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Translating Knowledge into Practice: Implementing Evidence-Based Practices and a Case Study of Medication Algorithm Implementation

Sy Atezaz Saeed, M.D., Christina Rausch, MSW

“Research on the quality of care reveals a health care system that frequently falls short in its ability to translate knowledge into practice, and to apply new technology safely and appropriately.”

Crossing the Quality Chasm, Institute of Medicine Report, March 1, 2001

Mental health systems are moving toward evidence-based practice guidelines as a way to improve mental health services. Evidence-based practice guidelines rely on exhaustive reviews of the empirical literature to evaluate such features as efficacy, safety, tolerability, spectrum of action, indications, and contraindications for available treatment options. One application of practice guidelines is the medication algorithm. Medication algorithms recommend more specific treatment sequences that are often accompanied by tactical recommendations (e.g., at what dose, over what period of time, at what therapeutic blood levels) for particular strategies (e.g., specific medications). Although commonly used in the treatment of cancer, diabetes, and other chronic general medical disorders, algorithms are relatively new to psychiatry. With the substantial growth in the number of empirical studies of medication options for the treatment of mental disorders, psychiatry has seen a significant increase in the number of evidence-based treatment guidelines which in turn have served as the foundation for specific treatment algorithms. For example, the American Psychiatric Association^{1,2,3}, as well as the Agency for Health Care Policy and Research⁴, have developed and disseminated evidence-based guidelines which have set the stage for the development and implementation of algorithms based on both scientific evidence and expert clinical consensus^{5,6}.

If you build it, will they come?

Research shows that the divide between knowledge and practice remains wide. Despite extensive evidence and agreement on effective mental health practices for persons with severe mental illness, research also shows that routine mental health programs do not provide evidence-based

practices to the great majority of clients with these illnesses. This is true for the evidence-based practices (EBPs) in both psychosocial and medication management arena⁷⁻¹⁰.

Research on what impacts practice behavior tells us that guidelines are not self-implementing. This research shows that education alone does not strongly influence the practice behavior of health care providers¹¹⁻¹³. Studies of impact of practice guidelines suggest that publication and distribution of guidelines, although necessary, is not sufficient to change the practice of clinicians^{14,17}. Treatment guidelines must be contextualized to the actual process of care. Sustained change requires a restructuring of the flow of the daily work so that routine procedures make it natural for the clinician to provide care in the new way. Intention to change is necessary but also not sufficient for change. Practice behavior changes when intention to change is combined with the necessary skill and the absence of environmental constraint¹⁸. This paper will address some of the skill and constraint areas. However, there are additional efforts that may also be necessary to change practice behavior. These additional efforts include^{11,19}

- Increasing consumer demand for services.
- Changing financial incentives and penalties.
- Using administrative rules and regulations.
- Providing clinicians with ongoing supervision and feedback on practices.

Texas Medication Algorithm Project (TMAP)^{20,21} has provided us with some insights as regards to a successful implementation of medication algorithms and guidelines in the public-funded sector for three disorders: schizophrenia, bipolar disorder, and major depressive disorder. Specific features of TMAP included use of the following:

- Empirically supported agents in the algorithm.
- Diagnostic reliability procedures.
- Psychometrically sound measurement of multiple domains.

- Patient- and clinician-perspective measures.
- Training and ongoing supervision of treatment providers and assessment personnel.
- Patient and family education that allows the patient to be an active partner in care.
- Enhanced collaboration/communication between and across disciplines and providers.

The knowledge base that addresses implementation related issues and opportunities regarding evidence-based practices in mental health settings continue to grow. In this paper we summarize some of the lessons learned in the course of implementing evidence-based practices in general, and the implementation of evidence-based medication guidelines and algorithms in particular.

Lessons learned from Implementation efforts:

Raising Awareness:

Seeking commitment and “ownership” by state agencies to provide leadership to implement can be a significant challenge. Implementation of evidence-based practices must focus on raising awareness of these practices and supporting the workforce to change practice. The planning efforts should recognize the necessity, and the complexity, of building state and local infrastructure to support not only the implementation of EBPs but the sustainability of these practices. It is very important that efforts to increase awareness do not minimize the time it takes to raise awareness and create buy in of major constituency groups, especially providers, consumers, and family members. It is also very important that “champions” are identified within these constituency groups early on and that they are supported by the organizational leadership as they carry the message.

Top-Down versus Bottom-Up Approach:

While state leadership is ideal to create and sustain the momentum for implementation at the provider level (also known as the top-down approach), it is possible to create momentum in states where implementation was not mandated or encouraged by incentives. Evidence-based practice implementation may be achieved at a grassroots level. This critical mass of “early adopters” can encourage state policy changes supportive of their

organizational shift (the bottom-up approach). In this case, it is possible to gain critical grassroots support through a variety of approaches to providers, consumer groups, associations, and other behavioral healthcare organizations. These include discussing federal movements toward evidence-based practice, the outcomes of practice as usual versus optimal care, state support of these changes, the competitive advantage of implementation for providers, and liability risk of sub-optimal care, among other topics. These conversations are long-term and involve personal relationships to be optimally successful.

Working Collaboratively:

Implementation of evidence-based practices calls for a team approach. The team is comprised of representatives of key disciplines and stakeholder groups (such as consumers and their families, mental health care providers, mental health/consumer advocacy groups, etc.). The key clinical disciplines for implementation of medication management evidence-based practice include psychiatry, clinical pharmacy/pharmacology, medicine, nursing, social work, psychology, and public health, as well as administrators from implementing organizations.

Consensus-building activities related to adoption of evidence-based psychopharmacological practices (EBPPs) should involve both the leadership of mental health agencies and the key stakeholders (such as psychiatrists, other physicians, psychologists, pharmacists, social workers, nurses, other providers/clinicians, consumers, family members, and representatives of advocacy groups).

