UNCLEAN RESEARCH AND CLINICAL CHANGE

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The building of a permanent system that will allow as thorough and objective an evaluation of the Fort Logan clinical program as possible has been the first priority goal of the Fort Logan Research Department in its first three years. Drs. Alan Kraft's and Paul Binner's papers in this volume describe our attempts and difficulties in building such a system, and the initial types of analyses that the system has made possible. I would like to focus on another facet of the role of the Fort Logan Research Department: our participation in rapid feedback clinical research involving close collaboration between the researcher and the clinician.

In many ways the role of the clinician is incompatible with the role of the researcher. The clinician needs to be decisive and uncompulsive. He is placed in situations where important decisions must be made rapidly on the basis of what little information is available. In making such decisions he often uses common sense, and after committing himself to a course of action he rarely expends a great deal of energy ruminating about all the other courses of action he might have taken. In many ways the clinician feels he must have faith in what he is doing or his treatment will suffer.

The researcher, on the other hand, is more likely to believe nothing and to question everything. He is unwilling to come to hasty conclusions and still less willing to act on them. At times he may support positions which are regarded as having more than a passing strangeness by the clinician, and he may even be looked on as a sort of prima

donna who can be a source of some very creative ideas but is not necessarily expected to be too practical about them. It usually takes the researcher a great deal of time to gather, check, and recheck his data, and then come to conclusions. The clinician, dealing with his everyday clinical crises, simply does not have the kind of time the researcher has to solve the problems facing him.

The research department's participation at Fort Logan in a type of rapid feedback program evaluation leading to clinical change illustrates our attempts to bring the roles of the clinician and of the researcher closer together. This rapid feedback approach uses research methods to obtain quickly a broad base of information on which a hospital crisis situation can be resolved. Researchers, administrators, and clinicians then work together in planning a course of action intended to resolve the crisis and improve clinical functioning. As is so often the case in clinical decisions, such action must be taken on the basis of inadequate data; but, as a result of the rapid action research procedure, the data on which the action is based are broader and more reliable than previously.

As an example of this rapid feedback approach to information-gathering, I would like to describe a chain of events that took place around a crisis at the Fort Logan Mental Health Center involving our admissions policy. From the outset the admissions policy of the Fort Logan Mental Health Center was set up so that all prospective admissions would be evaluated in the community clinics prior to admission. Since the Center is decentralized, both administratively and geographically, into a number of semiautonomous treatment units, these admission evaluations were not carried out by a central admissions committee, but by eight separate evaluating units, each attached to its psychiatric team. Each team carried out its pre-admission evaluations in the community clinic of the county served by the team. Although each team did its own evaluation of prospective admissions, a hospital-wide admissions policy was drawn up and a document describing this policy was circulated both within the Center and in the referring community (see Appendix I).

After the Center opened, problems began to develop around its admissions policy. Some members of the referring community felt that the Center was not accepting some of the more seriously ill patients referred for treatment. We had noted in the research department that the majority of referrals came from the community psychiatric hospitals, rather than from the clinics; therefore, we recommended to the clinical

administration that they consider reviewing the admissions policy and shifting the major locus of admissions evaluations from the community clinics to the psychiatric hospitals.

Complaints from the community about the Center's admissions policy grew, and the crisis reached a peak during an emergency meeting held at the Center. At this meeting the clinical administration reiterated the growing complaints from the community that Fort Logan was not accepting all the patients within its province as a state hospital. Because of the disagreement around this issue, it was proposed that a retrospective study be done of all patients referred (but not admitted) to Fort Logan from the two major psychiatric hospitals over a specific time period. This proposal was accepted and two 3-man subcommittees were formed to study the referrals from the two hospitals concerned.

These subcommittees met jointly to establish a procedure. It was decided that each committee would evaluate a series of consecutive patients from Denver General Hospital and Colorado Psychopathic Hospital who had been referred over approximately a four-month period but had not been admitted. The total size of the sample of patients was to be around 40, with approximately 20 referrals from Denver General and 20 referrals from Colorado Psychopathic Hospital being evaluated. Our procedure with each patient was, first, to study material in the case history pertinent to the referral; then, to interview the physician who made the referral—and his supervisor if this applied —and, finally, to interview the patient himself whenever this was possible. A semistructured interview schedule with both open and closed questions was constructed as the basis for these interviews. The interview schedule included questions not only about the specific patient under study, but also general questions about sources of dissatisfaction with Fort Logan's admissions policies, and sources of friction between the hospitals. Following the collection of data about each patient, the subcommittee members made judgments about whether or not, in their opinion, the patient should have been admitted. The interview data on areas of dissatisfaction and friction between the referring hospitals and Fort Logan were analyzed after all the interviews were completed.

