A Public-Academic Partnership to Support a State Mental Health Authority's Strategic Planning and Policy Decisions

Anthony Salerno, Ph.D.
Lisa B. Dixon, M.D., M.P.H.
Robert W. Myers, Ph.D.
Anne M. Smith, L.M.S.W.
J. Steven Lamberti, M.D.
Thomas C. Jewell, Ph.D.
Susan M. Essock, Ph.D.

Mental health authorities across the country face numerous challenges in developing effective and practical strategies to adopt and sustain research-supported and stakeholder-endorsed mental health practices. This column describes how an academic center assists a mental health authority in making policy decisions by the use of advisory panels of multiple stakeholders, including members of the research community, advocacy organizations, service providers, and consumers. An advisory panel that focused on services involving family members for adults with serious mental health problems serves as a case example. (*Psychiatric Services* 62:1413–1415, 2011)

Dr. Salerno and Dr. Essock are affiliated with the Department of Psychiatry, College of Physicians and Surgeons, Columbia University, New York, where Dr. Essock is also with the Division of Mental Health Services and Policy Research. Dr. Salerno is also with the McSilver Institute for Poverty Policy and Research, Silver School of Social Work, New York University, New York. Dr. Dixon is with the Division of Health Services Research, University of Maryland School of Medicine, Baltimore, and the U.S. Department of Veterans Affairs Capitol Health Care Network Mental Illness Research, Education, and Clinical Center, Baltimore. Dr. Myers is with the Division of Adult Services, New York State Office of Mental Health, Albany. Ms. Smith and Dr. Jewell are with the Family Institute for Education, Practice, and Research, Department of Psychiatry, University of Rochester, Rochester, New York, and Dr. Jewell is also with the Center for Practice Innovations, Columbia University. Dr. Lamberti is with the Severe Mental Disorders Program, Department of Psychiatry, University of Rochester Medical Center, Rochester. Send correspondence to Dr. Salerno at 92 Winchester Dr., Monroe, NY 10950 (e-mail: anthony.salerno@nyu.edu). Dr. Dixon and Brian Hepburn, M.D., are editors of this column.

Of necessity, state mental health systems provide services beyond the evidence base—people's needs simply are more varied than the topic areas addressed by research. The New York State Office of Mental Health (OMH) has commissioned the Center for Practice Innovations (CPI) in the Department of Psychiatry at Columbia University to convene panels of experts to review and synthesize the research evidence for particular topic areas in which OMH is considering adopting, expanding, or changing practices.

The goal of each panel is to provide the public partner with practical recommendations. Examples of topics include improving psychotropic prescribing practices, supporting cognitive enhancement for people with schizophrenia, and promoting a family-friendly mental health system. CPI provides a complete list of topics addressed by the advisory panels during the past several years along with brief summaries on its Web site (www.practiceinnovations.org/AdvisoryPanelbrRecommendations/tabid/63/Default.aspx).

This column describes how the panels are developed and uses a case example to illustrate their functions.

Convening and structuring an advisory panel

The process of convening a meeting of an expert advisory panel to inform the decision-making activities of the OMH includes three key steps.

Step 1: planning and problem definition

The first step in the process of organizing an advisory panel is for staff from the academic center and the public partner to clarify the focus of the meeting. This ensures that the questions addressed by the panel accurately capture the issues of greatest import to the public partner. Planning meetings with OMH focus on the key questions that need answers before OMH takes the next steps.

Several criteria are considered in setting the advisory panel meeting agenda so that recommendations are practical, measurable, and meaningful. In our case, the CPI gathers perspectives and information that help

OMH understand the benefit of a practice, the costs and risks associated with implementation, the sustainability of a practice, the degree to which the current system is positioned to integrate new practices, the supports and resources needed, the number of stakeholders likely to be affected, the degree to which the practice is consistent with current regulatory and fiscal systems, and the training and resource demands associated with the practice.

Step 2: panel composition

On the basis of the information needs and administrative challenges or opportunities outlined by OMH, CPI enlists topic-area experts from within and beyond its home institution. Because researchers typically are eager to affect policy, acceptance rates have been very good. Panel membership also emphasizes the inclusion of various stakeholder groups, such as advocacy organizations, service providers, and consumers, who reflect a diversity of cultural backgrounds and perspectives.

