

PROCEEDINGS

2004 Best Practices Symposium

**NASMHPD Medical Directors Council and the
NASMHPD Research Institute, Inc.
in joint sponsorship with the
Missouri Institute of Mental Health
University of Missouri -- Columbia School of Medicine**

*Transforming Knowledge and Research into Practice
in the Public Mental Health Sector*

*Focus on: Pharmaceuticals...Pricing & Acquisition,
Use of Mortality Data, Creating Recovery Facilitating Systems of Care, and
Prevention Strategies for SMHAs*

**October 4-5, 2004
Savannah, Georgia**

Monday, October 4, 2004

Welcome, Opening Remarks and Discussion

*Panelists: Robert W. Glover, Ph.D. Executive Director
National Association of State Mental Health Program Directors
Alexandria, Virginia*

*Joseph Parks, M.D., Medical Director
Department of Mental Health, State of Missouri and
Chairperson, NASMHPD Medical Directors Council*

Dr. Glover opened the Symposium with an update on NASMHPD activities and an overview of important issues to state mental health commissioners. He announced that eight states will receive CMHS state incentive grants to reduce seclusion and restraint; three states--Washington, Hawaii and Massachusetts--have been approved to receive the grants thus far. In addition, NASMHPD was recently awarded a contract to operate the Seclusion and Restraint Technical Assistance Center funded by CMHS for the three years. NASMHPD will work with states that receive the state incentive grants, and hopefully with broader learning communities, to affect change in use of seclusion and restraint. The TA Center also will collect uniform data on seclusion and restraint use and publish the aggregate data.

Dr. Glover highlighted several issues of interest to commissioners, some of which will be addressed at the summer 2005 commissioners meeting, including:

- *The interface between the criminal and juvenile justice systems and state mental health systems.* Twenty-eight percent of the beds in state mental hospitals now serve forensic patients, and sexually violent predators account for a rising percentage of that population. At the same time, the number of acute care beds in the community is diminishing.
- *The relationship between health and mental health.* Particularly as state agencies reorganize and mental health is folded into the overall public health agency, Commissioners are increasing their focus on the link between health and mental health, including the relationship with morbidity. Technical reports developed by the Medical Directors Council have encouraged this focus.
- *Suicide prevention.* Suicide prevention is a growing concern, and has greater national visibility as a result of the final report issued by the President's New Freedom Commission on Mental Health. NASMHPD recently became a subcontractor to the nationwide, toll-free suicide prevention hotline and will assist with network development. In addition, recent passage of the Garrett Lee Smith Memorial Act will direct funds to youth suicide prevention and state suicide prevention planning. NASMHPD has invited Oregon's Senator Gordon Smith, who was instrumental in the bill's passage, to its winter commissioners meeting, as well as representatives from the Suicide Prevention Action Network (SPAN USA). In November, NASMHPD will give a presentation on youth suicide prevention for eight states in collaboration with the Association of State and Territorial Health Officers in Chicago.
- *Medication.* Medication continues to be a high priority due to its high cost and proposed Federal changes that may inhibit access to medications. With the rule changes, persons discharged from state mental hospitals may have greater difficulty maintaining their medication regimens in the community. In addition, several states are trying to cut access to behavioral health medications under Medicaid.
- *Co-occurring disorders.* Co-occurring disorders may involve mental illness and substance abuse (MISA) or developmental disabilities and mental illness (DDMI). Multiple systems serve these MISA and DDMI individuals, including the criminal justice system. There is a tendency for each system to downplay responsibility for people with co-occurring disorders. Dr. Glover noted that NASMHPD recently completed a report that included recommendations that came out of an experts' meeting on DDMI individuals; the report is now available on the NASMHPD Web site.
- *Implementing the agenda of President's Commission on Mental Health.* While little new funding is available, SAMHSA/CMHS is coming out with an action plan in response to the goals outlined by the President's Commission. The action plan is expected to include objectives aimed at breaking down the silos that exist among agencies and eliminating eligibility barriers for services needed by individuals with mental illnesses. Dr. Glover noted the challenge of implementing such an action plan,

including the call to expand public sector mental health services, at a time when state Medicaid programs are facing significant cuts. He reported that four of the 16 Commission's subcommittee reports have been released and are available on SAMSHA's Web site: rural health, acute care, criminal justice and housing. In response to the Commission's final report, the only new money of significance for state mental health initiatives is state incentive grants for mental health planning and perhaps funding for criminal justice systems to develop mental health courts and other diversion programs.

- *Work force and budget issues.* Long-time commissioners are expressing great concern about recruiting and retaining competent people in their state systems. Recruiting psychiatrists is a major problem, especially psychiatrists who specialize in specific areas or populations. Recruiting and retaining qualified people for residential programs in the community is also difficult. The pay is low, work is tough, and turnover is high. Another concern is that education and training programs do not adequately prepare people to work in the public sector. Public sector work force and budget issues are closely related. Noting that that new commissioners seek strategies for how to deal with budget cuts, Dr. Glover indicated that NASMHPD produced the paper *Closing the Gap* on this issue and may do further work.

Dr. Glover also reported on a development that affects funding for the Medical Directors Council meeting and reports. In the past pharmacy companies have underwritten the costs of some of the medical directors' meetings and report production. Concerns about conflicts of interest have caused drug companies to pull-back and institute lengthy review processes for their funding decisions. Given these constraints, NASMHPD is seeking funding for next year's Symposium, and will only be able to fund one medical directors report in 2005 (instead of two).

Dr. Parks, Chair of the Medical Directors Council, proposed several alternatives to producing in-depth technical reports, including issue papers. Another option is for medical directors who share an interest in a subject to work together to generate an issue paper or a "technical report light." He pointed out that the biggest expense of the technical reports is the meeting and travel cost to host the consensus meeting. He asked the medical directors to think about topics for future reports that would lend themselves to being completed in different formats (e.g., an approach where parties collaborated and communicated by phone or e-mail).

Noting that a work force task force had formed in his state and was seeking data, one participant asked whether there were any databases that documented mental health work force issues. Dr. Glover indicated that the NASMHPD Research Institute, Inc. conducted a state survey a while ago, but focused more on the community work force. Another group is examining the interplay between work forces in public mental health and veterans' facilities. However, there is no coordinated effort studying work force issues at this time. Per Dr. Glover's request, medical directors then compiled a list of the major work force concerns. The list included:

- Training across disciplines and sustainability of that training;
- Recruiting and retention, especially in substance abuse;
- Lack of people to work on acute units;
- Shortage of child specialists, especially psychiatrists;
- A shortage of trained staff in rural areas;
- Prohibitive malpractice rates;
- Need for updated curricula in public mental health for medical schools, psychology and social work programs;
- Lack of competitive salaries;
- Safety issues with forensic populations;
- Role of physician extenders;
- Pre-degree and post-degree training;
- Excellence among all clinical staff;
- Need for more community workers;
- Case manager turnover and salaries;
- Lack of compensation for psychiatrists to supervise or provide training, which reduces the quality of training for staff;
- J-1 visas;
- Lack of funds to support interdisciplinary teams;
- Impact of unionized work force (and impact when union jobs disappear due to hospital closing); and
- Budget cuts which reduce training support.

