

Transforming API: A New Vision of Alaska's Mental Health System

**Final Report Of The
API Quality Assurance Committee**

February 1999

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EXECUTIVE SUMMARY

In February 1998, a Letter of Agreement was signed by representatives from the Alaska Psychiatric Institute (API), the API Governing Body, the Division of Mental Health and Developmental Disabilities (DMHDD), and the Alaska Mental Health Board (AMHB) to establish an API Quality Assurance Committee that would investigate, develop recommendations, and complete a final report encompassing a variety of issues relating to provision of quality care at API (please see Exhibit 1 to this report). Those issues included:

- 1. Treatment issues at API** to ensure treatment is fully responsive to the individualized needs of consumers and geared toward maximizing the ability of consumers to function as independently as possible within the least restrictive environment.
- 2. Assurance of quality at API**, including external review by an independent entity, to be formulated by the API Quality Assurance Committee and the Integrated Community Quality Assurance Steering Committee, which was charged with developing a quality assurance system for community mental health programs.
- 3. Involvement of consumers/advocates** with the objective of maximizing the involvement of consumers and families in treatment planning and the treatment process at API.
- 4. API governing structure** with respect to enhancing the policy-making role of the API Governing Body and ensuring broad-based stakeholder representation in the governance structure and process, including increased consumer representation.

The Committee met six times between June 1998 and January 1999 to develop reports and formulate recommendations addressing the four issue areas identified in the Agreement. The Committee approached its mandate within the framework of three overarching concepts: instituting a policy-making governance structure at API; increasing consumer involvement in all aspects of treatment, program development and implementation, and quality assurance at API; and developing and implementing a recovery-based treatment philosophy at API. Through its deliberations, the Committee identified seven specific issue areas to address its charge and prepared individual reports on the following:

- Governance
- Individualized Treatment
- Quality Assurance and Outcomes
- Special Populations—Adolescents

- Special Populations–Forensics
- Interrelationship with Community
- Training

Overall, the recommendations of the Committee are designed to affect a paradigm shift toward the use of a recovery-based treatment model at API and to increase the involvement of consumers and advocates at all levels of the operation of the hospital, as well as in the treatment of patients. It is assumed that increased consumer and family involvement will be central to the future implementation and monitoring of the recommendations made in this report.

The Committee assumes that day-to-day monitoring and implementation of its recommendations will rest with the API Governing Body. It is further assumed that general monitoring and implementation of the Committee's recommendations will occur through a variety of mechanisms, including the application to API of the statewide quality assurance process administered through the Division of Mental Health and Developmental Disabilities (DMHDD), monitoring by the Alaska Mental Health Board (AMHB), and review by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

It is the Committee's firm belief that implementation of these recommendations will allow API to assume its intended role in Alaska's mental health system as a recovery-oriented inpatient facility.

The Committee's recommendations are listed below by section within this report with additional background discussion to those recommendations in each section. These recommendations are listed numerically, but are not prioritized.

Governance

1. Enhance the role of the API Governing Body to that of a policy making body through administrative regulations setting forth the role, membership, duties, and responsibilities of the Governing Body and chief executive officer.
2. Modify the API Governing Body Bylaws with respect to Duties and Responsibilities to include the evaluation, hiring, and termination of the API Director; oversight of API internal planning and external planning participation; and increased fiscal and budgetary management authority (please see Exhibit 2 to this report).
3. Change the API governance structure to ultimately provide for 51% consumer representation on the Governing Body in order to ensure consumer and minority interests have significant input into the governance of API. Increase the existing consumer representation on the API Governing Body with the initial appointment of

no less than four consumer representatives and pursue the goal of 51% consumer representation as expeditiously as possible.

Individualized Treatment

1. Treat persons at API with dignity and respect and appropriately offer them the rights and privileges that are available to persons with physical illnesses. A patient advocate position should be created at API to ensure this occurs.
2. In order to maintain a recovery focus in the treatment of persons admitted to API, ensure that individual consumers are an integral part of their own treatment process and planning.
3. Afford all persons admitted to API the opportunity to include members of their natural support system in both treatment planning and the treatment process itself. Parents and guardians of children must have the opportunity for active involvement.
4. Provide persons at API a quality of care that is representative of the best that can be made available in an inpatient setting.
5. Ensure that long-term patients at API are afforded community alternatives to hospitalization whenever possible.
6. Increase the emphasis on understanding the needs of consumers coming to API from rural locations and achieve cultural competence in the operation of API.

Quality Assurance and Outcomes

1. Revise the *Integrated Standards and Quality of Life Indicators*, which was developed through the DMHDD Quality Assurance Steering Committee, to include inpatient services standards. These revisions should address the development of clinical standards that review services specific to an inpatient setting. Standards should include, but not be limited to: the use of restraints and seclusion, patient and family member involvement in the inpatient planning and treatment process, medication use, clinical appropriateness of treatment, the use of rewards and punishment as a means of behavior management, and the use of a level system in inpatient management. All proposed inpatient services standards should undergo a review by the Quality Assurance Steering Committee, as well as a public review process.
2. Create a single, integrated quality assurance review system encompassing all inpatient and outpatient facilities, including API and DET providers. This review will include an assessment of: 1) consumer satisfaction/ dissatisfaction, 2) community

involvement, 3) clinical standards, 4) rural and cultural competence, and 5) interface between providers and API upon admission and discharge of patients.

3. Internal quality assurance review at API will include the establishment of a consumer advocate position within API, increased consumer and family member involvement in the quality assurance process, and implementing recommendations with respect to integrating, to the extent feasible in an inpatient setting, the psychosocial approach to recovery within API's treatment modalities.
4. Maintain and rely on the external quality assurance review processes that impact API, including but not limited to, the statewide quality assurance review process through DMHDD, review by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), welcoming consumer advocates including the Disability Law Center at API, and support for the Alaska Mental Health Trust Authority (AMHTA) grievance redress system.
5. Maximize education of the API Governing Body regarding Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and instruct the Governing Body to examine other ways of increasing consumer involvement in the JCAHO process.

Special Populations–Adolescents

1. Develop a full system of mental health care for adolescents and recognize API's limited role as an acute, secure inpatient facility within that system.
2. Create a multi-disciplinary team to coordinate all existing and current statewide children and adolescent planning efforts. This team would include, but not be limited to, representatives from child welfare, education, mental health, service providers, family members, community members, consumers, and advocates. Creating a comprehensive statewide mental health system in which API is able to effectively function as an acute, secure inpatient facility can only be achieved through the involvement of many stakeholders.
3. Develop and complete a transition plan, with timelines and a fiscal note, to address the need for alternative intensive (secure) residential and transitional living services for adolescents in the community.

