mental illness + medication algorithms
a guide for mental health planning + advisory councils
This guide will help state mental health planning and advisory council members and others advocate for the implementation of medication algorithms to advance the quality of care for persons with mental illnesses.

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Introduction
The development and use of guidelines or algorithms has become increasingly more popular among medical professionals and organizations. Medication algorithms have been developed for many chronic medical illnesses, such as diabetes mellitus, hypertension, and asthma. One reason for the expanded need for guidelines or algorithms, particularly in psychiatry, is the availability of so many different treatment options, as well as methods of treatment, making it difficult for clinicians to remain informed regarding new information. Without the use of a guideline or algorithm, clinicians frequently find themselves “doing their best,” which can potentially lead to inconsistent delivery of health care, and poorer patient outcomes. Medication algorithms become a tool for practitioners to improve their standard of care through using effective treatment techniques.

With the challenges many mental health systems are facing today as a result of an economic downturn, it is important for planning councils and other stakeholders to understand how medication algorithms can be effective in improving outcomes for consumers. Medication algorithms can also produce some cost savings. However, it is imperative that cost savings occur within a context of care improvement.

Basics about Algorithms
In the medical literature, the terms guideline and algorithm are often used interchangeably. There is however, a distinct difference between the two terms. Where guidelines are systematically developed recommendations intended to assist the clinician in treatment decision making, treatment
algorithms go a step further by providing the clinician with a step by step process that identifies treatment alternatives at key decision points. In other words, if a medication is not working, what is the next-best treatment option?

The framework for an algorithm is often broken down into strategies and tactics. The strategies are divided into treatment stages. At each stage of the algorithm, the clinician is given the acceptable medication treatment options. The tactics refer to how to best implement the selected treatment regimen at a particular stage in an individual patient. Tactics address issues such as dosing, monitoring symptom response, and treatment duration.

Why Medication Algorithms?

One of the main reasons that a health care system would create or use a medication algorithm is to improve the quality of care for the patients that they serve. One of the best ways an algorithm can facilitate improving the quality of patient care is through increasing continuity of care within and across providers. When clinicians are presented with comparable clinical situations, the decision-making processes regarding treatment options should result in similar answers; however, it has been well documented that there are large discrepancies and variability in treatment of patients with mental illness. Because medications are a part of recovery for most people with serious mental illness, such results offer evidence that providing clinicians with algorithms would be useful in reducing inappropriate variation. The use of a uniform clinical documentation system is one way in which this variance can be addressed. Uniform documentation not only assists with continuity of care, but can also help provide guidance for future health care decisions.

Another manner in which an algorithm can help improve outcomes is by compiling and evaluating new information about treatment options as it becomes available. Every month, over 30,000 articles are archived in a database managed by the National Library of Medicines. It is unrealistic to
believe that clinicians can sort through this information, evaluate the quality of the reporting and then assimilate that information into their current practices. Algorithms that are appropriately developed and updated can aid clinicians in this unmanageable task and therefore assist in the clinical decision making process, in hopes of improving patient care.

Health care administrators are often faced with the challenge of containing costs, while still improving the quality of the care provided to consumers. From an administrative point of view, algorithms provide several potential benefits. Through the use of algorithms, costs may be more predictable, helping plan future budget needs. They may also help create more cost efficiency of treatment. Although there may be an immediate increase in cost (i.e., medication costs, increased initial outpatient visits), cost benefit can be seen in other areas. A more thorough and complete clinical response may lead to a reduction in overall hospitalizations and long-term use of outpatient services.

Over the last decade, five new antipsychotics have been introduced to the market. One can expect that more antipsychotic agents will be available for use in the upcoming years. Although it is feasible that a new agent will far exceed the others in efficacy and safety, the usual scenario is one where the new agent is equal in efficacy to agents already available on the market. Lacking evidence to determine the therapeutic variations, the conclusion is that differences generally lie within safety, patient variability, and tolerability. Algorithms can define where a new medication fits in the sequence of steps for optimal clinical outcomes and whether or not they are cost effective options.

Since algorithms provide the framework for clinical decision-making, they can also help classify costs related to specific treatments or outcomes. Theoretically, this allows health systems to define costs associated with a specific intervention and link the cost to patient outcomes. It also better allows systems to identify environmental factors that can influence both cost and patient outcomes.
It is important to remember that algorithms can help assist the clinician in clinical decision-making, but they are not a substitute for clinical judgment and common sense. An algorithm should allow clinicians to tailor the treatment to an individual patient. A well-constructed medication algorithm is not a cookbook for care, but can guide the clinician through multiple treatment options. By including prior history, consumer preference, and past response in each step of the algorithm, the intention of the algorithm is to make individual treatment decisions with the goal of achieving full remission, community integration, and recovery.

