychiatry to be given during the Annual Meeting

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For more information contact Kristen Moeller at 202-682-6109 or kmoeller@psych.org

Nineteen Candidates Pass the New Streamlined Administrative Certification Exam

Stuart B. Silver, MD

The new, single written examination combining multiple choice and brief essay questions was administered for the first time in May, 2002. Of the 26 candidates who sat for the examination, 19 passed (pass rate of 73%). The application deadline for the May, 2003 test was February 1, 2003. Early applications are encouraged in order to allow candidates more time to prepare.

Dr. Fichtner, President of the AAPA, assembled a two-day comprehensive course in psychiatric administration and management. It was presented for the first time at the Philadelphia APA convention in May, 2002. The course sold out both days. Many of the participants in the course also sat for the examination during the convention. They achieved a 78% pass rate suggesting that although the course was not required or recommended by the APA Committee on Psychiatric Administration and Management, and although many who took the course did not sit for the examination, nonetheless, those who used the course to help prepare found it helpful.

The APA Committee on Psychiatric Administration and Management last year streamlined the application and examination processes for APA certification in that field. The examination process is now shorter and less expensive. The committee has eliminated the oral portion of the examination; and has changed the application pre-requisites to enable young and early career psychiatrists to pursue certification. Elimination of the oral examination means that candidates could receive certification just a few months after applying, assuming they pass the written test.

APA Certification in psychiatric administration and management reflects the candidate's knowledge and skills in four areas: psychiatric care management, administrative theory, budget and finance, and law and ethics, as each applies to mental health administration. APA believes the additional skills and experience found in psychiatrists who fill administrative roles, even part-time, deserve recognition through a certification that recognizes those qualifications. In addition, certification is a visible demonstration of knowledge and skills that may increase a psychiatrist's opportunities for employment or promotion in some settings.

Perhaps most important, persons preparing for the examination go through a substantial educational process which often includes studying texts and articles (some specifically recommended in the application materials), talking with professionals in other fields (e.g., an organization's human resources or budget director, attorney, or senior managers), and/or attending courses, seminars, or workshops on mental health administration.

Prospective candidates must be certified in general psychiatry by the ABPN or an equivalent body, and must have at least one year of substantial experience in general or clinical administration (verified by letters of reference). The experience need not be extensive, but should provide familiarity with general management concepts. A year as an assistant unit or program director, for example, may suffice. Applicants may substitute a year of administrative training during residency or two semesters of graduate-level management courses for the post-residency experience. APA membership is not required.

Further information, application materials, and study recommendations can be obtained from Kristen Moeller, APA Department of Continuing Medical Education, (202) 682-6109 (e-mail kmoeller@psych.org).

Dr. Silver is the Chair of the APA Committee on Psychiatric Administration and Management.

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

COLUMN INTRODUCTION:

Perhaps the ultimate ethical decision for a Psychiatrist Administrator (or any Administrator) is when to resign. At our workshop at the last APA Institute on Psychiatric Services, titled "Ethical Principals in Psychiatric Administration: Issues, Challenges and Dilemmas", Steven Sharfstein, MD, commented that this is the biggest ethical dilemma of all. He mentioned one criteria would be the need to do something new. At the same meeting, Fred Gottlieb, MD, stressed that resigning should be the last choice. We opened up the question to our ethics committee.

ETHICAL QUESTION:

What ethical issue would lead you to, or already has led you to, resign your position as a Psychiatric Administrator?

Response 1:

In response to the upcoming Ethics column as referenced in your March 12, 2002 letter, please find the following:

I have recently appointed myself as the Psychiatric Administrator of my own solo outpatient private practice. This followed ten years as a primarily, hospital based Psychiatrist and Psychiatric Medical Director at two different hospitals. Although many factors entered into this transition, the primary reason was essentially that of ethics, as referenced in this column.

