NASMHPD Medical Directors Council

2000 Best Practices Symposium Proceedings

Transforming Knowledge and Research into Practice in the Public Mental Health Sector:
Focus on Use of Antipsychotics/Medicaid Formularies, Seclusion/Restraint, State/Academic Collaboration and Mental Health courts

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Jointly sponsored by the Missouri Institute of Mental Health and The University of Missouri-Columbia School of Medicine

Bob Glover, Ph.D., Executive Director of the National Association of State Mental Health Program Directors (NASMHPD) welcomed participants to the Medical Directors Council's 5th Best Practices Symposium. Dr. Glover believed that the annual Symposium is one of the best meetings for facilitating peer support and responding to issues that are relevant to state mental health authority (SMHA) Commissioners. He also acknowledged the unrestricted funding support from Eli Lilly and Company and Janssen Pharmaceutical/Research Foundation for the Symposium and other continuing education efforts. Finally, Dr. Glover expressed appreciation to the Missouri Institute of Mental Health and the University of Missouri-Columbia School of Medicine for their making continuing medical education credits available.

Thomas Hester, M.D., Chairperson of the Medical Directors Council and Georgia's Medical Director, also welcomed members and described the Council's role and activities. Dr. Hester referred participants to the Council's web site at www.nasmhpd.org for past Symposium proceedings, minutes from the quarterly meetings, a roster of Medical Directors by state and the Council's technical reports.

A Dialogue on Psychotropic Medications: Medicaid Formularies, Performance Measures and Error Reduction

Moderator: Tom Hester, M.D.
Medical Director, Georgia

Presenter: Robert W. Glover, Ph.D.
Executive Director, NASMHPD

Robert Littrell, Pharm.D.
Director, NASMHPD Research Institute Inc., Performance Measurement System
Director, Research and Data Management Center, University of Kentucky
Lexington, Kentucky

Dr. Glover: Understanding Current Efforts to Work with Medicaid Directors and Increase Access to Newer Psychotropics in a Fiscally Responsible Manner

Dr. Glover gave a brief history of the growing interest in access to and cost of psychotropic medications. With the release of the Surgeon General's first-ever report on mental health, NASMHPD approached other organizations around partnering around significant issues of mutual concern. The association of Medicaid Directors and its Executive Director, Lee Partridge, were interested in working with NASMHPD to address the burgeoning cost of psychotropics; five out of the top seven expensive drugs funded by Medicaid are psychotropics. Issues of mutual concern included problems with formularies, reviews that slow down introduction of new medications and implications of best practices.

To launch a discussion on these important issues, NASMHPD will meet with the Medicaid Directors in Washington, D.C. on November 12-14, 2000. A subgroup of Medicaid Directors and their Pharmacists will work with a group of NASMHPD Medical Directors, have a robust discussion and make recommendations for future steps. The group's discussion and recommendations will be drafted into a written report and be circulated. Dr. Glover anticipates sharing the report with the State Superintendents during their March 2001 meeting.

Dan Luchins, M.D. (Illinois) will co-chair the meeting along with the Medicaid Director from Massachusetts. Additional Medical Directors who will participate in the meeting include Tom Hester, M.D., Megan Hornby, M.D. (Oregon), Steve Karp, M.D. (Pennsylvania), Judith McGee, M.D. (Arkansas), Steve Shon, M.D. (Texas) and Dale Svendsen, M.D. (Ohio). NASMHPD will also bring pharmacists Robert Littrell and Craig Roberts to the meeting. Dr. Glover indicated that Medicaid Directors from Texas, Iowa, Pennsylvania and Massachusetts are expected to attend.

Dr. Littrell: Review of Recent Studies Regarding Psychotropic Drugs Discuss ORYX Developmental Measures

Dr. Littrell gave an overview of recent studies regarding the use of psychotropic drugs, including:

- Schizophrenic Patient Outcome Research Teams (PORT) paper published in a 1998 Schizophrenia Bulletin. This study, consisting of direct client interviews

and medical record reviews, tracked compliance with certain treatment recommendations for 719 clients with schizophrenia in two different states. The results indicated that conformance to recommendations were "modest at best." Compliance with pharmacologic treatment methods was slightly better than compliance with non-pharmacologic treatment, such as family interventions. Conformance was found to be better in rural areas than urban. The study also found an interesting distinction between compliance within the Caucasian population and non-white population. Black patients were more likely to be over-medicated based on guidelines and less likely to have comorbid depression treated than their Caucasian counterparts. The study also flagged inpatient use of adjunctive medications and other dosing issues. Dr. Littrell described the study as a "mixed bag of results" but important to stimulate the discussion about best practices for psychotropics and effective treatment.