**Cautions about the use of Algorithms**

Although medication algorithms have the potential to improve treatment outcomes as well as produce cost savings, some potential issues must be considered. Development of algorithms can occur through a variety of ways, some of which have more scientific rigor than others. Some consideration must be given to how the algorithm was developed. Algorithms developed by expert consensus panels may be limited if panel member selection did not cut across a broad section of experts of differing opinions.

Algorithms that are developed through reviewing scientific literature and conducting independent research may be more rigorous, but the research parameters must be carefully evaluated for application to a broad range of people, some of whom may react differently to treatment because of cultural or biological factors.

In addition to a consideration of individual factors when implementing algorithms, the accurate diagnosis of persons seeking treatment is essential if the algorithms are to be effective. Similarly, algorithms cannot simply be implemented. The algorithms must be updated frequently to reflect newly discovered treatment approaches or newly developed medications.

Finally, when considering the implementation of medication algorithms, it is important to consider the degree of flexibility
that individual practitioners have to deviate from the prescribed steps of the algorithm, and to define the types of explanations and documentations from established guidelines that practitioners must maintain.¹

**Patient Expectations of Algorithm-Based Treatment Strategies**

Medication algorithm programs emphasize the importance of a sound relationship between the patient and his or her physician (or prescriber). Together, the patient and physician should make decisions about what treatment(s) are best suited for the patient. The physician should discuss the potential benefits and side effects associated with the medication treatment. The patient should share with the physician any information regarding his or her symptoms and medication side effects. The approach of sharing information is not only essential in establishing a strong partnership between the patient and physician, but is also necessary to better optimize the patient’s medication treatment.

The National Mental Health Association has produced a program entitled “Dialogue for Recovery” that contains strategies to make the maximum use of the often-limited amount of time that the physician has to spend with the consumer. Simple steps such as preparing for the visit, taking notes, and being honest with the provider about the medication, its effects, and events in one’s life can go a long way toward improving the effectiveness of time spent with the provider. The Dialogue for Recovery program also includes a symptom checklist that facilitates communication with the provider.²

After the decision to initiate a medication is made, the patient will meet with his or her physician and treatment team (nurses, pharmacists, psychologists, and social workers) on a frequent basis. Optimally, during each medication visit, a thorough evaluation of symptoms and side effects will be conducted to determine whether or not changes are needed to the medication treatment. The patient and the treatment team can discuss possible options if the patient has not
improved or is suffering from medication side effects. These options include taper and discontinuation of the current medication while another medication is started; adjustment of the dose and/or schedule of the current medication; or, the addition of another medication to help manage the symptoms or side effects the patient is experiencing. The goal of this partnership is to provide the patient with the most effective and safest medication treatment possible.

**Which Algorithm is Right for Me?**

Prior to selecting a treatment algorithm for use within a system, several questions should be addressed. First, is the algorithm generalizable to the population that is served? In other words, was it developed to fit the needs of administrators, providers, and clients in a particular treatment setting that is similar to yours? One way to ensure this is by implementing an algorithm in which the major stakeholders (clinicians, administrators, clients, payors, advocates etc.) are involved in the development process. If an algorithm is adopted for use, it should be tailored to the needs of the patient population and to the clinical setting in which it is to be implemented.

The second factor to consider is how the algorithm was developed. It is important to keep in mind is that not all algorithms are the same. Some are very specific in defining treatment options where others provide only general concepts. Certain algorithms allow for flexibility in treatment options, whereas others are rigid in their recommendations. Additionally, not all algorithms are developed through the same process. Some are based solely on expert opinion versus evidence from the literature. Some only include the facts and remain “silent” where no facts exist or make recommendations based upon expert consensus.

Additionally, the algorithm needs to have a process in place by which it is updated as new treatments become available. All guidelines and algorithms should recommend that all of the newer antipsychotic agents be available to prescribers and consumers. It is important to consider these issues when
making the decision to adopt a particular guideline or algorithm for a system.

**Medication guidelines and algorithms for schizophrenia**

A number of guidelines and algorithms have been developed for the treatment of schizophrenia. Although each was developed using different methodologies, the guidelines and algorithms complement one another, and collectively provide physicians with a powerful resource. The guidelines and algorithms have been considered major advancements in the treatment of schizophrenia. The most recognized guidelines and algorithms are discussed below and summarized in Table 1 (see page 12).

