Keystones for Collaboration and Leadership: Issues and Recommendations for the Transformation of Community Psychiatry

The American Association of Community Psychiatrists
Pennsylvania Psychiatric Leadership Council
Allegheny County Office of Behavioral Health
Coalition of Psychiatrists for Recovery

Edited By
Wesley E. Sowers, MD, and Kenneth S. Thompson, MD

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Introduction

The field of psychiatry is at an important crossroads in its evolution. Over the past several decades, a great deal has been learned about the brain, pharmacology, and biological processes contributing to behavioral health disorders. These advances have been embraced by psychiatry in its quest to develop effective treatment for these illnesses, and they have created much excitement and hope about uncovering new ways to help people deal with the tragedy of mental illness. At the same time, people who have used psychiatric services express a great deal of dissatisfaction with current services. Partially as a result of this, these people have developed non-professional resources, on an individual and collective basis, to help themselves recover from behavioral health disorders. A worldwide recovery movement has developed and has been critical in helping people shake themselves loose from limited expectations and associated hopelessness.

While both of these developments provide reason for hope, there has not yet been an adequate structure for linking these two revolutions of optimism in a synergistic manner. The purpose of this document is to create a vision for our profession that incorporates the capacity to promote health and wellness through a comprehensive conceptualization of human processes and an integrated, holistic approach to treatment and services. This vision should include elements needed to re-establish psychiatry's strong position in leadership and collaboration.

To accomplish this, a historical perspective on the current state of our profession is needed. In recent times a variety of forces has converged to constrict the scope of psychiatric practice to one focused on biological aspects of illness. This has been evident in our residency training programs, which have been increasingly disabled in their mission to develop competence in areas such as prevention, mental health promotion, psychosocial interventions, and leadership. Financial and administrative pressures from payers and mental health service organizations have reduced the ability of psychiatrists to engage in therapeutic activities outside of medication management. Research has had a limited scope in community psychiatry, and has struggled to translate science into service or service into science, limiting its potential to support an expanded role for psychiatrists. High caseloads and limited time to engage in empathic communication have created circumstances that no one can be happy with. Consumers, families, and communities want more personal contact and more choices in the services they receive. Psychiatrists lament that all they have time for is writing prescriptions and completing required documentation. The President's New Freedom Commission on Mental Health Care joins this chorus by noting that the mental health care system is "fragmented and in disarray."

It is time that psychiatrists in public service, and those they work with in Pennsylvania and around the country, think differently than they have in the recent past. It is time to begin transforming both the profession and mental health care. To do this, psychiatrists must develop a thorough understanding of recovery as a goal and a process and embrace the added value of effective partnerships with

consumers, families, other disciplines, and stakeholders in addition to their expertise in managing medication and the biologic aspects of illness. At the same time, systems of care must creatively develop methods to support psychiatrists in this effort.

Critical to the transformation is a greater understanding of what underlies the health and mental health of people in communities. Many of our country's neighborhoods are socially and economically distressed with limited resources to promote mental health or treat mental illness. A public health perspective, incorporating skills in community-based scholarship, leadership, and advocacy, is a fundamental element of what community psychiatric practice needs to encompass today.

It is our hope that this report will create a vibrant vision for a service- and health-oriented psychiatry with a broad, trans-disciplinary approach to practice that allows a primary role in supporting recovery in individuals, families, and communities while struggling for social change and health equity.

Participants/Contributors

The **American Association of Community Psychiatrists** (AACP) is an organization dedicated to the provision of quality care for persons with mental health and substance use disorders who are impoverished, discriminated against, disenfranchised, or otherwise underserved. The mission of the organization is:

……to inspire, empower, and equip Community Psychiatrists to promote and provide quality care and to integrate practice with policies that improve the well-being of individuals and communities.

The AACP has been working over the past twenty years to ensure that all people in our society receive the treatment they need for behavioral health disorders. The organization has developed a variety of clinical standards, tools, and guidelines in addition to numerous position and policy statements, which have been influential in defining quality practice in community and publicly funded settings for the profession. Many of these products can be viewed at www.communitypsychiatry.org.

The **Coalition of Psychiatrists for Recovery** (CPR) is a national network of psychiatrists interested in the "recovery" of psychiatry and its transformation to a profession with greater scope and depth of practice. It was formed in June of 2005 for the purpose of creating a grassroots movement to "reduce reductionism" in the profession and reclaim the psychiatry of humanism and leadership. It is composed of psychiatrists, allied professionals, and consumers of services.

The **Pennsylvania Psychiatric Leadership Council** (PPLC) is an organization that has been working since May 2005 to develop a strategic plan for the recruitment and retention of psychiatrists in the public sector and community settings in the commonwealth. With support from the State Department of Public Welfare and the Office of Mental Health and Substance Abuse Services, the PPLC has focused on

creating new ways to think about psychiatric practice in the public sector and how to support it.

The **Allegheny County Coalition for Recovery** (ACCR) is a grassroots organization of stakeholders that has been working since 2001 to increase the public's recognition that people can and do recover from serious mental illnesses and substance use disorders. The Coalition has developed a number of products and sponsors a variety of events designed to reach out to the general public, users of behavioral health services, and providers of those services, with information and resources related to the transformation of behavioral health services and the recovery process.

On March 3 and 4, 2006, the AACP held its annual winter meeting in Pittsburgh. The conference was titled **"Keystones for Leadership and Collaboration: Transforming Community Psychiatry."** Members of these three organizations (the AACP, PPLC, and CPR) made up many of the nearly 100 psychiatrists participating in this event. In addition, about 100 consumers and 200 allied behavioral health professionals attended this meeting and were discussants for the 34 focused discussion groups and six dialogues that took place during the two days of the conference. The outputs from these discussions provide the primary source for most of the content of this report.

Process

Each of the 34 Transformation Discussion Groups had three co-facilitators who represented distinct perspectives (psychiatry, consumer, family member, etc.). The discussions lasted about 90 minutes. The participants were provided with a brief overview of the topic they would be discussing and were then asked to identify the major issues for change in this area and to make some recommendations about how these changes might be realized. They were asked to identify what changes the profession must make, what individual psychiatrists could do to improve the quality of their practices, and how systems, consumers, and communities could support those changes. Participants were able to choose the discussion topics they wanted to join.

Following the discussion group, the co-facilitators were asked to submit a report to the course directors outlining the major points of discussion in the group. A draft was prepared from these reports and additional input was requested from members of the AACP, the PPLC and CPR, who were unable to attend the meeting, through a "virtual conference" process. Members were asked to review the drafts and share any additional ideas that occurred to them. Group co-facilitators were likewise asked to elaborate on the initial drafts. Relevant suggestions were then incorporated into the discussion reports.

The discussion reports were compiled in a topical manner and considered various perspectives for their recommendations. The Executive Summary organizes the outputs from the groups from the vantage point of each change agent, i.e. psychiatrist, profession, system, consumer. The Transformation Discussion Summary reports are

organized by topic, and we have attempted to be as inclusive as possible with regard to the ideas that were put forward. These ideas may be controversial in some cases and in many cases there will be some overlap between discussions.

Purpose

The purpose of this report is primarily to stimulate further discussion and to provide a foundation for thinking about grassroots change and reclaiming a broad-based, humanistic psychiatry. It should be useful not only to the organizations involved in its development, but to entities across the country and across disciplines that are considering transformation to more effective, recovery-focused practices and the psychiatrist's role in the systems being contemplated. The ideas contained in this report are clearly just a starting point, and will require consensus building, prioritization, and in some cases, further elaboration before meaningful change processes can occur. With this as a foundation, the opportunity to begin those tasks is present, and hopefully, for those who see the need for change, the opportunity will not be squandered.

Part I:

Transformation Discussions Executive Summary

Professional Issues

Definition and Vision

The transformation of psychiatry is predominantly about changing the profession, although there are many things that individual psychiatrists, systems, and other stakeholders might do to support these changes. The executive summary of this report will provide suggestions for change from all of these perspectives, but changes at the professional level would seem to be the most compelling place to begin. In thinking about these changes, further focus will be obtained by first considering how the profession must define itself and create a new vision. Second, it will consider how training can support that vision, and finally how leadership and advocacy might bring these ideas to fruition.