- 5-state Mental Health Statistics Improvement Project (MHSIP) funded by the federal Center for Mental Health Services. CMHS gave grants to Colorado, Massachusetts, Texas, Georgia and South Carolina to use similar performance indicators of performance on use of new generation anti-psychotics and the penetration rates for different diagnostic categories. The project revealed how difficult it is to compare data, particularly aggregated data, if standardization did not occur at the client or event levels. Some of the interesting findings included a higher than expected utilization rate of new generation antipsychotics (approaching 50%-60%) and racial discrepancies in the penetration rate. (Whites were more likely to receive these medications than non-whites).
- 7-State Medication Policy Study. The National Institute of Mental Health (NIMH) provided a small grant to survey seven states about access, cost and coverage policies for the new generation of antipsychotics. The 1999 survey was directed to the SMHAs in Colorado, Georgia, Texas, Illinois, Kentucky, Massachusetts and South Carolina. Therefore, the Medicaid data was provided via the SMHA. Dr. Littrell highlighted some of the survey results, including that Medicaid provided funding for new generation drugs in all seven states; four states had some specific funds that they set aside for these agents in inpatient and/or outpatient settings; very few restrictions existed for these medications (such as prior authorizations, algorithm guidelines, treatment failures requirements); any restrictions tended to be in outpatient settings; and that one state reported that medication funding would follow clients to ensure continuity in drug treatment between inpatient and outpatient settings.

Dr. Hester added that the 30-day readmission rate is a useful mechanism for examining continuity issues. In Georgia, they discovered that within hospitals that had high 30-day readmission rates, more than 25% of these individuals had their

medications changed from new generation in the hospital to atypical when they transitioned into the community.

Dr. Littrell gave a brief overview of the development of the NASMHPD Research Institute's Performance Measurement System (also known as ORYX). The Performance Measurement System grew out of a response to data requirements put forth by the Joint Commission on Accreditation for Health Organizations (JCAHO) and the need for state hospitals to align new data systems costing between $5,000 - $50,000. An appointed group of SMHA Commissioners recommended that NASMHPD Research Institute create its own performance measurement system to meet JCAHO's requirements and ensure the resulting data was meaningful to Commissioners and providers. As of October 2000, 212 hospitals participate in the Performance Measurement System, representing almost every state hospital in the country. By mid-2001, 28 hospitals in New York will also participate. Only three states are not participating in the overall performance measurement system (South Dakota, Pennsylvania, and Rhode Island); the District of Columbia and Puerto Rico are participating.

Participating organizations and hospitals submit data on every episode of treatment in their hospitals each month. For $4,700 per hospital per year, Performance Measurement System participants may select measures that meet JCAHO's requirements as well as additional measures.

Dr. Littrell highlighted the Performance Measurement System's various measures detailing the measures for psychotropics:

- New Generation Antipsychotic (NGAP) Measure This measure's numerator is the count of clients who received scheduled new generation antipsychotics while the denominator is the count of clients who received any scheduled anti psychotic.
- Medication Error Measure The numerator is the count of medication errors and the denominator is the duplicated client count. Dr. Littrell explained that the denominator should be total number of doses dispensed but that number is difficult to collect. NASMHPD Research Institute will strive to uncover this total number of doses in a pilot project.
- Readmission rate
- Seclusion and Restraint
- Elopement rates
- Injury
- Global Assessment Functioning (GAF)
- BASIS 32
- Brief Psychiatric Rating Scale (BPRS)

- Multinomah Community Adjustment Scale (MCAS)
- Child Adolescent Functional Assessment Scale (CAFAS)

He cautioned that no one measure should be looked at in a vacuum nor is one measure a stand alone indicator of a mental health system's functioning. JCAHO currently requires states to report on four of these measures and will require two more (for a total of six measures) in 2001. Dr. Littrell indicated that 60% of participating organizations are already collecting data on six measures.

At this point, the session was closed to non-Medical Directors due to the confidentiality requirements of NASMHPD's data collection contracts. Any Medical Directors or NASMHPD member seeking more information about this closed discussion on state level data should contact Roy Praschil at 703-739-9333 for a written synopsis.