**American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Schizophrenia** was developed in 1997 by a work group of psychiatrists with clinical and research expertise in schizophrenia. A comprehensive review evaluating treatment and outcome literature was conducted prior to the initial draft of the guideline. After widespread review by internal and external organizations and individuals, the guideline was revised and approved by the APA Assembly and Board of Trustees.

Each recommendation is coded into one of three categories: [1] recommended with substantial clinical confidence; [2] recommended with moderate clinical confidence; and, [3] may be recommended on the basis of individual circumstances. Recommendations are also stratified according to phase of treatment (acute, stabilization, or stable).

Psychopharmacological treatment information regarding dosing, side effects, and implementation of specific antipsychotics are discussed. Psychosocial treatments are also detailed in terms of efficacy and implementation.

The APA Guideline is a well-organized, comprehensive set of recommendations of psychopharmacological and psychosocial interventions for patients with schizophrenia. Many issues facing physicians, including homelessness, comorbidi-
ties, and suicidal/violent behavior, are covered thoroughly. However, it is the thoroughness that makes the APA Guideline difficult for physicians to operationalize and use. Another weakness is the lack of timely review of the guideline. Since its development in 1997, there have been substantial gains in terms of treating schizophrenia, namely the newer atypical antipsychotics. With the exception of risperidone, the APA Guideline does not address these newer agents in its recommendations. Revisions to the guideline are planned at three- to five-year intervals.

The Expert Consensus Guideline Series (ECGS) Treatment of Schizophrenia guidelines were initially published in 1996 and revised in 1999. The guidelines are based upon the surveyed opinions of experts on medication and psychosocial treatment of schizophrenia. These experts were presented with a skeleton algorithm based on the findings of recent research on treatments for schizophrenia. They were then asked to indicate the appropriateness of the treatment on a nine-point scale. The 1999 guidelines also incorporated the expert opinion on policy, financing, and administrative issues critical to the care of patients with schizophrenia.

Treatment choices are designated as one of the following based upon statistical analyses of expert responses to the survey: (1) first line (usually appropriate as initial treatment for a given situation); (2) second line (reasonable alternatives for patients who cannot tolerate or do not respond to first line treatments); and, (3) third line (usually inappropriate or used when other alternatives have not been effective). Treatments of choice are strong first line recommendations.

Unlike the APA Guideline, the ECGS are user-friendly as recommendations are provided in a clinically relevant, table format. These guidelines are also intended to provide physicians with expert opinion in areas of the treatment of schizophrenia where evidence is lacking. It must be noted though that the ECGS are solely based upon expert opinion, not evidence.

The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations were developed
with the goal of improving the quality and cost-effectiveness of care for individuals with schizophrenia. Treatment recommendations were based upon exhaustive literature reviews, and the levels of evidence are provided. The PORT recommendations mainly address pharmacological treatments, but psychosocial interventions, family interventions, vocational rehabilitation, and assertive community treatment/intensive case management are also discussed.

The PORT recommendations consist of 30 specific treatment recommendations, of which 18 are on psychopharmacological, three on electroconvulsive therapy (ECT), and nine on psychosocial approaches to treatment. Recommendations regarding dosing, choice of antipsychotic, monitoring of plasma levels, duration of treatment, and adjunctive treatment are detailed and references supporting these recommendations are provided.

These numbered recommendations are clear and concise, and easy to incorporate into clinical practice. Because of the required evidence from the literature, areas in which research is lacking were not addressed. The PORT recommendations, similar to the APA Guideline, were developed during the early 1990’s and have yet to be revised to include recent evidence of pharmacological and psychosocial treatments.

**Texas Medication Algorithm Project (TMAP)** represents a collaborative effort of public mental health, academia, and patient advocacy to improve the care provided to individuals with schizophrenia. The TMAP algorithms not only provide general recommendations for treatment of schizophrenia, but also provide a structured framework for decision-making processes for physicians. Based upon research literature and expert opinion, the TMAP algorithms have been revised recently to include newer agents introduced to the market. The Texas approach to Medication Algorithms has proliferated to many other States.