Psychiatry has been increasingly identified with biological aspects of practice. The need for thinking of a way to revitalize and recapture psychiatry comes from concerns about the reduced scope of practice that is commonly promulgated in community settings, and the failure of training programs to counteract these narrower views of what it means to be a psychiatrist. There will continue to be a need to develop the knowledge and practice of biological psychiatry, but other areas of expertise that define a broader scope of practice and leadership cannot be lost. It may be useful to think about this broader concept of psychiatry, incorporating the wisdom of other disciplines such as sociology, anthropology, and humanities, as a "humanistic" psychiatry as distinct from the "neuropsychiatry" that has recently dominated the field. The professional identity of this discipline must rest on connectivity, interactivity, and collaboration, recognizing and confronting uncertainty. This humanistic or holistic psychiatry would avoid framing all suffering and discomfort as pathology and develop an alternative view of professionalism that would reduce negative images held by the community. It would revitalize the concept of spiritual or existential healing with a focus on the purpose and meaning of life and suffering. Partnership with each person in his or her recovery process would set the tone for this discipline. A humanistic psychiatry would embrace the scholarship of applied knowledge (or community-engaged scholarship) as its primary focus. This scholarship would be instrumental in developing a new vision for the discipline that would include:

- Developing the core concepts of collaboration and network development.
- Clarifying ethical concerns from both individual and professional perspectives, and application of ethical principles to guide practice.
- Integrating assessment and planning for individuals that is informed by the multiple influences of environment including culture, spirituality, gender, race, sexuality, occupation, age, and many others.
- Defining the roles of the psychiatrist in the community, incorporating concepts of advisor, interpreter, teacher, student, partner, confidant, and healer.
- Developing theoretical aspects of transition facilitation, including end-of-life issues and establishment of identity as agent of change.

- Applied advocacy, both accommodative and transformative, based on public health and preventative medicine principles to address health disparities and aid distressed communities.
- Redefining outcomes and evidence that apply to complex communities and circumstances.
- Creating a research agenda relevant to clinical practice that encourages innovation, flexibility, investigation of positive deviance, and experientially successful practices.

The emphasis must be on how psychiatrists can better apply what they know and how effectiveness can be evaluated. The elements of and the magnitude of the changes that are necessary will need further debate and refinement, but there is little question that psychiatry must determine if it has been reduced by its own lethargy, apathy, and lack of vision, or by other forces created by the systems we work within. In either case, it is critical that answers be formulated that can transcend these obstacles.

Training

A redefined and refocused psychiatry will need a new agenda for training new psychiatrists and re-educating those currently in practice. The curricula of training are shaped as much by politics as by principle, so change will not be an easy process. It will not be impossible, however, and just as biological interests supplanted psychoanalytic interests over the past twenty years, a humanistic approach to psychiatry can rival biologic perspectives in establishing its value.

Training programs will need to realign priorities and add significant elements to their curricula in order to provide the necessary skills to graduates. The organizing concepts of recovery promotion, leadership, and collaboration should largely govern the way these new priorities are set. Training should emphasize the value of the relationship in the healing process and the mutual engagement required for facilitation of change. Communication skills, emotional management, characterologic analysis, and systems dynamics must be priorities for training. Leadership skills must be recognized as a critical aspect of education and as necessary for carrying out this agenda. The scope of training must be expanded to restore skills related to systems management if a new generation of psychiatrists is to be equipped to influence evolving systems of care.

A new concept of scholarship that emphasizes the application of knowledge, teaching, and community involvement, focusing on process, technology transfer, and evaluation, must be developed and supported by departments of psychiatry, training programs, and CME programs.

Public health and prevention must become important elements for thinking about improving the health of communities. The interactivity and interdependence of various elements of society must be clarified through a research agenda attuned to understanding cultural complexity and social values. Attention to sub-populations with

special attributes, such as the homeless, people with criminal justice involvement, children, people with addictions, etc. will be an important part of this agenda.

Integration and collaboration of systems providing services and facilitation of that result will be another essential element of training. Systems of care approaches with emphasis on analysis of efficacy and improvement should be at the core of how service delivery is conceptualized and taught.

Psychiatrists in training must be exposed early to recovery concepts and theories of change. The professional and individual roles in developing successful recovery must be thoroughly understood and related to all areas of practice.

To accomplish these broad areas of transformation, strategic planning must occur and the identification of priorities for change and useful strategies to achieve these goals must be carefully debated. Among the actions that should be considered are the following:

- Create professorships and fellowships in Community Psychiatry with support from a variety of public and private sources.
- Establish tracts for trainees with public service interests with enhanced mentoring, clinical experience, and scholarship.
- Strongly advocate for change in competencies specified in residency training standards.
- Engage with Residency Review Committee (RRC), American College of Graduate Medical Education (ACGME), American Association of Directors of Psychiatric Residency Training (AADPRT), and the American Board of Psychiatry and Neurology (ABPN) to further agenda for change.
- Create academic partnerships with underserved areas and sequestered populations that would provide exposure to trainees, faculty opportunities, and continuing education.
- Identify and recruit potential psychiatrists with public health interests early in their training through the creation of a supportive professional community.

On a practical level, training programs must equip their trainees to meet the challenges of the profession through broader didactic offerings and expanded clinical exposure in diverse settings. Likewise, CME activities must begin to address issues other than medication management. Areas in need of enhancement would include:

- Exposure of trainees to persons in successful recovery in the community and to principles of recovery processes.
- Provision of opportunities for participation in integrated care, mentoring, and interaction with consumers and family members.
- Incorporation of recovery-enhancing practices in all training experiences and emphasis on the development of skills for effective engagement and collaboration with service users in the planning process.
- Emphasis on the development of skills and knowledge essential for leadership such as group therapy, family systems therapy, clinical team activities, economics

of health care, service system planning and management, evaluation, and consultation.
- Interaction with religious communities and awareness of the value of spiritual/religious foundations in clinical practice and their relationship to recovery.
- Exposure and experience in working with end-of-life issues and development of skills to work effectively in this area.
- Exposure to practice and theory of psychiatric rehabilitation to model recovery-oriented practices.
- Experience working with primary care providers, in primary care settings and in consultation, and in management of uncomplicated physical health problems in psychiatric settings.

Leadership and Advocacy

Although psychiatry was once prominent in the leadership of mental health services, this has not been the case for some time. There have been a variety of factors that have contributed to the decline in psychiatry's leadership role. Training has evolved in a way that leaves most graduates of residency programs ill equipped for leadership roles, and many of the deficits in training are alluded to above. Economics has likewise created some barriers to using the psychiatrist's time for anything other than the provision of direct services. If psychiatry is to reclaim a role in the leadership of behavioral health services, it is critical that it develop a vision and rationale for psychiatric leadership and clarify the unique contributions that it has to make. In addition, creative solutions to the economic obstacles must be developed.

To accomplish this in a credible way, significant discussion with other professions and communities must occur, as well as some much-needed soul searching. It will be necessary to clarify the ethical issues of the profession and to confront perceptions that it is governed by self-serving motivations. While agreement on ethical principles is often difficult, keeping these issues prominent in thinking about the activities the profession is involved with will be important and will assist engagement with the community and inform the advocacy agenda. Likewise, frank examination of stigma and prevailing attitudes within psychiatry will bolster the credibility of the process as the change agenda evolves.

Advocacy efforts must shift the focus away from narrow guild issues to a broad consideration of quality of care for all members of society. The interests of the profession must be subservient to efforts to assure that quality care is well defined and implemented. Toward this end, psychiatry must be involved in:

- Development of quality and performance standards for all aspects of community behavioral health care, which are relevant and practical, for clinicians and programs.
- Emphasis on prevention, creating rational systems of care, and building resilience in individuals and communities.
- Creating opportunities for more effective communication with clients, allied caregivers, and communities, and developing partnerships for advocacy.

- Developing integrated systems of care that incorporate unified approaches to individuals with multiple and diverse needs.
- Creating a relevant research agenda that addresses recovery-enhancing practices, services in non-traditional settings, complex environments and cultural influences, quality improvement processes, and evidence-informed practices.
- Consultation to clinical teams, behavioral health agencies, and larger systems of care.
- Political advocacy through consultation, activism, public education, and community organization.

Individual Psychiatrists' Issues

Clinical Practice

Many of the changes outlined in the previous section for the profession will obviously be the subject of much debate and impact the politics that govern psychiatry. Clearly, not everyone will agree with all aspects of the changes recommended. Some will find them impractical or undesirable. Change does not come quickly to large groups or systems, and it usually requires some compelling incentive to occur. When it does come, it usually occurs in an incremental fashion rather than abruptly. While some may say that this is true of individuals as well, executive function is at least a much more consolidated and simple process. From this perspective, changes in the practices of individual psychiatrists may be most critical in actually creating some momentum for change.

Two related concepts emerged most prominently from recommendations for individual psychiatrists regarding their clinical practices: recovery-oriented practice and collaboration. Traditional approaches to practice have often been somewhat paternalistic. They have focused on maintenance of what has been perceived to be chronic, unremitting conditions. Psychiatrists have been perceived to be somewhat arrogant, autocratic, and in some cases unapproachable. While these perceptions are certainly not always valid, it seems clear that there will need to be some fundamental shifts in how individual psychiatrists think about their roles and the people that they provide assistance to and with whom they work.

With regard to recovery-enhancing practices, the following recommendations emerged:

- Embrace principles of a recovery-focused practice, giving priority to clients' individual needs.
- Incorporate non-judgmental, motivational, hope-inspiring therapeutic approaches and change management techniques into practices.
- Recognize the relationship as a primary healing factor in doctor-client interactions.
- Employ resiliency-building approaches, empowerment, positive reinforcement, curious inquiry, and respectful interactions to establish trusting relationships.