One of the lessons learned from implementation efforts has been that simply having researchers and community providers work together on a project does not necessarily result in more collaborative research efforts. They may understand each other better and develop positive personal relationships, but the conduct of research and the transfer of research to practice will require more planning and structural support. There is relatively little funding for research and increasingly available funding is from federal sources through state agencies. State agencies need to establish a collaborative structure of

various stakeholders to develop research priorities and provide coordinated support of these efforts.

Leadership

Strong, consistent, and visible state leadership is essential. Leaders need to send a message of support to the broad constituency, but especially to state bureaucracy. Retraining of state agency staff is essential as these individuals often are directly responsible for the development of policy and support structures that will sustain implementation efforts.

Having a consistent, clear message about exactly what the state's expectations are regarding evidence-based practices is crucial. The state must also define what they mean by the term "evidence-based practice," which specific practices qualify, and what the essential elements of that practice are for the state. Otherwise, every community practitioner believes they are providing evidence-based practices. During needs assessments conducted with consumers, family members, providers, and local/regional mental health administrators, many have noticed that there are major problems with the definition of "evidence-based practices" and which practices qualify. Providers and administrators often believe they are providing evidence-based practices. Sometime states have not clarified which practices they recognized as evidence-based, leading to confusion with providers and administrators in the system. Some states have adopted the six evidence-based practices recognized by SAMHSA/Dartmouth as "evidence-based."

In some states, the implementation of evidence-based practices is made more complex due to the comprehensive system reforms efforts that are reconfiguring the institutions historically responsible for providing mental health services. While this offers opportunity to align care in more effective ways, practically many policy and program leaders, providers, and consumers may feel overwhelmed by the magnitude of change. A major leadership challenge is the promotion of evidence-based practices as an integral part of reform rather than an additional undertaking or an initiative competing for already limited resources. In addition, there may be pockets of resistance to the overall reform efforts.

Tying EBP implementation to reform efforts may cause some to resist statewide implementation.

State-Wide Implementation:

One concept that has been discussed has been "statewide" implementation - the idea of starting up evidence-based practices concurrently across the state in various locations to minimize the time it takes for consumers to access these services. This goal of uniform statewide adoption has been found to be extremely difficult. Providers of mental health services across the state are in various stages of readiness, interest, and propensity for risk taking. Often early adopters are much more ready to engage in implementation. To achieve statewide implementation, the trick would be to encourage those who are hesitant to implement, and that may involve potential sanctions for not implementing. However, sanctions are not likely to win true buy-in; they may risk resistance and these organizations may expend the least possible effort necessary in implementation to avoid sanction.

Aligning Policies and Priorities:

There are significant state-level policies and systems that need to be in alignment with EBPs if a state wants to take EBPs statewide. These include data systems that can track which EBP services people receive and their outcomes. It also includes a quality improvement process and an outcome management system. For medication management, length and frequency of patient visits and medication formularies are often major issues. As part of the quality improvement process, it is important that there is a coordinated management and evaluation of the data and that the results are shared with the State Division of Mental Health and reports are quickly provided back to community clinicians and administrators.

How to Impact Practice Behavior:

Workshops that present compelling research on the effectiveness of evidence-based practices typically do not lead to implementation, nor do they necessarily encourage all persons to support EBPs. Administrators and practitioners need compelling reasons to implement beyond the strength of the research. In addition,

consumers may question the recovery base of the six EBPs and the need for randomized controlled trials (rather than qualitative studies) to prove “evidence.” Some consumers will not advocate for practices they do not feel ownership of, and didactic presentations may not create ownership. Earlier we have cited research on what impacts practice behavior. This research can significantly inform EBP training efforts.

Case in Point: Training for Medication Management:

The use of medication algorithms requires a certain level of physician education and support if they are to be used appropriately. Training should be informed by the literature on what does and doesn’t impact practice behavior¹¹⁻¹⁹. Training for stakeholders is critically important and should include strategically important competencies such as:

- *Diagnosticians:* A small number of identified personnel per agency should be trained in the use of the Structured Clinical Interview for the DSM-IV (SCID) or other structured approaches to conduct reliability checks of the diagnoses.
- *Treatment Providers:* Psychiatrists should be trained in the use of treatment algorithms and accompanying interventions (e.g., patient/family psycho-education).
- *Assessment Personnel:* The use of evidence-based Psychopharmacotherapy requires, in part, that patients are assessed across clinically relevant domains in an ongoing manner and that those data are fed back to the treatment provider to inform their clinical decision-making. Training in this outcome assessment system requires that, at minimum, assessors and psychiatrists be trained appropriately and to an acceptable level of reliability. Personnel collecting, transferring, and storing the clinical data should be trained for competency and reliability in measures. They should also receive ongoing site supervision and available consultation subsequent to initial training. The examples of these areas of measurement include:
 1. Core syndrome and related symptoms.
 2. Instrumental functioning: employment, social relations, and ADL.

3. Community tenure (versus hospitalizations).
4. Family burden.
5. Medication compliance.
6. Side Effects.
7. Cost of treatment.
8. Satisfaction.

- *Patient and Family Education:* Psychiatrists, other providers, and consumers should be trained in the use of patient and family education materials. They should also receive ongoing site supervision and available consultation subsequent to initial training.

It is important that training is not offered only at the beginning of implementation. Initial training should be supplemented with repeated “booster” sessions.

Sustaining the Practice:

A number of strategies have been found to be useful in maintaining the skills learned in training sessions and sustaining the new evidence-based service. Helpful efforts include:

1. Implement both intra- and interagency support groups.
2. Identify/obtain or develop manuals and other learning resources (videos, computer-based learning modules) to supplement training events.
3. Implement a “cascading” model of training e.g., agency staff trained will become “local experts” (train the trainer approach).
4. Identify methods for determining the fidelity of EBPP implementation. The ability to measure fidelity is necessary to ensure the transfer of training to the service delivery site.
5. The provision of feedback on fidelity should be used only as a developmental and learning tool and not as an administrative mechanism tied to negative consequences.
6. Maintenance of an evidence-based practice LISTSERVE.
7. Consider offering awards/recognition of exemplary implementation of EBPPs.