At the first hospital, Administration recruited me, I would later find out, to fix a seriously problemed Psychiatric Unit. The medical staff, however, was unwilling to back me despite clear violations of insurance, UR, billings, accreditation and patient care standards. This especially involved a particular physician, clearly with issues of ethics as well as competence, who was already well entrenched within "the system". His relationship with some key influential physicians seemed also to cause the administration to be less willing to join me in going against that obstacle. As I was supposed to monitor, as well as report these violations, (felt better left unreported by some) it appeared that I myself was becoming the received villain. Change appeared to be unlikely, let alone imminent, therefore I was no longer willing to have my name associated with that organization. I would otherwise be condoning poor standards of quality of care. I would also have liability administratively for these clear violations, given my position as Medical Director.

I was recruited by the administration of my second hospital, for a similar position, unfortunately in a similar situation, as it would be discovered. Also, similar to my first position, there were two psychiatrists there that had very significant quality of care and ethical issues. Unlike my first position, the medical staff and administration here were supportive of taking appropriate action and fully supported the quality of care changes needed and my leadership to do so. A couple of years after I got there, however, the CEO changed, thus did the vision for the hospital. One of the many areas then targeted for "efficiency" was the psychiatric unit. Subsequently, an independent management company was brought in. This company seemed very adept, concerning regulatory as well as ethical patient care issues, at "walking a fine line", with the main emphasis of course being the "bottom line".

At the urging of the Medical Executive Committee, these two "Quality Challenged" psychiatrists resigned. For the last year and a half, I became the only full time attending physician. Despite constant and increasing pressure to do so, I was unwilling to admit more patients than I was able to provide quality of care to. I refused to discharge patients for "administrative" reasons, thereby substituting financial for clinical decisions making. To increase revenue, I was "encouraged" to devote more and more of my time to direct patient care (for which I was compensated fee for service). However, this then required fabrication, at the very least creativity, in documenting my hours devoted to Medical Director duties, as regulations were now requiring. This new company had the philosophy, of which I was clearly advised; their management plan did not require much input from a Medical Director, at all. My stipend as Medical Director (at that time approximately one half of my income) was cut by 70% in order to accommodate this "shift of focus". Being very uncomfortable with the decisions being made and the reasons for them, (patient care clearly not being the driving force), I was unwilling to take this uninvolved role. I refused to merely "rubber stamp" policies and practices, which I felt to be substandard care, merely to satisfy regulations and profit projections. This violated my medical ethics, but was also concerning from the standpoint of medico legal culpability, which my title nonetheless left me with. Once again, I found myself in the position of having responsibility, yet without authority.

In both of these Medical Directorship situations, it became clear to me that in today's healthcare environment, the prevailing philosophy is, it seems, the quality of patient care is inversely related to institutional or sometimes even personal financial viability. Low cost and high quality are seen as mutually exclusive. I don't agree with that premise nor the proposed solution of diluting care. My rules have not changed, but apparently the game has. While in my previous administrative roles, being unwilling to tolerate, much less practice what I considered to be substandard and deceitful patient care, I found myself in constant conflict with administration and even more concerning, sometimes colleagues over our apparent discrepant goals. I was unwilling to participate in or condone dishonest documentation, merely to satisfy regulatory compliance. Nor was I willing to condone or participate in what was designed to appear to be patient "care", knowing that it really wasn't. I found myself no longer able to be both an effective and ethical psychiatrist as well as an Administrator. The Biblical teaching became quite clear that, [at least this] "man, cannot serve two gods".

Lawrence B. Beasley, MD

Response 2A:

Hi,

Actually, I am very close to resigning my position as chair of the hospital's medical ethics committee secondary to an ongoing failure of my medical colleagues to find a way to educate residents via attending modeling and an associated failure to develop a means to follow federal, state and hospital mandates regarding end of life care. My failure to recruit like-minded colleagues is untenable. I continue to find myself one of very few hospital physicians providing the teaching and direct patient/family intervention regarding EOL care. Nursing staff are our staunchest allies. Several months ago I resigned as Chair of the hospitals palliative care committee for similar reasons. The argument of "at least something is being done" no longer outweighs my frustration and anger. I have been at the same institution for 30 years. My sadness is palpable. Regarding psychiatric administrator responsibilities, new hospital ownership has left me with some similar feelings. Primary issues of concern center on administrative snafus that preclude reasonable patient care for an inner city population. I never imagined leaving a hospital setting for a full time practice but yet it almost has become a personal mental health mandate. I would prefer my response to remain anonymous or if not possible, please do not include.