- Facilitate consumer involvement in selecting the services they want in the context of available resources.
- Focus on strengths, hopes, and autonomy in developing recovery partnerships and collaborative planning arrangements.
- Recognize the primacy of consumer choices in creating medication plans, and foster investment in the plan through respect, participation, education, and empowerment.
- Ensure that planning processes are determined in the context of individual cultural and spiritual influences and that they are sensitive to traumatic experiences.

Recovery-focused practices can best be established through collaborative processes such as:

- Creating an environment of cooperation and interaction with all team members involved with an individual client.
- Creating bridges between disparate treatment cultures (i.e., addiction and mental health), using the recovery paradigm as a unifying principle to integrate services.
- Developing relationships with clergy, educators, primary care providers, correctional institutions, and other entities involved in the system-of-care network.
- Emphasizing the relationships necessary to facilitate transitions in various phases of life and the skills needed to develop them.
- Providing consultation to PCPs and others providing care to individuals outside the behavioral health systems.

For many, implementing these distinct practices will require the acquisition of additional knowledge and skills. In many cases, psychiatrists will need to make sacrifices to ensure that they receive the training that they need. Although some systems will be willing to facilitate and provide funds for these training imperatives, many either can't or won't. It will be particularly important to develop knowledge and skills in the following areas:

- Non-pharmacologic approaches to address behavioral health disorders.
- Person-centered treatment planning processes and their application in diverse treatment settings.
- Clinical practices informed by environmental experience such as culture, religion, sexuality, and traumatic events.
- Treatment of substance use disorders as single disorders and when co-morbid with other mental health issues.
- The relationship of homelessness and housing to health status and the importance of providing housing first in recovery-facilitating processes.
- Local and regional disaster planning, psychiatric first aid, self-care, and helper care issues.
- Correctional systems, their impact on persons with behavioral health issues, and how this influences clinical planning and outcomes.
- Principles of psychiatric rehabilitation and recovery and how they might inform clinical practices.

- Principles of transition management and their application through treatment processes and the life cycle, including assistance with end-of-life planning.
- Evidence-informed clinical practices, including circumstance-specific evaluation and service improvement.
- System dynamics as they apply to children, families, communities, agencies, and systems of care.

Leadership and Advocacy

Psychiatrists are not currently handed leadership roles, nor is there an expectation that they will eventually grow into one. In many cases leadership from psychiatrists is not valued or welcomed. Until this changes, psychiatrists will need to be creative and politically astute in their attempts to have an impact on systems of care. In most cases they will need to learn how to develop relationships through which they can exert influence without any actual authority. Psychiatrists will not often have significant support for the advocacy efforts that they make; so much of what they do will be uncompensated financially, but the investment may pay off in a variety of other ways that are less concrete. The goodwill created by these efforts is not easily measured, but will fundamentally change the way the profession is understood and embraced.

There are several levels where leadership and advocacy may be applied by individual psychiatrists. Within agencies issues that may require attention include the following:

- Standardization of service-planning processes across programs and phases of care so that the plan is truly consumer owned.
- Implementation of recovery-enhancing practices throughout the system.
- Opportunities to support families and engage them in dialogues about their fears and concerns.
- Interaction with religious communities and other influential community groups.
- Flexible housing options and housing-first approaches to address the needs of the homeless persons.
- Opportunities for consumers to develop skills as peer counselors, to be employed in these roles and incorporated into the clinical team.
- Broad participation of consumers in administrative processes.
- Collaborative relationships with law enforcement and judiciary and creation of cross-training opportunities.

In the community, the following activities should be considered:

- Join with families in advocacy efforts, facilitate mutual support, and provide education on emotional disturbances in children.
- Expand involvement with the school system and create a presence in the community.
- Provide education regarding homelessness, criminal justice system, end-of-life issues, disaster response, prevention, and other relevant/misunderstood issues.
- Promote practices that will enhance the health of communities and the stability of families.

- Create relationships with advocacy and community groups and provide consultation to their efforts.

On the level of policy and community obligations:

- Provide opportunities to discuss social policy and justice on a variety of controversial issues such as abortion, impact of war, end-of-life rights, and capital punishment.
- Examination of factors influencing health disparities in local communities.
- Promote public health and prevention activities.
- Create a legislative agenda that includes provision of adequate resources for behavioral health care and parity in coverage.
- Develop conduits for informing and influencing legislators.
- Promote voter registration and participation in elections.
- Strategies to break "silo" organization of services and financing to allow continuous and integrated services.
- Expand priorities for services, addressing the needs of all who need them, not only those with serious mental illness and addictive disorders and not excluding populations in need, such as people with criminal justice involvement.

Service Systems' Issues

The transformation of psychiatry serves not only the profession, but will enhance the quality of services that systems of care provide and the outcomes that persons using those services experience. Psychiatry cannot by itself implement the changes recommended in the preceding sections without significant support from agencies providing care and governmental administrations providing funding and oversight. Consistent with the theme often repeated in this report, collaboration between these parties will be critical in effecting the needed changes for quality improvement.

Service systems must create a new vision for the services they provide and the psychiatrist's role in them. Systems serious about transformation must:

- Create cultures of inclusion that value all inputs (including psychiatrists and consumers) and actively seek them.
- Embrace recovery principles and enhance support for the psychiatric rehabilitation model, stressing resilience, productivity, and creativity or "capacitation."
- Systems must design services to meet the needs of clients, rather than the needs or convenience of organizations.
- Define the role of psychiatry in clinical and administrative activities, and assure that they are used accordingly.
- Expand capacity to address both mental health and addictive disorders and develop collaborative and integrative approaches to do so effectively.
- Establish liaisons with communities, related service agencies, and community and religious groups, and provide consultation with psychiatrist involvement.
- Focus on prevention activities and public health, creating opportunities for early identification and intervention.

In redefining the roles of psychiatrists, systems will need to be creative in identifying funding priorities and mechanisms to support them. Some possible priorities and solutions follow:

- Support and development of psychiatric rehabilitation programs.
- Behavioral health services in primary care settings and primary care in behavioral health settings.
- Create opportunities to free psychiatrist's time through physician extenders, use of primary care providers and supervisory relationships.
- Develop alternative to fee-for-service payment arrangements to allow more flexible use of psychiatric resources.
- Create funding arrangements and collaborative agreements that would facilitate smooth transitions and support continuity of care.
- Develop workforce (nursing, social work, psychology), in addition to psychiatry, to work collaboratively in mobile services, tele-psychiatry, web-based consultation, and clinical teams for most efficient use of resources.

With limited resources, systems will not be able to stretch existing resources far enough to implement all the necessary changes either. Systems must join psychiatrists and the community in advocating for the following:

- Reform of disability support system that encourages return to productivity.
- Public education to reduce stigma and expand opportunities for persons with disabilities.
- Expanded opportunities for international medical graduates.
- Encourage simple, evidence-informed prescribing practices with a focus on relationship building and incorporation of non-pharmacologic interventions.
- Adequate funding for prevention and clinical services to reduce incidence and prevalence of behavioral health morbidity.
- Development and use of clinical tools that are interactive and support equity in services and recovery-focused practices.
- Development of adequate housing options and reduction in the rate of homelessness.
- Creation of alternatives to incarceration of persons with behavioral health disabilities and reduction of "warehousing" in these settings.
- Creation of quality cultures through training in quality management principles throughout the workforce, grassroots participation, and incentives rewarding excellence.

Consumer and Community Issues

Ultimately, those who have the most power to create change are those who have a vote. Apart from the other benefits of working with communities and developing relationships with consumers, it will be extremely important to organize alliances of all stakeholders in systems of care. These alliances will also be in a position to

support efforts related to a transformation of psychiatry. These advocacy alliances can be facilitated when systems:

- Recognize and promote recovery as a universally relevant concept and a unifying process.
- Provide consultation to communities and assistance in developing culturally appropriate institutions to provide security and stability.
- Develop collaboratives that build on the strengths and wisdom of communities, providing support and advice to empower them.
- Raise awareness of civic processes and how to effectively create influence over public policy.
- Promote public health and prevention perspectives and develop partnerships with communities to promote health.
- Create a network of service providers addressing all aspects of consumers' needs, and establish means of continuing communication.
- Assist consumers in developing skills to effectively communicate and advocate for their interests.
- Use networks to strengthen anti-stigma efforts and create "normalization" of behavioral health conditions.
- Create frameworks for working in distressed communities and strengthening their resilience.
- Develop meaningful quality improvement processes within systems that include psychiatrists as well as consumers.
- Engage in public education related to the universal benefits of access to services.
- Create dialogues/town meetings devoted to issues related to behavioral health of individuals and communities.

This summary attempts to integrate and organize the output from a large number of topical discussions. As in any summary, many of the details have been omitted. Hopefully it will provide coherence and a framework for absorbing the more specific material that follows.