The TMAP algorithms specifically focus on pharmacological interventions, but do so comprehensively. The medication algorithm provides physicians with choices of antipsychotics at different stages based upon patient history, and safety
and efficacy data (Figure 1, page 11). Critical decision points are emphasized, in which different strategies are to be employed dependent on patient response. In addition, a side effect algorithm and a co-existing symptoms algorithm present evidence-based treatment strategies to relieve patients with schizophrenia from medication side effects and non-psychotic symptoms frequently accompanying exacerbations of schizophrenia. The TMAP algorithms also provide guidelines regarding recommended dosages for antipsychotics and other psychotropic medications, dosage changes, methods to assess response and side effects, frequency of assessment and re-evaluation, and minimum and maximum time periods to assess response. While the primary intent of the TMAP algorithms is on improving outcomes for patients, cost is present as a factor that can be considered and measured.

The TMAP algorithms for the treatment of schizophrenia are explicit, and more importantly, easy to implement in clinical practice. In fact, the Texas Implementation of Medication Algorithms (TIMA) has been undertaken with the goal of improving mental health care across the state of Texas. The focus of the TMAP algorithms is not as expansive as other guidelines, thus limiting the use of other nonpharmacological interventions.

**Comparison of guidelines and algorithms for schizophrenia**

Table 1 (see page 12) provides a simplistic comparison of the guidelines and algorithms described previously. While each guideline or algorithm possesses its strengths and weaknesses, an ideal guideline or algorithm would have characteristics of all these resources. Psychopharmacological and psychosocial recommendations should be based upon research literature, and tailored to important factors such as patient characteristics, patient history, and psychosocial issues. Finally, the ideal guideline or algorithm would be clear, concise, understandable, user-friendly, and easily implemented.
Figure 1
TMAP Algorithm for the treatment of schizophrenia

Choice of antipsychotic (AP) should be guided by considering the clinical characteristics of the patient and the efficacy and side effect profiles of the medication.

Any stage(s) can be skipped depending on the clinical picture or history of antipsychotic failures.

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**STAGE 1**
trial of a single NGA
(ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, or ZIPRASIDONE)

First episode or never been treated with a NGA

Partial or non-response

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**STAGE 2**
Trial of a single NGA

Partial or non-response

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**STAGE 2A**
Trial of a single agent
FGA*** or NGA
(not NGA tried in Stages 1 or 2)

Partial or non-response

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**STAGE 3**
CLOzapine

Partial or non-response

Clozapine refusal

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**STAGE 4**
CLOzapine
+(FGA, NGA or ECT)

Value in Clozapine failures not established

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**STAGE 5**
trial of a single agent
FGA*** or NGA
(not NGA tried in Stages 1,2 or 2A)

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**STAGE 6**
Combination Therapy
E.g. NGA + FGA, combination of NGAs, (FGA or NGA) + EDT, (FGA or NGA) + other agent (e.g. mood stabilizer)****

Case reports no controlled studies of combinations in long term treatment of schizophrenia

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FGA = First generation AP
NGA= Newer generation AP

* If patient is non-adherent to medication, the clinician may use haloperidol decanoate or fluphenazine decanoate at any stage, but should carefully assess for unrecognized side effects and consider a different oral AP if side effects could be contributing to non-adherence.

**See text for discussion. Current expert opinion favors choice of Clozapine.

***Assuming no history of failure on FGA.

****Whenever a second medication is added to an antipsychotic (other than Clozapine) for the purpose of improving psychotic symptoms, the patient is considered to be in Stage 6. See Description of Tactics and CDPs for more explanation.
Table 1
A comparison of guidelines and algorithms for the treatment of schizophrenia

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>APA</th>
<th>ECGS</th>
<th>PORT</th>
<th>TMAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-based</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>Consensus-based</td>
<td>+</td>
<td>+++</td>
<td>-</td>
<td>++</td>
</tr>
<tr>
<td>Specific pharmacological recommendations</td>
<td>+</td>
<td>+++</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Specific non-pharmacological recommendations</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Comprehensiveness</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>User-friendliness</td>
<td>+</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Ease of operationalize</td>
<td>-</td>
<td>-</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Updated reviews</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>++</td>
</tr>
</tbody>
</table>

APA = American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia; ECGS = Expert Consensus Guideline Series (ECGS) Treatment of Schizophrenia; PORT = Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations; TMAP = Texas Medication Algorithm Project.

**KEY:**
+++ = Strong; ++ = moderate; + = weak; - = absent
Medication Management Approaches in Psychiatry (MedMAP)

Medication Management Approaches in Psychiatry (MedMAP) provide approaches to the use of medications as treatment for schizophrenia. MedMAP offers both evidence-based guidelines and algorithms that were produced to optimize patient care in schizophrenia. The MedMAP manual is a collection of tools designed and used to initiate and manage medication treatment, to measure relevant patient outcomes, to document interventions and patient progress, and to encourage shared decision-making between the physician and patient.