NASMHPD is considering forming a work force task force, and Dr. Glover suggested that any medical directors interested in serving on that task force contact himself or Dr. Parks.

Pharmaceuticals: Pricing & Acquisition

*Section Moderator/Presenter: Joseph Parks, M.D.
(Commonwealth of Missouri)*

*Presenters: James J. Hill
Vice President for Pharmaceutical Contracting
Express Scripts*

*Neal Adams, M.D.
Medical Director, Adult Services
Department of Mental Health
State of California*

Mr. Hill opened his presentation by showing the historic and projected per member increases in pharmacy costs for health insurance plans and other payers from 2001 through 2007 for major therapy classes. Costs are rising at a rate of about 17.5 percent a year and seem to be accelerating. As a result, Pharmaceutical Benefit Managers (PBMs)

have to work harder to get the best possible prices for the most cost-effective available therapies. He also explained the key acronyms associated with the pricing process:

- AWP--Average Wholesale Price: AWP represents the average price at which wholesalers sell drugs to customers, including physicians and pharmacies. It is the most commonly used figure used by pharmacies and PBMs as a cost basis for pricing prescriptions. AWP is not set by manufacturers; it is established by a third-party, national reporting agency that collects and publishes pharmaceutical pricing data.
- WAC--Wholesale Acquisition Cost: This is the price that a wholesale supplier pays to the pharmaceutical manufacturer when purchasing pharmaceuticals.
- AMP--Average Manufacturer Price: AMP is the average price paid by wholesalers for products distributed to the retail class of trade. Mr. Hill explained that there are many classes of trade, such as retail, PBMs, and hospitals. Each class of trade has its own prices, and one class cannot purchase products at the price set for another class.
- ASP--Average Sales Price: ASP is the weighted average sales price across all payers (except Federal entities and hospitals) for a particular pharmaceutical, net of all discounts and rebates that accrue to the purchaser. Mr. Hill noted that the plan is to use ASP to calculate reimbursements under the Medicare Prescription Drug Improvement and Modernization Act. However, determining ASP will be very difficult; it will require knowing every current discount or rebate or pricing arrangement in place. Due to this complexity and lack of standard calculation, the use of ASP is being fought, particularly by private physicians who dispense prescriptions and whose reimbursement levels will change dramatically under the new system. ASP is due to begin January 2006, and Mr. Hill predicted that the government may need to step in and set ASP.

Mr. Hill also described the Federal Supply Schedule (FSS) for vendors doing business with the Federal government. If pharmaceutical manufacturers do not participate in the FSS, they cannot sell to the Federal government, the country's biggest purchaser of health care. Mr. Hill explained the two pricing schemes under the FSS; "Big Four" and dual pricing. "Big Four" pricing is based on the Veterans' Health Care Act of 1992 and is available to the Veterans Administration, the Department of Defense, the Indian Health Service, and the U.S. Coast Guard. Dual pricing is available to all government agencies other than the Big Four and says the Government must pay the lowest favored commercial customer price.

In reply to a question, Mr. Hill clarified that Medicaid falls under a different law, the Omnibus Reconciliation Budget Act of 1990 (OBRA 90). The price set by OBRA 90 is AWP less at least 15.1 percent. OBRA 90 also specifies that, if vendors sell to any entity at a discount deeper than 15.1 percent, the government must be given the same discount. However, as a result of CMS waivers, Medicaid plans often have deeper discounts than the OBRA rate of 15.1 percent. The average Medicaid discount is closer to 22.5 percent.

The discounts under the FSS are even deeper. The Big Four discount is close to 50 percent. There are two schools of thought about "leveling the playing field" for Medicaid. One thought is that Medicaid should go on the Federal Supply Schedule. The other is that OBRA 90 should be amended to get rid of supplemental rebates and change the discount rate to a straight 22 - 24 percent rate.

The Role of PBMs in the Pharmaceutical Marketplace. PBMs are designed to make drugs more affordable and safer. A cash-paying customer, with no medical insurance or available discounts, pays the market price for a drug. Mr. Hill remarked that cash transactions (i.e. unsubsidized direct transactions between customers and pharmacists) now account for only 20 percent of pharmaceutical consumer transactions. The rest are covered by Medicaid or other third party payers. Once implemented, the Medicare prescription drug program will eliminate almost all cash pharmacy business.

For a customer using a PBM prescription card, the cost to the third-party payer is discounted by 20 to 25 percent after the co-pay. The discount for mail prescriptions is even deeper.

Illustrating how PBMs enhance the safety, Mr. Hill shared that PBMs frequently generate drug-related warnings or clinical messages at the point-of-sale. Warnings may include therapeutic duplication, high dose warnings, drug age warnings, drug-drug interaction warnings, and pregnancy warnings. These edits result in a reversal of 10 percent of claims.

How PBMs Price Drugs. PBM prices are based on AWP and WAC and are the net of pharmaceutical manufacturer's rebates and retail pharmacy discounts. The manufacturer's rebate is based on the type of contract the manufacturer has with the PBM, and there are a variety of different contracts, including the following:

Formulary access rebate. Under this contract, the manufacturer pays a flat rebate for having its drug on the Preferred Drug List (PDL) or formulary. This type of contract is very rare.

Market share-driven contracts. Mr. Hill indicated that most contracts are based upon performance against a national market benchmark. These contracts may include (1) static tiers, whereby rebates are paid based on achieving defined market share tiers, and the higher the tier, the higher the rebate; (2) national market share, whereby if a PBM's distribution of a drug matches national market share, it receives a certain rebate (e.g., four percent); achieving better than national market share results in higher rebates (e.g., each successive performance tier is worth an additional two percent rebate); and (3) national market share tiers plus restricted access, whereby distribution of a drug on a restricted formulary (e.g., one or two drugs in a class) results in higher rebates than just achieving national market share or the successive tiers.