Special Populations–Forensics

1. Maintain the present level of psychiatric care within the Department of Corrections (DOC) while continuing to develop a full continuum of psychiatric services within DOC.

2. Oppose passage of sexually violent predator legislation that would require API to either house for evaluation or treat persons determined to meet the definition of a sexually violent predator.
3. Evaluate the impacts on API's forensic treatment program of the various pretrial diversion efforts presently underway for mentally ill misdemeanants, including more clearly defining the role of API with respect to competency or culpability evaluations of individuals charged with a crime who are not in custody (i.e. out on bail).
4. Identify and work collaboratively with community-based resources in order to move into community placement those patients who are appropriate for discharge, particularly those who have, historically, been difficult to place due to their need for intensive services or supervision, including those patients who have been treated at API because they were found Not Guilty by Reason of Insanity (NGI).

Interrelationship with Community

1. Alaska Psychiatric Institute (API), the Rural Mental Health Providers Association, and the Alaska Community Mental Health Services Association will collaborate in the establishment of protocols with respect to the interface between API and the community in terms of admission to and discharge of individuals from API. Existing Memoranda of Agreement will be used as vehicles to memorialize these protocols.
2. Evaluate the interface between API and community providers through the Statewide Quality Assurance review process administered within the Division of Mental Health and Developmental Disabilities. The RFP process used by the Division will clarify expectations with respect to the interface between community providers and API.
3. Request funding from the Alaska Mental Health Trust Authority to conduct a 3-year research project that tracks patient discharge and transition from API and the timeliness and nature of the initial contact with patients upon discharge; use as a basis for recommendations with regard to quality assurance through appropriate continuity of care.
4. Develop and fund public education efforts aimed at destigmatization of mental illness for those consumers who use inpatient services, including API and other community mental health services.

Training

1. Develop a comprehensive recovery-oriented training program addressing the training needs of API staff, leadership, and the Governing Body.

2. Ensure that all training efforts support treatment that focuses on patient strengths.
3. Identify predictable and adequate funding for development of quality staff and best practices at API through education and training of hospital staff, leadership, and the Governing Body.
4. Develop more extensive mutual education and training partnerships between API and a wide range of university programs, diverse cultural and minority groups, and local community mental health providers.
5. Create mechanisms for internal and external review of all training as a component of the quality assurance process.
6. Actively involve primary and secondary consumers in the development, delivery, and evaluation of all training efforts.

INTRODUCTION

In February 1998, a Letter of Agreement was signed by representatives from the Alaska Psychiatric Institute (API), the API Governing Body, the Division of Mental Health and Developmental Disabilities (DMHDD), and the Alaska Mental Health Board (AMHB) to establish an API Quality Assurance Committee that would investigate, develop recommendations, and complete reports on:

- treatment issues at API
- quality assurance at API
- involvement of consumers/advocates at API
- the API governing structure

This Letter of Agreement also contains a commitment that the Department of Health and Social Services and the API Governing Body will implement the proposed changes and agreements reached through the Committee's deliberations.

The Letter of Agreement outlined the membership of an API Quality Assurance Committee, which was comprised of:

Randall Burns	Alaska Psychiatric Institute
Kathy Craft	Alaska Mental Health Board/DMHDD
Sheila Gaddis	Alaska Mental Health Board
Susan LaBelle	Alaska Mental Health Trust Authority
Beth LaCrosse	NAMI Alaska/Consumer
Chava Lee	Children's Advocate
Walter Majoros	Alaska Mental Health Board
Pat Murphy	Alaska Mental Health Board
Terry Osback	Alaska Psychiatric Institute
Nettie Scott	API Governing Body
Wayne McCollum	Rural Mental Health Providers Association
Vicki Turner Malone	NAMI Alaska/Advocate
Brenda Knapp	Alaska Community Mental Health Services Association

Karl Brimner, DMHDD Director, participated in the committee process in an informational and ex-officio capacity. The Committee also acknowledges the valuable participation of a number of non-Committee members, including consumers, advocates, and API staff, who offered their thoughts with respect to improving the quality of care at API and defining the hospital's role in Alaska's mental health system.

The API Quality Assurance Committee met on June 18-19, August 25-26, September 23, November 3-4, December 15, and January 12 to discuss the issues outlined in the

Letter of Agreement and to formulate this report. As the Committee undertook its charge, members identified seven specific issue areas that were felt to most fully address treatment issues, quality assurance, involvement of consumers/advocates, and governance as delineated in the Letter of Agreement. Subgroups were formed to draft reports in the areas of Governance, Individualized Treatment, Quality Assurance and Outcomes, Special Populations–Adolescents, Special Populations–Forensics, Interrelationship with Community, and Training. This report represents a consolidation of those efforts and puts forth recommendations to affect a paradigm shift in the operation of API toward the concept of recovery. These recommendations also seek to clarify the role of API as an inpatient care provider within a comprehensive mental health system.

This report of the API Quality Assurance Committee addresses quality assurance and treatment at Alaska Psychiatric Institute (API) as one of three elements in developing a state centralized inpatient care facility to effectively replace the old API. The three elements are: the development of a new 54-bed facility, the development of adequate community services, and this quality assurance effort around hospitalization.

In a comprehensive, effectively functioning Alaska mental health system, API would provide inpatient care for individuals with highly complex needs who cannot be treated in the community. The implementation of the recommendations in the Community Services Implementation Plan, and other community alternatives, including DET beds statewide, will enable the downsizing of API and a more focused role for the hospital within the statewide mental health system.

GOVERNANCE

Committee Recommendations

1. Enhance the role of the API Governing Body to that of a policy making body through administrative regulations setting forth the role, membership, duties, and responsibilities of the Governing Body and chief executive officer.
2. Modify the API Governing Body Bylaws with respect to Duties and Responsibilities to include the evaluation, hiring, and termination of the API Director; oversight of API internal planning and external planning participation; and increased fiscal and budgetary management authority (please see Exhibit 2 to this report).
3. Change the API governance structure to ultimately provide for 51% consumer representation on the Governing Body in order to ensure consumer and minority interests have significant input into the governance of API. Increase the existing consumer representation on the API Governing Body with the initial appointment of no less than four consumer representatives and pursue the goal of 51% consumer representation as expeditiously as possible.