Part II:

Transformation Discussions Topics Summary

Section I: Professional Transformation

Redefining Psychiatry

Issues

Psychiatric research, education, and treatment are now defined rather narrowly, with the medical and biological aspects of theory being emphasized. The arts, humanities, and social disciplines have relatively little influence and are increasingly fading from training curricula. The profession is falling short in its capacity to understand the meaning of human interactions and endeavors. The clinical encounter is increasingly dehumanizing, and clinical inquiry is increasingly distant from the stakeholder's experience. The profession has become complacent in its biological posture and does not challenge itself to be more. There is a reluctance to address the role of power dynamics, the significance of suffering, and the uncertainty that are inevitably part of human behavior and that are particularly relevant to the practice of psychiatry. The result has been a reduction in psychiatry's ability to attract candidates with these interests, as well as demoralization within the profession.

Recommendations

- Develop the concept of humanistic psychiatry as a discipline distinct from biologic or neuropsychiatry.
- Incorporate wisdom of other disciplines such as sociology, anthropology, political science, literature, history, philosophy, and culture into research and training.
- Raise awareness regarding the importance of power dynamics and democratic process by opening all aspects of psychiatry to insights and contributions from consumers.
- Focus on the relationship as a healing factor in doctor-patient interactions.
- Develop the concept of the psychiatrist as a spiritual or existential healer and as an active partner with each person in his or her recovery process.
- Professional identity must rest on connectivity, interaction, collaboration, social justice, and the ability to confront uncertainty and the meaning of suffering.
- Reduce emphasis on diagnosis and the "pathologizing" of all instances of behavioral difficulties related to distress and turmoil.
- Community-engaged scholarship must become part of the discipline.

Supplementary Material

Lewis, B: *Moving Beyond Prozac, DSM, and the New Psychiatry: The Birth of Postpsychiatry* 2006 Ann Arbor, University of Michigan Press.

Leadership

Issues

There is very little in training programs today that actually prepares psychiatrists to provide leadership, and fewer opportunities to obtain experience while working. There is no clearly articulated rationale for leadership development in psychiatry to help overcome the many barriers that have limited the activities of psychiatrists in these roles. Psychiatrists are often perceived to be too costly, arrogant, uncooperative, and ill prepared for leadership roles. As a result, the psychiatrists' role has been ambiguous and frequently devalued despite the responsibility assigned to them for the welfare of the clients being served.

Recommendations

- Broaden the scope of training and practice to allow development of skills critical for leadership (group therapy, family systems therapy, clinical team activities, economics of health care, etc.).
- Create professorships and fellowships in Community Psychiatry that blend support from clinical activities and governmental funding.
- Advocate for change in competencies specified by Residency Training Standards.
- Develop vision and rationale for psychiatric leadership within the profession and in larger systems.
- Systems should create opportunities for psychiatrists' participation in policy development and administration.
- Develop additional resources to allow greater flexibility to participate in activities beyond clinical responsibilities (i.e., physician extenders).

Supplementary Material

AACP Guidelines for Psychiatric Leadership in Organized Systems of Care, 1997
www.communitypsychiatry.org

Ranz et al. *The Role of the Psychiatrist as Medical Director: A Survey of Psychiatric Administrators.* Administration and Policy in Mental Health and Mental Health Services Research. Vol. 27, No. 5, May 2004. pp. 299-312

Training

Issues

The academic community has focused on research and biologically oriented constructs of mental illness, and the skills developed by trainees have been constricted in this range. There is little emphasis or interest in public service issues relevant to community practice, and these activities are not valued or supported by departments of psychiatry. Standards established for residency training fail to support experience in community-based services.

Recommendations

- Redefine psychiatry to include a broader scope of practice and an expanded role in leadership of clinical systems.
- Apply pressure to change standards for training through penetration and advocacy with the Residency Review Committee, American College of Graduate Medical Education, American Board of Psychiatry and Neurology, American Association of Directors of Psychiatric Residency Training, and other relevant bodies.
- Establish tracts for trainees with interests in public service that provide mentors, community experience, and relevant scholarship through service agreements and government partnerships.
- Develop areas of communication, emotional management, characterologic analysis, and system dynamics as priorities for training.
- Create alternative concepts for professionalism that reduce elitist and self-interested images held by the community.
- Develop capacity to practice experientially (culture, religion, sexuality, trauma) informed clinical approaches.

Supplementary Material

Goldman, CR et al*: Community Psychiatry Training for General Psychiatry Residents: Results of a National Survey.* Community Mental Health Journal, Vol. 29, No. 1, February 1993

Community-Engaged Scholarship

Issues

This is one of four types of scholarship: knowledge generation, integration, pedagogy, and application or "community-engaged scholarship" (CES). There is little space for scholarship beyond what is sometimes termed "knowledge generation," or the research that drives most academic institutions. There are few opportunities to generate funds for other types of scholarship, and as a result, limited opportunities for promotion of scholars engaged in these other types of scholarship. There is little respect for CES in academic institutions.

Recommendations

- Community-Engaged Scholarship should be the primary scholarship of Community Psychiatry and must be established as a recognized and respected academic activity.
- Departments of Psychiatry must develop opportunities for faculty and demonstrate that this type of scholarship is valued.

- Establish faculty chairs and fellowships through stable funding streams, such as governmental grants.
- Develop an academic community, subdiscipline, and literature that will further define the scholarship of community engagement and applied knowledge.

Supplementary Material

Community-Campus Partnerships for Health, Community-Engaged Scholarship
http://depts.washington.edu/ccph/scholarship.html

Professional Ethics

Issues

Existing guidelines for professional ethics are inadequate and often irrelevant, focusing on issues that apply to very narrow concepts of practice. This narrow conceptualization does not include many issues of concern to community-based practitioners and primarily addresses individual ethical issues while paying little attention to ethical issues for the profession as a whole. There is an ill-defined separation between legal liability and ethical issues in many cases.

Recommendations

- Clarify ethical concerns for individual psychiatrists, the profession, and community-engaged practitioners.
- Clearly define potential conflicts of interest regarding financial gain, relationship issues, and scholarship.
- Confront issues of conflict between guild interests (profession) and consumer benefits (e.g., psychiatry vs. psychologists prescribing).
- Create dialogues related to justice in society and mental health care to address health disparities.
- Provide leadership in debates related to social policy and justice on issues such as abortion, capital punishment, drug policy, sexual offenders, and discrimination.

Supplementary Material

AACP Principles for Governing Corporate Donations, 2001,
www.communitypsychiatry.org

Moffic, SH: The *Ethical Way: Challenges and Solutions for Managed Behavioral Healthcare* Jossey-Bass, 1997.

Collaborative Relationships

Issues

There is no clearly articulated rationale to establish the value of collaboration at present. Many of the activities of psychiatry take place in an independent manner, and collaborative relationships are fairly circumscribed. Most psychiatrists are "raised" in a competitive climate rather than a cooperative environment.

Recommendations

- Develop the theory of collaboration, emphasizing the importance of investment by stakeholders in change processes, and understanding of its value.
- Define levels and types of collaboration, i.e., clinical, professional, community, individual, and organizational.
- Develop understanding of how planning and processes become validated through collaboration.
- Use of dialogues outside traditional contexts between potential partners from traditionally distinct groups to develop a basis for understanding and cooperation.
- Training should incorporate opportunities for participation in collaborative activities, systems knowledge, and non-clinical communication skills.
- Create opportunities for examination of competitive influences in professional and organizational interactions.

Supplementary Material

ACCR: Guidelines for Developing Consumer-Provider Dialogues 2005, www.coalitionforrecovery.org

ACCR: Universality of Recovery, 2006: www.coalitionforrecovery.org

Workforce Development

Issues

One aspect of workforce development is looking at how to ensure proper training and quality of service in the community and is addressed in other sections of this report. Another aspect is ensuring that adequate numbers of a profession are available to meet needs. The profession is not currently able to meet the needs of the population. This is due to limited success in recruiting young physicians to the field, especially those who have values consistent with serving underserved populations and who desire skills that are not presently part of many training programs. Community psychiatry is undervalued and stigmatized, as is public service. Under-funding of public programs also makes it more difficult to recruit adequate numbers of psychiatrists and create an attractive work environment. Leadership in this area is lacking.

Recommendations

- Identification and early recruitment of potential psychiatry candidates.
- Provide opportunities for participation in integrated care, mentoring, and for interaction with consumers and family members in medical school and residency training.
- Advocate for adequate funding and staffing in community settings.
- Create alternatives to fee-for-service payment arrangements to help support broadened scope of practice and geographic range.
- Expand opportunities for and availability of nurses and physician assistants to extend practice in collaboration with and under the supervision of psychiatrists.
- Expand opportunities for international medical graduates.
- Develop collaborative advisory relationships with primary care providers and methods of compensation for supervisory activities.