8. Publication of an EBPP newsletter to share successes/benefits and encourage research and publication by providers can be quite helpful.
9. Linkage with other states' Centers of Excellence and national project teams working in this area.
10. Quality improvement efforts including internal steering committees involving consumers, family members, clinicians, and administrators to review fidelity and outcomes. This committee offers recommendations for improving the service and develops strategic plans to achieve this goal.
11. At least one hour of client and outcome-centered supervision weekly focusing on reinforcing the specific EBP skills, and leaving administrative issues for another time.

Funding:

It is important to address the funding needs. As an example of one evidence-based practice, the major areas of cost and resource utilization for medication management are those associated with the following activities:

- Professional time (psychiatrists, other physicians, psychologists, pharmacists and/or pharmacologists, etc.).
- Other Personnel (e.g. data entry and other office personnel).
- Infrastructure support and quality control.
- Hardware and software.
- Supplies, phone/fax, administrative support for documentation needs, etc.
- Travel.
- Consultations, including on-site training and technical assistance and fidelity assessments.
- Compensation for time and/or travel for participation from advocacy group(s), consumers, and family members.

Remove other Barriers:

It is critical to identify and remove obstacles as they arise in the implementation process. Administrative support and leadership is instrumental to accomplish this goal. Barriers to the implementation of medication guidelines and algorithms have been summarized elsewhere by one of the authors²². Some of the major areas include:

1. Length of medication visit time, frequency of visits, and physician access to medications are resource issues that must be addressed for the successful implementation of medication algorithms.
2. Remove redundancies in documentation and paperwork requirements.
3. Consider electronic medical records.
4. Policies and workflow issues that prevent implementation of the model as specified.

Conclusion

A number of organizational and clinical issues have been identified in this paper relating to evidence-based practice in general and medication management in particular. Change management techniques may prove helpful in shifting complex systems. Although we have identified numerous changes that are important, both clinically and administratively, barriers are not insurmountable. For the benefit of our patients and family members, accountability and quality of care, evidence-based practices must be moved into routine services in our community mental health centers.

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THOMAS W. HESTER, M.D.



Aloha, fellow members and friends of the American Association of Psychiatric Administrators (AAPA). Welcome, "E Komo Mai", to my final President's column. In my Fall 2004 column, I described the strategic goals and associated actions that

were developed at our Executive Council meeting on May 4, 2004. These goals are: 1) Increase Visibility and Value; 2) Improve Financial Status; and 3) Expand Membership. The Executive Council has continued work on these goals during conference calls on October 7, 2004; December 9, 2004; and February 17, 2005. The current status of these goals and actions are as follows:

1. Increase Visibility and Value

- Increase publication of the AAPA NewsJournal from two (2) to (4) times annually. In spite of the excellent editorial work of Dr. Sy Saeed and sufficient number of high quality submissions, we have not yet been able to secure adequate funding either through ads or grants to support this expansion.
- Re-institute the AAPA CME Course on Administrative Psychiatry at the May APA meeting. Notwithstanding the efforts of Dr. Shiv Hatti to assemble an excellent faculty and submit a timely, revised application, our course was not accepted.
- Sponsor APA workshops. I am pleased to report that Dr. Jeanne Steiner's proposal, "Women as Leaders: Opportunities and Strategies for Success," was accepted. It is scheduled for Thursday, May 26, 11:00 a.m. – 12:30 p.m., Room B 308, Level 3, Georgia World Congress Center.

2. Improve Fiscal Status

- Drs. Doug Brandt, Barry Herman, and Shiv Hatti made numerous efforts to secure grants to support our NewsJournal. To date, we have not received notice of a grant award.

- The Council carefully prepared a budget for 2005 that is balanced. This was achieved because of anticipated lower costs for the upcoming APA meeting in Atlanta and reduced expenses for our website development and maintenance. In addition, this budget anticipates \$10,000 in revenue through grants and/or advertisements.

3. Expand Membership

- Dr. Doug Brandt's initiative to send letters of invitation for a free one-year AAPA membership to all Chief Psychiatric Residents has produced results. I would like to welcome 35 Chief Psychiatric Residents who have joined us.

As you can see, it is important that we remain focused on achieving these strategic goals and develop new actions in order to further strengthen our organization. One action under consideration by the Executive Council is to develop the CME course into a free-standing, revenue generating conference. I look forward to re-invigorating our approach to these goals at our meeting in Atlanta. Our meetings are scheduled as follows: Membership Luncheon Tuesday, May 24, 12 noon – 2:00 p.m., Embassy Suites Centennial, Legacy Ballroom A/B Main Level with Altha J. Stewart, M.D. as our speaker. The Executive Council will meet on Tuesday, May 24 at 2 p.m. at the Embassy Suites Centennial in the Studio Room.

It has been my pleasure to serve as your President. I am deeply grateful for the wonderful support I have received from the Executive Council and from Frances Roton, our Executive Director. I have especially enjoyed working with Dr. Shiv Hatti and know he has the energy, focus, skills, and dedication needed to move our organization forward as the incoming President. I look forward to seeing you in Atlanta. Thank you, "Mahalo."

VIOLENCE AND RESTRAINT REDUCTION: ONE HOSPITAL'S EXPERIENCE

Daniel W. Hardy, M.D., J.D.; Malini Patel, M.D.; Bruce Bonecutter, Ph.D; and Starr Kaplan, M.S.H.S.A.