Background to Recommendations

The Letter of Agreement that led to formation of the API Quality Assurance Committee required that the API governance structure be reviewed and that mechanisms be developed to enhance the policy-making role of the Governing Body and ensure broader-based stakeholder representation in the governance structure and process. The Committee's recommendations redefine the role of the Governing Body as that of a policy maker, rather than advisory to the DHSS Commissioner, and ensure representation on the Governing Body more accurately reflects the intent of incorporating representatives of the public, consumers and family members, and providers to achieve a broader based policy making perspective. The recommendations also expand the authority of the Governing Body to encompass management of the API Director position, involvement in the hospital's planning efforts, and fuller authority in fiscal and budgetary issues.

API Governing Body: Currently, API operates within the Division of Mental Health and Developmental Disabilities (DMHDD) under the Department of Health and Social Services (DHSS) and functions under the guidance and direction of an eleven member Governing Body. The Governing Body membership is currently comprised of

four public members, including one consumer representative, representatives of the Alaska Mental Health Board (AMHB), and the Alaska Community Mental Health Services Association (ACMHSA); the DHSS Commissioner's designee; the DMHDD director; and three API employees (hospital director, medical director, and nursing director).

DHSS is given the statutory authority pursuant to A.S. 47.30.660 to operate API as part of its powers and duties to provide a comprehensive mental health system for the citizens of the State of Alaska. The current API bylaws provide that the decisions of the Governing Body are advisory:

“Decisions by the Governing Body are in the nature of recommendations to the Commissioner. The Commissioner of DHSS is the final authority on all matters relating to the operation and administration of the Institute.”

The bylaws of the API Governing Body set forth the nature and extent of the Board's powers, duties, and responsibilities. The Committee recommends specific revisions to the bylaws (as shown in Exhibit 2 to this report) to broaden the scope and authority of the Governing Body to that of a policy-making body.

Consumer Inclusion: The mental health system of the State of Alaska as a whole is moving toward inclusion of consumers in planning, governance, and internal and external quality assurance review. The Committee members unanimously believe that this change of policy direction includes API. The Committee concludes that meaningful consumer (including cultural and minority) representation is currently not present on the API Governing Body and supports a delineation of Governing Body membership in regulation and in the organization's bylaws to reflect representation of consumer and minority interests. There was significant and meaningful deliberation within the Committee with regard to recommending that a percentage of the Governing Body membership be consumer representatives. A substantial number of Committee members felt that a Governing Body comprised of 51% consumer representatives is necessary to properly reflect consumer interests and there was agreement that having only one consumer on the Governing Body, as is currently the case, does not constitute “meaningful involvement.” After thoughtful consideration, there was consensus that the appointment of no less than four consumer representatives on the Governing Body would represent a good faith effort toward attaining the ultimate benchmark of 51% consumer representation.

Staff Participation on the Governing Body: The Committee recommends that API staff participation on the Governing Body be consistent with current requirements of Joint the Commission on Accreditation of Healthcare Organizations (JCAHO), while acknowledging that the Commissioner's appointees may include other additional API staff.

Selection of API Director: The Committee supports moving the appointment of the Director of API out of the political arena in order to ensure that the individual chosen to

fill that position has the ability to lead the hospital. This would be accomplished through amendments to the bylaws of the Governing Body, as well as recommended statutory and/or regulatory changes, to place the responsibility for selection, evaluation, and termination of the API Director with the Governing Body, in consultation with the DHSS Commissioner. Through regulation, under the Committee's recommendations, the composition of the Governing Body will reflect a broad base of consumer, minority, provider, and agency perspectives, all of which would be brought to the Director selection process.

Independent Entity: In their efforts to remove API from the political process and ensure its mission of helping consumers recover based on the latest and best medical practices, many consumers and advocates have argued for several years for the creation of an independent Governing Body similar to the Alaska Railroad Corporation, Alaska Permanent Fund, Alaska Housing Finance Corporation, or the Alaska Student Loan Corporation, which have a legal existence independent and separate from the State of Alaska. This debate also occurred in good faith in the API Quality Assurance Committee's deliberations. It is the position of the Committee that an independent and/or paid Governing Body does not lead to depoliticization of the process and, therefore, is not recommended in this report.

INDIVIDUALIZED TREATMENT

Committee Recommendations

1. Treat persons at API with dignity and respect and appropriately offer them the rights and privileges that are available to persons with physical illnesses. A patient advocate position should be created at API to ensure this occurs.
2. In order to maintain a recovery focus in the treatment of persons admitted to API, ensure that individual consumers are an integral part of their own treatment process and planning.
3. Afford all persons admitted to API the opportunity to include members of their natural support system in both treatment planning and the treatment process itself. Parents and guardians of children must have the opportunity for active involvement.
4. Provide persons at API a quality of care that is representative of the best that can be made available in an inpatient setting.
5. Ensure that long-term patients at API are afforded community alternatives to hospitalization whenever possible.
6. Increase the emphasis on understanding the needs of consumers coming to API from rural locations and achieve cultural competence in the operation of API.

Background to Recommendations

Consumers who come to API need intensive mental health care. They are not hospitalized to be managed, but rather to be engaged in a focused, purposeful and consistently personalized recovery process which maximizes their ownership of their own recovery. The existence of mental illness does not define who the person is or predetermine their ability to achieve recovery. The responsibility of staff is to look for and build upon strengths. Staff, in essence, must undertake roles as technical assistance resources and as mentors with responsibility to help consumers increase their ability to understand and manage their illness, increase their skills for healthy living, and maximize their belief in their recovery.

Consumer Participation in Treatment: Patient involvement at every phase of treatment is essential to recovery. Persons with mental illnesses must have the opportunity to take an active role in their own treatment and make treatment choices just as that opportunity exists for persons with physical illnesses. The importance of consumer participation in treatment is even more essential for persons with a mental illness. It is a part of regaining control where control in life has been lost through mental illness. Recovery from major mental illness is now possible with appropriate medications and psychosocial rehabilitation. The use of older, less effective anti-psychotic medications can result in extreme extrapyramidal symptoms and/or tardive dyskinesia. We now realize that the traumatic and negative effects of institutionalization can cause much psychological damage to a person suffering from a mental illness. Similarly, patients experience a loss of control and depersonalization when seclusion and restraints are used. All restraint and seclusion use should be documented for appropriateness in treatment, including usage that is part of a behavioral management plan. All interventions used prior to seclusion and restraints should also be documented in order to identify precipitating factors and as evidence of the presence of early intervention strategies.