Supplementary Material

Svendsen, DP, Cutler, DL, Ronis, RJ, et al.: *The Professor of Public Psychiatry Model in Ohio: The Impact on Training, Program Innovation, and the Quality of Mental Health Care*; Community Mental Health Journal, Vol. 41, No. 6, December 2005

Annapolis Coalition on the Behavioral Health Workforce: www.annapoliscoalition.org

Section II: Clinical Services

Clinical Teams

Issues

There has been a lack of clarity about the psychiatrist's role on clinical teams, especially in community-based programs. They are not, in general, well prepared to be team players, and in many cases they lack the skills needed to provide clinical leadership and to facilitate change. While team-building skills are needed, there are few opportunities, even for those possessing these skills, to use them. Despite evidence that strong relationships between psychiatrists and clinical teams enhance outcomes, there is minimal effort to cultivate these relationships.

Recommendations

- Create a vision for psychiatry's role in team management and team building.
- Training programs must provide experience in leadership, including change management, decision-making processes, and group therapy.
- Expand opportunities to participate in a range of clinical teams during training.
- Ensure that psychiatrists have opportunities to participate in team meetings in all settings and that consumers have a role in the function of the team.

Supplementary Material

Fichtner, CG, Stout, CE, et al*: Psychiatric Leadership in the Clinical Team: Simulated in Vivo Treatment Planning Performance as Teamwork Proxy and Learning Laboratory.* Administration and Policy in Mental Health, Vol. 27, No. 5, May 2000, pp 313-337

Cultural Competence

Issues

There has been a lack of clarity about what cultural competence means for psychiatric practice. In multi-cultural settings, it is not possible for individual psychiatrists to be "fluent" with all the cultural influences that they encounter. There has been a tendency toward stereotyping in considering cultural issues, and it is not always recognized that an individual may have several cultural influences (i.e. ethnic, religious, sexual, occupational, etc.), all of which may have significant impact on their beliefs and preferences. Most psychiatrists have few skills for understanding cultural influences and how to help craft culturally appropriate interventions effectively.

Recommendations

- Define meaning of cultural competence for psychiatric practice and corresponding skill set to enable effective engagement of cultural issues.
- Develop concept of culturally informed practice incorporating a process of humble inquiry and learning that allows clients to assume the role of teacher.
- Psychiatrists should ensure that service plans are determined in the context of individual cultural influences.
- Increased awareness of disparities created by discrimination based on cultural identification and misunderstanding.

Supplementary Material

Lim, RF: *Clinical Manual of Cultural Psychiatry*. American Psychiatric Publishing, Inc., Washington, D.C., 2006

Collaboration in Medication Management

Issues

The management of medication has become the major focus of most psychiatrist-service user (consumer/family member) interactions. Typically, the psychiatrist has been the dominant agent in making decisions about medication. Service users are often reluctant to speak assertively about their preferences and concerns about the medications they are prescribed. Often service users do not feel adequately informed. With limited investment in medication planning, adherence is often poor. Psychiatrists frequently have limited communication with other service providers (team members) working with their clients, and coordination between them and primary care physicians is poor in most cases.

Recommendations

- Foster greater investment in medication plan through increased participation, education, and empowerment of consumers.
- Encourage simplified and evidence-based prescribing patterns by expanding length of contacts and improving skills in non-pharmacologic interventions.
- Recognize primacy of consumer choices in creating medication plans, and encourage wise decisions through educational activities.
- Train consumers to be assertive in discussing options, asking questions of their psychiatrist, and enlisting support of clinical team for medication concerns.
- Engage in team-building activities that define a collaborative role for all members in creating medication plans.
- Coordinate care with Primary Care Providers and invest greater attention in physical health concerns, medication interactions, and management of side effects.

Supplementary Material

Sowers, WE, Golden, SA: *Psychotropic Medication Management in Persons with Co-occurring Psychiatric and Substance Use Disorders.* Journal of Psychoactive Drugs, Vol. 31 (1) March, 1999

Psychiatric Rehabilitation

Issues

Although rehabilitation psychiatry has embraced recovery-oriented practice for quite some time, it has obtained very little recognition or interest within the psychiatric establishment. It has not been featured in training programs, and many psychiatrists would be hard pressed to discuss what it is, let alone how to use it. The terminology and practice of "rehabilitation" is frequently misunderstood and has a pejorative connotation for some people; it is seen as a warehouse for disabled "patients." The implications of disability and the benefit system discourage the goals of rehabilitation, which include a return to productive life (i.e., home, school, work). Psychiatrists often lack skills and understanding of the paradigm that is needed to work effectively in the rehabilitation context.

Recommendations

- Training programs should establish a prominent role for psychiatric rehabilitation programs as clinical sites for exposure to recovery-oriented practice.
- Define psychiatrists' role in the rehabilitation process clearly, and expand awareness of the functions of these services.
- Create an enhanced identity for rehabilitation stressing resilience, recovery, productivity, and creativity.
- Initiate discussion of new terminology to destigmatize rehabilitation, such as "capacitation."
- Systems must support the rehabilitation model by providing adequate resources.
- Advocate for reform of disability support system that encourages return to productivity.
- Promote rehabilitation model to guide transformation processes.

Supplementary Material

AACP: Psychiatric Rehabilitation: Issues and Answers for Psychiatry 2000
www.communitypsychiatry.org

Liberman, RP, Silbert, K: Community Re-entry: Development of Life Skills. Psychiatry (68)3, 220-229, 2005

Person-Centered Service Planning

Issues

Currently, systems of care are fragmented and poorly coordinated. Psychiatrists have not generally been seen as helpful in overcoming the obstacles to person-centered planning, and there is a lack of clarity about what it is. Psychiatrists are rarely directly involved in planning processes, and are often relegated to providing little more than a signature. Their orientation is often problem/illness focused, and they are not well oriented to strength-based thinking, stage of change informed planning, or to collaborative decision making. They often see this as a process that adds to their documentation burden.

Recommendations

- Training should emphasize development of skills for effective engagement and collaboration with service users in the planning process.
- Place emphasis on the primacy and value of the service plan as a treatment contract and the role the psychiatrist has in it.
- Place focus on strengths, hopes, and autonomy in collaborative planning.
- Provide leadership in moving toward standardization of planning process across programs and levels of care so that the plan is one that the consumer truly owns and carries.
- Systems must provide opportunities for psychiatrists to participate in planning processes without creating additional burdens.

Supplementary Material

Adams N, Grieger DM: *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*. Elsevier Academic Press, Burlington MA 2005

Sowers, WE: LOCUS M-POWER Planner. Deerfield Behavioral Health, Inc. 2006 www.locusonline.com.

Recovery-Oriented Practices

Issues

Most psychiatrists have been trained in a culture that has embraced a medical model of service delivery in which physicians occupy a position of authority and are the primary decision makers. This has made it difficult for many to adopt a more collaborative approach in their practice. The psychodynamic tradition also supports a degree of distance in relationships that creates barriers to developing partnerships. Current funding arrangements and large caseloads create environments that discourage the formation of meaningful relationships between consumers and psychiatrists and participation by psychiatrists in a broad array of clinical management issues that promote recovery. Training programs have not

yet incorporated recovery-focused practices into their curricula, and research has maintained its focus on the brain rather than services.

Recommendations

- Training programs should incorporate recovery-enhancing practices into curricula at all levels and across all rotations.
- Continuing education opportunities related to recovery-focused practice should be strongly encouraged and should include opportunities to interact and to have dialogues with service users in non-clinical settings.
- Emphasize development of ability to recognize recovery-oriented practices and how to measure them.
- Establish leadership role in advocating for systems reform and recovery-enhancing services, emphasizing consumer satisfaction and service.
- Assume active role in developing a collaborative relationship with clients and developing recovery partnerships.
- Systems should support integrated services (breakdown silo organization) and consumer choice in service selection.
- Systems should develop creative alternatives to current funding mechanisms and develop methods to extend psychiatrists' capacity to have adequate time with clients and to expand their focus from medication management.

Supplementary Material

AACP Guidelines for Recovery-Oriented Services. 2002
www.communitypsychiatry.org

AACP ROSE (Recovery-Oriented Services Evaluation). 2003
www.communitypsychiatry.org

Transition Management

Issues

Communication between clinicians and agencies involved in transition plans is poor in an egregiously fragmented system of care. There are significant discontinuities in planning and assessment. Relationships between the psychiatrist and the service user are frequently transient, and usually do not survive transitions from one level of care to another. There is a lack of quality standards to govern transitions and adequate monitoring of these processes. As a rule, reimbursement arrangements are not aligned in a way that provides incentives for investing energy into the transition process. Training programs generally pay very little attention to this area of clinical practice.

Recommendations

- Emphasize adoption of recovery-focused practices that would dictate the use of adequate supports, and employ continuous elements in transition planning.
- Develop quality and performance standards to guide transition processes and to help establish accountability.
- Training programs should include attention to service management in general and transition management in particular, emphasizing individual needs and the stress of transitions.
- Structure funding arrangements in a manner that will reduce abrupt transitions and support continuity in care.
- Design systems to meet needs of service users, rather than the needs or convenience of organizations.
- Create opportunities to preserve long-term relationships between psychiatrists and their clients.