Bid Matrix Contract. In a bid matrix contract, rebates are based on formulary position and benefit design. The benefit design must restrict access and also have a financial incentive for members to use the products listed on the formulary (e.g., differential co pays for formulary and non-formulary products). Thus, rebates vary within the matrix, ranging from smaller rebates for open benefits with all manufacturers to higher rebates for closed formularies with exclusive manufacturer arrangements. Mr. Hill indicated that other requirements can be added to the matrix to encourage use of formulary drugs, but more complex designs make these contracts more complicated and thus more expensive for PBMs to manage. A PBM's biggest costs are data system costs, which run into the hundreds of millions of dollars.

Drug Transaction Flow. Mr. Hill presented a graphic representation of the complicated drug transaction flow involving pharmaceutical manufacturers (often referred to collectively as Pharma), wholesalers, retailers, patients, plan sponsors (end payers), PBMs (who generally own their own mail order facilities), and data purchasers.

1. Retailers purchase pharmaceuticals from either wholesalers or manufacturers. Large retail chains with their own warehouses typically purchase directly from Pharma.
2. PBMs purchase drugs for mail-order. Most PBMs purchase brand name drugs from wholesalers because the prices are better. Some large PBMs, however, will negotiate directly with Pharma, particularly for generic medications.
3. The patient goes to the pharmacy to fill the prescription or sends the prescription to a mail-order pharmacy. The transaction is routed to the PBM, which checks on 32 different data elements, including pricing information, drug interactions or allergies, and then sends an almost instantaneous reply as to whether the drug is covered and what the patient should be charged.
4. Once the prescription is filled, the PBM invoices the plan sponsor. Depending on the negotiated contract, the plan sponsor will pay the amount of the drug, any clinical program fee, and an administrative fee to the PBM for the transaction. After receiving payment from the plan sponsor, the PBM pays the pharmacy.
5. Once the pharmacy is paid, the PBM bills the manufacturers for rebates. Once the rebates are paid, the PBM allocates the rebate to the various client plans based upon the provisions in each plan's contract.
6. PBM the supplies member de-identified data to national data collection agencies. These agencies collect all transaction data and issue reports on national market share. These reports help PBMs determine how they perform across the nation.

Mr. Hill remarked that Express Scripts processes about 75 million prescription claims on a quarterly basis. Overall, Medicaid accounts for about 20 percent of retail claims. The Veterans Administration and Department of Defense (DOD) are the biggest purchasers in the world. Express Scripts now processes all of DOD's claims (mail-in and retail), representing about 12 million claims per quarter. When the Medicare prescription drug program begins, the Federal government will pay for close to 50 percent of all pharmacy claims.

Dr. Adams, California's medical director, presented information on pharmaceutical pricing and acquisition in California. Dr. Adams serves as the chairman of the state's Common Drug Formulary Committee, a committee formed to better manage the state's pharmacotherapy and costs.

Given California's tremendous variety among its 56 counties, generalizations about the state's mental health system are difficult. The system is very decentralized and county-driven. The county governments are responsible for outpatient, inpatient and jail-based services. The state mental health authority operates the state mental hospitals and provides services in some prisons.

In the county-based outpatient system, the state's Medicaid program Medi-Cal, is central to service delivery, reimbursement to counties, and pharmacy benefits. Currently the cost of second generation antipsychotics is over 500 million dollars and growing. The reasons are polypharmacy, expanded indications, high levels of use in primary care and Special Needs Facilities (SNFs), and inappropriate use. As a result, Medi-Cal is moving toward an algorithmic approach for second generation antipsychotic to stave off closed formularies and prior authorization requirements.

Dr. Adams explained that care providers need to consider not only the *price* of the medications, but also the *cost* of treatment. For example, second generation antipsychotics involve ancillary costs related to treating side effects, additional medications when efficacy is suboptimal, laboratory monitoring, medical care to manage co-morbid conditions, as well as psychosocial treatment. The price of the medication is just one component of the overall treatment cost.

Dr. Adams acknowledged the public sector's real concern about the very expensive price of psychiatric medications, which is wreaking havoc on public budgets and threatening access to medication. There is also the risk that funds for psychosocial treatment and other services will be diverted to pay for biological treatments. Dr. Adams asserted that health care administrators must do more than simply manage the medication budget. Decision makers need to think about how to best manage and use the limited resources available for people with chronic diseases.

As much as 60 to 80 percent of the population served by counties is covered by Medi-Cal, including their pharmacy costs. The rest of the county population must be cared for with general funds. In the state hospital system, pharmacotherapy is paid for only by general funds. Counties commonly rely on the use of samples to cover clients who do not have Medi-Cal; some county medical directors claim that if samples were not available, the medication needs of many patients could not be met. However, these types of practices perpetuate current inequities. Dr. Adams maintained that samples and patient assistance programs (pharmaceutical companies offering limited supplies of free medications to low-income people), as well as gratuities provided to potential purchasers by drug companies, are all embedded in the high prices of drugs. Providers are caught in a vicious circle – depending on the pharmaceutical companies to support activities for

which other funds are not available, yet inadvertently contributing to the high cost of drugs.

The rising cost of drugs has important implications for service delivery, including a significant risk of developing different classes of care. People with resources will have continued access to the second generation antipsychotics. People on public assistance may be treated with first generation antipsychotics or generics, while others with no resources may receive no care at all. In New Mexico, for example, there is no public pharmacy benefit for low income people who do not qualify for Medicaid. Another possible implication is the reduction of other services in order to preserve open formularies.

California's Tier System. In response to a legislative mandate, California is implementing a tier system approach for drug acquisition. State law required five state agencies (mental health, corrections, developmental disabilities, youth authority; and the state university system) to form a purchasing cooperative--the Common Drug Formulary Committee--and establish a common drug formulary. The law also permitted the Department of General Services (DGS), which would be the purchasing agent for the common drug formulary, to engage a PBM, if necessary, to improve pricing and purchasing.

Aiming to develop an alternative to market share pricing, the Common Drug Formulary Committee developed a tier system in which drugs would be assigned to one of two tiers. Tier one drugs were the first-selection drugs. All the drugs in tier one must be tried before moving to tier two unless there are specific clinical indications.

The Committee had to consider both clinical and budget issues when developing the tiers. The tiers were designed to provide an incentive for negotiating with manufacturers, and not intended to interrupt ongoing pharmaceutical treatment. Thus, the tier system is invoked when patients begin medication or their medication is changed.

All physicians had to be trained in the tier system. During the implementation stage, there have been issues with monitoring compliance; monitoring has been especially difficult in the corrections system. The system has been in place for a year and a half, and cost effectiveness data are not available yet. However, Dr. Adams said that the state has been able to obtain better medication prices and been more successful at discounting.