Step 3: organizing the advisory panel meeting

Before the panel advisory meeting convenes, presenters and participants receive an orientation by e-mail that describes the purpose and focus of the meeting so that they can come prepared to address key areas of concern to OMH. At the meeting, the OMH commissioner or a member of the commissioner's cabinet outlines why the topic is important to OMH. Panel members report the current state of the evidence on the topic and what is known about facilitators of and barriers to adoption. This part of the meeting may include participation by researchers, policy makers, service providers, consumers, family members, and advocacy organizations. The presentations are discussed and alternative interpretations of the information presented are considered. When possible, consensus recommendations are developed. Finally, the panel decides on its next steps, for example, to draft and distribute a summary for comment or to further analyze existing data sets.

Case example

Each practice area addressed by an advisory panel has its own unique history and context in New York State, and this reality shapes each panel's work. The following case example illustrates how a multistakeholder advisory panel was organized to examine evidence-informed practices pertaining to involving family members as a means of promoting recovery for adults with serious mental health problems.

In this example, the OMH deputy commissioner for adult services and his lead staff person for working with families approached CPI about exploring the relative merits of a newly designed consumer-centered family consultation model that had been field tested for several years in parts of New York State. In addition, OMH was interested in hearing about alternative approaches that research and experience suggested would help promote recovery for clients served by OMH.

Development of consumer-centered family consultation

In 2003, OMH created the Family Institute for Education, Practice, and Research at the University of Rochester to promote family-oriented services through training, resource development, and consultation to providers in New York State. At the time OMH approached CPI, OMH and the Family Institute had had several years of experience providing training and consultation supports to mental health programs interested in adopting multiple-family groups (MFGs), the practice with the strongest empirical support at the time (1). Ultimately, 34 agencies volunteered to join this initial effort, and 26 agencies (76%) successfully implemented at least one MFG. Ultimately, the challenges associated with sustaining and expanding this practice precluded widespread uptake, and OMH began to look for alternative approaches to involve families in a client's treatment.

OMH and the Family Institute had explored brief approaches believed to have broad applicability across program types, clinical conditions, and cultural populations. This led to the development of consumer-centered family consultation (CCFC), a brief approach shaped by integrating the perspectives of consumers and stakeholders from various cultural backgrounds (2). CCFC is a highly transparent process with a defined scope and purpose. It consists of one to three meetings that involve the consumer, one or more family members, and the consumer's mental health practitioner. The focus of the meeting is to discuss practical information related to the consumer's mental health problems, treatment, and recovery; general guidance on how family members can be supportive; and education about resources available in the community, including the National Alliance on Mental Illness (NAMI).

In 2006, nearly 50 agencies from various mental health programs joined OMH and the Family Institute to examine the practicality, value, and organizational challenges associated with implementing CCFC. After 18 months of experience with this approach, the Family Institute had collected utilization data, information on lessons learned, and questions about CCFC in its formative stage of development. Those early findings showed that staff in mental health agencies accepted the model and its utilization, prompting OMH to examine how CCFC compared with existing best practices across the nation for promoting family involvement in treatment.

Participation in the advisory panel

Given the topic under review, the CPI director worked with the OMH deputy commissioner for adult services and the director of the OMH evidence-based practices initiatives to determine which researchers and stakeholder representatives to invite to participate in the advisory panel. CPI's academic partners identified prominent researchers in the family services field, and OMH staff identified local stakeholders. Eventually the group included family-oriented researchers, OMH policy makers, staff of provider organizations and NAMI, consumer advocates, and Family Institute faculty. [A list of attendees and their affiliations is available at the CPI Web site and in an on-

line supplement to this column at ps.psychiatryonline.org.]

Panel members provided feedback and observations concerning the current state of the evidence base for interventions that involve family members and on OMH's efforts to implement CCFC. The researchers reviewed evidence suggesting that family interventions of short duration (four sessions) that place fewer demands on the family than the MFG intervention may provide significant benefits to consumers and their family members (3). For example, research from the U.S. Department of Veterans Affairs (VA) suggests that a single, long-term approach, such as family psychoeducation, does not meet the needs of all families. Rather, a menu of family-involving services, including family education and short-term family consultation, should be available and has now been included in the VA Uniform Mental Health Services package (4).