Abstract:

This article describes the evolution of a multi-disciplinary violence and restraint reduction program at a large state psychiatric hospital. In 1995 Elgin Mental Health Center (EMHC) was a 625 bed state operated facility (SOF) with approximately 1150 employees and an average restraint usage of 1.60 hours per 1000 patient hours. By the end of fiscal 2004 (06/30/04) EMHC had 390 beds, approximately 850 employees, and an average restraint usage of 0.16 hours per 1000 patient hours. The paper explains how we accomplished a 90 per cent reduction in restraint usage and reduced patient aggression related injuries by 59 per cent, and outlines our plan for future reductions.

This article describes the evolution of a multi-disciplinary violence and restraint reduction program at a large state psychiatric hospital. In 1995 Elgin Mental Health Center (EMHC) was a 625 bed state operated facility (SOF) with approximately 1150 employees and an average restraint usage of 1.60 hours per 1000 patient hours. By the end of fiscal 2004 (06/30/04) EMHC had 390 beds, approximately 850 employees, and an average restraint usage of 0.16 hours per 1000 patient hours. The paper explains how we accomplished a 90 per cent reduction in restraint usage and reduced patient aggression related injuries by 59 per cent during a period of significant downsizing and severe financial constraints.

Step One: Identifying the problem; The Hawthorne Effect.

By the mid-1990s the use of restraints was being examined by many in the mental health field (1, 2). Our consumers were telling us that restraints were counter-therapeutic, and our data were suggesting that the process of applying restraints resulted in increased injuries to patients and staff alike. These concerns were being confirmed elsewhere (3, 4).

In 1995 our hospital administration undertook the tracking of all restraint episodes by unit and gave feedback to our staff on a quarterly basis on the number of patients, hours, and episodes of restraints. This information was benchmarked and compared with other Illinois state-operated hospital facilities. With little else accomplished beyond making staff aware of our concerns, by June, 1996 (end of FY '96), our restraint usage had fallen to 1.02

hours per 1000 patient hours, a decrease of 36 percent. It seemed obvious that if merely looking at the problem could effect a reduction of this magnitude there remained considerable room for further improvement.

Step Two: Finding our way.

What would later be recognized as the next major programmatic effort occurred in 1997 when EMHC psychiatric staff undertook to reduce violence and restraint usage by means of more assertive clinical treatment, including encouraging the appropriate use of court ordered medication. The results of the project were published in 2001 (5).

In 1998 nursing staff began debriefings of staff and patients involved in restraint episodes. Our peer reviewers were incorporating risk based information from sentinel event and critical case reviews into the peer review process, thereby identifying potentially problematic cases for contemporaneous review. A more comprehensive discussion of our peer review program was published in 2003 (6).

By the end of FY 1998 our Quality Strategies Department was tracking multiple markers and reporting regularly to EMHC medical and non-medical administrators. Restraint use for FY '98 was 0.71 hours per 1000 patient hours.

Step Three: Education, education, education.

It was imperative for clinical staff to appreciate that violence reduction equates on various levels to reduction of restraint usage. At one point we announced to a segment of our treatment staff that we intended to explore various strategies aimed at the ultimate goal of eliminating restraint usage. Staff's reaction was immediate and vociferous: It can't be done. We withdrew the suggestion. A month or so later we initiated a discussion of strategies to eliminate violence which staff warmly received. The strategies in both instances were the same.

Initial educational efforts included revising the format of our Comprehensive Psychiatric Evaluation to include specific assessment considerations of potentials for violence and suicide (See Box A, sections C and D).

Other efforts included producing a video training tape for all nursing and mental health technicians regarding early identification of and response to potentially suicidal or violent patients which is used as part of our orientation for new clinical employees; producing a video training

tape regarding the appropriate use of emergency and court ordered psychotropic medications which is now used by other state-operated hospital facilities in Illinois; ongoing CPI (Crisis Prevention Intervention) training for all direct care staff; and developing with psychology and nursing staff an on-the-job training curriculum for mental health technicians which incorporates, among other things, basic

mental status exam concepts and relaxation therapy techniques for use with patients.

In 2000 we undertook a major project in team building and promoting the role of the psychiatrist as the clinical team's leader. The results of this effort were incorporated in an article published in 2001(7).

BOX A
Comprehensive Psychiatric Evaluation

<p>A. Psychiatric History</p> <ol style="list-style-type: none"> 1. <i>Identifying Information (For forensic patients, include Legal Status and Disclosure of Limited Confidentiality)</i> 2. <i>Sources of Information and Chief Complaint</i> 3. <i>History of Present Episode of Psychiatric Illness</i> 4. <i>Past Psychiatric History *</i> 5. <i>Drug and Alcohol History (including relationship to present and past Psychiatric History)</i> 6. <i>Medical History **</i> 7. <i>Developmental History ***</i> 8. <i>Adult Psychosocial History ****</i> 9. <i>Family History</i> 10. <i>Hospital Course (if Annual Evaluation)</i> 	<p>B. Mental Status Examination</p> <ol style="list-style-type: none"> 1. <i>State of Consciousness and Orientation</i> 2. <i>General Appearance</i> 3. <i>Attitude, Cooperation and Interview Behavior</i> 4. <i>Motor Activity and Involuntary Movements</i> 5. <i>Affect and Mood</i> 6. <i>Homicidal/Suicidal Ideation</i> 7. <i>Speech and Thought Processes</i> 8. <i>Hallucinations/Delusions</i> 9. <i>Cognitive Functioning</i> 10. <i>Other</i>
<p>C. Assessment of Violence Potential *****</p> <ol style="list-style-type: none"> 1. <i>Irritation/Annoyance</i> 2. <i>Anger control problems</i> 3. <i>Anger triggers</i> 4. <i>Verbal assaults</i> 5. <i>Property damage</i> 6. <i>Physical assaults</i> 7. <i>Weapon use</i> 8. <i>Violence history</i> 9. <i>Anger control tactics</i> 10. <i>Present agitation/psychosis</i> <p><i>Analysis:</i></p>	<p>D. Assessment of Suicide Potential *****</p> <ol style="list-style-type: none"> 1. <i>Depressed or anxious mood</i> 2. <i>Agitation</i> 3. <i>Recent alcohol or substance abuse</i> 4. <i>Feelings of hopelessness, worthlessness or guilt</i> 5. <i>Vegetative signs of melancholia</i> 6. <i>Suicidal thoughts, plans, or preparations</i> 7. <i>Recent self-injurious act</i> 8. <i>Recent suicide attempt</i> 9. <i>Risk factors/Past (e.g. previous suicide attempt, family history of suicide)</i> 10. <i>Risk factors/Present (e.g. significant loss or other stressors, lack of support system)</i> <p><i>Analysis:</i></p>
<p>E. Known Risk Factors for Restraint Use (e.g. cardiac or respiratory problems, obesity, pregnancy, history of physical, sexual, or relevant psychological trauma)</p> <p>F. Other Risk Factors (e.g. arson, elopement, sexual acting out, etc.)</p> <p>G. Any Specific Age-related Issues?</p> <p>H. Patient's Strengths</p> <p>I. Diagnostic Formulation</p>	<p>J. Diagnoses (Axes I-V)</p> <p>K. Problem Identification and Treatment Recommendations</p> <p>L. For Forensic UST patients only: Fitness to Stand Trial Assessment</p>