After examining average daily costs and penetration rates for medications and then negotiating discounts and rebates with various manufacturers, the Committee ended up putting all medications into tier one except for Seroquel. Seroquel was eventually moved into tier one after further discussions. A significant factor in the decision was that the Departments of Mental Health, Developmental Disabilities and the Department of Corrections use antipsychotics very differently, with one department using Seroquel more frequently. The difference in Seroquel usage dramatized a fundamental challenge in the purchasing cooperative approach: reconciling differences among five agencies in terms of population, management style, and quality of care issues.

Dr. Adams also discussed next steps for the California initiative. While the legislative mandate allows counties to participate in the purchasing cooperative, DGS maintains it does not have sufficient staff to incorporate them into effort. Dr. Adams hopes to involve the counties in the future to give them some financial relief, and also to utilize their purchasing power to increase the Committee's leverage with the drug companies.

He also believes that the Committee should try a three tier system. The Committee has been successful in obtaining better prices from drug manufacturers, but needs to maintain the bargaining pressure. One risk is that the California legislature or state finance department may determine the current approach is not working and require a PBM. Dr. Adams pointed out that PBMs typically implement restricted formularies, market share based agreements, and prior authorization. That approach is not advisable clinically and could exacerbate current recruitment and retention challenges by making the system more constrained.

If physicians and decision makers in the treatment community accept the premise that price is *the* critical factor, they need to stop acting in ways that inflate the cost of medications. They need to refuse gratuities and not permit detailing, as these practices encourage increased use of drugs. They need to monitor utilization, purchase episodes of care, share some of the risk involved with pharmaceutical companies, and work to flatten the price of these medications. The public sector is the primary market for antipsychotic drugs. With similar clinical and administrative concerns, public sector decision makers should come together as a buying bloc and collectively determine ways to address the high cost of medications.

Dr. Adams suggested that the Medical Directors Council was a good group to tackle this initiative. Five state agencies in California do not constitute a large enough group to bring about significant change. One of the challenges would be determining per episode treatment cost, requiring a data system that could provide data for that calculation. Dr Adams concluded by asking for input from medical directors on dealing with the issue of better managing the costs of pharmacotherapy while preserving open access.

Medical directors engaged in a lengthy discussion after the two presentations. One commenter called for a broader view of treatment. At one time most other treatments were more expensive than drugs, such as psychotherapy, housing, hospitalization, assertive community treatment (ACT), and vocational rehabilitation. Medications used to cost only a few cents per day, so they were the primary form of treatment. Today, the annual cost for medication can range \$3,000 to \$6,000 per patient. Yet, there has been little to no impact on the rates of homelessness, hospitalization, involvement with the criminal justice system or other serious social problems. Instead the drug companies have been enriched and new class of side-effects may have been created (e.g., diabetes). He suggested that the Medical Directors Council develop a position paper addressing these pricing issues and the need to give clients choices about how their treatment dollars are spent.

Another participant asserted that the treatment community needs to look at ethical issues and take a stand on the money that Pharma spends on detailing, education programs and grants, which contributes to why drugs are so expensive. The position paper also could address these ethical issues and the need to find other ways to finance education programs and other activities.

One person reported that the Center for Evidenced-Based Policy is examining different classes of medication, systematically and objectively trying to identify differences among them. The Center is working with ten other states, including the state Medicaid office, to develop the study. However, the process has been slow, particularly as the pharmaceutical industry has been unwilling to share many of its studies. Until there is a broad registry of clinical drug trials available, any group that wants to evaluate drug efficacy will have limited data with which to work.

Buying medications based on disease episodes also was discussed. Missouri has used that approach by funding slots for people on Clozapine. Mr. Hill's presentation indicated that the Federal government may need to be involved in the slot approach, so as to not to run afoul of Medicaid best price equivalent rules and risk litigation.

The discussion prompted participants to think about the different public systems paying for psychiatric medications, and the challenge of maintaining continuity of care among the various systems. Dr. Parks added that states with political will can address this fragmentation issue. The challenge is figuring out how to build the necessary political will, perhaps another topic to be addressed in a Medical Directors Council position statement.

Another participant asserted that, over the long term, drug companies cannot continue raising drug prices 17 percent per year. With Medicare paying a large part of the nation's medical bills, the government is going to become increasingly concerned about "free enterprise." He suggested that the Medical Directors Council needs to get ahead of the curve and argue for a system that provides the needed drugs to people in the public mental health system in a rational and cost-effective way. The drug companies market these drugs as equivalent, so why are there significant price differentials among them? The Council could start the debate with a position paper that lays out the broad framework for discussion.

Finally, a participant discussed the push for evidence-based practices in the field, which is also relevant for the medication discussion. Noting that existing medication studies are not very strong, another participant cautioned that a close examination of the evidence base could lead to a "morass" and end up paralyzing the broader discussion about improved medication policy and practice.

Given the strong interest in this topic, the group decided that the pricing discussion would continue during the Council's business meeting.

***Creating Recovery Facilitating Systems of Care
Reduction of Seclusion and Restraint
Trauma Informed Systems and Services***

*Section Moderator/Presenter: Kevin Ann Huckshorn, R.N.
Director, Office of Technical Assistance
NASMHPD*

Ms. Huckshorn stated that trauma and seclusion and restraint use are significant issues that impact the development of the recovery-based systems of care called for by the President's New Freedom Commission on Mental Health and by the Institute of Medicine (IOM). In addition, they are both major issues affecting patient safety, which is also a high priority for IOM, as well as of the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). She added that the use of seclusion and restraint and the incidence of trauma, coercion and violence in mental health settings create an environment in which many people do not want to work.

Ms. Huckshorn highlighted the important role that the Medical Directors Council's technical report on seclusion and restraint had in the field as it framed seclusion and restraint reduction as a public health prevention model. The public health approach is an increasingly common framework used throughout the country.

NASMHPD's National Technical Assistance Center (NTAC) developed a training curriculum on reducing seclusion and restraint in 2002 and has been training states and refining the curriculum ever since. To date, 27 state delegations have been trained and have launched seclusion and restraint initiatives in one or more facilities. After collecting a great deal of informal feedback on states' experiences, NASMHPD will develop a database to capture the impact of these initiatives.