Response 2B:

Dear Dr. _________,

Thank you for your response. I am sorry to hear about the obstacles you have encountered. Any ideas about what has caused these obstacles? I'll follow your request and probably only anonymously excerpt part of your response.

H. Steve Moffic, MD

Hi,

Actually, as I think about your question, I find a parallel between new administration and my frustration with colleagues. Some of each are decent people whom I like. Yet at the same time, the stresses of clinical and fiscal realities often foster defenses/behavior that too quickly side step fiduciary responsibility. Patients and families come out on the short end. I guess I feel that as well.

I've always thought that what psychiatry and psychiatrists have to bring to medical ethics is rather unique. We should be better prepared to tolerate the ambiguities and untoward realities of life. We should be more patient and considered in our ability to weigh issues such as patient autonomy and open communication. In fact, I believe that I am pretty good at doing that in my professional life.

In a clinical setting with isolated consults here and there I am not overwhelmed and can plod through-as the chair and basically the sole physician working regarding their wishes and then finding a doctor to carry out those wishes in a reasonable manner with sensitive beside manner is not easy. Last week I was the one after 2 days of effort who wrote the order to disconnect a vent and sat with the patient and family. Found a colleague in peds (the patient was an 81 year old female) who helped and that was a pleasant surprise.

The parallel to my administrative life is that as the medical staff hide from both the time and interpersonal pain that they find in facing these issues with patients/families (they miss the satisfaction as well), is the same stance that new hospital administration takes in their hunkering down to overcome the onslaught of fiscal realities in the form of creditors. After 18 months however, they have accomplished a #31 million-dollar turn around. We are in the black for the first time in many years. In some ways aspects of patient care have improved. Quite a paradox.

I also wonder long and hard about personal issues that may impact on my thinking of leaving the hospital. Am I displacing, is it my age, am I over the hill, am I the "blind" mouse in "who ate my cheese?"? Whether or not I am missing my role in the equation, all I know is that I now look forward to the end of the hospital day… this is a very sad thought. My professional moments of satisfaction center around contact with residents, hospital patients, private practice and shelter work I have been doing for the past year in a MICA men's shelter-couldn't find a doctor who wanted to work with the population.

Sorry, just looked back on what I wrote and it's starting to sound like a therapy session…

Thanks for the question as it helps me continue to try to tease apart my role and subsequent response to my dilemma.

Response 3:

What ethical issue would lead you to—or already has led you to—resign your position as a psychiatric administrator?

The wording of this question implies a single answer; obviously, many situations plus variants apply. Those listed below in no particular order provide a sampling but hopefully allow a format for further discussion.

Violation of, or Inability to Preserve, Confidentiality

Particularly in a state system, there are a number of ways medical or employee record security could be usurped by the government, who employs the Superintendent of a hospital. I was once on the staff of a hospital, which had the FBI suddenly appear in front of patients and everybody and confiscate medical records (presumably with a court order and weapons for backup as there were no patient releases). I was not physically present and do not know what I would have done had I been but am no more likely to defy a Federal Officer than the next person. As an aside, there were no problems found, and yes, I did resign.

Dishonesty: Financial Misrepresentation,
Underhandedness, Other Shenanigans

A recent event at a general hospital where I served as Chief-of-Staff a few years ago provides an illustration: the hospital hopes to upgrade its bond rating; the Chief Financial Officer hoped to upgrade his personal rating; the monthly financial statement noted $750,000 of anticipated funding from Medicaid as actual income. Fortunately, the Board of Trustees (not the rather naïve Chief Executive Officer) discovered this attempt at fraud, corrected the error, and insisted that the CFO depart. Resignation of the administrator, not in this case a psychiatrist, was averted.

Sexual Misconduct

Hopefully all of us have gotten this through our heads, but the behavior of our heads almost never causes concern. This also might encompass an organization's condoning ongoing improper relationships among its members, failure to discipline and/or promotion of incompetence because of romantic relationships, turning a blind eye to misuse of patients in this area, and so on.