MedMAP consists of comprehensive recommendations of medication management of schizophrenia developed from the following sources: (1) the Patient Outcomes Research Team (PORT) recommendations; (2) the Texas Medication Algorithm Project (TMAP) schizophrenia algorithms; (3) the Mount Sinai Consensus Conference; and, (4) the Mount Sinai Conference on the Pharmacotherapy of Schizophrenia. From the initial selection of an antipsychotic to issues in antipsychotic polypharmacy, MedMAP provides detailed information on all facets of antipsychotic use to physicians and patients. Also included in the MedMAP resource kit are assessment tools for diagnostic evaluation, symptom severity, and functional outcomes, as well as data collection forms.

MedMAP emphasizes the importance of evidence-based practice in the medication management to improve and optimize health care for patients with schizophrenia. MedMAP is unique in that this resource kit includes a compilation of recommendations from other guidelines and algorithms, making MedMAP very comprehensive. Additionally, MedMAP was developed for easy implementation into clinical practice. Its recommendations for medication use, patient assessment, documentation, and consumer involvement are explicit and user-friendly.
Medication guidelines and algorithms for other psychiatric disorders

There are also guidelines and algorithms for other psychiatric disorders. Similarly, the goals of these guidelines and algorithms are to assist physicians in decision-making processes regarding treatment, and improve patient outcomes. The APA and ECGS have practice guidelines for a wide spectrum of psychiatric disorders and behaviors, such as major depression, bipolar disorder, obsessive-compulsive disorder, and agitation in older persons with dementia. In addition to schizophrenia, TMAP has also developed medication algorithms for major depression and bipolar disorder. More recently, several guidelines and algorithms have been developed for child and adolescent psychiatric disorders, including attention-deficit hyperactivity disorder and depression.

State Policy Implications

In considering the implementation of medication algorithms, several policy issues will need to be addressed. Issues related to selection of algorithm models, cost, and outcomes are important, as are the issues of liability and consumer participation.

1. Cost. While clearly the cost of any treatment intervention is important, the paramount factor in considering whether to implement medication algorithms should be based on achieving quality outcomes that improve the lives of persons with mental illnesses and their families. Algorithms should be premised on open access to medications first and cost, while a factor, should not be the primary decision factor. While some States have moved to adopt a variety of cost-saving strategies around the cost of medications, these are often short-sighted approaches that do not adequately capture the long-term cost of restricting access to medications. Initial savings from a “fail-first” or formulary approach to controlling medication costs may be remarkable, but these approaches often do not factor in the long-term costs that may be seen through increased use of hospitalization or emergency resources. Similarly, the use of med-
ication algorithms may be associated with a higher initial cost for medications, but if reduced use of emergency and other high-cost services can be realized, then the overall cost savings can be significant.

2. **Selection of algorithms.** As was previously discussed, various algorithms and treatment guidelines have emerged that focus on standardizing treatment models for persons with mental illnesses. Guidelines and algorithms should be based on a review of scientific literature and on empirical evidence of their validity and effectiveness. Algorithms should be based on achieving long-term positive outcomes rather than short-term cost savings. Since treatment practices change and evolve over time, and as new medications are being developed, adopting an algorithm model should include an examination of the age of the algorithm, and what kinds of procedures for updating the algorithms have been followed. It will also be important to include strategies for regularly updating the algorithms after implementation.

3. **Liability.** Requiring physicians to adhere rigidly to a medication algorithm or other standard of practice raises potential questions of liability for any untoward events. Medication algorithms and other practice guidelines should allow for flexibility for the individual practitioner to tailor treatment to the needs of the individual patient. This flexibility is important for providing optimal treatment for each patient. However, the practitioner should document reasons for departure from the algorithm, as one way of reducing potential liability from following, or not following, the algorithm.

4. **Involvement of stakeholders in planning.** Because implementation of medication algorithms has an impact on many constituencies, it is important to include stakeholders in development and implementation of the algorithms. Consumers, family members, provider agencies and staff, physicians, researchers, and others should be involved in the planning process from the inception.

5. **Training.** Because many medications, including newer medications, are included in medication algorithms, training for physicians and other professionals is needed
in order to ensure that they are knowledgeable about the latest medication practices. Additionally, consumers and family members will need training so that they can be most helpful in understanding the medication algorithm process and in most effectively reporting their own symptoms.