Seclusion/Restraint: Current Sate-of-the-Art

Moderator: Joseph Parks, M.D.
Medical Director, Missouri

Presenters: Robert Littrell, Pharm.D.
Director, NASMHPD Research Institute Inc., Performance Measurement System
Director, Research & Data Management Center, University of Kentucky
Lexington, Kentucky

Paul A. Smith, Ph.D.
Founder and Principal Author, Professional Assault Response Training
Citrus Heights, California

David H. Mandt, Sr.
President, David Mandt & Associates
Dallas, Texas

AlGene P. Caraulia
Founder and Consulting Director, Crisis Prevention Institute, Inc.
Brookfield, Wisconsin

Grant Stevenson
Consumer, Pennsylvania

Mr. Hirshman
Administrator, Allentown State Hospital, Pennsylvania

Joe Parks, M. D. (Missouri) distributed the Medical Directors' technical report and NASMHPD's position statement on the use of seclusion and restraint. Dr. Parks commented that the use of seclusion and restraint is not treatment but a safety measure of last resort. The Medical Directors have affirmed the importance of primary prevention and preventing acting-out crises from occurring in the first place. When discussing the use of seclusion and restraint, Dr. Parks stressed the importance of also addressing the issues of respect, self determination, power differential, culture and roles.

Dr. Littrell: Seclusion and Restraint Measures within the Performance Measurement System

Dr. Robert Littrell, Pharm.D., gave an overview of the seclusion and restraint measures collected as part of NASMHPD Research Institute's Performance Measurement System. A total of 39 states representing 140 health care organizations collect data on these measures, including:

- Percent of clients secluded (or restrained) at least once during the report period The numerator is the unduplicated number of clients with at least one seclusion (or restraint) event and the denominator is the total unduplicated number of clients.
- Hours of seclusion (or restraint) as a percent of inpatient hours The numerator is the total number of hours of seclusion (or restraint) during the report period while the denominator is the total number of inpatient days (less leave days) converted to hours
- Duration of seclusion or restraint incident (normally expressed as number of seclusion/restraint hours per 1,000 inpatient hours)

At this point, the session was closed to non-Medical Directors due to the confidentiality requirements of NASMHPD's data collection contracts. Any Medical Directors or NASMHPD member seeking more information about this closed discussion on state level data on the Performance Measurement System seclusion and restraint measures should contact Roy Praschil at 703-739-9333 for a written synopsis.

Panel Discussion with Mr. Stevenson, Dr. Smith, Mr. Mandt, Mr. Caraulia and Mr. Hirshman

Grant Stevenson launched the discussion by sharing his personal experience of being secluded and restrained at Allentown State Hospital. After being put in a one-point restraint due to an angry outburst, Mr. Stevenson felt traumatized and afraid that his treatment had been derailed by weeks, if not years, because of the incident. Mr.

Stevenson contrasted this event with another time a few years later when he acted out his anger by kicking a trash can on the unit. During this subsequent incident, a team was called in to talk him down and the use of seclusion and restraints was avoided. Paul Smith, who formerly worked within the Missouri SMHA, described some of the key components in his Professional Assault Response Training. The training is "hands-on" training which involves executive and direct line staff. Participants learn to:

- know how to follow treatment plan
- observe threatening behavior
- communicate with threatening patients
- suggest alternatives to assault
- evade punches and kicks
- protect breathing and circulation
- get a good grip on people who need to be restrained
- communicate staff activities to clients and
- record afterward.

AlGene Caraulia and the Crisis Prevention Institute, Inc. teach staff to approach and reduce anxiety of the agitated person. Mr. Caraulia stressed that acting out behavior is a communications process; if staff can decode the person's behavior pattern, they can de-escalate the process without use of physicals prematurely.

The training involves teaching staff how to maintain their own anxiety levels so they can be more professional, use verbal techniques and know how and when to go to physical techniques. Mr. Caraulia maintained that in order to foster cultural change and improve patients' quality of life, reducing seclusion and restraint use must be a high priority, high profile goal, staff and patients must be educated.

Finally, Mr. Caraulia cited three studies that demonstrate the effectiveness of such training: 1) an Idaho State Blackfoot Hospital study in which the use of restraints declined after training was introduced; 2) The rate of assaults fell from 31.5 assaults per month in 1988-1999 to 25.3 assaults per month in 1990-1991 at Arizona State Hospital once the psychiatric nurses and technicians were trained. After all clinical staff were trained, the rate dropped to 18.2 assaults per month; and 3) Clark Summit State Hospital experienced a reduction in restraints from 1,132 restraints in 1998 to 150 in 1999 and 260 seclusion episodes in1998 to 20 seclusion episodes in 1999.