Dictated by: _____
 Admission Annual

Date: _____

* Includes psychotropic medication treatment and compliance history

** Includes only conditions relevant to psychiatric diagnostic or present treatment considerations

*** Includes physical and sexual abuse history

**** Includes pending legal issues

***** Any "Yes" answer must be followed up with questions which will elicit details such as "How often?" "When was the last time?" and "What were the circumstances?"

Step Four: Dealing with the unexpected.

Our hospital, and other state-operated facilities in Illinois, had been experiencing gradual downsizing since the early 1980s. Staff reduction during those years had generally been accomplished by attrition. In the spring of 2002, however, the formal announcement was made that Illinois was facing a budgetary deficit of 5 billion dollars. Layoffs at EMHC were rumored, as was the closing of the hospital. The hospital's FY '03 budget was substantially reduced, and by the end of calendar '02 more than one in five members of our hospital staff had left, many taking advantage of an emergency early retirement incentive offered by the State as part of its cost-cutting measures. During the remainder of '02 staff and patients alike were regularly bidding farewell to respected colleagues and valued care-givers.

Morale at our hospital suffered. But quality clinical care was still being delivered to our patients. Our consumer specialists formalized their roles in the violence and restraint reduction effort with the adoption of WRAP (Wellness Recovery Action Plan) promoting consumer empowerment, and with administrative support an active Consumer Council was created by and for our long-term forensic patients. We missed no opportunity to remind our staff that EMHC's restraint usage and violence rates were still among the lowest in the State.

We are convinced that this project gave us a vehicle by which our clinicians could remain focused on the demonstrably positive outcomes they were achieving, and thus was critical in our hospital's ability to survive and flourish during this difficult period in our history.

Step Five: The work continues.

During 2003 our emphasis focused on promoting more active consumer involvement in treatment and discharge planning. Our clear expectation of our patients and our treatment teams is that absent special circumstances all patients will attend and contribute to their treatment staffing meetings from start to finish. Our Consumer Council has been active in promoting this effort. Our staff psychiatrists now attend, on a rotating basis, meetings of the Consumer Council where they have the opportunity to interact with their patients under more normalizing circumstances than on the units.

During fiscal '04 we began the implementation of the Illinois Medication Algorithm Project (IMAP), a variation of the Texas Medication Algorithm Project (TMAP). We also instituted a number of patient led or co-led therapy groups.

By the end of fiscal '04 our restraint usage was 0.16 hours per 1000 patient hours.

Step Six: The future.

Our hospital is presently actively engaged in implementing further non-coercive environment improvements consistent with the recommendations of the National Technical Assistance Center for State Mental Health Planning (NTAC) of the National Association of State Mental Health Program Directors (NASMHPD). This includes such modest changes as adding to our Comprehensive Psychiatric Evaluation a section on Known Risk Factors for Restraint Use (See Box A, section E), and such major efforts as effecting a meaningful change in staff culture. While not suggesting that restraints should never be used, the message we are attempting to convey is that restraints are harmful to patients and staff alike. We hope to be able to report further progress in the future.

Dr. Hardy is a Clinical Professor of Psychiatry at Loyola Stritch School of Medicine, and Medical Director of the Forensic Treatment Program at Elgin Mental Health Center; Dr. Patel is a Clinical Associate Professor of Psychiatry at Rosalind Franklin University of Medicine and Science/The Chicago Medical School, and Medical Director of Elgin Mental Health Center; Dr. Bonecutter is a Clinical Assistant Professor of Psychology in the Dept. of Psychiatry at University of Illinois at Chicago and the Executive Director of Greater Illinois North Region Network in the Illinois Dept. of Human Services; and Starr Kaplan is the Facility Risk Manager/Performance Improvement Manager at Elgin Mental Health Center, Elgin, Illinois.

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Nominating Committee Report May 2005

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ETHICAL MODELS IN PSYCHIATRIST ADMINISTRATORS

H. Steven Moffic, M.D.

In many prior columns, we discussed how psychiatrist administrators could respond to various ethical dilemmas according to our newly adopted Ethical Principles for Psychiatrist Administrators. Most of these were real life dilemmas. However helpful it may have been to consider ethical solutions to these dilemmas, we did not present any “success stories.”

Coincidentally, over the past year, the American Association of Community Psychiatrists and myself created an award called the Moffic Award for Ethical Practice in Community Psychiatry. This award was open to practitioners, administrators and others who work in community psychiatry. As it turned out, three out of the four co-awardees won for their administrative psychiatric work. Perhaps their work can serve as aspiring models of ethical ideals for psychiatrist administrators.