Finally, research suggests that successful engagement starts with exploring the deeply felt concerns of consumers about involving family members. Interviews with consumers revealed that many are grappling with concerns about personal autonomy, independence, and burden on family members (5). As part of the discussion at the meeting, researchers mapped key elements of CCFC to the research literature and found none that conflicted with services involving families of adult clients that were known to be acceptable and effective.

Administrators of agencies that implemented the CCFC approach were eloquent both in their support of the model as a relatively "easy lift" and of the need for low-burden ways to assess implementation fidelity. CCFC was praised as a brief, feasible approach that was integrated easily into the core clinical process. Providers also supported continued refinement of the intervention, especially the development of a manual and clinical forms that would serve as memory aids and as a means of monitoring uptake of the intervention. They also requested flexible instructional resources such as DVDs and online training.

Consumers and family members expressed an appreciation for the efforts of OMH to promote flexible approaches that are clearly described, less demanding of time, focused on mental health education, and respectful of consumer and family preferences. They regarded the emphasis on merging consumer and family perspectives that often reflect cultural and religious values as a strength of the CCFC approach. Successful policy decisions that promote specific practices must be informed by the recipients of these practices. This means ensuring that consumers' and family members' perspectives are reflected in the design, evaluation, and adaptations of new practices.

Consensus of the panel and recommendations

The advisory panel endorsed OMH's decision to promote CCFC. It also presented several actionable and practical recommendations, including the need for a clear definition of the CCFC approach; a thorough evaluation of the CCFC pilot initiative; and an exploration of the kinds of resources and supports needed to promote staff competency and widespread implementation of the CCFC model. The panel also suggested that OMH consider adapting the CCFC approach to involve family members in support of specific evidence-based practices in the areas of work, health self-management, and co-occurring disorders.

Conclusions

Mental health authorities are continually faced with the challenge of developing policies that enhance quality. This requires an understanding of the barriers and supports in the current system of care. Policy makers throughout the country struggle to make informed decisions that are practical, fiscally sound, clinically effective, and aligned with the preferences, values, and needs of recipients.

Strategic planning meetings of multiple stakeholders are a productive and efficient means of insuring that planning efforts by the state mental health authority are well informed with respect to both the evidence base and the practical realities of offering acceptable high-fidelity, high-quality practices. The structure of such meetings can promote a process that identifies the topic area, presents the related evidence base, describes the current treatment landscape with respect to the practices under consideration, and generates actionable recommendations.

When consumers, family members, providers, researchers, and policy makers convene to consider "What next?" they can reach an understanding of the current evidence base. Together, these constituencies can identify steps that should be taken when the state mental health authority must, of necessity, operate beyond the reach of accumulated research.

Acknowledgments and disclosures

The authors acknowledge the financial support provided by the New York State Office of Mental Health (NYSOMH) to the Family Institute for Education, Practice, and Research at the University of Rochester to develop, field test, and improve the CCFC model. Furthermore, the NYSOMH supported the Center for Practice Innovations, which organized the advisory panel.

The authors report no competing interests.

References

1. McFarlane WR: Multi-Family Groups in the Treatment of Severe Psychiatric Disorders. New York, Guilford, 2001
2. Family Institute for Education, Practice, and Research and the New York State Office of Mental Health: Consumer Centered Family Consultation Manual. Rochester, NY, University of Rochester, Department of Psychiatry, 2007
3. Dixon L, Dickerson F, Bellack A, et al: The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statement. Schizophrenia Bulletin 36:48–70, 2010
4. Uniform Mental Health Services in VA Medical Centers and Clinics (VHA Handbook 1160.01). Washington, DC, US Department of Veterans Affairs, Office of Mental Health Services, 2008. Available at www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762
5. Glynn S, Dixon L, Cohen A, et al: The Family Member Provider Outreach program. Psychiatric Services 59:934, 2008