Program structure must consistently support rather than limit achievement of a highly individualized, consumer-owned treatment process. Ideally, patients are assessed to determine their level of acuity and to establish appropriate supports. The current levels system at API must be assessed in that context. The levels system is effective when it is tied to the way the hospital supports the person rather than manages that person's behavior.

Evidence of positive interaction by staff would include behaviors which demonstrate respect for the patient as a person, such as active listening skills that value what the patient says, consistent support of individual choice on the part of the patient when working toward healing and recovery, and sustained efforts to ensure individual rights and protections. Patients must be satisfied with information on mental health, treatment, and patient rights that is provided to them by staff. There must be assurance that review of treatment plans in the quality assurance process reflects that treatment planning is based on consumer strengths and consumer goals.

Consumer Support Systems: The ability of a person with mental illness to develop and rely on a support system within the family and community has proven to be one of the most significant contributors to recovery. Consumers may wish to include families, friends, and partners in treatment decisions and as sources of support during hospitalization. Consent for their participation in all aspects of the recovery process should be offered to consumers throughout their hospitalization. Furthermore, hospital coordination with mental health centers can ensure that persons who have mental illnesses have advanced directives on file, and that these directives are followed.

Consumers have the right to expect that their treatment team will value and provide opportunity for inclusion of family and friends. Scheduling of meetings should reasonably accommodate the needs of family and friends who show an interest in

being involved in the recovery process and adequate time should be allocated to listen to them and offer support to them. Family and friends are often the best allies and historians for persons with mental illness. At other times, family members and friends are in desperate need of support and education to help them assist consumers to be successful at the point of their discharge from API.

Community Alternatives for the Long-Term Population at API: As a part of the Community Mental Health/API 2000 Project, which is implementing community mental health services in response to a downsized API, it is recognized that community alternatives need to be developed for the long-term population at API. Most of these persons have complex physical and/or developmental and mental health needs. While this population suffers from the effects of long-term institutionalization, they do require regular support and, in some cases, a secure residential setting. However, a substantive range of community alternatives to long-term hospitalization currently does not exist in the state. Residents of Harborview were successfully placed into the community through a combination of specialized foster care, nursing home, and small residential placements. A similar process must be developed to ensure that long-term patients at API are afforded alternatives to hospitalization whenever possible.

Rural and Cultural Competence: API faces the challenge of providing inpatient mental health services to people from an expanding range of cultural groups who are growing increasingly diverse, as is the state of Alaska as a whole. The foundation for increasing cultural competency among API staff and in the provision of services lies in the stated principles and values of the API Governing Body, as well as in the ability to individualize services and support patients through a structure that can accommodate diverse needs and perspectives while providing quality care.

In FY97, 28% of API's patients were Alaska Native, 2% American Indian, 6% African American, 2% Asian or South Pacific Islander, 2% Hispanic, and 2% "Other." This represents a 43% minority population at API, with the remaining 57% of patients being Caucasian. This high representation of minorities speaks to the need to develop culturally competent practices, training, and programs, in terms of both individualized treatment and general hospital services.

Some of the institutional barriers faced by API in providing a culturally diverse therapeutic environment have been:

- balancing the need for staff diversity with the need for specialized staff skills
- prohibitive travel costs and operational budget shortfalls
- lack of community support and follow through
- staff who experience difficulty with a changing workplace
- leadership changes and multiple reorganizations
- physical design features that affect optimal functioning of the hospital

Suggested actions to accomplish cultural competence at API include:

- designing an organizational cultural competence self-assessment, involving API Governing Body members, staff, community volunteers, consumers, advocates and families and culminating with a specific action plan
- developing culturally appropriate curricula as part of training programs
- hiring ethnic interns who are associated with a professional field
- designating “minority” representation on the Governing Body
- incorporating ethnic artwork and architecture into the hospital
- revising the API mission statement and strategic plan to operationalize the concept of cultural competence
- revisiting the API Policy and Procedure Manual to adopt as a policy statement some basic assumptions about cultural competence:
 - ⇒ API staff, clinical and non-clinical, can better meet the needs of people who receive services by enhancing their cultural competence.
 - ⇒ Cultural competence is a dynamic, ongoing process, not a goal or outcome; there is no single activity or event that will enhance the cultural competence of API Governing Body members or API staff members.
 - ⇒ Cultural diversity training is not effective in isolation. Concrete management and programmatic changes are required.
 - ⇒ Hiring staff from the same cultural background as the target population does not necessarily ensure the provision of culturally appropriate services, especially if those staff are not in decision-making positions, or are not themselves appreciative of, or respectful to, cultural differences.
 - ⇒ Establishing a process for enhancing cultural competence should be viewed as an opportunity for positive organizational and individual growth.

Cultural competence is a dynamic process that requires hard work and commitment. The long-term nature of the process requires a commitment of resources, both human and fiscal, toward implementation in order to enhance the cultural competence of API staff and Governing Body members. Hospital leadership must recognize the fact that staff and funders may be uncomfortable with both the organizational change and the personal introspection necessary to enhance the cultural competence of hospital programs and services.

QUALITY ASSURANCE AND OUTCOMES

Committee Recommendations

1. Revise the *Integrated Standards and Quality of Life Indicators*, which was developed through the DMHDD Quality Assurance Steering Committee, to include inpatient services standards. These revisions should address the development of clinical standards that review services specific to an inpatient setting. Standards should include, but not be limited to: the use of restraints and seclusion, patient and family member involvement in the inpatient planning and treatment process, medication use, clinical appropriateness of treatment, the use of rewards and punishment as a means of behavior management, and the use of a level system in inpatient management. All proposed inpatient services standards should undergo a review by the Quality Assurance Steering Committee, as well as a public review process.
2. Create a single, integrated quality assurance review system encompassing all inpatient and outpatient facilities, including API and DET providers. This review will include an assessment of: 1) consumer satisfaction/ dissatisfaction, 2) community involvement, 3) clinical standards, 4) rural and cultural competence, and 5) interface between providers and API upon admission and discharge of patients.
3. Internal quality assurance review at API will include the establishment of a consumer advocate position within API, increased consumer and family member involvement in the quality assurance process, and implementing recommendations with respect to integrating, to the extent feasible in an inpatient setting, the psychosocial approach to recovery within API's treatment modalities.
4. Maintain and rely on the external quality assurance review processes that impact API, including but not limited to, the statewide quality assurance review process through DMHDD, review by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), welcoming consumer advocates including the Disability Law Center at API, and support for the Alaska Mental Health Trust Authority (AMHTA) grievance redress system.
5. Maximize education of the API Governing Body regarding Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and instruct the Governing Body to examine other ways of increasing consumer involvement in the JCAHO process.