Two of these awardees found ways to use an administrative position to benefit populations of patients in new ways. As they did so, they also benefited their organization.

Ronald Hellman, M.D. is one of those awardees. About a decade ago, working as a staff community psychiatrist in Brooklyn, he came to realize that as much as community psychiatry had helped patients from various minority groups to receive improved care, one group seemed to fall through the cracks. That group was lesbian, gay, bisexual or transgendered (LGBT) people who were also living with chronic mental illness, thereby being doubly stigmatized. He found this to be true both locally and nationally. His solution was to begin an administrative project to correct this problem. Using LGBT-sensitive educators on staff as the key for change and overcoming resistance, by 2002 he got a LGBT Affirmative Program going. By 2002, the success of the program enabled funding for growth, creating the Rainbow Heights Club. In the last 2 years, the club has grown to 200 members, who come in from all over metropolitan New York. The program offers a full range of psychiatric, advocacy, vocational and social support services. It has studied and documented its impact in research publications, presentations and the training of graduate students.

The other awardee who helped patient care as an administrator is Maggie Bennington-Davis, M.D. Becoming Medical Director in 2001 of a psychiatric inpatient program in a general hospital, Salem Hospital in Oregon, her goals were to address the ethical challenges

of coercion and confidentiality. Adapting a trauma-influenced approach developed by Sandra Bloom, M.D. of Philadelphia, she initiated a variety of simple, yet far-reaching changes, such as staff eating with patients (and having their lunch paid for), twice-daily inpatient unit-wide meetings, extensive signage and an attempt to treating the patients with hotel-like hospitality.

Resistance was strong and Dr. Bennington-Davis had to make herself more available to lead and model these changes. At first, she debriefed every patient in seclusion or restraint, 24 hours, 7 days a week. This necessitated middle-of-the-night drives to the hospital. Results have been striking. Even with less staff with managed-care driven short stays, over a 2 year period, there was a 97% reduction in seclusion and restraint, much less injuries as well as increased staff, patient, family and police satisfaction. The success has led to consultation with other hospitals in Oregon, around the country and even internationally.

The final administrative psychiatrist awardee is David Moltz, M.D. His work has been accomplished from a variety of administrative positions and instead of directly involving patients, he has focused on helping other health professionals. Though often ignored as an ethical imperative, it is clearly stated in the Preamble to the AMA Principles of Medical Ethics: “... a body of ethical statements developed primarily for the benefit of the patient... a physician must recognize responsibility not only to patients, but also to society, other health professions, and to self.” Since administrative psychiatrists have some degree of responsibility for other health professionals, this ethical goal is especially important.

One of these administrative roles for Dr. Moltz was being on the Board of Directors for the American Association of Community Psychiatrists. While in that position, he was co-chair of the ethics committee that developed this award. He also saw a need for, and shepherded acceptance for, policies governing corporate donations, conflicts of interest and e-mail voting. Perceiving another area of relative neglect, he also co-founded the Committee for Persons with Mental Illness Behind Bars.

Locally, in Maine, he has used his administrative skills and opportunities to address several ethical challenges. They include leading review teams for State Hospital Critical Incidents and working on behalf of the NAMI Board to reach a compromise state formulary. He has

also been instrumental in leading the successful development of new projects. One was a list-serve to connect psychiatrists and process such ethical challenges as a state formulary. In addition, in order to better connect mental health and medical systems in Maine, especially in rural areas, he led the development of a “Consultation Project,” whereby primary care physicians are coupled with volunteer psychiatrists via e-mail or telephone. This has helped to address the often inadequate psychiatric skills of such physicians who have described these consultations as “like a mini-course in psychiatry.”

However, perhaps the most challenging ethical decisions made by Dr. Moltz have come when he has to choose between more administrative work and patient care for himself. As one letter of support emphasized, “he has avoided the pitfall that many psychiatrists fall into: letting their clinical competence paradoxically pull them away from clinical work to become administrators.” Although he was a long-time Medical Director at a community mental health setting, he turned down an opportunity to become Mental Health Commissioner in Maine in order to stay closely involved with patients and families.

Conclusions

These award-winning administrative psychiatrists provide several examples of how to address administrative ethical challenges. One common theme is finding way to adhere to the highest ethical standards of patient care, while at the same time not unduly jeopardizing an organization and not increasing direct costs. Related to that is a common theme of seeing where gaps in service or education for populations exist and then trying to find creative and innovative solutions. All the awardees seem to show humility and respect for others.

There are certainly many other examples that would be worth knowing. If you know of someone who has made a contribution to ethical administrative psychiatry, please let me know (smoffic@mail.mcw.edu). If we receive enough replies, we will present them in future columns or even set up another award!

Dr. Moffic is a professor in the Department of Psychiatry & Behavioral Medicine, as well as in the Department of Family and Community Medicine, at the Medical College of Wisconsin. He is the Ethics Column Editor for the Psychiatrist Administrator and Chair of AAPA Ethics Committee.

Invitation for Comments

We are indebted to Steve Moffic for his continued contributions to our journal and to our field. As any thought provoking article would, this article triggered several thoughts for me. Being a psychiatrist administrator, and as someone who believes that more psychiatrists should be in the leadership roles in the behavioral healthcare systems, I am not sure what to make of the following section in the article:

[to this author(Dr. Moffic)] “perhaps the most challenging ethical decisions made by Dr. Moltz have come when he has to choose between more administrative work and patient care for himself. As one letter of support emphasized, ‘he has avoided the pitfall that many psychiatrists fall into: letting their clinical competence paradoxically pull them away from clinical work to become administrators’. Although he was a long-time Medical Director at a community mental health setting, he turned down an opportunity to become Mental Health Commissioner in Maine in order to stay closely involved with patients and families”.