Role of Planning Councils

State Mental Health Planning and Advisory Councils can play a pivotal role in helping to plan, implement, monitor, and advocate for implementation of medication algorithms for persons with mental illnesses.

To further explore the implementation of medication algorithms in your State:

- Gather the resources listed in this document and distribute them to planning council members.

- Host a meeting on medication algorithms, and invite experts and stakeholders to address the topic. Be sure to include other consumer groups, advocates, and state policy makers along with local and state chapters of NAMI and the National Mental Health Association.

- Collaborate with the State mental health authority to educate mental health consumers and their families about medication algorithms, symptoms and medication side effects, and communicate with mental health providers, using the National Mental Health Association’s Dialogue for Recovery as a model for educating these stakeholders.

- Gather information about the different kinds of medication algorithms and practice guidelines, and form a workgroup with representatives of the planning council, state mental health agency, and other stakeholders to consider the evidence supporting the different guidelines and algorithms. Develop a set of recommendations based on this study.

- Examine existing policies that might restrict the effectiveness of implementing medication algorithms, such as
restricted formularies or “fail-first” policies. Where potential policy conflicts occur, make recommendations to the appropriate policy-setting body, such as the mental health administration, or the State Medicaid agency.

• Encourage the State mental health administration to develop procedures to evaluate and improve the measurement of outcomes, so that the full effect of implementing medication algorithms and other improvements in the treatment system can be effectively monitored and evaluated.

Endnotes


References


Texas Medication Algorithm Project. Available at: www.mhmr.state.tx.us/CentralOffice/MedicalDirector/TMAP.html Accessed on April 22, 2003.

Resources

Organizations

NAMI
The National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
1-800-950-6264
www.nami.org

NARSAD
National Alliance for Research on Schizophrenia and Depression
60 Cutter Mill Road, Suite 404
Great Neck, NY 11021
1-800-829-8289
www.narsad.org

NIMH
National Institute of Mental Health
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
1-301-443-4513
www.nimh.nih.gov

NMHA
National Mental Health Association
2001 N. Beauregard St., 12th Floor
Alexandria, VA 22311
1-800-969-6692
www.nmha.org

NASMHPD
National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
1-703-739-9333
www.nasmhpd.org
SAMHSA
Substance Abuse and Mental Health Services Administration
Rm 12-105 Parklawn Bldg.
5600 Fishers Lane
Rockville, MD 20857
1-301-443-0001
www.samhsa.gov

New Hampshire - Dartmouth Psychiatric Research Center
105 Pleasant Street
Concord, NH 03301
1-603-271-5747
www.dartmouth.edu/~psychrc/about.html

Internet Resources

APA
American Psychiatric Association Practice Guidelines
www.psych.org/clin_res/prac_guide.cfm

ECGS
Expert Consensus Guideline Series
www.psychguides.com

PORT
Schizophrenia Patient Outcomes Research Team Treatment Recommendations
www.ahcpr.gov/clinic/schzrec.htm

PRC
New Hampshire - Dartmouth Psychiatric Research Center
www.dartmouth.edu/~psychrc/pubs.html

TIMA
Texas Implementation of Medication Algorithms
www.mhmr.state.tx.us/CentralOffice/MedicalDirector/TIMA.html

TMAP
Texas Medication Algorithm Project
www.mhmr.state.tx.us/CentralOffice/MedicalDirector/TMAP.html
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The National Association of Mental Health Planning and Advisory Councils
The state mental health planning and advisory councils have joined together to form the National Association of Mental Health Planning and Advisory Councils (NAMHPAC). Federal law requires the establishment of mental health planning councils to review state applications for block grant funding, to serve as advocates for adults with serious mental illnesses and children with serious emotional disturbances, and to monitor and evaluate state mental health planning systems. Although these activities are mandated, many states do not provide funding to support them. In many cases, this lack of funding combined with council members’ often short tenures prevents these organizations from making their full impact on service delivery and consumer empowerment. NAMHPAC provides technical assistance to these organizations in the areas of exemplary practices, organizational development, and information sharing. In addition, NAMHPAC provides a national presence on mental health policy issues on behalf of the state planning and advisory councils.

We hope that each planning and advisory council member will closely read this document and use its information to develop the state plan for year 2004 and beyond. In addition, NAMHPAC will contact members of state councils to encourage them to use these materials, to evaluate how the materials were used, to identify topics for future pamphlets, and to gather suggestions for dissemination of such pamphlets.