David Mandt explained that better communication, more staff input, better training, changes in culture, more involvement of patients and parents can result in a decrease in seclusion and restraint. He pointed out that when facilities have restricted the use of seclusion rooms, staff has come up with alternatives to handle crisis situations.

Mr. Hirshman described the experience of Allentown State Hospital in Pennsylvania. The hospital developed a specialized, interdisciplinary team, Psychiatric Emergency Response Team (PERT), to respond to patient crises. Mr. Hirshman mentioned that the leadership for this initiative came from the ranks and that direct line staff buy-in was critical.

Dr. Parks posed the question "What is the hardest part for trainees to grasp?" to each panel member.

Mr. Mandt responded that it was hardest for direct care staff to understand that they can take their time in responding to crises. Often, there is a sense of urgency that staff must regain control quickly. Instead, staff should be asking "What can we do to help you (the patient) calm down?" Both patients and staff need to feel safe and be treated with respect and dignity. Once the situation has de-escalated, staff can find out what the underlying problem or need is.

Mr. Carualia believed that staff should not take acting out personally. A crisis can be scary and trigger staff's survival mechanisms. Staff's challenge is to not turn into a counter-assaultive person and decode what's happening in front of them.

Mr. Hirshman stressed the importance of a team responding to a crisis as one consistent unit; if there is chaos within the team's own ranks, the problem won't be resolved. Dr. Smith stated that the staff can mistakenly believe that they have the authority to restrain. More accurately, staff have the authority to protect the safety and security of patients and restraint may be a tool to accomplish that goal. A hospital's responsibility consists of 1) developing an individual treatment plan; 2) providing a program and structure which supports the individual plan; and 3) having sufficient trained and dedicated sufficient to implement this plan. The training stresses that staff's job is not to restrain but to provide services in accordance with the individual treatment plan.

Mr. Stevenson expressed that staff need to understand that "we're human beings and not just patients" and should be treated with dignity and respect.

A Medical Director inquired about whom to train in these techniques. Should hospitals expect all front-line clinicians to be able to respond to crises or should there be specialized teams? Panel members responded that everyone should be trained in the crisis intervention process and emergency procedures regardless of whether they are the staff to implement the procedures. As a result, all staff will be able to take steps to stop acting out behavior before it hits an emergency stage. While staff members may not have the ability to do advanced physical skills, they should still

receive training so they can help to de-escalate the situation and understand what other staff members are doing.

Another Medical Director inquired about strategies for addressing the overcrowded, stressful hospital environment. Mr. Hirshman described an approach adopted by Allentown State Hospitals to create a more invigorating environment. For several years, the hospital has had a centralized program where by patients live in a dormitory section within the hospital and move off the unit to participate in their treatment. As patients move around the hospital, much like students changing classes, they can have a new perspective and experience a fresh start a few times per day.

Another panelist cited the need for creating a more supportive environment regardless of the physical constraints (e.g., positive reinforcement for clients and peer support meetings for staff). Crisis is a chaotic environment and administrators need to develop procedures to help avoid and minimize the chaos.

Someone questioned whether consumers should be involved in post-crisis debriefing. Panelists encouraged consumer involvement and suggested role playing if the patient can't be involved. A few trainers recommended that both the caregiver and patient go through the training together as all can benefit from training in interpersonal communication and conflict resolution.

Panelists also address the re-traumatization of patients and the need to have individual plans for patients. Given that 80% of adult female patients have been molested and 60% of males have been molested, any across-the-board policy about using face-up or face-down restraints can end up retraumatizing patients unintentionally. Similarly, if a person has an injury or is otherwise vulnerable, staff must take that into account when if holds are necessary.

Dr. Parks posed the question, "What is a common mistake by administrators?" Panelists responded that administrators who believe they don't have the time to be trained will be at a loss if faced with potential litigation. Both patients and staff need to see administrators participate in the training to believe reduction in seclusion and restraint is truly a hospital priority.

Another common administrator mistake is to short cut the training process. If abbreviated training simply focuses on restraint methods, the hospital will send the message that using restraint and seclusion (and not avoiding them) is the priority, which places the facility at a higher risk of law suits. Mr. Stevenson also recommended that administrators get to know their patients and have their doors open.

Criminal Justice and Mental Health Interface: Mental Health Courts ... What Have We Learned?