Ms. Huckshorn reported that CMHS developed a national action plan for seclusion and restraint reduction in 2003. As a result, the Center is funding eight state projects to develop best practices over the next three years. As CMHS did not specify which best practices are to be used as a model, there is a risk that some states will not use currently understood best practices. However, with funding from CMHS, NASMHPD and HSRI in Boston are teaming up to conduct a large-scale evaluation project and help move the discussion of seclusion and restraint reduction best practices to evidence-based practices. The evaluation project will result in a submission to SAMHSA's National Registry of Effective Programs and Practices (NREPP), a compilation of rigorous, evidence-based mental health and substance abuse programs.

Ms. Huckshorn provided a brief summary of the current knowledge base for seclusion and restraint reduction. She noted:

- The reduction and even elimination of seclusion and restraint is possible in every kind of facility and type of population;
- Reduction does not necessarily require a lot of resources, although it may require reallocation of resources;

- The reduction of seclusion and restraint requires a culture change in the way the people are served and how the people who serve them are regarded;
- Despite training, change at the local level is slow. Applying the training can be difficult when people go back to their facilities and have to deal with overcrowding, budget cuts and competing priorities; and
- The biggest challenge to reducing seclusion and restraint is placing it on the radar screen of state leaders and maintaining that focus for several years.

The reduction of seclusion and restraint has become a priority for several reasons. The New Freedom Commission called for a system transformation and the recovery of everyone served by the system. Services and supports need to be consumer and family oriented, and the focus of care must increase consumers' ability to self-manage illness and build resiliency.

Studies on recovery have identified seclusion and restraint reduction as a cornerstone in creating a recovery-oriented system of care. It maximizes resources, increases safety, reduces work force turnover, and teaches staff respect for the people they serve. Seclusion and restraint reduction also moves from a focus on control to a focus on partnership and mutuality between staff and consumers, which helps facilitate treatment. Human beings do not flourish in systems characterized by control. Control often ends up in coercion.

Ms. Huckshorn reviewed the primary constructs for reducing seclusion and restraint. The first construct is valuing the reports and input from consumers and staff. Scores of stories from staff and consumers indicate that use of seclusion and restraint is extremely traumatizing for both. The second construct is emphasizing leadership principles. There must be a champion(s) with formal power and credibility to make substantive changes at the facility level. The third construct is the public health prevention approach, which identifies contributing factors and creates remedies to either prevent or minimize the problem.

The public health perspective shifts the discussion from "safer use" of seclusion and restraint to a focus on preventing use in the first place. Beginning in 2000 when stories about deaths from seclusion and restraint were in the media, Congress, Center for Medicare and Medicaid Services (CMS) and JCAHO all began to focus on safer use of seclusion and restraint use and changed their regulations accordingly. Current rules only address prevention through debriefing activities, recommending that staff "debrief the event in effort to learn how not to repeat it," with no specific guidance.

Providers around the country do not know how to debrief. Ms. Huckshorn indicated that NTAC is creating a checklist of what constitutes rigorous debriefing. Root-cause analysis is at the highest evidence-based level of rigorous debriefing. Due to time constraints, not every seclusion and restraint incident can be rigorously debriefed. However, such analysis should be done for frequent repeaters or egregious incidents.

Using the public health prevention model of primary, secondary and tertiary interventions, Ms. Huckshorn explained that primary preventions create therapeutic environments that help avoid or minimize the occurrence of conflicts. Secondary interventions are designed to respond the minute a situation starts to develop. People may begin quietly but quickly escalate to pacing, shouting, or kicking over a trashcan. And tertiary intervention involves debriefing the event and taking corrective action based on what is revealed.

Ms. Huckshorn briefly touched on the relationship between trauma informed care and mental health treatment. She noted that trauma informed care is an emerging science. There is a lot of evidence supporting the presence of trauma in patients in mental health treatment environments. Trauma informed care is mental health care grounded in and directed by a thorough understanding of the neurological, biological and psychological and social effects of trauma on human beings. Acknowledging the prevalence of clients' exposure to trauma and the impact on services, trauma informed mental health care encompasses early diagnostic evaluations and consideration of trauma in adults and children.

Ms. Huckshorn pointed out that the majority of mental health staff know very little about trauma and do not recognize its significance in their daily work. In an effort to better address work force issues, her office has been gathering information from direct care staff about their experience of restraining clients. Staff report staff injuries, symptoms of stress, emotional impact of being involved in or witnessing disturbing instances of seclusion and restraint, and feelings that no one cares about the effects of seclusion and restraint practices on the workers. She commented on the contradiction between paying direct care staff minimum wage and involving them in disturbing and possibly abusive activities, but at the same time expecting to attract and retain healthy and effective staff members.

Ms. Huckshorn described the six core strategies for reducing the use of seclusion and restraint. Participant packets contained a paper that operationalized each strategy, providing a useful "how to" template for states. The core strategies include:

Leadership. Leadership is needed at all levels within facilities, including direct care workers, advocates, consumers, nurses, and psychologists. Leadership must highlight oversight, and involve daily or weekly reports with client and staff names, in addition to monthly, aggregate data. Determining how seclusion and restraint could have been avoided best occurs by examining specific, individual instances.

Use of data. Core measures must separate out reports of seclusion and restraint, with both number of events and hours of use. Another core measure should be data on involuntary medication, especially intramuscular medication. It is important to monitor facilities' use of medication as they reduce seclusion and restraint, as well as consumer and staff injuries due to fears that staff injury rates will increase. Through anecdotal reports, Ms. Huckshorn relayed that only one state that has reported a consistent increase in injuries since starting to reduce seclusion and restraint. Most states have reported a

slight increase at the beginning followed by either a downward trend or a flat line. (The group had a brief discussion about the lack of a national data on injuries. The multi-state seclusion and restraint grant initiative may encourage states to overcome their reluctance to share data.)

Work force development. The reduction of seclusion and restraint and the corresponding needs for certain staff knowledge, skills and abilities must be integrated into human resources policies and procedures. The hiring process is oriented toward identifying potential employees who would be a good fit in a facility that is trying to reduce use. The philosophy of reducing use also can be incorporated into job descriptions and competencies, employee evaluation standards and annual reviews, and new employee orientation materials. Current employees also will need training on key concepts.

Review and implementation of prevention tools. The core strategy paper contains a series of questions for facilities to pose to determine their progress in several areas, including use of trauma assessment tools to identify the risk of violence and the seclusion and restraint history; use of de-escalation or safety surveys and contracts; and environmental changes, including comfort and sensory rooms.

Debriefing. The first stage of debriefing occurs immediately after the incident and aims to mitigate the effects of the event. Everyone involved is checked, documentation is completed, and the milieu returns to pre-crisis level. The second stage may occur several days later and involves senior staff conducting rigorous analysis and problem-solving in order to avoid recurrences.