Background to Recommendations

Quality assurance is a comprehensive process to measure all aspects of service delivery at API and then, using the information gained from that process, to improve policy-making, service planning, program development, service delivery and accountability. The quality assurance process must involve all stakeholders in order to facilitate development of a comprehensive vision of service quality against which performance can be assessed.

Statewide Quality Assurance: Bringing API under the comprehensive umbrella of a statewide mental health quality assurance review process recognizes its role as a component of Alaska's mental health system. A Quality Assurance Integration Project was proposed through the Division of Mental Health and Developmental Disabilities (DMHDD) in 1996. In March 1997, the Quality Assurance Steering Committee was formed to develop a comprehensive quality assurance system covering all state-funded mental health, developmental disability, and early intervention/infant learning programs. The product of that committee's work, entitled *Integrated Standards and Quality of Life Indicators*, will be used as a baseline for developing a revised "inpatient services" quality assurance review tool. The methodology of coordinated site reviews, measurement of consumer results and satisfaction, improved fiscal accountability, tracking improvement plan follow-up, and a process to address individual consumer concerns will be applied to API. There will be particular focus on the issue of coordination between API and community mental health providers upon patient admission to and discharge from API in order to ensure the appropriateness of admission, quality of treatment both at API and in the community, and the existence of community supports upon discharge from API. The Committee further recommends that the revised inpatient services standards in the *Integrated Standards and Quality of Life Indicators* be applied not only to API, but also to all inpatient psychiatric facilities in Alaska receiving State DET funds.

After discussion regarding the application of a rating system to this quality review process, the Committee recommends that API's performance be rated based on the quantitative information gained from an assessment that API has "met", "partially met", or "not met" a specific standard. Technical assistance will follow assessment of API to help API address any areas of change recommended by the review team.

Continued Stakeholder Involvement: It is important to ensure ongoing full participation of API, providers, consumers, and advocacy groups in designing a shared vision of service quality. The information gained through quality assurance reviews will be used in policy-making to promote improvement of services within that vision. Quality assurance requires a sustained effort using formal avenues for stakeholder collaboration. The API Governing Body will promote the continuing meaningful stakeholder involvement necessary to evaluate and modify the system.

SPECIAL POPULATIONS—ADOLESCENTS

Committee Recommendations

1. Develop a full system of mental health care for adolescents and recognize API's limited role as an acute, secure inpatient facility within that system.
2. Create a multi-disciplinary team to coordinate all existing and current statewide children and adolescent planning efforts. This team would include, but not be limited to, representatives from child welfare, education, mental health, service providers, family members, community members, consumers, and advocates. Creating a comprehensive statewide mental health system in which API is able to effectively function as an acute, secure inpatient facility can only be achieved through the involvement of many stakeholders.
3. Develop and complete a transition plan, with timelines and a fiscal note, to address the need for alternative intensive (secure) residential and transitional living services for adolescents in the community.

Background to Recommendations

Adolescent Care: It is important to recognize that major problems with respect to adolescents services in Alaska's mental health system are external to the operation at API. In many cases, API is providing secure temporary residential placement for children rather than hospital services. The children's unit of the hospital was officially opened in September 1965. It is currently a 12-bed unit specializing in the care and treatment of adolescents, ages 13 through 17, who have severe psychiatric, organic, and behavior disorders that require an acute, secure, inpatient setting. Providers, parents and the community use API in a variety of other ways, however, including diagnosis, short-term care, and emergency respite care.

Residential diagnostic treatment programs are a necessary component that is now lacking in a comprehensive statewide system of care. The limited adolescent bed capacity at API, and the mix of levels of need among the adolescent population, have precipitated discussion of providing alternative intensive residential treatment service options outside of API, including secure (locked) residential treatment and transitional living options. There are adolescents who need an inpatient level of care, however, there are not always sufficient beds at API to treat those children with serious mental

illness. The children's unit at API often reaches capacity with children who would be better served by secure temporary residential placement.

Developing a full continuum of care for these adolescents through the collaboration of all parties, including adolescents and family members, is necessary in order to erase feelings of confusion, frustration, guilt, despair and ineffectiveness and to allow for the realization of positive outcomes from treatment.

Community Alternatives: The API Quality Assurance Committee recognizes that the lack of a range of both outpatient and inpatient treatment options for adolescents within the state is a significant challenge to providing appropriate treatment for these youth. Many adolescents are currently "defaulting" to API by virtue of this lack of comprehensive treatment options. The Committee also recognizes that the treatment options available both before admission to API and after discharge must meet the multiple and changing needs of children and their families.

The development of community care alternatives is central to API's successful provision of children's mental health care. Without community supports both before admission to API and after discharge, adolescents risk coming into contact with the juvenile justice system, returning to API after discharge, or becoming homeless. The recommendations in this report, when implemented, will make great strides toward improving the overall system of care for adolescents in Alaska, and will also allow API to function in its intended role of providing inpatient care and treatment to adolescents who have severe psychiatric, organic, and behavior disorders and require an acute, secure, inpatient setting.

Understanding the Situation: Many parents and family members experience feelings of anger, frustration, confusion, fear of discovery, guilt, overwhelming despair, and physical exhaustion from their encounters with the adolescent mental health service system. Their experiences with the mental health system are generally preceded, however, by difficulties in and/or with other systems, including home, school, child welfare, and the juvenile justice system. These issues need to be explored and addressed in order for API to function appropriately in its intended role with respect to adolescents.

Children are guaranteed under state and federal law to have access to a free and appropriate education. Individual Education Plans (IEPs) need to be prepared for children with mental illnesses and emotional disorders who are in Alaskan schools. These plans are necessary to address their educational needs.

