A Review of:

"Evaluation & Assessment of Laguna Honda Hospital Behavioral Care & Service Access: A Final Report"
by Davis Y. Ja & Associates

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The Author

Dee Roth, MA, was Chief of Program Evaluation and Research for the Ohio Department of Mental Health for 36 years. The office developed, tested and documented the Ohio Mental Health Consumer Outcomes System and promulgated it to all community mental health agencies in Ohio. A web-based data repository was also developed, along with a series of data reports for use by both planners and treatment staff. Ms. Roth developed and administered a grants program to enable universities and other organizations in Ohio to conduct research of interest to the public mental health system and also instituted a number of mechanisms for dissemination of results. She was principal investigator on two NIMH grants, studying homeless persons and severely mentally ill individuals living in the community, and her most recent research was in the area of the variables predicting the successful adoption of an evidence-based practice by community mental health organizations. She is the author of a number of scholarly publications, and has worked at the national level with the National Association of State Mental Health Program Directors Research Institute, NIMH and SAMHSA. Ms. Roth joined the Board of Pacific Institute for Health Innovation in 2006.

Pacific Institute for Health Innovation

Pacific Institute for Health Innovation (www.pihi.org) is a non-profit organization in San Francisco dedicated to improving the quality of life and well-being of individuals and families who suffer with mental disabilities. To achieve this mission, they work to develop, implement and promote programs and strategies that demonstrate the capacity to help people achieve and sustain recovery from mental illness.

Ms. Roth's work on this review reflects PIHI's ongoing commitment to:

1) Advocating at the local, state and national level for rehabilitation and recovery approaches and models of care,

2) Promoting and implementing clinical quality management approaches that enable programs and systems of care to ensure that the services they are providing are effective, and

3) Supporting clinical and research initiatives, which promote the adoption of these and other truly evidence-based approaches into mainstream psychiatric and mental health practice across all human service sectors.

Overall, I found the DYJ report to be interesting and some of the conclusions and recommendations to be well-founded. However, I also found some methodological flaws and some recommendations that seem not to be supported by the data. In addition, I had some questions. Some of these may simply reflect my lack of understanding of the Laguna Honda Hospital system, and especially of the lawsuit that was the impetus for the report. Another caveat: while I've tried to organize these comments into some loose sections, many simply refer to specific pages of the report and are in no particular order.

Evaluation Scope

The DYJ Report states (page 9) that the evaluation was carried out to accomplish the following goals:

1. Conduct an assessment of the mental health and substance abuse services needed, provided and available to LHH residents.

This sentence is a fair statement of the question around which the majority of the evaluation work was done. However, in other sections of the report, the goal is overstated or misstated. See below under Methodological Issues.

2. Determine the level of community expertise available to promote better discharges and linkages of class members to CBHS mental health and substance abuse services.

As far as I can see, this goal was not addressed in the evaluation. There are some mentions of community linkages and discharge issues, e.g., on page 28 regarding Relationships with TCM, and on page 30 on Facilitators of Discharge. However, it does not appear to me that the question of "community expertise available to promote better discharges and linkages" was evaluated, and this would seem to be a critical component of successful discharge for the patients in question.

3. Make recommendations regarding mental health and substance abuse services provided at LHH in order to promote and support discharge so that LHH residents who can benefit from either on-site or community-based mental health/substance abuse services are provided with those services in a timely manner.

A number of recommendations were made, but the grounding of these in the evidence elicited by the evaluation varies a great deal. See below under Recommendations Section.

Methodological Issues

1. In a credible, well done evaluation, it is critical to state clearly what the central question is, and to define terms. The DYJ Report confuses the central question by calling their task "an evaluation and assessment of Behavioral Health Services and Service Access" (page 4). When I read this, I assumed that the services themselves were going to be evaluated. Generally, this means at least measuring service components against a set of established quality standards or evaluating the effectiveness of services. Neither of these activities was performed. The waters are further muddied by references to evaluating "the quality of behavioral health services" (page 15) and "the quality of care at LHH (page 23). The best statement of the scope of the DYJ activities appears on page 9, but further clarity could have been achieved by a slight wording change to: "Conduct a study of the mental health and substance abuse services that were needed, provided and available to LHH residents", and the deletion of all references in the report to evaluating service quality.

2. There are many references to the "random sample" of patient charts that were reviewed. This is incorrect. It was initially a random sample, but during the chart review process, decisions were made to a) reduce the number of chart reviews and b) fill out the remaining slots with only those patients still residing at LHH (page 36). Many subsequent claims were made about "the random sample", but a

simple demographic comparison indicates that the sample was far from random. The Study Group, from which the sample was drawn, was 29.4% black and 44.0% white (page 32). The chart review sample was 46.0% black and 28% white. Clearly, the chart review group cannot be regarded as a random/representative sample of the overall behavioral health patient group. (Incidentally, this difference in the groups indicates to me that race could be a strong interactive variable in what is happening around discharges.)