Supplementary Material

AACP Continuity of Care Guidelines: Best Practices for Managing Transitions Between Levels of Care. 2001 www.communitypsychiatry.org

AACP/AAAP Joint Task Force: Continuity of Care Guidelines for Addictions and Co-occurring Disorders. 2001 www.communitypsychiatry.org

Integrated Care of Addiction and Mental Health Issues

Issues

Most psychiatrists have limited training in or knowledge of addictions and their treatment. As is the case for many others in our society, stigma influences their perceptions of persons with addictive disorders and clinical interactions with them. Most psychiatrists are not proficient in motivational and recovery-oriented practices, and tend to have an overly biological focus. The systems they work in often lack integrated perspectives or capability. There is a lack of parity in reimbursement of substance use disorders, and limited availability of qualified providers treating co-occurring disorders.

Recommendations

- Psychiatry should have a significant role in developing standards of competence and excellence for programs and professionals treating co-occurring disorders.
- Training programs must expand exposure of trainees to persons in successful recovery in the community and to recovery concepts and principles, emphasizing engagement skills.

- Incorporate non-judgmental, motivational, recovery-focused therapy and change management techniques into psychiatric practice.
- Enhance skills related to collaborative medication management and knowledge of interactions between mental health and substance use.
- Establish integration as the guiding principle for the treatment of interacting illnesses, using the recovery paradigm as the bridge between treatment cultures.
- Reorganize funding mechanisms to create parity of coverage in behavioral health and support integrated services.
- Expand the role of psychiatrists in addiction treatment and their exposure to it in training.

Supplementary Material

AACP Principles for the Care and Treatment of Persons with Co-occurring Psychiatric and Substance Use Disorders, 2000 www.communitypsychiatry.org

AACP Position Statement on Program Competencies in a Comprehensive Continuous Integrated System of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders, 2001 www.communitypsychiatry.org

Engagement of Children and Families

Issues

Families and their youth affected by mental illness often have a hard time accepting that problems exist and often feel lost and stigmatized by a diagnosis. They feel that they need more contact with the psychiatrist. Anti-psychiatry advocates disparage screening and medication and believe psychiatrists are pushing a dangerous agenda. Psychiatrists are often seen as aloof and not connected in a human way. Parents often feel they are to blame, and that may be reinforced in their interactions with psychiatry. Youth are turned off by the perceived arrogance of psychiatrists who rush to take action before they have been able to establish a trusting relationship. There are not nearly enough child and adolescent psychiatrists.

Recommendations

- Join with parents in advocacy efforts; facilitate mutual support and education on emotional disturbances in children.
- Encourage and empower youth, enabling them to speak for themselves in administrative and policy settings regarding the care they receive and how to improve it.
- Expand opportunities to support families and their youth as they engage in dialogues about their fears and concerns.
- Expand involvement with schools and establish presence in the community.
- Employ resiliency-building approaches, empowerment, positive reinforcement, curious inquiry, and non-judgmental interactions in the context of long-term relationships.

- Enhance skills in non-pharmacological approaches to address mental health issues with emphasis on relationship building.
- Prevention activities should be given greater focus, creating opportunities for early identification and intervention.

References

AACP: CALOCUS 2002 (Child and Adolescent Level of Care Utilization System) www.communitypsychiatry.org

ACCR: Guidelines for Developing Resiliency and Recovery-Oriented Behavioral Health Systems for Children and Families, 2006 www.coalitionforrecovery.org

Incorporating Spirituality

Issues

Spirituality is ill defined for most psychiatrists and is often considered only in the limited context of religious practice when it is considered at all. There has been little communication between psychiatrists and religious communities or spiritual leaders (i.e., clergy). Psychiatrists receive little training related to religious cultures or how to use them for clinical benefit. The impact of faith on healing and recovery is not well recognized.

Recommendations

- Define the dimensions of spirituality/religion as they apply to emotional life and function and their relevance to psychiatric practice.
- Increase interaction between psychiatrists and religious communities on both personal and professional levels.
- Incorporate religious/spiritual inquiry into practice (spiritual competence).
- Revitalize concept of existential healing in psychiatry with focus on the purpose and meaning of life and suffering.
- Incorporate awareness of the role of spiritual/religious values in training related to recovery processes, with exposure to effective models of practice.

Supplementary Material

The Royal College of Psychiatrists, Spirituality and Mental Health http://www.rcpsych.ac.uk/mentalhealthinformation/therapies/spiritualityandmentalhealth.aspx

End-of-Life Care

Issues

Discussions of death are often avoided in our society and in our profession. Participation in the dying process is foreign to our common experience, usually taking place outside our homes, exported to other venues. Although our ultimate transition is from life to death, psychiatry (typically concerned with transitions) has not been a significant force in helping people to address issues of choice related to the time and circumstances of their death or the preparation of individuals and family members for death. Likewise, the role of psychiatry has been limited in ensuring adequate palliative care. Consultation liaison and geriatric psychiatry have not been involved adequately in activities related to death.

Recommendations

- Clarify end-of-life issues that psychiatry ought to be involved with.
- Trainees should be exposed to end-of-life issues and counseling to allow the development of skill and comfort in this area. (Incorporation into consultation-liaison and geriatric psychiatry experiences.)
- Knowledge of pain management, palliative care, hastened death, and end-of-life choices should be part of psychiatric skill set.
- Work with communities to build awareness and comfort in addressing end-of-life issues.
- Advocate for a legislative agenda that ensures the exercise of end-of-life rights and choice.
- Develop skills to address end-of-life issues when children are involved.

Supplementary Material

Smith, DM, Pollack, D: *A Psychiatric Defense of Aid in Dying*. Community Mental Health Journal, Vol. 34, No. 6. December 1998

Homelessness and Housing

Issues

Homeless populations are often difficult to engage, and skills for doing so are not well developed among practicing psychiatrists. Approaches to housing are often too rigid in how they assess “readiness” and do not consider the wishes of persons being housed. A partial consequence of this is that a full range of housing options is not often available, creating mismatches that are not conducive to stability. The distinction between chronic homelessness and persons who are temporarily homeless is not well made, resulting in some inappropriate services in many cases. Funding for outreach and non-traditional services is inadequate and inflexible.

Recommendations

- Training programs must develop better understanding of the spectrum of homeless persons, their needs, and the engagement skills needed to assist them.
- Create a services research agenda to better understand the continuum of housing opportunities that lead to success in housing stability and rehabilitation across the heterogeneous homeless population.
- Recognize importance of providing housing as the very first step in rehabilitation and as entree to recovery.
- Advocacy for flexible housing options and adequate and sensible funding.
- Educate the community regarding homeless populations and the mutual benefits of humane responses to homelessness.
- Provide opportunities for psychiatrists to work in underserved, non-traditional settings where they may engage in outreach activities and promote recovery concepts among homeless persons.
- Create meaningful and measurable service outcomes for outreach and other programs serving homeless people.
- Take responsibility for ensuring adequate transition planning.
- Educate the community regarding homeless populations and the mutual benefits of humane responses to homelessness.

Supplementary Material

AACP: *Clinical Guide to the Treatment of the Mentally Ill Homeless Person.* Gillig, PM, McQuistion, HL Editors, American Psychiatric Press, Inc. Washington, D.C., 2006

AACP: Position Statement on Housing Options for Individuals with Severe and Persistent Mental Illness, 2001 www.communitypsychiatry.org

Section III: Transformation of Advocacy

Political Advocacy

Issues

Advocacy efforts in the behavioral health community have not been well coordinated, and there has been no unified agenda from behavioral health stakeholders. The role of psychiatry in broad political agendas has not been clear, nor has there been significant consensus on these issues. Although the medical profession still retains a degree of credibility in the public's mind, there has been a failure to capitalize on these perceptions to facilitate change, or to strengthen the profession's credibility through wise advocacy choices.

Recommendations

- Create dialogues around a psychiatrist's ethical obligation to engage with communities.
- Define roles and methods for psychiatry's participation in both accommodative (i.e., resisting restrictions on necessary care) and transformative advocacy (i.e., reform of health care financing)
- Create agenda for both individual (assistance to individual clients) and professional advocacy (guild interests and social interests) based on ethical principles.
- Use opportunities to engage in activities that influence the discussion of controversial issues and form collaborative partnerships for change.
- Advantageous use of perceptual capital from the public to create forums for discussion and influence policy.
- Activate and inform constituents while strengthening liaisons with advocacy organizations.