While there are current and ongoing efforts to strengthen and enhance Alaska's child welfare system, the problems that have plagued that system have not yet been fully addressed. These problems include an insufficient number of social workers and mental health programs, lack of prevention and early intervention services, the need to more strictly enforce existing laws, an insufficient number of foster parents, families who create problems for adolescents, and parents who are not involved with the care

of their adolescent. As part of the positive changes occurring within the child welfare system, the Committee believes there would be benefit from increased coordination among the various divisions within the Department of Health and Social Services, particularly the Division of Family and Youth Services and the Division of Mental Health and Developmental Disabilities, to address changes in both the mental health and the child welfare systems.

Numerous adolescents who suffer from mental illnesses and emotional disorders pass through the juvenile justice system, where treatment of mental health problems is not a major focus. Dealing with problems that may precipitate an adolescent's entrance into the juvenile justice system will address this issue in the form of prevention, but it is also necessary to consider how mental health services can be better coordinated for adolescents who find themselves within that system.

There is compelling evidence that it is necessary to develop a comprehensive and cooperative system of participation, communication, and action between appropriate agencies in order to adequately address adolescent mental health needs, develop solutions to identified issues, and promote change in the system of adolescent mental health care.

SPECIAL POPULATIONS–FORENSICS

Committee Recommendations

1. Maintain the present level of psychiatric care within the Department of Corrections (DOC) while continuing to develop a full continuum of psychiatric services within DOC.
2. Oppose passage of sexually violent predator legislation that would require API to either house for evaluation or treat persons determined to meet the definition of a sexually violent predator.
3. Evaluate the impacts on API's forensic treatment program of the various pretrial diversion efforts presently underway for mentally ill misdemeanants, including more clearly defining the role of API with respect to competency or culpability evaluations of individuals charged with a crime who are not in custody (i.e. out on bail).
4. Identify and work collaboratively with community-based resources in order to move into community placement those patients who are appropriate for discharge, particularly those who have, historically, been difficult to place due to their need for intensive services or supervision, including those patients who have been treated at API because they were found Not Guilty by Reason of Insanity (NGI).

Background to Recommendations

Mental Health Services in Corrections: The Committee agrees with all efforts to decriminalize mental illness. It also endorses the proposition that a full continuum of psychiatric care be available within the Department of Corrections (DOC), which would continue to minimize both the number of inmates needing transfer to API for hospital-level treatment and the number of persons released from jail with a chronic mental illness who need immediate commitment to API because of the persistence or severity of their illness.

The Committee highlights the fact that the mental health system cannot be effective, and API cannot hope to limit its role in that system, unless there are appropriate mental health services in Corrections.

Sexual Predator Legislation: Proposed legislation before the Alaska Legislature last session provided for the civil commitment of correctional inmates determined to be “sexually violent predators.” This legislation required an extensive evaluation process for those correctional inmates who might meet criteria defining them as sexually violent predators, and then ongoing involuntary, secure mental health treatment for any inmates meeting this definition after their release from prison. This treatment (in a locked setting) was to continue until a court found that the person no longer posed a danger. The original legislation would have required both the evaluation process and subsequent treatment services to be provided at API, Alaska’s only public psychiatric hospital.

The Committee is opposed to any attempts to house these individuals at API. This opposition is based on the Committee’s belief that the evaluation and treatment of such persons at API: 1) is contrary to API’s mission; 2) would expose those fragile and vulnerable persons with true mental illnesses presently hospitalized at API to persons with a history of violent, predatory behaviors; and 3) would absorb funding that would otherwise be used for mental health treatment services either at API or at the community level.

Finally, it is generally understood that there is no known effective treatment for changing those behaviors associated with sexual predation, and the proposed legislation would place many professional clinical treatment staff (e.g., physicians, psychologists) in difficult ethical positions, since their professional organizations are beginning to take positions in opposition to their members being asked to provide such “treatments.”

Pretrial Diversion: Laudably, the Alaska Mental Health Board, the Alaska Mental Health Trust Authority, and the Division of Mental Health and Developmental Disabilities have been working to eliminate the incarceration of the mentally ill for the commission of minor crimes. Several such efforts are being implemented.

In Anchorage, for example, a pilot project run by DOC is presently underway to provide case management services to no more than 30 chronically mentally ill individuals who have a history of minor offenses for which they previously would have spent considerable time in jail or at API undergoing treatment following a finding that they were not competent to go to trial. The goal of the pilot project is to provide community, wrap-around services to these individuals in order to determine whether such intensive mental health services result in: these persons maintaining more stable lives; a reduction in their criminal behaviors; and a reduction in their hospitalizations or jail-time.

In addition, the court system in Anchorage has identified two judges in district court to handle the majority of misdemeanor work where the defendant is either known to be chronically mentally ill or the behaviors of the person at the time of the alleged commission of the crime suggest that the defendant’s mental illness may be a factor. These judges are making appropriate and therapeutic efforts to avoid incarcerating

persons with mental illness; instead, their goal is to either reconnect these persons with local mental health services and/or to have these individuals evaluated as to their competency to stand trial (or their mental culpability at the time the alleged crime was committed) while remaining free on bail.

Unfortunately, an unforeseen or unanticipated result of these efforts to avoid inappropriate incarceration of mentally ill misdemeanants, especially the work of the Anchorage “mental health court,” has created a new group of persons requiring services not presently provided by API forensic staff: court-ordered *outpatient* evaluations. In the past, persons referred to API from the courts for evaluation were generally in state custody, i.e. in jail pending further action, prior to being admitted to API and were returned to custody following the completion of their evaluations and discharge from API. These patients are considered incarcerated while at API, and the time spent as patients at API counts toward completion of any sentences that might be imposed by the court.

Several different types of court-ordered evaluations are typically performed by API, including: 1) evaluations for competency to stand trial; 2) evaluations for mental culpability, which is a retrospective assessment of the patient’s psychiatric and psychological condition at the time an offense is alleged to have occurred; and 3) examinations for “Aid in Disposition,” which are requested when issues of mental disability or risk to the community are being considered either at the time of sentencing or release of an inmate. These patients are evaluated and treated on API’s forensic unit, giving API staff the time to observe and appropriately evaluate and treat these individuals.