Patient Abuse

Known incidents of abuse of patients or failure to protect the rights of patients; failure of the organization to investigate and discipline, if necessary, allegations of violation of patient rights; failure to follow guidelines as set out by review and governing organizations; even, in these days, failure to document having adequately protected patients.

Safety Issues

Inability to provide a hygienic and secure environment for patients and staff.

Conflict of Interest

Your brother-in-law holds the contract for food services at the hospital where you are administrator; yet, his bid was neither the lowest nor his product the best, etc.

Constraints and Proper Treatment

Such things as orders to treat after evaluation indicates no evidence of psychiatric illness; confinement of convicted felons to hospitals with no evidence of needed treatment; court orders not to provide treatment for psychotic persons awaiting trail, etc.

June A. Powell, M.D.

Response 4:

Dear Dr. Moffic:

Naturally, I would not resign my position until I had made every effort to correct the situation within the system in which I was working. Should I be unable to do this I would resign position, if:

1. I believed that patient care was being significantly compromised for any reason.
2. I believed that patients were being consistently abused or misused by staff.
3. I believed that unethical research was being conducted.
4. I believed in a private system, that profits were foremost and were being given too much consideration vis-à-vis patient well-being.
5. I believed that staff were being abused or misused, through either underpayment, poor training, or poor hiring practices.
6. I believed that higher levels of the administration were not responsive to the needs of staff or patients on a consistent level.

Sincerely,
Dave M. Davis, M.D., F.A.P.A., F.A.B.F.P.

Response of Editor:

I, too, like any psychiatrist administrator, have been faced with this question. I have resigned from one position for ethical reasons. Years ago when I was Medical Director at an academic Managed Behavioral Healthcare organization, I resigned because I felt my authority was no longer commensurate with my responsibility. This was a principal developed by AAPA's former President, Gordon Clark, M.D., when he was President of the American Association of Community Psychiatrists. In my situation, I felt prevented from making decisions that would allow the best care for our patients possible under the financial parameters. Someone with limited psychiatric knowledge was demanding to do that instead.

However, as helpful as Dr. Clark's principle was to me at that time, there seemed to be no ethical context for that principle. Now we have our Ethical Principals for Psychiatric Administrators, which indeed do apply to our question at hand. Actually, our committee members who have responded touched on so many of the relevant sections and annotations that I will only make a brief summary here.

Overall, the key part of our ethical principals is in the preamble.

"The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals and to self."

Annotation (1): *"… if and when the psychiatric administrator can no longer follow these principals, resignation would be an ethical obligation"*.

Let's briefly review how our commentators reached the conclusion of this annotation. One felt he could no longer keep patient needs primary. Others emphasized being unable to also serve the needs of "other health professionals", including the educator of residents, and the needs of "self", in the sense of too much internal suffering and conflict. Another touched on several organizational ethical lapses, including compromising confidentiality, financial fraud, an unsafe environment, conflicts of interest, unethical research, and that profits came clearly first. Possibly it is those organizational ethical concerns that will often turn out to be the most crucial for the psychiatrist administrator, since it is the organization that defines and requires a psychiatrist administrator.

Since resigning is such an important decision, one specific annotation becomes relevant here, i.e. Section 2, Annotation 1:

"… Consultation with more senior administrators in another setting is advisable."

Members of the AAPA can be helpful in that regard.

H. Steven Moffic, M.D.

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You probably have noticed a recent change in the frequency of how often the *Psychiatrist Administrator* is delivered to your mailbox. With this issue you probably are also noticing a change in the quality of paper and a few format changes. This is a reflection of the fiscal challenges AAPA face today. Last year our Council decided to reduce the frequency of the Journal from 4/year to 2/year until we resolved the financial difficulties. As you know, the journal has been funded partially through an inconsistent flow of grants and partially through the membership dues. The Council continues to work on this area. I'd appreciate any suggestions that you may have for this area.

Sy Saeed, M.D.
Editor

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.

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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.

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