3. The report states that grounded theory methodology was used to elicit themes out of the staff interviews (page 18). There is a decent description of this methodology in the first paragraph on page 57, but there are indications that it was not followed. I've done a lot of this, and it feels like the list of codes on page 58 is both sparse and overly general, given the types of questions asked. The more serious problem lies in the "Key Questions for Interviewers" document on page 54. If this is what interviewers were given during their training, it likely severely biased what they heard from interviewees and how they coded and interpreted the data. The question areas (page 55) are more generic, but judgments about what was happening would likely have been made already, given the "Key Questions" document.

4. The percentages reported on page 42 are technically correct, given the frame "of the 9 remaining patients". However, evaluators familiar with the policy use of findings and with the fact that things tend to get quoted out of context, would have calculated the percentages differently, to give a clearer picture. It should have been: 12 patients had severe diagnoses, of which 25% were residents for less than 30 days or had been diagnosed with mental illness in the past but displayed no documented mental illness symptoms during their residence, 42% had no documentation of any type of psychiatric evaluation or service in their charts, and 33% had received treatment by a psychiatrist during the study period.

5. This is minor, but the use of the word "claimed" on page 18 feels a little pejorative and transmits skepticism.

Comments on Recommendations

1. The convening of a system-level group to specify where policies are needed to enhance behavioral health coordination and to resolve responsibility and authority issues is a good idea, but care should be taken to make this a broadly representative group. There should also be a specific charge to the group about their recommendations needing to be a broad conceptual framework, and needing to leave details, specific policy-writing, etc., to subsequent groups. This group should start out with consideration of what the mission of LHH is in the overall SFDPH system of care. I found it odd that there was so little discussion in the report of what the mission and function of LHH is supposed to be, according to SFDPH directives and other documents—those must exist somewhere! It does seem that there is an "identity uncertainty" for many people, but the report could have been more helpful in stating the current mandated responsibilities of the hospital.

2. Under "LHH Policy Level Recommendations", it seems like a good idea to move toward a standardized treatment model for behavioral health patients, but the insistence that "all disciplines have equal input into service delivery decisions" (page 46) seems a bit over-prescriptive at this stage of the game. There are undoubtedly areas where the recommendations of various disciplines could be in conflict, so the goal might more reasonably be that disciplines have equal, and collaborative, input, but that there is also a clear statement of the circumstances in which one set of recommendations can override another.

3. In the section on LHH Operational Level Recommendations, the DYJ Report begins by stating that there are a number of "areas that need to be considered" (page 46). It then starts recommendations in this frame but rapidly moves into a very prescriptive and directive mode. This culminates in the recommendation "that higher salaried physicians be replaced by registered nursing staff, social workers and psychologists" (page 47). On my first read of this report, I put a note in the margin next to the

above sentence: This came out of the blue! I can see no evidence in the data collected in the evaluation that would support this conclusion. On the contrary, earlier recommendations stress the importance of there being policy and operational groups who sit down and figure out what the appropriate treatment roles of various groups should be. This very specific recommendation about replacing doctors with other staff seems to echo politics, not data.

Other Questions/Thoughts/Issues

1. There seems to be confusion within the report about whether there now are or should be separate, special behavioral health units—at least I was confused.

2. The report could have been greatly enhanced by the use of some examples from the data that explain and clarify the concept being discussed, particularly regarding interview data. Places where this would have been especially helpful: differing philosophies of patient care (page 19), medical model of care (page 20), and integrated model of care (page 20). However, I found example i on page 24 not helpful—how does this explain or amplify middle management in psychology, nursing and social work's assertion that more training is needed in the integrated service model?

3. By the end of the second read of the DYJ Report, my assumption was that, in order to be in LHH, patients had to have a medical need, and some of them would also have a behavioral health need. If this is the case, it wasn't explained very well in the report, and such an explanation could have lent clarity to some of the discussion.

4. It's clear from the data that behavioral health patients are getting discharged more rapidly than others (medical-only?) in the hospital. This led me to wonder whether the issue is that the lawsuit was about the expectation that they should be being discharged even more rapidly. If this is the case, it would have been helpful to have that stated in the report, clarifying the settlement expectations.

5. This is probably just my total-outsider status, but I couldn't understand where the discipline of psychiatry fits into the overall LHH organizational structure. Some references in the report seem to indicate that they are part of the Medical department (and thus would fall under "medical doctors"), and some places make it sound like they are a separate department, perhaps linked to the behavioral health unit? This may be totally unimportant, because everybody out there understands the structure. On the other hand, it could be indicative of some lack of understanding by DYJ Associates or persons interviewed for the study.

6. It wasn't clear to me from the report what TCM was; I had to ask someone before I could finally figure out the report material pertaining to this organization.

I hope these thoughts have been helpful. If you have any questions or comments regarding this review, or any of PIHI's other local and state advocacy projects, please contact Janice E. Cohen, M.D. at (415) 566-6683.

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