However, these new, court-ordered *outpatient* evaluations are placing API’s staff in a difficult situation for a number of reasons, including: 1) reduced opportunity to observe and evaluate the person, because the individual is not residing on the forensic unit; 2) arrangements to locate and transport the person to API for interview/evaluation are complicated, with the person often not showing up at the time and date set for the evaluation; and 3) outpatient evaluations are adding significantly to the workload of API’s one forensic psychologist, who is already evaluating and treating up to ten (10) persons at a time on the forensic unit, as well as another 5 to 10 additional court-ordered evaluations of persons who are in jail and are either awaiting transfer to API or, because of a lack of beds or the level of danger posed by the client, will be evaluated in jail through a series of interviews.

As the number of court-ordered outpatient evaluations increase, it appears that API will have to seek additional funding to provide this new service through contracts with private mental health providers, or seek to have these evaluations performed by local community mental health center staff as a part of their existing grants. The Committee recommends that this latter option be considered, since the individuals identified by the mental health court as appropriate for an outpatient evaluation will generally be persons who present a severe or chronic mental illness and who, if they are known to the court, may already be served by the local community mental health center or, if

unknown to the court, should no doubt be linked to local community mental health services. However, the Committee understands that this may not be possible because it creates a dual relationship with the client, as both treatment provider and competency evaluator/witness, a relationship that both compromises the therapeutic relationship and presents real ethical concerns for licensed clinicians.

Therefore, the Committee recommends that API contract for these services and be adequately funded to provide for outpatient evaluations. Further, the Committee recommends that the defense attorney bring the client and attend the exam, which will serve to increase both reliability and timeliness.

Placement of NGI Patients: At this point in time, API is, perhaps understandably, experiencing difficulty placing its longer-term NGI patients into the community. The primary difficulty involves API's ability to secure commitments from community mental health centers to assume these individuals as clients and to continue their treatment in a community program. The Committee recommends there be an evaluation of those cases where API and the courts believe the person is appropriate for community placement, an evaluation that balances both the public safety concerns related to these individuals and the level and intensity of services that would be required in order to house these individuals in the community. There should be particular emphasis on investigating and identifying costs and possible funding sources to facilitate the movement of appropriate NGI patients into the community, ensuring that all appropriate safety measures are in place, should the courts approve the release of an NGI patient into the community.

INTERRELATIONSHIP WITH THE COMMUNITY

Committee Recommendations

1. Alaska Psychiatric Institute (API), the Rural Mental Health Providers Association, and the Alaska Community Mental Health Services Association will collaborate in the establishment of protocols with respect to the interface between API and the community in terms of admission to and discharge of individuals from API. Existing Memoranda of Agreement will be used as vehicles to memorialize these protocols.
2. Evaluate the interface between API and community providers through the Statewide Quality Assurance review process administered within the Division of Mental Health and Developmental Disabilities. The RFP process used by the Division will clarify expectations with respect to the interface between community providers and API.
3. Request funding from the Alaska Mental Health Trust Authority to conduct a 3-year research project that tracks patient discharge and transition from API and the timeliness and nature of the initial contact with patients upon discharge; use as a basis for recommendations with regard to quality assurance through appropriate continuity of care.
4. Develop and fund public education efforts aimed at destigmatization of mental illness for those consumers who use inpatient services, including API and other community mental health services.

Background to Recommendations

Patient Turnover: The issue of continuity of care is a critical concern and contributes to frequent complaints about Alaska's mental health system. It is especially critical since more than 45% of the admissions to API are for the first time and 15% are second admissions. The transient nature of API's population is further pronounced by an historically decreasing length of stay. Data for FY97 shows that 31% of consumers stayed at API for less than three days, with the majority of those individuals being admitted because of suicide ideation associated with alcohol or drug abuse. Approximately 66% of consumers stayed less than 12 days, while only 10% stayed for more than 30 days. It is difficult for API to ensure continuity of care if its services are primarily crisis, respite or detox. That function also conflicts with the role of API as an inpatient care facility, which is envisioned in its downsizing to a 54-bed hospital.

Achieving Continuity of Care: Achieving continuity of care from the local community to API and back to the local community is the desired goal of the Committee's recommendations. API must have the ability to effectively transition a consumer back into the community, and there must be sufficient community supports in place to address individual mental health needs. Without these, the likelihood of the consumer's failure in the community setting and return to API is substantially increased. Community care providers must be allowed consultation privileges, with the agreement of the consumer, to ensure that the best, most current information possible drives treatment decisions.

The elements necessary for achieving continuity of care are knowledge and information about each consumer's needs and resources. That information is required by both API and the local community mental health providers in order to ensure the treatment being received is appropriate to a particular individual. Only by knowing the patient's history can a provider, whether it be API or a community mental health provider, understand the appropriateness of a particular course of treatment. To ensure there is appropriate information exchanged at the time of admission to and discharge from API, the Rural Mental Health Providers Association, the Alaska Community Mental Health Association, and API will collaborate in the establishment of protocols. Memoranda of Agreement between API and community mental health providers will be used to memorialize these protocols, which will be designed to ensure continuity of service to consumers upon their admission to and discharge from API. Community mental health providers would become a part of the discharge planning for any consumer being discharged from API. Ideally, community mental health providers would remain involved upon admission of a consumer to API.

To ensure that the protocols established in the Memoranda of Agreement are being implemented and are successful, the Committee recommends that API and community mental health providers be evaluated on the success of patient linkages to local mental health services, where such services are agreed to by the patient and local provider. This evaluation will occur through the Statewide Quality Assurance review process within the Division of Mental Health and Developmental Disabilities. Additionally, the Committee recommends the required protocols be included in the Division's RFP process to facilitate the monitoring and evaluation of those protocols.

Community Resources: The Committee notes that there are insufficient resources available in many rural communities to support individuals upon their discharge from API. The Committee's recommendation for a 3-year study funded by the Alaska Mental Health Trust Authority will, in the examination of patient discharge and transition from API, help to identify effective care practices and resources that exist in some rural programs that can be replicated in other rural communities. In the interim, it is advisable to develop protocols that are sensitive to the size of individual programs and that outline the minimal essential tasks to be done by both API and the community upon patient discharge. The Committee has recommended this be done through a collaborative effort between API, the Rural Mental Health Providers Association, and

the Alaska Community Mental Health Association, which will be delineated within the existing Memoranda of Agreement between API and community mental health providers.

Complicating Factors: During its discussions, the Committee identified several complicating factors relating to the subject of interrelationship between API and the community. Below is a discussion of several of these points, which is provided as additional background to the Committee's recommendations.

