

DEVELOPMENT OF THE RESEARCH DEPARTMENT

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INTRODUCTION

In planning for a new major mental health facility, the need for building in a potential for self-description and evaluation seemed self-evident. Consequently, almost a year before the first patients arrived, plans were made to develop such a potential in the form of an extensive semiautomated information retrieval system. A plan submitted to the National Institute of Mental Health (NIMH) was approved, and the system receives a great deal of its support under grants from that agency.¹

In addition, budgetary requests approved by the state after the first year of operation made possible the development of research positions independent of grant support. The combined state and NIMH support provided seven professional and 10 supporting and technical research positions. The department reached what is, hopefully, a temporary plateau in the fall of 1964, when the director, Dr. Paul Polak, and the research psychiatrist, Dr. Bernardo Gaviria, left for two years' leave, Dr. Polak to work with Maxwell Jones in Scotland and Dr. Gaviria to study at the Menninger Foundation.

The evolution of the two components of the research department, the project staff and the state-supported staff, has given the department its unique character, each component contributing special strengths to the over-all effort. We will briefly trace this evolution to give the necessary background for the studies reported in the next section.

THE RECORD SYSTEM PROJECT

The aim of the Record System Project is to make available a broad sample of the information ordinarily found in the patient's chart. Its method is to take advantage of some of the information already gathered, devise check lists of the material to be collected, process the check lists onto IBM cards, and retrieve and analyze the information stored with the aid of mechanized data-processing equipment. Its purpose is to make available a base of information for a variety of uses, either administrative, clinical, or research. Its strategy is to be as open-ended as possible so that it may lend itself well to a variety of uses and a variety of users.

In designing this system a number of important decisions about its content were made. First, that the content of the information collected should be as representative as possible of clinicians' thinking, i.e., items were included for collection because someone planning or doing the clinical work thought they were important to know, not because we had any a priori evidence that they were important. Second, that the information in the clinical area should consist of judgments made as much as possible in the clinician's own manner. That is, our forms indicated what observations or judgments should be recorded but usually not how the judgment should be made.

Leaving the judgments largely undefined, of course, poses a considerable number of problems in assessing the reliability of what is collected. Although we assume that not all clinical judgments collected are made in a uniform manner, we are not simply at the mercy of a mass of data of unknown reliability. For example, we have some observations that are done independently by two raters. Standard inter-rater agreement measures have already indicated sufficient reliability to provide useful predictions in one study.² Similar judgments appearing on different documents filled in by different individuals can also be compared for inter-rater agreement. In addition, global judgments can be related to detailed judgments to compare the content of summary concepts, such as diagnoses or judgments of good or poor prognosis. Still another avenue of analysis is to look at judgments to determine if raters differ systematically in relating their judgments to either criterion variables or detailed observations.

We have, in brief, a variety of ways in which we can assess the reliability and validity of data we are collecting. The aim is to establish the relationships between what we think we understand about the

patients and what we judge happens to them. Accomplishing this aim will give us a base line of how consistent and predictively valid are the clinical judgments made during the course of the daily clinical work. If consistency and validity prove to be unsatisfactory, it would seem just as important to improve the quality of these judgments, because they were used to guide clinical work, as it would be to improve them for research purposes.

The actual content of the data collected ranges from simple demographic information from the admission form to clinical judgments from the mental status examination, social history, physical examination, or psychological testing; evaluations taken from ward ratings of behavior while in the treatment program (MACC Scales),³ ratings from occupational therapy, recreational therapy, or work therapy; information on response to treatment ratings made at time of discharge; information on movement and length of stay, and judgments from scales sent to informants at specified times after discharge. We estimate that around 850 items of information are routinely collected on the average psychiatric patient during the course of hospitalization. Far from being exhaustive, these items represent only a skeleton of the total information generated during the course of treatment. Complete details of the content, forms, and procedures of the work may be found in *The Manual of the Fort Logan Record System*.⁴

In essence, then, this project has set out to make available a stable and comprehensive base of information for analysis of such questions as: What are the characteristics of the people served? What was troubling them? What were the antecedent factors? What was done for the patients? How did they respond to treatment? Obviously, with the multiple goals of the program, we could not set out to test all of them immediately. Moreover, although evaluation of the new program is important, simply to describe what is happening is also crucial. With the development of new policies and administrative structures a picture of what is happening is essential before we can attempt focused evaluative studies. We felt that the proper sequence of investigation was: 1. to work out a comprehensive descriptive picture of what is happening; 2. to follow this by more focused investigations attempting to evaluate a problem area; and 3. then to try to develop program improvements and changes on the basis of these findings. Following this, of course, the cycle of investigation, evaluation, and change begins again.

THE RESEARCH DEPARTMENT

Building the department with state supported positions provided the vital counterbalance to the operating characteristics of the Record System Project. While the record system's strength lies in providing a stable base of information, its weakness is its relative inflexibility in altering the base rapidly and its relative inability to help with questions falling outside the information collected. Here research department staff provided the flexibility needed to work on these unforeseen and constantly changing problems.