Moderator: Daniel Luchins, M.D. Medical Director, Illinois

Presenters: Honorable Stephanie Rhoades District Court Judge Anchorage District Court Anchorage, Alaska

John S. Goldkamp, Ph.D. Professor of Criminal Justice Temple University Philadelphia, Pennsylvania

Dr. Luchins introduced the importance of mental health courts by reminding the audience that the major site of treatment for persons with serious mental illness has shifted from state facilities to prisons. Among the 10,000 inmates in Chicago's Cook County Jail, 1,000 individuals have significant mental illness that are being treated. Four hundred of these individuals require a separate facility within the jail, constituting the second largest mental unit in the state. Mental health court is one option for re-engaging these individuals with the mental health system.

Dr. Goldkamp: What is a Mental Health Court?

Dr. Goldkamp relayed several incidents featured in the media where a person with mental illness was brought to the attention of the criminal justice system. These incidents were characterized by relatively minor violations (bike theft, purse snatching, threatening comments) which escalated into major incidents with tragic consequences. In each case, the person had a prior history with both the mental health and criminal justice systems. Dr. Goldkamp posed the question, "Where could have mental health courts have intervened in these situations?" Dr. Goldkamp, who along with Cheryl Iron Guinn, wrote the current text book on mental health court, gave a brief history of mental health courts in the Unites Dates. Similarly described programs existed in the 1960's in Illinois and New York. More recently, mental health courts have evolved in Broward County, Toronto, Alaska, King County Court, Seattle Municipal Court, Marin County, Indianapolis, Honolulu and Brooklyn (planned). Dr. Goldkamp cautioned that the list was not exhaustive as he regularly learned about "new" courts operating. The number of mental health courts would also grow if Congress passed pending legislation (H.B. 2495) which would provide $400,000 to 25 sites for mental health courts.

Current mental health courts can trace their origins to a 1980's focus on jails overwhelmed by drug arrests. Dr. Goldkamp highlighted the paradigm shift that occurred once drug courts evolved, viewing the person as someone with problems and

adopting a hands-on, non-adversarial role. Today approximately 600 drug courts exist in the United States.

Mental health courts have varying definitions from "almost any court-related mental health initiative" (Hank Steadman) to "specialized courts with separate dockets with dedicated, knowledgeable personnel" (H.B. 2495) to "collaborative effort of criminal justice and mental health treatment system to use case managers to improve case processing time, improve access to public mental health system and rate of recidivism" (NACO).

Dr. Goldkamp provided his view on the mental health court's characteristics:

- Target problems in the target population they address Most courts try to address persons with severe mental illness who are not reached by the community mental health system and are found in the criminal justice system. However, courts have different emphasis on whom they serve, from nuisance offenders (misdemeanors to those charged with more serious offenses (felonies).
- Are judge-centered This model derives from the drug courts which are "problem-solving" courts
- Represent a new working relationship between the mental health system and courts This partnership is new and can be an "uneasy marriage." The past judicial approach was simply to refer the person out and have the problems addressed somewhere else. Now, the judicial system attempts to screen and identify persons with mental illness at the early stages.
- Involve special court room procedures Mental health courts have more informal, non-adversarial procedures which involve a mix of incentives and sanctions. One-on-one discussions between the judge and person with mental illness often occur.
- Rely on a range of supportive services for the mental health court to draw upon The follow-up from mental health court involves a variety of agencies collaborating and providing services in team approach.

While mental health courts share similarities, they also can have profound differences, including:

- Different legal contexts which dictate what a specific court can and cannot do (e.g., civil commitment laws and criminal justice penalties)
- Different points of intervening with the case
- Varying policies about whether a person can utilize the mental health court after a conviction
- Use of sanctions and incentives employed (e.g., inducements such as better housing or supports to threats of jail)

- Available community resources to support the mental health court treatment process.

Finally, Dr. Goldkamp maintained that more questions than answers exist given the relatively short history of mental health courts. He raised several important issues, including:

- Lack of a consistent definition or standard for mental health courts
- Challenges of working around and through the legal system's constraints
- Conflict between the criminal justice system's goals and mental health treatment goals
- Challenge of early and speedy identification given privacy constraints within the two systems
- Distinction between and appropriateness of voluntariness and coercion within mental health courts
- Definition of successful outcomes from mental health courts
- Capacity of system for interagency cooperation

Judge Rhoades: New Initiative in Criminal Courts Focusing on Mentally Ill Persons in the Criminal Justice Population