Inclusion of consumers and family members. It is very important for facilities to move towards transparency and involve consumers and family members in order to inform their work, policies, regulations, rules, and daily operations. Ms. Huckshorn commented that the public mental health sector is in the forefront of including consumers and family members.

Transitioning to a discussion of trauma informed systems of care, Ms. Huckshorn remarked that NASMHPD has played an instrumental role in making trauma more of an issue for public mental health, including developing one of the first policy statements on trauma informed care and trauma survivors. CMHS has kept the issue alive through its support of some small contracts and a big research study.

NTAC has worked with some of the care systems that are very involved in trauma work. Key principles of trauma informed care include systems: (1) are inclusive of the survivor's perspective; (2) are informed by research and evidence of effective practice; and (3) recognize that coercive interventions cause traumatization and re-traumatization and should be avoided.

Until recently trauma exposure was thought to be rare and associated primarily with combat violence, major disasters, and tragedies such as the events of September 11th. Recent research, however, has changed this perspective. For example, 56 percent of the

members of a general population adult cohort reported at least one significant event of trauma or violence in their lives. Within the public mental health population, 90 percent has been exposed to some form of trauma, while most have had multiple experiences. Ms. Huckshorn commented that trauma is epidemic in the mental health population, especially among women. The rate of post traumatic stress disorder (PTSD) in people with serious mental illnesses is substantially above the average in the general population.

Ms. Huckshorn went on to talk about signs that care systems are not sensitive to trauma: (1) consumers are labeled and pathologized as "manipulative," "needy," or "attention seeking; " (2) misuse or overuse of displays of power; (3) culture of secrecy, no monitoring of staff, and no advocates; (4) little use of least restrictive alternatives other than medication; (5) emphasis on patient compliance rather than collaboration; and (6) staff members are disempowered and devalued, and they in turn treat clients the same way.

Ms. Huckshorn briefly covered four important elements that go into creating a system that is trauma informed: trauma assessment, safety planning, environmental responsiveness, and appropriate language.

- *Trauma assessment.* The purpose of trauma assessment is to identify a past history of trauma, violence, or abuse, as well as reports by consumers on what they are currently experiencing. Ideally, the assessment should be done upon admission or shortly thereafter so that information is available as soon as possible. However, an effective trauma assessment may require the development of a therapeutic relationship with the consumer, so in some cases the assessment may have to be revisited later in the treatment process. The assessment should minimally include the type of abuse, who perpetrated the abuse, and the age when it occurred. It is also important to remember that people perceive trauma in different ways. What might be traumatic for one person might not be traumatic for someone else. The assessment also should include history of seclusion and restraint and episodes of homelessness. Assessment results and feedback must be addressed in treatment planning.
- *Safety planning.* Safety planning not only is important for people who have trauma histories but is also a way to reduce seclusion and restraint use. Safety planning tools (e.g., de-escalation preference surveys and individual crisis planning) allow consumers to develop individualized plans of care for dealing with their own issues, triggers, stress response, and self-soothing strategies.
- *Environmental responsiveness.* Ms. Huckshorn encouraged participants to review their materials about how facilities can create an environment that is less coercive and less likely to cause trauma, including the technique of sensory modulation.
- *Appropriate language.* Mental health providers have been trained in medical language and terminology. As much as they can, however, they should start to

phrase things differently and refer to people as individuals and remember they are treating people, not diseases.

While NASMHPD/NTAC has copyrighted the core strategies, the information is available on the NASMHPD Web site and fully available for use. The training material also will be available through the NASMHPD Seclusion and Restraint Technical Assistance Center. Medical directors interested in any of the materials should send specific requests to Ms. Huckshorn via email.

Tuesday, October 5, 2004

Use of Mortality Data

Session Co-Presenters/Moderators: Dale Svendsen, M.S.

*Medical Director
Department of Mental Health
State of Ohio*

*William Tucker, M.D.
Former Medical Director
Office of Mental Health
State of New York*

Dr. Tucker discussed the importance of the mortality review process to improve mental health systems. Every health care system says it does mortality reviews, but no one pays attention to the results. Dr. Tucker felt that the primary reason for inadequate mortality reviews is that there is no periodic, regular feedback that benefits clinical decision-making. The important purposes of mortality reporting are: (1) understand why patients in inpatient settings die and determine whether they die for different reasons than an age-matched, socio-economically-matched, non-mentally ill population; (2) prevent unnecessary deaths, especially those to which treatments may have contributed; and (3) alert clinicians to possible causes of death so they can intervene when similar situations arise.

After two years of sustained effort in the New York system, Dr. Tucker reported that they were finally able to receive meaningful mortality reports on inpatient deaths within one month of death. Once the information started arriving, Dr. Tucker began providing feedback to the clinical directors.

He presented the following mortality information for Fiscal Year 2004:

Total inpatient deaths (in 4,200 beds)	91
Natural causes, expected	50
Natural causes, unexpected	34
Accidents	5
Suicides	2

The deaths of primary interest were the unexpected deaths from natural causes (e.g., someone dying in the middle of the night from arrhythmia). Dr. Tucker provided several clinical profiles of patients, a brief overview of their physical and mental health histories, their causes of unexpected death, and the systemic questions raised as a result. Formulating and responding to questions about what led to the unexpected death can translate into improved delivery and coordination of care, such as:

- Knowing that atypical antipsychotics cause weight gain, how much weight gain is tolerable before another drug should be considered? (A woman with schizophrenia, hypertension, massive obesity and a 100 percent weight gain during her hospital stay died during her sleep.)
- How to coordinate and monitor the multiple medications used to treat psychiatric symptoms and side effects and issued by psychiatrists and internists who write prescriptions independently? (A woman who was on a medication that causes falls, broke her neck as a result of fall, and died during the resulting surgery.)
- Have systemic causes been considered when patients exhibit new symptoms? (A man with psychiatric illness and systemic problems suddenly developed confusion and agitation, received a combination of psychoactive medications, developed congestive heart failure and pneumonia and died; yet no one considered that the confusion and agitation were new symptoms of the systemic illness he had had for many years.)

Dr. Tucker provided an overview of the current mortality review process in New York:

- All deaths in the state hospitals are reported within 24 hours;
- Mortality reviews are conducted within one month and sent to the central office.
- The central reviewer (Director of Medical Services) reviews cases and summarizes findings.
- The Chief Medical Officer (Dr. Tucker's position) reviews the medical director's summaries for possible interventions and lessons on a quarterly basis.
- The Chief Medical Officer contacts individual hospital clinical directors with feedback on a quarterly basis.