Supplementary Materials

AACP: Position Statement on the President's New Freedom Commission, 2003
www.communitypsychiatry.org

AACP: Position Statement on the Representative Payeeships, 2002
www.communitypsychiatry.org

Stigma Reduction

Issues

Psychiatry has not modeled destigmatization well. The predominant culture has been one in which "patients" are often considered to be "different," and it has encouraged the creation of separation and distance in relationships. As a profession psychiatry has had a small role in addressing stigmatization in the general public, and has failed to address stigma existing within psychiatry, particularly attitudes related to specific populations (i.e., substance users, homeless, GLBTs). Psychiatry has not confronted its own biases sufficiently and has been lethargic and minimally effective in addressing public misperceptions related to behavioral health problems.

Recommendations

- Develop effective collaborations with anti-stigma efforts to create "normalization" and move toward parity.
- Recognition of recovery as a universal concept (everyone has something to recover from) and celebrate successes in recovery.
- Encourage psychiatrists and other physicians to engage in frank and unashamed discussion of personal experiences with behavioral health issues.
- Confront stigma within the profession and develop educational opportunities to enable honest self-examination of biases and attitude change.

Supplemental Material

ACCR: Hope and Change: Universality of Recovery Booklet, 2007
www.coalitionforrecovery.org

Prevention and Resiliency Building in Communities

Issues

Psychiatry has not been significantly concerned with prevention and/or the capacitation of communities, distressed or otherwise. There has not been a forum for, or significant interest in, thinking about the mental health *of* communities in addition to the treatment of behavioral health problems *in* communities. By failing to develop and integrate public health concepts, psychiatry has not contributed to the capacity of communities to support those in need and to reduce stress- related mental health and substance use problems. There has been little discussion or examination within the profession of the inequities contributing to the decline of communities or the social costs associated with it.

Recommendations

- Incorporate a public health perspective into training programs.
- Develop knowledge base and research agenda for defining elements of community health, risk factors, and preventive interventions.
- Provide consultation to communities and assistance in developing culturally appropriate safety measures and strong institutions.
- Develop collaboratives that build upon the strengths and wisdom of communities, providing support and advice to empower the communities and experience to enhance the knowledge of professionals.

Supplemental Material

Prevention Institute: http://www.preventioninstitute.org/mental.html

Disaster Preparedness

Issues

There is limited involvement and connection to disaster preparations in the psychiatric community. Psychiatrists are not routinely trained in the basics of crisis assistance and working with the long-term consequences of trauma as well as its impact on those who respond to it and provide assistance. In the event of disaster, psychiatrists need to have awareness of how to care for themselves as well as the community. There is little awareness of how cultural, ethnic, religious, and socio-economic differences affect disaster planning and responses.

Recommendations

- All psychiatrists should become familiar with the basics of disaster care and local disaster plans.
- Psychiatrists should be involved in disaster planning, establishing standards of care in disasters, public education, professional education, and local relief corps.
- Psychiatrists should become familiar with psychiatric first aid, self-care, and helper care issues.
- Systems should support and encourage involvement of psychiatrists in disaster preparedness.
- Place focus on populations most likely to be overlooked and underserved in the event of a disaster, and facilitate the representation of these populations in the planning process.
- Psychiatrists should take an active role in creating connections to the community to raise awareness, alleviate fears, and dispel fear mongering.

Supplemental Material

Ng, A.T. *The Helper Who Needed Help*. Psychiatric Issues in Emergency Care Settings, 2005 4(2):19-22.

Ng, A.T. *The Role of Emergency Psychiatry in Disaster Management*. Psychiatric Issues in Emergency Care Settings, 2004 3(1):20-26.

Health Disparities

Issues

There has been some confusion in the understanding of the scope of the term "health disparities" with regard to whether it should be limited to considerations of disparities in access to health services or whether it must consider disparities in health status more broadly. A variety of factors related to social class affects health status of populations—service access being one among them. Psychiatrists, when considering this problem at all, have largely focused on services. A broader agenda for addressing disparities has not been developed, and improving access will not be sufficient in itself to correct social inequities that lead to increased vulnerability in distressed communities.

Recommendations

- Clarify distinctions between health status and health services disparities, and create an agenda for practice and advocacy based on public health principles.
- Create frameworks for working with distressed communities and strengthening their resilience.
- Embrace public health and prevention perspectives, and develop partnerships with communities to promote health.

Supplemental Material

Lim RF, Lu FG, Hilty DM: The Impact of Social Inequalities on Health Care. In *Behavior and Medicine, 4th Edition,* edited by Wedding D, Stuber ML, Hogrefe and Huber, Cambridge, MA, 2006, pp. 287-299.

Post E, Cruz M, Harmann J: *A trial of incentives to improve depression therapy appointment adherence among low-income African Americans*. Psychiatric Services 57(3):414-416, 2006.

Engaging Consumers, Supporting Peer Support

Issues

Few psychiatrists have taken an active role in engaging and working with the recovery community. The value of peer counselors on clinical teams or of peers informally sponsoring persons in recovery is not widely accepted or promoted by the psychiatric community. Psychiatrists are often unaware of how to help clients make connections to peer support and do not recognize it as an important part of the service plan.

Recommendations

- Clarify roles of psychiatrists in collaborative relationships with consumers.
- Enhance psychiatrists' awareness of the role of mutual support in recovery processes.
- Promote incorporation of peer support in service planning.
- Create opportunities for consumers to enhance skills as peer counselors and participate in consumer education and support training.

Supplementary Material

Peer Support and Advocacy Network: http://www.peer-support.org/

Integrated Systems of Care

Issues

Recognition of the Systems of Care model for child and adolescent services is slight, even among child and adolescent psychiatrists, and this type of thinking is rare among adult psychiatrists. As a public sector concept, training programs have not embraced it. There has been a significant degree of resignation to fragmentation in service delivery. Most attention that has been expended on this issue has been around working through the many obstacles that fragmentation creates rather than creating coherent systems.

Recommendations

- Advocate for strengthening collaboration with all influences and services (i.e., education systems, primary care) through integrative processes.
- Develop creative solutions (i.e., telepsychiatry) to expand application of SOC principles in diverse settings.
- Develop capacity to provide services/support to caregivers through the adult system.
- Shift focus of training and practice to prevention, systems design, and resiliency building.
- Incorporation of systems-of-care models into child and adult training programs.

- Use Systems of Care concepts as templates for transformation initiatives.

Supplementary Material

Pumariega, AJ, Winters, NC Editors *The Handbook of Child and Adolescent Systems of Care* Jossey-Bass, San Francisco, 2003

Section IV: Transformation of Systems of Care

Systems Transformation

Issues

Psychiatry has had a limited role in transformation initiatives and has not defined the role that it should have in any clear way. Rather than setting the course for change, psychiatry has often seemed to be a reluctant follower. Psychiatry has not often modeled practice consistent with recovery principles. Leadership in this area has been feeble and does not inspire change. Systems are being rebuilt with processes informed by recovery principles, but without significant input from frontline public psychiatrists.

Recommendations

- Incorporate recovery-enhancing practices into clinical psychiatric practices.
- Develop processes and clinical tools that support recovery-focused practices.
- Systems serious about transformation must create cultures of inclusion that value all inputs (including psychiatry) and make them possible.
- Advocate for parity, increase in behavioral health resources, and appropriate incentives to enable system development.
- Training in leadership and systems-oriented thinking.
- Emphasize outcomes, how they should selected, and how they may be achieved incorporating evidence-informed thinking.
- Training is paramount; psychiatrists must become knowledgeable about recovery principles.

Supplementary Material

Institutes of Medicine: *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, 2005
www.iom.edu/CMS/3809/19405/30836.aspx

Community and Systems Consultation

Issues

Few psychiatrists possess appropriate skill sets to provide consultation to communities and service delivery systems. The value of consulting psychiatrists is not always clear to those in need of it, and psychiatrists do not always understand their role in consulting situations. Although there are a few psychiatrists who are valued as “foreign experts,” systems are generally reluctant to involve local expertise. Training has provided very little assistance in preparing psychiatrists to take on this role. Leadership skills, though necessary, are not well developed to allow psychiatrists to be successful in these roles.

Recommendations

- Articulate the role and scope of psychiatry in consultation.
- Develop skills for consultation as part of leadership training, problem solving, mediation, and systems focus.
- Create job descriptions that support consultation opportunities.
- Provide significant consultation opportunities in training programs.
- Assist system administrations in understanding the value of using psychiatrists and local expertise for consultation needs.

Supplementary Material

Cutler, DL, Huffine, C: *Heroes in Community Psychiatry: Professor Gerald Caplan*. Community Mental Health Journal, 2004 Vol. 40, No. 3, pp 193-198

Access in Rural Communities

Issues

It has been difficult attracting psychiatrists to rural areas for a variety of reasons. Many have little idea of what rural practice might be like and hold a stereotypic view of rural communities. There is in many cases significant isolation for psychiatrists practicing in rural areas with few opportunities for professional interactions or teaching. Providing good care may be hampered by a lack of awareness of cultural aspects of rural living. Inadequate resources have been made available to extend the capacity of more psychiatrists to provide care to those in rural settings.