Judge Rhoades shared statistics from the Bureau of Justice revealing that nationally 16% of people in state prisons and jail have a mental illness. In Alaska, 37% of people in prison or jail are "mental health trust beneficiaries," a broader definition which includes individuals with brain injury and chronically alcoholic persons who suffer psychoses. Thus, in Alaska on any given day, 1,154 individuals in prison or jail also have a substantial cognitive deficit. Yet, the state has only 79 psychiatric beds, eight of which are forensic beds. Four of these eight beds are occupied by persons who are deemed not guilty but mentally ill leaving only four open beds for people to move through. Judge Rhoades' interest in mental health courts grew out of frustration with participating in a mechanism that simply cycles people through without doing anything for them and her personal interest as a family member. She indicated several trends that contribute to the need for mental health courts: high civil commitment criteria (it's easier to get into jail); a variety of nuisance and quality of life crimes on books; disincentives for a defense attorney to request a competency hearing (as that hearing may take longer to obtain than the actual sentence); and the eventual accumulation of prior convictions which end up leading to longer sentences for the defendant. Simply put, the court system does not "flush out" the inappropriate arrests of persons with mental illness.

Judge Rhoades became involved with a task force looking at mentally ill offenders. The task force made recommendations to the Governor and proposed using existing

resources to reformulate the court system and focus on people charged with misdemeanors. She explained that felons already were assigned specialized probation officers and, if they were convicted, could obtain day treatment through funds set aside by the correction system. The result of the task force's efforts was a specialty therapeutic court within the Anchorage District Court based on the drug court model.

Judge Rhoades described the Alaska mental health court as tremendously collaborative and very time-consuming. The Court has established a relationship with the Department of Corrections where staff examine the daily arraignment lists and bookings to see who might be eligible to appear in mental health court. The Court accepts referrals from any source (Department of Corrections, police, prosecutors, family, individual). The next step is an "opt-in hearing" where the defendant learns the purpose of the court and decides whether to participate in developing an individualized treatment plan, following the plan and returning to the judge to give updates with the provider. The treatment plan becomes a condition of bail or sentencing with the Judge able to return the person to jail for non- compliance. Judge Rhoades reports that most people opt-in when given the choice.

She articulated several benefits of having a judge involved with this process, including:

- People have access to treatment from providers whom they may have burned out previously.
- Treatment providers are more willing to become involved again.
- Defendants become more engaged because they have a judge who will cajole, admonish, re-engage, do whatever it takes to get them to continue and a team of lawyers and case managers supporting them.
- As necessary, the case manager and the judge can serve as a classic good cop/bad cop in order to motivate the defendant.

The Alaska mental health court also has a companion program, the Jail Alternative Services Project (JAS), which provides case coordination for 40 people who are seriously mentally ill with psychotic features. The case coordinator meets with the person to implement the plan and help him/her succeed.

The Court has seen more than 250 people and served 54 people through JAS over a 2-year period. Among the 54 seen by JAS, the clinical recidivism figures are promising: 47 people had been hospitalized in their lifetime prior to JAS (since 1967); 27 people had been hosptialized one year prior to JAS; and since entering JAS, 20 of the 54 have been hospitalized during the two-year period. In addition, the average length of stays went down. The JAS project allows the Court to catch people on bail or probation violations instead of later on when have seriously decompensated.

Statistics for legal recidivism reveal that the 54 JAS clients had 77 felony arrests and 404 misdemeanor arrests in their lifetime. In the year prior to entering JAS, these individuals had 13 felony and 183 misdemeanor arrests. During their JAS participation, the clients have had1 felony arrest and 30 arrests for misdemeanors (which also include violations of the treatment plan/probation).

Dr. Rhoades stressed that cross-training is important for judges to learn more about mental health treatment and resources. She encouraged Medical Directors to become involved with any task force considering mental health courts as that is their opportunity to get in on the ground floor of planning and develop the state's model.

State Academic Collaboration

Moderator: Philip Veenhuis, M.D., M.P.H.
Medical Director, North Carolina

Presenters: Joseph P. McEvoy, M.D.
Professor, Department of Psychiatry
Duke University Medical Center
Durham, North Carolina

Harold Carmel, M.D.
Clinical Director
John Umstead Hospital
Butner, North Carolina

Dr. Veenhuis offered some reflections on the progress of treatment in psychiatry over the last 38 years, including better organized services, enhanced medications and improved ability to diagnosis. However, there continues to be a lack of treatment availability and the cross-institutionalization of persons with serious mental illness (who end up in jails and nursing homes). Dr. Veenhuis expressed his hope that state/academic collaboration efforts might eventually impact on these important areas, too.