Consumer concerns about confidentiality may prohibit the transfer of information which might enhance treatment and discharge planning. Confidentiality also complicates continuity of care for adult children who either choose to exclude their parent(s) from participating in their treatment and care or whose parent(s) may be excluded by virtue of not being notified when a crisis occurs, even though these individuals depend on their parent(s) for support. There is also the belief that confidentiality is sometimes used by treating clinicians as a block to patient/family communication.

Consumers are currently admitted to API via numerous entry points, some of which have little or no information about the consumer. This lack of a single point of entry results in poor or no communication of the individual consumer's history, situation, or needs. As a result, consumers may not receive the treatment necessary to stabilize their condition. The Committee's recommendation to establish protocols for transmittal of information to and from API in Memoranda of Agreement between API and treating organizations can begin to address this issue of communication. Further, it would be advisable for law enforcement representatives to contact local community mental health providers for evaluation of individuals prior to transporting them to API.

Concerns also stem from the fact that consumers are sometimes discharged to the community without the knowledge or input of the local community mental health center. Often, the time that elapses between discharge of these individuals and when they are seen by a mental health professional is lengthy. Additionally, there may be inadequate resources at the local level to meet the consumer's needs, local community mental health providers may lack the appropriate training or skills to maintain the level of care needed by these individuals, and there may be a lack of familiarity by API staff of local resources.

Consumers are sometimes discharged from a secure, monitored environment at API to being unmonitored in their village/community. There is often a loss of continuity in terms of the consumer and provider rapport that has been established during inpatient treatment at API, leaving consumers feeling abandoned when they are discharged back into the community, particularly in rural areas. Transition programs are needed in rural areas to assist individuals in their return to a community setting.

Another inhibitor to continuity of care lies in the fact that certain medications, especially atypical psychotropic medications, are not available in some communities. Consumers

are often unable to continue or obtain their medication due to factors such as remote location, lack of authorization, and cost.

Individuals may also face transportation and housing dilemmas during and upon their return to their local community, should they become stranded due to weather or flight schedules, or because they have no housing upon their return.

Furthermore, difficulties arise in terms of involving family members in the treatment of consumers who have been brought from rural locations for treatment at API. Distance and the cost of travel many times prohibit family members from participating directly in the treatment of the consumer. API has instituted an 800 number for use by family members in order to simplify and encourage contact with patients and also makes on-campus housing available for families who request it.

TRAINING

Committee Recommendations

1. Develop a comprehensive recovery-oriented training program addressing the training needs of API staff, leadership, and the Governing Body.
2. Ensure that all training efforts support treatment that focuses on patient strengths.
3. Identify predictable and adequate funding for development of quality staff and best practices at API through education and training of hospital staff, leadership, and the Governing Body.
4. Develop more extensive mutual education and training partnerships between API and a wide range of university programs, diverse cultural and minority groups, and local community mental health providers.
5. Create mechanisms for internal and external review of all training as a component of the quality assurance process.
6. Actively involve primary and secondary consumers in the development, delivery, and evaluation of all training efforts.

Background to Recommendations

A Comprehensive Approach: There is no assurance that other efforts to achieve best practice at API will be successful if API does not commit to a comprehensive, ongoing training plan that extends to all API personnel, including its leadership team and the API Governing Body. Approaching these training efforts from a “strengths” rather than “deficits” perspective invites a belief in the ability of staff, hospital leadership, the Governing Body, consumers, and others touched by the process to thrive and grow.

Further, the attitude within API must communicate confidence in the ability of all API staff and leadership to increase their competence, both individually and collectively. Best practice mandates that training be regarded as the underpinning of all efforts to operate API's programs and deliver quality services to mental health consumers utilizing those services. Given the reality that best practice is something that is itself ever changing and evolving, it is essential that there be strong internal and external recognition that training needs will never be fully satisfied or no longer needed.

API Governing Body: A training plan must be developed for the Governing Body that ensures its members are initially well educated to the mission, goals, purposes, and functions of the hospital and its programs, and to their own leadership role. This training plan must ensure that members stay informed about, and in contact with, consumers and that consumers take an active role in the provision of ongoing training to the Governing Body.

API Leadership: It must not be assumed that individuals hired to provide leadership to API can do so without continuing to hone and refine their skills. The training plan developed for API's leadership team must be designed to provide the training necessary to function as effective managers and to acquire the specialized knowledge and skills that are required to implement a rehabilitative or recovery-based treatment model.

API Staff: Staff training should be multi-disciplinary, as well as discipline specific. Each service within API must develop its own training plan, and then coordinate with other disciplines to ensure that individual training plans combine to create a holistic training plan for API. It is also necessary to develop staff incentives and staff ownership of training processes in order to encourage openness to new learning and skill enhancement.

Funding: Funding a comprehensive training program must be accepted as a legitimate and necessary part of achieving best practice at API. There must be a commitment by the Governor, Department of Health and Social Services, the Legislature, consumer advocates, and other stakeholders to the funding of training efforts. In order to not interrupt the provision of services at API, adequate funding is also necessary to provide for the costs associated with temporarily filling longer term employee positions during continuing training.

Affiliations and Training Partnerships: Universities mandate that their faculty provide service and engage in research. Many university programs require that their students undertake internships. Building the bridge to higher education will create an atmosphere at API that is receptive to change and innovation. Education and training within the system and affiliations with external educational institutions and research institutes can also be highly persuasive inducements when recruiting high caliber applicants for API staff positions.

The Committee recommends that API develop affiliations with diverse cultural and minority groups, including Alaska Native organizations, to ensure that API staff have the regular and ongoing training necessary to develop and deliver a culturally sensitive and competent program. Effective treatment of consumers necessitates this type of training component because of the high representation of minorities with differing cultural backgrounds within the API population.

Inviting staff of community mental health providers to participate in training at API will strengthen the continuity of care provided to consumers. This joint training will create a common ground from which to approach consumer issues and needs, and will help facilitate the necessary programmatic coordination between API and community mental health providers to better serve consumers.

Consumer Involvement: The Committee recommends consumer involvement in all aspects concerning training of API staff, leadership, and the Governing Body. Consumers, both primary and secondary, must have an active role in both the development of training and its delivery. To ensure that best practice is achieved at API, the perspectives of those receiving treatment must be recognized and incorporated into the individual discipline training plans and throughout a holistic training plan for the hospital.

Training overarches all elements of the operation of API. Only through training will the Committee's recommended shift toward the recovery-oriented operation of the hospital be realized.