In response to a question, Dr. Tucker advised that commissioners should put someone in charge of mortality reviews within their systems. While that person does not have to be the medical director, it should be a person who can look at the whole system, has sufficient clout, and has the willingness and ability to make informed judgment calls on issues. Commissioners should want to know if these deaths are preventable and, if so, what systemic changes are needed.

A participant raised the concern about public sector patients who die in community hospitals, and the challenge of obtaining reliable mortality information. State Departments of Health compile that mortality data, yet accessing the information is often a political, cumbersome, and sometimes futile process.

In addition to improving the quality of mortality reviews, states need to address risk management issues, including how the media and advocacy groups respond to mortality data. A participant shared that a series of newspaper articles on deaths in his state's community mental health system led to a better connection with the state epidemiologist and an ability to access all death certificate information. Dr. Tucker commented that this concern underscores the importance of collaborating with community mental health providers. Another participant added that a focus on mortality data must include both the in-hospital population and those served by the community mental health system, given the much higher death rates in the community.

Dr. Svendsen gave an overview of the mortality and morbidity process in Ohio. Mortality and morbidity check reporting by state hospitals began about ten years ago, and the final report is reviewed by the hospital medical director and Dr. Svendsen for quality control. An annual report goes to the SMHA director. A Quality Assurance Committee also performs morbidity/mortality reviews, the results of which are protected by law. Sometimes root-cause analyses are required. If the Committee doesn't initiate them, they are initiated by the medical director's office.

Detailing state hospital deaths and deaths within 30 days of discharge for a six-year period through FY2003, Dr. Svendsen shared that the most frequent causes of death, including heart disease (29 percent). Overall, the results were similar to those reported by Dr. Duckworth in his presentation on Massachusetts during the previous year's Symposium.

In view of the high incidence of heart and cardiopulmonary disease, Dr. Svendsen requested that medical directors and CEOs of state behavioral health organizations (state hospitals) implement the American Heart Association guidelines for the evaluation and management of heart failure and improve coordination of mental health care with primary care. He does annual performance evaluations of each medical director, and they are rated on compliance with this request.

Dr. Svendsen noted that the other startling revelation from the data was the high suicide incidence (25 percent), half of which occurred within 30 days of discharge. As a result of a root-cause analysis, it was recommended that a suicide risk evaluation process be developed. With some encouragement from Dr. Svendsen's office, all state hospital medical directors have collaborated and developed a suicide risk evaluation process that is conducted with every patient.

He also recommended that each behavioral health organization improve the continuity of follow-up care. One important issue was the length of time between discharge and a patient's first follow-up appointment. The data showed that a high number of suicides occurred during the period before the first scheduled appointment. Patients either never scheduled an appointment, or they made an appointment and committed suicide before the appointment date.

Dr. Svendsen then compared the mortality and morbidity data for Ohio with the Massachusetts data. One significant difference in data was that the Massachusetts data was from the community mental health system rather than the hospital system. Some of the comparisons he shared were:

- There were 608 deaths in Ohio among 31,000 admissions (19,000 people in unduplicated count) from 1998-2002. In Massachusetts, 297 deaths occurred among the 32,289 people served by the department in 1998-1999.
- Heart attacks were the number one cause of death in both states--21 percent in Ohio and 33 percent in Massachusetts. In Ohio, suicides were second at 18 percent, and accidents were third at 14 percent. In Massachusetts Dr. Duckworth combined injuries, accidents, suicides and homicides and reported a 16.5 percent rate for the first year of the study and a 14.5 percent rate for the second year. Cancer death rates were substantially higher in Massachusetts (a 12.5% two-year average compared to seven percent in Ohio). Although the Ohio death rate for diabetes was low (three percent), Dr. Svendsen expressed concern about diabetes because of the antipsychotics currently used. The Massachusetts study did not report diabetes deaths.
- There was an alarming 6.6 fold increase in mortality from heart disease over the two-year period for the age 25-44 population in Massachusetts, raising concerns about any connection with use of antipsychotics. In Ohio, the increase in mortality from heart disease was 2.6 fold among the 25-44 year old population.
- In Ohio, there was a high 26.8 fold increase in suicide deaths among the youngest cohort (ages 15-24). The data for Massachusetts indicated that the suicide rate for the study population was seven to eight times that in the general population.

In his conclusion, Dr. Svendsen noted that policy makers are paying increased attention to the link between health and mental health, as evidenced by the New Freedom Commission's report statement that mental health is essential to overall health, and the Bazelon Center's report on integrating physical and mental health care. Dr. Glover added that a recent presentation on smoking to the state mental health commissioners made a significant impression. Commissioners also are examining the link between health and mental health, and trying to determine their appropriate role. He suggested that medical directors talk to their commissioners about strategies for strengthening the connections between physical and mental health care.

Participants shared their experiences and raised questions about mortality and morbidity reviews. Arizona began a mortality and morbidity review process which encompasses all enrolled seriously mentally ill individuals throughout the mental health system, including community facilities. For the entire system, the death rate was about 450 deaths per year. In the community setting, the review found inadequate case management (e.g., failure to follow up on missed appointments) and a failure to coordinate care (e.g., clinicians prescribing medications for mental health conditions without regarding treatment for

clients' physical health problems). Another alarming finding was the high number of individuals in the mental health system obtaining narcotics and benzodiazepines from their primary care providers. These findings were used to start a new initiative with the state's Medicaid health plans to improve care coordination.

Another participant commented that an examination of mortality and morbidity should address both why patients are dying and whether the mental health care system is doing enough to prevent and ameliorate those problems that result in death.

One person expressed concern about preventable deaths in children, particularly children in residential facilities, and the impact of seclusion and restraint and medication use. Others suggested that adult mortality is the major problem in the mental health system; for example, the highest absolute numbers of suicides involve adults. Another participant commented that the issue is really identification of and prevention aimed at vulnerable populations, whether children or elderly people.

Prevention Approaches for SMHAs

Section Moderator/Presenter: Robert Eilers, M.D., M.P.H.

Medical Director

Division of Mental Health Services

Department of Human Services

State of New Jersey

Dr. Eilers opened with an overview of the Medical Directors Council's draft technical report, *Prevention Approaches for State Mental Health Authorities*. The report was designed to raise awareness and provide a framework for addressing prevention issues. However, it does not give a detailed roadmap, as prevention is a diverse field with many implications and issues involved.