In North Carolina, there are four psychiatric hospitals and four medical schools. Three of the hospitals and medical centers have a significant collaborative relationship involving rotation of residents and medical school clerkships. At the Dorothea Dix Hospital in Raleigh, the current medical director is a University of North Carolina faculty member on contract. At least 50% of UNC students do clerkships at Dix. Residents also serve as primary on-call staff with back-up from full-time staff. The one university and hospital that do not have as close a working relationship, Wake

Forest University and Broton Hospital, suffer from the realities of being 125 miles apart.

In addition to hospitals, the universities collaborate with community-based programs through Area Health Education Centers (AHEC). These free standing centers were originally federally funded programs to bring medical education into the communities. In North Carolina, there are nine AHECs, six affiliated with UNC and one with Wake Forest, Duke and Eastern Carolina respectively. UNC residents also spend one day per week at community mental health centers.

Dr. Veenhuis outlined several advantages of the academic/state collaboration for SMHAs and Medical Directors:

- Increased recruitment ability given the attraction of an academic connection
- Availability of residents (and the increase in manpower) to serve patients
- Enhanced quality of care

The medical schools also experience advantages, such as more teaching beds, an available research population and support for faculty positions through state contracts.

There can be some disadvantages for the SMHA with this arrangement. The SMHA has some costs resulting from the partnership and during tight fiscal times, these costs may be questioned or eliminated. Also, when faculty need to be off site, problems can emerge, particularly as a hospital prepares for HCFA and JCAHO visits.

Dr. Carmel: Description of Linkages Between Academic and State Mental Health Systems... Educational, Research and Cost Advantages

Based on his experience, Dr. Carmel described hospital settings in California, Colorado, Virginia and North Carolina which have used a variety of state/academic partnerships.

At Taskadoaro Hospital, a maximum security forensic hospital 200 miles from Los Angeles and San Francisco, the partnership began as pharmacological consultations in the mid-1980's. Eventually a forensic fellowship was established, given the high volume of criminal commitments, evaluations and court appearances.

Colorado Mental Health Institute in Pueblo was 110 miles away from the only medical school in the state, yet collaboration existed. All physicians were university faculty assigned full-time to the hospital. The core of the hospital's medical staff came from the Career Residency Program, where a resident could double his/her salary for one year as a staff psychiatrist at the state hospital. As a result of the medical school's

department chair's strong personal and professional commitment to the public sector, there were many linkages between the Colorado Department of Mental Health and the university throughout the state. The medical school also began public psychiatry and forensic programs. Despite the distance, a strong and mutual connection existed between the university and state hospital.

Dr. Carmel served as Medical Director in Virginia, which has nine psychiatric hospitals. The closest state/academic partnership existed between the University of Virginia (UVA) and Western State Hospital, including important UVA clinical research based at Western State. In Richmond, the Medical College of Virginia and Central State Hospitals have a connection. This relationship was a bit turbulent, given the partners' proximity to the central office and the severe scrutiny of the hospital's practices. In Northern Virginia, the Northern Virginia Mental Health Institute has residents from local medical schools rotating through its doors.

In his current position as Clinical Director at John Umstead Hospital in North Carolina, Dr. Carmel reported that his hospital's affiliation with Duke University as critical for recruitment, retention. State psychiatrists are offered to spend time at Duke doing research, teaching, pursuing clinical interests while the hospital is able to recruit university faculty to work at the state hospital.

Dr. Carmel referred participants to a handout "A Ten-Year Update of Administrative Relationships Between State Hospitals and Academic Psychiatry Departments," a November 1994 article that appeared in Hospital and Community Psychiatry. Seventy-one of responding medical school departments of psychiatry indicated they had relationships with state hospitals, some dating back thirty or more years. Approximately 40% of the state/academic relationships were less than ten years old. The types of relationships varied from integration (a small percentage) to contracts and other financial mechanisms for doing business (faculty consultation, teaching supervision or CMEs) to the most common relationship, resident training and rotation.

To quickly capture the current prevalence of state/academic relationships, Dr. Carmel examined state hospital vacancies in the APA newsletter and the Psychiatric Times web site, assuming state hospitals would mention academic affiliations in their recruitment ads. He found that of the 57 state hospitals that placed recruitment ads, 31 indicated a link with medical school departments of psychiatry. For these 31 hospitals, 11 of the ads were placed by the medical school recruiting for faculty members who would be based at the hospital. In four of the 57 ads, the state hospital was described as a major teaching site or division of the department.

