

I echo the recommendation of Li and Mathis to include patient demographic data in the IPFQR data. There is evidence that odds of seclusion and mechanical restraint in response to injurious assault by a patient differ between patients admitted voluntarily and involuntarily and that duration of these episodes differs between females and males (2). Li and Mathis note evidence of racial disparity in use of restraint (3). Demographic information for each hospital's patient population should be summarized in the IPFQR data to allow for more careful comparisons between facilities.

In addition, hospitals should report patient demographic information for each seclusion and mechanical restraint episode and, crucially, the duration of each episode. Such data would allow CMS to report facilities seclusion and restraint episodes per 1,000 patient days and provide summary statistics (e.g., percentiles, maximum) for the durations of these episodes in each facility. Episode-level data would also allow researchers to study patient-level correlates of seclusion and restraint duration and identify inequities. Reporting data at this level of granularity is not infeasible; many hospitals report such data quarterly for their participating psychiatric units to the NDNQI. The NDNQI data are proprietary, however, and limited to seclusion and restraint in response to injurious assault. Collecting similarly detailed, nationwide data on all seclusion and mechanical restraint episodes and making these data available to the public would be an important step toward improving the quality and safety of U.S. psychiatric care.

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Effect of Contact-Based Interventions on Stigma and Discrimination

TO THE EDITOR: In a recent Open Forum, Anthony Jorm reviewed the status of research on contact with people with mental illness as an approach for reducing the public stigma of mental illness (1). Contact decreases stigma when the public interacts with people in recovery from mental illness. Jorm highlighted concerns about the status quo of stigma reduction research, ending his essay with a list of standards to guide future research. Community-based participatory research (CBPR) was noticeably absent from his list. CBPR is an approach to empirical investigation in which people from a focal community (e.g., people with serious mental illness) partner with scientists to conduct all phases of social

research. Proponents of CBPR recognize general principles of human behavior and behavior change that lead to the traditional research approaches driving pursuits of psychiatric services (2). But with the maturing of psychiatric science comes the realization that these general principles are contextually based and that essential factors in culture and community can affect both behavior and behavior change. Given that community is an essential construct in understanding psychiatric illness and services, members of that community need to be part of the research team addressing the specific empirical concern. Hence, services research should be driven by CBPR teams in which constituents of the community are partners. For stigma research, these teams would include advocates with lived experience. Note that people with lived experience are not objects of study, but rather full partners in carrying out the project, interpreting results, and translating results into policy.

This kind of empowered approach to services research echoes the recurring call for people with lived experience to be at the center of antistigma programs (3). Being on the receiving end of stigma, they should be driving solutions. They do this not from a position of sympathy but rather empowerment. All the rest of us—service providers, family members, researchers—are their allies. I expect that CBPR will have a special kinship with contact-based approaches compared with other antistigma strategies, such as education. Contact-based interventions place people with lived experience at the center of antistigma interventions. Hence, future research needs to incorporate CBPR to make sure this agenda is reflected.

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COVID-19 Impact on Learning Among New York State Providers and Learners

TO THE EDITOR: During a time when the landscape of learning was already evolving to meet the needs of busy learners, the impact of COVID-19 necessitated a shift from in-person to remote learning. The Center for Practice Innovations (CPI) serves as a critical resource in spreading evidence-based practices (EBPs) identified by the New York State Office of Mental Health (OMH) to support the transformation of behavioral health care service delivery throughout the state.

Since its inception, CPI has offered a hybrid approach, offering training and technical assistance both remotely and in person to adapt to learner and program needs.

Given its already robust online learning platform, CPI was able to rapidly pivot to offer entirely online content, including new training and resources, to support learners during COVID-19 (1). First, CPI converted all in-person training to a virtual format. Whereas in-person training typically occurs in day-long sessions (given that learners have to travel to training locations), CPI, consistent with adult learning principles (2), delivered remote training in shorter sessions, often spread across days and with significant breaks within and between those days. Second, CPI created and disseminated a series of training sessions to adapt EBPs for telehealth and address specific COVID-19-related concerns. Third, as onsite practicum placements closed, CPI offered graduate programs access to the online platform to provide their learners with supplementary learning and skill development. Fourth, OMH provided people throughout the state with an emotional support line by toll-free phone and online, leveraging CPI's online platform to provide training for people staffing this line.

After this shift, CPI saw a rapid increase in new training registrations. In the 6 months prior to March 2020, the mean \pm SD number of new training registrations was 24,406 \pm 9,075. In March and April 2020, those registrations jumped to 57,092 and 42,380, respectively. In these months, while we saw increases from people working for the state's behavioral health providers, we also saw a large increase from out-of-state behavioral health care providers who were already on contract with CPI for training and facing similar limitations on in-person gatherings (particularly in March) and people staffing the support line (largely in April 2020). May 2020 registrations continued a little higher than average (28,319 registrations), and June 2020 saw a return to average (22,868) as New York began phased reopening.

CPI's online learning platform has provided additional educational opportunities for learners since the start of the pandemic. Providing training in both synchronous and asynchronous formats has allowed learners the flexibility to access this content (3). While online learning has demonstrated effectiveness compared with in-person learning (2), training alone is not sufficient to change practice (4). Gaining clinical competencies requires scaffolding with practice and coaching to create a holistic learning experience. Hence, CPI also continues to offer remote technical assistance to help learners apply what they have learned and to help supervisors coach their staff. As the system reopens, providers and learners will need continued training and resources to incorporate EBPs into their practice, and CPI is committed to continuously adjust the balance and format of remote and in-person resources to meet those needs.

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