After agreeing to this general procedure, the Denver General subcommittee and the Colorado Psychopathic Hospital subcommittee each proceeded independently to evaluate its sample of patients referred but not admitted. After data collection and data analyses, the subcommittees wrote independent reports, summarizing their findings and making recommendations for clinical change. These reports were distributed

approximately 10 weeks after the decision to carry out a study was made.

In all, the two subcommittees made judgments about 36 patients referred to Fort Logan but not admitted in the time period under study. In the judgment of the committee members, 10 of these 36 patients should have been admitted. However, in two cases, in which treatment had been offered by Fort Logan and rejected by the patients concerned, it was the opinion of the committee members that treatment should not have been offered. In their reports both committees described the cases of their disagreement with the Fort Logan evaluators in considerable detail. Both committees found that some teams at Fort Logan were involved in much more disagreement with both Denver General and Colorado Psychopathic Hospital on admission policies than other teams. Each instance in which the subcommittees disagreed with the judgment of the Fort Logan evaluators was fed back and discussed in detail at meetings of the clinical staff of each team, which were attended by the clinical director. In addition to the judgments about each of the 36 patients in the study, which were discussed in detail with the team members involved, the analysis of interview data with the referring physicians formed the basis for recommendations by both the subcommittees for improvement in Fort Logan's admission policies. Although each of the subcommittees made its recommendations for clinical change independently, these recommendations were strikingly similar.

Both subcommittees felt that highest priority as an area for improvement should be given to the rewriting and clarification of the document defining Fort Logan's admission policies. The indefiniteness of the admission policy as described in the admissions document (see Appendix I) left much room for its interpretation in different ways by different Fort Logan teams, and by different referring physicians. The resulting confusion seemed to be causing a great deal of ill feeling between Fort Logan and the two psychiatric hospitals. Both committees also recommended that steps be taken to transmit these clarified policies more clearly both to Fort Logan staff members and to the sources of referral to Fort Logan in the community.

In addition, both subcommittees recommended that when patients were not accepted for treatment at Fort Logan but referred to other community resources, the Fort Logan evaluating team should give greater assistance in the referral. One of the subcommittees recommended that a further study be undertaken of the Fort Logan evaluat-

ing teams as referring resources in their own right with an aim to improving this function. Both subcommittees also suggested a shortening of the time period between the referral of a patient to Fort Logan and his evaluation by the center's staff. It was also recommended that feedback from the Fort Logan evaluating team to the referring hospitals be improved and that the Fort Logan form describing all patients referred to Fort Logan be revised.

It was the impression of both subcommittees that the procedure of carrying out a study of Fort Logan's admission policies had communicated to the hospitals Fort Logan's concern about the friction around admissions policies, and a willingness on Fort Logan's part to change. It was the impression of the two subcommittees that ill feelings toward Fort Logan from both hospitals were diminished by the very act of doing the study.

In order to carry out the committee's recommendation on the revision of Fort Logan's admissions policies, the hospital appointed a new committee with a membership representing the two subcommittees that had made the original study, the clinical administration, and the team members responsible for admissions evaluations. This committee's revision and clarification of the Fort Logan admissions policy resulted in the new admissions document shown in Appendix II. In addition, Form P48 of the data system, which describes all patients referred to Fort Logan whether they are admitted or not, was revised and expanded.

It is still too early to evaluate the impact of the new admissions statement on Fort Logan's relationships with the referring agencies, but our initial impression is that it will help to clear up some of our difficulties with the sources of referral to Fort Logan in the community.

The study of Fort Logan's admission policies has had other effects. A study of the Fort Logan evaluating teams as referring agencies is currently under way. In addition, some of the findings and recommendations of the two subcommittees were incorporated in Fort . Logan's application for a Hospital Improvement Project Grant.

DISCUSSION

The problem of the Fort Logan Mental Health Center's admissions policies does not seem to be unique. Most hospitals have some friction with other hospitals about admissions policies, and when a hospital departs from the traditional role of a state hospital and insists on

evaluating all patients prior to admission, there is bound to be friction. The admissions crisis was selected for description in this paper not because of any unique properties it demonstrates but because it illustrates how action research can play a meaningful role in the solution of some of the problems arising in the operation of a mental health center. The rapid feedback action research approach we have been trying to develop at Fort Logan as part of the role of the research department has been useful in the solution of other problems, such as the work dissatisfaction and resignation of a large number of the Center's team leader psychiatrists in its second year of operation. As was the case in both the team leader crisis and the admissions policy crisis, a rapid initial project aimed at helping to solve an acute crisis was followed by a long-term research project with a methodology leading to more reliable and valid data. In this type of clinical action research several factors seem to us to be important.