Dr. Carmel also reviewed the factors that support public-academic liaisons offered by John Talbott and Milt Greenblat:

- strong and committed leadership
- positive and supportive attitudes by leaders
- collaboration is viewed as mutually beneficial rather than benefitting one party over the other
- good program design that maintains high quality (staff, training experience)
- systemic factors which can align to promote the collaboration
- adequate and attractive funding flow

Dr. Carmel stressed that such collaboration involves the joining of two different cultures. In order to be maintained, the relationship must be a priority and each party's perceived self interests and needs must be congruous.

The public academic partnership can also be pulled apart by a variety of factors. Personnel changes, resource constraints and/or political pressures can affect the commitment to the relationship. The Department's needs may also change, due to either internal or external pressures.

Dr. McEvoy: Description of Linkages Between Academic and State Mental Health Systems... Educational, Research and Cost Advantages

When he arrived at John Umstead Hospital in 1989, Dr. McEvoy initially strengthened the state/academic partnership by focusing on the adult admissions unit which admitted 180 patients per month. Dr. McEvoy maintained that people are more interested in collaboration if there is a new admission unit, given the more varied population. At the beginning, Dr. McEvoy also rearranged the structure from a general rotation to a module system where staff worked primarily with a certain type of patient (people with affective disorders, people with psychoses, etc.). This new system was helpful in attracting young faculty members who wanted to work with certain types of patients. As admission rates have burgeoned, the system has changed once again; however, those physicians who have a research focus are able to screen new admissions every day and take on those patients who fit their criteria.

Dr. McEvoy explained how he is employed by Duke and works at JUH. To him, this contract arrangement demonstrated a commitment to the academic/state partnership on behalf of the state. Dr. McEvoy discussed how he and his colleagues are "blue collar clinicians" who like patient care and also enjoy teaching. This state/academic arrangement is successful because the clinicians are not too academic nor hands-off people. John Umstead's approach is that clinical research is done on regular wards and interwoven with regular clinical care. Dr. McEvoy also attributed some of the collaboration's success to good luck. High quality residents have gone through the Duke program and afterward joined John Umstead's staff. During his tenure, there have been needs for new sites to test new antipsychotics, as well as available funding.

Once Dr. McEvoy learned that nicotine research occurred in other Duke departments, he obtained funding from the National Institute of Drug Abuse (NIDA) to study smoking in patients with major psychiatric disorders. With Jeff Lieberman at UNC, Dr. McEvoy is a co-principal investigator in comparative studies of antispychotics for people with schizophrenia at fifty sites around the country and at thirty sites for people with Alzheimer and behavioral problems. These types of major research initiatives result in the state favorably viewing the state/academic relationship.

According to Dr. McEvoy, John Umstead Hospital benefits from the relationship by filling its positions with top- notch physicians, which also enhances the recruitment of RN's and social workers. When the hospital has extremely challenging patients, the hospital can consult with very knowledgeable people, including experts in substance abuse. In addition, having residents, students and other trainees as colleagues around the hospital can be very invigorating for staff.

Duke experiences several benefits, as well: John Umstead physicians provide clinical teaching without pay; residents and faculty are able to work with really interesting patients with less managed care; and the hospital offers a high volume and varied patients for possible inclusion in inpatient studies.

Dr. McEvoy also expressed some of the downside for the hospital: 1) it can be challenging to negotiate fair costs with Duke; 2) researchers must go through Duke and then through the hospital's IRB, requiring staff effort to read protocols, follow-up; 3) some research studies are a "wash out" and don't help patients; and 4) academia and hospitals can have competing agendas (e.g., staff may go to outside meetings and not pay the same attention to HCFA and JCAHO details).

Bill Tucker, M.D. (New York) discussed how his state hospitals have benefitted from their collaboration with eleven medical schools in New York. Many hospitals have set up a second opinion program whereby the diagnoses of people who have been hospitalized over five years are reviewed by university faculty staff. Of the first 100 persons served, 70 percent were able to be discharged within three months once they were properly diagnosed, took their medications and had their blood levels checked. New York utilizes junior university faculty who can work on a hospital ward one day per week to supervise physicians and provides them with an extra 20% stipend. Panelists suggested that the university should be helpful and available without swooping in and imposing supervision.

One participant voiced the question, "What might strongest pressure that could fracture the state/academic liaison?" Dr. McEvoy responded the greatest pressure is from accelerating admissions which may overburden the clinician researcher. Staff who are striving to launch an academic career (with the requisite reading, writing and

grant-writing) could end up being driven away from state hospitals by burgeoning case loads. Dr. Veenhuis concluded the session by observing that the future of quality care is dependent on continuing academic/state collaboration.