I think, this section refers to our different obligations to us, society, and patients (all in the AMA Preamble). Over time, one or the other may take precedence for any individual psychiatrist. Some may feel that they can do more good at the systems level. Some may feel that they can do best by keeping some strong involvement in direct patient care. Indeed many psychiatrist administrators feel that it is important to them, personally and professionally, to always keep seeing patients in any system for which they have administrative responsibility. Should this be the norm? I would like to invite our readership to comment on this. I think this topic might be a good one to explore in a future article.

Sy Saeed, M.D.
Editor

The 2005 “*Career Administrative Psychiatry Award*” and other Updates from the APA Committee on Psychiatric Administration and Management (CPAM)

Stuart B. Silver, MD

We look forward to having a large and enthusiastic attendance with participation by members of the American Association of Psychiatric Administrators at the 2005 Award Lecture entitled “Administrative Adventures in Public Psychiatry: 1967-2005.” The lecture will take place at the Atlanta APA Annual Meeting on Monday, May 23, 2005 between: 9:00AM and 10:30AM. The location will be at the Georgia World Congress Center, Level 4, Room A412.

The speaker will be the 2005 recipient of the award, Gabriel Koz, M.D, Professor of Psychiatry at both New York University School of Medicine and the Eastern Virginia Medical School. He is currently the Hospital Medical Director at historic Eastern State Hospital of Williamsburg, Virginia. His career has spanned forty years of public service, scholarship, leadership, and teaching. From Lincoln Hospital in the South Bronx of the 1960s to the consolidation of the Manhattan Psychiatric Center, Dr. Koz has been the psychiatrist on the spot to make things work. He was cited by Dr. Ezra Griffith as “... the man from South Africa who was so at ease living out the principle that everyone deserved outstanding health care. And systems should be competently organized to deliver that care.” We all will benefit from the perspective of a man whose experiences have been forged in some of our most difficult care settings and during some of our most turbulent times.

We feel proud to be able to honor Dr. Koz who indeed exemplifies the award definition - “a nationally recognized clinician-executive whose effectiveness as an administrator of a major mental health program has expanded the body of knowledge concerning management of mental health services delivery systems, and whose effectiveness has made it possible for him/her to function as a role model for other psychiatrists.”

The written examination combining multiple choice and brief essay questions will be administered for the fourth

time on the afternoon of Monday, May 23, 2005 at the annual meeting of the APA in Atlanta. The deadline for applications has passed, but those interested in next year’s examination should be in touch with Mark Anderson, the committee liaison, at MAnderson@psych.org.

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.

Prospective candidates for the examination 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 to sit for the examination.

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

LITERATURE SCAN

The *Literature Scan* is our regular column that reviews recent literature of interest to administrators in behavioral health care systems. The column covers a period of approximately 6 months. Papers are selected on such topics as administration, consumer satisfaction, delivery of health care, education, efficacy, ethics, evidence-based practice, leadership, and management. The daily demands of administration and practice often leave little time for browsing journals. It's our hope that this column may fill the gap.

Chou JC-Y. Review and Update of the American Psychiatric Association Practice Guideline for Bipolar Disorder. *Primary Psychiatry*. 2004 Sep; 11(9):73-84. (Review)

This article summarizes the recommendations in the 2002 APA bipolar practice guideline and reviews new relevant research available since its publication. New research on antipsychotics is reviewed, the concept of directional efficacy of mood stabilizers is discussed and expanded, and the importance of understanding the research basis of the guideline before applying its recommendations to clinical practice is described.

Foster EM, Connor T. Public Costs of Better Mental Health Services for Children and Adolescents. *Psychiatric Services* 2005 Jan; 56(1):50-55.

Preliminary analyses in this study revealed that mental health services delivered as part of a system-of-care approach are more expensive. However, when expenditures in other sectors were incorporated, the gap in expenditures was reduced from 81 to 18 percent. The authors suggest that reduced expenditures in other sectors that serve youths, such as the juvenile justice system and the child welfare system, offset the cost of improved mental health services.

Harmon JS, Edlund MJ, Fortney JC. Disparities in the Adequacy of Depression Treatment in the United States. *Psychiatric Services* 2004 Dec; 55(12):1379-1408.

The purpose of this study was to assess whether disparities in depression treatment are due to differences in rates of treatment initiation or to differences in the quality of treatment once treatment has been initiated. Data were analyzed for the role of age, race or ethnicity, and type of insurance on rates of initiation of depression treatment for persons with self-reported depression and on rates of adequate treatment for those receiving treatment. The study concluded that disparities in depression treatment appear to be due mainly to differences in rates of initiation of depression treatment, given that rates of adequate care generally did not differ once treatment was initiated.

Henry AD, Lucca AM, Banks S, Simon L, Page S. Inpatient Hospitalizations and Emergency Service Visits Among Participants in an Individual Placement and Support (IPS) Model Program. *Mental Health Services Research* 2004 Dec; 6(4):227-37.

The authors examined inpatient hospitalizations and emergency service visits among clients with serious mental illness in supported employment (SE) programs based on the Individual Placement and Support (IPS) model. Only IPS/SE clients who were also high in regular mental health services had less hospitalization and emergency visits than matched controls.

Hirshbein LD. History, Memory, and Profession: A View of American Psychiatry Through APA Presidential Addresses, 1883-2003. *American Journal of Psychiatry* 2004 Oct; 161(10):1755-63. (Review)

The address of the retiring president of the American Psychiatric Association has been a traditional part of the annual meeting since 1883 and has become an opportunity for the president to reflect on the state of the profession by engaging with the history of psychiatry over time and the story of its future.

Kilbourne AM, Schulberg HC, Post EP, Rollman BL, Belnap BH, Pincus HA. Translating Evidence-Based Depression Management Services to Community-Based Primary Care Practices. *The Milbank Quarterly*. 2004; 82(4):631-59.