The Role of the Research Department

We feel that it is important for the research department to extend—with indefinite boundaries—into the hospital administration, the clinical area of the hospital, and the community outside the hospital, and that members of the research department should be regarded as responsible members of the hospital staff. Members of the research department, first of all, had to be present at the emergency meeting on the admissions crisis in order to suggest that a study be done; secondly, they had to be regarded as sufficiently responsible members of the hospital community for their suggestion for a study to be taken seriously. We think it important that the Fort Logan Research Department is located in offices close to the clinical and administrative areas of the hospital, and we do our best to lure unsuspecting clinicians and department people into the research area, by using such shopworn devices as free doughnuts and coffee at our weekly research feedback meetings. On the other hand, research department members attend clinical and hospital-wide meetings, function as active members on many hospital committees, and participate in clinical work on the psychiatric teams. In our opinion, researchers working in a therapy-oriented mental health center should be regarded as responsible members of the hospital staff, not as starry-eyed, creative but quite impractical beings who can function only if they are kept in an area isolated so far as possible from the everyday problems the rest of the hospital must face.

If the boundaries between the research department and the rest of

the hospital become more indefinite and if the research staff is caught up in hospital crises, one may well ask how the research department can maintain the objectivity that is so necessary for impartial evaluation of the total hospital program which is its major goal. I am not sure that we can provide a convincing answer to this question, except to say that our impression so far is that we have been able to maintain a fair degree of objectivity, in spite of our involvement with the clinical program. We feel that the dilemma of the researcher is, after all, similar to the dilemma of the clinician who must maintain, at the same time, an investment in his patient and an objectivity about him.

The Appropriate Time For Action

We feel that the proper timing of this type of program evaluation research is crucial to its success. In the case of Fort Logan's admissions policy problem, an effective time for a rapid feedback study presented itself when the crisis actually reached a peak. The hospital director, the team members, and the referring community had all reached a point where they were keenly interested in moving in a reasonable direction that would help solve the disagreements about admissions. At this point, we felt that the study needed to be completed quickly, before the urgency of the crisis diminished, and thus the likelihood of clinical change coming from the study decreased. In order for this rapid feedback program evaluation research to lead to useful clinical change, then, we feel that the research intervention should be appropriately timed. In this respect, again, the role of the researcher has distinct similarities to the role of the clinician.

Speed

We feel it is important that the process of collecting and analyzing data be much faster than is usual in research, if the results of the investigation are to be used effectively. The present study dealing with admission policies led to written reports and recommendations on the part of the Denver General and Colorado Psychopathic Hospital sub-committees in approximately 10 weeks. We think that if it had taken much longer the issue would no longer have been a keen one, and effective action would have been difficult.

Willingness to Violate Some Research Principles

Because of the necessity for rapid feedback, many research principles cannot be adhered to in program evaluations research of this type. For

example, the Colorado Psychopathic Hospital and Denver General subcommittees knew little about the reliability and validity of their instrument for evaluating the series of nonadmitted patients. Some reliability was obtained by making two relatively independent studies on two separate hospitals, with independent data-collection analysis and recommendations, but we really do not know the degree of reliability and validity of the instrument we used to gather our data.

Willingness to Make Rash Statements
on the Basis of Inadequate Data

We think that the role of the researcher should not end when he has fed his analysis of data back to the clinician. He can also assume some of the responsibility for participating in decisions about clinical change and improvement based on his data, and he is in just as good a position to do this as the clinician who receives the data. These recommendations do not need to be followed, and in the case of the admissions study many of the recommendations made by the Colorado Psychopathic Hospital and Denver General Hospital subcommittees were not followed.

Effective Feedback

We feel that verbal feedback of findings and recommendations is much more effective than written feedback, and where written feedback is made it should in all cases be followed by face-to-face discussion. Finally, we believe that written reports should be short and concise. We have made it our practice to put technical data and detailed discussions of research methodology into appendices.

It is clear that our procedure for effective research involvement in broadening the base of information on which clinical crises can be resolved is at present "half-baked." Each crisis has been different, and has required different procedures for effective research involvement. I am not sure how we will eventually evaluate our rapid feedback procedure, and realize that the present paper represents more of an impressionistic account of our experience with a certain approach than an objective report firmly based on reliable and valid data. It gives us meager comfort to realize that this is a dilemma which our clinician colleagues find quite familiar.

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