Health promotion and illness prevention strategies complement treatment services. They involve interventions that can prevent multiple problem behaviors and enhance positive behaviors in at-risk populations. Dr. Eilers referred to the study of Adverse Childhood Experiences (ACE), which looked at childhood trauma and how it affects ten outcomes. Adverse experiences in childhood can lead to risky behaviors such as substance abuse, risky behaviors due to mental health problems, and medically-related high risk behaviors. The study illustrated how distal--that is, environmental--causes can have significant effects on outcomes.

Dr. Eilers described some of the challenges involved in promoting a prevention model. The effort will involve new ways of thinking, a new language, and new skills. It will require a more active role for consumers and their families. Another challenge is, if resources are provided, people will want to see results; yet prevention is not an activity with immediately apparent results. Most preventive interventions cost only a few dollars and can lead to significant changes over time.

The technical report includes definitions of promotion and prevention. The World Health Organization (WHO) defines promotion as "the process of enabling people to increase control over, and to improve their health." Strategies for the promotion of mental health relate to improving the person's quality of life and the potential for health, rather than just ameliorating symptoms and deficits.

Prevention activities are generally directed toward risk factors and are implemented at specific periods before the onset of a problem or disorder. Prevention efforts also can be used after the onset of a disorder to reduce the severity, course, duration, and associated disabilities.

Dr. Eilers mentioned two different approaches to classifying prevention stages or efforts. The first approach is classifying interventions as primary, secondary and tertiary. The more recent classification system is universal, selective, and indicated. Primary and universal interventions are comparable in that both target the general population. Secondary and tertiary interventions are directed towards arresting the severity of illnesses (secondary), and reducing disabilities and relapse (tertiary). Selective strategies target populations at *higher* risk for developing disorders; indicated strategies target *high risk* populations.

To illustrate the universal, selective and indicated approaches, Dr. Eilers again referred to the ACE study. A universal intervention would address a geographic area or general population (e.g., students in a school). A selective effort would target those children who have certain risk factors (e.g., factors related to family or environment). Indicated prevention efforts would deal with those who already have a significant problem (e.g., conduct disorder).

Dr. Eilers indicated that a major challenge will be to prove that promotion and prevention programs are effective and that they reduce costs in the long run. While some prevention data are highlighted in the technical report, there is a growing body of information on current efforts. The field is still in the early stages of developing and conducting evidence-based research on prevention. The President's New Freedom Commission promoted recovery and resiliency as prime goals and discussed some specific ways to address health promotion and prevention. SAMSHA has come out with some specific interventions in promotion and recovery. The concept of recovery is relevant to secondary and tertiary prevention, as recovery includes a focus on reducing severity and disability and preventing further effects after someone has developed a disorder. Similarly, illness management (i.e., another preventive intervention) empowers consumers and gives them a better way to manage themselves and their own illnesses.

The Council's technical report on prevention addresses the implications of promotion and prevention within the public mental health system. One of the implications is the need for a broader continuum of care that starts with promotion and prevention aimed at the general population. Promotion and prevention also go beyond treatment to support the recovery process for people with serious mental illnesses. This approach requires better

coordination, more participation from stakeholders, and involvement of new stakeholders, including primary care providers and communities.

Stating that SMHAs will want to utilize best practices, Dr. Eilers observed that there are scientific standards for prevention effectiveness and efficacy. Guidelines published by the Society for Prevention Research are one set of standards. Best practices also need to be culturally sensitive. A tension exists between maintaining fidelity to effective interventions and permitting flexibility to adapt interventions for a community.

One important issue is building capacity. As the draft points out, professionals and paraprofessionals require ongoing training to sustain prevention programs. Prevention needs to be integrated into professional curricula, licensing, exams, trainings and certifications for mental health workers.

The technical report also addresses special populations, including pre-natal and early childhood populations, youth, and older persons. Early interventions are critical to reduce risk and increase resiliency among the pre-natal and early childhood populations. There are a number of empirically validated child-focused and community-focused prevention programs aimed at young children up to eight years old that are designed to prevent the later development of substance abuse, violence and delinquency. For youth, a variety of home-based, school-based and community-based programs are needed to foster well-being and prevent problem behaviors and reduce the risks of suicide, mental illness and involvement with the juvenile justice system. Resiliency-building programs are also needed for youth who are already in the public mental health and/or juvenile justice systems.

And given the suicide rates among the older population, preventive interventions are required with older persons, too. Since most older adults have contact with their primary care physicians, interventions may be directed toward physicians, educating them about screening and treating depression in elders. Nontraditional approaches are also needed, including telemedicine and services from community, social, volunteer and religious organizations.

In closing, Dr. Eilers summarized the technical report's recommendations, including suggested actions for state mental health authorities, NASMHPD, the NASMHPD Medical Directors' Council, the NASMHPD Research Institute, and the National Technical Assistance Center. The recommendations underscored the importance of using a developmental framework to implement mental health promotion and prevention activities and prioritizing the earliest possible detection of mental health problems.

A lengthy comment period followed the presentation. Medical directors offered the following recommendations for the next iteration of the technical report:

- Provide commissioners with more concrete action steps they can implement in their state. Currently, the report is too theoretical and policy-oriented. Given the Council's

limited funding, it is unlikely there will be follow-up reports on prevention, so this technical report must include explicit recommendations.

- Focus on the prevention issues that have been discussed at the Council's Symposia, namely early psychosis intervention, prevention of trauma and suicide prevention. In addition, the report should address the need to partner with community-level services as much of prevention really occurs at the community level.
- Add an executive summary that provides compelling reasons for SMHAs to initiate prevention efforts and outlines "actionable items" that commissioners can pursue to begin and address prevention in their states.
- Use a two-tier approach to offer commissioners a range of prevention initiatives to consider. The first tier should include high priority activities (e.g., suicide prevention and early psychosis intervention), while the second tier would offer other promising initiatives (e.g., depression screening).
- Include a strong statement from the medical directors that state plans should address prevention and some SMHA resources should be directed toward prevention. Medical directors acknowledged the long-standing concern that putting resources into prevention would mean fewer resources were available for people with serious mental illnesses, the population that SMHAs are mandated to serve. Noting this tension, medical directors indicated there are preventive interventions that will benefit the public sector population. Prevention is a central issue in public health, and SMHAs and NASMHPD need to figure out appropriate ways to incorporate prevention into their agendas.
- Include brief case studies of successful prevention projects. Medical directors suggested programs in Oregon and Maine as good examples. Others added that substance abuse prevention programs offer good models, as well. The report also should include available data that demonstrates effectiveness of preventive interventions.

At the end of this session, the formal agenda for the 2004 Best Practices Symposium concluded. Participants continued their discussions as they transitioned to the business portion of the meeting (see separate Medical Directors Council meeting minutes).