Equally important, the department staff can also focus on areas covered by the record system and seek to improve and elaborate the data in certain key areas. This has resulted in the development of additional major projects within the research staff, such as the treatment failure, follow-up projects and a variety of special studies.

THE FAILURE PROJECT

The failure project grew out of our dissatisfaction with the criteria of success or failure of patient treatment available to us, namely, length of stay, discharge ratings, readmissions, or posthospitalization ratings. It was felt that such measures reflected only success or failure as seen by the clinician or the institution, and did not take into account the goals of the patient, his family, referring agents, or other community representatives. Consequently Dr. Polak, with the aid of several research department personnel, designed a multipronged attack on the problem. Although his leaving has slowed the work, it is currently being carried forward by several of his co-workers.

His plan, in brief, is to study the conventional criteria of success and failure already mentioned. In addition, a special group is examining the problem of suicide, which we see as one form of treatment failure. Another portion of the study is attempting to generate new and better criteria of success and failure by considering the treatment goals of patients, relatives and community representatives. From the criteria elicited, he hopes to study the factors that relate to treatment failures and, on the basis of these factors, to reduce the existing failure rates by devising new treatment approaches.

THE FOLLOW-UP PROJECT

The follow-up study grew out of dissatisfaction with the kinds of information currently available on the posthospitalization adjustment

of our patients. Before he left, Dr. Gaviria laid out the plans for an extensive and intensive study of these posthospitalization careers. That study also is being carried forward—at a reduced pace—by one of his co-workers.

The follow-up study aims to extend the information currently collected on the personal, social, and work adjustment of former patients through the use of interviews modified from Freeman's and Simmons' material.⁵ Repeated mental status examinations based on the one currently used by the center are also being collected. Dr. Gaviria's plans include interviews with both patients and their friends or relatives who can give a clear picture of the patients' functioning.

We anticipate that this study, as it develops, will give us a much more detailed picture of what happens to our patients after discharge than either the simple discharge rating or the follow-up questionnaire we mail. This study is in the preliminary stages of working out the mechanics of locating discharged patients and then of trying out the instruments selected. Much more work will be needed to develop and implement fully the improved follow-up system on a larger scale.

SPECIAL STUDIES

Special studies initiated by the research department have largely developed from institutional crises that needed empirical study on a relatively rapid basis. Dr. Polak has a special talent for taking these situations, working out an immediate plan of attack, and bringing the investigation to completion promptly. The usual demands for precision in research design and measurement do not intimidate him. He knows full well the limitations of his data and reports them forthrightly, but proceeds to give the institution the benefit of the best empirical evidence that can be gathered in the existing time and circumstances. He and other department members have undertaken investigations of the intake evaluations performed at the two main referring hospitals;⁶ a study of the reasons team leaders were resigning;⁷ and several surveys of Center staff morale.^{8,9} Further reference will be made to some of these in the section on results.

An important by-product of these special studies is the frequent involvement of personnel outside the research department, such as department heads and team people, which serves to strengthen the ties between research and clinical personnel that are so important to the functioning of the research department.

RESEARCH PHILOSOPHY

At this point we feel that it is important to make explicit some of the philosophical positions that were implicit in the preceding sections, because they decidedly influence how the department functions and what it produces.

The first position that we have tried to maintain is that we are an integrated part of a service organization and not a detached "ivory-tower" group of researchers. Hence the importance of being able to do special studies as needed and the emphasis on clinical, in addition to administrative, data in the Record System Project. Our aim is to provide the kinds of services that will enhance the functioning of the institution. In a sense, our model is the research and development group in an industry rather than the research institute or academic group in pursuit of pure knowledge.

Closely related to this is our primary orientation to applied research, mainly related to program description, evaluation, and improvement as opposed to basic research or applied work in other areas. There has been some disagreement among us as to how strictly we should hold to this. The current line is that thoroughly done applied research may well lead to basic studies needed. If our applied goals cannot be reached without these basic studies, then they properly fall within our province. If the basic work is not critical to meeting our applied goals, then we should not invest our resources in it. Actually, until now, this has been a largely academic debate because a critical test case has not arisen. It is an important point, however, because it is very easy, and in many ways appealing, to have a research department spend a considerable part of its resources on work that will probably not have a very immediate impact on the functioning of the institution.

Another aim has been to involve people outside of the department in research, and in this effort we have taken a relatively permissive attitude toward research studies proposed. We have tried to avoid discouraging or censoring an idea before it can even be tried. It seems that many interesting research ideas die before they get a fair trial because the potential researcher is immediately confronted with all the difficulties of doing good research. Not that we like to see poorly designed or executed studies; we do feel, however, that often an interim step is necessary before more tightly designed work can be expected.

SUMMARY

In summary, the research department has been developed to aid in the task of describing, evaluating, and improving the functioning of the center. Its activities are focused on three main structured efforts: 1. the Record System Project, 2. the Failure Project, and 3. the Follow-up Project. In addition, it engages in a variety of special studies as they are needed. The department focuses its efforts on work that will likely enhance the functioning of the center. It seeks to identify itself clearly with the service aims of the institution and to encourage research activities by individuals in all branches of the center.

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