This article discusses barriers to introducing and sustaining evidence-based depression management services in community-based primary care practices and suggests organizational and financial solutions based on the Robert Wood Johnson Foundation Depression in Primary Care Program. It focuses on strategies to improve depression care and discusses the challenges involved given the structural, financial, and cultural differences between mental health and general medical care.

Liberman RP. Drug and Psychosocial Curricula for Psychiatry Residents for Treatment of Schizophrenia. Part I. *Psychiatric Services* 2004 Nov; 55(11):1217-19. Part II. *Psychiatric Services* 2005 Jan; 56(1):28-30.

The November column proposed a curriculum on the pharmacotherapy of schizophrenia for psychiatry residents that is based on empirically validated research, treatment guidelines, and algorithms. The January column proposes a competency-based curriculum on the psychosocial treatment of persons with serious and persistent mental disorders. The curricula draw from two national consensus panels that identified 11 core competencies for the effective treatment and rehabilitation of persons with serious mental illness.

Olfson M, Marcus SC, Wan GJ, and Geissler EC. National Trends in the Outpatient Treatment of Anxiety Disorders. *Journal of Clinical Psychiatry*. 2004 Sep; 65(9):1166-73.

This article examined changes in outpatient treatment of anxiety disorders in the U.S. between 1987 and 1999. The rates of treatment, psychotropic medication use, psychotherapy, number of outpatient treatment visits, type of provider, and source of payment were determined. The study found an increase in the proportion of the population who receive outpatient treatment for anxiety disorders, greater use of psychotropic medications, but no significant trends toward less common use of psychotherapy.

Power K, DeMartino R. Co-occurring Disorders and Achieving Recovery: The Substance Abuse and Mental Health Services Administration Perspective.

Biological Psychiatry 2004 Nov 15; 56(10):721-22. The authors review the charge of the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA includes three centers that engage in program activities focusing on substance abuse treatment, mental health services, and substance abuse prevention. Although SAMHSA doesn't engage in research, it attempts to translate the science of research into programmatic services and supports for providers on the front lines of service delivery.

Sierles FS, Vergare MJ, Hojat M, and Gonnella JS. Academic Performance of Psychiatrists Compared to Other Specialists Before, During, and After Medical School. *American Journal of Psychiatry*. 2004 Aug; 161(8):1477-82.

Compared to other physicians, psychiatrists scored higher on measures of verbal ability and general information before medical school and on evaluations of knowledge and skills in behavioral sciences during medical school, but they scored lower on United States Medical Licensing Examinations (USMLE) Step 3. Participants included 5,701 physicians who graduated between 1970-2001. The results generally confirmed the authors' expectations and they call for more attention to the general medical education of psychiatrists.

Stein MB, Sherbourne CD, Craske MG, Means-Christensen A, Bystritsky A, Katon W, Sullivan G, and Roy-Byrne PP. [Quality Care for Primary Care Patients With Anxiety Disorders.] *American Journal of Psychiatry* 2004 Dec; 161(12):2230-37.

This study evaluated the quality of care provided to 366 primary care outpatients with anxiety disorders in university-affiliated clinics. Based on the results, which showed that quality of care was rated moderate to low, the authors recommended that practice guidelines and implementation of quality improvement programs are needed for anxiety disorders in primary care.

Strine TW, Chapman DP, Kobau R, Balluz L, Mokdad AH. Depression, Anxiety, and Physical Impairments and Quality of Life in the U.S. Noninstitutionalized Population. *Psychiatric Services* 2004 Dec; 55(12):1408-13.

The authors found that mental health impairment is strongly associated with reduced health-related quality of life and health behaviors, frequently at levels equal to or exceeding those of physical health impairments. Based on the prediction that depression will be second only to heart disease as a source of burden of disease by 2020, a better understanding of barriers to the recognition and treatment of depression appears vital to increasing the quality and duration of life for the U.S. population.

Swartz MS, Swanson JW. Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data? *Canadian Journal of Psychiatry*. 2004 Sep;49(9):585-91. (Review)

This paper reviews the empirical literature on the effectiveness of involuntary outpatient commitment. Taken as a whole, existing naturalistic and quasi-experimental studies moderately support the view that the procedure is effective, however these studies have methodological limitations. Two randomized controlled trials have conflicting findings and are reviewed in detail. The policy remains controversial.

MANUSCRIPT REVIEWERS:

Psychiatrist Administrator is currently seeking psychiatrists interested in serving as a manuscript reviewers for the journal. If you are interested in serving in this capacity, please contact (or send inquiries to):

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Treatment for Adolescents with Depression Study (TADS) Team. Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents with Depression. *JAMA*. 2004 Aug 18;292(7):807-20.

The objective of this randomized controlled trial was to evaluate the effectiveness of four treatments among adolescents with major depressive disorder. The combination of fluoxetine with cognitive-behavioral therapy offered the most favorable tradeoff between benefit and risk for adolescents. An accompanying *JAMA* editorial comments on the contributions of the trial with special emphasis on the recent controversial safety concerns regarding treating adolescents with depression.

Jo Dorsch is the Health Sciences Librarian at the Library of the Health Sciences-Peoria, University of Illinois at Chicago, where she is also an associate professor with an adjunct appointment in the College of Medicine.

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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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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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).

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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.

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AAPA MEMBERSHIP LUNCHEON

Tuesday, May 24

12 noon - 2:00 p.m.

Embassy Suites Centennial

Legacy Ballroom A/B

Altha J. Stewart, M.D. - Guest Speaker

“Administrative Psychiatrists in the 21st Century: Challenges and Opportunities”

AAPA COUNCIL MEETING

Tuesday, May 24

2:00 p.m. - 5:00 p.m.

Embassy Suites Centennial

Studio - Main Level

AAPA SPONSORED WORKSHOP

“Women as Leaders: Opportunities and Strategies for Success”

Thursday, May 26

11:00 a.m. - 12:30 p.m.

Room B308 Level 3

Georgia World Congress Center

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