Recommendations

- Create academic partnerships with rural areas that could include exposure for trainees, designated faculty positions, fellowships, mentors, and continuing education.
- Develop psychiatric extenders, mobile services, and tele-psychiatry in ways that are financially sound.
- Create networking opportunities, shared coverage arrangements, and telephone and/or web-based consultation opportunities.
- Develop creative collaborations with primary care providers, clergy, and educators.
- Develop financial, lifestyle, and professional incentives to recruit and retain psychiatrists in rural settings.

Supplementary Material

AACP: Position on Access to Psychiatric and Psychopharmacology Services in Underserved Areas, 2007 www.communitypsychiatry.org

Rural Institute: Rural Facts; Rural Mental Health, http://rtc.ruralinstitute.umt.edu/MentalHealth.htm

Correctional Psychiatry

Issues

In light of the large number of persons with behavioral health problems involved in the criminal justice system, there has been little linkage between the criminal justice system and community providers. Psychiatry is no exception, and jails and prisons have not always been recognized as an unfortunate but critical component of the community rather than being separate from it. The role of psychiatry in relation to criminal justice personnel has not been clear, and there has been a reluctance to create connections between them, although there are appreciable commonalities in the goals of their activities. Psychiatrists have not done a good job of considering the impact of criminal justice involvement and associated experiences (i.e., trauma) in clinical practices. Psychiatrists have not confronted their personal biases with regard to this population and how it affects their involvement with persons who have been incarcerated.

Recommendations

- All psychiatrists should be familiar with correctional systems and have some exposure to working with clients in these settings.
- Training and practice should emphasize community forensics rather than forensic evaluation and testimony, as well as the use of evidence-based practices that support successful outcomes in the community.
- Psychiatry should develop formal and informal collaborative relationships with law enforcement, the judiciary, and correctional staff on all levels and promote and participate in cross-training initiatives.
- Develop strategies to break through “silo” organization of services to promote continuity of care, communication, and smooth transitions to the community.
- Facilitate peer support opportunities for persons re-entering the community and for the creation of a welcoming environment for community services.
- System must develop creative ways to support these activities through development of blended funding, expedited access to benefits, housing options, diversion programs, and information sharing.
- Advocate for alternatives to incarceration, adequate funding, continuity of care, and prevention. Raise awareness of how these measures will benefit everyone.
- Promote services that are spiritually and culturally informed, recovery based, and sensitive to traumatic experiences.

- Develop a quality and research agenda for services provided to persons with criminal justice involvement.

Supplementary Material

AACP: Position Statement on Persons with Mental Illness Behind Bars, 2001
www.communitypsychiatry.org

AACP: Position Statement on Post-Release Planning, 2001
www.communitypsychiatry.org

Quality Improvement

Issues

Most psychiatrists lack familiarity with quality management principles and have had little participation in quality processes or peer review. Quality standards for psychiatric practice are not well developed beyond medication management. Too often, emphasis has been on adopting practices designed to meet regulatory requirements rather than create change or improve the way services are delivered. Systems have not been creative in finding ways to allow psychiatrists to participate in quality-related activities.

Recommendations

- Create a quality culture and identity through training in quality management principles along with continuing education, supervision, and specific quality project consultation opportunities.
- Advocate for meaningful quality processes within agencies that include psychiatrists and consumers and that facilitate a grassroots approach to improvement processes.
- Develop quality standards that are relevant and practical for community psychiatry and allow for professional accountability.
- Enhance peer review processes through which psychiatrists can establish benchmarks and self-monitoring practices.
- Systems must create opportunities for involvement and develop plans for meaningful participation of all stakeholders to ensure that the definition of quality is relevant to all constituencies.
- Develop financial supports and recognition for maintaining quality practices and create appropriate incentives for learning, excellence, and ongoing changes in practice as evidence dictates.

Supplementary Materials

AACP: Position Paper on Standards of Quality Management in Implementing Public Sector Managed Care Systems, 1999 www.communitypsychiatry.org

ACCR: Consumer-Oriented Continuous Quality Improvement Guidelines, 2000 www.coalitionforrecovery.org

Resource-Need Matching

Issues

Discontinuous and fragmented systems of care allow clients to fall through the cracks without having their needs adequately addressed. Inefficient use of resources leads to poorer outcomes and ultimately increased expense. Payment determines services in many cases, rather than quality. Psychiatrists and other providers have not used rational systems to make decisions regarding intensity of service, so these decisions have been idiosyncratic, highly variable, and inconsistent. This has resulted in the imposition of external resource management, which is in no one's best interest, except perhaps those who profit from it.

Recommendations

- Psychiatric training must include systems management and financing, and exposure to clinical tools that balance clinical needs and applied resources (i.e., LOCUS, ASAM).
- Increase understanding of addictions and appropriate services to address them in the context of stage of change and severity of disability.
- Use available tools to manage resources and level of care decisions to ensure consistency, efficiency, and equality in service provision.
- Advocate for the rational and accountable use of public resources, creating rational incentives to enhance quality and raising awareness that access to needed services ultimately benefits everyone.
- Recognize and promote the importance of providing care, early intervention, and prevention services to all who need them, not only to those with severe illness.
- Facilitate consumer involvement in selecting the services consumers want in the context of available resources.
- Expand knowledge of outcome data, cost of care, and evidence-based interventions to inform practices.
- Provide leadership in implementation of balanced and uniform processes to guide resource-need matching that is inclusive of all stakeholders.

Supplementary Material

AACP: LOCUS (Level of Care Utilization System for Psychiatric and Addiction Services), 2000 www.communitypsychiatry.org

AACP: CALOCUS (Child and Adolescent Level of Care Utilization System), 2002 www.communitypsychiatry.org

AACP: Principles for Defining Medical Necessity in Mental Health Treatment, 2000 www.communitypsychiatry.org

Primary Care

Issues

There is currently minimal interface with primary care physicians or integration of physical health and behavioral health care. Current methods for financing health care create barriers to integration. Integration requires an expanded skill set that most psychiatrists have been reluctant to try to master. As a result they have had limited comfort in managing physical health issues, although they frequently have the strongest relationship with the service user.

Recommendations

- Psychiatric training should provide experiences in primary care settings and encourage management of uncomplicated physical health problems.
- Create funding mechanisms to support service provision in primary care settings.
- Psychiatrists should be involved in supervision of primary care physicians (PCPs) managing behavioral health issues.
- Develop conduits for communication and collaboration with PCPs.
- Public education in primary care settings; reduce shame and reluctance to seek treatment.
- Develop four models of integration, cross-overs (providing care in primary care or psychiatric setting), integration, and collaboration.

Supplementary Materials

AACP: Position Paper on the Interface and Integration with Primary Care Providers, 2002 www.communitypsychiatry.org

Research, Outcomes, and Evidence-Based Practices

Issues

The primary research agenda has focused on biological investigation, and funding for service-focused investigation is more difficult to obtain. Outcomes have been defined by academics in many cases, rather than persons receiving services. The current treatment culture sees the evaluation process as burdensome rather than useful. While the recent movement toward identification of evidence-based practices attempts to address these issues in some ways, the rigidity and constriction of practice suggested by narrow definitions of evidence make many psychiatrists uncomfortable. More "testable" practices (such as medication management) are more likely to achieve an evidence base.

Recommendations

- Create a relevant research agenda and expand funding for service-focused and qualitative investigation of recovery-oriented practices.
- Promote person-centered outcome (quality of life) measures development and create collaborative relationship with service users for this purpose.
- Promote evidence-informed practices in psychiatry as method to improve the quality of care.
- Initiate discussions on the nature of evidence and create opportunities for successful practices to inform research agenda.

Supplemental Material

AACP Position Statement on Implementation of Evidence-Based Practices, 2006
www.communitypsychiatry.org

Frese, FJ, Stanley, J, Kress, K., & Vogel-Scibilia, S. *Integrating evidence-based practices and the recovery model,* 2001 Psychiatric Services, 52(11), 1462-1468.

Conclusion

The issues and recommendations contained in this report are wide ranging and, in some cases, controversial. There will be some readers who will take issue with what they may see as unfair or inaccurate criticism. As noted earlier, the guiding principle in compiling this document has been inclusiveness, ensuring that all significant viewpoints are heard and considered. If some of the observations or opinions contained herein are provocative, the hope is that psychiatrists, and others interested in transformation of behavioral health systems of care, will be stimulated to examine their circumstances in ways that they might not have considered otherwise. Whether the assertions under consideration are accepted or rejected is less important than the fact that they have been scrutinized and that we have been pushed to see things in a new light.

Clearly, whenever people are considered collectively, the descriptions obtained will not apply equally to all individuals in the group, and for some, they may not apply at all. It is of less concern that the report accurately describes all elements of the profession and possible exceptions to the generalized comments contained in the report than it is that it provides a vision for what psychiatry should be, and what its role in the broader issues around system transformation ought to be. With this perspective in mind, this report should provide a useful starting point for consideration of new initiatives in training, leadership, advocacy, and scholarship in psychiatry.